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Addressing Spiritual Concerns in State and Federal Facilities

A number of friends and colleagues have expressed regret that they could not pray with clients or address spiritual concerns in other ways when they were in "Public" facilities. This essay shares some encouraging discoveries and experiences with respect to addressing spiritual concerns in state and federal facilities/programs.

During twelve years of medical school, residency, and *locum tenens* temporary assignments, I worked on 22 secular psychiatric units/services/programs in twelve different hospitals and mental health clinics. Eleven of these facilities and 21 of these programs were state or federal facilities/programs. I started out with the assumption that it was not legal and/or allowed to talk about spiritual concerns with patients in a state or federal program. I also assumed there were few Christians among the mental health professionals with whom I worked, and that I would encounter mental health professionals who would be antagonistic towards my Christian beliefs.

Several experiences have been consistent with these initial negative expectations. On several inpatient units, the treatment teams treated Christianity as if it were a psychiatric diagnosis. On another inpatient unit, Bibles were actually prohibited. As described below, during my senior year of residency, one of my supervisors reprimanded me for talking with patients about spiritual concerns[1].

I have also made some encouraging discoveries and have had some very positive experiences. During my psychiatric residency I read survey research claiming that 80 to 90 percent of people receiving mental health care were Christian[2]. This surprised me, since a much smaller percentage of my own patients talked about their religious beliefs. In addition, I discovered that the law governing separation of church and state was not as restrictive as I had assumed: it is not legal for a government institution to promote certain beliefs preferentially or to discriminate against certain beliefs (for example, having reading material or clergy available for only one religion or denomination). ***However***, asking about a person's personal spiritual/religious concerns, giving them the option to include spiritual issues in their mental health care, helping them access resources which they request, talking about spiritual concerns in the context of a belief system

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[1]Sadly, some of this caution with respect to Christianity and the Bible is legitimate. Many mental health professionals have had negative experiences with religious precepts being used in destructive ways. For example, Dr. Josephson describes devout religious families with destructive patterns of enmeshment, rigidity, and emotional harshness that were supported by spiritual precepts. He also describes how these destructive patterns were associated with individual developmental psychopathology (Josephson, AM. "The Interactional Problems of Christian Families and Their Relationship to Developmental Psychopathology: Implications for Treatment." *Journal of Psychology and Christianity* 12:112-328, 1993). It can be very helpful to ask antagonistic mental health professionals about their negative experiences with religion.

[2]1997 research results indicate that 94% of Americans believe in God, 90% pray, and 40% report having life-changing spiritual experiences (Steere D. *Spiritual Presence in Psychotherapy: A Guide for Caregivers*. New York: Brunner/Mazel, 1997, pp.13, 43, 54, 280).

which a patient already shares, and even praying with patients in this context *do not* preferentially promote or discriminate against any given belief.

I decided to do my own research by being more proactive. During my senior year of residency, I asked every patient in my Veterans Administration outpatient clinic (numbering 75 by the end of the year), "Is spirituality currently a part of your life?", "Is this important to you?", and "Would you like to address spiritual concerns as a part of your mental health care?" Nine of every ten patients reported that they were Christian, and all but two of these Christian patients wanted to address spiritual concerns as part of their mental health care. Many were also thrilled to include prayer, and several commented spontaneously, "I've never had a psychiatrist ask me about my beliefs before. I didn't think I was allowed to talk about these things or ask for prayer." How to address spiritual concerns with non-Christians was still a difficult question, but I thought, "I can at least start with the 90 percent who are already professing Christianity, and who want to include Christian spirituality in their mental health care."

Several weeks after beginning this adventure with including faith in mental health care, one of my supervisors discovered I was talking with my patients about spiritual concerns and reprimanded me:

Supervisor: "I don't think you should be talking to your patients about religion."
Dr. Karl: "You mean I am expected to address every other important aspect of my patients' lives, but that I am forbidden from addressing spirituality?"
Supervisor: "No, that's not what I'm saying."
Dr. Karl: "Do you mean that if I ask about spirituality, the patient states that they have important personal beliefs, and the patient requests that these beliefs be addressed in their mental health care, that I am forbidden from complying with this request?"
Supervisor: "No, that's not what I am saying. I'm just saying, 'don't push your own agenda on your patients.'"

This interchange expresses a valid concern that I not abuse the power differential to "push my own agenda." It also illustrates how erroneous assumptions on the part of our colleagues (for example, that the patient did not share my beliefs, and that I was pushing my agenda on the patient) can contribute to a negative response to Christianity. Following this interchange I continued to ask every patient about his or her religious beliefs and to address spiritual concerns and pray with any patient that requested that I do so. The subject was never mentioned again in any supervisory setting, and I graduated with our program's award for "superior academic achievement and contribution to health care."

