The SPIRITual History

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Spirituality can be defined as a belief system focusing on intangible elements that impart vitality and meaning to life's events. Often spirituality is expressed through formalized religions. Recently, the interplay of spirituality, religion, and health care has been explored in the medical literature. Spiritual belief systems impact on the incidences, experiences, and outcomes of several common medical problems. Unfortunately, there is little recent literature addressing the process of conducting a medically oriented spiritual history. One approach to assisting the physician in spiritual history taking, a mnemonic, SPIRIT, is presented as a guide to identifying important components of the spiritual history. This article addresses the issues of when and whom to interview, as well as specific professional and ethical issues related to this topic. Two case examples from my practice are presented to illustrate the utility of the SPIRITual history. *(Arch Fam Med. 1996;5:11-16)*

Spirituality can be defined as a belief system focusing on intangible elements that impart vitality and meaning to life's events. In developed societies, spirituality is typically expressed through formalized religions. Recent literature has begun to address the importance of religious and spiritual factors in health care.[1-4] Belief systems can influence patients' perceptions of health and illness and direct the utilization of traditional and alternative medicine.[5-11] Religious beliefs and practices have been found to affect patients' experiences with cancer,[6] communicable diseases of childhood,[10-12] pregnancy and family planning,[13,14] affective disorders and mental health,[15-19] alcoholism,[20] coronary artery disease,[21] and the acquired immunodeficiency syndrome.[22] Conversely, religious affiliation has been correlated with a reduction in the incidence of certain diseases, such as cancer,[23,24] coronary artery disease,[25] and dementia.[26] Decisions about terminal care and advance directives often reflect religious considerations[27,28] and stimulate exploration of issues of meaning, purpose, design, hope, and faith.[29-32] Unfortunately, ethical dilemmas and the breakdown of communication between patients and health care workers can result from poorly understood or conflictual belief systems.[33-38]

Several barriers have prevented widespread patient inquiry about spirituality in contemporary medicine. Western physicians practice in a Cartesian model whereby rigid mind-body separation predominates and scientifically derived physical evidence is paramount. Although readily acknowledged, holistic health care remains more of an ideal than a reality. A smaller proportion of physicians than the general patient population maintain personal spiritual orientations[39]; therefore, the overall importance of this realm to patients may be underestimated. Since spirituality is infrequently taught in medical training, even interested practitioners feel ill-prepared to handle this topic. Pragmatic issues seem overwhelming. The goal of this article is to assist the reader with addressing spirituality as a relevant medical topic.

THE SPIRITual HISTORY

An important first step is to equip physicians with the means for conducting a

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Sample Questions for the SPIRITual History

Mnemonic	Questions
S—**S**piritual belief **S**ystem	What is your formal religious affiliation? Name or describe your spiritual belief system.
P—**P**ersonal spirituality	Describe the beliefs and practices of your religion or spiritual system that you personally accept. Describe the beliefs or practices you do not accept. Do you accept or believe . . . (specific tenet or practice)? What does your spirituality/religion mean to you? What is the importance of your spirituality/religion in daily life?
I—**I**ntegration with a spiritual community	Do you belong to any spiritual or religious group or community? What is your position or role? What importance does this group have to you? Is it a source of support? In what ways? Does or could this group provide help in dealing with health issues?
R—**R**itualized practices and **R**estrictions	Are there specific practices that you carry out as part of your religion/spirituality (eg, prayer or meditation)? Are there certain lifestyle activities or practices that your religion/spirituality encourages or forbids? Do you comply? What significance do these practices and restrictions have to you? Are there specific elements of medical care that you forbid on the basis of religious/spiritual grounds?
I—**I**mplications for medical care	What aspects of your religion/spirituality would you like me keep in mind as I care for you? Would you like to discuss religious or spiritual implications of health care? What knowledge or understanding would strengthen our relationship as physician and patient? Are there any barriers to our relationship based on religious or spiritual issues?
T—**T**erminal events planning	As we plan for your care near the end of life, how does your faith impact on your decisions? Are there particular aspects of care that you wish to forgo or have withheld because of your faith?

spiritual history, since thorough information gathering and processing is critical to all of medicine. Several spirituality scales and measures of religiosity are available[40-42]; however, they are highly structured and may not be optimal for generating personalized dialogues with patients about their spirituality and health care. The nursing and psychology literature are replete with many excellent clinical approaches; however, the physician has a fundamentally different relationship and agenda with patients than these professionals. Furthermore, the average physician has little exposure to writings in these disciplines.

