Psychiatric Evaluation of a "Monk" Requesting Castration: A Patient's Fable, With Morals

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Three silences there are: the first of speech,
The second of desire, the third of thought;
This is the lore a Spanish monk, distraught
With dreams and visions, was the first to teach.
—Henry Wadsworth Longfellow,
The Three Silences of Molinos

The cowl does not make a monk.
—Medieval proverb

fable . . . an invented tale . . . a story of supernatural or highly marvelous happenings . . . intended to enforce some useful truth or precept
—Webster's Third New International Dictionary

CASE PRESENTATION

History of the Presenting Problem

An Anglo man who introduced himself as "Brother David," a "monk" from "Ascension Monastery," was referred by a urologist in private practice for a psychiatric evaluation at the University of New Mexico Health Sciences Center during the summer of 1995. The consultation was prompted by concern about the patient's request for an elective bilateral orchiectomy. The patient could not explain the urgency behind the request, and he denied a recent or specific precipitant for it. He was willing to comply with the psychiatric evaluation simply because he thought that the urologist would "help" him if the psychiatrist said it was "OK."

Over the course of five evaluative sessions with one of us (M.H.), the patient stated that he wished to undergo an orchiectomy because he felt that his sexual impulses interfered with his spirituality. He described his sexuality as a stumbling block and a barrier between himself and "the Creator." He had worked hard for many years to minimize and master his sexual feelings and felt that he had achieved good success. Nonetheless, he felt that castration was the final and best option to ablate his sexuality. His body, he said, was merely a tool of the mind and spirit. He described his testicles as obsolete, useless, and harmful to his purpose in life. He likened his genitalia to "a pest . . . a fly you swat away that keeps coming back." He also described guilt, shame, and conflict surrounding his sexual impulses. However, this was not the case for his nocturnal erections ("when the vehicle wants to stimulate itself"), which he saw as normal physiology. He reported that a past trial of finasteride had not been helpful. He stated that he had been considering the orchiectomy procedure for 10 years and thinking seriously about it for the preceding 2 years.

In describing the beliefs behind his castration request, Brother David talked about other "monks" he knew who felt that castration had been helpful to them in diminishing or eliminating their sexual impulses. In this context, he lamented his male hormones as "a lot of chemistry that I don't need . . . stimulating areas I have been trying to ignore, or move on from." He felt that his refractory sexual nature was a feature of "lower existence." He repeatedly suggested that his hormones might, in fact, be partially responsible for his rebelliousness with respect to following rules in the monastery. In explaining his wishes, Brother David referred to two scripture passages: "If your right hand offends you, cut it off" and "there be eunuchs, which have made themselves eunuchs for the Kingdom of Heaven's sake. He that is able to receive it, let him receive it." When asked whether it might, in some way, be a spiritual failure to need an orchiectomy to deal with his sexuality, he replied, "[God] cares about overcoming, not *how* you overcome . . . . Is it a failure for a cripple to be given crutches?" He expressed chagrin over the difficulties he had experienced in complying with the restrictions of his religious life, but he felt that overall he had gained much more than he had lost by joining the monastery.

Psychiatric Evaluation

Brief background. **Brother David was the second of three children. He described his family upbringing as "laid back" but punctuated by occasional chaotic emotional responses from his homemaker mother. While this was difficult and resulted in distance between family members, the patient said that he always felt cared for. During childhood he felt closest emotionally to his grandfather. He discussed his early life as otherwise uneventful, and he denied physical and sexual abuse. He was raised as a Catholic. He related that during his young adulthood he became disillusioned with the Church ("it talked the talk, but didn't walk the walk"), and he abandoned his early thoughts of becoming a priest.**

The patient's first sexual interaction occurred at age 8 and involved another boy of similar age. He stated that this "homosexual" experience was pleasurable. From early adolescence he recognized that he was aroused by males and not by females. He became openly gay during college, and he briefly underwent supportive psychotherapy, which he described as very helpful overall. Brother David described his behavior over the next few years as promiscuous; he reported numerous homosexual partners, daily masturbation, and brief experimentation with transvestitism and sadomasochistic sexual practices, which he did not like. He received frequent treatment for sexually transmitted infections ("that was before AIDS"). In retrospect, the patient described feeling never satisfied, experiencing life and sex as if he were "marking time."