As mentioned above, since finishing residency I have worked on a number of secular psychiatric units. I have asked the same questions to several hundred more patients, and have obtained essentially the same results. I have been surprised by how many patients assumed it was not acceptable and/or safe to discuss their religious beliefs. And I have continued to be struck by the number of patients who have been deeply grateful I was willing to include spiritual concerns in their care.

I have also had many surprising and encouraging interactions with other mental health care providers. While working on the first 20 of the 22 secular psychiatric units mentioned above, I tried to discover and contact other Christians, but only in subtle and indirect ways. I would make comments indicating that I was a Christian and then wait for other Christians to approach me. And I would occasionally approach co-workers who had in some way indicated that they were

Christian. With this approach, I usually discovered a small number of Christian co-workers on any given unit.

My experience during a three-week temporary assignment at a state hospital in 1994 was dramatically different. While on this assignment I felt inspired to be much more direct and proactive instead of dropping hints and waiting for others to respond. But I realized that religion can be a very personal and/or threatening subject, and that some people might be threatened or offended if asked "Are you a Christian?" I therefore thought carefully about how to question my co-workers in a way that would be non-threatening. In some situations I would simply ask a colleague, "Were religious beliefs or activities important in your family of origin?" At other times I would begin by sharing briefly about my interest in the place of spirituality in mental health care, and then ask what their experience with spirituality had been. People who were not Christian or who had had a negative experience with religion did not seem to be threatened or offended by these questions, and those who considered themselves active Christians were very willing to talk about their beliefs.

I was amazed by the results of my experiment. During the three weeks I was at this facility, I discovered more than a dozen Christian co-workers, including the facility executive director, the medical director, two staff psychiatrists, a staff psychologist, our unit director, one of the social workers on our unit, and a number of nurses and aids. Most of these individuals had not been aware that so many of their colleagues were also believers, and a number of them expressed keen interest when I suggested pursuing networking/mutual support of some kind. Furthermore, many of these Christian staff members were under the (mistaken) impression that it was illegal to talk with patients about spiritual concerns at a state facility.

Since this amazing and encouraging experience, I have returned for several brief assignments to one of the state hospitals I had worked in previously. I returned to the same hospital and the same units I had worked on before, but decided to try the new approach. The results were just as dramatic: I discovered many Christian co-workers, including the facility executive director, two unit directors, several social workers, a psychologist, two psychiatrists, and a number of nurses, aids, techs, and administrative support staff. The way in which I met the facility director was probably one of the most dramatic aspects of this experience. I was speaking with several nurses about the issue of spirituality in mental health care, and as we were talking a woman walked up and stood listening to our conversation. Eventually, she asked, "Would you like to do an in-service training for our staff about spirituality and mental health care?" "Certainly," I replied, "Who would I need to talk to about this possibility?" "I'm the facility director, so you would probably need to speak with me." It turned out that she was a committed Christian. She informed me that in addition to her liking the idea of me speaking with the staff about spirituality, the accreditation board had recently cited their facility for inadequately addressing the spiritual needs of their patients – she needed to address this concern to maintain accreditation. I eventually presented an in-service training session for the non-professional staff. Although I could not promote Christianity as the only way to address the spiritual needs of patients, I used illustrations and examples from my own experience (explicitly Christian) throughout my presentation.

Both the facility director and the medical director were present for my presentation. I wondered (with some anxiety) what the medical director would think, since he was not Christian (he happened to be Jewish). Even with the explicitly Christian examples and illustrations he thought the presentation was excellent. In fact, he requested that I give the presentation again so that those who couldn't make it to the first in-service training session could hear what I had to say,

and he also requested that I present the same material to the professional staff.

I am including here two points from this presentation that I think are especially important:

Concern that proselytizing in a situation where there is a power differential would be unethical: There is a power differential between staff and patients. It is important not to abuse this power differential in any way. This includes obvious things like not making patients bribe you to give them privileges, or using your influence in the professional relationship to sell them Amway or Tupperware. This also applies to using the power differential to impose your faith on patients, whether it be atheism, agnosticism, Buddhism, or Christianity. However, asking about a person's personal spiritual/religious concerns, giving them the option to include spiritual issues in their mental health care, talking about spiritual concerns in the context of a belief system which a patient already shares, and helping them access resources which they request, *do not* abuse this power differential.

