REFLECTIONS

A Religious Psychiatrist's Ethnographic Self-Report

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The religious identity of psychiatric patients is deemed important as it may impact upon the understanding of patients' problems and the quality of the therapeutic relationship. It would seem important that the psychiatrist should also be sensitive to the role of his/her own religious identity and its effect on clinical work. Nevertheless, even in studies by and about psychiatrists who have religious roles within a community, this component has tended to be ignored. A series of self-observations are offered by a religious Jewish psychiatrist to describe the effect of religious identity on himself and his patients during clinical work in Israel. Three types of situations were apparent: when he was unsure about his religious identity, when he was unsure about his professional identity, and when he was dealing with essentially religious rather than psychiatric issues and having to differentiate between his own role and that of a rabbi. These observations support the need to be sensitive to the effect of one's religious identity on clinical work, while appreciating that, as Andrew Sims has stated, the psychiatrist's "attitude towards the patient who shares his faith is as a fellow believer and not as a priest."

INTRODUCTION

The concept of professional neutrality was applied particularly to psychotherapy, but is applicable to most areas of mental health work, symbolizing the presence of the therapist for the benefit of the patient as a detached professional, present to reflect and help analyze patients' difficulties without burdening them with the therapist's own crises and urges. It has become increasingly clear that such neutrality is more assumed than real and that many aspects of a therapist's identity are presented to a patient.

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The age, sex, phase of life, height and weight, skin color, name, style of clothing, all convey aspects of a therapist's identity to patients. These are unavoidable and unchangeable aspects of therapists that one may or may not think about, and will have an effect on professional work. Each of these aspects of identity has an internal effect, influencing one's self-view and way of communicating and working with others. Above all, they impact upon patients.

All therapists also have a religious identity, whether atheist, agnostic or believer. This religious identity may or may not be visible. Religious values may well influence the behavior of mental health workers and therefore affect their patients, both directly and via their expectations from the therapeutic encounter. The aim of this account is to describe and evaluate the presentation of the religious identity of a modern orthodox Jewish psychiatrist in Israel as seen through his own eyes. If ethnography is a description of the attitudes and behaviors of a particular cultural group (1), then this may be seen as an ethnographic self-report. Ethnographic accounts are normally the work of anthropologists. Anthropology in the last decades has become more reflexive, looking in upon itself and noting the effects of being a viewer (2). So too, the psychiatrist has been used to view him/herself as an impartial evaluator. Only in the last years has an increasing awareness developed of the many aspects of the person in the psychiatrist's chair. This, then, will be such a reflexive view of one aspect of the psychiatrist's identity.

Religious identity has become an important component of mental health work for several reasons. Following Freud's pejorative references to religion as an illusion and a universal neurosis, the two subjects, psychiatry and religion, became adversaries. However, the general population continues to hold religious beliefs, in contrast to the predominantly nonbelieving culture of psychiatrists. A consequence of this gap was described by Kung (3) as "the last taboo" in that psychiatrists were avoiding discussing religious issues with their patients.

The developing role of psychiatry during the last century meant that it became the forum for discussing many of the life issues previously shared with the priest. In the Western world, as churches emptied, community mental health centers filled. At the same time, psychoanalysis was gaining trappings that many considered more worthy of a religion. In a provocative and entertaining account, Nelson and Torrey (4) wrote of the psychiatrist in this new role:

Psychiatrists themselves use psychiatry to satisfy their needs in the ritual and

social area. This is especially true in traditional psychoanalysis, in which Freud is revered in similar fashion to Jesus in religion. Freud had his own disciples, was betrayed by one of them (Jung), and left a body of writings that is accepted as the ultimate authority in doctrinal disputes. Not only can these writings be found conspicuously displayed in virtually every psychoanalyst's office, but a picture of Freud often gazes benignly on the proceedings. Furthermore, the analytic institutes are remarkably religious in character—authoritarian, with varying degrees of orthodoxy, open only to true believers, and with excommunication the fate for anyone who transgresses. (p. 365)

There have been many fluctuations in the relationship between religion and psychiatry. Anton Boisen (5) was a clergyman who, after his own psychotic breakdown, founded pastoral counseling for psychiatric patients, training clergymen to work alongside psychiatric staff in hospitals and clinics. In 1969, an issue of the *International Psychiatry Clinics* series was devoted to Clinical Psychiatry and Religion (6). Sections were devoted to treatment of religious personnel and collaboration of clergy and psychiatrist, but nowhere is the religious identity of the psychiatrist considered. From the presentations in this early collection on religion and psychiatry we learn that clergy have psychiatric disorders, and clergy may even help psychiatrists do their work, but there is no acknowledgment that psychiatrists have religious identities nor that they have spiritual crises.

