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USE SPIRITUALITY RELATED BELIEFS IN TREATMENT OF PSYCHIATRIC ILLNESSES

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Abstract
Background: Spirituality is a theme of religion and philosophy, which are Humanities and work on empirical principals. Psychology and psychiatry are developed from philosophy but have scientific attitude. Patient care is a complex issue and needs conversion of both of these principles.
Aim: We made an attempt to evaluate that use of spirituality principles in patient's treatment is helpful or not.
Material and methods: Total 510 patients were evaluated. Study group of 260 patients were given spiritual consideration in standard treatment and control group of 250 patients were only given standard treatment. World Health Organization Quality of Life (WHOQOL)-BREF raw score were compared using student t test.
Results: We found that there was significantly more improvement in study group as compared to control group in terms of World Health Organization Quality of Life (WHOQOL)-BREF score.
Conclusion: We arrived at the conclusion that spiritual consideration gives added improvement in treatment of psychiatric illnesses. We should not ignore spiritual beliefs of patients.
Keywords: spirituality, beliefs, psychiatric illness, psychology

Introduction:

Science in itself always use to challenge the existence of god or super natural power, but in every culture there are belief systems which are deeply rooted in spiritual beliefs. Many times these belief systems make persons belief firmly that a particular type of illness is a result of some super natural power like god or demon. This belief can hamper improvement in psychiatric illness on treatment. Psychiatry as a science denies existence of such super natural causes of illness in first glance as a branch of science, but this ignorance creates a grey area where unscientific treatment methods and faith-healing blossom. Religious belief in faith-healing does not depend on any scientific evidence that this can achieve any evidence-based outcome (*Village, Andrew 2005*). If a patient is willing to opt for faith-healing, a psychiatrist has options like one can reject the request, can keep oneself detached from the issue, approve the request and try to understand the practices concerned so as one can make a reasoned decision (Sarkar S, Seshadri 2015). But the choice is mostly towards rejection of request due to lack of understanding of spiritual angle of the treatment.

Some studies show that prayers for patients can speed up their recovery from illnesses (3). Faith healing practices are associated with improving mental well-being (4). On the same ground a systematic review failed to establish that distant healing can be achieved by prayer(5). In this regard despite weak evidence that prayers and faith-based practices have a therapeutic effect, the psychological benefit of such interventions cannot be ignored(6). One study of physicians and patients in an outpatient setting found that 91 percent of patients believe in God, compared with 64 percent of physicians(7).

There is no need to challenge or accept faith-healing on scientific grounds, if it benefits patient even in a minor fraction without any harm, it can be welcomed. Psychotherapy deals with changing maladaptive thoughts to healthy one and for this using spiritual belief system is not a sin. So the thought of spiritual counselling comes in mind. Spiritual counselling is a psychological tool which uses person's spiritual belief system for mental healing.

Western scientific principal that is more modern, denies traditional methods as non-scientific (8) but in highly spiritual countries where spiritual beliefs are so dominating one cannot ignore them in whole. Studies

say that spiritual assessment of patient not only fastens patient's healing but also strengthen the bondage between doctor and patient (9)

Material and Methods

Participants and procedures

Our study was conducted in Udaipur district of Rajasthan, India. In this region people of various religions i.e. Hindu, Muslim, Sikh and Jain are in good number and have high faith in religious rituals. A stratified random sample design was used for data collection and conducting study. HOPE questions and The World Health Organization Quality Of Life (WHOQOL)-BREF were applied at 0, 1 and 6 months interval. Our study spanned 6 months. Total 610 persons visiting in outpatient department (age range 18 to 60) were evaluated. 100 were excluded because they had low score on spirituality scale (HOPE question). Out of this 260 adults were included in study group and 250 in control group. Study group was allowed to incorporate spiritual methods of their own choice in treatment. Control group was strictly refused to go for any type of spiritual treatment (faith healing, prayer, sacred place visit, meeting spiritual guru, etc). Along with this both the groups received standard psychiatric treatment for their disease. Informed consent and ethical committee approval was taken accordingly.

