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Psychologists Shouldn't Ignore the Soul

When I was an intern, patients frequently asked if they could talk to me about God.

By Dr. David Rosmarin

In my first six months as a predoctoral psychology intern at McLean Hospital, I was approached by at least 10 patients asking essentially the same question: Can I speak to you about God? They wanted to discuss their problems not in psychological terms but in spiritual ones. I guess the yarmulke on my head suggested I was an appropriate person to offer guidance.

I was not. I am a practicing Orthodox Jew and a clinical scientist, but I am no theologian. At the time, I did not even have my supervisors' permission to speak to patients about their spiritual lives. I typically responded by suggesting the patient ask his case manager about a chaplaincy visit, though I knew the hospital did not employ an on-site chaplain.

It was hardly surprising that patients wanted to speak about God. Psychological science has consistently shown that spirituality can shape how someone thinks. "Religion and spirituality have the ability to promote or damage mental health," a 2014 review of research into spirituality and mental health concluded. "This potential demands an increased awareness of religious matters by practitioners in the mental health field as well as ongoing attention in psychiatric research." Why has this been neglected?

Even though Sigmund Freud's work is largely discredited, his classification of religious belief as "neurosis" reflected a deep antipathy toward anything that hinted at the metaphysical. Patients who professed religious beliefs were viewed as ill or immature. Having a spiritual perspective was considered a pathological problem to be targeted in the course of treatment.

In my career I haven't encountered much explicit antipathy toward religion. Yet Freud's perspectives still have lingering effects: Psychiatrists remain the least religious of all physicians. Clinicians tend to disregard spirituality in the provision of services. I was taught in graduate school to leave God at the threshold of the therapy room.

The result is a chasm between practitioners and patients. In 2015, I published a study that found 58% of patients at my hospital reported significant interest in discussing spirituality with their clinicians. Such discussions can be medically useful, as they help patients to engage more in the treatment process. Further, in another report, belief in God was associated with a significant reduction in depressive symptoms during treatment.

Ignoring spirituality in some cases feels like a form of malpractice. Recently a patient came to me with tears in her eyes and described how she felt angry at God for cursing her with a severe mood disorder. But she also longed for spiritual solace and connection and was even angrier at the field of psychiatry for not giving her a venue to address spiritual concerns.

Clinicians who want to discuss spirituality with their patients have another barrier to overcome. After years of neglect,

most have no training in how to raise the subject in an effective and culturally sensitive manner. That's why McLean Hospital recently created a [Spirituality and Mental Health Program](#), which I direct, to serve the spiritual needs of patients. The first of its kind in any nonsectarian psychiatric hospital, we are developing ways to ask patients about their spiritual lives, training clinicians to provide spiritually integrated care, and conducting research on the relevance of spirituality to mental health. We also have a hospital chaplain now.

Addressing spirituality with psychiatric patients does not require detailed knowledge of religious traditions and practices. We have developed a simple two-question approach that can be used with all patients, regardless of their faith or lack thereof. We begin by asking "Do you wish to discuss spirituality with me?" A negative response ends the intervention; a yes triggers the second question: "How is your spirituality relevant to your symptoms and treatment?" The conversation typically takes off from there.

For many patients, their spiritual lives provide hope, meaning, purpose and a connection to the divine. All of this can serve as a resource to cope with emotional distress. But spiritual life can also be a struggle. Some feel unjustly punished by God, while others have been violated by religious individuals. And having existential spiritual concerns can cause or exacerbate emotional pain.

Whether the effects of spirituality are positive or negative—or both—patient responses to this simple assessment have been very favorable. It is not uncommon for patients to report on hospital exit surveys that the brief discussion about spiritual life was the highlight of their treatment.

I'm not sure the field of psychiatry as a whole is ready to evolve toward a more spiritually open ethos. But for now I am grateful to have not only permission to speak with patients about God, but a professional duty to do so.

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