

# Spirituality and Religion in Canadian Psychiatric Residency Training

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**Objective:** Mental health professionals are increasingly aware of the need to incorporate a patient's religious and spiritual beliefs into mental health assessments and treatment plans. Recent changes in assessment and treatment guidelines in the US have resulted in corresponding curricular changes, with at least 16 US psychiatric residency programs now offering formal training in religious and spiritual issues. We present a survey of training currently available to Canadian residents in psychiatry and propose a lecture series to enhance existing training.

**Methods:** We surveyed all 16 psychiatry residency programs in Canada to determine the extent of currently available training in religion and spirituality as they pertain to psychiatry.

**Results:** We received responses from 14 programs. Of these, 4 had no formal training in this area. Another 4 had mandatory academic lectures dedicated to the interface of religion, spirituality, and psychiatry. Nine programs offered some degree of elective, case-based supervision.

**Conclusion:** Currently, most Canadian programs offer minimal instruction on issues pertaining to the interface of religion, spirituality, and psychiatry. A lecture series focusing on religious and spiritual issues is needed to address this apparent gap in curricula across the country. Therefore, we propose a 10-session lecture series and outline its content. Including this lecture series in core curricula will introduce residents in psychiatry to religious and spiritual issues as they pertain to clinical practice.

(Can J Psychiatry 2003;48:171–175)

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## Clinical Implications

- Mental health professionals increasingly acknowledge the need for competency regarding religion and spirituality issues in psychiatry.
- Canadian psychiatry residents receive little formal instruction in the interface of religion, spirituality, and psychiatry.
- Adding a core academic lecture series focusing on religious and spiritual issues to current academic programs would give residents a knowledge base in this area.

## Limitations

- The survey did not address individual programs' reasons for including or omitting training in religious and spiritual issues, nor did it address residents' perceived need for such training.
- It is possible that the survey results do not represent all available training, because only 1 or 2 individuals from each program were contacted.

**Key Words:** psychiatry residency education, religion, spirituality, training requirements

Psychiatry has traditionally distanced itself from spiritual and religious issues. Freud described religion as “a universal obsessional neurosis . . . a regression to primary narcissism” (1), a view influenced by his personal, conflicted, experiences of faith and religion (2). Early drive theories iden-

tified religion as suppressing normal sexual desires and thus contributed for decades to psychoanalysts' view of religion as a source of guilt and dependency. Today, psychiatrists retain a general discomfort about addressing religious or spiritual issues in clinical work and research. The “anti-tenure” effect of

pursuing research in these areas has been well described and contributes to young clinicians' avoidance of them for fear of a negative impact on their careers (3,4).

Over the last 2 decades, mental health professionals have become increasingly aware of the need to incorporate patients' spirituality into mental health assessments and treatment plans, although the psychiatric community has not fully embraced a biopsychosocial-spiritual model. This change has been driven by recognition that religion plays a central role in the lives of many North Americans: a 1996 Gallup poll found that 96% of Americans believe in God, while 21% of psychiatrists and 28% of clinical psychologists are known to be atheist or agnostic (5). In another survey, 72% of Americans agreed with the statement, "My whole approach to life is based on my religion." By contrast, only 39% of psychiatrists and 33% of clinical psychologists accepted the statement, "My religious faith is the most important influence in my life" (6). Clearly, a disparity exists between the religiosity of the general population and that of the mental health practitioners who serve this population.

The growing public interest in reincorporating spirituality into health care delivery is well documented. One study found that 94% of inpatients believe spiritual health to be as important as physical well-being, and although 77% wanted spiritual issues to be considered in their care, only 10% to 20% had conversations with their physician on the topic (7). A similar interest in religious and spiritual issues occurs in users of psychiatric services. For example, a survey comparing the spiritual needs of 51 psychiatric inpatients with those of 50 medical inpatients reported that 80% of psychiatric patients and 88% of medical patients expressed the need for prayer. In addition, 65% of psychiatric patients and 66% of medical patients expressed a need for a visit from a chaplain to pray with them (8). Are patients turning to complementary and alternative therapies to have the spiritual component of their experience acknowledged and addressed? A 1998 study of predictors of alternative health care users found that "for many individuals, the use of alternative health care is part of a broader value orientation and set of cultural beliefs, one that embraces a holistic, spiritual orientation to life" (9).

