# Ethical Considerations at The Intersection of Psychiatry and Religion

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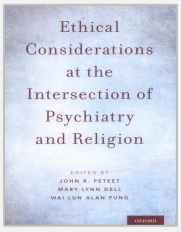


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# Introduction

*John R. Peteet, M.D., Mary Lynn Dell, M.D., D.Min., and Wai Lun Alan Fung, M.D., Sc.D., FRCPC*

PSYCHIATRY AND RELIGION/SPIRITUALITY SHARE A CONCERN FOR HUMAN flourishing, individual beliefs and values, and social context. Yet tensions between science and religion, and especially between psychiatry and the behavioral sciences and religion, have historically hindered constructive dialogue, creating uncertainty about how to approach ethical questions emerging at the interface between them. Many questions arise: What is the clinician's role in treating patients with unhealthy forms of religion? How should a therapist approach a patient's existential, moral, or spiritual distress? What are the ethical implications of taking into account a patient's religious beliefs as they bear on decisions about treatment, parenting, or end-of-life care?

Psychiatric ethics have traditionally focused on the implications of generally accepted principles and professional virtues, including respect for the patient's culture and values. Both the *Resource Document on Psychiatrists' Religious and Spiritual Commitments* published by the American Psychiatric Association (APA) and the *Position Statement on Spirituality and Religion in Psychiatry* published by the World Psychiatric Association (WPA) emphasize the need to understand the place of religion/spirituality as a source of these values. Conversely, religious ethics often emphasize caring for the ill and impaired. However, few resources are available for understanding the ways in which religion/spirituality informs the relevant values of patients and their clinicians, how clinicians should address conflicting values, or what principles should guide the interaction between clinicians' own professional and personal commitments. Discussions within the APA's Caucus on Spirituality, Religion, and Psychiatry of this conceptual and practical lack led to this project.

Our aim in this volume is to help readers think more clearly about these issues as they are encountered by psychiatrists and other mental health professionals, religious professionals working in mental health settings, bioethicists, healthcare ethics committee members, and trainees in all of these disciplines. Rather than philosophical arguments or practice guidelines, the contributors offer a conceptual framework for understanding the role of religion/spirituality in ethical decision making and pragmatic guidance for approaching challenging cases. Authors in Part One explore several dimensions of the ethical challenges presented by

religious/spiritual in psychiatric practice, and those in Part Two describe ways of approaching these in different treatment contexts. Wherever appropriate, we have asked psychiatric and religious professionals to collaborate.

In Chapter Two, John Peteet addresses psychiatry's lack of a clearly articulated set of values with which to approach the complexities of clinical work within a pluralistic context. He suggests that four core values—prevention and treatment of disease, patient centeredness, relief of suffering, and enhancement of functioning—can be traced to psychiatry's roots in humanistic medicine. When each is counterbalanced by the others from the perspective of the clinician's and the patient's worldviews, they offer a value-based approach to understanding the patient's disorder, chief concern, and prerequisites for flourishing. This approach, reflected in the Jonsen Four Topics Model for ethical reasoning (Jonsen, Siegler, & Winslade, 2015), frames and illuminates the relevance of religious and spiritual commitments in clinical work.

In Chapter Three, Mary Lynn Dell and Daniel Grossoehme discuss the relationship between religion/spirituality and psychiatric ethics, beginning with a review of religious ethics and religious bioethics from the perspectives of several major world faith traditions. Elements of Jewish, Christian (Catholic and Protestant), Islamic, Hindu, and Buddhist religious ethics are considered, with particular attention to how ethical teachings of these traditions interact with common elements of psychiatric ethics. Our hope is that this chapter will be helpful as readers become more aware of when and where theological perspectives have particular relevance in psychiatric practice.

In Chapter Four, Allan Josephson explores religious/spiritual and ethical aspects of psychiatric diagnosis. He argues that because diagnosis involves knowing the patient "through and through," it of necessity includes knowledge of the patient's religious/spiritual or secular worldview and related commitments. After considering how these present challenges in the care of patients struggling with issues of meaning, moral distress, and authority/autonomy, he discusses ethical challenges for diagnosis presented by a pluralistic psychiatric culture, including overdiagnosis and a loss of perspective on the whole patient.

In Chapter Five, James Griffith and Gina Magyar-Russell acknowledge that personal spirituality sets a standard for relational and ethical living but consider three major ways in which religion can be unhealthy and potentially harmful: when "sociobiological" religion obscures personal spirituality, when religion becomes a venue for mental illness, and when individuals experience spiritual struggle.

