APA Resource Document

Resource Document on Ethics at the Interface of Religion, Spirituality, and Psychiatric Practice

Approved by the Joint Reference Committee, April 2021

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Introduction

Historically, psychiatry has had a fraught relationship with religion. One example can be found in the writings of Sigmund Freud, who was dismissive of religion and viewed it as a form of mental illness, drawing parallels between the rituals of obsessional patients and those of very religious people (Breakey 2001). However, there are also works throughout history demonstrating the harmonious relationship between psychiatry and religion, suggesting that the notion of an adversarial relationship between the two may not be a complete picture (Frankl 1975, Meissner 1984, Meissner 1987).

Our conceptions of disease and the field of psychiatry in general have changed significantly since Freud; however, the interface of religion, spirituality, and psychiatry remains a topic of interest and importance. Indeed, the search for meaning is a universal theme for religion, philosophy, and psychiatry alike. Although there is not one universally accepted definition of religion or spirituality, religion is often considered to be the system of beliefs and practices related to the sacred or divine, with basic tenets rooted in historical context and held by a community or social group (Psychiatric Clinics of North America 2007, WPA 2016). The word “spirituality” is sometimes used interchangeably or in lieu of “religion.” However, spirituality is broader in scope than religion: while religion is often seen as the institutional aspect of spirituality, spirituality “refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred” (Puchalski 2009). Spiritual practices can take on many forms, including private prayer, belonging to a faith tradition, ritual and symbolic practices, reading scripture, yoga, meditation, quiet reflection, listening to music, playing games, acts of compassion, and taking long walks.

There are a few notable documents that address this topic. The first is the American Psychiatric Association (APA)’s 1989 *Guidelines Regarding Possible Conflict Between Psychiatrists’ Religious*

Commitments and Psychiatric Practice published by the APA Committee on Religion and Psychiatry. These guidelines were revised in 2006 by the APA Corresponding Committee on Religion, Spirituality and Psychiatry and retitled as the *Resource Document on Religious/Spiritual Commitments and Psychiatric Practice*. The Royal College of Psychiatrists published a position statement in 2013 entitled *Recommendations for psychiatrists on spirituality and religion*, and the World Psychiatric Association also published a *Position Statement on Spirituality and Religion in Psychiatry* in 2016. These documents convey several well-agreed upon principles. For example, psychiatrists should maintain respect for their patients' beliefs, and if an unexpected conflict arises in relation to such beliefs, it should be handled with concern for the patient's vulnerability. Likewise, psychiatrists should not impose their own religious, nonreligious, or antireligious beliefs (i.e., proselytize) in their interactions with their patients (APA 1989, APA 2006, Royal College of Psychiatrists 2013, WPA 2016).

Although these basic principles remain valuable and important, additional dimensions of the relationship between religion, spirituality, and psychiatric practice deserve attention. For example, from the patient's perspective, those with strong spiritual and religious beliefs sometimes feel misunderstood or even judged by their psychiatrist. They question why their psychiatrist is neglecting their spirituality and religion when formulating their mental health concerns and initiating treatment. On the other hand, psychiatrists may question the extent to which they can ethically engage in exploring and understanding the religious and spiritual beliefs of their patients, and how to best integrate such beliefs into patient care.

The question becomes, where and how do the tenets of religion and spirituality intersect with the biopsychosocial model of modern psychiatric treatment in psychotherapy, in psychiatric research, and even in the use of psychiatric medications? As such, the APA Ethics Committee has written this Resource Document to expand upon current resources, with the aim of providing clear guidance for the ethical psychiatrist in relation to the religious and spiritual aspects of patient care.

Patients' Perspectives

Religion and spirituality help many people to conceptualize their life experiences, values, beliefs, and behavior (Abernethy 1998). A majority of patients report that religion is important to them (Verhagen 2010), and many individuals seek mental health treatment to address issues that may have a spiritual dimension such as hope, identity, purpose, meaning, and morality (APA 2006). Therefore, perhaps not surprisingly, studies have shown that the majority of patients want their health care providers to inquire about their religious and spiritual beliefs and to incorporate them into their treatment (Cook 2013). However, given the lack of training in how to talk about religion and spirituality in psychiatric treatment, coupled with the history of tension between religion and mental health care, many providers have historically avoided the subject (Moreira-Almeida 2014).

