

**The Spirituality Gap: Does this exist between Patients and clinicians?: Can we
bridge this gap?
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Spirituality in recent times has become an area that has been discussed at important professional meetings and conferences. This area has in the past, been alienated by the world of psychiatry. In medicine the dividing lines between religion and science have been clearly drawn. This artificial separation is in marked contrast to the earliest roots of medical practice. In many parts of the world a holistic view of the person has survived this is seen in Chinese medicine, in the healing arts of the American Indians and in our own culture as seen among Indigenous Australian peoples.

The last fifty years have seen a gradual rapprochement between science and faith. The western model of the dichotomised mind body has been challenged on many fronts. Wig and Narendra used illustrations from Hinduism, to show the interrelationship of mental health and spirituality in India where the mind body dichotomy concepts is not followed. The converging influences with the impact of Eastern religious thought, emergence of New Age thinking, the popularity of alternative health providers have all called for a more holistic understanding of health related issues. In an American study Astin J et al found that the central reason why many people are looking outside the biomedical model for their health care was the need for whole person therapy.

There is increasing awareness across professions of the importance in the area of spirituality and religiosity holds to many patients. Thus there have been suggestions and research validating the incorporation of aspects of spirituality and religiosity into multidisciplinary assessments and interventions for patients with psychological and physical illness.

The domain of spiritual aspects of psychiatric patients has been overlooked in psychiatric assessments and in planning management of these patients. Reasons for neglect often cited include among others is the emphasis on psychiatry solely as a scientific model, and the presence of a religiosity gap (or spiritual gap) between clinicians and their patients.

The first Australian Survey on Patients Spiritual needs and Attitudes found that the significant majority rated spirituality as very important to them in their illness and to their ability to cope. A survey simultaneously carried out of Psychiatrists predominantly who attended to the cohort who took part in the survey found that 90% of the Psychiatrists surveyed rated spirituality of the patient as not important. This raised the very real and important issue of the Spiritual Gap that existed between the Clinician and the patient who was seeking help. The presence of a Practical Gap was also identified with the Medical professionals.

In a study in New Zealand a "Practical Gap" was confirmed between patients and their therapists. This study found that while two thirds of the sample of patients reported beliefs in "God", Atheism and agnosticism were more frequently reported in the sample of psychiatrists, suggesting the presence of a religiosity gap, thus replicating similar

studies in UK and USA. This study further found that only 11% of the sample of patients reported a spiritual history being taken in their psychiatric assessments. Psychiatrists confirmed that these beliefs were important in the psychiatric assessment yet they only occasionally took a spiritual history. This is referred to as the “practical gap” Lack of practical skills and poor teaching may be attributed to the “Practical Gap”. This study also found that 94% of psychiatrists surveyed said that they had not received formal or informal training in this area in their postgraduate training

This paper will address this important issue with results of surveys and randomised control trials using the spiritually augmented cognitive behaviour therapy demonstrating the positive adjunct use of the patient’s appropriate spiritual and religious practices. Thus ways to eliminate the ‘Spiritual and Religious gap between patients and their clinicians to benefit patients will be explored. The evidence of significant improved outcomes in controlled trials using an added spiritual focus will be discussed.

In conclusion the evidence suggests that the integration of spirituality into treatment can have an enhancing effect on recovery. Spiritually based interventions and collaborations that can enhance successful treatment must be used, thus being able to achieve positive health outcomes in a sustainable manner, thus we may be able to achieve our goal of social and emotional well being and wellness maintenance for patients.

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