Original Research

Spirituality and Psychiatry in Canada: Psychiatric Practice Compared With Patient Expectations

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Objective: This study compares psychiatrists' and psychiatric patients' practice, attitudes, and expectations regarding spirituality and religion.

Method: We mailed surveys to all Canadian psychiatrists registered with the Royal College of Physicians and Surgeons of Canada (n = 2890). The response rate was 42% (n = 1204). We recruited patients from a Canadian on-line survey (n = 67) and from a local mental health clinic (n = 90).

Results: Psychiatrists had lower levels of beliefs and practices than did patients and the general population. In both groups, 47% felt there was "often or always" a place to include spirituality in psychiatric assessment, although the perceived importance differed. Among patients, 53% felt it important to have this issue addressed, and 24% considered the psychiatrist's spiritual interest important in their choice of psychiatrist. Barriers to addressing the issue of spirituality and mental health related to psychiatrists' concern regarding its appropriateness and patients' perception that interest is lacking. Psychiatrists' own beliefs and practices were strong predictors of spiritual inquiry.

Conclusions: Although psychiatrists report lower levels of spiritual and religious belief than do patients, they acknowledge that it is important to include this topic in patient care. Increased discussion and education may lower reported barriers to including spirituality and religion in routine psychiatric assessment.

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Clinical Implications

- Psychiatrists' beliefs and practices predict inquiry into their patients' spirituality.
- Patients say that spirituality is an important issue to address as part of their psychiatric treatment.
- Discussion and education regarding spirituality and mental health may help psychiatrists to address this issue with patients and overcome perceived barriers.

Limitations

- The study's small patient group limits generalizability.
- The study used quantitative questions; qualitative questions might have allowed more individual expression on the subject.

Key Words: *spirituality, religion, psychiatry, mental health, survey, characteristics*

Literature reviews indicate that, on average, high levels of religious involvement are associated with better physical and mental health (1,2). It is also clear that, at times, religion or spirituality can be used negatively and can become incorporated into an individual's psychopathology (3). The psychiatrist's ability to understand the meaning of religion or spirituality to the patient is important for accurate assessment and treatment (4).

Studies consistently suggest that patients are interested in having this area of their lives addressed but that physicians rarely do so (5,6). In part, this may be owing to differences in religiousness between psychiatrists and patients (7,8). Even when physicians and patients both report strong religious orientation, physicians infrequently inquire about religion (9). In a national survey of 508 Canadian physicians, 52% indicated that religion was important in their lives, but how this influenced their practice was not addressed (10).

There is growing recognition in medicine that "patients present themselves as integrated beings whose physical, emotional and spiritual welfare are entwined" (11). In the field of mental health, the increased interest in this interrelationship is seen in recent publications (12,13) and journals dedicating entire issues to the topic (14,15). Clearly, this is relevant to practice and to patients, yet there are no Canadian data on this area.

This study investigates the role of spiritual or religious beliefs, practices, and attitudes in Canadian psychiatric practice. We examined 1) levels of beliefs and practices, 2) opinions about the role of spirituality or religion in the therapeutic process, 3) predictors of spiritual or religious interventions in psychiatric treatment, and 4) potential barriers to addressing spirituality as part of psychiatric assessment and treatment.

Methods

Subjects

We mailed surveys to all psychiatrists registered with the Royal College of Physicians and Surgeons of Canada (RCPSC). A French translation was sent to those who preferred to correspond in French. Of 2890 members, 1204 (42%) responded, proportionally representing all Canadian provinces and territories.

To obtain a representative, national sample of psychiatric patients, we linked an on-line survey to the University of Saskatchewan's Department of Psychiatry Home Page. We contacted mental health sites across Canada to request a link to the site, and we placed advertisements in local and national newspapers inviting individuals to visit the sites and complete our survey. The on-line survey had low response rates, and we therefore invited patients in the local mental health clinic (MHC) to participate while in the waiting room. Patients were not asked to provide their diagnosis. We obtained informed consent and included Canadians aged 18 years or over who had seen a psychiatrist at some point. Participants had been seeing a psychiatrist for a mean of 4.36 (SD 5.23) years. Ultimately, 157 patients (67 on-line and 90 MHC) participated. There were no differences in beliefs between the on-line and MHC patients.

