Religious beliefs and practices in acute mental health patients


Abstract

Background Holistic practice involves caring for the physical, psychological, social and spiritual needs of patients. Spiritual assessment is an important part of the patient’s overall assessment. Religion is a component of spirituality and is supported by a recognisable formal system of beliefs. Religious beliefs might help patients in their search for meaning in life, especially in difficult circumstances such as during an episode of illness. A small, retrospective anonymous audit of patients’ notes (n=23) was undertaken to assess the recording of patients’ religious affiliations, beliefs and practices in an acute mental health unit for older people.

Conclusion All individuals had a religious affiliation documented in their notes, but there was a lack of recorded information about their beliefs and practices. The findings showed that religious beliefs were only discussed with patients who had psychotic symptoms that had a religious content. Therefore, it would seem that patients on this unit are not having their spiritual and religious needs met. Staff training on religious awareness might help to address these issues.

Religious beliefs and practices in acute mental health patients and should not be limited to finding out which organised religion an individual belongs to (Stuart and Sundeen 1991).

Religion is a component of spirituality and is supported by a recognisable formal system of beliefs. Religious beliefs might help patients in their search for meaning in life, especially in difficult circumstances, such as during an episode of illness. Rituals of prayer, attending a place of worship or carrying out religious practices in the home can help to give structure and meaning to daily life, often in a supportive social environment.

These beliefs might also influence people’s perception of their illness and their ability to cope with it. Thus, nurses and other healthcare professionals should not underestimate the importance of religion and spirituality to the wellbeing of patients and families (McGilloway and Myco 1985).

The Patient’s Charter (DoH 1992) states that the NHS has a duty to respect cultural and religious beliefs. Although there are national standards for recording a patient’s ethnic group, such standards have not been developed for recording religious affiliation and beliefs (NHSE 1994). It has been argued that collecting ethnic group data without religion and other cultural factors is inadequate for assessing patients’ sociocultural needs (Hilton 1996).

There is a dearth of research relating to religion and patient care, especially in the UK. One audit aimed to identify whether ethnic origin and religion were being routinely documented on patients’ admission sheets. Of the 55 case notes reviewed, 64 per cent contained a record of religion (James 1999). This is similar to a survey carried out on the acute assessment ward at Northwick Park Hospital, where four out of 12 inpatients were misidentified: two Jewish patients, one atheist and one Hindu were all recorded as religion unknown (unpublished
survey). This has implications for the care provided on the ward and for rehabilitation, for example, encouraging patients to participate in religious activities that they previously found supportive might be helpful as part of the rehabilitation process.

Accurate recording of religious records is also important because religious affiliation data are used by the hospital chaplaincy to enable ministers from appropriate religious groups to visit inpatients and contribute to their spiritual care.

We observed where the Gideon Bible, New Testament and Psalms is kept on the ward. The emphasis of this text is Christian. Of the nine copies of the Bible found on the 13-bed ward, only two were located by the beds of Christian people. Others were found in the lockers of Jewish and Hindu patients, while others were out of reach on high shelves or the tops of wardrobes. Leaving these volumes by the beds of all patients in a multi-faith society has the potential to be interpreted as insensitive or as a lack of understanding of an individual’s religious beliefs.

**Audit**

The aim of this audit was to assess the recording of religious affiliations, beliefs and practices in the notes of patients admitted to an assessment ward for older people with mental health problems.

The study was based on an audit model. No standards for collecting religious data were identified, using the internet, CINAHL, ClinPSYC and Medline databases. It was therefore necessary to set a standard. This involves setting a ‘gold standard’ for a clinical care issue and the practitioner’s clinical performance is compared to this. If the standard is not met, remedial action should be taken to improve the practitioner’s standard, and the audit is repeated to ensure improved performance (Firth-Cozens 1993).

Because enquiring about religion is a sensitive issue (Neelam and King 1993), it was decided that a multidisciplinary group, including patients, would be useful to decide if the study should be undertaken. Religious affiliations of group members included Jewish, Moslem, various Christian denominations and those with no affiliation or beliefs.

A standard and rationale for the study were set and ratified by both medical and nursing audit committees. The standard stated that staff should be ‘aware of their patients’ religion, and their level of commitment to it’. The rationale was to ensure that staff are sensitive to an individual’s religious beliefs as an integral part of his or her life, and also to ensure that an individual’s religious needs are met, for example, weekly attendance at a religious establishment.