Debate continues regarding the optimal ways of addressing issues related to spirituality and religion. Proponents of physician involvement can be found across specialties (10,11). They point to research findings that support a positive relationship between spirituality and health and that clinicians take a spiritual history during the assessment process and remain open to discussing spiritual issues during the course of treatment. Opponents to addressing spirituality in the context of patient care argue that scientific evidence for an association between spirituality and health status is lacking. In addition, they identify several ethical concerns regarding physician involvement in a patient's religious or spiritual affairs (12).

Although the debate about the relation between health and spiritual or religious practices continues, it is clear that patient

belief systems play a key role in patient development and remain a powerful influence on responses to current illness and life demands. Therefore, it is important that psychiatrists be knowledgeable about religious and spiritual issues to be sensitive to the role these beliefs and practices play in their patients' lives.

The American Psychiatric Association (APA) has recognized that psychiatrists require a basic understanding of religious and spiritual issues and has changed its assessment and treatment guidelines accordingly. Curricular changes in US residencies have since followed. In addition, more than one-third of medical schools in the US now offer courses in religion and spirituality (13). Further, authors from the UK and New Zealand have also reviewed the need for specific education of psychiatric trainees in this area (14,15). Educational resources on religion and spirituality are increasingly available for mental health professionals (16,17).

We present below a summary of training in religion and spirituality currently available to psychiatry residents in the US. We also discuss the results of a survey of currently available training on these topics in Canadian psychiatry residency programs and present a proposal for a 10-session lecture series to address the paucity of available training.

### **Incorporation of Religion and Spirituality into US Curricula**

A 1990 survey regarding religion and spirituality training in psychiatric residency programs in the US found that very few programs had training in this area (18). The *APA Practice Guidelines for the Psychiatric Evaluation of Adults* (19) were updated in 1995 to include gathering information on "important religious influences on the patient's life" in the personal history and performing an evaluation that is "sensitive to the patient's . . . religious/spiritual beliefs." The Accreditation Council for Graduate Medical Education (ACGME) *Program Requirements for Residency Training in Psychiatry* (20) were amended to reflect these new guidelines. Two changes in the ACGME requirements related specifically to including didactic and clinical instruction on religious and spiritual factors.

A model curriculum addressing the changed training requirements was prepared by Larson, Lu, and Swyers (21). The curriculum is organized into 11 modules that address the following topics: the relation between religion and mental health; interviewing and assessment skills; religion and spirituality in human development; working with clergy; working in the consultation-liaison setting; introduction to God images; introduction to charismatic religious experience; introduction to cults; and religious and spiritual issues in the treatment of women, substance abuse, and abused persons. The model curriculum also identified specific training objectives (Table 1).

In 1999, to support the incorporation of training in religion and spirituality into residency curricula, the National Institute for Healthcare Research (a nonprofit advocacy organization)

**Table 1 Selected objectives from Larson and others' model curriculum**

Knowledge objectives:	
•	to understand a differential diagnosis for spiritual and cultural phenomena at the individual and spiritual or cultural system level
•	to understand the role of culturally based healers and care providers
•	to understand the variety of spiritual experiences and traditions, each with its unique perspective on transpersonal issues
Skills objectives:	
•	to recognize features that differentiate normative religious and spiritual experiences from pathological phenomena
•	to provide appropriate psychotherapeutic interventions that reflect an understanding of patients' religious and spiritual experience
Attitudinal objectives:	
•	an awareness of the resident's own attitudes toward various spiritual and cultural experiences and the possible biases that could influence his or her assessment and treatment of patients with these experiences

**Table 2 Religion and spirituality training available in 14 of 16 Canadian psychiatric residency training programs**

Training available	Number of residency programs
Lectures	4 <sup>a</sup>
Research electives	3
Case-based supervision	9
Clinical electives	2
No training available	4

<sup>a</sup>Number of hours of lectures at each of the 4 programs: 1, 1, 3, and 4 hours respectively.

established the John Templeton Foundation Spirituality and Medicine Award for Psychiatric Residency Training Programs. By 2001, 16 psychiatric residency programs in the US had received this award. In most of the programs, the mandatory curriculum spans the length of the residency and has both a didactic and a clinical component. Time devoted to the didactic component ranges from 12 to 81 hours. The clinical component includes group case-based discussions, teaching clinical interviewing skills needed to take a religious and spiritual history, formal collaboration with chaplains, and mandatory case-based supervision during clinical rotations. Many of the programs also offer both clinical and research elective opportunities.