There are circumstances when religion and spirituality may cause harm to a patient. For example, patients may avoid beneficial treatments when they conflict with their religious beliefs. Patients may also view their decision to enter into psychiatric treatment as evidence that they are failing to trust God or consider their mental health symptoms as evidence of moral weakness (René 2011, WPA 2016, Cook 2013, Curlin 2007). Other patients may seek types of treatment that are known to be harmful (e.g., conversion therapy), or use their religious beliefs to impel suicide, violence, and self-neglect. These beliefs may also be used to justify undue suffering, such as abuse by partners or parents (Cook 2013, Griffith 2010, Moreira-Almeida 2014, WPA 2016). A depressed patient's religious beliefs may also

exacerbate their feelings of self-blame and sinfulness (René 2011). There is clinical guidance available on how to respectfully interact with patients whose treatment may be endangered by their religious beliefs, and with those who have had religious beliefs imposed upon them (Griffith 2010).

Despite these possible negative effects of certain religious beliefs and practices, a vast body of literature supports the fact that religion and spirituality are usually associated with positive health outcomes (Moreira-Almeida 2014). Religion and spirituality can help patients to find hope, meaning, and purpose while trying to live with sometimes devastating psychiatric symptoms. In fact, more than 80% of patients report using their religious beliefs and practices to cope with social stressors and mental health symptoms (René 2011). Patients who report religious and spiritual beliefs have been found to have less depression, anxiety, suicide attempts, psychosis, and substance use disorders. In addition, religious and spiritual patients tend to experience a better quality of life, faster recovery from depression, and overall better psychiatric outcomes. For example, one study showed an association between attendance at religious services and a decreased depression risk and six-fold reduction in suicide risk (VanderWeele 2017). Other studies have similarly found improved psychotherapeutic outcomes when psychiatrists incorporate religious elements into their work with patients (René 2011). The influence of religion and spirituality on health and healing has been explicitly recognized by the APA. It, along with the American Psychiatric Association Foundation and the Interfaith Disability Advocacy Coalition (a program of the American Association of People with Disabilities), convened the *Mental Health and Faith Community Partnership* to foster collaboration and dialogue between psychiatrists and clergy to improve care for individuals facing mental health challenges by explicitly accounting for both medical and spiritual dimensions.[1] That partnership led to the 2018 publication of *Mental Health: A Guide for Faith Leaders*, which provides an overview of mental illness and treatment and offers recommendations for faith leaders in making referrals to mental health professionals and supporting the mental health of their congregations (APA Foundation 2018). Psychiatrists should also be aware of the literature supporting the advantages of active collaboration with clergy in the care of patients of all ages (see, e.g., Thiel 1997, Larson 1988, Weaver 2003, and Dell 2004).

Religion and spirituality are also often associated with social support networks and community resources. As evidenced by the success of Twelve Step Programs such as Alcoholics Anonymous, religious and spiritual communities can offer "stability, inspiration, and practical support" for individuals with mental illnesses (APA 2006) and addiction. Involvement in Alcoholics Anonymous consistently shows a modest positive relationship to post-treatment abstinence (Emrick, 1993). Similarly, Project MATCH, a spiritually-focused Twelve Step Facilitation therapy, yielded ten percent higher total abstinence rates compared to Cognitive Behavior Therapy or Motivational Enhancement Therapy (Project MATCH Research Group 1997, 1998). It can be particularly important for patients who face stigmatization, isolation, and victimization to maintain their religious affiliations and related community supports as part of their overall recoveries (René 2011).

Although patients with religious and spiritual beliefs tend to have better psychiatric outcomes, they are also at risk for feeling misunderstood or even judged by their psychiatrists. Some patients may find it difficult to trust their psychiatrists for fear that they will trivialize or suggest changing their religious beliefs (Curlin 2007). Other patients may be concerned that their psychiatrist may impose their own religious beliefs on them, or that their psychiatrist may make assumptions about their individual beliefs

[1] More information about the *Mental Health and Faith Community Partnership* is available at https://www.psychiatry.org/psychiatrists/cultural-competency/engagement-opportunities/mental-health-and-faith-community-partnership.

based on their religious affiliation (Moreira-Almeida 2014). These experiences are especially concerning given that many of our patients already face discrimination and prejudice in the community and have come to treatment seeking empathy and understanding.