During the standard setting meetings, various data were identified as being relevant to patient care. These included documenting the religious group, denomination or sect on the computerised admission sheets in medical and nursing notes. Any religious practices, either in the home or place of worship, should be stated with a view to ascertaining pre-morbid or usual level of activity, to help patients to feel more at home on the ward or during rehabilitation. Specific religious requirements should also be highlighted and whether or not staff attempted to meet these. A record should also be

**Literature review**

The literature suggests that religious and spiritual issues are of significant importance to many older patients. Recent publications acknowledge that religion might fulfill positive and supportive roles in the lives of some people, while for others, religion might be a destructive and damaging experience (HEA 1999, MIF 1997). The intrinsic belief-related aspects of religion, and the extrinsic participatory and social aspects, might be important elements of people’s lives. It is clear that religious leaders are keen to be involved in the care and support of people with mental illness. However, taboos about discussion of patients’ religious and spiritual needs within mental health services also exist (Copsey 1997).

There is evidence that religious beliefs are associated with a more rapid time to remission in depressive illness in older people. Using a statistical model, which controlled for demographic, physical, psychosocial and treatment factors, those with religious beliefs were found to be more likely to have remission from their depression than those without such beliefs (Koenig et al 1998). A similar observation regarding the rate of improvement in depression was found in people with higher religiosity (where religiosity was defined as salience of religion compared to salience of other aspects of life) in a community survey in the Netherlands (Braam et al 1997).

Religiosity, however, was not associated with incidence of depression (Braam et al 1997).

Another study of 106 patients (mean age 74.4 years) attending an outpatient clinic for older people indicated (through questionnaires) that religion is a powerful cultural force in the lives of older medical patients and is integrally related to both mental and physical health. For example, there was less religious activity and lower scores for intrinsic religiosity among people with anxiety and depression compared to those without these diagnoses (Koenig et al 1988).

A holistic and individualised approach to nursing supports the assessment of religious and spiritual care needs (Stockwell 1985). The literature quoted above also suggests that religion is likely to be important for mental health in older people. This information, together with ward observations, prompted the authors to study the recording of religious data on inpatients.
kept on patients’ concerns regarding the stigma associated with mental illness and if they perceived other members of their religious group to have negative attitudes towards them. Religious needs, for example, plans for the next religious festival, transport to a place of worship, or attending friendship clubs were also acknowledged as relevant to patient care.

Case note review Notes from the last completed admission were reviewed for 23 consecutive inpatients. This included the front page of the computerised admission sheet, assessment letters immediately before admission, medical and nursing notes, discharge correspondence, day unit follow up after discharge, and instructions to examine previous discharge summaries. Case note review was carried out by one person to ensure consistency of data collection.

Results The mean age of the patients was 75 years (range 64-90 years). Eighteen patients were female and five were male. Three patients had dementia, 11 had an affective disorder, seven had a schizophrenic or delusional disorder, one had an affective disorder plus alcohol dependence and one did not have a psychiatric diagnosis. On comparing nursing and medical records, nurses were significantly better at recording religion than medical staff (chi squared ($\chi^2$) =16.8, d.f.=1, p<0.05) (Table 1).

Religious affiliation was recorded for all patients in their notes. Two sets of notes incorrectly stated Church of England on the computerised front sheet, but elsewhere in the notes patients were identified as Methodist and Jewish. Eighteen patients were Christian, three were Jewish and two were Hindu. Denominations were only specified for the Christian group (Box 1).

A person's usual level of religious practice was not adequately addressed in any of the notes in terms of their attendance at a place of worship or practising their religion at home. However, three sets of notes included comments that suggested religious involvement, none of which were explored further. These included:

- A Roman Catholic who said her hobbies included church activities.
- A Christian who said: ‘We didn’t enjoy Christmas’.
- A Jewish woman who was encouraged to join her family for Yom Kippur (the Jewish day of atonement) ‘if she wished to do so’.

In terms of religious requirements, diet was mentioned in four sets of notes and a Roman Catholic chaplain was called when a patient’s husband died. There was no record of any questions about religion being asked by staff or of concerns expressed by patients about the stigma of mental illness in terms of reintegrating with members of their religious group on discharge. Although there were discharge plans in all patient notes, none of these mentioned religious issues such as plans for the next religious festival.

Three patients had psychotic symptoms with a religious content. For example, a Hindu believed that he had a special relationship with Jesus – one that was out of character with his previous life-long beliefs, his religious practices and his culture. Their beliefs were initially discussed in depth, although as the psychosis resolved, there was no discussion of any ongoing real-life religious needs or beliefs. An adviser from the same religious group as one of the patients was contacted to confirm whether the beliefs she held were similar to those of other members of the group. This is because it is often difficult for a healthcare professional to know whether a person’s beliefs are within religious and cultural norms. If outside the norm, and unacceptable to other members of their religious group, beliefs could well be psychotic. In another set of notes, a patient’s symptoms were attributed to religion: ‘she had fairly obsessional beliefs and behaviour due to her religious beliefs’. Another woman was reported to have said she heard God talking to her, but there was no clarification as to whether this might have been a usual occurrence rather than a psychotic phenomenon. In addition, one Jewish patient was referred to as an ‘Austrian refugee’ who had escaped from the Nazis. She could have been more appropriately described as a Jewish refugee, emphasising the importance of religious identity in her life history.

