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The Faith of the Psychiatrist

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Introduction

It has been observed that there is a “religiosity gap” between the psychiatrist and the user of mental health services (Cox, 1994). Psychiatrists are said to be less likely to be affiliated with a faith community, or to believe in God, than their patients. In this religious sense, the “faith” of the psychiatrist would appear to be less than that of the patient, if not also than that of the average member of the population. However, the faith of the psychiatrist might be interpreted in other ways. Faith might mean a generic kind of spirituality, not linked to any religious tradition. Faith might also mean an adherence to, and trust in, a particular theoretical framework or method or school of therapy, or perhaps to the scientific method in general.

What, then, is the empirical evidence for the existence of a religiosity gap? What might the faith of the psychiatrist qualitatively appear to be? And does it make any clinical difference if there is a gap between the faith of the psychiatrist and the faith of the patient?

The Religiosity of Psychiatrists

Published studies of the religious affiliation and beliefs of psychiatrists were ascertained through a search of databases of publications in psychology and medicine, and through following up of references in papers so identified and in other known papers touching on this subject. In fact, the electronic searches did not prove to be a very effective way of identifying the relevant empirical studies. However, as there appear to have been a limited number of studies of this kind, and as authors tend to cite publications of other related studies in reports on their own research, a group of nine publications was readily identified. Although it is difficult to be confident that this list is completely exhaustive of all such studies in the published literature (and the author would be interested to hear from anyone who knows of other such studies), it would appear unlikely that there are many (if any) such studies which have not been identified here.

A tenth study (Huguelet et al., 2006) will also be discussed, in which only a small number of psychiatrists is included. This study is of interest by virtue of the attempt to survey the religious affiliation and beliefs of a sample of users of mental health services and their clinicians.

The samples, response rates, and findings of the nine studies are summarised in Table 1.

Five of the studies were undertaken in the United States, two in the United Kingdom, one in Canada, and one in Australia and New Zealand. Response rates varied between 31% and 84%. Resulting sample sizes varied between 71 and 2890. Only three studies included suitable comparison groups within their study, but most cited statistics from other surveys (usually census or general populations surveys) by way of comparison.

Most of the studies were of randomly selected or complete samples of all practising or registered psychiatrists, selected on the basis of place of practice or nationality or membership of the relevant psychiatric association or college. However, two samples were specifically of old age psychiatrists, and one was of trainee psychiatrists.

Seven of the studies included some kind of information on religious affiliation, although the kinds of questions asked vary significantly and the resulting statistics are therefore not strictly comparable between studies. Similarly, seven studies enquired in one way or another about belief in God. However, only four studies reported data on both religious affiliation and belief in God for exactly the same sample of psychiatrists.

Although much of the research illustrating this trend is from the United States, two important studies have been conducted in the United Kingdom. The first of these (Lawrence et al., 2007) studied 316 members of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. They found that 58% of their sample reported religious affiliation. They did not include a control group in their study. The second (Neeleman and King, 1993) studied 231 consultants and trainees in psychiatry at the Bethlem, Maudsley and Royal Free Hospitals. They found that only 27% reported a religious affiliation, and only 23% reported a belief in God. Although they did not have a control group, they noted (on the basis of other published surveys) that up to 80% of the population believe in God. They also suggested that the difference from the general population in terms of religious affiliation (as opposed to belief in God) was much less.

This area of research has been marked by lack of suitable comparison or control groups, to the extent that it is difficult to say with confidence that evidence for a “religiosity gap” actually exists. Most usually comparisons are made with general population surveys, which assume that mental health service users are representative of the general population. In fact, there is reason to believe that religious affiliation protects against mental health and that mental health service users may therefore be less likely to be so affiliated than other members of the population (H. G. Koenig, 2005). However, one study from the US showed that psychiatrists were less likely to be religiously affiliated or to believe in God than other physicians (Curlin et al., 2007). Another demonstrated lower rates of religious affiliation amongst psychiatrists than social workers or family therapists, but only very slightly lower rates than clinical psychologists (Bergin and Jensen, 1990). Perhaps the best study to date, conducted in Canada (Baetz et al., 2004), did include a comparison group of mental health service users and found that 51% of psychiatrists, but 71% of patients reported belief in God. However, psychiatrists and patients were not different in terms of self-perception as either “spiritual” or “religious”.

Huguelet et al studied one hundred patients with a diagnosis of non-affective psychosis who were being treated in a public psychiatric out-patient facility in Geneva (Huguelet et al., 2006). The great majority of these patients (92%) identified spirituality as an important aspect of their lives and 66% found religion subjectively important in coping with their illness, but only 40% reported having talked about religion with their clinician. The clinicians involved in treating these patients (n=34, including n=19 psychiatrists) were much less likely to be religiously affiliated (53% v 92%) but were only slightly less likely to acknowledge the importance of spirituality in daily living (77% v 86%) in comparison with the patients. Perhaps the most important finding of this study, however, was that the clinicians were often unaware of their patients’ religious involvement or beliefs, or else their perceptions were inaccurate. None of the psychiatrists reported initiating discussion of religion with their patients.

