'Introduction to Spirituality, Health Care and Mental Health'

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Introduction

In the modern world much emphasis is placed on the intercultural understanding of moral/ religious issues. Mental health science, with its holistic approach, becomes very relevant to this dialogue. It is inevitable to feel that science and spiritual matters may not be entirely 'compatible', and in everyday clinical practice the areas in which physicians usually deal or recognise matters of the 'soul' are limited. The religious affiliation of patients is written in the case notes, generally not by the doctor, and religious matters may be an issue touched on in cases of patients - or their relatives - objection to certain types of treatment, or in terminal care and bereavement. In fact, spirituality is part of the psychology of any individual, and may not refer to a specific affiliation or evidence of religious practice but to the way the individual understands the 'world', 'people' and 'events' from his/her most intimate, existential, perspective.

When it comes to mental health, awareness of spiritual aspects of the person will tell us about the patient's personality, core constructs, attitudes and finally ability to cope, comply and improve – or indeed the opposite. It will also tell us about the patient's background, upbringing, social milieu, and it will help us understand why methods of treatment or care plans acceptable to one sector or society may not be acceptable to other groups.

What is 'spirituality'?

'Spirituality is an individual and a social phenomenon that becomes embodied in culture and formal religions. These in turn address the need to explain conduct, morality, rituals and superstitions' (Lawrence, 2004).

Spirituality has been defined in a number of ways. The word 'spirit' derives from the Latin '*spiritus'*, meaning breath. Human minds can be seen as unified by the conscious perception of existence, and it is conceivable that at the beginning of one's life the mind might hold the innate ability to develop a spiritual propensity and language, serving the purpose to provide a response to automatic existential questions such as needing to ask where we come from, why we suffer and why we die. 'Spirit' equals a possible life-force which vitalizes human life; yet as a psychic phenomenon it is intangible (Swinton, 2001). Through this life-force the human being is motivated to search for the meaning of existence, and this occurs in a 'transpersonal' way - which means beyond the purely individual sphere of one's perceptions, and with reference to 'another' source of life and energy not appreciable in strictly empirical terms.

In itself it is a broad and nebulous term, since it encompasses different levels of expression, from the generic notion of a 'soul' to its anthropological and cultural developments. These are embodied by many religious faiths which also carry historical heritage in the form of morality, customs and rituals. In this way, whilst the belief in a transcendent aspect of human life is at the core of spirituality, its philosophy and teachings may be reflected in different ways according to the faith of groups or of individuals.

According to Swinton (2001) *the central features of spirituality are:*

- *Meaning: the ontological significance of life; making sense of life situations; deriving purpose in existence*
- *Value: beliefs and standards that are cherished; having to do with the truth, beauty, worth of a thought, object or behaviour; often discussed as 'ultimate values'*
- *Transcendence: experience and appreciation of a dimension beyond the self; expanding self boundaries*
- *Connecting: relationship with self, others, God/higher power, and the environment*

- *Becoming: an unfolding of life that demands reflection and experience; includes a sense of who one is and how one knows.*

Categories of spirituality have been broadly defined as the beliefs in a power greater than oneself, purpose in life, faith, trust in providence, finding meaning in suffering, gratitude for life, life as a gift, and behavioural expressions such as prayer, meditation, group worship.

Spirituality and diversity

The personal experience of the transcendent is innate and universal, and in turn acts as foundation to the unique language and identity of individuals (Piedmont, 1999). Societies are formed by individuals assembled under different religions that deal with the question of human origins, existence, morality and social interactions. (Turner, 1995; Dollahite, 1998). Formal aspects of spirituality are first acquired through families and social network, verbal and written traditions and rituals. The meaning of innate spirituality may therefore be said to assume a global relevance, whilst religions witness to diversities between ethnic groups and the right each group and individual have to be respected in their make-up, beliefs and ways of life. (Sachs, 2002). Diverse communities of faith will therefore in their own language interpret and explain life, survival, disease and death.

Until recently, spirituality has been seen as a predominantly religious issue, yet many people do not - or elect not to - subscribe to a particular faith or its ritual expression. These people are indeed still 'spiritual'. This relates to their need to find a sense of purpose and meaning in life, and it could show as interest in nature, arts, music, literature, poetry, or indeed to the personal constructs around the meaning of one's life, the importance of friends and family, social concerns and civic accountability. Even then, the link with their own race and cultural heritage will bring on particular expression to their non-denominational spiritual interests.

