Religion & Spirituality in Clinical Practice

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Declaration of Interest

Professor Cook reports grants from Guild of Health and Wellcome Trust, outside the submitted work; and The author is an Anglican priest, President of the British Association for the Study of Spirituality, and a past Chair of the Spirituality & Psychiatry Special Interest Group of the Royal College of Psychiatrists.

Learning Objectives

1. Understand the basic nature of the concepts of spirituality and religion and their relevance to clinical practice in psychiatry
2. Be aware of the key arguments in the current debate concerning spirituality and religion in clinical practice and the corresponding implications for good psychiatric practice
3. Know how to take a spiritual history

Abstract

Spirituality and religion have assumed importance in psychiatric practice in recent years both because of a growing evidence base and also because of the desire of mental health service users that such matters should be better addressed as an aspect of their care. However, there has been controversy around interpretation of the evidence base and around issues of good practice, notably about defining appropriate professional boundaries. A sensitive and patient-focussed clinical enquiry is therefore important as a basis for discovering whether and how spiritual/religious concerns are important to patients and, if so, how they might most appropriately be addressed in treatment. Many of the concerns of patients and professionals regarding spirituality overlap with the recovery agenda and so are easily addressed implicitly, and without need to impose the language of spirituality or religion. However, for some patients, transcendent concerns that are not a part of this agenda are easily overlooked.

Introduction

Clinical psychiatry has to take account of a wide variety of beliefs, behaviours, and values that influence the self-understanding of the patient or service user. This is necessary both to enable an in-depth understanding by the clinician of the personal history and mental state of the patient, and also in order to inform management and planning for recovery. For many people spirituality and/or religion are found to be particularly important as a fundamental framework within which their self-understanding is shaped and many mental health service users express a wish to be able to talk about such matters with professionals providing their clinical care.

Whilst recent years have brought an increasing appreciation of the importance of spirituality and religion in clinical practice (Cook et al., 2009), and a growing research evidence base to support this (Koenig, 2005), there has also been much debate about the research evidence and about the implications for good clinical practice (Cook, 2013a). There is further reason to believe that the beliefs and attitudes of mental health professionals are often different than those of service users, and that this presents scope for misunderstanding (Cook, 2011). There is therefore need for psychiatrists to be well informed about the relevance of spirituality and religion to clinical practice, the associated evidence base, and the ongoing professional debate, in order that they may both meet the aspirations and needs of their patients and also work according to accepted standards of good psychiatric practice.

The Evidence Base

It is beyond the scope of the present paper to offer a review of an evidence base that now spans many thousands of quantitative research studies, let alone qualitative studies and clinical articles. However, it is important to note that there is a growing and large evidence base, and that whilst there is a general consensus that it suggests that spirituality and religion are beneficial for mental wellbeing, there is still fierce controversy, and scope for alternative interpretations of the research evidence (Sloan, 2006). Undoubtedly much research has been of poor quality and there is need for more rigorous methodology, but there have also been significant studies of good design. Critical systematic reviews have been undertaken which take the key methodological considerations into account, notably by Harold Koenig and his colleagues (Koenig et al., 2001, Koenig et al., 2012, Koenig, 2009).

The work of Richard Sloan and others provides a useful summary of the main counter-arguments employed in the debate in the USA (Sloan et al., 1999, Sloan, 2006). Notably, these include not only scientific critique of the methodology, design and interpretation of much of the quantitative research in this field, but also concerns that focus more on ethical issues and professional practice. Much of the UK debate has also focussed on concerns around good practice and potential for boundary violations (Cook, 2013a, Poole and Higgo, 2011).

There is also debate about the strength and nature of the relationship between religion/spirituality and mental health. Smith et al (2003), in a review of 147 studies of religiousness and depression, found only a weak correlation ($r = -0.096$) between religiousness and fewer symptoms of depression. Hackney and Sanders (2003), in a

meta-analysis of 34 studies, found that it was possible to come to different conclusions concerning the relationship between religiosity and mental health, depending upon the definitions of religiosity and mental health employed. Whilst their overall correlation between religiosity and mental health was positive (r=0.10), they were able to find support for overall positive and negative correlations, or for a lack of any relationship between religiosity and mental health, depending upon the definitions employed. In particular, institutional definitions of religiosity (focussing on the social and behavioural aspects of religion, such as attendance at religious services, ritual prayer, etc) tended to produce weak or negative correlations.

