

REVIEW ARTICLE

Clinical implications of spirituality to mental health: review of evidence and practical guidelines

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Objective: Despite empirical evidence of a relationship between religiosity/spirituality (R/S) and mental health and recommendations by professional associations that these research findings be integrated into clinical practice, application of this knowledge in the clinic remains a challenge. This paper reviews the current state of the evidence and provides evidence-based guidelines for spiritual assessment and for integration of R/S into mental health treatment.

Methods: PubMed searches of relevant terms yielded 1,109 papers. We selected empirical studies and reviews that addressed assessment of R/S in clinical practice.

Results: The most widely acknowledged and agreed-upon application of R/S to clinical practice is the need to take a spiritual history (SH), which may improve patient compliance, satisfaction with care, and health outcomes. We found 25 instruments for SH collection, several of which were validated and of good clinical utility.

Conclusions: This paper provides practical guidelines for spiritual assessment and integration thereof into mental health treatment, as well as suggestions for future research on the topic.

Keywords: Spirituality; religion and psychology; practice guidelines; spiritual therapies; diagnosis

Introduction

Spiritual and religious beliefs are common worldwide. According to recent surveys,¹ at least 90% of the world population is currently involved in some form of religious or spiritual practice. There is consistent evidence that religiosity and spirituality (R/S) play a role in several aspects of life, especially mental health.²

Three systematic reviews of the academic literature have identified more than 3,000 empirical studies on spirituality and health.³⁻⁵ In general, individuals who have more R/S have less depression, anxiety, suicide attempts, and substance use/abuse, and experience better quality of life, faster remission of depressive symptoms, and better psychiatric outcomes.¹⁻³

In view of this evidence, many professional organizations, such as the American College of Physicians, the American Medical Association, the American Nurses Association, and the Joint Commission on Accreditation of Healthcare Organizations, recognize that spiritual care is an important component of health care and that health care professionals should integrate it into clinical practice.^{6,7} Concerning mental health, the World Psychiatric Association,⁸ American Psychological Association,⁹ American Psychiatric Association,¹⁰ and Royal College of Psychiatrists¹¹ all have sections dedicated to R/S.

However, translating research findings into practice is not always easy. There is a discrepancy between health care professionals' perception of the importance of addressing R/S during clinical care and the actual implementation of this approach.^{12,13}

Consistently, patients, physicians, medical students, and medical educators have assigned more importance to R/S in clinical encounters than has actually been done in clinical care and teaching.¹⁴⁻¹⁶ Most physicians have never addressed this issue in clinical practice¹⁵ and most patients continue to have undetected spiritual needs.¹⁷ Several reasons may help explain the neglect of R/S issues by mental health professionals: lack of awareness of the available evidence; lack of training on how to deal with R/S in clinical practice^{16,18}; influence of materialist authors and ideologies that dismiss or pathologize R/S¹⁹; historical myths of a perennial conflict between science/medicine and religion^{2,20}; the religiosity gap (mental health professionals being less religious than general and clinical populations)^{21,22}; and institutional rivalry between medicine and religion, since both deal with human suffering.

In psychiatry, these barriers were enhanced by the views of famous neurologists and psychiatrists in the 19th-20th centuries who suggested religion was a form of hysteria and neurosis.^{1,2,23} As a result, when religion came up in the clinical encounter, it was often either ignored or treated as part of the pathology that had to be corrected with treatment.²³ These negative attitudes towards religion have influenced many psychiatrists in the 20th century.²⁴

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In 2003, a national random sample of 1,144 U.S. physicians found that psychiatrists were less religious than other physicians. This gap and the lack of training on issues related to R/S and medicine make it more difficult for some psychiatrists to empathize with religious patients and provide appropriate, culturally competent care to these patients.²⁵ However, this same survey found that psychiatrists were more likely than other physicians to recognize positive and negative influences of R/S and to address R/S with patients.²⁶

In summary, despite the large body of empirical evidence on R/S and mental health and the recommendations of many professional associations, the translation and implementation of this knowledge to clinical practice has remained a challenge. Within this context, evidence-based practice guidelines on R/S could help mental health professionals better understand and integrate this information into their clinical practice. Therefore, the present paper aims to further examine the role of R/S in psychiatric practice and provide sensible, evidence-based guidelines on how to conduct spiritual assessment and utilize this information in mental health treatment.