In 1974, the Reverend J. E. Runions, a Baptist minister, a child and adult psychiatrist, and Associate Professor of Psychiatry in Canada, published an evaluation of 70 patients who had sought his care because "they know of his religious commitments to the authority of the Bible and the sovereignty of Jesus Christ, in an evangelical denominational setting" (7, p. 79). Reverend Dr. Runions concluded that the psychiatrist accepts "religious experience as a personality asset, without at the same time losing sight of the neurotic uses and psychotic dysfunction of religion." What is so interesting is that although the cases were referred because of his "double identity," his functioning is described purely as a psychiatrist and even within the case study presented, no attention is given to the possible effect on his clinical work of being a Baptist minister.

From the above studies, it emerges that if psychiatrists have a strong religious identity, it grants them intellectual understanding of their religious patients but no further, and they remain a *tabula rasa* for their patients. The next studies reflect an opposite trend in which religious identity significantly impacted on the psychiatrist's work.

Christian psychiatry is a term used to deseribe an evangelical movement in the United States. Atwood Gaines, an anthropologist who has written

extensively portraying the beliefs and values of psychiatry as a culture, wrote an ethnographic account of the work of five Christian psychiatrists (8). In his searching interviews with them and their staff in 1981-82, he tried to tease out the components of this dual identity. Deeply religious, the most agreed-upon component of their work was the use of prayer as therapy, both with a patient and for a patient. Depending on the clinical situation, one of the psychiatrists would pray with his patient, and as part of the prescription, "confession, repentance, forgiveness, and intercession were included in the patient's prayers." Further, among the goals of therapy and included in the prayers *for* patients, was that a secular patient should be led to Christ. Three of the psychiatrists perceived the therapeutic relationship as triadic, God being the addition to the usual dyad and the ultimate source of healing. The lack of an agreed corpus of belief and practice for their professional work led Gaines to conclude that "there is no 'Christian Psychiatry,' but only Christian psychiatrists."

Galanter, Larson and Rubenstone (9) sent a questionnaire with 121 items to 260 psychiatrists, members of the Christian psychiatry movement, and received completed replies from 193. Nearly all described themselves as "Born Again." The effect of their religious beliefs on their practice was noticeable in certain aspects: Bible and prayer were considered more effective than medication or psychotherapy in treating suicidal intent, grief reaction, sociopathy, and alcoholism. The authors present a case of a woman treated for depressive psychosis after the suicide of her daughter, revealing a clear impact of Christian psychiatry. While still psychotic, the patient's Christian psychiatrist would not allow her to bring her Bible to sessions, as she might read of Judas hanging himself after the death of Christ and be influenced to do likewise. However, once she was no longer psychotic and it was considered therapeutic for her to experience her grief and anger, he read her selected quotations from the New Testament that justified these emotions.

A study that is comparable in its focus on the psychiatrist-cum-religionist but very different in its account of an Afro-Brazilian possession cult, is Thomas Csordas' ethnography of the work of a Brazilian psychiatrist, Dr. Rubim, Professor of Psychiatry and elder of a Brazilian cult, known as *candomblé*, a form of Yoruba from West Africa (10). Three clinical cases are described. In one, he is called in as a psychiatrist, diagnoses an adjustment disorder, and offers help. The patient refuses, insisting her problem is religious. Dr Rubim persists and relates: "In trying to get her to accept me, I told her about my contacts with the *candomblé*. I just used my position as *ogan* in order to be accepted. She continued to

refuse me, saying that when intellectuals go to *candomblé* it's out of curiosity and not because they believe" (p. 7). Eventually he refers her to the head of the cult to treat her state of possession. In another case, the head of the cult refers to him a cult member in a psychotic state. Dr. Rubim describes with admiration the capacity of the cult head to distinguish between possession states that are religious, hysterical, or simulated. Dr Rubim describes his own progress in the cult, although there is little on his experience as *ogan*, an office in the cult, and its impact on his work as a psychiatrist. My impression is that his attempts at persuasion in the first case were rather half-hearted, as he virtually admits he was *using* his religious status.