Based on a broad survey of the spirituality literature as well as personal experiences and discussions with many professional colleagues and patients, the following concepts were developed. As with any interviewing tool, this is a starting point. Each physician is encouraged to develop his or her own comfortable approach to patients. The topic is delicate but should not be considered taboo. Inquiry has been found to produce generally positive, relationship-building results.

Inquiry about spirituality is best accomplished after the physician has developed a safe and comfortable relationship with the patient. This conversation can occur independently or be incorporated into the social or lifestyle history. As with any topic, it is best to begin with a general statement that affirms the belief that this topic is important and relevant to medical care. For example,

> Many people have strong spiritual or religious beliefs that shape their lives, including their health and experiences with illness. If you are comfortable talking about this topic, would you please share any of your beliefs and practices that you might want me to know as your physician.

With such prompting, patients often will share important, detailed information. Some will express no formalized religious orientation; by virtue of their humanness, however, atheists, secular humanists, and agnostics maintain personalized belief systems that can be explored by their physicians equally well. In my experience, patients have never been offended by such gentle questioning, even if they do not consider this topic relevant to their care.

To facilitate more directed discussion, the mnemonic SPIRIT has been developed as an interviewing tool to aid physicians in spiritual history taking.

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

Each letter represents an important component of the impact that spirituality may have on patients' experiences with wellness and illness. Illustrative questions are outlined in the **Table**. The following two cases from my practice illustrate the utility of this approach in spiritual inquiry.

Mrs J is a 52-year-old former intensive care nurse with hypertension, obesity, and hypercholesterolemia presenting for her yearly physical examination.

Mr O is a 42-year-old businessman, new to the area, who is in need of a primary care physician. He has been undergoing treatment for depression and is recovering from alcoholism.

S—SPIRITUAL BELIEF SYSTEM

As a general orientation, the physician should identify the formalized spiritual belief system to which the

patient subscribes. In developed cultures, people commonly associate with a formal religion. Furthermore, most will identify one of the so-called great religions: Buddhism, Christianity, Hinduism, Islam, or Judaism.

Each religion espouses a core set of tenets, beliefs, and practices. It is beyond the scope of this article to describe these and their many associated faith traditions. For a detailed understanding of tradition-specific tenets and practices, an outstanding series on health, medicine, and faith traditions is given in a "Suggested Readings" section at the end of this article.

Mrs J had ascribed to Christianity as a child and younger adult. Recently she has changed faith traditions and is a practicing Hindu.

Mr O grew up as a Roman Catholic; however, he no longer is a regular attender of any religious institution.

P—PERSONAL SPIRITUALITY

People develop their own individualized spirituality over the course of a lifetime. The relative importance of specific tenets and practices will vary widely, both among individuals and over time for each believer. Life events often shape belief systems in dramatic ways. Trauma, crises, and even ordinary transitions challenge one to reflect on values, beliefs, and the search for meaning. The physician should approach each patient individually and avoid making assumptions or generalizations. Furthermore, the dialogue should be carried out longitudinally to identify changes in belief systems as they occur.

Mrs J rejects the caste system concept of Hinduism but believes in karma. She describes her illnesses as consequences of actions in her past and present lives. She is seeking to moderate her lifestyle and produce a "right body" through "right thinking."

Mr O maintains many of the beliefs, tenets, and practices of Catholicism. He struggles with feelings of guilt over his depression and alcoholism and his worthiness in the sight of God. He knows that God is his ultimate source of strength and health, however.