Definitions

The definition of spirituality has been subject to much debate.²⁷⁻³⁰ Some authors have proposed including positive psychological constructs such as peacefulness, harmony, meaning, purpose, and satisfaction in life in the concept of spirituality.²⁹ However, other authors think that this conceptual expansion of spirituality to include positive psychological constructs is misguided. Spirituality is often related to these constructs, but is not equal to them. It seems better to define spirituality as a separate construct, related to the transcendent, the non-material and sacred aspects of existence and the universe.^{27,28} Therefore, the present article will use the following definitions⁴: 1) spirituality: the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community; 2) religion: an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality); 3) religiosity: the extent to which an individual believes, follows, and/or practices a religion.

R/S and mental health

There is a complex interplay between mental health and R/S, so one cannot hold a simplistic perspective that labels R/S as either “good” or “bad” for health.¹⁸ For example, a recent Brazilian study of 168 outpatients with bipolar disorder³¹ found that religion was reported as important in the participants’ lives (84%), and that intrinsic religiosity (i.e., religion as an end in itself and central to the person’s life) and positive religious coping (e.g., seeking support from a religious community, searching

for religious meaning in life and stressors, collaborative partnership with God) were strongly associated with lower depressive symptoms and better quality of life. However, although less prevalent (18%), negative religious coping (e.g., conflicts with God or the religious community, framing disease as a punishment from God) correlated with worse quality of life. Adding to the complexity of these findings, 30% of patients reported religious beliefs that conflicted with their treatment, and 23% indicated that their religious leaders interfered with mental health treatment.³¹

Similarly, high importance of religion to patients’ lives and a complex mixture of mainly positive (83%) but also negative (14%) aspects of religiosity were reported by 89 Swiss outpatients with schizophrenia or schizoaffective disorder. Baseline importance of spirituality among patients with positive use of religion predicted fewer negative symptoms, higher quality of life, and better social functioning at 3-year follow-up.^{32,33}

When interviewing or following up a patient, however, clinicians should bear in mind that R/S is often not a stable or fixed state in patients’ lives. In the Swiss study cited above,³³ although R/S remained stable and mostly highly important and positive for the majority of patients after 3-year follow-up, it changed (increased, decreased, changed from positive to negative or vice versa) in 37% of patients. An interesting finding was that patients who changed their religiosity, regardless of direction, displayed lower self-esteem and poorer quality of life as compared with those whose R/S did not change, even after controlling for clinical status and emotional functioning. As stated by these authors elsewhere: “spiritual and religious concerns may become part of the problem as well as part of the recovery.”³⁴ Such findings demonstrate the need for a more refined understanding of the interplay between R/S and mental health, and underscore the need for careful exploration of R/S with patients.

Assessing R/S in clinical practice

In July 2013, we searched PubMed using the Boolean query “(spiritu*[title] OR religio*[title]) AND (clinical practice OR interview OR history) AND (psychol* OR psychiat* OR mental).” This yielded 985 articles (empirical studies and reviews) published within the past 15 years. These articles focused primarily on mental health issues, but when appropriate, we also included papers dealing with related medical conditions. To find additional references, we screened the retrieved articles for related references. We also reviewed guidelines provided by medical associations and other published sources on spirituality and health. The most agreed-upon application of R/S into clinical practice was the need to obtain a spiritual history (SH).^{6,35,36} The SH explores the importance and practical implications of R/S in patients’ lives as it applies to their illnesses.

