

Spirituality, Religion and Health: The importance of its Application to
Clinical Practice

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Abstract

There has been a need to include the spiritual and religious dimension of patients into their care. This need is evidenced from recent Australian patient surveys that have been published.

Objective

To review the evidence for this need and to suggest the parameters in which this dimension might be applied

Method

The phenomenology of spirituality and its relevance to health and psychological well being is considered. The concept that doctor and the clinician is a healer is visited. The evidence that exists for the need of spirituality and religiosity for the patients is examined.

Results

There is a need to address patient's spiritual needs at different levels. Using data and experience the author suggest what clinicians might not do and what they might do. Thus this need of the patient might be attended in an ethical and sensitive manner

Conclusions

In considering the spiritual dimension of the patient the doctor can send an important message that he or she is concerned with the whole person – a message that enhances patient physician relationship, which is likely to increase the therapeutic impact of their interventions.

Key Words Spirituality, Religiosity, Doctor, Clinical practice

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'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 Osler [1]

Spirituality is a concept globally acknowledged [2]. However, attempts to reach a consensus regarding its nature have not met with success [3]. 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 becomes possible to see why so many different definitions of spirituality have been proposed.

Human beings are considered to have 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, this may be a divine being or ideals hinted at through such experiences as beauty, awe and love. Most people would hold that correct action in the outer realm consists of justice and magnanimity, and the inner realm dealt only through sincerity [4]. These principals may arise from different contexts thus in the monotheistic faiths one acts justly to know God, whereas in Buddhism one acts justly to be released from suffering [5]. But most people "with various beliefs" have spiritualities that are fundamentally similar.

Spirituality and Mental Health

Mind Body and Spirit are integrally connected. Western medicine dichotomised the body mind and soul / spirit in comparison to the eastern system [6]. Historically it has

been acknowledged that psychiatry has had three revolutions. The first being in the Middle Ages when mental illness was accepted as an illness rather than the earlier held belief that mental illness was a curse of God and treatments included corporal punishments. This of course saw mental illness move from the realms of religion to mental health. This period was also known as the 'Age of enlightenment'. The second revolution was the 'Age of psychoanalysis' thus an understanding into the possible dynamics into the stance that Freud took towards religion- the fear of return to the 'dark ages' pre age of enlightenment era could have been part of this reasoning. The third revolution is considered the 'Age of deinstitutionalisation' which was heralded by the advent of the neuroleptic Chlorpromazine. From this flowed the end of the paternalistic model that was the realm of management for patients with mental illness. It is now believed that we are heralding the fourth revolution the 'Age of empowerment of the consumer'. This has been a force that is currently seeing the need for re evaluating and changing our practises. An area of importance is the consideration and validation of the spiritual dimension of the patient and the need for 'whole person therapy'.

While medical training in the western world has been strongly concerned with more easily measured physical aspects, in the area of the mental needs it has virtually been mute on how to minister to the spiritual needs of our patients. Learning the spiritual aspects of medical care is not a typical part of medical school or the college curriculum and yet from the evidence we have it is emerging as something that our patients want and expect us to do as part of our caring for them. An Australian study [7] validated these findings and replicated results of similar studies in USA, New Zealand [8]. In patients interaction with clinicians / psychiatrists they do not cease to be human beings with deep and wide ranging needs. Indeed in times of illness,

questions of life and death may loom all the more strongly in a patient's consciousness. In times of crises, illness and transition, spiritual issues are likely to come to the fore of human awareness for both patients and professionals. Indeed, recognising patients' spiritual concerns may be viewed as an essential part of the 'patient-centred medicine' increasingly seen as crucial to high-quality patient care [9].

DOCTORS AND CLINICIANS ARE HEALERS.

Doctors and Clinicians are healers importantly through the caring relationships they form with patients. Caring often requires calling out an individual's inner strengths. These strengths amongst others include spiritual resources, which support integration or wholeness of body, mind and spirit. By addressing the spiritual and religious dimensions in patient care clinicians can truly be holistic and bring well-being to the fore front- the need of the day. Thus 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 well being and recovery.