Thus far, with the exception of Christian psychiatry, the relationship between the religious psychiatrist and his religion in the course of his work may best be described as detached. Sims (11) portrays and criticizes this state of affairs:

> The psychiatrist does not have two realms of thinking—that of a psychiatrist which is rational and scientific explaining but excluding believing, and held from Monday to Saturday; and the other mystical, credulous, naïve, anti-scientific and anti-psychological, and reserved for Sunday. (pp. 162-163)

An interesting final example from the interface between psychiatry and Judaism is a description of an inpatient unit for Hassidic patients in Brooklyn, New York, by Trappler et al. (12). The components of the program that enabled the community to use the facility included collaboration with the Community leaders, minimal use of expressive psychotherapy, emphasis on medical management, absence of socialization and milieu treatment, and making the staff aware of the details of normative Hassidic Jewish life. The first author is an orthodox Jewish psychiatrist but there is no account of his experience in combining these two aspects of himself.

A change has occurred in the classification of mental disorders that also has implications for the current exercise. The fourth edition of the DSM has renamed V codes as Other Conditions That May Be a Focus of Attention. A new category has been included in this list: religious or spiritual problems. According to the DSM-IV (13):

> This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (p. 685)

In addition, an outline for cultural formulation was produced to enable

the assessor to evaluate the person's cultural background, understand the link between his/her culture and symptoms, and also the effect these differences may have on the relationship between the individual and the clinician (13, pp. 843-49).

This new development has been hailed as a major advance (14). Psychiatrists had tended to equate religious expression with psychopathology, and placing these issues into a separate category was felt to be giving them a special recognition. However, it also can be seen as part of what Csordas (10) termed "increasing medicalization of human life to the point of presumed omniscience for psychiatry" (p. 8). Apparently religious problems are now one of the areas of expertise of psychiatrists.

The observation that the patient's cultural background may influence the relationship with the clinician is certainly true. If it has been appreciated that the patient's cultural background requires understanding, then surely it is appropriate to review the impact of the clinician's religious backgrouhd on the relationship. Countertransference distortions during dynamic psychotherapy as an example of related issues have been noted by Spero (15) to have received surprisingly little attention, and he suggests that therapists may not be "hearing" the religious issues as they arise in therapy. For an account of the influence and management of countertransference when a religious therapist treats religious patients, see Spero (16), in which he also notes that there are moments of difficulty inherent to such situations, not necessarily related to countertransference. I have purposely not used the term countertransference to describe many of the issues described in the following account. While this term is appropriate in some examples, in most the issues are not specific to that particular interaction but emerge from general aspects of religious identity. As will be shown, this does not make the situations simpler to manage, for while there is much that I may know of myself in my interactions, I may nevertheless have no final resolution for them.

I present a sequence of observations on aspects of myself as a modern orthodox Jew and the way they expressed themselves during a period of psychiatric interviewing and therapy.

AN ETHNOGRAPHIC SELF-REPORT

The first moment—the yarmulke.

Modern orthodoxy as a form of Jewish religious identity may be classified most easily by what it is not. Ultra-orthodox Jewish men have distinctive clothing, the community lives in enclaves, and is educated apart from the rest of society. Throughout their lives most men study full time

in *yeshivas*, and the contact with the outside world is kept to a minimum. The prime value in life is learning the Torah and keeping its commandments. In contrast, the secular Jew in Israel will know of the Jewish festivals and may have studied Torah briefly, but it has no implications for his lifestyle, which is essentially Western. Between these two is the modern orthodox Jew, who attempts a commitment to both sets of values. He maintains the range of religious practices while being an active member of the secular world, accepting any kind of work and study as long as it does not overtly contravene religious law. The male may be distinguishable in that he wears a hat or yarmulke at all times, while married women may cover their hair with a wig or scarf. The form of attire may tend toward being modest, although not to the extent of ultra-orthodox women who wear sleeves that extend beyond their elbows and dresses below their knees (17). In short, as a modern orthodox male, I wear a yarmulke.