**Incorporation of Religion and Spirituality into Canadian Curricula**

Given the growing importance of training in religious and spiritual issues in clinical psychiatry, we surveyed Canadian

psychiatry residency programs to evaluate the current availability of training. In June 2001, we mailed a letter describing recent developments in US curricula to the program directors of all 16 Canadian residency programs. The letter asked for a complete outline of didactic teaching, case conferences, and supervision in which religion and spirituality were directly addressed. From September to November 2001, we sent follow-up phone calls and e-mails to programs that had not yet responded. We received 14 responses.

Of the 14 responding programs, 10 did not provide didactic teaching (Table 2). The 4 programs that provided mandatory didactic teaching devoted to it 1 hour, 1 hour, 3 hours, and 4 hours of teaching, respectively. Six of the 10 programs that did not provide didactic teaching offered case-based supervision to interested residents, usually in the context of psychotherapy supervision. Three of the 4 programs that provided mandatory lectures also had case-based supervision available. Four programs provided no formal or informal instruction whatever. Two programs offered formal elective experiences, including the opportunity to spend one-half day weekly working with members of a denominational counselling service. In 3 programs, residents were involved in related research endeavours, with supervision being provided by faculty working actively in this area.

A limitation of this survey is that it did not formally assess residents' perceived need for training in this area nor did it evaluate their satisfaction with currently available training. However, informal discussions with residents across the country show support for the introduction of a formal lecture series.

In summary, most Canadian training programs currently do not offer residents training that will prepare them to competently address the interface of psychiatry and religion or spirituality. Mandatory training is limited to 4 residency programs that provide between 1 and 4 hours of teaching. Most available case-based supervision relies both on resident motivation and on supervisor interest and knowledge base in this area.

**Proposal for a Canadian Curriculum**

We have developed an academic curriculum (Table 3) to address the lack of currently available training. Because the field of religion and spirituality is vast, the proposed curriculum is limited to 10 academic sessions (90 to 120 minutes each) to facilitate its incorporation into existing curricula. We have excluded such areas of study as the sociology of religion and the role of rituals in cultures and religions in an effort to keep the focus on clinical relevance; however, they can be added if time and resident interest allows. The particular religious traditions covered in sessions 3 to 6 should be selected to reflect local diversity and challenges in clinical practice.

The proposed curriculum differs in its approach from the curriculum developed by Larson and colleagues (21). Rather than focusing on the needs of specific groups, such as substance abusers, the proposed curriculum emphasizes imparting basic

**Table 3 Selected elements of a proposed academic lecture series on religious and spirituality in psychiatry<sup>a</sup>**

Session	Objectives
Introduction	<ul style="list-style-type: none"> <li>• Course overview</li> <li>• Historical relation between psychiatry and religion</li> <li>• Review of recent research on religion and spirituality and mental health</li> <li>• Definitions of religious and spiritual concepts</li> </ul>
Religion and spirituality in human development	<ul style="list-style-type: none"> <li>• Review of prestige and 6 stages of religious faith, as developed by James Fowler (integrates theories of the major developmentalists Piaget, Erikson, and Kohlberg)</li> <li>• Review of the integrative psychobiological approach to personality development, as described by Cloninger, with a focus on developmental steps 9 to 15</li> </ul>
Overview of selected major religions – Buddhism, Taoism, Hinduism	<ul style="list-style-type: none"> <li>• To learn about Eastern traditions, with a focus on attitudes toward mental health</li> </ul>
Overview of selected major religions – Christianity	<ul style="list-style-type: none"> <li>• To learn about Christian traditions, with a focus on attitudes toward mental health</li> <li>• To learn about working in collaboration with chaplains and other clergy</li> </ul>
Overview of selected major religions – Islam	<ul style="list-style-type: none"> <li>• To learn about Islamic traditions, with a focus on attitudes toward mental health</li> </ul>
Overview of selected major religions – Judaism	<ul style="list-style-type: none"> <li>• To learn about Judaic traditions, with a focus on attitudes toward mental health</li> </ul>
Transpersonal psychology	<ul style="list-style-type: none"> <li>• Review of definitions of transpersonal terms (for example, spiritually transformative experiences [STEs]), kundalini episodes, and spiritual emergencies) and theories</li> <li>• Case-based discussion (for example, differentiating STEs from psychosis)</li> </ul>
First Nations spirituality and Shamanism	<ul style="list-style-type: none"> <li>• Overview of First Nations traditional spiritual beliefs and practices</li> <li>• Role of shamans in past and present aboriginal cultures</li> <li>• To learn about referring to spiritual healers</li> </ul>
Religious and spiritual issues in psychotherapy	<ul style="list-style-type: none"> <li>• To distinguish healthy and unhealthy religiosity and spirituality, as well as to differentiate psychopathology from traditional spiritual practice and discuss therapeutic intervention options</li> <li>• To review the impact of religious and spiritual beliefs and practices on transference, countertransference, and boundary issues in the therapeutic relationship</li> </ul>
Resident-facilitated case conference	<ul style="list-style-type: none"> <li>• Cases prepared by residents and submitted to the course director to be discussed by residents and a panel of faculty selected by the course director</li> </ul>

