

## **Pilot Study and Evaluation of Postgraduate Course on “The Interface Between Spirituality, Religion and Psychiatry”**

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**Objectives:** *Understanding the role of religion and spirituality is significant for psychiatric practice. Implementation of formal education and training on religious and spiritual issues, however, is lacking. Few psychiatric residencies offer mandatory courses or evaluation of course utility. The authors present findings from a pilot study of a course on the interface between spirituality, religion, and psychiatry. Course objectives were to increase both residents’ understanding of clinically relevant spiritual/religious issues and their comfort in addressing these issues in their clinical work.*

**Methods:** *A 6-hour mandatory course was implemented for third- and fourth-year psychiatry residents at the University of British Columbia. Teaching sessions consisted of didactic and case-based modules delivered by multidisciplinary faculty. The Course Impact Questionnaire, a 20-item Likert scale, was used to assess six areas: personal spiritual attitudes, professional practice attitudes, transpersonal psychiatry, competency, attitude change toward religion and spirituality, and change in practice patterns. A pre/post study design was used with the questionnaire being administered at week 0, week 6, and 6 months follow-up to two groups of residents (N=30). Qualitative feedback was elicited through written comments.*

**Results:** *The results from this pilot study showed that there was increased knowledge and skill base for residents who participated in the sessions. Paired t test analysis indicated a statistically significant difference between the pre- and postsession scale for*

*competency. No other statistically significant differences were found for the other components.*

**Conclusion:** *The findings suggest improvement in the competency scores for residents and overall usefulness of this course; however, limited conclusions can be made due to a small sample size and lack of adequate comparison groups. Establishing educational significance will require gathering larger usable control data as well as validation of the Course Impact Questionnaire tool to distinguish between different skill levels.*

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Several factors provide an impetus for including education on religion and spirituality within psychiatric training. First and foremost, understanding the spiritual and religious belief systems of psychiatric patients affords clinicians insight into patients’ health-seeking behaviors and an explanatory model for mental health issues, which in turn impacts treatment acceptance and adherence. Overlooking the spiritual aspects of a patient’s experience may devalue the patient’s perspective, undermine a successful working alliance, and impede successful negotiation of treatment (1).

Second, there is increasing awareness that cultural context needs to be considered when assessing the clinical impact of the patient’s religious and spiritual experiences. Many cultures continue to practice traditional healing methods and spiritual practices salient to their understanding of wellness (2). Cultural sensitivity, cultural safety, and cultural competence, which includes attention to religious and spiritual issues in clinical practice (3), have become important markers for efficacious service (4). Spiritual and religious beliefs are often a key marker in the identity of individuals and communities beyond boundaries of ethnicity and even national identity (5, 6).

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Third, there is a growing public interest in complementary and alternative therapies, as these treatment modalities often directly address the spiritual component of the healing process (7). This puts an onus on psychiatric clinicians to be aware of and understand the large body of scientific research that explores the association between religion/spirituality and physical and mental health outcomes. A positive association has been found between spirituality and health, after controlling for confounding variables (8–12). Potential factors contributing to this relationship are enhanced positive psychological states (i.e., inner peace, faith, hope, mystical experience acting through psychoneuroimmunologic or psychoneuroendocrinologic pathways) (8, 13) and positive religious coping behaviors, such as benevolent reappraisal, in which the stressors are redefined through religion as benevolent and potentially beneficial, or collaborative religious coping, in which the individual seeks control of the situation through a partnership with God (14). Negative health outcomes can also be associated with religious practices when religious beliefs encourage avoidance or discontinuation of medical treatment, failure to seek timely medical care, avoidance of effective preventative health measures (e.g., immunizations, prenatal care) or religious abuse (e.g., child abuse conducted under a perceived religious mandate) (15, 16). Conceptual clarity around the different aspects of religion and spirituality and their construct meanings has increased in the last 5 years (11, 17).