The effect of the yarmulke for myself and my patients is an announcement. Had I been a Western psychiatrist with a deep and firm religious faith as a Protestant or Roman Catholic, there is no moment when the fact of my religious orientation need be apparent. No uniform, no public identity. Wearing a yarmulke is like waving a flag: "I am Jewish" (outside Israel), and in Israel: "I am modern orthodox." Does the patient wish to have this aspect of myself thrust upon him? For some, it makes them feel separate from me, while for others it makes them feel comfortable: "You are a religious person," some say. Meaning what? "You believe in God, you go to synagogue." For them, it seems to represent something reliable. And for me, does it mean I am more predictable? Does it exert a form of control or represent a control I exert over myself?

In the study by Gartrell et al. (18), 7% of male psychiatrists reported having had sexual relations with their patients. It would be pleasant to imagine this figure is lower among religious therapists. What the yarmulke does imply both to myself and to my patients is that it is worn out of commitment and that I am guided by a code of behavior.

My religious identity, therefore, has external expression and all patients are aware of this feature of myself. The influence of my religious identity on nonreligious people may be apparent in several ways:

Working with Secular Patients

A young woman is recovering from a psychotic episode and is still fragile. I feel that she trusts my decisions as a therapist. With a shy smile she tells me she is interested in studying religion, perhaps becoming more religious. I feel flattered and uncomfortable. It is not psychotherapy in which I

would interpret what she may mean, but instead I suggest that this is not a time to make life decisions or major changes, but first she should get more settled and strong. At the same time, I feel a certain disappointment at myself. Modern orthodoxy is a form of bridge between two worlds. Is my position of politely discouraging her a reflection of this pale version of religion? Presumably this is part of my sense of discomfort.

A woman is seeking a recommendation for an abortion. I am aware of feeling very uncomfortable, doing something I would prefer not to do. I do not intend to impose my world view on her. At such a moment, I see myself as no different from a secular therapist, which leaves me wondering whether my identification is indeed superficial. I would think she also feels uncomfortable having to ask a religious person for his recommendation.

One patient uses the sessions to tell me about his sexual exploits, particularly with married women and married religious women. We have discussed many aspects of this behavior, including his telling me about it, but now I wonder whether my declared religiosity is a red cloth to him, inciting him to be a "naughty boy." I feel he is saying: "You with your yarmulke are sitting on your sexuality. You don't try to pick up women and screw around. In the meanwhile I pick up the wives and friends of people like you." We all experience this type of behavior in therapy, yet in a religious person it resounds with a decision that is not just personal (my moral code) but also religious (the Code of Jewish Law). This is linked to the issue of dependence that psychiatry has traditionally accused religion of engendering (19). Enough religious people are morally unscrupulous and enough secular people morally scrupulous for it to be clear that there is still a personal decision to be made.

When evaluating and treating modern orthodox people, whose religiosity is similar to my own, I feel an added ease, values understood, interests shared. This sense of identification can itself be blinding to the meaning of the patient's religious identity for him/herself. In psychotherapy, Spero (15) has described the consequence of the lack of awareness of the therapist to his own views and beliefs in that "putative cultural similarity occludes to the point of uselessness" (p. 8). This may be compared with clinical situations when treating a young person the age of, or even the friend of, one's own children, when there is a tendency to see less psychopathology than is actually there. This is not an issue related specifically to religion as it may be true of shared socio-economic class, profession, etc.