Data collection tools

1. HOPE questions-The HOPE questions were developed as a tool to help practicing doctors begin the process of incorporating a spiritual assessment into the medical interview of their patients. These questions have not been validated by any research. The strength of this approach is that it allows exploration of an individual's general spiritual beliefs and concerns and serves as natural follow-up to discussion of other spiritual support systems (10). The HOPE questions cover the basic areas of inquiry for doctors to use in formal spiritual assessments of their patients

HOPE Approach to Spiritual Assessment

a) Spiritual Resources - What are your sources of hope or comfort?
b) Organized Religion - Are you a member of an organized religion?
c) Personal Spirituality - Do you have spiritual beliefs, separate from organized religion?
d) Effects on Care - Do you wish to consult with a religious or spiritual leader when you are ill or making decisions about your healthcare?
2. The World Health Organization Quality of Life (WHOQOL)-BREF

The WHOQOL-BREF has two items from the Overall QOL and General Health and 24 items divided into four domains: Physical health 7 items (DOM1), psychological health 6 items (DOM2), social relationships 3 items (DOM3) and environmental health 8 items (DOM4)(12).

Statistical analysis

Data was analyzed using graphpad instat and SPSS software. Student's t-test was applied to derive statistical significance.

Results

Self-developed socio-demographic profile was used for data extraction. Table 1 incorporates the data in appropriate classification module.

Table 1: Sociodemographic features

		Study group n=260	Control group n=250
Age (mean±SD*)		29±6	30±7.2
Sex	Male	142 (54.6)	136 (54.4)
	Female	118 (46.4)	114 (46.6)
Religion	Hindu	210 (80.7)	240(96)
	Muslim	49(18.9)	20(4)
	Other	1(0.4)	0(0)
Education	Illiterate	69(26.2)	12(4.8)
	undergraduate	140(53.8)	182(72.8)
	Graduate	52(20)	56(22.4)

*SD – Standard deviation

Persons with high spirituality based on HOPE questionnaire were included and persons with low spirituality were excluded from the study.

	Included in study	Excluded from study	
Subjects	510	100	
HOPE questionnaire response	Spiritual	Non spiritual	
World Health Organization Quality of Life (WHOQOL)-BREF			
	Study group N=260	Control group n=250	P value
Score at 0 month (mean±SD)	45±7	44±9	0.1610
Score at 1 month (mean±SD)	62±4	52±5	0.0001
Score at 6 month (mean±SD)	72±5	60±7	0.0001

Discussion

The study was planned to see the effect of spiritual belief consideration in improvement of psychiatric patients. The persons were first screened for having spiritual beliefs by using HOPE questions. Persons low on spiritual beliefs was excluded from the study. Included patients were classified in study group and control group on the basis of random classification. Study group patients were allowed to use their spiritual methods of treatment along with standard drug treatment provided to them. Control group patients were denied of having any spiritual treatment of their choice and only provided standard drug treatment. Both the groups were provided standard drug treatment based on their respective classification according to international classification of disease 10 (ICD 10).World Health Organization Quality of Life (WHOQOL)-BREF scoring at 0, 1 and 6 month demonstrated gradual improvement in terms of World Health Organization Quality of Life (WHOQOL)-BREF score in control and study groups. Analysis demonstrated more improvement in study group as compared to control group. This difference was statistically significant and not a spurious finding.

Conclusion

This study demonstrated clear cut improvement in study group (62±4) as compared to control group (52±5) after 1 month of treatment. It also demonstrated improvement in study group (72±5) as compared to control group (60±7) after 6 months of treatment. Both the results were statistically significant with p value of 0.0001. This is clear from this study that spiritual belief consideration is very significant for speedy and complete improvement of psychiatric patients and it should be judicially applied in treatment protocol.

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