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EMPIRICAL REPORT

A Descriptive Study of a Spirituality Curriculum for General Psychiatry Residents

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Abstract
Objective The study collected data on the attitudes of residents toward religion and spirituality in their practice after taking part in a 3-year curriculum on spirituality during their residency.
Methods This is a descriptive, single-site study with psychiatry residents as subjects. A questionnaire was given to the residents at the end of their third year of residency ($N = 12$).
Results The responses heavily endorsed the religiousness/spirituality curriculum to be helpful and meaningful. Residents consider addressing spiritual and religious needs of patients to be important (76.9%) and appropriate. For majority of the residents (69.2%), there is strong agreement in the management of addictions having spiritual dimensions. Residents also strongly agreed that treatment of suffering, depression, guilt, and complicated grief may require attention to spiritual concerns (92–100%).
Conclusion Regardless of cultural or religious background, the residents endorsed the curriculum as a worthwhile experience and increased their appreciation of the place of spirituality in the holistic care of patients with psychiatric conditions.

Keywords Resident: cross-cultural psychiatry · Professional development

The integration of spirituality into psychiatry residency training is a challenging undertaking. Psychiatry and behavioral sciences in their academic and clinical underpinnings have a tradition of distancing themselves from religion and spirituality [1]. There are historical and professional reasons for this exclusion, related to how psychiatry and psychology emerged as distinct disciplines. While the roots of these disciplines were interwoven with religion and spirituality, in an effort to establish themselves as distinct scientific undertakings, it was thought necessary to distance themselves from these roots [2].

A different picture is now emerging as numerous studies have supported the association of religiousness and spirituality with general health, improved psychological well-being, and diminished symptoms in people with mental illness [3, 4]. The Association of American Medical Colleges (AAMC) has stressed the importance of "patient's stories in the context of patient's beliefs, family, and cultural values" in their Medical School Objectives Project [5, 6]. Spirituality can be related to these elements, with special relevance for patient care, interpersonal and communication skills, and professionalism [7]. The American Psychiatric Association (APA), with the APA Foundation and the Interfaith Disability Coalition, has collaborated in a program called Mental Health and Faith Community Partnership, with the goal of promoting dialogue between mental health professionals and spiritual leaders [8].

Residency training programs have started to incorporate spirituality with a multicultural approach into the curriculum [9–11]. Between 1998 and 2006, the George Washington Institute for Spirituality and Health (GWISH) Foundation has funded 33 psychiatry residency training programs that address spirituality and mental health [12]. Cultural psychiatry has been instrumental in developing a fuller, more inclusive conceptualization of religiousness and spirituality, particularly relevant with changing demographics among physicians and patients [13, 14]. One curriculum study has recommended putting the emphasis in training on spiritual history taking, as opposed to general broad knowledge of many religions [15]. Another study on psychiatry residents identified multiple

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resident "roles" and potential "barriers" in addressing spirituality [16]. Assessments of spirituality training in psychiatry residency found it increased knowledge and skills and was positively received among the residents [17, 18].

Methods

Participants

Twelve residents were enrolled in the formal curriculum from all years of the psychiatry training program beginning in 2007. All 12 residents completed the survey after they finished 3 years of the curriculum from 2010 to 2012. The residents were from ages 30 to 53 years, nine men and three women, and were from seven countries (USA, India, Pakistan, United Arab Emirates, Nigeria, Sierra Leone, and Spain). Residents self-identified as Christians (4), Hindus (4), Muslims (3), and an agnostic (1).

Curriculum Development

From the outset of the program, a working definition of spirituality, especially in its significance and application to clinical practice in medicine and psychiatry, was derived from a multitude of disciplines. A consensus conference defined spirituality as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to other, to nature and to the significant or sacred" [19]. Elements of such a definition have identified spirituality as that which allows a person to experience transcendent meaning in their life, to experience a sense of interrelatedness as arising from the search for the sacred, and as addressing the deepest sense of becoming and participation [20, 21]. Spirituality, in our view, is that which gives ultimate meaning to a person's life and is intimately connected to a person's deepest experiences involving relationships, religion, and culture. Religion is "institutionalized spirituality" tied to community beliefs and rituals often incorporated into cultural practices [22].

Spirituality was incorporated into the existing curriculum and training program with the following goals: to increase awareness of the residents' own spirituality; to elicit a patient history which is respectful of the spiritual, cultural, and religious dimensions of the life of the patient; to respond to the suffering of the patient in a compassionate and caring fashion; to assemble literature relevant to spirituality in psychiatric residency training; to become familiar with instruments that measure spirituality; and to assess and respond in clinical practice to the spiritual dimensions of mental illness across the life cycle, with particular reference to depression, anxiety, grief, addiction, and end of life issues. It was incorporated in compliance with the six elements of core curriculum competencies adopted by the Accreditation Council for Graduate and Medical Education (ACGME): patient care, medical knowledge, patient-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice [23]. It was projected that the new elements would enhance awareness of and a commitment to spirituality as part of holistic patient care.