Spirituality and Religiosity as subjects of Psychiatric Discourse

If psychiatrists are less likely to believe in God, or to be religiously affiliated, they appear nonetheless eager to engage in debate on the place of spirituality and faith in clinical practice. A recent editorial by Harold Koenig in *Psychiatric Bulletin* (Harold G. Koenig, 2008) suggested that good psychiatric practice should include:

- Taking a spiritual history
- Supporting healthy religious beliefs
- Challenging unhealthy beliefs
- Praying with patients (in “highly selected cases”)
- Consultation with, referral to, or joint therapy with trained clergy

None of these proposals were completely new, and the key points had been made previously by distinguished speakers at meetings of the Royal College of Psychiatrists (A. Sims, 1994, Cox, 1994, Hrh the Prince of Wales, 1991). Regardless of this, Koenig’s editorial provoked a controversy, in which correspondents described themselves as “alarmed” at his recommendations (Poole et al., 2008, Lepping, 2008). The proposal to consider praying with patients in “highly selected cases”, about which Koenig himself had urged caution, was described as “troubling” (Carter, 2008), “dangerous ground” (Mansour, 2008) and “highly controversial” (Mushtaq and Hafeez, 2008). Why, then, was there such a heated response?

Partly, I think, the answer may be found in transatlantic cultural differences. The United States is a very religious nation, and the United Kingdom is very secular. The acceptability and language of public religious discourse are very different in our two nations. Secondly, I wonder if there is a misunderstanding about the nature of religion and spirituality? It is patently obvious that not all people (psychiatrists or patients) are religious. It is not at all obvious that there are any people (including psychiatrists or patients) who are not spiritual. In fact, many would argue that spirituality is a universal dimension of human experience (Andrew Sims and Cook, 2009). Thirdly, it might be argued that such emotive responses are indicative of an approach to engagement with patients which is found to be threatening or personally challenging in some way. At the very least it would appear that discussion about religion or spirituality engages doctor and patient in a level of discourse which is seen as transgressing professional boundaries (Poole et al., 2008). But fourthly, and finally, there seems to be the strong implication that discussing such matters with patients might be actually harmful. Whilst abuses of spirituality or religion undoubtedly may be harmful, it is not at all clear what the evidence is for suggesting that these subjects should not even be discussed with patients.

Faith in Psychiatry

In 1965, in his classic work *The Faith of the Counselors*, Paul Halmos suggested that counselling (within which he explicitly included psychiatry) was itself a kind of “faith” (Halmos, 1979). In particular, he saw it as going beyond that which is purely research based and entering into a domain within which (quite properly) people are treated as having value and being worthy of respect and

even love. Similarly, HRH The Prince of Wales, in his address to the College in 1991, reminded psychiatrists that:

Care for people who are ill, restoring them to health when that is possible, and comforting them always, even when it is not, are spiritual tasks (Hrh the Prince of Wales, 1991)

The then Archbishop of Canterbury, George Carey, in his address to the College in 1996 (Carey, 1997) suggested that there is a common inheritance of religion and psychiatry. In particular:

- They both understand health as something “beyond the physical”
- They share values of faith, hope and love
- Psychiatry & religion need each other
- Society needs psychiatry & religion to work together

Perhaps, then, we should think of the “faith of the psychiatrist” in at least two different ways. On the one hand, it refers to his or her sense of belonging to a faith community, or holding of religious beliefs. On the other hand, it reminds us that psychiatry itself possesses some of the characteristics of a faith tradition, characteristics which overlap significantly with those of the religious traditions themselves. This should not be a cause for concern, but rather for celebration. It reminds us that human beings are of greater value than can be demonstrated by the scientific method alone. It also suggests that there may be important non-religious (or at least non-exclusively religious) ways in which there is no gap between the faith of the psychiatrist and his or her patient.

Clinical Practice

Does the faith of the psychiatrist make any difference to clinical practice? In a study of evangelical Christian psychiatrists in the United States, respondents reported the Bible and prayer as more effective than psychotropic medication or insight based psychotherapy in the treatment of grief reactions, sociopathy and alcoholism (Galanter et al., 1991). It would therefore appear that faith can, at least in some circumstances, affect psychiatrists’ perceptions of what is most likely to help their patients. However, perhaps more importantly, mental health service users report that it is important to them to know the religious or spiritual orientation of their patients, and that spirituality or religious orientation affect their choice of psychiatrist (Baetz et al., 2004).

Whilst there are undoubtedly possibilities for spiritual or religious abuse in clinical practice, the American Psychiatric Association long ago drew up *Guidelines Regarding Possible Conflict Between Psychiatrists’ Religious Commitments and Psychiatric Practice* (Committee on Religion and Psychiatry, 1990). Fundamentally, these guidelines require that psychiatrists show respect for the religious beliefs of their patients, and that they should not impose their own religious (or anti-religious) beliefs or ideologies upon their patients. Within the guidelines, assessment of patient spirituality and religious belief are accepted as fundamental. Members of the Royal College of Psychiatrists may well ask why we do not yet have such guidelines in the UK?

