What proportion of psychiatrists take a spiritual history?

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Background:

Spirituality is defined as that area of human experience where people feel connected to a larger dimension of meaning and experience. The Somerset Spirituality Project found that many clinicians either ignore an individual's spiritual life completely or treat their spiritual experiences as nothing more than manifestations of psychopathology.

Keeping the Faith - a charity report from The Mental Health Foundation, funded by the Department of Health, explored how spiritual activities as part of an integrative approach can support the mental health and healing of patients.

Recent research has noted the salience of religion and spirituality to those with serious mental illness (Bussemer & Bussemer, 2000; Sullivan, 1998).

Psychotic patients who reported using their religion for coping with illness had more insight into their illness and were more compliant with medication protocols than those who did not (Kirov et al, 1998). Self-esteem, life satisfaction and quality of life has been consistently associated with positive religious coping (Koenig et al., 1998b; Pargament et al., 1998b).

Training guidelines exist for taking a spiritual history (Larson et al., 1997). There are a number of models for spiritual assessment which include: Maughans' model (Swinton 2001), *Healing from Within: a guide for assessing the religious and spiritual aspects of people's lives* (Culliford & Johnson, 2001) and the *HOPE* questionnaire (Anandarajah & Hight, 2001). The care programme approach also highlights the spiritual beliefs of a patient to be an important aspect of their rehabilitative process while the key performance indicators also have laid stress on spirituality. However many psychiatrists still feel reluctant to broach this subject for fear of overstepping their professional boundaries.

In order to provide holistic care to our patients we cannot afford to overlook taking a spiritual history. As clinicians, it allows us to identify and utilize pre-existing defences that have been used successfully in the past. This can help in drawing up strategies to reinforce coping behaviour. Another important aspect is the utilization of readily available support structure in the community (e.g. social support and social networks).

Spirituality is also an important aspect of cultural competence. Though first-hand knowledge of a patient's cultural background does not necessarily prevent biased reactions, it does reduce the distortions produced by stereotypical thinking.

Methodology:

A cross-sectional survey was conducted across the entire Oxleas NHS Foundation Trust asking career grade psychiatrists if they took a spiritual history or discussed the impact of spirituality on their patient's lives. Respondents were invited to provide any comments or feedback about their viewpoints. Electronic case records were also accessed to find out the proportion of patients who had any documentation of an assessment of their spiritual needs.

The questionnaire was sent via email to 123 psychiatrists out of whom 74 responded giving a response rate of 60%. Amongst the ones who did not respond 10 were on annual leave. Most of those who responded chose to explain the situations in which they took the history and the factors hindering them from doing so more frequently.

Electronic case records revealed that only 45% of the patients had any record of a spiritual preferences/history in the column for spirituality.

Results:

Of the 74 psychiatrists who responded to the questionnaire, 37 (50%) said they sometimes took a spiritual history or discussed the impact of spirituality on their patients lives. The rest 37 (50%) did not discuss the topic at all. There were 2 people (5.4%) who claimed that they always took a spiritual history while others discussed the issue as and when they felt it was relevant to the case - generally in terms of psychopathology.

Another finding was that amongst the ones who took a spiritual history, most were consultant psychiatrists (15/37). Very few of the trainees did so; the reason cited being the emergency assessments, which did not give them time to go into details about such issues.

Responses included:

'It is sometimes difficult to delineate spiritual experiences from psychopathology.'

'I ask with minority ethnic cultures or if the topic has emerged in the core assessment.'

Examples given of what was asked:

'Do you have a faith that helps you at a time like this?'

'In difficult times what keeps you going?'

Reasons for not asking included:

'Don't consider it important/relevant in the culture that we live in'

'Assume that most of the patients don't give importance to spirituality'

'Do not consider it important'

'Another tick box - a waste of time'

'Feel that it is too personal'

'Lack of time - more important things to discuss and explore in assessment.'

'Might make some psychotic patients even more paranoid or reinforce their beliefs'

'I am not aware of the tools to use'

'Are we allowed to ask that?'!

Discussion:

The road to recovery from a mental illness is not simply about the disappearance or amelioration of the symptoms. It involves cognitive reprocessing of the entire episode, an emotional understanding of the event including the spiritual and social consequences.

A number of studies in 1950s and 1960s, as well as some recent studies, report an association between religion and worse mental health (Dreger, 1952; Cowen, 1954; Rokeach, 1960; Dunn, 1965; Shafer, 1997; Sorenson, 1995).

On the other hand, credible studies indicating health benefits with religion/spirituality have been published in a range of clinical journals: (Neeleman & Persaud, 1995; Bradley, 1995; Idler & Karl, 1997; Koenig et al, 1997; Ortega et al., 1983).

Spirituality can be both a boon and a bane. Many patients have felt rejected by their respective religious communities, especially those that attribute mental health problems to sinfulness or inadequate faith and those that have a narrow range of acceptable appearance and behaviour. In certain parts of northern Europe, religion is seldom used as a way of coping with stress, probably reflecting low rates of religious involvement.

Importantly, people who do not espouse any religion may nonetheless have a spiritual dimension to their life. Our patients put it best when they say this:

'For me it has been a spiritual journey. Regardless of what anyone else chooses to call it, that's what it's been for me'. (Mahler in Weisburd, 1997)

‘Nonetheless I am convinced that depression can be a pilgrimage; an arduous journey in which one must be prepared to be broken in order to live again (or indeed in) some cases to live for the first time’. (Inglesby, 2004; Baker et al. 2004).

This cross-sectional survey was an attempt to look at how we as psychiatrists address something that is important to our patients - their spirituality. The questionnaire did not quantify the reasons for not taking a spiritual history but it did look qualitatively at the impediments to the process by inviting comments. The frequency of taking a spiritual history was not noted and the responses may not necessarily reflect the complete picture. Yet the responses do provide a starting point to benchmark the process of spiritual history taking, and may be grouped into:

- Lack of awareness about the important role of spirituality in people’s lives
- Fear of overstepping professional boundaries
- Lack of information for appropriate tools to use
- Considered to be unimportant

Conclusion:

Spiritual history taking is a much neglected field. There is a glaring lack of awareness about the importance of this aspect in a patient’s life. The information about how to take a spiritual history is not routinely taught and there is little information disseminated to trainees about how to take a spiritual history.

Even though 50% of the psychiatrists in the survey stated that they took a spiritual history, it was generally sporadic and in the context of assessment of delusions.

With the incorporation of spiritual needs in the care programme approach and key performance indicators, the government is acknowledging the importance of this issue.

Patients have long identified spirituality to be an essential component in their recovery process. It is time that we as clinicians start listening to our patients and discussing with them what gives meaning and purpose to their lives.

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