When taking the SH, it is essential to be aware that R/S is a multidimensional construct that may be articulated by patients in many different ways. These dimensions include beliefs, rituals, sense of transcendental connection, views

of God, ethical implications, mystical experiences, community or private religious practices, and so forth.^{4,5}

It is also important to avoid assumptions based on patients' affiliation or social background. Even in the same R/S tradition, there are different subgroups with diverse practices, interpretations of sacred texts, and behavioral implications. In addition, growing multiculturalism and religious syncretism make it essential to investigate each patient's own R/S beliefs and practices.³⁷

Our group of authors recently published a systematic review of the use of instruments for taking a SH, discussing their strengths and weaknesses on the basis of 16 attributes (including ease of memorization, validation, and range of R/S areas covered).³⁶ Most of the 25 instruments were developed for general use in clinical practice, and only two were developed specifically for mental health: the Royal College of Psychiatrists Assessment³⁸ and the Spiritual Assessment Interview.³⁹ The FICA (faith, importance, community and address), which obtained the highest score (covering 13 items), is a brief measure that takes only 5 minutes to administer and is useful both in general and in psychiatric practice when shortage of time is an issue.³⁵ The other highly ranked instruments were SPIRITual History⁴⁰ and FAITH⁴¹ (covering 12 items) and HOPE⁴² and the Royal College of Psychiatrists Assessment³⁸ (covering 11 items) (Box 1). The latter measure is the only instrument directed specifically for mental health and takes 20-25 minutes to complete. It is more useful for mental health professionals, as it provides a more comprehensive exploration of psychosocial issues.

Besides assessment, the SH may also have therapeutic implications, sending a message to patients that the clinician is concerned with the whole person.⁴³ Some studies show that assessing patients' R/S is associated with improved patient perception of healthcare quality. To our knowledge, the first study to investigate the feasibility and impact of taking a SH was by Kristeller et al.⁴⁴ These investigators studied 118 consecutive outpatients of four oncologists. Patients were alternately assigned to either usual care or usual care plus a SH, which lasted about 6 minutes on average. The SH was well-accepted by patients and oncologists. After 3 weeks, patients from whom the SH had been obtained showed less depressive symptoms, better quality of life, and a greater sense of interpersonal caring from their physicians compared to the control group. In another study,⁴⁵ 83% of internal medicine patients aged 55 years or older with depression or anxiety reported that it was extremely or somewhat important to discuss spiritual issues when counseling for mental disorder. No patient said it was not important at all. Patients who chose to include R/S were more likely to use positive religious coping and collaborative problem-solving styles than those who did not wish to include it.

Likewise, in a recent study of 3,141 internal medicine inpatients at a university hospital in the U.S.,⁴⁶ 41% desired a discussion about R/S concerns during hospitalization. However, only half of those had such discussions, demonstrating a large unmet need. Another important

finding was that patients who had discussions on R/S issues during hospitalization had were 40 to 120% more likely to rate the quality of their healthcare at the highest level, compared to than those who did not have such discussions. It is notable that this association between discussing R/S and patient satisfaction was present regardless of whether the patient had initially said they wanted such a discussion.⁴⁶

With regard to psychiatric patients, Huguelet et al.⁴⁷ conducted a randomized controlled trial to investigate the impact of taking a SH during standard care of schizophrenic outpatients. Psychiatry residents received 90 minutes of training and 10 to 40 minutes of supervision on taking a SH during a regular appointment. Potential clinical usefulness of the SH was identified by psychiatrists in 67% of patients. Patients accepted the assessment well, and more than one-quarter wished very much to discuss R/S issues with their psychiatrists. After 3 months, patients who received the SH did not differ from patients who had not with regard to reports of satisfaction with care or adherence to medication. They did, however, have better appointment attendance (only 8% receiving the SH missed appointments during the 3-month follow-up, vs. 26% of those who did not receive the SH).

In summary, there are several good instruments for taking a SH during the clinical encounter, two of which are transcribed in Box 1. What limited evidence is available suggests that taking even a short SH may raise important clinical issues, have an impact on patients' satisfaction with care, and perhaps even influence clinical outcomes.