Because spirituality and religion often play major roles in patients' lives and disease courses, increasingly psychiatrists are appreciating the importance of considering how religion and spirituality may be affecting their patients' health. The biopsychosocial model is one of the most widely-used approaches to conceptualizing a patient's mental health and related treatment. However, this model has been criticized for failing to consider religion and spirituality in patients' world perspectives and well-being. For this reason, some writers have advocated for the adoption of the bio-psycho-social-religious/spiritual model—where religion and spirituality constitute a fourth dimension—in order to provide additional context and move toward a more meaning-centered patient approach (Verhagen 2017). This newer model emphasizes the importance of integrating psychotherapeutic, pharmacotherapeutic, sociotherapeutic, and spiritual factors when taking a holistic approach to mental health care (René 2011). The bio-psycho-social-religious/spiritual model is also conducive to incorporating religious and spiritual considerations into assessment and treatment planning throughout the lifespan. Religion and spirituality are often important considerations in child development, family life, and all stages of adult development, especially in later years which may involve illness and end-of-life issues (Josephson 2004, Swinton 2012).

Recovery-oriented care in mental health care, which first gained popularity as a social movement in the late 1980s, focuses on the whole person (mind, body, spirit, and community) (SAMHSA 2012). Rather than solely focusing on symptom reduction and return to premorbid functioning, recovery is seen as a process or "journey" that supports the patient in finding a meaningful life (Jacob 2015). The principles of recovery are based on emotionally powerful concepts such as hope, meaning, purpose and respect and may tap into aspects that may have deep personal or spiritual connotations (Gomi 2014). As the model focuses on all facets of life, this may involve an exploration of the religious and spiritual beliefs for some patients. A "strength-based approach" can assist in supporting the patient in remaining hopeful, coping with stressors, or connecting with faith-based or spiritual communities through their faith, belief, and practices.

Cultural Sensitivity

Cultural sensitivity in health care involves the recognition of differences in cultural knowledge and identity, and it can be addressed at multiple levels, such as within health systems and institutions, training, models of care and patient intervention (Kirmayer 2012). Religion and spirituality are often major components of cultural identity; they are multidimensional constructs that can be expressed in many ways and can impact patients' health care decisions. These facets can include beliefs, rituals, conventions, views of God, ethical implications, mystical experiences, community or private religious practices, and sense of transcendental connection, among others (Moreira-Almeida 2014).

The cultural identities of both the patient and the psychiatrist might affect the way in which psychiatric concerns are described and evaluated. Cultural differences have the potential to hinder communication, the psychiatrist's ability to accurately diagnose mental health disorders, and the ability to develop a strong therapeutic alliance (Curlin 2007). Religious and spiritual practices can determine behavioral variables, such as alcohol consumption, use of substances such as cannabis, and patterns of sexuality, sleep, and diet that, in turn, influence physiological variables that directly impact a person's mental

health; for example, fasting can affect medication adherence (Whitley 2012). Another example is the role for faith communities in contributing to the well-being of LGBTQ+ youth, as noted in a recent publication from the Group for the Advancement of Psychiatry (GAP 2020). Psychiatrists who are familiar with these strategies are better able to assist faith communities in such efforts.

A psychiatrist's ability to consider the relevance of patients' religious and spiritual beliefs to the understanding, etiology, diagnosis, and treatment of psychiatric disorders, as well as to their patients' perceptions of mental illness, is paramount in providing patient-centered psychiatric care (WPA 2016). In fact, the National Institutes of Health states that awareness and attention to issues of cultural competency reduce health disparities and enhance clinical care by "enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients" (National Institutes of Health 2015). Prior literature also suggests that patients are more satisfied when psychiatrists account for their own frameworks of understanding distress and treatment (Huguelet 2009). This begins with a conscious effort on behalf of the psychiatrist to reconcile their own explanatory models with those of their patients.

The DSM-IV (APA 1994) initiated the diagnostic code V62.89 Religious or Spiritual Problem ("This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values that may not necessarily be related to an organized church or religious institution" (APA 1994 p. 685) to provide a non-pathological diagnostic category of distressing experiences involving religious or spiritual phenomena to facilitate the differential diagnosis of these phenomena and whether they are psychopathological or not. The DSM-IV also initiated the Outline for Cultural Formulation (Appendix I) where, in the section on "Cultural factors related to psychosocial environment and functioning," "religion and family" were explicitly cited for assessment. In the DSM-5 (APA 2013), not only were both innovations retained, but "religious affiliation" was explicitly cited for assessment along with other cultural identity variables in the revised Outline for Cultural Formulation in the section on "Cultural identity" (APA 2013 p. 750). Secondly, the Cultural Formulation Interview (CFI) was added as an assessment tool of 16 questions for clinicians to ask patients to obtain information relevant to the Outline for Cultural Formulation; "religion and spirituality" were listed as components of stressors and supports, role of cultural identity, self-coping, past help-seeking, barriers, and help-seeking preferences (APA 2013 p. 752-754). Finally, the CFI Supplementary Module #5 on Religion, Spirituality, and Moral Traditions provided 16 additional questions for clinicians to ask patients about their spiritual, religious, and moral identity; role of spiritual, religious, and moral traditions; relationship to the problem; and potential stresses or conflicts in relationship to spirituality, religion, and moral traditions (APA 2013b).

