Spirituality and Occupational Hazards of Psychiatry

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Introduction

Occupational hazards are the dangers to human health and safety that are associated with work. Psychiatrists and other professionals in the field of mental health are as threatened by them, as are those who work in other spheres. Increased awareness and understanding of the potential risks should help to mitigate their effects among those who are vulnerable. There is some evidence that psychiatrists are less susceptible to neurosis than the general population, but the situation with regard to psychosis is very different. Mental health professionals who are predisposed to psychiatric disorder generally manifest problems before they complete their undergraduate studies, undoubtedly because of the pressures imposed upon them by academic requirements. Some consider themselves immune to psychological problems, and to those a discourse on occupational hazards in their field of activity will seem inappropriate. They may consider that if they took the possible eventuality seriously, that would be analogous to the emperor of Japan, who while traditionally claiming an origin from the sun god, humbled himself by declaring himself to be merely mortal. For psychiatrists, however, it should be a priority to determine which professional situations cause them maximum concern and to establish how to desensitise themselves in such contingencies.

In the days when their expertise was largely confined to the asylum, psychiatrists were estranged from other medical specialists. They developed a culture of their own that was to some extent alienated from the rest of society. The transfer of psychiatric care to the community has engendered change and nowadays professionals have the bonus of more social engagement, which has a concomitant therapeutic effect.

Stress

High levels of occupational stress are associated with a low level of general and mental health. Occupational stress is experienced when occupational demands exceed the resources that an individual is able to mobilise personally. Psychiatry and anaesthesia are generally identified as the medical specialities that present the highest risk to practitioners; in the former there is a sustained level of stress and in the latter periodic stress. While periodic stress may be positively stimulating, prolonged exposure to stress is counterproductive and an impediment to professional success. Psychiatrists who report that they enjoy being stressed may be psychologically resilient, but they are not necessarily physiologically resilient. Psychiatry is a stressful profession in which the sources of negative experience may include the workload, inadequacy of resources and inadequate support. The nature of the

work places high demands on individuals alongside low control, and in conjunction with these there is the inherent trauma of dealing with suffering. Poor relationships with colleagues and poor team working conditions may contribute to the difficulties. Additionally there may be service pressures, which include investigations, complaints and even court cases.

Hazards

Harrison *et al*. have drawn attention to some significant features of the occupational hazards associated with psychiatry.[1] Rates of alcoholism, drug abuse and suicide among personnel working in mental health have been reported to be elevated, but there is a lack of any authoritative report about the occupational hazards of psychiatry. Psychiatrists are expected to exhibit a neutral and sympathetic attitude towards their patients, but the impediments to this are of such magnitude that the effort may be regarded metaphorically as akin to a fish attempting to block the salt of the sea from its body. All psychiatrists from time to time experience vicarious traumatisation as a result of empathetic engagement with a patient and their traumatic material, and this is distinct from transference. It is what happens when psychiatrists have to stand in their patient's shoes. Negative life events endured by patients may sometimes impinge on the psychiatrist's mind, however strong their psychological insulation.

Psychiatrists practising in a country other than their native one are perhaps in an advantageous position. They may be able to distance themselves to some extent from patients belonging to the host culture because they have a reduced grasp of the patients' situation in life and therefore identify less readily with their sufferings. That may enable them to disengage easily once they leave the workplace and render them more capable of resisting stress than mental health professionals who are from the same culture as their patients. To put this colloquially, perhaps their ignorance is bliss. Conjecturally, this may account for the relatively large representation of professionals in the mental health profession who have been trained in other countries than the one in which they are professionally engaged.

