The role of spirituality in specialist psychiatry: a review of the medical literature

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Abstract
A review of the international medical literature was undertaken on the role of spirituality in the discipline of psychiatry, within the context that a perceived change is taking place in the health care environment in South Africa. Revitalized interest in spirituality was evident from the literature partly because Western societies have, through the migration of people, become more heterogeneous in recent years. The literature concurred that spirituality must be incorporated into the current approach to the practice and training of psychiatry, but within the professional scope of the discipline, while all faith traditions and belief systems should be regarded equally. Beyond South Africa, it is envisaged that the review has implications for the practice of psychiatry in Africa.

Keywords: Spirituality; Practice and training; Psychiatry; Medical literature; Qualitative inquiry

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Introduction

An earlier review of the South African medical literature related to the changes in mental health care delivery in South Africa identified a prominent issue regarding African traditional health practice, namely: whether the work done by traditional healers should be regarded as a religion or a modality of psychotherapy.[1] Some of the literature compared the traditional healer to the Western psychotherapist and considered traditional health practice more as psychotherapy than a religion[2-3], whilst others referred to African cultural beliefs as being primarily a religious and spiritual practice.[4-5] Within the context of mental health care delivery, such views require further study and clarification, specifically in terms of the relevance of spirituality to the discipline of psychiatry not only in South Africa, but also in Africa and countries outside of the continent. Several international authors from different countries have reported extensively on the role of spirituality in psychiatry since the 1980's. The countries include: the Unites States[6-9], Canada[10-11], the United Kingdom (UK)[12-15], the Netherlands[16-18], Brazil[19-20] and Australia.[21-22] Such content related to a range of issues:

- A systematic analysis of quantitative research on religious variables by Larson et al, found in four psychiatric journals between 1978 and 1982 revealed a considerable lag in the diffusion of academic knowledge and skills to evaluate religion in psychiatric theory, concept and methodology.[6] Larson et al., also reviewed the Glossary for Technical Terms of the revised third edition of the Diagnostic and Statistical Manual (DSM-III-R) for its references to religion and concluded that the high rate of illustrative case examples of psychopathology that involve religion, indicates cultural insensitivity in interpreting religion.[7]
- Koenig et al., provided ''a rebuttal to skeptics'' on religion, spirituality and medicine[8] and in several other editorials, he provided overviews to physicians on religion, spirituality and medicine.[23-25]
- Andreasen, as editor of the American Journal of Psychiatry at the time, stated in 2001: ''*We must practice and preach the fact that psychiatrists are physicians of the soul as well as of the body.*''[26]

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- Baetz et al., reported on the association between spiritual and religious involvement and depressive symptoms in a Canadian population.[10] Subsequent research for lifetime, 1-year incidence and past psychiatric disorders found that higher worship frequency was associated with lower odds of psychiatric disorders.[11]
- Sims from the UK, used the term ''cure of souls'' as point of departure and considered how the three groups: psychiatrists, religious people and patients, would differ in their understanding of its meaning.[12] He quoted Bhugra, who explained the problem as two next door neighbors: ''*. . . (the) two neighbours (psychiatry and religion)... should be on very good terms, but, due to a long-forgotten episode over the niggle about the size of the fence, have fallen out . . .*''[27]
- Culliford set a definition of spirituality within the context of the World Health Organization's quality of life (WHO-QOL) domains and the facets proposed for a WHO-QOL Spirituality, Religious and Personal Beliefs (SRPB) module.[13] While referring to an often quoted definition of spirituality by Murray and Zentner[28], he identified a new paradigm of research, moving beyond positivism, that includes qualitative research approaches such as participant observation, phenomenology and unstructured in-depth interviews.[13]
- Moreira-Almeida provided an overview of spirituality and psychiatry in a Brazilian context.[19] He and Koenig discussed the WHO-QOL SRPB that was used in a cross-cultural study in 18 countries, while considering the attributes of an ideal inclusive, trans-culturally validated measurement of religiousness and spirituality.[20]
- D'Souza and Rodrigo described an approach to ''spiritually augmented cognitive behavioral therapy'' (SACBT), which was developed and tested by a multidisciplinary team involving various clinical professionals, members of the hospital's pastoral team and an indigenous elder.[22]
- Robert Cloninger is, for example, also well known for the incorporation of spirituality in the existing approach to specialist psychiatric and psychotherapeutic practice.[29] His widely adopted theory of personality introduced a broadened and integrative approach to the psychiatric assessment, care and management of personality problems.[30] His theory involves four temperament dimensions and three character dimensions. The three character dimensions include self-directedness, cooperativeness and self-transcendence.[31-32]

It was against this background, where spirituality was observed to play an increasing role in secular fields such as health, mental health and psychiatry that a review of the international medical literature was undertaken.