The role of spirituality in health

The issue of spirituality is becoming increasingly topical in healthcare. The National Health Service (NHS) is developing spiritual care policies to ensure that services are sensitive and responsive to the needs of patients, relatives and carers. The Patient's Charter (1991) states that all patients can expect NHS staff to acknowledge their spiritual needs and aspirations and be sensitive to the wide variation in values and cultural backgrounds of their patients. The Human Rights Act introduced in 2000 sets down the rights of an individual to religious observance. Everybody has spiritual needs which forms a part of the biopsychosocial approach to care. The NHS recognises this need for physical, mental, social and spiritual care and is reflected by the increasing number of chaplains/spiritual caregivers at a time of shorter patient stay in hospital and decreasing number of long-stay patients. The NHS is also required to provide worship space appropriate to all faith groups.

Understanding spirituality can lead to better doctor - patient relationships and less litigation, thereby benefiting both sides (Chan K-P et al, 2003). Health Care providers need to respond to the changing and developing needs of this multi-cultural nation and develop services in line with best practice. The World Health Organisation (WHO) describes health as a state of physical, mental and social well being and not merely the absence of disease or infirmity. Taking a holistic view encourages us to understand what is important to an individual.

Discoveries and advances in neuroscience have made scientists interested in the relationship between the mind and the immune system and research shows increasingly that the spiritual dimension is of utmost importance in health and illness. Asking about a patient's faith in the social history can yield some very useful information. This is a culturally diverse society and it is widely recognised that different world views can have a far reaching effect on the perception of disease and hence on the reaction to illness and recovery from it. A diagnosis of serious illness can provoke a crisis of meaning of life, also called spiritual crisis (Ellerhorst-Ryan, 1985; Doyle, 1992; Elsdon, 1995; Carroll, 2001).

On the other hand, people who are in touch with their own spirituality have a better chance of staying (mentally) healthy and/or recovering if they become ill.

Doctors have reported how their faith can help them in their professional lives to experience more fulfilling ways of working and surviving the frustrations of a troubled health service (Chan K-P et al, 2003). Understanding colleagues showed respect for their spiritual needs and doctors were relieved from undertaking certain procedures e.g. obstetricians with regards to abortion. In 'Duties of a Doctor', the GMC tells us to recognise our limitations (including that arising from personal beliefs) to avoid prejudice and to refer a patient on as appropriate. Doctors should be aware of how their own value systems may impact on others; show respect for patient's faiths and their own with regards to controversial issues which include blood transfusion, organ transplantation, fertility, etc. The NHS is expected to make every effort to provide for the spiritual needs of patients as well as staff.

Relevance of spirituality to coping with disease

Patients' attitudes to spirituality and religion affect attitude to diagnoses and treatment. In psychoimmunology, outcome has been linked to anxiety and hope. The stronger the spirituality of the patient in the face of severe illness, the better the expectation of coping. Scientific reports confirm the relevance of spirituality to outcome in chronic pain, diabetes, haemodialysis , malignancies, fractures, coronary bypass surgery , terminal illness and other medical and surgical pathologies. It is reported as producing a more positive attitude in AIDS sufferers. Individual prayer has been found to generate a more positive emotional state in preparation for cardiac surgery and a better psychological recovery in burns patients. In polio survivors, there is description of increased awareness and appreciation of the support received.

In a study of 108 women suffering from gynaecological cancers, Roberts et al. (1997) reported that 85% had some connection with religion and 76% felt that religion had an important place in their life. Forty nine women had become more religious since their illness and in 93% cases they found that religion

helped them sustain a hopeful attitude. Similar findings applied to cohorts with breast cancer (John, 1991). Here, factors such as relationship with God and religious coping behaviour were associated with survivor's well being in a sample of 32 women suffering from the disease (Gall, 2000).

Reed (1996) studied cohorts of healthy, non - severely ill and terminally ill patients and found that in those with terminal cancer faith and prayer were effective coping mechanisms, stronger than in those with curable conditions, the healthy coming last in religious concern (Reed, 1996). Cross-cultural factors are relevant. Jewish and Christians are, for example, reported to adopt the same religious motives in explaining the upheaval of a diagnosis of cancer (Kappeli, 2000).