Working with Ultra-orthodox Patients

The issues that arise during work with ultra-orthodox people are varied. Two ultra-orthodox men enter, one is clutching a text that he opens on sitting down. He starts to read from it. I am aware that he does not want to be in the clinic, but would prefer to be studying. For him, I may as well be secular, or perhaps I am "worse," as I apparently think I am keeping the commandments. During years of clinical work with this population, when greeted by a person with his head down, I tend to start with matters from his own world. He is reading, so after I have introduced myself, and asked some basic questions, such as name and age, I will ask him about the book. Having previously been retiring, he responds readily, leading to a discussion of the contents. I am interested in the book, both out of curiosity to understand this young man, but also out of intellectual curiosity. I may discover a book I had not seen of Rabbi Nahman of Bratslav or an interesting Kabbalistic text or Bible commentary. I sense this to be a weakness, following my own interests, but it is what I do, as it also facilitates the conversation.

In a regular interview with an ultra-orthodox person who is bronght for evaluation, I invariably take a little time to reach the main problem. Unless a person has come because he/she wants help, I have found that to ask "What is the problem?" usually merits no reply. If particularly withdrawn, I will ask about the content of his yeshiva studies. As in the previous section, the rationale is that this is the centerpiece of any ultra-orthodox male's life. But I must admit that I enjoy these studies, and relish the opportunity to discuss Torah.

I have been discussing a change of medication with a patient as she is not improving. She remarks: I would like to discuss it with my Rabbi. I pause. I personally rarely ask questions of rabbis. Other patients rarely say: I will go and ask an authority, implying: You are not my authority. I sit on my irritation. Would I be more understanding if I myself turned more to rabbis? Is it I who lacks submission to authority rather than this being any reflection on my patient? I collect myself and ask if I may give the patient an open letter that explains to the rabbi my considerations and suggestion and asking for the rabbi's decision.

On many occasions I have suggested going with a patient to his/her rabbi, and in another ease had a series of telephone discussions with a rabbi and sent him reports. On many occasions, teachers and *roshei yeshiva* (principals of yeshiva) have accompanied patients to interviews. These issues have been presented elsewhere (20), but in terms of this ethnographic report, these have tended to be interesting and pleasurable.

The rabbis have been very courteous and have been very interested to share impressions, describe their own experiences, and hear about current treatment approaches. They have usually had no difficulty distinguishing their own work from mine, and after initial counseling, if their own intervention was unsuccessful, they would be happy to refer the patient for medication or behavior therapy. Their experiences were always very interesting, as the rabbis had a lot of field experience. And was there also an element of feeling flattered by the interest, and at spending time with a "spiritual parent"?

Psychiatrist or Rabbi?

A fast day is approaching and a patient calls to ask if he should fast or if he should take medication during the fast. I usually feel uncomfortable, as I am not a rabbi. Even if I knew the criteria for fasting or not, or taking medication or not, I would not feel happy telling someone how to proceed, particularly if he is ultra-orthodox. My choice is to say whether I think he needs the medication during the fast, and if he is physically strong enough to fast. If I think someone should not fast, I suggest he check with his rabbi.

I have offered treatment but the patient declines as, he tells me, he puts his trust in God. On the tip of my tongue is the commentary on the phrase in the Torah "and he will surely heal" (*Exodus* 21:19) that states: "From here we learn that doctors were given by God the power to heal" (*Talmud Bava Kama* 85a). It is this sentence that makes it a duty to seek medical help, and to be willing to break the rules of Sabbath observance in order to receive this help. I stop myself from telling him. I tell him he must go to his rabbi to discuss this refusal, and offer to send him with an open letter. Here is an interesting situation. I am not his rabbi so do not feel I can tell him how to behave. However, as a fellow Jew should I not feel it a duty to tell him he must seek help? I do not, because we are both Jews but from different societies and I cannot tell him how he should decide. If I press my opinion on him too forcefully, I will lose him. And would it be different if we were "the same" religiosity? He knows my opinion and concern. He has his reasons, personal or spiritual, for seeking a rabbi's advice. The best I can do is help understand his concerns and ensure he is not lost to follow-up except by his own choice.

I am explaining to a patient the basis of exposure treatment for phobias. It is similar to Maimonides' statement on how to change your character: If you tend to excessive anger, become excessively silent for a

period. After you have done this for a period you will reach the golden mean.