### **Current Training in Psychiatric Residency Programs**

It is clear that belief systems play a key role in psychological development and remain powerful influences on responses to illness and other life stressors. The APA Practice Guidelines for the Psychiatric Evaluation of Adults were updated in 1995 to include gathering information on “important religious influences on the patient’s life” in the personal history and performing an evaluation that is “sensitive to the patient’s . . . religious/spiritual beliefs” (18). The Accreditation Council for Graduate Medical Education (ACGME) program requirements for residency training in psychiatry were amended to reflect these new guidelines and, by 2001, a significant number of American psychiatry programs included a mandatory curriculum on religion and spirituality that spanned the length of the residency program (19–23).

In contrast with the American training programs, a recent survey of Canadian psychiatry residencies found that most Canadian programs did not offer residents training

to prepare them to competently address the interface of religion and spirituality with psychiatry (7). Of the 14 out of 16 residency programs that responded to the survey, 10 provided no didactic teaching. Mandatory training was limited to four residency programs, with the majority of teaching in these programs occurring through the availability of case-based supervision, thus relying on both resident motivation and supervisor interest and knowledge in this content area (7). This lack of education limits clinicians’ ability to take a religious/spiritual history and challenges clinicians to incorporate their patient’s belief systems into treatment plans when appropriate. Other challenges to incorporating religion/spirituality into clinical practice have been addressed by researchers in the field and include: lack of understanding on what is meant by spirituality and religion, a focus on biomedical models and pathogenesis, bias toward the association of spirituality with psychopathology, and concerns regarding ethical issues and ambiguity about professional roles (5, 6, 9, 17, 19, 24–33).

To address some of these challenges we developed a lecture series for psychiatry residents. The purpose of this pilot study was to assess if this educational intervention has an impact on residents’ attitudes and comfort level for incorporating patients’ spiritual and religious beliefs into practice.

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## **Method**

### **Course Content**

The 6-hour “Interface between Psychiatry, Religion and Spirituality” mandatory course was delivered to postgraduate year 3 (PGY-3) and PGY-4 psychiatry residents at the University of British Columbia in winter 2005.

This curriculum was drawn from Larson, Lu, and Swyers’ 1997 model curriculum which was developed to address training requirements necessary for topics related to religion, spirituality, and mental health (20). The course content was delivered by multidisciplinary professionals. The methodology of the curriculum was primarily based on both didactic instruction and case-based discussions.

Session 1 looked at definitions of religion and spirituality and the historical relationship between these areas and psychiatry. The concepts of religion and spirituality are increasingly distinct within the Western social scientific literature, with religion being viewed as associated with institutions, prescribed theology, and ritual and the construct of spirituality viewed as being an individual phenomenon, identification with personal transcendence, and

meaningfulness (17, 19, 24, 25, 30, 34). The construct definitions were compared and contrasted with spirituality, defined broadly to include aspects of oneself that may or may not include a personal relationship with God versus religious understandings of connection to a divine being. Implications of construct meanings were emphasized from a cultural lens whereby either construct is shaped by historical and cultural events (34).

Session 2 reviewed scientific evidence for associations between spirituality, religion, and mental health. Available research examining the neurobiological effects of spiritual and religious practices was reviewed. For example, a recent study examining the impact of mindfulness meditation on frontal activation asymmetry and mood was reviewed (13). Session 3 reviewed the clinical assessment process with a focus on spiritual history taking and formulation and session 4 was a case-based discussion of spiritually related phenomenology.

Session 5 focused on transference and countertransference issues in assessment as well as in psychotherapy and session 6 was a case-based discussion with a panel of faculty; both faculty and residents provided cases. Further curricular details are available on request from the authors.

**Evaluation of Course Impact: Course Impact Questionnaire Development**

A review of the literature found no published evaluations of courses focused on this material at the residency level and no validated assessment tools available for this content area. Therefore, in order to establish whether the “Interface between Psychiatry, Religion and Spirituality”

curriculum was meeting its objectives (Table 1), we developed the Course Impact Questionnaire. The questionnaire is a 20-item self-report measure of students’ knowledge on six domains. The first domain contained four items on *personal spiritual attitudes*, the second domain had seven items on *professional practice and attitudes*, the third domain had three items on *transpersonal psychiatry*, the fourth domain had five items on *competency*, the fifth domain had one item on *attitude change*, and the sixth domain had one item on *change in practice patterns*. Items were rated on a seven-point Likert scale (1 = strongly disagree, 7 = strongly agree). Two items were scored on separate scales consisting of a four-point frequency scale (attitude change) and the other on a 10-point frequency scale (change in practice patterns). All items are available upon request.

