

The importance of spirituality in medicine and its application to clinical practice

Russell D'Souza

Nothing in life is more wonderful than faith — the one great moving force which we can neither weigh in the balance nor test in the crucible . . . Faith has always been an essential factor in the practice of medicine . . . Not a psychologist but an ordinary clinical physician concerned in making strong the weak in mind and body, the whole subject is of interest to me.

William Osler¹

While spirituality is a concept globally acknowledged,² there is no consensus on how to define it.³ Spirituality can encompass belief in a higher being, the search for meaning, and a sense of purpose and connectedness. Although religiosity and spirituality are not synonymous, there can be a wide overlap between them.⁴

In discussing spirituality, one is really discussing the ways in which people fulfil what they hold to be the purpose of their lives. Thus it is easy to understand why so many different definitions of spirituality have been proposed.

Some perceive human beings as having two realms of existence. The outer realm consists of a person's interaction with the world. The inner realm is his or her interaction with the transcendental, which may be a divine being or ideals hinted at through experiencing such feelings as awe, love, and appreciation of beauty. Most people would hold that correct action in the outer realm consists of justice and magnanimity, while the inner realm deals with sincerity.⁵ These principles may arise from different contexts. For example, in the monotheistic faiths one acts justly to know God, whereas in Buddhism one acts justly to be released from suffering.⁶ But, despite differing beliefs, the concept of spirituality is fundamentally similar for most people.

History, mental illness and medicine

Mind, body and spirit are integrally connected. Western medicine, unlike traditional Eastern systems, has dichotomised the body/mind and soul/spirit.⁷

Historically, psychiatry has undergone major changes considered by some to be "revolutions". Medieval concepts of mental illness stressed that individuals had free will and were responsible for their actions — mental illness came from sin and the resulting punishment from God. As sin was central to mental illness, religious activity was believed to be central to cure.⁸ The first major revolution in psychiatry was in the 17th and 18th centuries, when the so-called "Age of Enlightenment" saw a move away from the realm of religion to the science of mental health.⁸ Then, in the late 19th and early 20th century, the work of Sigmund Freud heralded the "age of psychoanalysis".⁹ A third revolution, the "age of deinstitutionalisation", came with the discovery of chlorpromazine in 1954. The drug brought about significant improvement in the control of symptoms, leading to the closing down of many asylums and the movement of patients into the community.¹⁰ The latest age, which could be called the "age of empowerment and consumerism", began in the mid-1990s and continues today. It is an age in which we are informed of patients' needs, including the spiritual and religious dimensions of managing their mental illness.

ABSTRACT

- Recent international and Australian surveys have shown that there is a need to incorporate the spiritual and religious dimension of patients into their management.
- By keeping patients' beliefs, spiritual/religious needs and supports separate from their care, we are potentially ignoring an important element that may be at the core of patients' coping and support systems and may be integral to their wellbeing and recovery.
- A consensus panel of the American College of Physicians has suggested four simple questions that physicians could ask patients when taking a spiritual history.
- Doctors and clinicians should not "prescribe" religious beliefs or activities or impose their religious or spiritual beliefs on patients. The task of in-depth religious counselling of patients is best done by trained clergy.
- In considering the spiritual dimension of the patient, the clinician is sending an important message that he or she is concerned with the whole person. This enhances the patient-physician relationship and is likely to increase the therapeutic impact of interventions.
- Doctors, health care professionals and mental health clinicians should be required to learn about the ways in which religion and culture can influence patients' needs and recovery.

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The spiritual dimension of the patient

Medical training in the Western world has strongly revolved around the more easily measured physical aspects of patients and their care. Learning how to deal with the spiritual aspects of medical care is not a typical part of medical school or college curricula, yet evidence is emerging that it is something our patients want and expect us to do as part of the care we provide.¹¹⁻¹³ In patients' interactions with clinicians and medical practitioners, they do not cease to be human beings with deep and wide-ranging needs. Indeed, it is in times of illness, crisis and transition that life, death and other spiritual matters may loom all the more strongly in a patient's consciousness. Recognising patients' spiritual concerns could be seen as an essential part of the patient-centred medicine that is increasingly thought to be crucial for high-quality patient care.¹⁴

Integration of science and humanism for the patient's health

It can be difficult to avoid emphasising the idea that science and humanism are on two opposing sides. It is an opposition that translates easily into stereotypes — science as cold and unfeeling, and humanities as warm-hearted and well intentioned but less scientific. But both sides can be united under the umbrella of "medical humanities", in a shared approach that deepens our understanding of human health and wellbeing. An approach that

calls on multiple perspectives — biomedical, spiritual, philosophical and sociological — can help clinicians develop insight into the relationship between patients, doctors and the health care system, thereby enhancing their capacity to cure, relieve and comfort patients.¹⁵

Doctors and healing

Doctors and clinicians are healers through the caring relationships they form with patients.¹⁶ Caring often requires calling on an individual's inner strengths. These strengths, among others, include spiritual resources that support integration or wholeness of body, mind and spirit. By addressing the spiritual and religious dimensions in patient care, clinicians can be truly holistic and bring patients' wellbeing to the forefront. Spiritual and or religious care that is ethical and sensitive is an invaluable part of total patient care.

