Spiritual Assessment in Clinical Practice

Christina Puchalski, MD, MS

Spirituality is an essential element of healthcare because spirituality is, as Viktor Frankl wrote, the essence of our humanity. Spirituality speaks to what gives ultimate meaning and purpose in a person's life. It is that part of people that seeks healing and reconciliation with self or others. Spiritual values such as hope, faith, and altruism can help people handle adversity and cope with suffering and illness. Religions offer people a language of hope and ways to understand their suffering. Religious and other spiritual communities also offer people social support.

Many studies have indicated that spiritual and religious beliefs and practices may affect healthcare outcomes, including mortality, cardiovascular disease and depression. Research in meditation and prayer has shown positive health benefits of these practices and has suggested a role for spiritual beliefs in resiliency and coping with stress.

There is also institutional support for the inclusion of spirituality into healthcare. The Joint Commission on Accreditation of Healthcare Organizations requires that, when a hospitalized patient requests spiritual care, it should be provided. The American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, the American Psychiatric Association, the American Academy of Physician Assistants, the American...
Association of Colleges of Nursing, the Council on Social Work Education and other organizations have identified training objectives that support the inclusion of spirituality in the curriculum. Many professional organizations, such as the American College of Physicians, the American Medical Association, and the American Nursing College also recognize that spiritual care is an important element of the ethical obligation health-care professionals have to attend to all dimensions of a patient’s suffering and to be present fully to their patients in a compassionate way.

There also have been significant changes in medical school education with regard to spirituality and health. More than 70% of medical schools now teach courses on spirituality and health, many of them required. The Association of American Medical Colleges has published guidelines for these courses. One of the learning objectives is that all students will know how to take a spiritual history. Furthermore, courses on spirituality have been added to residency programs, specifically in psychiatry, internal medicine, and family practice. In all these courses, there is a requirement that residents learn how to complete a spiritual assessment.

Patients also voice their support and
request for a more integrated approach to their care with their spiritual issues addressed by their healthcare professionals. In a study by Ehman, 85% of patients noted that their trust in their physician increases if that physician addresses their spiritual concerns. In addition, 95% of the patients for whom spirituality is important want their doctor to be sensitive to their spiritual needs and to integrate it in their treatment; 50% of the patients for whom spirituality is not important feel that physicians should address patients' spiritual issues in the case of serious and chronic illness. In another study, patients in a family practice setting felt that it was important for physicians and healthcare providers to address their spiritual issues and beliefs. The study also found that 95% want their spiritual beliefs addressed in the case of serious illness, 86% when admitted to a hospital, and 60% during a routine history.

**Meaning and purpose are things that all people seek; the inability to find that meaning and purpose can lead to depression and anxiety.**

**RECOGNIZING SPIRITUAL ISSUES IN THE CLINICAL SETTING**

For the courses in medicine on spirituality and health, a definition of spirituality was derived by consensus conference of clinicians, medical educators, and chaplains. Central to this definition is that spirituality has to do with a person's search for ultimate meaning in life through participation in religion, as well as through relationships with God or family, and expressed in nature, rationalism, humanism, and the arts. All these factors can influence how patients and healthcare professionals perceive health and illness and how we interact with one another. Thus, the definition includes a personal expression of spirituality as well as a relational one to others.

Spirituality is broader than religion, and in listening for spiritual themes from patients, it is important to recognize that spirituality can be expressed in many different ways. Thus, for some patients, church is the spiritual community; for others, it may be likeminded friends or family. Spiritual practices may range from prayer and meditation to walking in the woods, listening to music, or painting.

In a consensus conference between the Association of American Medical Colleges and the George Washington Institute for Spirituality and Health, medical educators, clinicians, medical ethicists, and chaplains developed guidelines for spiritual care. Of particular importance was the guideline that clinicians should create environments where patients feel they can trust their clinician and share whatever concerns that patient has, including spiritual concerns. Thus, the first step in communicating with patients about spiritual issues is to communicate a genuine interest in and compassion for the patient. By creating an atmosphere of caring compassion and a willingness to be open to whatever concerns the patient raises, the interaction becomes focused in a patient-centered model of care. In this model, there is recognition that a patient's understanding of illness can be affected by many factors, including spiritual and religious beliefs and practices.

In listening to the patient's story, one can identify themes, including spiritual themes. The most common spiritual themes include lack of meaning and purpose in life, hopelessness, despair, guilt or shame, lack of connection or love with others or with God, anger at God or others, and abandonment by God or others.

Meaning and purpose are things that all people seek; the inability to find that meaning and purpose can lead to depression and anxiety. People find many sources of meaning and purpose throughout their lives that may be transient — jobs, relationships, accomplishments, and financial success. However, the challenge for all people is finding meaning and purpose even in the midst of failed jobs, bad relationships, missed accomplishments, and unattained successes. Ultimate meaning and purpose is that meaning that sustains people in
the emptiness of their external lives, or as people face dying. Spiritual and religious beliefs play a significant role in how people transcend their suffering to find such ultimate meaning.25

Hopelessness often arises in the midst of serious illness. Studies have indicated that people who are more hopeful during illnesses do better in regard to depression and other health indicators.26,27 How people come to understand hope also varies. Initially, hope may be lodged in cure or recovery, but when that is not possible, people may have a hard time tapping into resources of hope. In those times, hope may be manifested as acceptance, finding important goals or activities, living life fully in the face of difficulty, finding meaning, and eventually experiencing a good quality of life and death. Helping people restructure their thinking so that they can see hopefulness in the midst of despair is an essential part of therapy. Spiritual and religious beliefs offer people a language of hope. Religious and spiritual communities offer people support as people try to find hope and meaning for themselves.