I continue: The Midrash on Vayeshev (*Genesis* 37:1) also supports this approach: Jacob's name alone is mentioned after listing all the army of children of Esau. The reason Jacob follows the list was to teach him to overcome his fear of Esau. As is its way, the Midrash brings a parable: If a man is afraid of a pack of dogs he should go and sit among them until his fear subsides. (*Genesis Raba* 84:3)

So we see, I continue, that this way of treating phobias is according to the Midrash and Maimonides. I cannot help feeling a fraud and manipulator. I use the treatment because of the research done on exposure and not because of the Midrash. If my reason for using exposure is because of the research, and the patient accepts the treatment because of the Midrash, am I being dishonest?

There are many situations that have not been included, in which the overall reason for consultation was a religious issue: An ultra-orthodox man who had asked a monk to teach him the New Testament (this may sound reasonable to a Western ear, but not if you consider that the ultra-orthodox do not read secular newspapers, watch TV or go to the cinema; only Jewish religious books are in their homes); a young woman unsure of marrying the man her parents had suggested for her; a young man who felt homosexual urges.

The process in these types of situations was to assess if the person was psychiatrically unwell (excluding religious problems as a form of unwell). If it was indeed a religious issue, with whom did they want to discuss it? Finally, did they have a religious adviser/rabbi and where did he fit into the situation? In the three above examples, they had been referred by their rabbis, who sought guidance, suspecting serious psychopathology that required medication. The first received medication. In the case of the young woman before marriage, her rabbi had thought she was possessed by a *dybbuk*, and he was relieved to know this was not my impression, while the girl herself responded with great relief to an opportunity to think aloud for an hour in the absence of social pressures. These two problems did not require a specifically religious therapist and my reactions were not specific to my religious affiliation. The third problem is not simple, and reveals an area of difficulty that should trouble the religious psychiatrist. The professional organizations behind the DSM and ICD may have declared homosexuality not to be a disorder (21), but in religious Judaism it remains forbidden. Religious Judaism has not been able to consider where that leaves the young man sitting before me, and many other people (16).

An ultra-orthodox patient gets up to leave. "Good new moon," he says with a smile. Most people are unaware when the new moon comes. Religious people have to know when it is new moon as there are special prayers. He is sharing with me features of our common observance. Smiles of recognition pass between us.

DISCUSSION

The writing of this account of the expressions of my religious identity in my work has not been easy. I find that describing moments when my religious identity interacts with my role as a psychiatrist reveals the moments of doubt in those identities. In summarizing, there are three main situations:

1. Situations that make me question my religious identity, whether I am sincere or manipulative, sure or doubting.
2. Situations that question my role as a psychiatrist, if I am pursuing topics out of self-interest or flattery, and not for the good of the patient.
3. Purely religious questions. Do they exist, as distinct from and not reducible to other life issues? Do I succeed in appreciating my role here as a psychiatrist or am I blurring roles, playing rabbi, doing that which I am not trained to do and which is not in my patient's best interest?

In a seminal paper on the religious role of the psychiatrist, Sims (11) states categorically that the psychiatrist "does not instruct his patients in Christian or moral precepts nor carry out religious office in his professional setting" (p. 160). What then of the religious identity of the psychiatrist? He concludes: "the psychiatrist who is a religious believer must and will inevitably practice his faith in his everyday work, but his attitude towards the patient who shares his faith is as a fellow believer and not as a priest" (p. 160). Religious people come to psychiatrists for different reasons and with different expectations of what they will receive when they visit a priest, even if the presented subject is identical. The message of Sims, and of an address by the Archbishop of Canterbury to psychiatrists (22), and of Scott Peck (23), best-selling author, is that psychiatrists cannot ignore the spiritual lives of their patients, while if they aspire to do so they need to be in touch with their own spirituality, whether formal and within a religious structure, or not.

Finally, Korner (24) posits that faith is a central feature of our lives and interactions, and woe to the psychiatrist who neglects it as nonscientific. We help patients have faith in themselves, we have faith in our own ability

and in our patient's ability, and we have faith that each of us can transcend aspects of ourselves, and face unanswerable questions. He concludes:

> Mystery will always remain: the mystery of life lived in action and relatedness as opposed to the specimen in the laboratory. Where we confront mystery, we will require faith. (p. 549)

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