In his mid-20s, Brother David "realized that there's more to life than sex . . . than reproducing," although he had not had heterosexual experiences and had not fathered children. He felt that he wanted to change in order to "learn the truth" and returned to reading the Bible. Around that time he found out about a monastery from two

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"monks" whom he met one evening at an advertised public gathering. He joined the religious community shortly thereafter.

Brother David stated that he had been celibate over the ensuing years, had frequently moved with the others at the monastery, and had little contact with his family. Nevertheless, he reported that his commitment to "rising to a higher level" was not as strong as he would have liked it to be. He engaged in frequent masturbation and felt considerable remorse. He had left the monastery for a time as recently as 3 years before the psychiatric evaluation. At that time he had obtained an outside job. This foray was short-lived, though, as he quickly "realized that there was nothing in the outside world" for him. He felt that his religious dedication had been intermittently undermined by his rebellious nature but that he belonged within the monastery's spiritual community.

Brother David gave the impression that the monastery was a branch of the Catholic Church, but not so "rote" in its teachings. He did not give further information about the monastery, except to refer to his "bishop" and the other "monks" and to indicate that he could not be reached by telephone or mail.

Brother David agreed to ask one of the other "monks" if he would come in to discuss his positive personal experience with castration. At the fifth meeting, Brother David was accompanied by Brother Thomas, a middle-aged heterosexual man who had also been involved with the monastery for more than two decades. Brother Thomas had undergone bilateral orchiectomy in 1994 elsewhere in the United States. Since that time he noted a "75% decrease" in sexual interest and attention toward women. He reported that this change pleased him and that the procedure had helped him with his spirituality.

Psychiatric review of symptoms. Brother David stated that other than the counseling he had received in college, he had not previously received psychiatric treatment or psychotropic medications. He reported having symptoms of mood disturbance in the past, such as anhedonia, sleep disturbance, appetite changes, mild suicidal ideation, and dysphoria connected to the feeling that at times he "didn't belong." Once during college he had taken a handful of aspirin when feeling confused, depressed, and impulsive, but he could not identify a specific precipitant. He had not attempted suicide again. He currently felt that suicide was not an option, stating that one "cannot gain anything from it." His most recent period of significant depressive symptoms had occurred 3 or 4 months before the evaluation and was short-lived. He reported that since he had entered the monastery his dysphoria had been less pronounced, his sense of sexual conflict had diminished, and his depressive episodes had become less frequent. He denied mania, panic attacks, auditory, visual, and olfactory hallucinations, paranoia, self-mutilation, obsessions, and compulsions. He denied having physical health problems, including head injuries or seizures. He had not used alcohol, tobacco, or drugs in 20 years. He further denied a family history of psychiatric illnesses.

Mental status examination. Brother David presented as a healthy man of medium build, wearing dark, casual clothing. He was punctual, polite, pleasant, and engaging, and his manner was consistent over the course of the five interviews. His speech had regular tone and rhythm but was often slow, as he appeared to be very deliberate in his choice of words. He used humor sparsely. He had difficulty describing his mood; he said it was in general "OK." His affect was somewhat restricted, with a normal range; it varied in accordance with the content of the dialogue. His thought process was linear and clear. He revealed no extreme or unusual beliefs (outside of his desire for an orchiectomy), and there was no evidence of psychotic symptoms. The patient did not appear impulsive. He acknowledged past suicidal tendencies but denied suicidal or homicidal ideation at the time of the evaluation. He denied the desire to hurt or mutilate himself. His capacity for self-reflection, his insight, and his judgment were adequate and appropriate to the context of the consultation. In general, his thinking about a number of topics appeared to be flexible throughout the interviews, yet he was concrete and fixed—even to the point of lacking language—regarding his options for spiritual growth.