Patient suicides cause significant disruption in the professional and personal lives of psychiatrists. An awareness of the inevitability of counter-transference guilt and self-doubt may be helpful in such eventualities. When psychiatrists have no opportunity to ventilate their own professional frustrations and express their own spontaneous reactions to this and other kinds of problem that they encounter from day to day in their working environment, they burn out prematurely.[2] Depression is a psycho-biosocial condition, and psychiatrists need to be constantly aware that they are bombarded with social problems and that they too may succumb to depression in this age of proliferation of the condition.[3]

It has been said that psychotherapists feel superior to others, falling victim to an omnipotent-God complex. However, mental health act powers can make psychiatrists feel superior. Viktor E. Frankl once commented humorously that

psychiatrists may not be omnipotent and omniscient, but they are omnipresent in their attendance at international conferences![4] That phenomenon has its strongly positive aspect; international conferences are de-stressing events as well as sources of educational benefit. Mental health professionals who think they are of the standard normal type are liable to categorise as psychopathological any behaviour that they regard to be deviant. In the absence of true idealism, they are also prone to intrusiveness with regard to other people's personal lives; indeed, psychotherapy may deteriorate into psychological voyeurism. Humility is required; without it, mental health professionals may fail (or refuse) to accept any potential superiority on the part of the person they are assessing. Psychiatrists are supposed to form an opinion about the negative behaviour of specific people and to distinguish that behaviour from mental illness, and they thereby run the risk of becoming judgemental. Being judgemental about other people may become a personal handicap; psychiatrists are supposed simply to assess patients, not to adjudicate on them.

Occupational hazards may not take the form of major psychiatric disorders, but may present as subtle personality changes. Bullying is one occupational hazard in the mental health profession. Practitioners who lack insight into the potential dangers of some of the techniques they practise may become subtle manipulators in their personal life and adopt autocratic techniques in their work environment. Psychological bullying is hard to detect, and it results in anxiety and depression among its victims. Those who do the bullying have been subjected to conduct disorders or adjustment disorders in the past, and the process is like the phenomenon of the abused becoming abusers.

Many psychiatrists consider the practice of psychiatry as a self-exploratory pilgrimage with the goal of reaching their own inner truth. Loss of spiritual conviction is an occupational hazard of psychiatry that is seldom recognised. Psychiatrists easily get caught up in the reductionist trap of the cognitive sciences. They are more likely than other medical specialists to suffer from depression towards the end of their lives. Some psychiatrists become so fixated with feelings of omnipotence that they choose to die voluntarily when they develop terminal illness, rather than enduring defeat by death. Others, when stripped of their pride owing to terminal medical conditions, remain in a state of denial and opt to die alone, depriving themselves of the care and support of fellow human beings. That scenario is reminiscent of the death of Haile Selassie, who continued to believe that he was still the emperor of Ethiopia even when he had been imprisoned by the military and was dying of complications following a prostate operation. Patanjali, the compiler of the Yoga Sutras, stated that the fear of judgement is the main contributor to our fear of death. If that is true, the ruminations of a retired psychiatrist whom I once knew become comprehensible; he complained that his mind kept going backwards to his work experience all the time, and he wondered whether he could have treated some of his patients differently, notably ones who had committed suicide. There was no rest for him even after his retirement.

Medical scientists who are non-religious and espouse a strict biological model of the mind tend to care less for prolonging life.[5] **T**his could be true of mental

health professionals who are sceptical about post mortem existence whilst they deal with suicidal behaviour. The age-old belief in human spiritual existence has weakened with the growth reductionist views of mind. Right from the beginning of their medical education, medical professionals are exposed to reductionist models of mind and consequently, the concept of spirituality becomes inappropriate in their thinking. The concept of a Supreme Being becomes irrelevant if there is no life after death. After completing the anatomy dissection and physiology classes, I used to wonder where the soul resides!

Psychiatrists are supposed to be more aware of social stigmatisation than the general population, but in fact they may lack sensitivity to this and fail to identify that their colleagues are afflicted with psychiatric disorders. Sufferers belonging to an ethnic minority have the disadvantage of an additional stigma. Psychiatrists who think they have superior coping mechanisms have experienced secondary depression when suffering from physical illness. They are not immune to the pressures that all face as human beings.