In Chapter Six, Len Sperry considers how clinicians should approach the various spiritual and religious concerns that adult patients present in everyday psychiatric practice. These include those noted in the V code, Religious or Spiritual Problem, in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (APA, 2013). The author presents a taxonomy of these concerns that is useful in making treatment decisions and an ethical framework for responding to them. He emphasizes the patient's informed consent and the competency of the psychiatrist in addressing religion and spiritual issues, which has implications for professionals' scope of practice.

In Chapter Seven, Nancy Kehoe examines the unique ethical dilemmas faced by religious professionals in dealing with mental health and illness. Some of these are rooted in a lack of understanding of mental illness and its impact on the community; others have to

do with the multiple relationships with members of the congregation and lack of objectivity when conflicting concerns emerge. Still others relate to the inevitable boundary crossings and risk of boundary violations, decisions regarding confidentiality, and the situation of being the sole religious leader in the community with unclear guidelines for oversight or accountability.

In Chapter Eight, Don Postema considers the role of religion/spirituality in the work of ethics committees. He reviews the history of ethics committees and consultation, notes the re-emergence of the religious and spiritual in medicine and healthcare, and uses a challenging case to illustrate the need to integrate moral, religious/spiritual, and psychiatric perspectives.

In Chapter Nine, James Lomax and Nathan Carlin discuss the clinical implications of a mental health professional's personal religion/spirituality by focusing on the example of fundamentalism and the importance of understanding and managing one's countertransference reactions to the patients whom it has shaped.

Chapter authors in Part Two identify and address ethical challenges involving religion/spirituality in various areas of psychiatric practice: outpatient (Morgan Medlock and David Rosmarin), inpatient (Shad Ali and Abraham Nussbaum), geriatric psychiatry (John Peteet), community psychiatry (Tony Benning), consultation liaison (Marta Herschkopf and John Peteet), forensic psychiatry (Michael Norko), child and adolescent psychiatry (Carol Kessler and Mary Lynn Dell), addiction psychiatry (Chris Cook, Eilish Gilvarry, and Andrea Hearn), emergency and disaster psychiatry (Sam Thielman and Glen Goss), disability psychiatry (Bill Gaventa and Mary Lynn Dell), international psychiatry (Walid Sarhan and Alan Fung), psychiatric research (Alexander Moreira-Almeida, Quirino Cordeiro, and Harold Koenig), and psychiatric education (Gerrit Glas).

Given the lack of universally accepted definitions of religion and spirituality, we use the following working definitions in this book: *Spirituality* refers to one's relationship to something larger that gives life meaning, and *religion* refers to a tradition of spiritual beliefs and practices. The two are not identical but often travel together; we recognize this by using the term *religion/spirituality* wherever appropriate. The term *ethics* is also subject to various definitions; we use it simply to mean inquiry into what is good and right.

## JONSEN, SIEGLER, AND WINSLADE'S FOUR TOPICS MODEL: A HELPFUL PARADIGM FOR ETHICAL ANALYSIS

Many of the chapters feature case examples that illustrate the relevance for decision making of medical indications, patient preferences, quality of life, contextual factors, and religion/spirituality in relation to culture. Several contributors use the Jonsen Four Topics (or Four Quadrant) Model in their discussion. The editors have employed this model as a helpful tool for almost three decades to provide a consistent framework for the systematic analysis of ethical dilemmas that have arisen in clinical work—primarily in consultation liaison psychiatry, as well as in work with ethics committees, in general clinical ethics consultations, and in

educational sessions with trainees learning and working at many levels in numerous medical disciplines.

The originators of the Four Topics method, Albert R. Jonsen, Mark Siegler, and William J. Winslade, developed this four-part model to bring order and consistency to the way in which ethicists and clinicians consider ethical quandaries. This method is especially helpful when the emotions of patients, family members, and medical care providers risk coloring the understanding of the facts and the true nature of the ethical issues at hand. By working through and identifying the information requested in each section, all individuals involved in a particular dilemma are more likely than not to be assured that what matters most to them is included in ethical analysis and decision making. Although it was not originally intended and is not predominantly used by clinicians concerned with ethical issues at the intersection of psychiatry, ethics, and religion/spirituality, we have found the Four Topics Model to be very applicable to mental health and ethics quandaries because of its broad conceptualization of personhood.

The first topic or quadrant is Medical Indications. This section focuses on the medical problems at hand and the accompanying diagnostic, therapeutic, and prognostic considerations. Although it is not always the most important contributor to understanding and addressing the ethical quandary, this body of medical/psychiatric information must be understood as well as possible to provide the best conceptual understanding for matters included in the other three sections.

The second topic or quadrant involves Patient Preferences. What does the patient decide or want to do in the current circumstances? If the patient is not able to speak for himself or herself at the time of the consultation or when the ethical quandary arises, has anyone else been authorized to speak for and make decisions on behalf of the patient?