Survey Content

We asked respondents for both surveys to rate their belief in 1) "a higher power," 2) in "God," and 3) in "an afterlife." Ratings were marked on a visual analogue scale anchored between 1 ("not at all") and 5 ("very much so"). For the statistical analyses, we combined responses into a single belief variable. In a separate forced-choice question, respondents categorized themselves as "spiritual," "religious," "both," or "neither." The wording of questions was neutral with regard to particular religious or spiritual beliefs.

We used the Duke Religion Index (16) to measure organizational religiousness by asking the question "How often do you attend church or religious meetings?" and to measure private participation by asking the question "How often do you spend time in private religious activities (for example, prayer, meditation, or readings)?" Six possible responses ranged from "never" to "weekly or daily" activity. The Duke Religion Index also incorporates 3 statements to measure intrinsic religiousness (combined into 1 for analyses): 1) "In my life, I experience the divine," 2) "Spiritual/religious beliefs are what lie behind my whole approach to life," 3) "I try hard to carry my spirituality/religion into all dealings in life." Responses were rated from 1 ("definitely not true") to 5 ("definitely true"). No test–retest reliability is reported. In our study, Cronbach's alpha was 0.89 for the index.

Attitudes toward addressing spirituality and religion were assessed differently in the patients' and psychiatrists' surveys, but enough similarities existed to allow comparison. "Frequency of inquiry into patient's spirituality/religion as part of care" was rated on a 5-point scale from 1 ("never") to 5 ("always"). Patients used the same scale to rate the degree to which their psychiatrists had inquired. Both were asked whether they "feel spirituality/religion has a role in psychiatric care," and responses were rated on a similar 5-point scale. For psychiatrists, we adapted barriers to addressing spirituality and religion from Ellis and others (6). These included "lack of time," "lack of familiarity," "inappropriate," and "feel patient is not interested." We offered patients the following 5 choices: psychiatrist is "too busy," "not familiar," "doesn't feel it is appropriate," "doesn't seem interested," and "issue has been addressed."

Questions addressing whether patients chose their psychiatrist because of similar spiritual and religious beliefs; similar cultural or ethnic background; and belief in spirituality or religion affecting outcome in a "positive" or "negative" manner were answered on a 5-point scale from 1 ("never") to 5 ("always"). In addition, we asked patients how important it was to "know the spiritual or religious orientation of their psychiatrist" and whether it was "important to have spiritual or religious needs addressed as part of psychiatric treatment." We rated these responses on a 5-point scale ranging from 1 ("not at all important") to 5 ("very important").

We asked psychiatrists whether they felt that spirituality or religion affected outcome in a positive or negative manner, and we also asked about the frequency of recommending and initiating referrals to clergy or other spiritual helpers. Again, we rated these responses on a 5-point scale ranging from 1 ("never") to 5 ("always").

Data Analysis

We used independent *t* test, chi-square test, and the Mann–Whitney *U* test to compare psychiatrist and patient responses, depending on the type of variable. We used multiple regression analysis to determine which variables predicted spiritual inquiry and psychiatrist attitudes; we controlled for

Table 1 Respondent characteristics

	Psychiatrists $n = 1204$	Patients $n = 157$	P
Men %	61	35	< 0.001[a]
Women %	39	65	—
Age (years): mean (SD)	47 (9)	38 (13)	< 0.001[a]
Years in practice: mean (SD)	15.6 (9.6)	—	—

[a] Independent *t* test

Table 2 Beliefs and activities of psychiatrists and patients (scale 1 = "not at all" to 5 = "very much so")

	Psychiatrists median	Patients median	Mann–Whitney U	P
Strength of beliefs	3.7	4.5	67 230.50	< 0.001
Intrinsic religiousness [a]	2.9	3.0	84 894.5	0.03

[a]"experience divine," "approach to life," "all dealings in life"

Table 3 Self-perception of spiritual or religious

	Psychiatrists %	Patients %	Canadian population %	P
Consider self				
Spiritual	43	46	58	ns
Religious	5	5	—	—
Both	29	27	—	—
Neither	23	21	—	—

age, sex, and years in practice. We analyzed data using the Statistical Package for the Social Sciences (SPSS), Version 11, software (17).

Results

Demographic Data

Table 1 summarizes psychiatrists' and patients' demographic characteristics. The expected 2:1 female-to-male response rate for patients (18) contrasted with the 1:2 female-to-male response rate for psychiatrists and was similar to the 70:30 sex ratio for Canadian psychiatrists registered with the RCPSC. Psychiatrists were significantly older than patients.