Profound despair can stem from an existential crisis, lack of meaning and purpose, hopelessness, and extreme loneliness. People need a sense of connection to others and a sense that they are loved and cared for. Spiritual and religious communities offer that sense of love and connection for people. Thus, in listening to a patient’s story, one might hear themes of support from the church community or family. However, one also can hear themes of abandonment and anger at the community of support or at God. This sense of abandonment by or anger at the community that offered solace at one point in a person’s life can lead to a profound sense of despair and isolation.

Religious themes can cause distress in people’s lives. Anger at God is often normal in the face of serious illness, yet it can lead to conflict, guilt, and despair. It is important to allow people to talk about that anger in a safe environment where they do not feel they will be judged. It is often in the clinical setting that patients will share such feelings. In their religious communities, they may be told that it is wrong to be angry at God, or that it reflects a weakening in one’s faith to be angry at or feel abandoned by God. In the clinician’s office, the patient may find a safe haven to explore these feelings in greater depth. Koenig and colleagues28 found that negative religious coping was associated with poorer physical health, worse quality of life, and greater depression in medically ill hospitalized older adults but that positive religious coping was associated with better mental health in those patients. Understanding how spirituality and religion relate to patients’ understanding of their illness and their ability to cope is an important aspect of providing comprehensive patient-centered care.

THE SPIRITUAL HISTORY

As in any other part of the history, listening to themes alone will not elicit all the information needed to provide good medical care. Thus, specific questions need to be asked to target specific areas of information such as depression, social support, domestic violence, sexual preferences and practices, and so on. Patients may not think to volunteer information to a clinician unless they are invited to share in that particular area.

This is particularly true of spirituality. While patients are interested in having spirituality integrated into their care, it is not yet a common practice to have
physicians address spiritual issues. Patients may need an invitation to share in this area. A spiritual history is simply a set of targeted questions aimed at inviting patients to share their spiritual and religious beliefs, if desired.

A number of tools have been developed to use for spiritual history taking. These include FICA, SPIRIT, and HOPE. A tool I developed with several colleagues, can be done in a time-efficient manner. It is outlined in the Sidebar (see page 153). These questions are meant to serve as a guide for the discussion about spiritual issues.

The goals of the spiritual history are:
- Invite the patient to share spiritual and religious beliefs if they chose to do so.
- Learn about the patient's beliefs and values.
- Assess for spiritual distress (eg, meaninglessness, hopelessness etc), as well as for spiritual resources of strength (eg, hope, meaning and purpose, resiliency, spiritual community).
- Provide an opportunity for compassionate care whereby the healthcare professional connects to the patient in a deep and profound way.
- Empower the patient to find inner resources of healing and acceptance.
- Learn about patients' spiritual and religious beliefs that might affect healthcare decision making.

The spiritual history normally is completed during the social history section of the history and physical. While asking the patient about living situation and significant relationships, the clinician can transition into how the person cares for himself or herself. Questions about exercise and how one deals with stress and difficult situations are an important part of self-care. In this context, the clinician then asks if spiritual beliefs and practices are important to the patient. This lodges the spiritual history within the clinical context.

The spiritual history is patient-centered. If the patient does not identify as spiritual or religious, or if the person does not wish to discuss spirituality, then the clinician should not force the questions. It is important to respect patient's privacy in these issues.

Clinicians must also be careful about how the questions are asked and what kind of information should be discussed within the clinical context. Proselytizing is not allowed in the clinical setting, as this would violate the trust that patients place in clinicians. There is a power differential between clinicians and patients. Patients may feel vulnerable with their clinicians, and that vulnerability needs to be honored and protected. A well-meaning clinician may share personal beliefs with the patient, but the patient may adopt or superficially agree with the clinician's beliefs out of fear that their medical care could be compromised if they don't agree. That is why clinicians must be sensitive to appropriate boundaries and honor these boundaries.

Clinicians, as a whole, are not trained spiritual care providers. Chaplains, clergy, pastoral counselors, and spiritual directors are trained to work specifically with patients' spiritual issues. Chaplains are certified by chaplaincy organizations to work specifically with patients in healthcare settings to help them work through spiritual crisis or distress. Chaplains also are trained to participate in and lead rituals that may be important to patients and to facilitate connection with the patients' clergy if needed, within healthcare settings. Chaplains work with patients of any religious or nonreligious backgrounds. Clergy are ordained, trained in religious care, and work predominantly with patients from their religious denomination. Pastoral counselors are master's- or doctoral-trained counselors; half of their training is in how spiritual and religious issues affect manifestation of and coping with the presenting symptoms. Spiritual directors are not counselors; rather, they are trained to assist people in their spiritual journey by helping them discern how God or the divine is working in their lives.

The spiritual history is a screening tool to help identify spiritual issues, but more in-depth spiritual counseling should be done with trained spiritual care providers. Some mental health professionals may have more training in spiritual assessment, diagnosis, and treatment than other healthcare professionals, but even then, the focus of the training is different from trained spiritual care providers. Many patients can benefit from the unique training of all these different professionals.

**SUMMARY**

Spiritual needs are important to many patients. There is institutional support for the inclusion of spiritual care in the holistic care of patients. There is also data that patients want their spiritual beliefs integrated into the care of their patients and that spiritual beliefs may benefit patients in some healthcare outcomes, resiliency to stress and adverse situations, and coping with suffering. A spiritual history provides an opportunity
in the clinical encounter for the patient to share spiritual beliefs if that is what he or she chooses to do. It also helps the clinician to identify spiritual distress, as well as spiritual resources of strength, and to provide the appropriate therapy and referrals needed to give the patient the best care from a biopsychosocial-spiritual framework.

REFERENCES


10. Accreditation Council for Graduate Medical Education. Special Requirements for Residency Training in Psychiatry. Chicago, IL: Accreditation Council for Graduate Medical Education; 1994.