I—INTEGRATION AND INVOLVEMENT WITH OTHERS IN A SPIRITUAL COMMUNITY

Belonging to a formal religious or spiritual group is an important association for many people. Identification with common believers, sharing in religion-based lifestyle practices, and the support offered by such an association is important to many patients. Such a group may be vitally important to a patient dealing with serious health issues. Furthermore, churches can be powerful environments for health promotion and centers for health care delivery.[13,15,29,43-47] Patients may have established close relationships with clergy who can act as counselors for many life issues and problems. Thus, the physician should attempt to discover if a valuable support system or health care environment exists within the patient's spiritual community.

Mrs J prefers to be addressed as Swami D, her name at the spiritual community where she now resides. She finds her "spiritual family" to be the major supportive force in her life. She is the head cook for the community, as well as a spiritual leader.

Mr O does not attend a single church regularly. He finds tremendous spiritual support in the Alcoholics Anonymous group that he attends frequently. Many of his friends and confidants come from this group.

R—RITUALIZED PRACTICES AND RESTRICTIONS

Many religions prescribe certain lifestyle activities and behaviors while prohibiting others. Prayer and meditation are commonly employed by patients and have measurable influences on health and well-being.[16,20,25,29,46,47] Dietary proscriptions are common, including non-Kosher foods for orthodox Jews; animal flesh for Adventists, Buddhists, and Hindus; and alcohol and caffeine for many faiths. Well-known, medically relevant prohibitions include the receiving of blood products by Jehovah's Witnesses and all allopathic medical care by Christian Scientists. Since the religion-specific lists of rituals and restrictions are extensive, the reader is directed to the "Suggested Readings" section for detailed discussions. The physician can discover which apply and attempt to understand their value and meaning for the individual patient by asking appropriate questions such as those in the Table.

Swami D is a strict vegetarian. She meditates 2 to 4 hours per day. She also prays actively to her God for direct intervention in her life.

Mr O prays daily for guidance and strength. He reads the Bible often and finds direction and comfort in this experience. He abstains from alcohol and tobacco, primarily from a spiritual standpoint.

I—IMPLICATIONS FOR MEDICAL CARE

The preceding revelations should be viewed in relation to the patient's overall health and health care needs. Preventive efforts can be reinforced by addressing a patient's spirituality and its role in lifestyle choices, including diet, exercise, and meditation or prayer. Important support systems can be brought into play. Conversely, the physician may discover potential conflicts in other health care efforts, such as refusal of childhood immunizations by an Amish parent.[48]

The physician frequently cares for patients with serious chronic or life-threatening illnesses. Suffering, as defined by Cassell,[49] is a complicated, multifaceted process. It affects the body, mind, soul, and spirit and requires a multidimensional approach to be successfully addressed. Encouraging spiritual reflection, openly discussing the search for meaning, and supporting therapy in one's spiritual community are potentially valuable measures that can be employed by the holistic physician.

Unfortunately, spiritual beliefs and practices can serve as barriers to the patient-physician relationship. Classic examples include the refusal of life-sustaining therapies by Jehovah's Witnesses and Christian Scientists. More common scenarios involve divergent views on issues of contraception, reproductive health, and religion-based alternative medicine (eg, faith healing). Many of these situations can be handled success-

fully if the physician is forthright and compassionate in communicating and seeks to understand patients' belief systems rather than passing judgment.

Swami D's lifestyle, diet, and ritualized habits have documented health benefits. Her mental health is helped by her spirituality. Nonetheless, she agrees that a role exists for traditional medical therapy for her hypertension. She will continue to take her antihypertensive medication and will attempt to add 30 minutes of brisk walking to her daily routine. She plans to address her community about this multidimensional approach to common health problems.

Mr O's depression is significant but well controlled without the use of medications. His lifestyle choices are essential for his continued recovery from depression and alcoholism. We discuss many of his somatic complaints as reflective of his ongoing struggle with integrity of mind, body, and spirit. He agrees to see a counselor who can address all of these elements. His need for continued Alcoholics Anonymous meeting attendance is stressed.