Spirituality and mental illness

When faced with a stressful situation, individuals change the way in which they behave. They adapt their behaviour to the stressful situation in a way that will allow them to cope longer, and in these moments spiritual matters come to the fore.

Their reappraisal looks outwards, to expedients enabling practical coping mechanisms, but also inwards, where moral and spiritual resources may be found to provide back up at a time of struggle. Why is this happening? Why to me? What does it mean to me? These are the key questions asked by those who suffer, the search for meaning allowing space for spiritual growth, attempting to compensate the weakening effect of the 'insult', a trauma or disease, indeed a mental illness.

An individual facing a critical situation may seek for solutions from what he/she perceives to be 'outside' his/her sphere of control. Spirituality may produce a dimension where control is handed over and at the same time shared with the transcendent, creating moral strength and detachment. Individuals reviewing their lives may decide to change their habits into healthier ones, perhaps to drink less alcohol or to smoke less. They may reorganize their

priorities and, for example, where financial concerns and career may have had primacy, health, family values and support may for example come in their place.

Moral growth through crisis equally relates to those individuals who do not subscribe to a religious group. In fact, the 'god' may not have a name or be culturally identifiable. Religious principles may be replaced by moral reflection. In today's world theophanies abound, minor and major sects, philosophical and heuristic ideologies and this is a particular phenomenon of western spirituality. It is, however, to be expected that as faith and dogmas may be disowned or forgotten at an individual level, the cultural principles of conduct underpinning Christianity, Judaism or Islam, for example, will remain at the core of the moral philosophy of individuals.

Spirituality is therefore bound to be relevant to the phenomenology of psychosis, affective illness, neurosis, to the coping with stress, bereavement, disease, to the management of anxiety and depression, of suicidal behaviour, to the care of the elderly and their carers.

The impact of spiritual matters is very important in the care of the elderly, where individuals seek connectedness and endurance at the end of life, and spirituality appears to preserves self esteem and individual integrity, further creating shared opportunities to benefit from a social network. Spiritual attitude and faith seems to help the older person cope with bereavement and to protect against depression, suicide. It also has a positive effect on the ability to cope of carers of persons with dementia. For elderly people in institutional care, spirituality has been associated with increased survival.

According to Swinton (2001), the primary ways in which spirituality contributes to the enhancement of mental health are through the feelings of comfort and well being it generates, and the support of rituals and beliefs shared by communities.

Swinton further presents the possible integration of spirituality and spiritual care in the context of schizophrenia, bipolar affective disorder, stress and anxiety, depression and dementia. Anxiety may be accompanied by feelings of sinfulness and loss of meaning in life, obsessional behaviours and fear of death;

depression by inability to love and feel loved, hopelessness, shame and guilt as well as loss of meaning in life. In dementia there can be loss of sense of meaning and awareness, or fear and inability to communicate at a transcendental level. The spiritual beliefs of families, friends and carers are also put to the test by the presence of mental illness.

Spirituality perspective in schizophrenia
(adapted from Swinton, 2001)

- Search for meaning, hope, value, purpose and restored relationships
- Continuum between distortion and clarity of belief structures
- Distorted perception of God/ transcendence, self and the world
- Religious delusions

Spirituality perspective in bipolar affective disorder

(adapted from Swinton, 2001)

- Need for positive value, meaning and hope.
- Heightened awareness of relatedness to God/transcendence.
- Continuum between distortion and clarity
- Increased legalism/dogmatism
- Need for forgiveness and reconciliation
- Search for meaning, hope, value, purpose and restored relationships

Spirituality perspective in stress and anxiety

(adapted from Swinton, 2001)

- Fear of consequences of sin
- Loss of meaning in life
- Obessional religious thoughts and actions
- Inability to focus on God
- Alienation and indifference
- Loss of previous spiritual belief
- No sense of future/fear of death

Spirituality perspective in depression

(adapted from Swinton, 2001)

- Hopelessness/dispiritedness
- Loss of meaning in life
- Loss of relationships/inability to love and feel loved
- Alienation from God or higher power
- Loss of inner strength
- Loneliness, desolation
- Shame and guilt

