

Resource Document on Religious/Spiritual Commitments and Psychiatric Practice

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- I. Psychiatrists should maintain respect for their patients' commitments (values, beliefs and worldviews).
 - a. It is useful for clinicians to obtain information on the religious/spiritual commitments of their patients so that they may properly attend to them in the course of assessment, formulation, and treatment.
 - b. Empathy for the patient's sensibilities and particular commitments is essential. Conflicts, either within the patient or within the clinician-patient relationship should be handled with a concern for the patient's vulnerability to the attitudes of the psychiatrist.
 - c. Interpretations that concern a patient's commitments should be made with empathic respect for their meaning and importance to the patient.
- II. Psychiatrists should not impose their own religious/spiritual, antireligious/spiritual, or other values, beliefs and world views on their patients, nor substitute such commitments or religious/spiritual ritual for professionally accepted diagnostic methods or therapeutic practice.
 - a. Clinicians should not force a specific religious/spiritual, antireligious/spiritual, or other ideological agenda on patients or work to see that patients adopt such an agenda.
 - b. Clinicians must not offer religious/spiritual commitments or ritual as a substitute for professionally accepted diagnostic methods or therapeutic practice.
- III. Psychiatrists should foster recovery by making treatment decisions with patients in ways that respect and take into

meaningful consideration their cultural, religious/spiritual, and personal ideals.

- a. Patients' religious/spiritual commitments may be important sources of hope and meaning.
- b. Some individuals with mental disorders are concerned with issues such as identity, hope, meaning and morality that may have a religious/spiritual dimension.
- c. Twelve Step Programs and mindfulness practice that some patients experience as having a religious/spiritual dimension may be important in treatment.
- d. Patients' religious and spiritual communities may facilitate their integration into full community life. Religious and spiritual communities may offer stability, inspiration, and practical support for mentally ill members.
- e. Individuals from certain religious groups may not trust mental health professionals who do not share their worldview, or are not endorsed by leaders of their community. Psychiatrists should address potentially important differences in religious/spiritual commitments early in treatment.

APPENDIX. Background and Examples

The following brief examples illustrate the kinds of problems that may arise when psychiatrists' commitments are interjected into clinical practice.

1. A psychiatrist with a religious commitment that homosexuality was sinful began treating a homosexual man for depression. The initial focus of treatment was on the patient's depression; the patient was not seeking to change his sexual orientation. After the depression lifted, the issue of homosexuality became more prominent in the therapy. Only after considerable therapeutic investment on the patient's part did he learn that the therapist's goal for him was to change his sexual orientation due to what the psychiatrist believed was sinful.
2. A devoutly religious psychiatrist pressed a severely depressed nonreligious patient to engage with her in prayer at the time of an initial therapeutic encounter. The patient had not anticipated a religious component to the therapy and was not accustomed to religious practice. She was quite troubled to find herself drawn into it, and her symptoms were aggravated.
3. A group of radical socialist psychiatrists conducted a medical clinic dedicated to implementing their ideological system. They explained to a series of troubled patients that the source of their symptoms lay primarily in their political plight and pressed them into participating in a political campaign without informed consideration of alternative therapy.
4. A psychiatrist provided interpretations to a devoutly religious man. In doing this, however, she denigrated his long-standing religious commitments as psychopathological. Because of the intensity of the therapeutic relationship, the interpretations caused great distress and appeared related to a subsequent suicide attempt.