Method

Ethics clearance for the research component of this study – which involved psychiatrist interviews - was granted by the Human Research Ethics Committee of the University of the Witwatersrand in 2007. The literature review as part of that study was conducted with the support of staff from the University of Witwatersrand's Faculty of Health Sciences' library, using the phrase ''*spirituality and psychiatry*''. The initial search covered the following databases: African Digital Library, Biblioline, BioMed Central, BMJ Clinical Evidence, Cochrane Library, Sabinet, Cudos, DOAJ, Ebsco Host, First Search OCLC, Thomson Gale, Ovid SP, JStor, MDConsult, Nexus, Oxford Scholarship Online, ProQuest, Psychiatry Online, PubMed, SAePublications, SAGE Premier Online, Science Direct, Scopus, Springer and Wiley Interscience. The search yielded 520 references. A literature review reference list was compiled from this initial database search of journal articles regarded as the most important references on: spirituality and practice related issues; spirituality and training; and users' perspectives on the role of spirituality. References that were excluded were those for which only abstracts were available, duplications, references not primarily covering psychiatry, or those only covering related areas such as quality of life. A descriptive record of each selected article was entered into an Excel spreadsheet according to a structured data sheet which included the following variables: record number; type of publication; country published; year; first second and third authors; title; journal reference; origin of author; text scope; method; and themes.

A thematic content analysis was made through the open coding of data. Open coding refers to the creation of certain categories pertaining to certain segments of text and is aimed at expressing data and phenomena in the form of concepts. Themes were not identified in advance, but derived from the interview and literature data.

Results

A total of 255 literature records were included in the formal review, of which there were: books (n=7); chapters in books (n=3); editorial comments (n=37); journal articles (n=202); and letters and reviews (n=6). A significant increase of literature records on the topic of spirituality and psychiatry over the past 20 years was noted. From 1986 to 1999 there were 39, whereas from 2000 to 2009, there were 216. Countries of origin of the literature records or authors were: United States (n=190); United Kingdom (n=15); Australia (n=13); Brazil (n=8); Canada (n=12); from Europe (n=6) - including the Netherlands, Germany, Norway and Switzerland; and other (n=11) - including China, Croatia, India, Israel, Nigeria, South Africa and South Korea.

Most literature records (n=204) were qualitative investigations or essay-type of overviews and commentaries and of these records, most were essays or commentaries (n=159), while others were literature reviews (n=22), conducted action research (n=10), or used focus group discussions (n=2), semi-structured, (n=7) or unstructured interviews (n=5). A total of 51 inquiries were quantitative in nature, using questionnaires in surveys (n=45), or structured scales of measurement (n=6).

In terms of themes identified from the literature, six concept categories were finally synthesized from the integrated data (Table I), in terms of which the literature content was summarized:

(1) Orientation in terms of spirituality and religion in psychiatry;
(2) Reality of spirituality and religion for practitioners and users;
(3) Routine assessment of spirituality and religion in psychiatry;
(4) Training of spirituality in psychiatry;
(5) Scope and boundaries of spirituality in psychiatry;
(6) Referral and collaboration on spirituality in psychiatry.

Orientation in Terms of Spirituality and Religion in Psychiatry

While psychiatrists are traditionally less inclined to be religiously or spiritually orientated than their clients or colleagues in other specialties, they are reported to be more comfortable and to have more experience in addressing religious and/or spiritual concerns.[12,33-37] This was also observed with regard to family practitioners, where participants in semi-structured interviews affirmed a role for family practitioners, although they differed in being comfortable addressing spiritual issues in their practice.[38-40] Psychiatrists do not necessarily have to have personal spiritual beliefs or convictions themselves, but as clinicians, they have to understand the importance thereof, as well as have skill and knowledge to make accurate assessments and appropriate referrals.

Many authors have referred to the significant increase over the past two decades in focus, research attention and publications in the field of spirituality and/or religion in general but also in particular regarding health, mental health and psychiatry.[41-45] Tracking the history of the split between religion and psychiatry over the past 200-300 years, authors referred to Freud's negative views of religion and the influence of his teaching on psychiatry in the 20th century.46 In addition to the historic split (''divorce'') between spirituality/religion and psychiatry[46-49], a recent process of reconciliation (''rapprochement'') has been observed over the past two decades in the long-divided healing traditions of science and medicine on the one hand and spirituality, and/or religion on the other.[50-53]