Spirituality perspective in dementia

(adapted from Swinton, 2001)

- Loss of awareness and relatedness to God/transcendence
- Loss of sense of meaning
- Hopelessness/dispiritedness
- Loss of meaning, purpose and value
- Apparent disinterest in spiritual dimensions

Spirituality and psychiatrists

Patients appreciate being asked about their spirituality, even if they do not subscribe to a formal creed. One USA study showed that among over 200 patients, 77% would like doctors to consider their spiritual needs and 37% would like to discuss these. Also, 48% expressed the wish that the physician would pray with them. In contrast, 68% physicians in this study had not considered or discussed any matter relating to spiritual needs with their patients (King, 1994).

Data from patients attending a rehabilitation centre also confirmed that over half (54%) would like to receive spiritual support, whilst in about 73% of cases no member of staff had mentioned spiritual requirements (Anderson, 1993). In another study, 22 patients who had survived a recent life-threatening illness were asked to comment on their experience. Their comments could be grouped in categories, including spirituality, prayer and rapport with the doctor. Faith was important in psychological healing and patients were happy to talk about spiritual matters with their physician. However, the physician was expected to have the required understanding disposition (Hebert, 2001). In the UK, a study of elderly in-patients showed that the input of the chaplain was much valued (Ross, 1997).

Psychiatrists still largely neglect to assess the spiritual dimension of their patients' psychopathology yet they equally feel that spiritual matters are relevant to psychiatry (Neeleman, 1993). A study of 208 Australian old-age psychiatrists yielded interesting results. 43% had no religious affiliation, 25% attended monthly services, 85% believed that there is a link between religion and mental health while 34% had never referred patients to a pastoral counsellor (Payman, 2000).

Awareness of spiritual and religious issues becomes particularly important when religious beliefs clash with prevalent morality and ethical judgment. There are, for example, instances of refusal of treatment by competent adults on the grounds of religion, and the possibility of tragic consequences must be borne in mind. Asser (1998), for example, described a series of 172 children who had died after their parents had declined standard treatment because they relied on faith

healing. Psychiatrists may be called to give an opinion in cases where psychopathology in the patient affects moral decisions, such as in maintaining pregnancies, supporting requests for termination, decisions to refuse treatment for terminal illness, or requests for the withdrawal of life support. In these cases consideration of legal frameworks and of patients' cultural and spiritual background becomes essential in discerning a balanced view.

Psychiatric training in the USA has incorporated the notion of professional respect for patients' beliefs and religious practice. Here in the UK, instruction is given that diagnosis and treatment at odds with individuals' morality should not be used. The DSM-IV includes a category of 'religious or spiritual problems'.

The Association of American Colleges Medical School Objectives Project indicates that doctors should '…seek to understand the meaning of the patients' histories in the context of the patients' beliefs, and family and cultural values' (AAMC, 1998) and in the United States, medical schools are now conducting courses on spirituality (Levin, 1997). In the UK the Royal College of Psychiatrist Spirituality and Psychiatry Special Interest group has been active for a number of years and encourages the integration of the teaching of spirituality at an undergraduate and postgraduate level.

The role of doctors and chaplains.

In recognition of the difference between religious and spiritual care, the NHS proposed that the title 'spiritual caregiver' should replace 'chaplain', as some faith groups associate chaplaincy with the Christian religion, which is not thought to be universal enough.

Religious care is intrinsically spiritual in nature and is given in the context of shared beliefs, values, liturgies and lifestyle of a faith group. Spiritual care is not necessarily religious and is usually given in a one-to-one relationship, is person-centred and makes no assumptions about personal conviction or life orientation.

It is argued that spiritual care should not be left only to religious leaders, and a number of healthcare providers give this care informally in the course of

their work. However, this needs to be acknowledged and training and support provided where necessary. There needs to be continuity of spiritual care from hospital to the community through partnerships between the NHS and community care givers. Difference in faith should not stop a doctor from providing spiritual care as part of a holistic package. History taking should routinely include spiritual beliefs and needs. It is important to note that a patient's belief may evolve and indeed change in line with life experiences. This must be acknowledged and supported without judgment. A doctor should be open and able to acknowledge his/her limitations in line with the requirements of a governing body such as the General Medical Council, and appropriate referral should be instituted with training and support as appropriate. Spiritual needs, which equate with any other aspect of care, must not be ignored because of prejudice or incompetence.