Practice guidelines

Here we suggest practical guidelines regarding the assessment and integration of R/S into the treatment of mental health patients.

General principles

First, a number of general principles should be kept in mind when assessing or addressing R/S issues with mental health patients:

- a) **Ethical boundaries.** The approach to R/S should be patient-centered, not prescribing, not imposing, and not proselytizing for spiritual or anti-spiritual worldviews.^{43,48}
- b) **Person-centered approach.** Implies appreciation of the physical, mental, and spiritual components of human beings, in what Cloninger¹⁹ has called "ternary awareness." All of these aspects have etiological and recovering implications for mental-disordered patients who trust clinicians in their quest for relief, well-being, and a full life.
- c) **Countertransference.** Given that clinicians' own spiritual or anti-spiritual values, beliefs, and personal history may raise important countertransference issues and influence clinical practice (e.g., having a strong or cold reaction, avoiding R/S issues or stressing them too much), it is important for clinicians to explore their own worldview and history of R/S issues.⁴⁹

Box 1 Spiritual history tools (FICA and Royal College of Psychiatrists Assessment)**FICA**³⁵**F - Faith and Belief**

Do you consider yourself spiritual or religious?
 Do you have spiritual beliefs that help you cope with stress?
 If the patient responds "No," the health care provider might ask, "What gives your life meaning?"
 Sometimes patients respond with answers such as family, career, or nature.

I - Importance and Influence

What importance does your faith or belief have in our life?
 Have your beliefs influenced how you take care of yourself in this illness?
 What role do your beliefs play in regaining your health?

C - Community

Are you part of a spiritual or religious community?
 Is this of support to you and how?
 Is there a group of people you really love or who are important to you?

A - Address in Care

How would you like me, your healthcare provider, to address these issues in your healthcare?

Royal College of Psychiatrists³⁸

The following questions are easily asked and not intrusive:

- What is the patient's spiritual/religious background?
- Are spiritual/religious beliefs supportive and positive, or anxiety provoking and punitive?
- What role did spirituality/religion play in childhood, and how does the patient feel about that now?
- What role does spirituality/religion play now in the patient's life?
- Is religion/spirituality drawn upon to cope with stress? In what ways?
- Is the patient a member of any religious community? Is it supportive?
- What is the patient's relationship with their clergy like?
- Are there any spiritual/religious issues the patient would like to discuss in therapy?
- Do the patient's spiritual/religious beliefs influence the type of therapy he or she would be most comfortable with?
- Do those beliefs influence how the person feels about taking medication?

Setting the scene

What is your life all about? Is there anything that gives you a particular sense of meaning or purpose?

The past

Emotional stress usually involves some kind of loss, or the threat of loss. Have you experienced any major losses or bereavements? What has been the effect, and what ways of coping have you tried?

The present

Do you experience a feeling of belonging and being valued, a sense of safety, respect and dignity? Is there openness of communication both ways between you and other people? Does there seem to be a spiritual aspect to the current problem? Would it help to involve a chaplain, or someone from your faith community? What more needs to be appreciated about your particular religious background?

The future

What does the immediate future seem to hold? What about the longer term? Is there a concern with death and dying, or about the possibility of an afterlife? Would it be helpful to discuss this more? What are your main fears regarding the future? Do you feel the need for forgiveness about anything? What, if anything, gives you hope?

Remedies

What kind of support would help you? How can it be asked for and from whom? Have you considered any self-help options?