Clinical impression and recommendations. The consulting psychiatrist concluded that Brother David's wish for castration was authentic, long-standing, and nonpsychotic in nature. Although the request was thought to be unrelated to delusional beliefs, his overvalued ideas regarding the relationship between sexuality and spirituality seemed unusual, rigid, and intractable. No symptoms of a current, full psychiatric syndrome were observed. However, it was noted that his past history was suggestive of a recurrent depressive disorder and of ego dystonia surrounding sexual desire and purposeful sexual behaviors. Thus, it was concluded that no strictly psychiatric contraindications to an orchiectomy were evident in this patient. Still, the consultant recommended that other approaches to his suffering (e.g., pharmacological therapy) be considered, as the effectiveness and the long-term medical and psychological implications of the surgical procedure were unknown.

The private practice urologist chose not to perform the surgery. The patient was then seen by a second urologist at the university hospital who conducted his own evaluation. Subsequently, an ethics committee meeting was requested jointly by the consulting psychiatrist and the urologist at the university hospital. The committee's discussion focused on the ethical aspects of such an elective procedure; no formal clinical recommendation was sought or offered. The urologist also spoke with officials of the Archdiocese in Santa Fe; it was unambiguously stated that Catholic doctrine fundamentally opposes the performance of castration for spiritual purity.

Ultimately, the second urologist also chose not to perform the bilateral orchiectomy. He did, however, prescribe a gonadotropin-releasing hormone analogue, leuprolide, for 6 months. The patient complied with treatment and was pleased by the results of this intervention. He also agreed to follow-up with psychiatric care but stated that the monks were going to travel for a while so that he could not commit to another appointment.

Consent

After the psychiatric assessment was completed and clinical recommendations were reviewed fully with Brother David, he was approached regarding possible publication of his case history in the medical literature. He was receptive to this idea, suggesting that it might help clinicians to understand better the sexual issues faced by their patients. It was explicitly and accurately discussed that his decision would in no way influence his clinical care at the University of New Mexico Health Sciences Center. The patient gave his permission; his consent was informed and voluntary.

Epilogue

Brother David and Brother Thomas were two of 39 members of the Heaven's Gate cult who, apparently believing that they would evolve into a supernatural life form, committed suicide in Rancho Santa Fe, Calif., in March 1997. Eight of the men who died were reportedly found to have been castrated (1); we do not know whether Brother David was one of them.

We were distressed to learn of the tragic and unanticipated end to this patient's life. It is only after careful study, thought, and consultation that we have chosen to publish this case report because of the many morals to its story. To protect confidentiality, we have disguised critical features of this patient's history and clinical presentation, in keeping with the literature on ethical case reporting (2–5).

DISCUSSION

Spirit and matter in man are not two natures united,
But rather their union forms a single nature.
—Catechism of the Catholic Church

Half the truth is often a great lie.
—Benjamin Franklin

Truth is stranger than fiction.
—Unknown

This patient's story is like a fable. It is instructive. It involves beliefs in supernatural persons or incidents. And in its fabric are woven both truth and deception. While this case raises many is-

sues, for the purposes of this discussion we will briefly explore how the morals of the story relate to cultism and to the complex clinical ethical issues in the physician-patient relationship.

Cultism

Careful observation of cult activities and extensive clinical work with cult survivors have dispelled the early belief that cults exclusively attract only psychologically damaged or psychiatrically disordered individuals (6–15). Indeed, it is estimated that 2,000 cults exist in this country and that between 5 and 10 million people in the United States have had substantial involvement in cults during their lives (9, 14). Of these, nearly one-half are thought to be healthy, normally maturing individuals who are recruited into cult membership during a period of exceptional but temporary vulnerability, such as after a divorce or the death of a loved one or during another difficult life transition such as adolescence (7–12). The remaining half may have had preexisting psychiatric illnesses that might have influenced their participation in cult activities (9, 10). Importantly, the prevalence of distress and clinically significant psychiatric symptoms is dramatically increased among those who leave cults, irrespective of prior history (9–12, 14–18).