Beliefs and Practices of Psychiatrists and Patients

On the visual analogue scale (Table 2), patients report higher rates of belief and intrinsic religiousness than do psychiatrists. There are no Canadian population comparison data for the combined belief measure we used; as part of the belief data, however, 54% of psychiatrists and 71% of patients reported belief in God (rated as 4 or 5 on the visual analogue scale), compared with 81% of Canadians (19). There is no difference in the perception of either group as "spiritual" and (or) "religious" or "neither" (Table 3).

Figures 1 and 2 present graphically the frequency of worship attendance and private spiritual activity, with Canadian data included for comparison (20). Psychiatrists and patients display a significant difference in overall worship attendance ($\chi^2 = 15.482$, df 5, $P < 0.008$). Patients also have a significantly higher frequency of regular private religious or spiritual practice ($\chi^2 = 30.802$, df 5, $P < 0.001$). Figure 3 compares religious affiliation for the 2 groups and the Canadian population (19).

The Role of Spirituality or Religion in the Therapeutic Process

Among both psychiatrists and patients, 47% agreed that religion or spirituality "often" or "always" has a role in psychiatric care. More patients than psychiatrists felt that spirituality and religion may have a positive impact ($U = 83\,696$, $P < 0.001$), but more psychiatrists felt that it could negatively affect patient outcome ($U = 75\,093$, $P < 0.001$). Of the psychiatrists, 50% responded that they "often" or "always" inquired about spirituality or religion. By contrast, 17% of patients felt that their psychiatrist had "always" or "often" addressed this issue ($U = 49\,054$, $P < 0.001$). Of psychiatrists, 9% "often or always" suggest referral to clergy or a spiritual helper, 46% at least "occasionally" do this, and 26% at least "occasionally" help initiate the referral. By contrast, 83% of patients stated that their psychiatrist had never suggested a referral to clergy or a spiritual helper. Of patients, 53% felt that it was important to them to have this issue addressed in their treatment, 47% felt that it was important to them to know the spiritual or religious orientation of their psychiatrist, and 24% said that it was a consideration in their selection of a psychiatrist, compared with 12% who felt that cultural factors were important in selecting a psychiatrist.

Sex Differences and Predictors of Spiritual or Religious Inquiry

Female psychiatrists had significantly higher levels of belief, practice, intrinsic spirituality, and belief in its positive effect, whereas male psychiatrists were more inclined to believe that spirituality or religion could have a negative effect (Table 4). Controlling for age, sex, and years in practice, we used multiple linear regression analysis to predict psychiatrist behaviour and attitudes to spirituality in practice. Personal beliefs and activities all predicted the likelihood of increased spiritual or religious attentiveness ($P < 0.001$), with the strongest predictor being intrinsic spirituality. As years in practice increased, the perception that spirituality has a role in psychiatry

Figure 1 Comparison of worship attendance for psychiatrists, patients, and the Canadian population

