SPECIAL GUEST CONTRIBUTION

Patient Spirituality and Mental Health: An Expanding Focus in Clinical Care and Research

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Introduction

Patient spirituality, a once disregarded dimension, is emerging in research and clinical care as a relevant factor in mental health. Internationally, psychiatry's professional associations have highlighted the need for developing sensitivity to this life dimension. A growing number of US psychiatric residencies now include training on how to address patient spirituality in clinical care. Quantitative research in the last 15 years in the U.K, the US, and other countries has discovered aspects of this complex dimension generally linked with beneficial mental health outcomes.(1,2) Research has also helped clarify aspects of negative religious coping.(3)

This two-part article summarizes some of the changes in focus, clinical education, and assessment in the field of psychiatry, as well as reviews research findings investigating spirituality and mental health.

Part I will discuss the growing professional recognition of spirituality as a relevant mental health factor in clinical care and research, and discuss some of the recent changes in residency training and clinical assessment to include patient spirituality.

Part II will briefly summarize some of the published research. Findings include positive clinical associations of spirituality with mental health in the areas of 1) prevention, coping, and recovery from depression, 2) suicide prevention, 3) substance abuse prevention and treatment, 4) coping with surgery and severe medical illness, 5) enhancing health behaviors, and 6) links with longevity. Research also identifies potential harmful aspects of some spiritual/religious beliefs or attitudes.

(Note: For an extensive overview, the Handbook of Religion and Health,
Oxford University Press 2001, reviews more than 1,200 published research studies, providing findings on the positive and negative effects of spirituality and religion on physical, mental, and social health from childhood to old age.(1) For research summaries and reviews, and other resources please also visit the International Center for the Integration of Health and Spirituality website: www.ICIHS.org)

Part I: The Growing Focus in Clinical Care

Renewed Professional Focus

Regarding psychiatry's renewed focus on spiritual factors, Dr. Ahmed Okasha from Egypt, past president of the World Psychiatric Association (WPA), stated that religion has remained "an important factor in most patients' lives, no matter where in the world they live." Speaking at the world congress of the WPA in 1999, he urged colleagues to make a more concerted effort to include "the philosophical and empirical study of the spiritual variable in mainstream psychiatric research." He emphasized psychiatrists would be better able to help their patients if "the vocabulary and concepts of religion were more familiar to trainees and practitioners." Failure to become more sensitive to this dimension can increase the distance between psychiatrists and those they serve--their patients, he noted.(4)

In the U.K., the Royal College of Psychiatrists identified the need to consider spiritual issues in 1992. The College noted "the need to emphasize the physical, mental and spiritual aspects of healing in the training of doctors in general and psychiatrists in particular. Religious and spiritual factors influence the experience and presentation of illness."(5)

In fact, a survey of 200 London psychiatrists in 1993 found 90% viewed religious beliefs as relevant to patient mental health and "to be considered during assessment and therapy...but interventions in this area, such as referral to and liaison with the clergy, were extremely rare."(6)

In his Royal College of Psychiatry Presidential address in 1994, Dr. Andrew Simms stated: "For too long psychiatry has avoided the spiritual realm...but psychiatrists have neglected it at their patients' peril. We need to evaluate the religious and spiritual experience of our patients in etiology, diagnosis, prognosis and treatment."(7) Dr. D. Crossley followed up in 1995 in the British Journal of Psychiatry, underscoring both the clinical and research neglect of attending to patient religion and identifying steps to take to address this neglect.(8)

In the US the American Psychiatric Association (APA) in 1990 issued "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitment and Psychiatric Practice,"(9) noting the usefulness for psychiatrists to obtain clinical data and information on "the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment."

The guidelines underscored that "no practitioner should force a specific religious, anti-religious, or ideological agenda on a particular patient." The Guidelines provided an example of a psychiatrist whose worldview differed from those of a devoutly religious patient. The psychiatrist interpreted the patient's long-standing religious commitment as "foolishly neurotic." The Guidelines noted, "Because of the intensity of the therapeutic relationship, the interpretations caused great distress and appeared related to a subsequent suicide attempt." The APA's "Practice Guidelines for the Psychiatric Evaluation of Adults" in 1995 also further called for a respectful, clinical assessment.(10) In the last three years, the APA's annual meeting has

included a large number of symposium and workshops on spirituality and religion.