The third topic or quadrant refers to Quality of Life. How does the particular disorder or illness and its treatments affect patients' quality of life and their ability to earn a living, to engage with family and friends as they find meaningful, and to participate in and enjoy what has mattered to them in their lives before, during, and after treatment?

The fourth topic or quadrant considers Contextual Features, the nonmedical but nevertheless significant elements that influence the kinds of decisions patients make for themselves in healthcare settings, as well as how the "system" interacts with patients and their loved ones. This is the quadrant that ensures that finances, legal concerns, social concerns, and other institutional matters relevant to ethical analysis and decision making are not forgotten. It is in this fourth quadrant, Contextual Features, that Jonsen, Siegler, and Winslade placed the reminder for ethicists and clinicians dealing with ethical dilemmas to inquire about religious and spiritual factors that may be influencing clinical decisions.

**The Four Topics Chart**

| Medical Indications | Preferences of Patients |
|---|---|
| The Principles of Beneficence and Nonmaleficence<br>1. What is the patient's medical problem? Is the problem acute? chronic? critical? reversible? emergent? terminal?<br>2. What are the goals of treatment?<br>3. In what circumstances are medical treatments not indicated?<br>4. What are the probabilities of success of various treatment options?<br>5. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? | The Principles of Respect for Autonomy<br>1. Has the patient been informed of benefits and risks of diagnostic and treatment recommendations, understood this information, and given consent?<br>2. Is the patient mentally capable and legally competent or is there evidence of incapacity?<br>3. If mentally capable, what preferences about treatment is the patient stating?<br>4. If incapacitated, has the patient expressed prior preferences?<br>5. Who is the appropriate surrogate to make decisions for an incapacitates patient? What standards should govern the surrogate's decision?<br>6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why? |
| **Quality of Life** | **Contextual Features** |
| The Principles of Beneficence and Nonmaleficence and Respect for Autonomy<br>1. What are the prospects, with or without treatment, for a return to normal life and what physical, mental, and social deficits might the patient expereience even if treatment succeeds?<br>2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment?<br>3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?<br>4. What ethical issues arise concerning improving or enhancing a patient's quality of life?<br>5. Do quality-of-life assessments raise any questions that might contribute to a change of treatment plan, such as forgoing life-sustaining treatment?<br>6. Are there plans to provide pain relief and provide comfort after a decision has been made to forgo life-sustaining interventions?<br>7. IS medically assisted dying ethically or legally permissible?<br>8. What is legal and ethical status of suicide? | The Principles of Justice and Fairness<br>1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment of patients?<br>2. Are there parties other than clinical and patient, such as family members, who have a legitimate interest in clinical decisions?<br>3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties?<br>4. Are there financial factors that create conflicts of interest in clinical decisions?<br>5. Are there problems of allocation of resources that affect clinical decisions?<br>6. Are there religious factors that might influence clinical decisions?<br>7. What are the legal issues that might affect clinical decisions?<br>8. Are there considerations of clinical research and medical education that affect clinical decisions?<br>9. Are there considerations of public health and safety that influence clinical?<br>10. Does institutional affilation create conflicts of interest that might influence clinical decisions? |

Jonsen AR, Siegler M, Winslade WJ. *Clincal Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 8th ed. New York, NY: McGraw-Hill; 2015.

## RELIGION, SPIRITUALITY, AND CULTURE

It is noteworthy that religion/spirituality and culture share an intimate and complex relationship, with important implications for both mental health and ethics. Multiple cultures may practice the same religions, leading to challenges in distinguishing cultural from religious prohibitions (e.g., appropriate dress, accepting treatment from members of other faiths). Multiple religions can co-exist in one culture, and mental health practitioners may encounter problems stemming from their lack of familiarity with differences relative to values regarding health beliefs and practices, child rearing, sexuality, family, and death and dying.

To provide clinicians a framework for organizing cultural information relevant to diagnostic assessment and treatment planning, the Outline for Cultural Formulation (OCF) was introduced in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (APA, 2000). In 2013, the DSM-5 updated the OCF and presented an approach to the assessment using the Cultural Formulation Interview (CFI), which has operationalized the process of data collection for the OCF. The revised OCF includes systematic assessment of the following domains: (1) cultural identity of the individual; (2) cultural conceptualization of distress; (3) psychosocial stressors and cultural features of vulnerability and resilience; (4) cultural features of the relationship between the individual and the clinician; and (5) overall cultural assessment (APA, 2013). The CFI contains 16 core questions (with both patient and informant versions) as well as 12 supplementary modules designed to expand on each domain of the core CFI for specific populations.