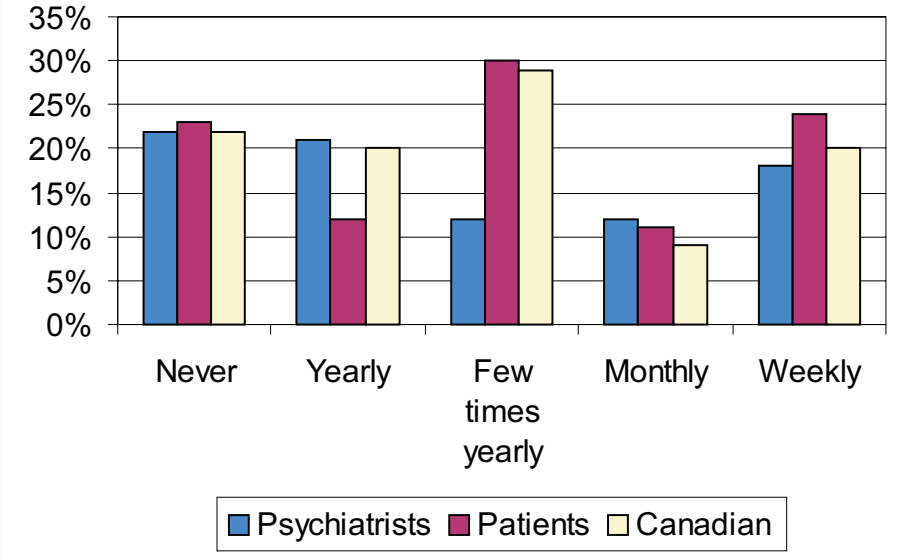
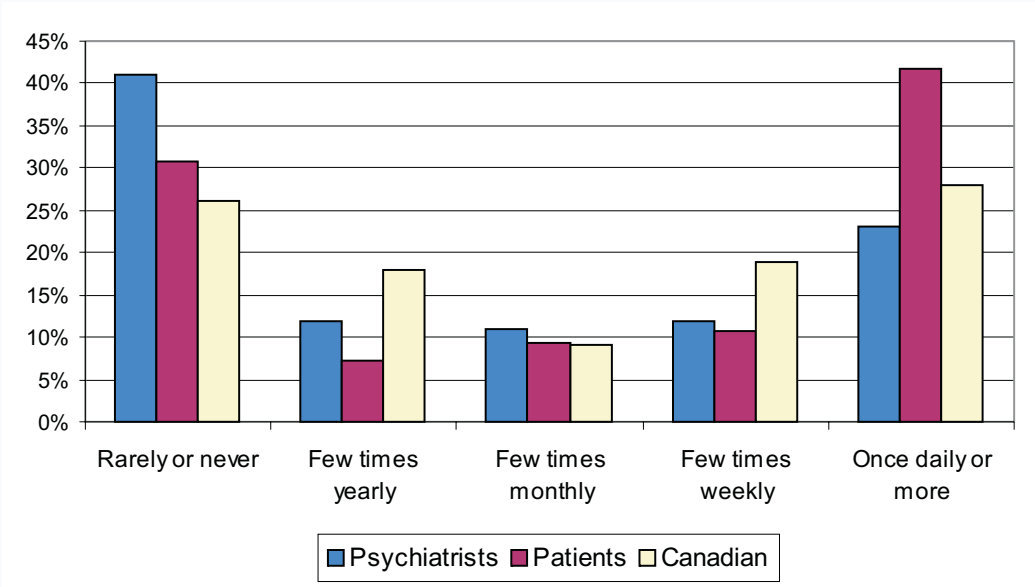


Figure 2 Comparison of private spiritual or religious activity for psychiatrists, patients, and the Canadian population



decreased. Similarly, increasing age was associated with a tendency to feel that spirituality or religion could have a negative outcome. There were no differences in responses of male and female patients.

Perceived Barriers to Spiritual or Religious Inquiry

Psychiatrists responded to a list of possible barriers to addressing spirituality and religion with patients (6). Items endorsed were "lack of time" (14%), "lack of familiarity" (16%), "inappropriate to do so" (36%), and "feel patient is not interested" (29%); 4% of respondents indicated that they did not have any barriers. Conversely, patients were asked whether their psychiatrist had inquired about spirituality or religion, and if not, what they as patients perceived the main barrier to be. One-third (34%) stated that their psychiatrist had at least occasionally inquired; nearly one-half (48%) of those whose psychiatrist had not inquired felt that their psychiatrist did not think it was important.

Figure 3 Religious affiliation of psychiatrists, patients, and the Canadian population