Clinicians' own religious or spiritual practices or non-practices may impact upon their ability to function effectively in this area of clinical practice. Thus this is an area we must take cognisance of. As doctors, we have been trained to be objective and to keep our beliefs and practices out, but over time we have strayed into keeping the patients' beliefs, spiritual, religious needs and supports out, thus potentially ignoring an important aspect that might be the core to their coping and support system, that is integral not only to recovery but to their 'well being' - 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 persons, not as diseases. A whole person is someone who has physical, emotional, social and spiritual dimensions. Ignoring any of these aspects of humanity 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 their illness [10]. Religious/ spiritual involvement is a widespread practice that predicts successful coping with physical illness [11]. Further studies by Koenig at Duke University suggest that high intrinsic religiousness predicts more rapid remission in depression, an association that is particularly strong in patients whose physical function is not improving [12]. In a meta analysis of more than 850 studies examining the relationship between religious involvement and various aspects of mental health, between two thirds and three quarters of these have found that people experience better mental health and adapt more successfully to stress if they are religious [13]. Another analysis of 350 studies examining religious involvement and health found that religious people are physically healthier, lead healthier live styles and require fewer health services [14].

Having said this, it is clear that 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

Patients spiritual needs can be addressed at the levels of academia, training and practice. In academia relatively little attention has been paid to spirituality: a search of the Medline 1966 database, in February 2000, [4] yielded 19301 out of 10074921 articles- less than 0.2%. Further examination of the first 200 abstracts revealed that only 68 dealt with spiritual issues. Given that spiritual considerations are absent from few consultations, this absence of overt recognition is remarkable. As regards to training, except in texts on palliative care [15] and in ethics courses and seminars, spirituality is not directly considered in medical teaching, even though spiritual considerations will be present when ever 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 CLINICAL PRACTICE?

It may be beneficial to adapt existing therapies to patient's spiritual perspective. There is evidence that cognitive therapies may be more effective if they take a patient's religious beliefs into account [16]. The Spiritually Augmented Cognitive Behaviour Therapy developed by our team, has shown efficacy in randomised controlled studies, in patients who rated spirituality as important or very important in the patients spiritual needs survey [17,18,19,24]. The Spiritually Augmented Cognitive Behaviour Therapy was associated with improved treatment adherence and higher satisfaction than the control arm in schizophrenic patients who had recovered from psychosis [20,24]. 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 compliance with medication- a major barrier to outcomes in psychiatry and greater patient overall satisfaction [21,24].

We have included some thoughts in these regards, based on clinical experience, outcome studies and common sense.

What Doctors and Clinicians should consider:

Doctors should not ‘prescribe’ religious beliefs or activities for health reasons. Doctors and clinicians should not impose their religious or spiritual beliefs on patients or initiate prayer without knowledge of the patient’s religious background and the likely appreciation of such activity. Doctors and Clinicians should not provide in-depth religious counselling to patients, something 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 [22]. A spiritual history is not appropriate for every patient, although for those with illness that seems to threaten life or way of life, it probably is. A consensus panel of the American College of Physicians have suggested four simple questions that physicians may ask ill or seriously ill patients [23]. 1. “Is faith (religion, spirituality) important to you?” 2. “Has faith been important to you at other times in your life?” 3. “Do you have someone to talk to about religious matters?” 4. “Would you like to explore religious, spiritual matters with someone?” Taking a spiritual history is often a powerful intervention in itself [21]. The Doctor and clinician may consider if appropriate supporting the patients spiritual religious beliefs that aid in coping. Religious and spiritual patients, whose beliefs often form the core of their system of meaning, almost always appreciate the doctor’s sensitivity to these issues. The doctor and clinician can thus send an important message that he or she is concerned with the whole person, a message that enhances the patient- physician relationship, the corner

stone in good medical care, which may increase the therapeutic impact of the intervention and move to achieve positive well-being. (24)

Our calling as physicians and clinicians is to cure sometimes, relieve often and comfort always. The comfort conveyed when a doctor or clinician supports the core that gives the patient's life much meaning and hope is what many patients want in their therapy with health care professionals as evidenced in surveys. (7) Finally considering these issues and approaching questions of spirituality and religiosity of patients will not only improve patient care, doctor-patient relationship and focus on well-being but may well come to be seen as the salvation of biomedicine.

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