Discussion

The standard set for this audit was not met. Although patients’ religious groups were generally known, commitment to them was not recorded. The study limitations are that it was carried out retrospectively and the sample size was small ($n=23$). A prospective study liaising directly with patients would have been a better way to accurately document religious beliefs. However, given the caution identified about tackling religious issues in any format, for example, in a survey, psychiatrists considering that questions about their own beliefs were too intrusive (Neeleman and King 1993), the retrospective design was unlikely to cause distress to patients or staff.

Most of the patients in the audit had functional illnesses and were likely to return to the community.

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<tr>
<th></th>
<th>Religion recorded</th>
<th>Not recorded</th>
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<tbody>
<tr>
<td>On computerised front sheet</td>
<td>16 (includes two incorrect)</td>
<td>7</td>
</tr>
<tr>
<td>Medical notes</td>
<td>6</td>
<td>17</td>
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<td>Nursing notes</td>
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<td>3</td>
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Table 1. Recording of religion in the case notes

Box 1. Denominations of the Christian patients

- Church of England (9)
- Roman Catholic (5)
- Methodist (2)
- Christian Scientist (1)
- Not specified (1)
Information about religious participation might be important to help them reintegrate into the local community. Despite study design limitations, the questions asked appeared to reflect potentially important questions and the review of patients’ notes was comprehensive and consistent.

The general absence of data suggest that questions were not being asked about religious life, suggesting a lack of awareness or interest in these matters, or a view by staff that they are irrelevant. The difference in religious belief between psychiatrists and patients has been documented. Neelaman and King (1993) stated that whereas up to 80 per cent of the population believe in God, only 23 per cent of psychiatrists believed in God. This might contribute to the lack of information obtained from the patients’ notes as medical staff might not feel comfortable asking questions about religion (Neelaman and King 1993). The audit results also reflect the observation that nurses seem to be better than doctors at discussing religious and spiritual matters. The founders of modern nursing, for example Florence Nightingale, believed that spirituality is intrinsic to the human experience in contrast to psychiatrists, such as Freud, who viewed religion as a pathological condition, and who had a profound influence on the development of psychiatry (Weaver et al 1998).

It might be that questions are being asked about religious practice, but that these are not being recorded in the medical and nursing notes. From the findings, it is not possible to be sure about the level of religious practice of any individual. It is possible that the data were correct in suggesting that this group of patients did not participate in formal religious practice. However, since all patients were affiliated to a religious group, it is difficult to believe that none had any practical involvement or religious beliefs. Local experience in the community suggests that there is considerable involvement of older people in religious organisations, for example, attending mass regularly, playing the church organ, organising church meetings, lay leadership, attending clubs or receiving support from ministers of religion. Religious involvement of inpatients, therefore, requires further exploration.

Experience of the local community suggests that it is valuable to have an understanding of different religious denominations and practices. For example, Pushit-Marg Hindus only eat food prepared by members of their sect, which has practical implications for day or residential care, and Jewish people of Orthodox background might be reluctant to attend a friendship club at a reform synagogue. In our study, it appears that religious denomination is only being recorded for Christian people, but it is potentially important for other religious groups also. The only recorded discussions of religious beliefs were among patients experiencing psychotic illnesses with a religious content. In the authors’ opinion this reinforces the perception that religious beliefs are viewed as pathological by mental health service professionals, as echoed by a recent headline in The Times newspaper ‘Psychiatrists treat religion like an illness’, above an article by religious correspondent G Gledhill (Gledhill 1999). This fear is widely held by patients and could inhibit their willingness to discuss religious issues (Copsey 1997, HEA 1999).

Religious needs are an important part of the information required by nurses on admission (Ritter 1989). Contemporary nursing philosophy embraces holism and demands that nurses learn the appropriate skills to enable them to provide care in all domains, including the spiritual of which religion is a part (Greenstreet 1999). Most hospital publications on care in a multifaith society are meticulously compiled but focus on diet, care of the dying and a few general beliefs held by each religious group (Restall and Byrne 1998). This might be adequate in the general hospital setting, but it is not ideal for mental health care where the meaning of religious beliefs to the individual patient and knowledge of the local religious organisations and support network is paramount.

Conclusion

The findings of this audit suggest there is a tendency for nurses and medical staff to ignore the religious beliefs of patients with mental health problems, unless they are of psychotic intensity. It is not possible for individual health professionals to have a detailed knowledge of all religious groups with whom they might come into contact. There is, however, a need to move towards training in religious awareness for the multidisciplinary teams in mental health care, to enable them to discuss beliefs, attitudes and involvement in religious life with patients and their families.