The Spirituality and Psychiatry Special Interest Group (SIG) of the Royal College of Psychiatrists has taken an interest in the development of the new College curriculum and the place (or lack of a place)

of spirituality and religion within it. In the process of its work on this subject, the SIG working group proposed that the following might be included amongst fundamental spiritual competencies of the psychiatrist:

- Explore how your own spiritual/religious beliefs may/may not coincide with those of your patient.
- Identify when spiritual/religious beliefs facilitate or obstruct the doctor-patient relationship.
- To become able to engage and be comfortable with the deepest level of personal experience which embodies human spirituality.
- Discerning when spiritual concerns are best dealt with within the doctor-patient relationship and recognising when additional pastoral care is required.

The faith of the psychiatrist is as much a reality affecting the clinical consultation as is any other personal attribute: gender, sexuality, race, social class, culture, personality or political belief. We can try to be completely objective and professional and to ensure that these attributes do not affect our clinical practice. However, the reality is that sometimes they do. Being aware of this, and knowing how to address it, is arguably the best way to demonstrate professionalism and sensitivity to the concerns of patients.

Conclusions

It would appear that there is evidence that psychiatrists are less likely to identify with a particular faith tradition, or to believe in God, than their patients. It is less clear that psychiatrists perceive themselves as less spiritual than their patients and, in fact, there is some evidence that they do not. More research is needed to clarify the nature and size of this “religiosity gap”.

Whatever the quantitative dimensions of the religiosity gap at a population level, individual clinical interactions between psychiatrist and patient will always involve a spiritual and religious component, whether this is explicit or implicit. Where psychiatrist and patient experience no gap, and agree about spiritual or religious matters, the danger may be of collusion in avoiding examination of potentially harmful aspects of shared belief or practice, but the potential benefits of identifying ways in which faith may benefit treatment and recovery are perhaps less likely to be overlooked. Where a gap exists, and there is disagreement about spiritual or religious matters, the danger may be of an abuse of the asymmetry of power between psychiatrist and patient in order to undermine the faith of the patient. But such consultations also offer the potential benefit of constructively critical, and mutually affirming, engagement with the ways in which different spiritual and religious traditions throw light on the patient’s condition and their response to it.

What would seem clear to this author, although apparently controversial for British psychiatry at present, is that spirituality and religion are very relevant matters in the clinical practice of psychiatry, which should be identified and addressed in the interaction between psychiatrist and patient. Professional debate and training on this matter, further research, and introduction of guidelines to foster and affirm good practice and to prevent bad practice, are all much needed.

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Table 1: Studies of religious affiliation and beliefs of psychiatrists

Authors	Psychiatrists							Comparison Group(s) included in study (Comparison statistics cited)
	Selection criteria	Nationality	Questionnaires (n)	Response (n)	Response (%)	Religious Affiliation (%)	Belief in God (%)	
Lawrence et al 2007	All registered members of Faculty of Old Age Psychiatry	UK	688	316	46	58		None
Curlin et al 2007	Stratified random sample of practising US psychiatrists	US		100	63	83	65	Other physicians: Religious Affiliation 90% Belief in God: 77%
Baetz et al 2004	All Canadian psychiatrists registered with Royal College of Physicians & Surgeons of Canada	Canada	2890	1204	42		54	Patients: Belief in God 71% (81% cited for general population)
Shafranske 2000	Random sample from 1997-1998 American Psychiatric Association Membership Directory	US	355	111	31		73	(General Social Survey Chicago: 96% Belief in God)
Payman 2000	Members of the Section of Psychiatry of Old Age of the Royal Australian & New Zealand College of Psychiatrists	Australia & New Zealand	207	142	69	56	40	
Waldfoegel et al 1998	5 Psychiatric Residency Programs	US	152	121	80	70	77	
Neeleman & King 1993	All consultants/trainees in psychiatry at Bethlem/Maudsley & Royal Free Hospitals	UK	275	231	84	27	23	("Up to 80%" belief in God cited for General Population)

Authors	Psychiatrists							Comparison Group(s) included in study (Comparison statistics cited)
	Selection criteria	Nationality	Questionnaires (n)	Response (n)	Response (%)	Religious Affiliation (%)	Belief in God (%)	
Bergin & Jensen 1990	National sample of psychiatrists	US	(425 overall)	71	(59% overall)	66		Religious Affiliation: Marital/Family Therapists: 89% Social Workers: 92% Clinical Psychologists: 70% (1984 Gallup Poll: 91%)
American Psychiatric Association (APA) Task Force 1975	Members of APA (& members of AMA practising psychiatry) - Providers of services to religious institutions	US	2198	1000			70	(92% Religious affiliation cited for General US Population)
	Members of APA In Washington DC area - Non-Providers of services to religious institutions	US	498	259	56		40	
	US Census of Psychiatrists – 1970	US	25329	17564 (14843)		77		
	US Census of Psychiatrists - 1970: Providers of services to religious institutions	US	2198	N/A		87		