The clinical approach

In psychiatry we consider biological, psychological and sociological factors responsible for psychopathology. The clinical psychiatrist's reference set is in 'normal schemata' and these are challenged by patients' mental illness. Here one deals with individuality rather than standardization, quality rather than quantity, and on a one-to-one, the clinician's psyche is also being tested versus that of the person seeking help. The psychiatrist should seek an in-depth knowledge of his/her own motivational moral attitudes and of his/her accepted or rejected spirituality before embarking on dealing with the same in individuals who are vulnerable by virtue of their illness. A non-judgmental attitude can arise out of self-reflection and acceptance of the wholeness and uniqueness of individuals.

A spiritual dimension, from subliminal to overt, applies to diverse life phases in different degrees. Pathoplastic and healing effects of spirituality become more critical at especially introspective periods, statistically challenged by disease, frailty, the final resurgence of unresolved conflicts or indeed the inability to articulate one's unmet needs.

We should therefore: (Lawrence, 2002)

- acknowledge the possible spiritual dimensions in ourselves and others
- develop a deeper understanding of cultural and intercultural dimensions of patients
- develop a readiness to ask 'sensitive' questions concerning the patient's spiritual outlook
- follow the therapeutic lead if one presents
- avoid judging patients' behaviour according to ones understanding of the spiritual
- aim throughout to support our patients and promote their psychological integrity.

At a clinical level, a simple method of addressing spiritual issues in the assessment of mental state has been suggested by Puchalski (1999). She cites four questions:

1) Do you consider yourself spiritual or religious?
2) How important are these beliefs to you, and do they influence how you care for yourself?
3) Do you belong to a spiritual community?
4) How might health care providers best address any needs in this area?

Questions like these could be simplified for those with lesser verbal ability and in those with cognitive dysfunction.

A patient's spiritual history should include a reference to the more general spiritual belief system of the individual, as well as to unique aspects of his/her personal spirituality, and a summary of what spiritual norms 'must' be followed by the individual, or which the individual wishes to follow (this can relate to food, medication, transfusion, surgical procedures etc.) with respect to aspects of his/her treatment. These can on occasion be detrimental to health and call into question delicate ethical issues.

Finally, especially for elderly patients, it is important to be aware of their wishes, in case of terminal care, for example, and the likelihood of advanced directives. Elderly patients with mental health needs, as well those people having degrees of learning disabilities, may or may not be able to express their spiritual needs in a meaningful language. It is the moral, ethical and professional duty of those who care for them to seek to be aware that these needs are still met, as in each and every case - and without exclusion or prejudice - good doctors are ultimately called to work in respect and acknowledgment of the dignity of every human being.

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Postscript on teaching by St George's Hospital Medical School Interest Group in Spirituality and Mental Health, which includes this publication (*)

St George's Hospital Medical School claims a long tradition of excellence in undergraduate teaching, and the Mental Health Department remains at the

forefront of academic developments as it constantly seeks to critically review and update its curriculum in order to offer students a well integrated programme that gives ample opportunity to learn about the interaction between physical health and disease and many related psychological and social issues. The Medical School is situated in a very cosmopolitan area of London, and reflects the needs of its natural social habitat by instilling in its students foundations of good principles of ethical professional behaviour and of the necessity to consider the dignity of mankind and human diversity. In this search for progressive learning opportunities, a core issue that has been addressed is the relevance of the interface between spirituality and mental health.

Since 2002 a group of teachers has gathered to work on the best way to present the subject of spirituality to medical students. This was a pioneering endeavour, as this was to be the first medical college in the United Kingdom to undertake such work. This is in sharp contrast for example with the near hundred medical colleges in the United States, where teaching modules on spirituality has been the norm for many years.

The subject of spirituality has been integrated in the curriculum of undergraduate medical students at different levels, i.e. Common Foundation Programme, Special Study Modules and formal lectures. The lecture 'Introduction to Spirituality, Health Care and Mental Health' is part of the formal teaching programme for year IV medical students.

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