Psychiatrists must recognize that there are often diverse practices, interpretations, and behavioral implications within the same spiritual and religious traditions. For this reason, psychiatrists should avoid making assumptions about a patient based on that patient's religious or spiritual affiliations; this requires subtlety and attentiveness from the psychiatrist in order to avoid reductionism (Huguelet 2009, Moreira-Almeida 2014). Indeed, even for those who are unaffiliated, atheist, or agnostic, spirituality may still play an important role (Pew Research Center 2018). These are groups that traditionally face discrimination in American society, so psychiatrists should be aware of the strength of their patients' affiliations and their particular spiritual interpretations (Hordern 2016). Interpretations of a patient's commitments should be made with empathic respect for their meaning and importance (APA 2006). Furthermore, patients may identify as multicultural and/or religiously syncretic (i.e., they hold a

combination of beliefs; Moreira-Almeida 2014). This places heightened emphasis on the need to explore patients' identities without biases or precedent.

Psychiatrists' Perspectives

Psychiatrists should always maintain respect for their patients' religious and spiritual commitments – including their values, beliefs, and worldviews – throughout the course of treatment. A 2007 study indicated that, compared to other physicians, psychiatrists were more likely to be without a religious affiliation and less likely to frequently attend religious services, believe in God or the afterlife, or cope by looking to God. Additionally, psychiatrists were less likely to be religious in general, and more likely to consider themselves spiritual but not religious (Curlin 2007). In contrast, a 2014 survey indicated that 83% of adults were absolutely or fairly certain that they believe in God, and 77% of adults say religion is very important or somewhat important in their lives (PEW Research Center 2014, PEW Research Center 2017). Furthermore, a 2017 survey found that one-third of Americans say they do not believe in the God of the Bible, but that they do believe in another higher power or spiritual force in the universe (Pew Research Center 2018). These studies suggest that patients who prefer to see a like-minded psychiatrist could have difficulty finding a match because religion and spirituality is underrepresented among psychiatrists (Curlin 2007).

A recent study suggests that the vast majority of psychiatrists appreciate the importance of religion and spirituality at least at a functional level. In this study, 92% of psychiatrists reported that their patients sometimes or often mention religion and spirituality issues, compared to only 74% of other physicians. Furthermore, 93% of the psychiatrists believed it is usually or always appropriate to inquire about religion and spirituality, compared to only 53% of the other physicians. This suggests that psychiatrists are more likely to encounter religion and spirituality issues in clinical settings and are more open to addressing religious and spirituality issues with their patients (Curlin FA 2007). Because so many adults hold religious and spiritual beliefs, it is important for psychiatrists to ask their patients about their religious and spiritual commitments in order to properly assess, formulate, and treat their mental health needs (APA 2006). One way that psychiatrists may accomplish this is by taking a spiritual assessment of their patients at the beginning of treatment, and throughout treatment, as appropriate to their life stage (Camp 2011). Spiritual assessments enable psychiatrists to discuss spirituality with patients in ways that are not intrusive; they additionally communicate a respectful openness on behalf of the psychiatrist (René 2011). Additionally, spiritual assessments give patients permission to raise matters throughout the course of their treatment that may have otherwise gone unaddressed. Taking a proactive approach to understand patients' religious and spiritual beliefs prior to a crisis prepares the psychiatrist to integrate those beliefs in the context of crisis de-escalation. This understanding may also help psychiatrists work with patients to proactively strengthen their protective factors and challenge beliefs causing negative self-appraisals (Norko 2017). Even psychopharmacological treatments can be affected by specific religious practices, as noted in an anecdotal report about a patient whose Lenten-based abstention from coffee may have altered the effectiveness of her antidepressant response (Packer 2016). Similarly, it is possible that patients may avoid medications due to Passover-related dietary restrictions or Ramadan-related fasting, partly because they fear revealing the extent of their religious observances or are unaware that more health-promoting workarounds may be known to religiously-aware doctors. Inquiring about such observances in advance of holidays can acknowledge their importance to the patient and can circumvent unintentional outcomes that result from their neglect. These realities highlight the importance of addressing religion and spirituality in training (see, e.g., Larson 1997, Puchalski 2001).