Definitions

Spirituality is not easy to define. There are many definitions of spirituality and little agreement or consensus as to exactly how the concept should best be defined in the healthcare context. However, some definitions are more inclusive than others, and a broad approach that has been adopted in the Royal College of Psychiatrists Position Statement, *Recommendations for Psychiatrists on Spirituality and Religion* (Cook, 2013b), provides a helpful starting point for our discussion here (see Box 1).

Whilst this definition is somewhat imprecise and difficult to operationalise for research, it does incorporate the breadth of the ongoing debate. It also incorporates some of the key ambiguities, and avoids oversimplification.

1. Spirituality is a personal, individual and subjective affair, but is also concerned with relationship with others, shared beliefs and traditions, and with a wider reality.
2. Spirituality is concerned both with transcendence (a relationship to that which is above, beyond and greater) and immanence (an awareness of present objective reality)
3. Spirituality is concerned with meaning and purpose in life, and with things that are most valued. Although not explicit in the definition, it is thus also concerned with loss of meaning and purpose, or with circumstances and events that impinge adversely upon the things in life that are most valued.

It has been suggested that religion is easier to define than spirituality, a suggestion which those engaged in the academic study of religion will immediately recognise as fallacious. Definitions are variously concerned with beliefs and practices related to the sacred, and with individual, institutional and social expressions of these beliefs and practices. However, religiosity (how religious a person is) is a much easier variable to operationalise for research, and spirituality is easily confounded with psychological variables (Koenig, 2008). It is easier also to enquire about religion in the clinical context, as people usually know whether or not they identify with a particular religion, and can give answers to simple questions about attendance at places of worship, religious beliefs and devotional practices. Spirituality is often contrasted with religion as being more concerned with the personal, subjective and experiential, whereas the latter is portrayed as more ritualised, dogmatic, and institutional. This is an oversimplification.

In the contemporary context in western society (and to a variable degree in other societies also) people may identify with any of a number of key positions:

Spiritual and Religious
Spiritual but not Religious (SBNR)
Religious but not Spiritual (RBNS)
Neither Spiritual nor Religious

People who are spiritual and religious generally find it difficult to separate their spirituality from their religious faith. The former is an expression of the latter, and vice-versa. SBNR people, however, generally eschew identification with religious traditions whilst having a more or less coherent sense of their own spirituality which is not dependent on such traditions, even if it may draw on elements of them. Within this group would be included many so-called "new age" forms of spirituality, as well as others who draw on elements of various religions in an individual way, whilst not identifying with any of them. RBNS people would see their religious tradition as important, but would not self-identify as being "spiritual" (whatever that might mean to them). Finally, some people see themselves as neither spiritual nor religious, preferring to eschew both traditional religion and also newer forms of spirituality unconnected with religion.

In practice, few people seem to self-identify as RBNS, and the SBNR category appears to be growing and popular. Spirituality thus functions as a more inclusive category than religion, and many agnostics and atheists may be found who would identify themselves with the SBNR category. For many, spirituality is seen as a universal category, and it is suggested that all human beings experience a spiritual dimension to life. However, some atheists and agnostics find the category of spirituality unhelpful. Finding meaning and purpose in life in other ways, they do not see the need to identify things as "spiritual", and perhaps also find the term spirituality too redolent of religion. This raises the very valid question as to whether or not the term "spirituality" is really required at all? Perhaps it is only necessary to enquire about people's beliefs, values, practices and relationships? However, to adopt this approach would not seem helpful for the many people to whom spirituality is deeply important. It is therefore necessary to make sensitive enquiry as to what people understand by the word "spirituality", and whether or not it is important to them. This is just as important when it is discovered that "spirituality" is perceived as deeply unhelpful, and not to be discussed, as it is when it is discovered that spirituality is perceived as central to life and a key part of an overall understanding of both life and illness.

Clinical Practice

In any new clinical encounter, the psychiatrist and service user will not know in advance whether they share a spiritual/religious perspective, or whether they have significant differences about such matters, or what the nature and significance of any differences between them might be. It is therefore an important clinical task to manage such encounters with a respectful openness to the expectations and values of the other person.

In *Recommendations for Psychiatrists on Spirituality and Religion*, it is suggested that the stance of patients and colleagues, and indeed one's own stance on such matters, may reasonably be expected to fall into one of the following categories:

- identification with a particular social or historical tradition (or traditions)
- adoption of a personally defined, or personal but undefined, spirituality
- disinterest
- antagonism

Any questions that are employed, or statements made, at an initial encounter with a new patient or colleague should therefore be worded in such a way as to communicate respect equally for any/all of these positions. For example, "Would you identify yourself as a spiritual or religious person?" allows a spectrum of responses, from a definite "Yes" through to a definite "No", with various degrees of commitment in between. On the other hand, "How is spirituality important to you?" might well be taken to imply that spirituality should be understood as important, and that a positive response is expected. This might create unhelpful barriers to further communication or be the cause of misunderstanding.

