RELIGION AND SPIRITUALITY

Incorporating a spiritual history into a psychiatric assessment

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Objective: *To explore the importance of incorporating spiritual history into a psychiatric assessment and to develop and test a format for taking a spiritual history.*

Methods: *An overview of training and practice issues involved in taking a spiritual history is dealt with, and then the formal requirements developed, which include questioning style, content and form of the spiritual history, the evaluation of values and precautions to be considered. Finally its integration into clinical practice is considered.*

Results: *There are training exercises the clinician can do before taking a spiritual history. Clinicians must develop a trusting therapeutic relationship with the patient and approach the topic of spirituality with sensitivity. For a spiritual history to be useful an evaluation of the patient's value structure and possible expectation system needs to be undertaken and then available resources need to be identified.*

Conclusions: *A spiritual history needs to be incorporated into a psychiatric assessment. Clinicians should be trained to explore the patient's spirituality with sensitivity and skill so that the information obtained can be integrated into the greater psychiatric assessment and management of the patient, thus fulfilling the much required whole person assessment and therapy in the biomedical model.*

Key words: *psychiatry, psychiatric assessment, religion, spirituality.*

Unfortunately, spirituality refers to concepts that are hard to define and measure. A definition of spirituality could include 'personal views and behaviours that express a sense of relatedness to the transcendental dimension or to something greater than the self'.[1] Spirituality can encompass belief in a higher being, the search for meaning, and a sense of purpose and connectedness. There can also be a wide overlap between religiosity and spirituality.

Psychiatry has a history of ignoring, being in conflict with and attacking religion,[2] and dismissing spiritual experience as 'universal obsession neurosis', ego regression,[3,4] pathological thinking in need of modification, and a sign of emotional imbalance.[5] In many parts of the world there is now more spiritual awareness – 'spirit of the times'.[6] In 1995 a new diagnostic category, entitled 'religious or spiritual problems', was introduced in *Diagnostic and Statistical Manual of Mental Disorders* (4th edn; DSM-IV).[7] During the 1990s many articles on religion and spiritual issues in health and psychotherapy were published in mainstream journals.[6] This area has also been featured in many conferences of health organizations and associations.[8] Topics discussed have included the attitudes and skills of spiritually sensitive and competent therapists, and there has been a call for greater competency in religious and spiritual diversity in managing patient illness and recovery.

There is clear evidence of change. In its published guidelines, the American Psychiatric Association invites professionals to respect the patient's beliefs and rituals without enforcing diagnosis or using treatment at odds with

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the individual's morality. In Australia, national conferences including the Royal Australian New Zealand College of Psychiatrists (RANZCP) Annual Congress and the Annual Australasian Society for Psychiatric Research Scientific Meeting, have had papers presented in this area.[8,9] A recent RANZCP Part 1 written examination contained a question in the area of spirituality. This provides at least some evidence of the importance that this area is now gaining, in contrast to the neglect it received in the past.

SPIRITUALITY IN PRACTICE

Mental health practice often occurs in settings where there are significant constraints on the recognition of a spiritual dimension to the work. The setting in publicly funded mental health services is one where there should be an underlying assumption that a person's religious and spiritual beliefs should not affect access to health care and its benefits. This has possibly led to avoiding the issue of spirituality completely. In these services, staff may regard one's spiritual direction as a very personal matter, view this area as being outside the bounds of permissible discourse in one's work and hence rarely discuss spiritual experiences. Spirituality and science may be hard to integrate within clinical practice and the pressure to be scientific may cause some clinicians to shy away from the spirituality area.

TRAINING ISSUES

Another matter that needs to be considered is how traditional principles of morality within diverse races and cultures are to be accommodated in a system of medical education that is based on scientific rationality. This longstanding issue has become increasingly disconnected from sciences of 'the mind'. Western psychiatrists are trained to set aside their own spiritual and religious issues while assessing a patient. However, in the process they have tended to discard the patient's spirituality. There is a reasonable concern that this practice can lead to misdiagnosis and inappropriate treatments, in turn leading to loss of trust and loss of professional credibility.[10]

A New Zealand study found that only 11% of a sample of patients reported a spiritual history being taken in their psychiatric assessments.[11] When psychiatrists were surveyed, they confirmed that these beliefs were important in the psychiatric assessment even though they only occasionally took a spiritual history. Lack of practical skills and poor teaching could be partly responsible for this 'practice gap'. This study also found that 94% of the psychiatrists surveyed said that they had not received formal or informal training in this area in their postgraduate training. This may also be true of other specialties. To ignore spiritual and religious beliefs, particularly in the practice of psychiatry, could be seen as neglecting to carry out a fair and thorough assessment.[12]

TAKING A SPIRITUAL HISTORY

A format for taking a spiritual history, based on the work of Dr Gijsbers,[13] has been developed by an interdisciplinary team consisting of a psychiatrist, mental health workers, pastoral care members, aboriginal health worker and a drug and alcohol counsellor at the Centre for Excellence in Remote and Rural Psychological Medicine, University of Sydney, Broken Hill. This format has been effectively trialled. Reliability was demonstrated by a significant correlation between the spiritual histories taken by different trained clinicians on the same patient on two different occasions. A satisfaction outcome study on the patients who took part in this exercise suggested high acceptance of a spiritual history being taken by clinicians who followed the guidelines developed. Acknowledging the spiritual lives of patients may be achieved by taking a spiritual history. A spiritual history is likely to be appropriate for those with an illness that threatens life or a way of life. Taking a spiritual history in these cases is often a powerful intervention in itself.[14] A consensus panel of the American College of Physicians recently suggested four questions that physicians might ask seriously ill patients: (i) is faith (religion, spirituality) important to you at other times in your life?; (ii) has faith been important to you at other times in your life?; (iii) do you have someone to talk to about religious matters?; and (iv) would you like to explore religious matters with someone?[15]