Components of the spirituality curriculum were introduced over the 3 years of residency training. The outline of the curriculum, for each of the 3 years, is described in terms of didactic experiences in seminars, clinical and other training experiences, and evaluation.

Didactics, Seminars, and Psychotherapy Case Conference Series

Didactics in the first year of residency training involved welcoming residents and their distinct religious and cultural backgrounds. Essential ways that various world views, Hindu, Buddhist, Jewish, Christian, Muslim, agnostic, and atheist, addressed human suffering associated with mental illness were explored. Particular topics included professional and ethical standards, religious and spiritual context of psychiatric practice, and the body-mind-spirit connection. In the second year of residency training program, didactics and seminars introduced operational definitions of spirituality as they applied to the care of patients and families, ethical boundaries and cultural dimensions of spirituality in the patient-physician relationship, various measures of spirituality, and approaches in addressing and communicating spiritual issues with patients. A series of seminars and psychotherapy case conferences for Postgraduate Year-III residents discussed spiritual dimensions of specific clinical encounters, suffering associated with long-term mental illness, treatment and recovery from addictions, end of life care, and grieving. These special seminars were directly related to the teaching and supervision of the resident psychotherapy experience.

Clinical and Other Experiences

Clinical application involved faculty in Internal and Family Medicine who were medical directors of local hospice programs. These introduced the residents to pastoral care in the inpatient psychiatric units, and to spiritual dimensions in hospice care and in the care of children and families. In the second year, residents participated in conferences with the chaplains at both religious-oriented Medical Center and University Medical Center inpatient units. They participated in grand rounds addressing spiritual issues and in chaplain-sponsored seminars between

the hospital and various faith communities. Use of spirituality scales and inventories as part of history taking and evaluation were introduced. Residents also participated in ethical consults under the direction of the Ethics Program Director. Attendance at outside conferences on spirituality, focusing on taking spiritual histories and integrating spirituality in psychotherapy training, was also provided. The spiritual dimensions of addiction treatment and recovery were explored through participation in our intensive outpatient program, which included attendance at open Alcoholics Anonymous meetings.

Spirituality Dinners

The didactics and clinical experiences were bolstered by bimonthly spirituality dinners. Representatives of various world views presented application of their beliefs to the treatment of mental illness in interactive sessions. This was a distinctive feature of the curriculum that has received unanimous approval and was credited with developing a profound sense of community among residents.

Spirituality Awareness in Resident Psychiatric Practice

A fundamental research question was whether the addition of an identified spirituality curriculum influenced resident awareness of and attitudes toward the spiritual dimensions of clinical practice in psychiatry. The objectives of the spirituality program were evaluated using the Spirituality Awareness in Residents Psychiatric Practice (SARPP). At the time the study was developed and implemented, there were no instruments in the literature that answered the specific objectives of this study and a new survey questionnaire, the SARPP, was created and used. The SARPP is a 42-item survey instrument designed to assess the residents' individual views on the interface of spirituality and psychiatry (items 1–4), their definitions of spirituality/religiousness (items 5–8), their personal and professional attitudes toward spirituality (items 9–15), the spirituality curriculum and the ACGME core competencies (items 16–24), the impact of the spirituality curriculum on their clinical practice (items 25–36), and resident evaluation of the spirituality curriculum (items 37–42).

In assessing the residents' personal and professional attitudes toward spirituality, the SARPP asked whether discussions regarding spirituality should be initiated by the patients. This section also included an item asking the residents' about spiritual countertransference. Spiritual countertransference addresses the residents' personal experiences and observation that affect their attitudes toward spirituality and religion in general, and/or a specific denomination in particular. A negative attitude toward religion and spirituality can inhibit the residents' response to the patient's viewpoints where religion and spirituality may be important [24]. This also factors into their comfort level in addressing spirituality in patient care since residents will have to confront their own reservations and anxieties about religion and spirituality when they address these aspects in their patients.

This survey was an anonymous survey given to residents at the end of their third year of residency training. Responses to each item were categorized into five categories: Strongly agree, Agree, Not sure, Disagree, and Strongly disagree. The SARPP was given at the end of their third year since majority of the residents pursued fellowship training during their fourth year. A brief supplement paper and pencil survey, with nine closed- and four open-ended questions that supported the items on the SARPP allowed the residents to elaborate on some of their responses.

Results

A descriptive analysis of 29 items on the SARPP using the percentage of items endorsed by the residents constituted the evaluation of the effect of the curriculum on residents' attitudes toward spirituality.