Whilst the relevance of spirituality/religion to clinical practice makes this an appropriate area of clinical enquiry, it is also clear that there are important boundaries to be observed. Amongst these, are the boundaries of specialist expertise, boundaries between the secular and religious, and the boundary between personal and professional values (Cook, 2013a).

Psychiatrists have variable knowledge of spiritual and religious matters. On the one hand, psychiatrists need to be better informed about such things. On the other hand, it is important that they should not profess or imagine a level and kind of expertise that they do not have. Even for those clinicians who do know a lot about such matters, it is important to recognise here that the patient (or service user) is the expert on their own beliefs and practices. Whilst much may be known about (for example) Islam as a major world religion, it should not be assumed that any particular patient adopts more widely assumed norms, not to mention that most of the world's faith traditions incorporate a diversity of major and/or minor variations (such as the division between Sunni and Shiite in the case of Islam).

The current debate suggests that there is a divergence of views on how the boundary between secular and religious should be managed in clinical practice. Whilst there may be some agreement that a safe, neutral, space is needed within which matters of spirituality and religion can be explored when necessary, it is far from clear that the secular domain provides such a space. Many religious people find "secular" views and norms to be deeply biased against the religious point of view and an over-emphasis on secular norms can make it seem as though they may not talk about religious or spiritual matters (Cook et al., 2011).

The boundary between personal and professional values should always be acknowledged, at least in the mind of the clinician, if not in the course of explicit conversation with colleagues and patients. GMC guidance makes clear that the doctor should not normally discuss his/her beliefs with patients, unless directly relevant to patient care (General Medical Council, 2013). Clearly any such discussion that does take place needs to make clear what is a personal view, and what is a professional

view, and any kind of proselytising (implicitly or otherwise) is completely unacceptable.

GMC guidance also makes clear that patients should not be put under pressure to discuss or justify their beliefs (General Medical Council, 2013). This may be difficult if the beliefs in question relate closely to the psychopathology, or are directly relevant to treatment or compliance, and must be handled with extreme sensitivity. A good rule, in case of doubt, would be to discuss practice with a supervisor or peer, perhaps as a part of a case discussion in support of appraisal and revalidation. Careful documentation of practice, and of such discussions that are had, or of reasons for pursuing or not pursuing enquiry further, will also be important.

Recommendations for Psychiatrists on Spirituality and Religion provides further guidance intended to clarify and affirm the boundaries of good practice. These include recommendations concerning assessment, the need to respect the views of patients, carers and colleagues, the need for appropriate organisational policies, and the importance of addressing spirituality/religion in psychiatric training and in continuing professional development. Importantly, the need for willingness to work with leaders of faith communities, chaplains, pastoral workers and others is also affirmed.

Assessment

A variety of structured approaches have been devised as instruments for screening or assessment of spiritual wellbeing and spiritual needs, some of which have been designed primarily for clinical use, and others with research in mind. Assessment of spirituality, spiritual wellbeing, or spiritual needs, does not necessarily require the use of any of these instruments, and many clinicians devise their own form of enquiry. Such enquiry might include questions implicitly concerned with spiritual issues (eg "What motivates you and gives you reason for living?") or else might explicitly address the matter at hand (eg "Do you have any spiritual or religious beliefs that are important to you?"). Such questions need not be time consuming (contrary to assertions that clinicians do not have time for such things, (Sloan, 2006)) and are often helpful in establishing whether or not this might be a useful focus for further enquiry or, conversely, something that a patient would prefer not to discuss. Culliford and Eager (2009) have suggested that the initial brief questions that might usefully be asked in spiritual history taking include those about "What helps you most when things are difficult…..?" and those about spiritual identity ("Do you think of yourself as being either religious or spiritual?").