Another thought to ponder is that many of us think of Christians as the ones who proselytize, but we are blind to the ways in which other mental health professionals do the same thing. For example, I am aware of many situations in which therapists have tried to "help" their clients let go of "rigid, dysfunctional" values so that they could be "free to enjoy sex outside of marriage." What is this, if not proselytizing regarding their liberal, secular beliefs? I find the following widely accepted guideline to be most helpful: If a mental health professional is encouraging clients to change their values/beliefs in a direction you personally think is bad, then the mental health professional is engaging in inappropriate proselytizing. In contrast, if a mental health professional is encouraging clients to change their values/beliefs in a direction you perceive to be good, the mental health professional is just providing effective mental health care (sarcasm/irony intended).

Informed consent principles and self-disclosure: 1. Presenting <u>options</u> 2. Being explicit about the information supporting a given suggestion my own personal experience). Many in the field of mental health believe there is nothing wrong with sharing information from your own experience as long as you present suggestions as options (as opposed to being directive in a dogmatic or parental fashion), and as long as you clearly identify your information as coming from personal experience (as opposed to implying that it is coming from controlled scientific studies or widespread clinical experience described in journals). For example, if you had a patient with an Alzheimer's parent, you had also dealt with a parent who suffered from Alzheimer's disease, and you had located valuable books and/or community support groups, you would not hesitate to say, "I had to deal with a very similar situation, and I found the following resources to be particularly helpful. You might want to check them out." We can approach questions about spirituality in the same way. If a patient is struggling with hopelessness, and if I have had a similar struggle and have found my religious beliefs to provide valuable perspective, I can relate my experience and suggest this as a <u>optional</u> resource they can consider looking into.

An additional guideline regarding self-disclosure focuses on the therapist's motivation for disclosing. Many mental health professionals feel that self-disclosure is appropriate when it is therapeutic for the client (as would be the case in the illustration regarding Alzheimer's disease given above). Self-disclosure is not appropriate when it is motivated by the needs or agenda of the therapist. I cannot see any reason that self-disclosure regarding spirituality should be governed by different principles than self-disclosure regarding any other subject (Alzheimer's

disease, trauma, substance use, etc.).

September 2000 Addendum: We seem to be in a time of transition, with lots of variability and inconsistency regarding the attitudes and practices of mental health professionals with respect to spirituality and religion (in both public and private care settings). As of January 1, 1995, the Accreditation Council for Graduate Medical Education (ACGME) requires that psychiatry residency curricula include religion and spirituality.[3] Growing empirical evidence indicates that religious commitment provides physical and mental health benefits.[4] The entire August 2000 issue of *Psychiatric Annals* was devoted to spirituality and religion in the context of mental health care. Dr. Allan Josephson *et al.* discuss at length a "quiet revolution" going on in psychiatry: "The thrust of this... clinical paradigm shift is that religion and spirituality are now frequently seen as potential sources of strength in a person rather than as evidence of psychopathology."[5] Highlighting the variability and inconsistency, in the same issue of *Psychiatric Annals*, Dr. Shafranske reports that 75 percent of the psychiatrists surveyed still disapprove of praying with patients, and only about *one percent* actually do pray with their patients.[6]

Caution is understandable in this context of variability and inconsistency, but I would encourage others to consider the possibility that their supervisors, colleagues, and patients are more open to spirituality and religion than they had previously assumed. Find gentle and appropriate ways to explore this possibility before concluding that you cannot include spirituality and religion as you provide mental health care. As described above, my own experience has been surprising and encouraging.

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[3]American Medical Association, *Graduate Medical Education Directory* 1995-1996; *Program Requirements for Residency Education in Psychiatry.* Chicago: American Medical Association, 1995.

[4]See D.B. Larson and S.S. Larson, *The Forgotten Factor in Physical and Mental Health: What Does the Research Show?* Rockville, MD; National Institute for Healthcare Research, 1994; and D.B. Larson, J.P. Sawyers, and M.E. McCullough, eds. *Scientific Research on Spirituality and Health: A Consensus Report*. Rockville, MD; National Institute for Healthcare Research, 1998; for an extensive discussion of the research regarding the physical and mental health benefits of religious commitment.

[5]Allen Josephson, et al, "What's Happening in Psychiatry Regarding Spirituality?", *Psychiatric Annals*, August 2000 Vol. 30, 8:533.

[6]Edward Shafranske, "Religious Involvement and Professional Practices of Psychiatrists and Other Mental Health Professionals," *Psychiatric Annals*, August 2000 Vol. 30, 8:528.