We targeted three of the four levels of evaluation as described by Kirkpatrick (35): evaluation of reaction (satisfaction), evaluation of learning (knowledge or skills acquired), and evaluation of behavior (transfer of learning to workplace) (35). The fourth level, evaluation of results (transfer or impact on society), was not evaluated due to the exploratory nature of the study and limited sample size.

**Administration**

The Questionnaire was administered at week 0, week 6, and 6-month follow-up to two separate groups of residents who completed the course in January 2005 and September 2006 (N = 30). The comparison group were residents in the same years who were not taking the course because they were away on electives (N = 6). Unfortunately, as not enough responses were received from the comparison group at week 6 or from both groups at the 6 month follow-

**TABLE 1. Selected Examples of Knowledge, Skills, and Attitudinal Objectives**

<b>Knowledge</b>	<p><b>Residents should demonstrate understanding of:</b></p> <ol style="list-style-type: none"> <li>1. demographics of spiritual/religious beliefs in various patient populations</li> <li>2. research into the relationship between spirituality/religious beliefs and physical and mental health</li> <li>3. current research literature on neurobiology of spiritual experience</li> <li>4. spiritual/religious issues in psychodynamic therapy (e.g., significance of God images)</li> </ol>
<b>Skills</b>	<p><b>Residents should demonstrate competence in:</b></p> <ol style="list-style-type: none"> <li>1. taking a spiritual/religious history</li> <li>2. incorporating information gathered into the biopsychosocial/spiritual understanding of the patient, reflected in the diagnosis and treatment plan</li> <li>3. identifying how their own spiritual/religious beliefs might impact their case formulation, diagnosis and management plans</li> <li>4. recognizing and working through transference and countertransference reactions</li> <li>5. deciding when it is appropriate to refer to, or consult with, chaplains, spiritual directors, or culturally based healers</li> <li>6. correct use of DSM-IV-TR criteria of Religious or Spiritual Problem</li> </ol>
<b>Attitudes</b>	<p><b>Residents should demonstrate:</b></p> <ol style="list-style-type: none"> <li>1. awareness of their spiritual and cultural experiences and the impact of these experiences on their identity and world view, as well as possible biases that could influence their treatment of patients</li> <li>2. respect and acceptance of the diversity of spiritual and cultural experiences</li> </ol>

up to allow use in the analysis, the study used a pre/post design for assessment and analysis.

### Scale Reliability

Internal consistency for each scale, with the exception of *attitude change* and *change in practice patterns*, was evaluated using coefficient alpha (36). Each item for each scale was examined in terms of item-total correlation and the effect on coefficient alpha if the item were dropped. The analysis found that the items for personal spiritual attitudes had acceptable reliability ( $\alpha = 0.848$ ). For the *professional practice scale*, analysis indicated that the removal of item 9 (“There is a need for training in how to address religious and spiritual issues in psychiatric practice”) would result in an increase in internal consistency ( $\alpha = 0.323$  to  $0.437$ ). This scale was discarded and not included in the analysis. Similarly, for the *transpersonal psychiatry* scale, internal consistency would increase with the removal of item 14 (“I have a basic understanding of transpersonal psychiatry”) ( $\alpha = 0.063$  to  $0.681$ ). Finally, for the *competency* scale, internal consistency would increase with the removal of item 20 (“I am uncertain how to manage spiritual issues raised by patients”) ( $\alpha = 0.150$  to  $0.608$ ). By convention, a cutoff of 0.70 or higher was considered adequate for scale reliability. However, a more lenient cutoff of 0.60 is commonly used in exploratory research such as that described in this study (37). Therefore, reliability for these scales ranged from satisfactory to strong (0.608 to 0.848).