Brother David joined the cult during a young adulthood transition when he felt that his sexual behaviors were excessive and would not provide satisfaction or fulfillment in his life. By adopting the lifestyle of the cult and no longer engaging in sexual activity, he reportedly felt less anxious and dysphoric. In this sense, the cult's sexual beliefs and expectations apparently helped him to defend against his conflict over his sexual identity and behaviors. Like many defenses, however, this psychological "solution" was inflexible and limiting within the context of the patient's entire life.

Although cults vary widely with respect to their beliefs (sexual, religious, apocalyptic, UFO-related, psychotherapeutic, Satanic, and others), destructive cults differ from formal religions in that they are characterized by the common themes of "deception, dependency, and dread" (14). Formal religions generally are committed to disclosing theological doctrine truthfully, supporting personal inquiry, and promoting autonomous choice or acceptance of religious principles. In contrast, a destructive cult possesses four defining attributes. First, cult involvement entails the eradication of the individual self or the subordination of the self to the cult leader and the broader cult community. Second, a primary goal of the cult usually is the perpetuation and extension of exploitation (e.g., financial, sexual, physical) of cult members. Third, the cult leader is typically a highly authoritarian, determined, and charismatic individual who is alive and whose unusual life experiences (e.g., visions, trauma, dreams) become integrated into the cultic belief structure. Finally and most importantly, the cult uses power unethically to ensure the compliance of its members.

This last feature of destructive cults, the use of "unethically manipulative techniques of persuasion and control," has been described by Robert Lifton (6, 7) and others (8–15). These techniques include eight elements.

1. There is totalistic control of the everyday life of the cult members (milieu control), such as physical isolation, censorship, and restricted communication; highly narrowed work activities and social interactions; limited clothing and few possessions; and deprivation of food. In the Unification Church of Rev. Sun Myung Moon and in the Heaven's Gate cult, for example, recruits were required to travel in groups of two, to dress alike, to renounce their former lives and sell their possessions, and to relinquish their driver's licenses (8, 19, 20).

2. Cult leaders practice purposeful deception in order to appear to have special powers (mystical manipulation). For instance, before the 1978 mass suicide and homicide claiming 914 lives in Guyana, the leader of The People's Temple, Rev. Jim Jones, appeared to "cure" cult members miraculously of systematically fabricated medical illnesses (13).

3. Absolute and unquestioning loyalty to the cult organization and beliefs is present (demand for purity). This is seen in the rules of Heaven's Gate: offenses included deceit toward cult members or leaders, intentional disobedience, sensuality, and finding fault with cult leaders (19). Individuals who left the Heaven's Gate cult reported that while they were within the cult they were required to live for long periods in severe poverty and to drink "cleansing" liquids while forgoing solid foods (20).

4. Shame and harsh judgment are used to ensure the psychological vulnerability of cult members (cult of confession). In EST (Erhard Seminars Training) and other psychotherapy cults, for example, the use of "hot seat" confession rituals has been commonly reported (13).

5. Seemingly scientific, comprehensive, and distorted explanations are advanced in order to give cult beliefs the appearance of greater credibility (sacred science). This is well-documented in materials published on the Internet by the Heaven's Gate group and is also seen in other futuristic and UFO cults (19, 20).

6. A ritualized, narrow repertoire of phrases is used to limit independent thinking around cult beliefs and may facilitate dissociative experiences (loading of the language). In contrast to beliefs of the Catholic church, by referring to the person's body merely as a vehicle, the Heaven's Gate language presupposed a split between the mind and body, between the spirit and the material nature (19, 20). This language preempted reflection about the self and the body together forming one whole.