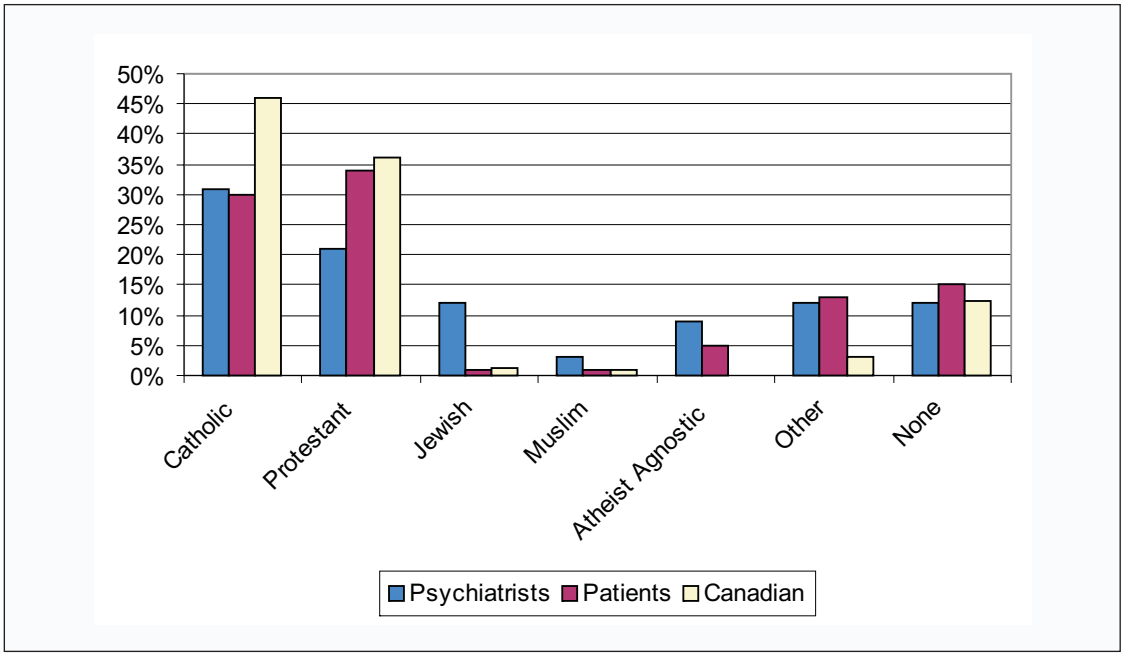


Table 4 Sex differences in beliefs and practices of psychiatrists (scale 1 "not at all" to "very much so"

	Men (*n* = 718) median	Women (*n* = 457) median	*Mann–Whitney U*	*P*
Strength of beliefs	3.3	4.0	136 156	< 0.001
Worship	2.8	3.0	157 124	ns
Prayer	2.6	2.9	153 095	0.009
Intrinsic	2.8	3.1	138 901	< 0.001
Positive effect	3.5	3.7	147 099	0.001
Negative effect	2.8	2.6	149 088	0.002

Discussion

Beliefs and Practices

Canadian psychiatrists have significantly lower rates of religious or spiritual beliefs, practices, and intrinsic religiousness than either Canadian psychiatric patients or the general Canadian population. Canadian psychiatrists also have lower rates of beliefs than those reported by family physicians (9,21) and psychiatrists (22) in the US, but higher rates than are reported by psychiatrists in the UK (8).

Patients have a higher level of private spiritual or religious activity than psychiatrists. Apart from demographic differences (for example, age, sex, income, and education), private activity may also, from the patient's point of view, reflect a coping mechanism, a search for meaning, or an increased expression of beliefs and experiences when faced with serious illness (8). Many cross-sectional studies of individuals with psychiatric symptoms indicate a high level of private spiritual or religious activity (2,12). In our previous work among inpatients with depression, we found that worship attendance was associated with lower levels of depression (23); however, the level of worship attendance of patients in the study is strikingly lower than their level of private religious activity.

Research in this area is hindered by definitional ambiguities, and in the survey, many respondents commented on difficulties they had with the word "religion." Although related, being religious and being spiritual are distinct, and "although a patient and psychiatrist may both believe they are important, the value that is placed on affiliation, authority, faith, and morality may be different" (21). With this in mind, 79% of patients and 77% of psychiatrists consider themselves religious or spiritual. Canadians and Americans endorse religion and spirituality differently. Gallup Polls in the US indicate that 30% of the population consider themselves spiritual, compared with 43% to 58% of Canadians. Conversely, 54%

of Americans consider themselves religious only, compared with just 5% of Canadians (19,24).

Role of Spirituality or Religion in the Therapeutic Process

The agreement between patients and psychiatrists on the importance of including spirituality in psychiatric care is similar to that reported in US surveys of family physicians and patients (6,9). Although psychiatrists endorse a positive effect from spirituality, they also view it as potentially having a greater negative influence, compared with patients; more male than female psychiatrists endorsed a negative effect. Other studies have not examined sex differences in perceptions of religion's influence (6,8,22).

In this study, the most important reason psychiatrists gave for not inquiring into patient beliefs and practices was that such inquiry is "inappropriate," a reason endorsed by more men than women. Female psychiatrists endorsed "feel patient is not interested" at a higher rate than their male counterparts. These responses may reflect personal discomfort with the subject, which in one study of academic (nonpsychiatrist) clinicians was found to be the sole predictor of lack of inquiry (25). One-half of the psychiatrists indicated that they inquired regularly about spiritual issues, which is consistent with the responses of UK psychiatrists (8). When we surveyed Canadian psychiatrists identified as religious, we found that, even among this devout group, only 80% routinely took a spiritual history of their patients (26).

