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LETTERS TO THE EDITOR

Spirituality in psychiatric consultation: health benefits and ethical aspects

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Religiousness is a potentially important way of facing and coping with life's difficulties. Spirituality has been found to be associated with feelings of hope, lower levels of depression, and improved social interaction, well-being, and quality of life.[1] Nevertheless, psychiatrists often underestimate the importance of their patients' spiritual experiences and beliefs, by either considering them to be mental symptoms or disregarding them altogether. One possible reason for this behavior is that there is scarce literature on how psychiatrists can actually integrate spirituality into clinical practice through an ethics-based approach.

Given that there is no ethical doubt that an essential task of good practice in psychiatric consultation is to obtain an adequate psychiatric evaluation, then spirituality, like any other complex topic to be managed during a consultation, should be clarified and explored. One suggestion to solve this conundrum is to obtain a "spiritual history," by asking the patient simple questions[2] such as "Is faith (religion, spirituality) important to you? Has faith been relevant to you in other contexts of your life? Do you have someone to talk to about your spiritual issues? Would you like to explore these spiritual matters with someone?" Furthermore, an important task in obtaining a spiritual history is to differentiate between healthy and pathological spirituality. In a previous issue of the Revista Brasileira de Psiquiatria, Moreira-Almeida and Cadeña summarize the characteristics that differentiate a healthy spiritual experience from a pathological one. When healthy, the experience is short-lived, there is no suffering, no social or occupational impairments, no psychiatric comorbidities; the experience is compatible with a tradition, and the patient has a discerning attitude towards his or her experience, has control over it, and achieves personal growth over time.[3] For instance, a patient reporting a religious or spiritual experience in which he/she feels able to communicate with the dead or with God could be rejected by his/her community, and this could cause deep suffering. However, this is not necessarily a case of pathological spirituality, as this suffering could simply be an effect of the patient's environment, rather than of the belief itself. All these features point to the need for an individual, contextualized approach of cultural spiritual experiences and reinforce the importance of setting an empathetic relationship with the patient during psychiatric consultation. We agree with the authors in that an adequate ethics-based psychiatric evaluation should be impartial so as to avoid misdiagnosing and/or mistaking cultural spiritual experiences for evidence of psychotic symptoms. However, it is also important to underscore that being impartial does not mean losing our ability to be empathetic. We can still be empathetic without the risk of causing clinical failure or patient discomfort, situations that may occur when the professional's feelings and personal opinions take part in the evaluation.

Even though there is scarce empirical evidence on how psychiatrists can include spirituality in the psychiatric setting, one study carried out in primary care[4] found that 33% of the patients agreed that physicians should ask them about their religious beliefs in a routine visit; this number increased to 70% among terminal patients. Also, 19% of the patients (and 50% of terminal patients) would agree to pray with their physicians in a routine visit.

In an interesting paper, Poole & Cook[5] debated the position taken by psychiatrists concerning praying or not with patients. In that article, Poole[5] argued that praying with patients may be construed as a violation of professional boundaries, as prayer is an activity based on personal convictions that have little to do with the medical practitioner's specific therapeutic expertise. In turn, according to the other author (Cook), praying with a patient would not always be interpreted that way. Notwithstanding, both arguments may be seen as potentially biased, as Poole discloses that he is an atheist, whereas Cook is a priest. Also, these arguments probably represent two extremes of a continuum of possible views concerning this topic, and they are not based on research data.

In short, even if unintentionally, patients' spiritual experiences often seem to be left aside during psychiatric consultation, even though they are known to play an important role in improving their health. Given the clear lack of studies on how these matters could be included in psychiatric practice, we reinforce the need for further investigations into healthy ways for patients and caregivers to include the evaluation of religiousness and spirituality into the medical and psychiatric setting.

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Disclosure

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