<sup>a</sup>A more detailed course outline is available from the first author.

knowledge about specific religious and spiritual traditions. This shift in emphasis will allow residents to become familiar with an overall approach to religious and spiritual issues in clinical care and to acquire a basic knowledge of several traditions reflecting Canada's culturally and religiously diverse population. This specific knowledge of several traditions can serve as a framework to be expanded as needed in addressing clinical situations.

Suggested course faculty include members of psychiatry, religion, and anthropology departments, as well as clergy and other religious leaders from the community. We recommend that course faculty supply additional references to reflect local diversity and supplement the suggested references.

To allow further course development, a method of evaluating the effects of adding a lecture series (such as the one proposed) to core curricula is needed. Changes in resident and faculty attitudes, in comfort levels with applying newly gained skills, and in practice patterns need to be evaluated and followed. If

rigorous evaluation shows that the curriculum is well received and effectively meets its goals, educators in other specialties and areas of health care, such as undergraduate medical training and nursing, may be interested in adopting a similar model.

## Conclusion

Psychiatry residents would benefit from receiving mandatory training in religious and spiritual issues as they pertain to psychiatry. Currently, Canadian psychiatry residency programs offer minimal instruction in this area. The proposed 10-session lecture series can be incorporated into existing curricula to begin addressing this need.

## Acknowledgement

The authors thank Dr Shamina Henkel for help with course development.

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Manuscript received January 2002, revised, and accepted July 2002.

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## Résumé : La spiritualité et la religion dans la formation de résidence en psychiatrie au Canada

**Objectif :** Les professionnels de la santé mentale sont de plus en plus conscients de la nécessité d'incorporer les croyances religieuses et spirituelles d'un patient dans les évaluations de la santé mentale et les plans de traitement. Aux États-Unis, des changements récents des lignes directrices sur l'évaluation et le traitement ont entraîné des changements correspondants aux programmes d'études, et au moins 16 programmes américains de résidence en psychiatrie offrent désormais une formation officielle en matière de religion et de spiritualité. Nous présentons un sondage sur la formation présentement offerte aux résidents canadiens et proposons une série de cours pour améliorer la formation existante.

**Méthodes :** Nous avons sondé les 16 programmes de résidence en psychiatrie du Canada pour déterminer l'étendue de la formation présentement offerte en matière de religion et de spiritualité relevant de la psychiatrie.

**Résultats :** Nous avons reçu des réponses de 14 programmes. Quatre d'entre eux n'offraient pas de formation officielle en la matière. Quatre autres avaient des cours obligatoires consacrés à l'interface de la religion, de la spiritualité et de la psychiatrie. Neuf programmes offraient un degré de supervision élective, basée sur des cas.

**Conclusion :** À l'heure actuelle, la plupart des programmes canadiens offrent un enseignement minimal sur les questions liées à l'interface de la religion, de la spiritualité et de la psychiatrie. Une série de cours portant sur les questions religieuses et spirituelles est nécessaire pour combler l'écart apparent entre les programmes d'études du pays. Par conséquent, nous proposons une série de 10 cours et en présentons le contenu. L'inclusion de cette série de cours dans le programme de base initiera les résidents en psychiatrie aux questions religieuses et spirituelles qui relèvent de la pratique psychiatrique.