The extent to which spirituality and religion has currently been (re-)considered and (re-) incorporated into the practice and training of specialist psychiatry is reflected by the history of its incorporation into the diagnostic classification systems, in particular the Diagnostic and Statistical Manual (DSM). Authors mentioned how the concepts were considered first in the DSM-III[67], where religion was still used in culturally insensitive examples of psychopathology only, and then in the DSM-IV, as a separate category that may be a focus of clinical attention, but which is not regarded as psychopathology.[54-56] A

Table I: Concept categories from literature content

Categories	*Subcategories*
1. Orientation in terms of spirituality and religion in psychiatry	1.1 Own view of and attitude towards spirituality 1.2 Academic view of medical science and of patients 1.3 Providers' perspectives 1.4 Principles in practice: history and philosophy 1.5 Definition of spirituality and religion; concepts and definition
2. Reality of spirituality and religion for practitioners and users	2.1 Extended model of care: "bio-psycho-social-spiritual" 2.2 Principles in practice: approach 2.3 Users' perspectives
3. Routine assessment of spirituality and religion in psychiatry	3.1 Need assessment 3.2 Communication and appropriate intervention 3.3 Liaison and referral 3.4 Presentation and symptoms 3.5 Assessment, measurement and research
4. Training of spirituality in psychiatry	4.1 Understanding of spirituality and its role in mental health care 4.2 Didactic teaching on spirituality and religious faith traditions 4.3 Approach towards spirituality and religion in psychiatry 4.4 Personal growth, professional development and competency
5. Scope and boundaries of spirituality in psychiatry	5.1 Ethics of spirituality in psychiatric practice; Principles in practice: ethics 5.2 Continued education and peer review 5.3 Psychotherapy
6. Referral and collaboration on spirituality in psychiatry	6.1 Facilitating appropriate referral and intervention for individual users 6.2 Information sharing and mutual awareness between disciplines 6.3 Addressing stigmatization of users with psychiatric conditions 6.4 Religious-spiritual traditions 6.5 Spiritual professionals' perspectives

particular tone and direction about how the role of spirituality should be regarded in the psychiatric profession was set by prominent international academics.[57-58] As the causes and manifestation of psychopathology are more deeply connected to culture and spirituality, Fabrega calls for the restoring of cultural psychology to its rightful place in the taxonomy, nosology and rationale of systems of diagnoses.[57]

According to Carr the social function of spirituality has to be recognized, as well as the internal validation of individual spirituality.[59] Rhi used a conceptualization of the traditional shaman as ''prototype'' of healer to contrast it with the one-sided materialistic, mechanistic view of patients - currently pervading modern medicine - that only chemically treats symptoms of disease.[60] Reports on the different official policy positions of the medical profession and the discipline of psychiatry in different countries, provided some perspective on the process, time and resources that were invested to achieve acknowledgement of the role that spirituality plays in the lives of people and to respond to it appropriately as a profession.[14,15]

No single perspective on the definition of spirituality seems to dominate in the postmodern culture. Multiple perspectives seem to exist.[13,26,28,61-67] Attributes of spirituality that were described included: ''a journey, transcendence, community, mystery of creation, transformation''[68]; ''the meaning and purpose of life, transcendence, connection with others and energy''[67]; ''relationships with others in faith community''[69]; ''inner realm reacting with the transcendental''[44]; and ''a person's attempt to make sense of the world''.[70] Considering the definition of the construct religion, authors regarded religion to have attributes such as: ''organized systems of principles, beliefs, rituals, practices, related symbols''[69]; ''the outer realm reacting with the world''[44]; and ''beliefs, practice and rituals related to the sacred or the 'numinous''.[62] The overlap between the two constructs included the search for the sacred and the process of establishing meaning[71], and the difference, that spirituality includes religion and relations with others, but is not limited by organized religion.[70]

Dein commented that the use of a Western definition of religion may not be useful in a cultural comparison with non-Western traditions.[72] Comments were made about the potential of religious institutions to become oppressive and divisive once contact with spiritual content has been lost. Cognizance should also be taken of other healing traditions, including Indian, Chinese and different indigenous perspectives.[73] Re-introduction of spirituality into health, mental health and psychiatry would make the field more ethical, caring and compassionate.[74]

Reality of Spirituality and Religion for Practitioners and Users

Gilbert outlined the discourse on spirituality and mental health over past decades and showed how it changed from focus on issues around ''race'' and ''color'' in the 1950's and 60's to religion in the present time.[15]

An approach towards considering the reality of spirituality in specialist psychiatry, would therefore have to first achieve clarity about the nature and definition of the boundary that exists between two adjacent, ''neighboring'' territories.[12,27] ''Turf battles'' between these spiritual professionals and health workers would be another matter which would benefit from clear guidelines and training in this regard.[12] Removal of such perceived tensions between patients' spiritual advisers and their psychiatrists may in itself allow patients to be more open about matters concerning their mental health and therefore may probably be more compliant with their psychiatric treatment.