One spiritual assessment model that allows for a rapid screen of multiple dimensions of spirituality is the "FICA" mnemonic developed by Christina Puchalski, MD and a group of primary care physicians (Puchalski, 2000). The mnemonic, "FICA" (Faith, Importance, Community, Address), helps the provider to avoid assumptions about a person based solely on their religious affiliation by exploring the patient's unique beliefs, the importance of these beliefs to the patient, whether they share these beliefs with a community group, and how they would like for their beliefs to be addressed in care. Examples of questions may include: "Do you consider yourself spiritual or religious?" (Faith and Belief); "What importance does your spirituality have in your life, and has your spirituality influenced how you take care of yourself and your health?" (Importance); "Are you a part of a spiritual community?" (Community); and "How would you like your psychiatrist to address these issues in your healthcare?" (Address in Care) (Puchalski 2000). Psychiatrists can then meaningfully consider their patients' cultural, religious, spiritual, and personal ideals and work towards expanding connections between those ideals and mental health when making treatment decisions.

Integrating religious elements into therapy has been shown to enhance the psychiatric outcomes of religious patients, and these techniques can be successfully implemented by religious and non-religious psychiatrists alike (René 2011). For example, in one study, nonreligious therapists had better outcomes in delivering religiously-enhanced cognitive behavioral therapy than did religious therapists (Propst 1992). Modified treatment interventions, including various forms of spiritually-augmented cognitive behavioral therapy, have proven effective when used appropriately. One study found that spiritually-augmented cognitive behavioral therapy can be beneficial in extinguishing hopelessness and despair, improving treatment collaboration, reducing relapse rates, and enhancing functional recovery for patients (D'Souza 2004). Another study found that spiritually-augmented psychotherapy accelerates improvement of depression and anxiety symptoms and reduces psychological problems of psychosomatic patients (Townsend 2002). Additional studies have similarly found that religious patients who receive religiously-based cognitive behavioral therapy reported a greater reduction in depression, social adjustment, and general symptomatology than those receiving standard cognitive behavioral therapy (René 2011). These studies suggest that, when used appropriately, modalities integrating religious and spiritual elements into treatment can be more effective than psychotherapy alone.

It is especially important for psychiatrists to develop a strong therapeutic alliance with their patients when incorporating religious and spiritual values into patient care. As previously mentioned, religious and spiritual beliefs are generally associated with better psychiatric outcomes; however, they can also cause harm by enforcing behaviors such as treatment refusal, shame, negative religious coping (e.g., passive deferral to God, attributing all problems to the Devil), and justification of harm (e.g., abuse of wives and children) (Moreira-Almeida 2014, WPA 2006). A strong therapeutic alliance can help discourage harmful and dangerous practices associated with religion and spirituality. However, psychiatrists must balance the ethical principles of patient autonomy with their professional obligations of providing effective – or at least non-harmful – care (APA 2015, Peteet 2018). If a patient's religious and spiritual beliefs conflict with the therapeutic goals and clinically-indicated treatment determined by the psychiatrist, the decision to exclude certain aspects of treatment based on a patient's spiritual and religious beliefs would be problematic. Furthermore, psychiatrists should not offer religious and spiritual commitments or ritual as a substitute for professionally-accepted diagnostic methods or therapeutic practice (APA 2006).

Issues of transference and countertransference often arise when exploring patients' religious and spiritual values and incorporating these beliefs into treatment. For example, a psychiatrist might avoid

discussion of religion and spirituality altogether, have a strong adverse reaction to certain content, or stress religion and spirituality too much and overstate its importance (Moreira-Almeida 2014). For this reason, it is important for psychiatrists to be cognizant of how their own religious and spiritual beliefs, or lack thereof, have the potential to influence their clinical practice. Psychiatrists are encouraged to explore their own instinctual responses to spiritual and religious content prior to and throughout their clinical work (Abernethy 1998). This also raises the question of whether a psychiatrist has the right to conscientiously object to providing certain medical services based on their own religious and spiritual values. The *APA Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* states that while caring for patients, physicians shall regard responsibility to their patients as paramount. It further states that psychiatrists should not be party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation (APA 2013c). As such, conscientious objection should never compromise the quality, efficiency, or equitable delivery of medical services; if it would not compromise these aspects of care, conscientious objection may be appropriate under certain circumstances (e.g., requested treatment is contrary to medical knowledge, psychiatrist is uncomfortable/incapable of providing requested treatment). In these cases, the objecting psychiatrist may transfer the patient's care to another clinician, so long as the transfer does not jeopardize the quality and timeliness of patient care (Savulescu 2006). The psychiatrist should also cooperate with the patient's request to release files and/or share information with contemporaneous and subsequent treating physicians (APA 2015).