There was a strong agreement (85.7%) among residents that psychiatry should not distance itself from religiousness and spirituality. A majority of residents think that appreciating their own spirituality would be helpful in patient care (71.4%). Residents also had a broad and nuanced conception of spirituality which included transcendence. See Table 1.

There was majority consensus on items related to core competencies in training which include knowledge of spirituality, assessment and awareness of patient spirituality, ethical and cultural sensitivity, addressing spiritual issues in holistic treatment planning, and working with spiritual leaders and other community resources.

However, items eliciting a wider array of responses were also identified. For instance, although residents endorse the validity of discussion of spiritual issues in psychiatry, there was less agreement on how it should be initiated, with only 42.8% agreement on it being initiated by the patient rather than the psychiatrist.

Additional areas related to training also have mixed results. There were mixed responses on residents' perception of their ability to take a spiritual history from a patient, and only 46% report increased awareness and integration of spirituality into their clinical practice. A complete list of SARPP items and percentages can be requested from the primary author.

Overall, the curriculum was considered meaningful by a majority of residents (69.2%), has expanded their appreciation of spirituality in practice (76.9%), and has improved their clinical expertise with issues of spirituality (92.3%).

Table 1 Survey outcomes

Spirituality Awareness in Residents Psychiatric Practice items	Agree or strongly agreed (%)	Disagree or strongly disagreed (%)	Not sure (%)
S/R in Psychiatry (1–4)			
Psychiatry should distance from R/S	–	85.7	14.3
Proposed definitions of S/R (5–8)			
Spirituality allows experience of transcendent meaning	92.8	–	7.1
Personal and professional attitudes for S/R (9–15)			
Discussion of spirituality issues should be initiated by patients	42.8	35.7	21.4
Appreciating own spirituality helpful in patient care	71.4	14.3	14.3
Spiritual countertransference can result in lessened attention	50.0	28.6	21.4
Relate S/R to ACGME core competencies (16–24)			
Awareness of patient spirituality facilitates compassionate and competent care	85.7	7.1	7.1
Knowledge of spirituality enhances competence in psych practice	78.6	7.1	14.3
Assessment of patient's S needs improves treatment planning and outcomes	71.4	–	28.6
Current research indicates S is an element of holistic care	64.3	–	35.7
Training enhances one's skills to communicate about spiritual matters	92.8	7.1	–
Dealing with S concerns is a professional issue involving ethical and cultural sensitivity	85.7	7.1	7.1
Awareness of S resources helps in addressing needs of patients	92.8	–	7.1
Working with chaplains and local R leaders provide better understanding of community resources	92.3	–	7.7
Addressing distressing S experiences in management of disorder is important	76.9	7.7	15.4
Spirituality in clinical practice (25–36)			
Profound spiritual experiences can be natural occurrences	46.2	7.7	46.1
Spirituality of patients should be assessed on a regular basis	30.8	46.2	23.0
Taking spiritual history is a challenging experience	76.9	–	23.1
Treating depression require attention to spiritual concerns	92.3	–	7.7
Assisting in resolving guilt includes focus on R/S issues	84.6	–	15.4
Spirituality is important element in complicated grief	100	–	–
End of life care enhance by attention to spiritual needs	100	–	–
Management of addictions has S dimensions	69.2	–	30.8
Evaluation by residents of curriculum (37–42)			
Curriculum in spirituality has been meaningful	69.2	–	30.8
Curriculum expanded my appreciation of S in practice	76.9	–	23.1
My clinical expertise with S issues has improved	92.3	7.7	–
I am able to take spiritual history	38.4	30.8	30.8
Resident discussion of S issues has increased	38.4	46.2	15.4
My personal/professional awareness and integration of spirituality into practice has increased	46.2	15.4	38.4

Discussion

The outcomes from the implementation of this spirituality curriculum show that several highly endorsed items were identified based on the surveys. The consensus is high among items that acknowledge the role spirituality in compassionate, competent care, and the need to be aware of and to address these concerns in patient care.

There is a majority agreement that spirituality should be included in patient care. However, there are differences in what incorporation of spirituality entails and how it should be incorporated into patient care. For instance, with regards to who should initiate the discussion, there was a more evenly distributed response for residents stating it should be initiated by the patient, those disagreeing with that statement, and those who are not sure who should initiate the discussion. The historical tradition of distancing psychiatry from religion is likely reflected in the nearly even distribution among residents with regards to whether they agree or are not sure whether profound spiritual experiences can be natural occurrences. These are important considerations in how the curriculum would be continually evaluated and modified so that it is relevant and applicable to residents. Another consideration in the integration of spirituality was when and how often assessment of the patient's spirituality

should be done. This item had fairly close numbers of residents agreeing, disagreeing, or not sure about whether spirituality assessment should be done on a regular basis.