TRAINING EXERCISES FOR CLINICIANS

There are exercises that clinicians can do to prepare themselves before taking a spiritual history. Clinicians can examine their own prejudices and biases, both positive and negative, around spirituality and religion. They can explore a religion from a different culture than their own. It may also be useful to familiarize themselves with some of the literature around spiritual experiences, pastoral therapy and spiritual direction. In addition, there are assessment issues that can be addressed by clinicians. These issues may include the possibility of a spiritual experience having psychotic elements, when a patient needs a spiritual referral, whom to refer the patient on to and finally, the part played by spiritual emergence. Clinicians may also wish to clarify the differences and overlaps between spiritual direction, pastoral care, counselling and psychotherapy. To supplement these exercises, clinicians may require appropriate supervision arrangements to be in place.

OPENING QUESTIONS

Clinicians are advised to consider an appropriate context for bringing in the spiritual-related questions. This might require considering important life events that have been causing the patient some concern. Sensitively seeking their permission before going into

details will be a step in the right direction. Their ambivalence or negativity might indicate an area of potential conflict that may in turn offer insight into an area of importance and perhaps into predisposing, precipitating or perpetuating factors for some of their current problems. Of course clinicians should be prepared to take a step back if it is a very sensitive topic, but they can also gently inform the patient that this might be an area worth exploring.

STYLE FOR HISTORY TAKING

Sensitivity is of paramount importance when taking a spiritual history. It requires the same sensitivity as taking a sexual history or a drug and alcohol history. The patient might not anticipate the questions and unexpected deep trauma might be uncovered, requiring recognition and management. There is an obvious need to encourage the development of trust prior to taking a spiritual history. Patients may well suspect that disclosing spiritual experiences may be construed as abnormal by the clinician and thus give restricted responses.

PRECAUTION

A concerted effort must be made to refrain from imposing the clinician's views on the patient. Boundaries must not be overstepped. Even the suggestion of subtle coercion must be guarded against. A respectful approach, together with sensitivity and the permission of the patient, are likely to impact positively and augur well for a good and comprehensive spiritual history being taken.

It is very important that the patient's integrity is respected. Doctors and mental health clinicians tend to be in positions of relative power in the patient–clinician relationship. Clinicians must therefore take all precautions to ensure that the patient's spiritual space is not invaded and that their vulnerability is not exploited.

FORM AND CONTENT

A complete spiritual history can facilitate counselling and psychotherapy enormously.[16] The initial issue is for the clinician to confront the general and cultural parameters of the patient's spirituality. Next, the more formal behavioural aspects as seen by the absence or presence of faith-driven behaviours can be explored. Religion and spirituality can be regarded as the two main components of the phenomenology of a person's faith. Religion is observable and is generally quantifiable, while spirituality is mostly subjective.

Spirituality enjoys both vertical and horizontal dimensions, thus encompassing both transcendental aspiration and compatible social networks. Its main purpose has been considered as giving stable meaning to life, and it is important to the integrity of the ego and its permanence.[17,18] Spiritual and religious variables lend themselves better to qualitative rather than quantitative exploration. The use of a detailed quantitative scale in this area may impinge on the quality of an effective comprehensive and spontaneous history.[19]

EVALUATION

It is important to identify a patient's values – what they are, why they hold them and what meaning they have for the patient. Cultural issues are crucial when evaluating a patient's value system because values are often brought by the culture and family background. It is also important to explore whether the patient's value system comes into conflict with that of the host culture or the outside world. In addition, it is useful to identify whether patients' values have an 'expectation' component. If expectations exist, provisions in the patient's support systems for patients to cope with failure to reach these expectations need be evaluated, and available resources to meet these expectations should be identified. For instance, forgiveness, atonement and restitution may be resources for a patient. Evaluation of the patient's value system is required in order for the spiritual history to be useful in understanding the patient and the place that their value and belief system have in their illness and in their health.

INTEGRATION INTO CLINICAL PRACTICE

It is proposed that spiritual matters and religion should be an integral part of a clinical psychiatric assessment. In the practice of exploring the area of spirituality, the aim should be to go beyond religious affiliation and practice and to reach a non-judgemental understanding taking into account general beliefs, cultural beliefs and values. Clinical practice should aim to explore the role that these values and beliefs have played in social and personal integration, or their opposite. It is important to find out whether these values and beliefs were sustained or rejected in later life. This information will place the psychiatrist and mental health clinician in a better position to formulate the problems faced by the patient, and may also be of value in reinforcing trust, credibility and the therapeutic alliance. In other words, this will be a positive step in working with the patient.

CONCLUSION

In conclusion, spiritual dimensions are intrinsic to any culture because cultures are inextricably entwined with morality, personal experience, conduct, concepts of shame, and psychological and social reward. Although religious practice might be found to be less prominent than in the past, spirituality has not necessarily declined. This is evident in the results of a survey of patients' spiritual attitudes and needs,[20] in which 79% of patients surveyed stated that spirituality was important to them.

Approximately two-thirds (67%) of surveyed patients said that their spirituality helped them cope with psychological pain. Thus, there is an argument that this area should be given consideration in the training of the modern psychiatrist and mental health clinician. This would mean that 'New Age' mental health clinicians are equipped to offer whole person therapy. This would, in turn, increase satisfaction and add quality to the biomedical model for patients' health-care needs thus fulfilling the much needed whole person therapy that many patients seek.[21]

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