Public Perception

The general public view is that mental health professionals run a high risk of psychiatric morbidity, and there is awareness that psychological disturbance may be the consequence of intensive introspection. Contemporary films may portray psychiatrists as highly venerated figures or as marginalised characters. Psychiatrists are considered to be hard, analytical and unfeeling, and there is a perception that they are prone to self-analysis, which makes them different from the rest of the community. It is a pervasive joke that in psychiatric wards the staff cannot be distinguished from the patients. 'Physician, heal thyself' is a familiar aphorism of hypomanic patients in hospital care. Psychiatrists are often regarded as absent-minded or preoccupied people. There is a wealth of popular anecdotes, like the one about the psychiatrist who left the cinema on his own, forgetting that his wife was with him. This stereotypical image perhaps emanates from the way in which first-generation psychiatrists[6] who were overly enthusiastic about psychoanalysis, were perceived. Second-generation psychiatrists tried to change their image by taking such measures as dressing smartly and paying particular attention to their appearance. Even so, psychiatrists are sometimes still avoided in social situations and even considered an embarrassment.

Several years ago, while I was waiting in front of the old All Saints' Hospital in Birmingham for transport, a boy came up to me and asked me whether I worked in that hospital. When I said I did, he exclaimed that I must be very courageous to work there as his mother had told him that those who were employed there would eventually become like their patients. This is illustrative of an enduring public perception of the fate awaiting mental health professionals. Arguably this is true for other dedicated professionals, not all of them psychiatrists. One such was Father Damien of Molokai, who became a leper after he devoted his life to the care of socially isolated Hawaiian lepers

in the eighteenth century. Such dedication is unusual, but it is still to be seen in modern times.

Comments

Psychologists postulate that people who wish to be cared for may express their wish by caring for others, an example of the defence mechanism of projection. This is indubitably an overstatement. Doctors may opt for the psychiatric specialism for ideological reasons or out of scientific interest in the workings of the mind, and study of consciousness. The personality traits of perfectionism, self-criticism and dependency are common among those who choose to focus on psychiatry. Even those who practise while afflicted with serious mental illness are enabled to continue effectively if adequate support is available to them. Overall, those in the mental health professional with a history of psychiatric disorder are more successful in coping when continuing to work in the profession than not. It is arguable that they become resilient, rather like experienced war veterans, and develop a better empathetic relationship with their clients.

What is needed is healthy ‘grounding’ that enables those afflicted to de-stress themselves. The more intensely they are involved in psychiatry, the more non-psychiatric concerns are required as a counterbalance. Unhealthy professional competition and a lack of team spirit are self-destructive and lead to psychiatric casualties. Psychoanalysis, too, at its worst can be destructive of practitioner and patient. Complementary therapists, particularly quantum therapists from across the Atlantic, have some cautionary words to which mental health professionals should pay serious attention. They believe that there is a subtle energy exchange that takes place between therapists and their patients, and that therapists should strengthen their energy reserve by practising prayer and meditative techniques on a regular basis.

A computer’s hard drive slows down as file fragments accumulate on it. From time to time it’s necessary to run a defragmentation programme to improve the performance of the machine. Humans also need defragmentation. Some attain it through disciplined prayer that gives them the opportunity to put to one side the preoccupations of daily life; this is one effective way of preventing and healing the recurrent trials of existence and the all too frequent subsequent development of depression. Relationships with others are more stable when there are common spiritual goals that help people to work together, creating a united force that provides a strong therapeutic occupational background. Such relationships have no opportunity to develop among those who are motivated primarily by financial goals – something that can affect patients and mental health professionals alike. Lack of love is often a key issue in the family and social background of psychiatric patients and for this, the prevalent mantra of psychiatry, ‘study the other’, when taken in isolation, misses the point. Spirituality, on the other hand, has the power to generate unconditional love, and the mantra of all faith traditions, ‘love one other’, brings humanity to our clinical endeavours.

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