Concordance of spiritual beliefs and/or religious affiliation and observance may be helpful to patients. However, psychiatrists are responsible for maintaining the frame of treatment and boundaries of competence and care. Specifically, psychiatrists' responsibility is to provide medically sound treatment according to psychiatric standards of care, regardless of spiritual commitments or religious affiliations. In some instances, it may not be appropriate for a psychiatrist to disclose their own religious and spiritual views to patients; conflict and disagreement could ensue in the event of differing views. If this does occur, conflicts should be handled with concern for the patient's vulnerability to the attitudes of the psychiatrist (APA 2006, Peteet 2018). On the other hand, consistency between a psychiatrist and patient's views might lead the patient to avoid discussing issues that they perceive as inconsistent with those shared views. However, there are certainly instances where psychiatrists sharing their own beliefs makes patients feel more comfortable in sharing as well, and this can strengthen the therapeutic alliance and allow the psychiatrist to more effectively address particular patient needs (Moreira-Almeida 2014, Verhagen 2017). There may also be instances of nonverbal representations made by psychiatrists regarding their religion, religious beliefs or values, such as wearing hijab, a yarmulke, a cross, a clerical collar or a turban. In cases such as these, the patient may assume a certain religious affiliation, and this assumption may be affirming, off-putting, or neutral. Although it is common for psychiatrists to list areas of interest and expertise in their professional credentials, (e.g., depression, anxiety, LBGTQ issues, psychoanalysis, and faith-based therapy), it is generally preferable for psychiatrists to indicate an openness to religious and spiritual issues rather than represent themselves as a religious psychiatrist of any one particular faith. In any case, psychiatrists should exercise care in any representation of themselves as particular types of religious therapists, be aware, and explicitly address with patients any instances in which the margins between psychiatric treatment and religious/spiritual intervention become blurred.

Religious orientation is not incompatible with ethical practice. Psychiatrists have a responsibility to ensure that all aspects of treatment, including biological, psychological, social and spiritual/religious are considered in the provision of care to patients. For example, it may be appropriate for a psychiatrist to pray with a patient if the patient has initiated a request that the psychiatrist pray with them, and if the

psychiatrist feels comfortable praying with the patient in a way that respects the patient's religious beliefs. While, it would be improper for psychiatrists to impose their own notion of prayer, they may support the patient in the patient's use of prayer and foster their spiritual strengths. However, just as some psychiatrists refer patients for specialist psychotherapeutic treatment while in their care, psychiatrists should be alert to situations when patients' religious/spiritual needs would warrant referral to a religious/spiritual community where their needs may be more fully met. In those situations, the psychiatrist maintains an obligation to continue to provide the psychiatric care the patient needs.

Conclusion

It is important for psychiatrists to explore and understand the religious and spiritual values of their patients as part of their assessment and treatment of mental health disorders. When possible and appropriate, psychiatrists may incorporate their patients' religious and spiritual values into treatment, just as they would for their patients' other values. Psychiatrists are encouraged to consider and remain open-minded about their patients' preferences for non-harmful but spiritually-valuable practices or treatments as an adjunct to standard mental health care. Based on their own values, psychiatrists may have limits on which types of treatments they are willing to provide.

However, when appropriate, the psychiatrist may refer the patient to another provider when the patient is requesting a specific treatment or framework of treatment that is contrary to medical knowledge or that the psychiatrist feels uncomfortable or incapable of providing. Furthermore, psychiatrists must not offer or promote treatments that are known to be harmful or non-beneficial to patients. Although at times a psychiatrist's appropriate self-disclosure about their own spiritual or religious beliefs and practices may benefit a patient, the psychiatrist must be thoughtful about maintaining appropriate boundaries when discussing these issues, and they should never impose their own spiritual or religious beliefs on their patients. The ethical boundaries in this area, as in many areas, cannot be reduced to absolute rules, but are best addressed by a commitment to the basic principles of providing compassionate, respectful, medically-appropriate care and avoiding gratifying the psychiatrist's needs or personal beliefs at the expense of the patient. Ultimately, these principles regarding care of the mentally ill rightly is, and should be, the bond that binds religion, spirituality, and the ethical psychiatrist.

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