7. Persistent invalidation of the cult member's perceptions and feelings takes place in order to advance cult ideals or goals (doctrine over person). In the Heaven's Gate group, putting oneself first, taking independent action, having private thoughts, having likes or dislikes, being distracted, having inappropriate curiosity, and trusting one's own judgment were offenses against cult rules (19).

8. Those outside the cult, including friends, families, and entire nations of people, are redefined as evil, unworthy, dehumanized, and perhaps deserving of retribution (dispensing with ordinary existence). A dramatic recent example of this feature of destructive cults is the Japanese cult that released poisonous gas in a subway in 1996 in an attempt to start a world war, thereby "saving" cult members and annihilating all others.

These manipulative measures accompany cult indoctrination, exhaust an individual's strengths, promote fragmentation, and lead to repudiation of the self and unquestioning acceptance of cult beliefs and practices (7–15). For these and other reasons, the destructive cult experience is one of devastating trauma and has been described as the "impermissible human experiment" (9, 14).

In retrospect, phenomena related to destructive cultism may be identified in Brother David's clinical presentation. Milieu control was evident in the fact

that Brother David could never be reached directly by letter or telephone. He appeared to be nearly alexithymic, since he was typically unable to characterize and articulate his internal emotional state. It was as if he experienced dissonant internal or affective milieu control in this respect. Demand for purity was present in the rule for total celibacy, both mental and physical. The issue of sexuality was likely one around which Brother David felt the most shame and guilt; this suggests a possible role of cultic confession. Loading of language and doctrine over person were evident in his narrow and concrete reasoning about options other than an orchiectomy for enhanced spirituality. Impressively, these features existed in an otherwise flexible, likable, and bright person. The connection of Heaven's Gate to *Star Trek* and UFOs and to Internet computer technology suggests the element of sacred science. Finally, Brother David had become highly dependent on the cult to find meaning in his life. He described being unable to tolerate life away from the monastery. In addition, it was clear that those outside the cult were thought of as incapable of reaching the higher plane of spirituality. It is uncertain whether he was uncomfortable with his homosexual orientation or his core gender identity. Nevertheless, gender itself was felt to not exist at the "next level," and Brother David's castration request may have represented a first step in departing from earth and earthliness. This way of thinking, conceptualized as dispensing with ordinary existence, relates directly to the stated motivation behind the group suicide of Heaven's Gate members.

Ethical Issues in the Physician-Patient Relationship

The most salient ethical dimensions of Brother David's case relate primarily to the fundamental principles of respect, clinical competence, autonomy, beneficence, and nonmaleficence in the physician-patient relationship. If given equal weight, these principles commonly come into conflict. In this particular case, respect for the patient's beliefs and preferences placed the urological surgeon in a tremendous clinical ethical bind: to perform a bilateral orchiectomy—electively and without clear or traditional medical imperatives—seemed neither certain to promote good (beneficence) nor to prevent harm (nonmaleficence) in the care of this patient. The psychiatric evaluation itself, though extensive, did not reveal possible indications for the procedure (e.g., repeated, perpetration of sexual violence upon others) or absolute contraindications (e.g., psychotically driven beliefs). Moreover, in addition to the usual surgical risks, the desired benefit of the requested procedure was questionable, because testosterone would continue to be produced by nongonadal endocrine sources such as the adrenal glands. Although it has yet to receive adequate study, early experience with surgical castration of sex offenders suggests that this continued hormone production is clinically meaningful, since sexual impulses, erections, and performance ability may persist in up to 25% of those who have been forced to undergo the procedure (21). In sum, despite the patient's request and clear statement of suffering, bilateral orchiectomy was not felt to be clinically indicated in this case. For these reasons, acting respectfully, competently, beneficently, and nonmaleficently toward Brother David entailed not respecting his apparently autonomous wishes for castration. It appears that this clinical conclusion was not unique to our institution; it has been reported that Do, the leader of Heaven's Gate, also had difficulty obtaining an orchiectomy and that other members of the cult had had to seek the procedure in Mexico (19).