Amongst the more structured approaches there is a bewildering variety of acronyms with similar and overlapping concerns. The general concern here seems to be with clinical utility, and often these instruments seem to be more useful as a mnemonic than in terms of any particular form of words that they offer. For example, "HOPE" (Anandarajah and Hight, 2001) helpfully reminds the clinician to ask about:

- sources of **H**ope, meaning, comfort, strength, peace, love and connection
- **O**rganized religion
- **P**ersonal spirituality and **P**ractices
- **E**ffects on medical (psychiatric) care, and **E**nd of life issues

Similarly, “SPIRIT” (Maugans, 1996) provides a reminder to enquire about:

- **S**piritual Belief **S**ystem
- **P**ersonal Spirituality
- **I**ntegration and **I**nvolvement in a Spiritual Community
- **R**itualised Practices and **R**estrictions
- **I**mplications for Medical Care
- **T**erminal Events Planning (Advance Directives)

The authors of both of these papers provide some sample questions to aid spiritual history taking according to their respective formulae.

Without wishing to add further to the list of acronyms and systems of spiritual history taking, Box 2 provides a short list of the key areas of enquiry that are important in psychiatry.

It is not suggested that history taking should always address all of these domains. Rather they might be kept in mind as at least sometimes essential areas of further enquiry, and as always potentially important. Enquiring about them all is, in any case, far too time consuming for routine clinical practice. At Tees, Esk & Wear Valleys NHS Foundation Trust a working group including service users and professionals has developed a “spirituality flower” (see Box 3) as a way of depicting five identified aspects of spirituality, each within a separate petal (Cook et al., 2012). This flower can be shown to patients on a laminated card and a simple question asked about whether or not any of these aspects of spirituality is important or relevant to the person concerned.

A wide range of instruments have been employed as ways of characterising and quantifying spirituality in research. As this article is primarily concerned with clinical practice, these will not be addressed here, but reference should be made to a number of helpful reviews and works of reference (de Jager Meezenbroek et al., 2012, Hill and Pargament, 2003, Hill and Hood, 1999). Amongst these instruments, it is worth noting the Royal Free Interview Schedule, in which subjects are asked to self-identify as spiritual, religious, SBNR, or RBNS (King et al., 1995, King et al., 2001). Interestingly, some of the European research undertaken using this instrument has suggested both that religion may not have the protective effect that North American research largely seems to suggest that it has, and also that being SBNR might even increase the risk of psychiatric morbidity (King et al., 2013). A new research instrument that has arisen from service-user based research, and which understands spirituality/religion as just one aspect of recovery, is the Service User Recovery Evaluation Scale (Barber et al., 2012).

Treatment

Spirituality and religion have a relevance to treatment across a wide range of diagnostic categories, therapeutic modalities, and sub-specialties. For example, there

is evidence that religious affiliation reduces the risk of completed suicide, and a knowledge of the ways in which religious beliefs and traditions influence attitudes towards suicide may be important in working with the religious patient with suicidal ideation (Cook, 2014). Spiritual and religious themes not uncommonly emerge as an important aspect of making sense of, and coping with, the experiences of psychosis and an awareness of how to respond constructively to such frameworks of meaning may be significant in helping patients to engage with recovery (Huguelet and Mohr, 2009). Particular considerations may arise where ethnic minorities are concerned (Fitch et al., 2010) but spirituality groups can also be open and accessible to a broad cross-section of patients in at least some treatment settings (Jackson and Cook, 2005, Salem and Foskett, 2009).

A limited number of explicitly spiritual approaches to treatment have received widespread acceptance in mental health services in Europe and North America. Amongst these, the SBNR approach of the Twelve Step programmes in the field of addiction recovery (Cook, 2009), and the now widely employed practice of mindfulness (Mace, 2008), deserve special mention.

Endeavours to help people recover from addiction have a long history, and many programmes for recovery have been (and are) informed by a religious framework of understanding. However, it is probably the influence of Alcoholics Anonymous and its sister organisations that has had greatest impact in promoting a spiritual programme of recovery. Whilst this programme is based primarily upon mutual help principles, it also now forms the basis for many residential and non-residential, professionally led, programmes for recovery and Twelve Step "Facilitation" is offered within professionally based treatment services, especially in North America. The spirituality of the Twelve Step programmes has been the subject of extensive literature, and some empirical research, and has clearly been the basis upon which many people with addictive disorders have built their recovery. It is concerned primarily with relationships – notably and initially with the relationship with alcohol (or another object of addiction) as something over which the addict is powerless. Later steps of the programme emphasise both restoration of relationship with other people, and also relationship with a "Higher Power", also explicitly referred to in the steps as "God *as we understood him*" (Alcoholics Anonymous World Services Inc, 1983). Perhaps surprisingly, this emphasis on a Higher Power of one's own understanding, has proved accessible to atheists and agnostics, as well as to members of almost all of the world's major faith traditions.