Relevance Affirmed by World Health Organization

The World Health Organization (WHO) published a position paper on how to assess quality of life across cultures stressing the importance of recognizing religion/spirituality and personal beliefs.(11) The WHO's six broad domains of quality of life relevant across cultures included: 1) the physical domain, 2) the psychological domain, 3) level of independence, 4) social relationships, 5) environment, and 6) spirituality/religion/personal beliefs.

The WHO report commented that spirituality/religion/personal beliefs might affect quality of life by helping persons cope with difficulties in their life, by giving structure to their experience, ascribing meaning to spiritual and personal questions, and more generally by providing the person with a sense of greater well-being. For many people religion, personal beliefs, and spirituality are a source of comfort, well-being, security, meaning, sense of belonging, purpose and strength, the report stated. However, the report noted some people feel that religion can have a negative influence on their life. Consequently, research which can help identify clinical benefits or harms of spirituality/religion allows each facet to emerge.

Life Dimension or "Disorder": Past Theoretical Assumptions

Historically, psychiatry, at least in the US, has often taken a less than neutral stance in assessing the role of religious/spiritual beliefs in a person's life. Freud viewed religion as "a universal obsessional neurosis...infantile helplessness...a regression to primary narcissism."(12) Contemporary US psychologist Albert Ellis, best known for his significant work on Rational Emotive Therapy, wrote:

> *Religiosity is in many respects equivalent to irrational thinking and emotional disturbance...The elegant solution to emotional problems is to be quite unreligious...the less religious they are, the more emotionally healthy they will be.(13)*

Freud's suppositions reflect his personal avowed atheism,(14) with his viewpoint embodied in his theoretical assumptions.(15) Yet to dismiss the spiritual/religious dimension as inherently pathological suggests a rather simplistic, non-neutral stance regarding a dimension of life centrally important to many. Furthermore, it lacks openness to recognition of the potential positive role religion/spirituality may play in some patients' lives.

Systematic Research Reviews Find Clinical Benefits

To bring objectivity to these theoretical assumptions, researchers investigated to what degree these assertions of religion/spirituality as psychopathology have found support in quantitative research in four leading western psychiatry journals.

A systematic review of psychiatric research published in the American Journal of Psychiatry in 1986 surveyed all articles published in psychiatry's top four general psychiatry journals during five years. These included the British Journal of Psychiatry, Canadian Journal of Psychiatry, American

Journal of Psychiatry, and the Archives of General Psychiatry. This comprehensive review found only 3 of the 2,348 quantitative studies contained a religious variable as the central focus of the study. Only 1 study used a state-of-the-art measure, a multi-dimensional religious commitment questionnaire previously tested for reliability. Only 2.5% of the quantitative studies included any religious variable including denomination, with more than three-fifths of this already small 2.5% using just a single item of denomination, inadequate in measuring beliefs, attitudes, or frequency of practices.(16) Consequently, studies of religious or spiritual commitment in psychiatry seemed to fall far short of the level needed to build such definitive theoretical constructs.

In the studies that did include a religious variable, researchers investigated whether findings would confirm US psychiatry's historical presupposition of harm. A systematic review of all quantitative articles published during more than 10 years in the American Journal of Psychiatry and the Archives of General Psychiatry found 72% of the findings revealed a positive clinical association between religious commitment and mental health, 16% were negative and 12% were non-significant.(17) Furthermore, parallel findings emerged in systematic reviews in the fields of family medicine(18) and epidemiology research.(19) High levels of benefit, if not higher, are documented in the recent Oxford Handbook of Religion and Health.(1) Similar reviews are now needed of journals beyond the US to assess whether studies reveal similar findings.