Psychiatrists are commonly asked by colleagues to assist in the care of patients who present complex moral issues (22). Indeed, the scope of psychiatric practice includes patients who are decisionally compromised, noncompliant, resistant, uncommunicative, erratic, terminally ill, institutionalized, traumatized, unlikable, or simply "hateful" (22–24). This was noted many years ago by Perl and Shelp (22), who felt that psychiatrists fill this niche in medical settings because they are perceived "as having added training in dealing with conflict, including moral conflict, as being more reflective, and as having more time to assess" patient situations. The two authors cautioned, however, that psychiatrists should not assume the role of moral guide when their primary tasks are to support autonomous decision making and to create a nonjudgmental context in which to explore complex problems and feelings. To this, we add that consultation psychiatrists also should seek to help identify wide-ranging, clinically relevant factors underlying apparent moral dilemmas. For example, noncompliance with treatment recommendations may actually be prompted by a patient's inability to read medication instructions or to pay for clinic appointments; by cultural beliefs, undiagnosed neurologic problems, or mistrust in the therapeutic relationship; or by misconceptions about the illness and the need for care (24).

Consultation-liaison psychiatrists and urologists together encounter particularly knotty clinical ethical problems when caring for patients with suspected past trauma and abuse (25). Recurrent urogenital pain and injury, genital self-mutilation, impaired sexual function, sexual impulsivity, sexual dysphoria, and odd, eroticized, or self-destructive behaviors all may arise in traumatized patients who present for urological care (25). The relentless, severe, and mysterious nature of these complaints may lead to multiple diagnostic procedures and surgeries. Patients may not fully reveal or recall previous trauma, and patients and physicians alike may not always understand the relationship of traumatic events to the current clinical situation. In such cases the urologist is placed in the position of unwittingly adding to the abusive experiences in patients' lives—of perpetrating new, but very "old" or "recapitulated" trauma. For these reasons, nonmaleficence is an especially critical ethical imperative for sound urological care and is a factor that consultation psychiatrists must watch for in their collaborative work with urological surgeons (25). The potential contribution of trauma to Brother David's case, including psychological trauma associated with cult involvement, is unclear and remains an untested clinical hypothesis.

In light of these issues, it is important to note that the university urological surgeon sought to preserve the doctor-patient relationship while providing optimal clinical care for Brother David. In no way did he abandon this patient or refuse to serve as his physician, despite the patient's problematic request. The urologist worked carefully to understand his patient well and to have his patient's capacity for decision making fully assessed. He astutely expressed concern about the accuracy of Brother David's report of his religious affiliation. He took time. He offered and proceeded with alternative care. He sought expert consultation and guidance from medical, ethical, and religious sources before making his final clinical judgment. He did not perform the bilateral orchiectomy.

Brother David's case also poses interesting ethical issues surrounding truth-

fulness in the physician-patient relationship. In essence, Brother David kept much of his life secret during the process of his surgical and psychiatric evaluations. The ethical questions related to the patient's incomplete or misleading statements are complicated in this instance, however, by his perceived need to protect his personal autonomy, to shield the cultic group, to preserve his belief system, and to safeguard his confidentiality. Ford (26) recently identified a number of other factors that may influence patients' lying, such as lying to manipulate the behavior of others, to assist in self-deception, to accommodate others' self-deception, and to avoid punishment. These issues may have been present in Brother David's case in varying degrees. For instance, he clearly did not disclose the whole truth when attempting to persuade his doctors of his need for the orchiectomy. Moreover, the extent to which Brother David was motivated, or perhaps coerced, to shield his cultic group remains uncertain but must be considered.