### Analysis and Results

The data were examined for normality, homogeneity, and missing data. Individuals with missing data for  $\geq 50\%$  of scale items were removed. For those completing  $\geq 50\%$  but  $< 100\%$  of the items, scores on the missing items were assigned using linear interpretation of the items (SPSS V14.0). This resulted in a final total of 22 residents for the analysis (15 women, 7 men). Within-group differences were calculated to determine the relative importance of religious and spiritual issues before and after the training

sessions using paired t tests on each scale (two-tailed). Statistical significance was set (0.05) and adjusted according to the Bonferroni method ( $0.05/6 = 0.008$ ) (38).

Results indicated a statistically significant difference between the pre- and postsession scale for *competency*. Mean scores increased from 7.2 to 11.7, indicating a shift in overall comfort with spiritual issues in clinical practice ( $p > 0.0001$ ). The remaining factors showed no statistically significant results ( $p < 0.05$ ) (Table 2).

### Discussion

The results showed a change in the desired direction in perceived knowledge and skill base. Lack of an adequate comparison group and 6-month follow-up data limit conclusions that can be drawn regarding overall course impact.

Qualitative feedback provided by students on the questionnaire was generally positive. A few residents felt that the predominantly hospital-based clinical environment encountered in residency did not support the inclusion of a spiritual dimension in assessment or treatment planning when clinically indicated. Anecdotal evidence from course instructors indicated that several residents were somewhat hostile toward the introduction of the course into the curriculum; this appeared to reflect the transference of personal attitudes toward spirituality to the professional context.

The present pilot study had several limitations. First, the lack of an adequate comparison group limits the generalizability of results. Although residents were assessed immediately after the training session and 6 weeks later, other factors cannot be ruled out as these may have contributed to the increase in perceived competency. Next, although instructors attended standardization meetings beforehand to review objectives and detailed lecture outlines in order to ensure consistency and avoid redundancy, individual teaching styles may have affected survey responses. Finally, although the questionnaires were anonymous it is possible that social desirability bias may have

**TABLE 2. Paired t-test Analysis of Course Impact Questionnaire Scales**

Scale / Session	Pre-Session Mean (SD)	Post-Session Mean (SD)	t value	p value*
Personal spiritual attitudes	14.9 (5.3)	13.9 (6.4)	1.26	>0.05
Transpersonal psychiatry	9.7 (2.1)	9.6 (2.5)	0.14	>0.05
Competency	7.2 (2.3)	11.7 (3.9)	4.60	0.0001
Attitude change	3.2 (1.6)	3.3 (1.2)	0.19	>0.05
Change in practice patterns	1.5 (1.0)	1.3 (0.5)	0.69	>0.05

\*Two-tailed

affected residents' responses. In the questionnaire responses, several residents identified themselves as being hostile to varying degrees to the topic, as described above; this is also likely to have impacted how the questionnaire was completed.

Establishing educational significance will require validation of the Course Impact Questionnaire tool and adding an efficacy indicator of spirituality in psychiatry in order to distinguish between different skill levels (39). This would be one step in establishing a link between personal attitudes toward spirituality and the potential for taking a spiritual history and incorporating these needs into treatment planning.

Based on the results of the Course Impact Questionnaire, a number of changes will be made the next time the course is offered. To allow a more clinical focus, the new curriculum has been expanded to 10 sessions and modified to include more case studies to increase focus on diagnostic and management issues. With regards to responding to the hostile attitudes in the class, course directors observed that having various faculty members involved in teaching the course prevented sessions from building on one another and shifted the emphasis of the course onto didactic content, making it difficult to address process issues. The next time the course is delivered, fewer faculty members will be teaching the course, thus allowing for more continuity and identification of process and countertransference issues that may impact course utility and subsequent clinical practice.

### Conclusion

The promising results of the pilot evaluation of the "Interface between Spirituality, Religion and Psychiatry" course as presented in this article show the feasibility of instruction in this area and underscore the need for further studies to evaluate program effectiveness. Further research is needed to examine current educational methods and their effectiveness in aiding the clinician in addressing spirituality and religious issues with their patients.

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