Instances where patients themselves are less comfortable with religious advice and therefore search out the advice of psychiatrists and psychotherapists instead[52], may, according to Sperry, place a bigger onus on the latter two disciplines to provide some form of spiritual directive as ''substitute secular priests''.[75] According to Fallot, consumers noted both the potentially supportive and burdensome roles of religions and spiritual recovery, while professionals reported both hope for, and discomfort with, these domains.[76] Brooks and Koenig and Puchalski et al., reported on the need for programs, facilities and service providers to make allowance for spirituality in terms of infrastructure, budget and environment for patients to express their spirituality and religiosity.[77-78]

Positive associations between spirituality (salience) and better health outcomes were identified from research reports and were used by some authors to motivate the importance of spirituality's role in clinical settings.[79-82] A positive effect was also reported on medical conditions such as cardiovascular disease, hypertension, stroke and other stress and life style related conditions.[83-84] The psychopathological symptoms that apparently benefitted from spiritual and/or religious involvement, included: depression[10]; suicidality[85]; anxiety; and substance abuse.[86-88] Explanations for the positive influence of spirituality and/or religion, included that religious belief provides a positive worldview which gives experiences meaning and which also acts as an agent of social control.

Rumbold, referring to Sulmasy, discussed the principles of spirituality and psychiatry in practice.[89-90] On a clinical level, approaches to including spirituality and religion in routine clinical history taking, in ''spiritually augmented cognitive behavioral therapy'' and the use of more established models for family medicine practice were discussed.[21,91] Puchalski described a model (''FICA'') that refers to faith and belief (F), importance and influence (I), community (C) and address or action (A).[92] The place of spirituality in psycho-social rehabilitation was also reviewed, including: conducting spiritual assessments; discussion groups; facilitating linkages to faith communities and spiritual resources.[76-93]

A theoretical model was described by Koenig to illustrate the complex pathways in which religion may influence physical health.[94-96] His model demonstrates the complex influence of religion on physical health, considering genetics, childhood training and other social influences. Other theorists such as Cloninger, Vaillant, Anandarajah and Flannelly also presented more elaborate theories on the reality of spirituality for psychiatry. Cloninger's Temperament and Character Inventory (TCI) based on his theory of personality with different temperament and character dimensions, has been part of the teaching curriculum in psychiatry for many years.[29,31] Vaillant used arguments pertaining to genetic evolution and language development, to propose the maturation of human spirituality as the ''third'' human evolutionary process.[97-98] He suggested that three evolutions could be identified, the genetic (Darwinian) evolution, a

cultural evolution (mediated by the development of language) and then the maturation of human spirituality. Anandarajah described two multidimensional models for spirituality applicable across culture and belief systems that could be used for patient care, education and research.[99] Flannelly et al., discussed the ideas contained in their ''ETAS'' (Evolutionary threat assessment systems) theory, referring to how brain mechanisms that evolved to assess environmental threats underlie psychiatric disorders.[100-101]

Actual and potential service users have indicated in studies that they regard the role of spirituality and religion in general and in health matters as very important.[10,11,33-34,65,102] The role of spirituality and religion was also regarded as important in a child and adolescent setting[70,103-107] as well as for the elderly and end of life/terminal illness scenarios.[108-112]

Routine Assessment of Spirituality and Religion in Psychiatry

Spirituality and religion may affect aspects of the presentation and symptoms of illness in different clinical scenarios.[113-115] To attend to the clinical needs of certain population groups, an understanding of how a religious or faith tradition may influence the presentation of patients is important, according to Carter.[116] It is well established how spirituality, for example, can influence the particular content of psychotic symptoms.[25,117]

It is a necessary skill to be able to differentiate between pathological and non-pathological religious involvement. Reviews of the literature over the years have covered the influence of religion and spirituality in a variety of psychiatric conditions such as mood and anxiety[30-34,118-121], psychosis and schizophrenia[117,122-125], alcohol and drug abuse.[86-88] Commitment to tribal cultural spirituality among American Indians was found to be a protective factor in suicide attempts[85], while fewer depressive symptoms in religious subjects were found in Canada.[10,11]