Attending to the spiritual dimensions of the patient can provide the physician with a more in-depth understanding of the patient and his or her needs. We may thus use a variety of spiritually informed therapeutic tools that can greatly facilitate the patient's coping ability, thus enhancing wellbeing and recovery.

Clinicians' own religious or spiritual practices or non-practices may affect their ability to function effectively in this area of clinical practice. As doctors, we have been trained to be "objective" and to keep our own beliefs and practices separate, but over time we have strayed into keeping patients' beliefs, spiritual/religious needs and supports separate from their care. Thus, we are potentially ignoring an important element that may be at the core of patients' coping and support systems and may be integral to their wellbeing and recovery — which is what we have set out to achieve in the first place.

Spirituality and religiosity for the patient

Patients want to be seen and treated as whole people, not simply as "diseases". A whole person has physical, emotional, social and spiritual dimensions. Ignoring any of these leaves the patient feeling incomplete and may even interfere with healing. For many patients, spirituality is an important part of wholeness, and when addressing psychosocial aspects in psychiatry this part of their personhood cannot be ignored.

There is evidence that many seriously ill patients use religious beliefs to cope with illness.¹⁷ Religious/spiritual involvement is a widespread practice that predicts successful coping with physical illness.¹⁸ Studies by Koenig et al suggest that high intrinsic religiousness predicts more rapid remission in depression, especially in patients whose physical function is not improving.¹⁹ In a meta-analysis of more than 850 studies examining the relationship between religious involvement and various aspects of mental health, a majority of studies showed that people experience better mental health and adapt more successfully to stress if they are religious.²⁰ Another analysis of 350 studies found that religious people are physically healthier, lead healthier lifestyles and require fewer health services.²¹

However, religious practices should not replace psychiatric treatments. This is because, while many people find that illness spurs them to metaphysical questions and helps them rediscover religion, no studies have shown that people who become religious only in anticipation of health benefits will experience better health.

Addressing patients' spiritual needs

The issue of patients' spiritual needs could potentially be addressed at the levels of academia, training and practice. In academia, relatively little attention has been paid to spirituality. In medical training, except in texts on palliative care²² and in ethics courses and seminars, spirituality is not directly considered, even though spiritual considerations will be present whenever patients' rights and needs are discussed. Doctors, psychiatrists and mental health clinicians should be required to learn about the ways in which religion and culture can influence a patient's needs.

What does all this mean for good clinical practice?

It may be beneficial to adapt existing therapies to patients' spiritual perspectives. There is evidence that cognitive therapies may be more effective if they take patients' religious beliefs into account.²³ The spiritually augmented cognitive behavioural therapy developed by our team has been shown to be effective in randomised controlled trials in patients who rated spirituality as important or very important.²⁴⁻²⁷ This therapy was associated with improved treatment adherence and higher satisfaction in the intervention group than the control group in schizophrenic patients who had recovered from psychosis.^{27,28} Patient-centred approaches, as a whole, help to maintain patient dignity and to ensure that the interventions offered are appropriate. These have resulted in positive outcomes, including better compliance with medication — poor compliance being a major barrier to achieving desired outcomes in psychiatry and greater patient overall satisfaction.^{26,27}

What doctors and clinicians should consider

Doctors and clinicians should not "prescribe" religious beliefs or activities for health reasons. They should not impose their religious or spiritual beliefs on patients or initiate prayer without knowledge of the patient's religious background and whether the patient would appreciate such activity. It is also not their role to provide in-depth religious counselling to patients — a task that is best done by trained clergy.

Doctors and clinicians should acknowledge and respect the spiritual lives of patients and always keep interventions patient-centred. Acknowledging the spiritual dimensions of patients involves taking a spiritual history.²⁹ This is not appropriate for every patient, although for people with life-threatening illness, it probably is. A consensus panel of the American College of Physicians has suggested four simple questions that physicians could ask patients:³⁰

- Is faith (religion, spirituality) important to you?
- Has faith been important to you at other times in your life?
- Do you have someone to talk to about religious matters?
- Would you like to explore religious, spiritual matters with someone?

Taking a spiritual history is often a powerful intervention in itself.³¹ Religious and spiritual patients, whose beliefs often form the core of their system of meaning, almost always appreciate a doctor's sensitivity to these issues. Doctors and clinicians can thus send an important message that they are concerned with the whole person, a message that enhances the doctor-patient relationship, the cornerstone of good medical care, which may increase the therapeutic impact of an intervention and move to achieve positive wellbeing.²⁷

Our calling as doctors and clinicians is “to cure sometimes, relieve often, and comfort always”.¹⁵ The comfort conveyed when a doctor or clinician supports the core that gives the patient’s life meaning and hope is what many patients say they want.¹¹ Considering these issues and approaching questions of spirituality and religiosity of patients will not only improve patient care, doctor–patient relationships and patient wellbeing, but may well come to be seen as the salvation of biomedicine.

Competing interests

None identified.

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