T—TERMINAL EVENTS PLANNING

Proactive discussions with patients about end-of-life issues are important. Religious or spiritual factors play prominent roles in patients' experiences with terminal illness, the dying process, and death.[30-32] Once the physician has explored a patient's belief system and has identified important values, he or she can more comfortably approach planning efforts about care issues in these situations. This may clarify the decision-making process and prevent overt conflicts among patients, physicians, family members, and surrogates. It also engenders trust from the patient with reassurance that the physician will attempt to honor the patient's requests.

Swami D sees the elimination of pain and suffering as a primary life goal. She believes her spirit will be passed to another life through reincarnation. Therefore, she emphasizes comfort measures at the end of life and refuses heroic life-supportive measures. She has prepared written advance directives.

Mr O looks forward to a long and productive life. Despite his depression and alcoholism, he has never seriously considered suicide. He values quality of life, however, over quantity. He has not contemplated end-of-life issues formally. He is encouraged to begin developing written advance directives as a general measure, and to discuss his values and attitudes with his partner.

WHOM TO INTERVIEW

Spirituality can be effectively discussed with patients of most age groups. Although the case examples presented above are both older adults, I have also explored spirituality with children and young adults. At least one study has confirmed the importance of addressing religious and spiritual concerns of hospitalized adolescents.[50] Younger children often hold strong basic spiritual beliefs (eg, acknowledgment of God and an afterlife, consequentialism, and differentiation between good and evil). These may be operative in experiences with illness, especially if serious or life-threatening. For example, a colleague relates the story of a 5-year-old girl with leukemia who was finally able to "let go and die peacefully" when she was able to discuss the spiritual meaning of her suffering and her passage to heaven.

It is often most appropriate to include a child's parents in spiritually oriented discussions. This can strengthen the triangular relationship of patient, parent, and provider. However, when an older child holds beliefs that are divergent from those of the parents, a private conversation may be most valuable.

The depth and focus of a spiritual conversation will likely differ based on the developmental age. A discussion with younger children may center on emotional factors, such as fear and uncertainty in facing illness. An older child who is capable of detailed, abstract spiritual thinking may discuss specifics such as religious justifications or restrictions for certain health-related practices (eg, birth control, drug use) or directives for care in face of a terminal illness.

WHEN TO INTERVIEW

As one might predict, evidence supports the direct relationship between appropriateness of spiritual dialogue and perceived severity of illness.[39] Discussing religion in the face of major illness, terminal disease, or dying is more relevant than when caring for patients with minor acute illnesses. The perioperative period is another time when inquiry may be relevant, especially if the operation has actual or perceived risk or involves general anesthesia. Clearly though, discussion of this topic should not be restricted to these types of patient encounters.

Health maintenance examinations present excellent opportunities to begin spiritual dialogues. Doors can be opened in a nonthreatening, nonurgent fashion and the topic can be legitimized for ongoing discussion. Based on survey evidence[39] and the clinical experiences of myself and many colleagues, patients are receptive at these visits to such information gathering and dialogue. It may also facilitate discussion of other relevant psychosocial issues by conveying the sense that the physician's interests extend beyond hard medical information.

Naturally, busy practitioners are concerned about the time commitment that is entailed in taking a spiritual history. In certain situations, such as extended office visits or hospital admissions for seriously ill patients, physicians may decide to gather all relevant spiritual information in a single encounter. Numerous observations of history taking by first-year medical students, residents, and practicing family physicians using the SPIRIT mnemonic have revealed that significant information can be gathered in 10 to 15 minutes (far less time than these clinicians predicted). In many situations, the spiritual data can be collected incrementally over a period of several visits as a matter of "clinical chattering." Identification of patient's spiritual system, rituals, and restrictions can be accomplished quickly; exploration of personalized spirituality frequently requires longer, ongoing dialogue. Collected information can be recorded in a special section created in the medical record, or simply outlined in SPIRIT format within the "Subjective" section of the traditional SOAP (subjective, objective, assessment, and plans) note. Simply put, physicians should con-

sider spiritual history taking early and often in their evolving relationships with patients. The time commitment is similar to that required for exploration of other important issues such as psychosocial stressors or alcohol and tobacco abuse. The rewards of this inquiry can be equally great.