Understanding Prevalent Patient Religious Coping:

At least two US studies have documented desires of psychiatric patients for spiritual support, with more research needed. A 1995 survey of 30 psychiatric patients with diagnoses including schizophrenia, bipolar disorder, unipolar depression, schizoaffective disorder, and personality disorder, found:

- A substantial 83% felt that spiritual belief had a positive impact on their illness through the comfort it provided and the feelings it fostered of being cared for and not being alone.
- 57% attended religious services as well as prayed at least daily.
  However, a quite sizeable 38% expressed discomfort with mentioning their spiritual or religious concerns with their therapist.(20)
    - A 1997 survey compared spiritual needs of 51 psychiatric inpatients with 50 general medical inpatients matched for age and sex:

  Some 80% of the psychiatric inpatients and 86% of the medical inpatients considered themselves spiritual or religious persons
  A substantial 48% of psychiatric patients and 38% of medical inpatients reported they were "deeply religious."
  When asked to what degree they relied on religion as a source of strength:
  68% of psychiatric patients and 72% of medical patients indicated "a great deal."
  Only 10% of psychiatric patients and 2% of medical patients indicated "not at all."

The study also found that 88% of the psychiatric patients and 76% of the medical patients reported having three or more specific spiritual/religious needs while hospitalized. These included

- the need to know God's presence (84% of psychiatric patients, 82% of medical patients)
- the need for prayer (80% of psychiatry patients, 88% of medical patients) and
- the need for a visit from a chaplain to pray with them (65% of psychiatric patients and 66% of medical patients).(21)

Historically, many US doctors have remained unaware of the central role religious faith might play in helping patients deal with illness. For example, one study at Duke University Medical Center found that 44% of hospitalized medical patients indicated that religious beliefs were the most important factor in coping with their illness. However, only 9% of physicians recognized this central role.(22) Religious issues often have remained neglected. The new focus in psychiatric residency training to become more aware of a patient's religious values and beliefs encourages more responsive care.

Illness and Spiritual Crisis:

Why might patients pronounce the potential relevance of spirituality to their care? A decline in mental or physical health often precipitates a spiritual crisis. Patients often start to question their purpose in life, the meaning of their work, their relationships, and their personal identity, as well as their ultimate destiny. Furthermore, patients may draw upon their spiritual/religious beliefs in dealing with anxiety about their diagnosis, pain from their illness, a sense of isolation, and feelings of loss of control.(23,24)

Religious practices and beliefs may promote a positive, optimistic world-view that gives meaning, which in turn provides a sense of purpose and direction and enhances hope and motivation.(25)

Ethical Concerns in Addressing Patients' Spirituality

A few healthcare professionals have argued that spiritual/religious issues have little place in medical care, calling spirituality a "non-medical agenda," (26) although these comments referred to medicine and not necessarily psychiatry or mental health care. Yet for those patients for whom spirituality and religion are significant, the ethical responsibility suggests the importance of attention to spirituality.(27)

Consequently, the physician who is committed to the patient's best interests should consider when and how best to respond to patient spirituality, if the patient deems it relevant, with the physician or psychiatrist doing so within appropriate professional boundaries. Because patients often draw on their religious/spiritual beliefs in the context of their serious illness, physicians who have no such belief systems themselves can still consider how best to respect and, when appropriate, support patients' beliefs that may assist them in coping with illness.

Psychiatric Residency Education

Mandates of the US Accreditation Council (ACGME) for Graduate Medical Education in 1994 required educating psychiatry residents about

religious and spiritual factors as a potentially relevant dimension of patients' lives.(28) To meet the need for instruction in addressing patients' religious/spiritual issues, a group of US psychiatrists from diverse religious persuasions-Buddhist, Hindu, Jewish, Christian, Moslem, and agnostic-formulated a model curriculum released in May 1996 at the APA annual meeting for use by psychiatric residencies in supporting the development of their own programs. The Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice: A Course Outline(29) provides three core units, eight accessory units and suggested learning formats.