The core CFI is a 16-item semistructured interview that follows a person-centered approach to cultural assessment, focusing on the individual's experience and the social contexts of the clinical problem (APA, 2013). The questions cover four domains of assessment: (1) cultural definition of the problem (questions 1–3); (2) cultural perceptions of cause, context, and support (questions 4–10); (3) cultural factors affecting self-coping and past help seeking (questions 11–13); and (4) cultural factors affecting current help seeking (questions 14–16). Questions 6 through 12, 14, and 15 have been regarded as having specific relevance to spirituality/religion (APA, 2013).

In addition, supplementary module 5 of the CFI focuses on Spirituality, Religion, and Moral Traditions, and its 16 questions aim to clarify the influence of spirituality, religion, and other moral or philosophical traditions on the individual's problems and related stresses. These questions address (1) spiritual, religious, and moral identity; (2) role of spirituality, religion, and moral traditions; (3) relationship to the presenting problem; and (4) potential stresses or conflicts related to spirituality, religion, and moral traditions (APA, 2013). The core and supplementary modules of the CFI are available online from the Multicultural Mental Health Resource Centre website: https://www.multiculturalmentalhealth.ca/clinical-tools/cultural-formulation/.

We hope that the contributions in this book will broaden the perspective of readers on the multifaceted interface between mental health and religion/spirituality and stimulate thoughtful reflection and conversation about its important ethical dimension across multiple professional disciplines.

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# International Perspectives on Ethical Issues in Religion and Psychiatry

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GLOBALLY, DISCUSSION OF THE PLACE OF SPIRITUALITY AND RELIGION within psychiatry has become particularly timely, both because of a resurgence of interest in religious belief and practice in many parts of the world and because of the increased movement of the world's populations, with the subsequent assimilation of a variety of belief systems and practices (Boehnlein, 2006). Because mental health providers everywhere are increasingly treating immigrants and refugees whose backgrounds are much different from their own, it is important for them to understand cultural factors, including religious thought and practices, that relate to mental health and illness.

Acculturation can bring about change in religious traditions, just as it can dynamically influence other areas of life for individuals and groups. Increased religiousness in contemporary societies has both positive and negative aspects (Boehnlein, 2006). One benefit is that religious belief systems may provide meaning for individuals or groups who have survived war, civil violence, torture, and/or natural disasters. Furthermore, a broad spectrum of religious organizations have historically funded and operated mental health services in various countries; clinicians need to be knowledgeable about the beliefs and political structures of these organizations so that the effectiveness of their services can be enhanced.

On the negative side, any religious fundamentalism can be damaging not only to individuals' mental health and social adjustment but also to peaceful coexistence among cultures. Religious fundamentalism is commonly seen by the public to be some sort of psychological imbalance, and mental health professionals may be asked to comment on behaviors that are seen as strange by the majority in society. This raises critical ethical questions about how psychiatric diagnoses and labels should be used to describe the individual who is acting upon a religious ideology. Should a religious ideology be described as a set of overvalued ideas or as a force contributing to terrorism?

PSYCHIATRY AND RELIGION/SPIRITUALITY (R/S) share an interest in human flourishing, a concern with beliefs and values, and an appreciation for community. Yet historical tensions between science and religion continue to impede dialogue, leaving clinicians uncertain about how to approach ethical questions arising between them. When are religious practices such as scrupulosity disordered? What distinguishes healthy from unhealthy religion? How should a therapist approach a patient's existential, moral, or spiritual distress? What should clinicians do with patients' R/S convictions about faith healing, same-sex relationships, or obligations to others?

Discussions of psychiatric ethics have traditionally emphasized widely accepted principles, generally admired virtues, and cultural competence. Relatively little attention has been devoted to the ways that R/S inform the values of patients and their clinicians, shape preferred virtues, and interact with culture.

*Ethical Considerations at the Intersection of Psychiatry and Religion* aims to give mental health professionals a conceptual framework for understanding the role of R/S in ethical decision-making and serve as practical guidance for approaching challenging cases. Part I addresses general considerations, including the basis of therapeutic values in a pluralistic context, the nature of theological and psychiatric ethics, spiritual issues arising in diagnosis and treatment, unhealthy and harmful uses of religion, and practical implications of personal spirituality. Part II examines how these considerations apply in specific contexts: inpatient and outpatient, consultation-liaison, child and adolescent, geriatric, disability, forensic, community, international, addiction and disaster and emergency psychiatry, as well as in the work of religious professionals, ethics committees, psychiatric education, and research.

Thick descriptions of case examples analyzed using the framework of Jonson and Winslow show the clinical relevance of understanding the contributions of religion and spirituality to patient preferences, quality of life, decision making, and effective treatment.

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