Brother David's religious tale may also be understood within the context of the cultures of New Mexico. Roman Catholicism is the most common religion in this state, but relatively dramatic variations in Catholic religious practices developed in the 1800s when there was little contact with European clergy (27). The Penitentes, referred to as Los Hermanos de Luz—The Brothers of Light—still engage in flagellation and self-punishment during reenactments of the crucifixion of Christ, practices which place them in uneasy association with the official church (28). The dynamic history of religious differentiation and tolerance together with the sparsely populated, austere landscape of New Mexico continue to attract many religious sects, some of which live in monastic isolation. In addition, Roswell, N.Mex., is the site of a supposed alien spaceship crash in 1947. It is a source of tremendous curiosity, and it is the destination of ritualized pilgrimages by many individuals each year. However, by neglecting to disclose his beliefs in extraterrestrials and suggesting his connection to the long-established, slowly changing Catholic church, Brother David deliberately deceived his caregivers.

Finally, during early discussions connected to this case, three other kinds of ethics questions were raised. In the ethics committee deliberation, for example, controversy arose around issues that were framed as rights—the patient's right to insist upon an elective procedure, the physician's right to provide care that he or she deems appropriate and do it in a competent manner, and society's right not to pay for unnecessary or questionable procedures. Second, concerns about the role of gender in the clinical care of this patient were also explored because of a question raised by Brother David. He expressed puzzlement that physicians in the past have performed elective oophorectomies for women's subjective and persistent symptoms. He suggested that his own analogous symptoms would be cured by the orchiectomy, and yet the procedure was, he felt, more difficult for him to obtain as a man. A third area of controversy triggered by this case relates to the greater acceptance of medical interventions that address genital or reproductive pathology and/or appear to enhance nature or natural sexuality (e.g., breast or penile implants, in vitro fertilization) than of those that diminish or seem to distort natural sexuality (e.g., orchiectomy, transsexual surgeries). While conscientious differences of opinion persist around such topics, this case is valuable in terms of making explicit the values that are operative within and throughout ethics-laden clinical decision making.

CONCLUSIONS

The morals of this patient's story are many and intertwined. Foremost is the observation that unusual requests from patients merit careful and prolonged clinical evaluation. Such requests often reveal unusual motivations in unusual individuals, requiring thoroughness, multiple sources of information, time, and other forms of clinical conservatism to understand well. While not all sources of distress in patients will result in a definitive diagnosis or a clinically effective, ethically acceptable treatment, it is nevertheless the tradition of medicine to inquire, investigate, and accompany the patient in the face of poorly understood suffering. The consulting psychiatrist may play a critical role in supporting troubled patients and in helping to clarify these complex issues, which may be camouflaged or obscured and otherwise may cause physicians to do harm unwittingly.

A second moral relates to psychiatry's incomplete understanding of the ties among psychopathology, coercion, sexuality, and cultism. Our field's diagnostic nosology does not yet adequately capture psychological aspects of cultic phenomena, nor does it offer an explanatory model to help understand the impact of sexual issues, conflicts, and behavioral expectations experienced by individuals affiliated with cults. Few empirical data in such areas exist. Does this inattention, as some have claimed, reveal a naive and mistaken belief among mental health professionals that cults provide a benign psychological home for societal misfits (13)? Further inquiry and self-reflection are imperative if we are to recognize and respond in clinically and ethically astute ways to patients whose lives may be affected by destructive cult experiences.

A third moral of Brother David's fable-like story—complete with its lessons, supernatural events, and untruths—is the value of recognizing patients' immense need for personal meaning in their lives. Brother David was a very likable, bright man who felt that his search for spirituality through the monastery had helped him. We can see how it also destroyed him, and, for this reason, we may be tempted to dismiss the nature and magnitude of his everyday cult experience over two decades. Brother David's life history nevertheless reminds us that spirituality is an important domain of psychological health that should be respected but not overlooked for its clinical implications.

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