Residency training courses build on curricula now in more than two-thirds of US medical schools focusing on spirituality and medicine.(30) The Association of American Medical Colleges (AAMC) also has provided curriculum objectives that underscore the importance of addressing patients' spiritual issues as part of becoming a compassionate doctor, stating physicians should seek to understand the patient "in the context of the patient's beliefs and family and cultural values."(31)

Also, from 1997-2000 in the conjunction with the then National Institute for Healthcare Research, now the International Center for the Integration of Health and Spirituality, the John Templeton Foundation awarded 16 outstanding programs in psychiatry and spirituality, including 13 general programs and 3 in child and adolescent. Awardees included Harvard, Baylor, and Georgetown.

The programs cover a variety of topics and use a number of different teaching approaches. Residents learn how to perform an in-depth spiritual-religious-values assessment as well as how to recognize spiritual strengths, distress, and supports. Patient interviews, either live or videotaped, are used to demonstrate psychopathology involving religious content on the one hand, or how spiritual/religious beliefs and practices can provide support or strength during psychiatric illness, on the other.(32) Teaching approaches have included clinical case conferences and group supervision to teach residents how to address and work with patients' spiritual issues. Some programs have panel discussions by members of the clergy or patients of various religious/spiritual backgrounds.

Aspects of the professional therapeutic relationship are also discussed with issues of transference and countertransference in relation to the spiritual aspects of the psychiatrist-patient relationship. Boundaries and ethical considerations are addressed.

(For more information on residency curriculum, please see "Spirituality in Psychiatry Residency Training Programs," in the International Review of Psychiatry (2001), 13, 131-138.31)

Assessment

In taking a spiritual or religious history a psychiatrist has the opportunity to learn more about a patient's spiritual/religious resources, potential motivations, or possible defenses without either advocating or disparaging a patient's particular religious beliefs.

Possible areas or inquiry might include the following: (For a fuller discussion please see "Religion and Mental Health: Evidence for an Association," International Review of Psychiatry (2001) 13, 67-78,(25) or

"Spirituality and Religion in Psychiatric Practice: Parameters and Implications. Psychiatric Annals 2000; 30(8):549-555.(33)

- What is the patient's spiritual/religious background?
- Are spiritual/religious beliefs supportive and positive, or anxiety-provoking and punitive?
- What role did spirituality/religion play in childhood, and how does the patient feel about that now?
- What role does spirituality/religion play now in a patient's life?
- Is religion/spirituality drawn upon to cope with stress? In what ways?
- Is the patient a member of a religious community? How supportive do they perceive it to be?
- What is the patient's relationship with their clergy like?
- Are there any spiritual or religious issues the patient would like to discuss in therapy?
- Does the patient's spiritual/religious beliefs influence the type of therapy he or she would be most comfortable with?
- Does the patient's spiritual/religious beliefs influence how he or she feels about taking medication, indicating views that may impact compliance?

After assessing the patient's religious background and spiritual needs, the psychiatrist may need to coordinate resources to meet those needs when appropriate. This may involve collaborating with a mental health professional trained in spiritual or religious issues, or skilled chaplains or clergy in an outpatient setting, or, in the case of inpatients, when appropriate, authorizing visits from a hospital chaplain, or the patient's clergy, or a friend from church, synagogue, mosque, or temple.

Summary of Part I

A renewed focus by psychiatry's professional organizations recognizes the potential relevance of patient spirituality/religion in clinical care. Quantitative research findings have generally pointed to benefits to mental health not merely harm, as some theorists had proposed. The acknowledgement of the World Health Organization of spirituality as one component of well-being across cultures along with patient surveys in the US have documented the potential relevance of spirituality/religion to many patients.

To better understand the role patient spirituality might play in either positively helping patients cope with mental illness on the one hand, or negatively adding to the conflict or distress on the other, psychiatry residency programs in the US are now incorporating curricula on addressing patient spirituality. This includes learning to take a spiritual/religious history to assess whether this dimension is relevant or important to the patient and discovering how it might help or hinder, and then learning how to potentially address these issues in the treatment setting.

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