Mindfulness is usually identified as originating from within the Buddhist tradition, although in fact it shows a close resemblance to contemplative practices of prayer and meditation from within many of the world's other major faith traditions, including Christianity (Cook, 2012, Knabb, 2012). Moreover, the growing evidence base for its effectiveness as a therapeutic tool in mental health care usually dissociates it from its religious roots and explores its value in a much more utilitarian fashion. Unlike the Twelve Steps, it does not require belief in any kind of Higher Power or God. It is concerned much more with attentiveness to the present moment, an attentiveness which acknowledges both the distractibility of human thoughts and also the presence of a range of experiences such as anxiety, craving, hallucinations or other mental phenomena. Mindfulness has been integrated into psychotherapeutic practices of diverse kinds (Mace, 2007). In the psychoanalytic tradition, this has included both a

focus on the attention given by the therapist to the analysand and also a focus on the attention given by the analysand to their feelings. In the cognitive behavioural tradition, a range of new therapies have emerged, including Mindfulness Based Cognitive Therapy (MBCT), Mindfulness Based Stress Reduction (MBSR), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT). MBCT is recommended by NIHCE as a relapse prevention treatment for depression, but has also been employed with some evidence of benefit in addictive disorders, eating disorders, anxiety disorders, psychosis and various other mental disorders (National Institute for Health and Clinical Excellence, 2009, Witkiewitz et al., 2013, Mace, 2008).

Recovery

A recovery approach has become increasingly normative to mental health care in recent years (Care Services Improvement Partnership et al., 2007). Key themes of the recovery approach that are also central to spirituality are shown in Box 4.

The ability of the recovery concept to articulate almost all of the key features of spirituality without use of the word "spirituality", and without reference to religious frameworks of reference (other than in its valuing of diversity), raises again the question of whether or not explicit reference to spirituality and/or religion are necessary in order to address the key themes and benefits of spirituality in practice. Some authors have referred to "implicit spirituality" as a way of acknowledging that some key issues referred to by others as being "spiritual" can in fact be discussed without using the language of spirituality at all (Pargament and Krumrei, 2009). There would seem to be little doubt that spirituality can be conveniently located within the recovery agenda, and that many of its significant concerns are most readily addressed from this perspective for the purposes of clinical governance and service planning and delivery. However, a key concern of both spirituality and religion that is not obviously addressed within this agenda is that of transcendence.

Transcendence has been located as a key component of both spirituality and religion, but in fact it is capable of a range of interpretations, some of which clearly do not require the language of traditional religion (Cook, 2013c). Mindfulness focusses on the immanent (present reality, including the objects of sense perception as well as the subjective experiences of consciousness), thus demonstrating that spirituality is not only concerned with transcendence. Many other spiritual and religious concerns, in contrast, do seem to be focussed around issues of transcendence. On the one hand, this may just be a reaching beyond (or deep within) oneself to "transcend" what has previously been perceived as humanly possible. On the other hand, it is often a spiritual, divine or supernatural reality that is sought (as in the Higher Power of the Twelve Step programmes) as a source of comfort, support and hope or healing.

Clinical Vignette

A 32 year old woman presented with a recent history of low mood and auditory verbal hallucinations. She asked if she could see a Christian psychiatrist. The psychiatrist whom she initially saw was an atheist but he assured her that he would be respectful of her beliefs and suggested that she might like to talk to a member of the chaplaincy team. This was duly arranged. It transpired that she had been engaged in a relationship with a married man, about which she felt deeply guilty. The voices that she heard were identified by her as being evil spirits sent to torment her. Working closely together, the psychiatrist and chaplain were able to encourage her to accept pharmacotherapy and reassure her that exorcism was neither necessary nor likely to be helpful. The chaplain was able to reassure her that a Christian psychiatrist would not have offered any different treatment and, after discussion with the psychiatrist, agreed to offer the ministry of reconciliation (confession and absolution). She made a good recovery.

Conclusion

Spirituality and religion are important to people, and they evoke strong feelings. For some service users, this has meant that they have felt patronised, misunderstood and alienated when their attempts to talk about things that matter to them have been labelled by psychiatrists as pathology. For others, it has been intrusive and offensive when they have felt that professional power has been used to impose an agenda that reflects more the personal values of the psychiatrist than it does those of the patient. Much depends, therefore, upon the sensitivity and skill of the clinician in ascertaining what matters to the patient and how it may most helpfully be acknowledged and addressed in treatment. Proselytising, whether for religious, political, or atheistic beliefs, is completely unacceptable and is an abuse of professional power.