- d) **Open-minded approach with genuine interest in and respect of patients' beliefs, values, and experiences.** Asking patients to share about their own R/S tradition is a good way to show genuine concern about the patient and his/her values. To improve cultural competence, it is important for clinicians to learn about patients' R/S traditions.³⁷
- e) **Self-disclosure.** Usually it is not appropriate for a clinician to disclose his/her own R/S views to patients. When clinicians and patients' worldviews are different, there may be conflict and disagreement. On the other hand, when R/S views are concordant, patients may avoid talking about issues they may perceive as inconsistent with the shared worldview. However, in some instances and when requested by the patient, clinicians should use their clinical judgment in sharing

their beliefs. Such sharing may help patients feel more comfortable in sharing their experiences and beliefs related to their tradition.⁴⁹

Spiritual history: which patients, where, and how?

The guidelines discussed in this section are based on the available evidence and on a broad review of clinical recommendations provided by professional association guidelines,^{50,51} journal articles,^{36,48,49,52} and textbooks written by experts in the field. In an attempt to make these recommendations more cross-cultural, we sought input from authors writing from a wide range of cultural perspectives.

The SH ideally should not be taken at the beginning of the interview, but after some rapport has been established, and should be conducted in a respectful and sensitive

manner, with “genuine humility and openness”⁵³ and “respectful curiosity.”³⁷ The use of language from the patient’s spiritual tradition may help show respect and build trust.^{49,53}

Exploration of the patient’s R/S may start after the patient indicates that this is important to him or her (e.g., using a religious word or object, carrying a R/S book) or by asking more general, existential questions (“What gives your life meaning?,” “What are your sources of comfort and strength when you are struggling with problems?,” “What helps you cope with your illness?”).^{49,52} These existential questions often lead to R/S when it is an important aspect of the patient’s life. If the patient is not religious or spiritual, these questions are helpful in exploring his or her worldview.³⁷

Another possible approach is to take a brief SH when assessing the patient’s sociocultural background or developmental history. Most reviews and guidelines recommend covering the following basic topics: 1) ask about faith and general R/S: “Are you religious, spiritual, or a person of faith? Is spirituality (or religion) important in your life?”; 2) organizational/community: “Are you part of a religious/spiritual community? Do you attend R/S meetings? Which activities? How often?”; 3) private practices: “Do you perform some private practice such as prayer, meditation, reading religious texts, or watching/listening to R/S programs or songs? When? How often?”; 4) impact: “Does your R/S influence the way you live your life and deal with your current problem? How? Some people say that R/S helps them cope with problems, and others find that R/S is related to troubles and conflicts. How is R/S affecting the way you deal with your current problem? How do your faith and religious community see your problem and treatment? Do they support it, oppose it, or are they neutral?”; 5) opening for other R/S aspects or needs: “Are there other R/S aspects of your life you would like to share? Do you have any other spiritual need that needs to be addressed?”⁵⁴

This initial assessment of R/S may reveal that a more in-depth exploration of the topic is needed. Areas that often warrant further examination include:

- Style of religious coping and relationship with his/her God or higher power (e.g., collaborative vs. passive vs. self-directed).⁵⁵
- Moral concerns regarding some decision to be made or action already performed. This also may raise questions regarding (self-) forgiveness.⁴⁹
- Possible sources of spiritual distress: negative religious coping (e.g., passive deferral to God, attributing all problems to the Devil), use of religious precepts to justify abuse of wives and children.³⁷ It is also important to distinguish when religious struggles are causes (e.g., too rigid or intolerant precepts leading to inappropriate guilt) or consequences (e.g., excessive guilt in depression) of psychopathology.¹⁸
- R/S resources the patients has used/developed throughout his/her life, since they may be useful in coping with current problems.
- Spiritual experiences: spiritual experiences (mystical, near-death, out-of-body, mediumship) may be life-changing, but also may raise fear and doubts since they

may not fit into the patient’s previous worldview.²¹ Spiritual experiences may also resemble psychotic and dissociative disorders, requiring a careful differential diagnosis. Guidelines for doing so are discussed in depth elsewhere.^{56,57}

- Spiritual development: previous positive and negative experiences regarding R/S that may have shaped the patient’s current worldview. This may involve traumatic or nurturing experiences with parents, other relatives, religious leaders, and other significant persons. It is useful to ask questions about the early environment (religious or secular traditions) in which the patient was raised and focus also on significant changes in R/S beliefs or practices throughout life.^{47,52}
- Conflicts with religious communities or with specific religious teachings.
- General religious beliefs, such as: a) about God: “What are God’s most meaningful characteristics?” (punitive vs. benevolent, distant vs. personal)⁴⁹; b) about life after death⁵⁸; and c) reincarnation.⁵⁹

Challenges to implementation

Given the low rate of translation of already available knowledge on R/S to clinical practice, it is useful to reflect on how to face this challenge.