There could be several variables that contribute to the wide distribution of responses as to how spirituality will be incorporated into clinical practice. This may include inadequate awareness of current literature supporting the role of spirituality and religiousness in patient care, as well as differences in the residents' individual inclination and comfort level in discussing issues of spirituality. A vast majority of residents finds taking a spiritual history to be challenging, and this may result in a decreased level of comfort in addressing spirituality issues. The variable responses as to whether spiritual countertransference can result in lessened attention to patient's overall needs may also affect the residents' inclination to address spirituality in clinical practice. Residents may be less likely to broach the subject of spirituality if they have their own anxieties or negative experiences with religion to avoid diminishing the therapeutic alliance. The effects of transference and countertransference on the ability of the residents to engage patients in conversation about spiritual issues are addressed during individual psychotherapy supervision. The findings in this study complement the Canadian study that identified the role of "communicator" for residents in addressing spirituality while identifying the "barriers" to discussing spirituality that include insufficient time, concerns about offending the patient, and insufficient training [16]. Just as in this study, the residents significantly favor learning more about spirituality in practice.

Regardless of cultural or religious background, residents consider attention to spiritual concerns to be important in the treatment of suffering, depression, guilt, and complicated grief. There is also strong agreement that the management of addictions and end of life care have significant spiritual dimensions.

The religiousness/spirituality curriculum was positively received among the residents who considered this to be a particularly helpful and meaningful experience. Several studies on spirituality training in other psychiatry residency programs were similarly well received indicating a positive development as psychiatry moves beyond what Verhagen referred to as "mortal combat with religion" [16, 18, 25].

A recent Position Statement by the Royal College of Psychiatrists has recommended a "sensitive exploration of religious beliefs" [26]. It advocates for psychiatry residency training and professional development that include learning the appropriate language and approach that is insightful, respectful, and sensitive to perceived notions of intrusiveness. Several pioneers have provided a conceptual framework for religious issues in psychotherapy making it an acceptable venue for spirituality [27].

The curriculum addresses incorporating spirituality in practice, including teaching various world views and improving skills in taking a spiritual history. The focus has been slightly revised to concentrate more on the second and third year of the residency program. The essential elements of the 3-year curriculum have been maintained while concentrating on an understanding of spirituality and religiousness in practice. The didactics and experiential components of the curriculum are condensed into 18 sessions during the second and third years of residency. In the original and subsequent revision of the curriculum, two reference texts were especially helpful; the *Handbook of Spirituality and Worldview in Clinical Practice* by Allan M. Josephson and John R. Peteet, and *Encountering the Sacred in Psychotherapy* by James L. Griffith and Melissa E. Griffith. Both texts were well-received and served as stimulus for discussion and exploration of spirituality in psychiatric practice [28, 29].

One of the limitations of this survey was the low sample size in a single training program site that limits the generalizability of the findings. The demographic composition of the residents in our program may not be representative of other psychiatry residency training programs. The lack of normative and validating data limited the statistical analyses on the results. However, there are similar areas of interest measured by the SARPP when compared to other studies evaluating spirituality curriculum in psychiatry residency. The item questions on attitudes found similar agreement with integration of spirituality being "appropriate" in psychiatry as in Kattan's study [16]. There were also questions on attitude change toward spirituality in psychiatry in the evaluation of the impact of the curriculum similar to Grabovac's study [17]. Similar to these two studies, several items addressed the resident's comfort level with integrating spirituality, their previous training and experience, and what they perceive as difficulties. There were items on competencies based on the ACGME similar to Grabovac's study and Kattan's Canadian Medical Education Directives for Specialists (CanMEDS) roles. Furthermore, the impact of the curriculum based on perceived and contemplated changes in practice were also included as in the other two spirituality curriculum studies.

Another limitation of this survey was the lack of assessment prior to the introduction of the curriculum. It may also be informative to have a measure of the curriculum's impact on the patients' receptivity to incorporate spirituality in treatment. There are current studies underway that are addressing these.

The residents endorsed the curriculum as a worthwhile experience which increased their appreciation of the place of spirituality in the holistic care of patients with psychiatric conditions. The varied religious and spiritual backgrounds of our residents was seen as a strength in introducing the spirituality curriculum into their training but one must wonder if it would be equally effective in other programs with a different resident population, drawn from different cultural/religious backgrounds. Our

experience shows that attention to the spiritual and religious needs of patients enhances the personal and professional growth of residents in their residency training program.

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Compliance with Ethical Standards The study with the residents was anonymous and completely voluntary.

Ethical Considerations This study was reviewed and approved by the Texas Tech University Health Sciences Center Institutional Review Board.

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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