Much of what has been discussed in this article does not require the language of spirituality or religion, and it is to be hoped that the recovery agenda will indirectly promote many of the concerns of spirituality without evoking its controversies. It is central to the good practice of psychiatry that clinicians are able to elicit the values and concerns of their patients, emphasise health over pathology, evoke hope, acknowledge diversity, and assist in finding meaning in the midst of bewildering and overwhelming experiences. However, for other patients, the language of spirituality and/or religion is likely to provide a more helpful (and hopeful) medium for the conversation. The good psychiatrist will gain at least a degree of fluency in this language, sufficient to recognise when and how to affirm helpful frameworks of meaning and adaptive coping resources.

Boxes

Box 1: Definition of Spirituality

Spirituality is:

a distinctive, potentially creative, and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately "inner" immanent and personal, within the self and others, and/or as relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth, and values.

(Cook, 2004)

Box 2: Key areas of enquiry in a spiritual history in psychiatry

Identity – Does this person self-identify as being Christian, Muslim, Buddist, SBNR, atheist, etc, and is this important to their self-understanding?

Relationships – What are the most important relationships in this person's life? Family, lovers and partners are often mentioned, but also God, involvement in church/synagogue, belonging to a faith community, relationship with nature/creation, etc. Are these relationships supportive – or a cause of stress?

Practices – Does this person engage in spiritual practices of any kind? This may not only include prayer, mindfulness, meditation, etc, but may also include such things as yoga, art, singing, dancing, writing etc. Do these things help when life gets hard?

Meaning and purpose – What makes life feel worthwhile? What really matters? (Answers to this are often in terms of relationships – above – but may also be in terms of social action, work, hobbies and other activities seen as important, creative and fulfilling.) Are there any religious/spiritual beliefs with which you struggle, or which are causing you anxiety?

Implications for treatment – Do any of the foregoing impact on whether or not a service user is likely to experience problems in accessing or receiving mental health services?

Box 3: The "Spirituality Flower"

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The Spirituality Flower

The petals of the flower represent five aspects of spirituality which may be of importance. Are any of these relevant to you? Would you like to discuss any of them further?

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Box 4: Key themes of the recovery approach that are also central to spirituality

- Values
- Emphasis on health rather than pathology
- Hope
- Empowerment
- Meaning
- Recognising expertise arising from experience
- Recognising value of diversity – cultural, sexual, religious
- Coming to terms with disability and ongoing illness
- Social inclusion
- Identity
- Narrative
- Detachment from / ongoing relationship with services
- Collaborative approach to treatment
- Personal qualities of staff
- Constructive and creative approach

(Care Services Improvement Partnership et al., 2007)

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MCQs

1. Which of the following statements about spirituality are true?
    a. Spirituality is more or less the same thing as religion
    b. People self-identify as either spiritual or religious, but very rarely as both
    c. Religion is concerned only with rules, institutions and hierarchies and does not allow for the subjective or experiential aspects of spirituality
    d. In research, religion is less easy to measure than spirituality.
    e. Spirituality is often concerned with relationship with oneself, others and a wider or higher reality
2. The research evidence base concerning the benefits of spirituality/religion for mental health is contentious because:
    a. Many early studies were of poor methodology and not designed to study the influence of spirituality/religion
    b. Religiosity is difficult to measure in research
    c. There have been very few published studies
    d. Adopted definitions of spirituality/religion and mental health make no difference to whether positive or negative associations are found
    e. Findings have no relevance to clinical practice
3. Assessment of spirituality in clinical practice:
    a. Is usually unnecessary
    b. Can be undertaken with help of the “HOPE” acronym
    c. Is necessarily time-consuming
    d. Is unimportant if the patient is an atheist
    e. Does not influence treatment planning
4. Boundaries not relevant to good handling of spiritual/religious issues in psychiatric practice include:
    a. Professional knowledge and expertise
    b. Those between chaplaincy and the clinical team
    c. Secular v religious
    d. Personal v professional
    e. Ego boundaries
5. The recovery approach in mental healthcare:
    a. Overlaps extensively with the concerns of spirituality
    b. Explicitly addresses spiritual, but not religious, concerns
    c. Avoids the need to explicitly address spiritual or religious concerns

d. Is difficult to combine with spiritual/religious care
e. Addresses all of the key concerns of spirituality/religion

Correct Answers:

1. e
2. a
3. b
4. e
5. a