Reasons for lack of discourse about spirituality and religion in psychiatry may include antagonism toward religion, as reflected by Freud (27); the desire to focus only on a biological basis for mental illness; fear of asking inappropriate questions; and lack of training to conduct such a discourse with sensitivity and nonintrusiveness. The American Psychiatric Association practice guidelines for psychiatric evaluation of adults include consideration of spiritual and religious issues as part of standard practice (28), and psychiatry residency programs in the US have started to incorporate spiritual and religious assessment into training. A recent survey of Canadian psychiatry postgraduate training programs reveals only minimal attention to the topic (29).

This study's limitations include the use of quantitative questions where qualitative questions might have allowed individuals more expression on this complex subject. We used forced-choice questions and phrased them to reflect established questionnaires; these were both limiting factors, as was, in particular, our use of "religion" or "spirituality" interchangeably. We kept the survey short to improve the response rate, which meant that some areas could not be fully examined. We attempted to sample patients from across Canada, but the low response rate from the Internet survey limited our ability to generalize from the responders. Nevertheless, 81% of Canadians report that they "believe in God" (20), so the patient response to our more specific questions, which indicates belief on the part of 71%, is reasonable. Similarly, responses to a more specific question indicate that 46% consider themselves to be spiritual (Table 3) and 24% attend worship weekly—percentages that are in the expected range (Figure 1). Responses indicating that 44% of patients pray daily suggest a higher number than the 28% reported for the Canadian population (Figure 2). However, as discussed above, it is known that people may turn to private religious activity when ill. The strength of the psychiatrist survey is that it is nationally representative, with a relatively good response rate.

Conclusions

Canadian psychiatrists have lower levels of religious or spiritual beliefs and practices than a group of Canadian psychiatric patients and the Canadian population. About one-half routinely inquire into their patients' spirituality and believe it has a role in psychiatric care, yet they also express concern about the appropriateness of this inquiry. The psychiatrist's own spirituality or religiousness is, not surprisingly, the strongest predictor of inquiry into a patient's spirituality or religiousness. We do not know whether the belief gap between patients and psychiatrists has clinical relevance; however, one-quarter of patients felt that the spiritual or religious orientation of their psychiatrist was an important factor in their choice, and it therefore appears to be an area that psychiatrists need to learn to address. Education about existing research, spiritual assessment, various religious beliefs and practices, and their meaning to the individual would enhance psychiatric assessment and, potentially, the treatment process as well.

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Résumé : Spiritualité et psychiatrie au Canada : la pratique psychiatrique comparée aux attentes des patients

Objectif : Cette étude compare les pratiques, les attitudes et les attentes des psychiatres et des patients psychiatriques en ce qui a trait à la spiritualité et à la religion.

Méthode : Nous avons posté des questionnaires à tous les psychiatres inscrits au Collège royal des médecins et chirurgiens du Canada (n = 2 890). Le taux de réponse a été de 42 % (n = 1 204). Nous avons recruté les patients dans une enquête canadienne en ligne (n = 67) et dans une clinique de santé mentale locale (n = 90).

Résultats : Les psychiatres ont des niveaux moins élevés de croyances et de pratiques que les patients et la population générale. Dans les deux groupes, 47 % croient qu'il y a « souvent ou toujours » place pour la spiritualité dans une évaluation psychiatrique, bien que l'importance perçue soit différente. Chez les patients, 53 % croient qu'il est important d'aborder cette question, et 24 % pensent que l'intérêt spirituel du psychiatre importe dans leur choix d'un psychiatre. Ce qui empêche d'aborder la question de la spiritualité et de la santé mentale est relié aux doutes des psychiatres quant à sa pertinence et à la perception qu'ont les patients du manque d'intérêt. Les propres croyances et pratiques des psychiatres étaient des prédicteurs efficaces de la quête spirituelle.

Conclusions : Bien que les psychiatres déclarent des niveaux de croyances spirituelles et religieuses inférieurs à ceux des patients, ils reconnaissent qu'il est important d'inclure ce sujet dans les soins des patients. Une formation et un dialogue accrus pourraient abaisser les obstacles déclarés à l'inclusion de la spiritualité et de la religion dans une évaluation psychiatrique de routine.