Clinical assessment and objective measuring of spirituality and religiousness also translate to be a research concern. Moreira-Almeida and Koenig addressed the issue of measuring and comparing variables with reference to the official World Health Organization (WHO) tool - the WHO Quality of Life Measure for assessment of spirituality, religion and personal beliefs (WHO-QOL SRPB). King et al. developed and tested a 20-item questionnaire that goes beyond conventional religious beliefs for use in psychological and health research.[126] Katerndahl and Oyiriaru developed and validated an instrument for each of the dimensions of a bio-psycho- social-spiritual model[127], while Koenig warned against domains correlating with positive psychological aspects, which may result in a tautological comparison.[62]

Training of Spirituality in Psychiatry

Undergraduate curricula in the United States have been developed following requirements from the national accreditation body.[128-131] For psychiatric residents, spirituality as a potential source of higher functioning for the patient, must be included in training programs.[78,132-133] Myths about religion and psychiatry should be dispelled and perceptions of young psychiatrists, that an interest in spirituality and religion should be avoided for fear of a negative impact on their careers, should be corrected.[134-135] Ways of introducing courses in spirituality in medical curricula and psychiatric residency programs in the United States and Canada have been well documented.[136-137]

Scope and Boundaries of Professional Specialist Psychiatric Practice

Defining boundaries, domains and roles will also have to result in the drafting of practical, ethical and professional guidelines for psychiatry and related disciplines.[138] What must be regarded as part of the scope of professional psychiatry should be clear and must be congruent with the general ethical principles that guide clinical practice.[139] Although the role of spirituality should be considered in clinical settings, the psychiatrist is not regarded as primary provider of spiritual interventions and guidance for patients.[48,140] Appropriate knowledge and skills to assess the (positive and negative) role of spirituality and religion, or the lack thereof, should be facilitated. What would constitute inappropriate spiritual interventions by psychiatrists, while involving third party funders for instance, will have to be identified and monitored.[141] Verification between training curricula, proven competency and ongoing professional conduct and practice is essential, while greater patient empowerment through autonomy and self-determination should be achieved.[142]

Referral and Collaboration between Psychiatrists and Spiritual Professionals

A sociological and anthropological understanding of spirituality and religions should be achieved. The unique approach of each tradition relevant to health, mental health and clinical medicine should be understood and explored.[60,68,72,74,85,116,143-146] Literature referring to a ''spiritual professional'' routinely described a resident Christian minister of religion in a hospital with experience and training in the pastoral care of patients with medical conditions.

Views and experiences of professional spiritual workers on the role of spirituality in health and psychiatry should be established and taken into consideration.[147-152] As a proper exploration of this theme represents an additional review of the non-medical literature as well, it was regarded to be beyond the scope of this inquiry.[153-154]

Discussion

A limitation of this explorative qualitative literature review that must be noted is that it should not be regarded as a comprehensive or systematic, ''stand-alone'' review of all the medical literature available. Its findings should also not be generalized beyond this particular sample of medical and psychiatric literature. In addition, an exploration of the bodies of nursing and allied professions' literature, of sociology, anthropology and of the religious literature was, for example, also beyond the scope of this review.

The discussion, however, about the validation of the roles of spirituality and religion and how this should be addressed in health care provision, and also as part of routine psychiatric assessment and intervention, has become a discourse of increasing importance in the international medical literature over the past two decades. From the literature, it became apparent that ''mindfulness'' towards spirituality, should be facilitated and that spirituality should be incorporated in the approach to specialist psychiatric practice and training, although in practical clinical and academic settings, this

discourse on the role and importance of spirituality, remains in many instances still largely marginalized. In view of the growing body of research on the relationship between religion and health, Krause recently presented a conceptual model to obtain a more coherent view of this field of research.[155] This model adopts a framework similar to Maslow's hierarchy of needs, including the need for self-transcendence, the need for church attendance, the need for sociality, the need for control, the need for meaning and the need for health.[156] The basic premise of the model is that there is a logical temporal ordering among these needs that are satisfied by religion, such that the satisfaction of one need sets the stage for the satisfaction of the need that follows.

Conclusion

In the South African context, the promulgation of the Traditional Health Practitioner's Act no. 35 of 2004, has become an important precipitant for the local review of the place of culture and religion/spirituality in secular areas such as health, mental health and psychiatry.[157] This recognizes that African traditional practice consists of a significant religious and spiritual component, in addition to just being part of people's cultural background. The literature concurred that if the role of spirituality is to be considered in the approach to health and clinical care, it should be done within clear professional boundaries, and with a perspective that can accommodate religious traditions equally. In the public sector domain, no preference for one particular tradition should be given over another, as a result of a practitioner or a dominant group being from the one tradition or the other. To build up relationships of mutual trust and understanding will require training and health education initiatives aimed at psychiatric practitioners, their patients and students and at the spiritual professionals to whom their patients may choose to be referred.

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