OTHER CONSIDERATIONS

It is important to address the extent of physician involvement in patients' spirituality. Ethically, the physician must always respect the patient's rights to autonomy in beliefs and practices, confidentiality, and privacy.[51] Furthermore, the physician must always be truthful in providing information and not be adversely influenced by the knowledge of patients' beliefs.

In a previous study,[39] physicians expressed concern over unduly influencing patients with their own beliefs. Although no one can be totally unbiased in human interactions, the cognizant and reflective physician should be able to avoid overt projection of spiritual beliefs and attitudes onto patients. At times, revealing one's own personal spirituality may be appropriate if it helps in building the patient-physician relationship or in breaking down barriers that have developed over conflictual belief systems. Generally this is done at the request of the patient and only if the physician feels capable.

My conversations with other physicians have revealed that participation in spiritual activities with patients is common and often appropriate. When patients initiate requests or accept physicians' noncoercive offers, prayer can be meaningful, especially prior to major surgery or at the time of impending death. Certainly many physicians will worship with patients in mutually attended churches or synagogues. This can strengthen the sense of community and belonging that reinforces professional relationships.

Physicians should also identify the spiritual resources available in their communities. Most hospitals provide pastoral care services. These clergy often have specialized training in the provision of spiritual care to the sick and injured. Involvement of personal clergy and lay leaders can be important, as they have established trusting relationships and often provide their services without fees to the patient. The physician may identify other health care professionals, such as psychologists, counselors, and social workers, who may have certain religion-specific practices. Although these resources can be extraordinarily helpful, they should not be used as substitutes for the dialogue that should occur between the primary physician and patient. In fact, patients may perceive that physicians are circumventing spiritual issues if referrals are made without appropriate physician interest and follow-up.

Several challenges face academicians and clinicians who care about this topic. Medical students are in need of systematic and ongoing education about spiritual inquiry and its importance in patient care. Curriculum committees should be challenged with a mandate to include humanities throughout the entire undergraduate experience. Residencies should serve to reinforce this training and support the time and effort it requires. More practitioner groups, such as Balint, should develop at the local level, where spirituality can be discussed as a professional issue. Conferences, seminars and workshops in the humanities and medicine need to flourish. And as health care reform continues to acknowledge the importance of cognitive (vs procedural) medicine, adequate financial compensation will hopefully follow for those who take time to address the breadth of patient issues that impact on overall health and well-being. Meanwhile, physicians should continue with their own personal exploration and participate in dialogues with other health care professionals, pastoral care staff, and clergy about the interplay of spirituality and medicine.

In summary, physicians can comfortably and competently talk with patients about spiritual and religious issues that may impact on health care. Many of the pragmatic and ethical issues have been presented for careful consideration and some general recommendations for practitioners are presented below.

- Consider spirituality as a potentially important component of every patient's well-being
- Consider addressing spirituality with patients early and often; although a spiritual history can be obtained in a single patient encounter, consider a longitudinal inquiry
- Use a tool, such as the SPIRIT mnemonic, to aid in history taking and charting of relevant information
- Respect patients' autonomy and privacy of spiritual beliefs and practices; avoid overt projection of your belief system onto others
- Identify the spiritual resources in your community and use them appropriately
- Reflect on your own spirituality and how it impacts on your concept of self, your relationships, and your practice

Contemplation of spirituality should better prepare us to explore this potentially vital area of our patients' lives.

The following are books in a series titled Health/Medicine and the Faith Traditions *(New York, NY, Crossroad Publishing Co), edited by Martin E. Marty and Kenneth Vaux.*

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McCormick RA. Health and Medicine in the Catholic Tradition. *1985.*

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