As noted above, a national survey of U.S. physicians conducted in 2003 found that psychiatrists were more likely to discuss R/S issues with patients than were other specialists and general practitioners. Physicians who more often discussed R/S issues with patients were those who were religious or who received training on R/S and medicine from books or other continuing medical education (CME) materials.⁶⁰ Another U.S. study investigated the impact of physician religiosity on anxiety treatment provided by 896 primary care physicians and 312 psychiatrists. Although religious and non-religious physicians did not differ in referrals for psychotherapy or psychiatric treatment, religious physicians were more likely to encourage patients to use religious resources.⁶¹

Possible strategies to overcome barriers to implementation of the clinical guidelines proposed here include fostering clinicians’ cultural competence, which will increase sensitivity to patients’ R/S issues, and disseminating knowledge about available evidence regarding the impact of R/S issues on mental health and how to address R/S in clinical practice. With regard to the dissemination of knowledge, the availability of training from undergraduate to postgraduate education programs is paramount, as is the availability of CME materials, e.g., conferences, papers, books, and online resources. Triggered by research in R/S, as well as by ethical and professional guidelines regarding holistic and patient-centered care, medical schools have started to incorporate courses on spirituality and health into their curricula.⁷ According to recent surveys, 90% of U.S., 59% of British, and 40% of Brazilian medical schools have courses or content on R/S.⁶² In mental health care, the Accreditation Council for Graduate Medical Education (ACGME)

guidelines underscore the importance of addressing R/S issues in psychiatric training.⁶³ In fact, a significant number of U.S. psychiatry programs include a mandatory curriculum on R/S.⁶⁴ Nevertheless, a recent survey of Canadian psychiatry residencies found that almost 72% of Canadian programs did not offer residents training to prepare them to address the interface of R/S and psychiatry.⁶⁵ Given that patient belief systems play a key role in patient development and remain a powerful influence on responses to current illness and life demands, it is important that psychiatrists be aware of religious and spiritual issues.⁶⁵

Future research

Despite the wealth of empirical evidence linking R/S and mental health, much remains to be learned. The two greatest challenges are understanding the mechanisms of this association and developing interventions to implement what is already known. To reach these goals, the following research guidelines are proposed⁶⁶:

- 1) theoretically driven empirical research to investigate hypothesis about the mechanisms by which R/S impacts health (finding these mechanisms will be important in developing new preventive and treatment approaches);
- 2) more studies about the actual feasibility and impact of taking a SH in mental health patients;
- 3) how to assess and address R/S in non-Christian contexts, such as Muslim, Hindu, Buddhist, and Native American patients (this is crucial, as the same words may have very different meanings and social implications in different cultures⁶⁷);
- 4) development and testing of the effectiveness of spiritual interventions alone and/or in conjunction with conventional treatments;
- 5) outcomes investigated should not only focus on improvement of mental disorders, but on positive outcomes and healthy psychology (as spirituality may promote the development of “salutogenic” factors more than a decrease of “pathogenic” factors).

Conclusion

The most widely acknowledged and agreed-upon application of R/S to clinical practice is the need to take a SH, which may improve patient compliance, satisfaction with care, and health outcomes. Concerning integration of R/S into mental health treatment, most spiritual interventions have positive results (superior to control conditions or to other intervention) and seem to be highly cost-effective and beneficial to religious patients.

Disclosure

The authors report no conflicts of interest.

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