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Perspectives of Patients with Mental Health Disorders on Integrating the Spirituality and Religion into Psychiatric Assessments: A Study in Iran

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Abstract

Background: In recent years, there has been a growing emphasis on exploring the influence of spirituality/religion on the management of mental health disorders. The aim of this study was to investigate the viewpoints of Iranian patients with mental health disorders regarding the incorporation of spirituality into their assessment.

Methods: This cross-sectional study was conducted in 2021 at Iran University of Medical Sciences. Initially, a questionnaire was developed based on key spiritual concepts identified from a literature review. The content and face validity of the questionnaire were evaluated by an expert panel, and its reliability was assessed using Cronbach's alpha coefficient. Data collection was carried out in the second phase, with the questionnaire consisting of 4 questions examining the patients' perceived need and willingness for their therapist to explore their spiritual and religious dimensions. Data analysis was performed using appropriate statistical tests.

Results: The questionnaire's validity was confirmed, and its reliability was demonstrated with a Cronbach's alpha value of 0.79. A total of 368 patients participated in the study. No significant associations were observed between the participants' educational level, diagnosis type, gender, and the questionnaire scores. Approximately half of the patients with mental health disorders expressed a desire to incorporate spiritual assessments into their psychological evaluations, with most welcoming this integration.

Conclusion: The findings of this study suggest that despite challenges and barriers, efforts should be made to integrate spiritual dimensions into the treatment of patients.

Keywords: Cross-sectional studies, Educational status, Humans, Iran, Islam, Mental health, Reproducibility of results, Spirituality, Surveys and questionnaires

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Introduction

In recent years, mental health has gained significant attention from health organizations (1). World Mental Health Day, observed on October 10, has been designated by the World Health Organization to emphasize the global focus on mental health. Efforts at both national and international levels have been dedicated to improving mental health within society. Among the various factors influencing health, religious and spiritual factors have been identified as potential contributors to mental well-being (2).

The initial phase of patient treatment and care involves the assessment process, which plays a crucial role in guiding the overall course of treatment. However, certain aspects related to the assessment of individuals with mental health disorders have not received adequate attention. Specifically, the spiritual and religious dimensions of assessment are frequently overlooked. In recent years, psychiatrists and psychologists have increasingly recognized the potential of interventions rooted in spirituality and religion within the field of mental health (3). However, prior to implementing such interventions, it is important to assess patients thoroughly and ensure their willingness to participate in the assessment process.

The concept of spirituality encompasses a wide range of meanings, making it challenging to provide a precise definition (4). From a lexical standpoint, the term “spiritus” refers to an essential aspect inherent in every individual, often associated with the life-giving breath (5). Similarly, the definition of religion is broad and encompasses both personal belief systems and institutionalized structures that encompass attitudes, beliefs, and practices related to worship or service to God or supernatural beings. While spirituality and religion are distinct concepts, they also share commonalities, although the extent of their interconnectedness varies (4).

In the context of spirituality, there is a quest for understanding the fundamental aspects of human existence. It involves a search for meaning and purpose in life, which can contribute to an individual’s overall well-being (6). It is recognized that spirituality can be an integral part of religious practices, but it can also extend beyond religious boundaries, embracing a broader sense of connection with the self, others, nature, or the transcendent (7,8).

Numerous studies have consistently demonstrated the positive impact of spirituality and religiosity on human mental health. These dimensions are recognized as adaptive behaviors, often sought by individuals when confronted with stress and challenging life circumstances. The presence of spirituality has been found to influence patients’ adherence to treatment, overall quality of life, and treatment outcomes. Furthermore, spirituality plays a crucial role in fostering a positive therapeutic relationship between patients and healthcare providers, contributing to improved therapeutic outcomes. The incorporation of spirituality and religiosity in mental health care can therefore yield significant benefits for patients (9, 10). The significance of incorporating spirituality within healthcare interventions has been underscored by scholarly investigations. (11-15).

Several studies conducted in Western countries have found that some patients express a desire for inquiries about their spiritual concerns (12,13). Furthermore, it has been observed that a subset of patients exhibits a proclivity towards including spiritual interventions within their treatment regimen (16). Notably, Iran, where the Muslim population predominates, and religion profoundly influences all life aspects, including healthcare, has witnessed a surge in research examining the nexus between spirituality, religion, and mental health, encompassing both local and global contexts (15). However, despite these endeavors, a noteworthy gap exists in the literature concerning the inclinations of Iranian patients with mental health disorders towards the integration of spiritual or religious assessments. The majority of investigations conducted in this domain have predominantly focused on western countries, thereby necessitating the conduct of studies within countries primarily inhabited by Muslim populations, given the significant disparities in cultural and religious contexts prevalent among these regions (15). Consequently, the present study endeavors to explore the proclivity of Iranian Muslim patients with mental health disorders towards the inclusion of spiritual and religion-related assessments in their profiles.

Materials and Methods

Study design

This cross-sectional study was designed to assess the inclination of patients with mental health disorders pertaining to the incorporation of spirituality and religion assessments into their profiles. The study was conducted over a period spanning from August 2020 to April 2021, encompassing two distinct phases. In the initial phase, an extensive literature review was conducted to ascertain the patient-centric definitions of spirituality and religion. Subsequently, a questionnaire was formulated based on the insights gleaned from the literature review.

A multidisciplinary panel, including three psychiatrists, a psychologist, and a social medicine specialist, collaboratively developed the initial questionnaire draft. In the subsequent step, the validity and reliability of the scale were assessed. Content validity and face validity were utilized to establish the validity.

To ensure content validity, the questionnaire was evaluated by 10 experts who possessed a minimum of five years of experience in the fields of psychiatry and spirituality. Additionally, 20 participants from the study population, comprising individuals with mental health disorders residing in Tehran, also assessed the questionnaire. The final version of the questionnaire was shared with each expert, who then responded to specific inquiries pertaining to the study aims. Specifically, they were asked to rate the necessity of each question on a four-point Likert scale ranging from “not necessary” to “completely necessary” (Question 1), evaluate the clarity and appropriateness of each question in relation to assessing the study aims (Question 2), and provide feedback on the wording of each question, suggesting revisions if necessary. Moreover, the experts were requested to assess the overall comprehensiveness of the questionnaire and recommend any additional questions or the removal of extraneous ones. The research team incorporated the experts’ comments and finalized the scale accordingly.

Reliability analysis was conducted using Cronbach’s alpha coefficient (α=0.79) to assess the internal consistency of the questionnaire. The final version of the questionnaire comprised four questions. The scale consists of three questions which scored between Not at all (0), Sometimes (1), In crisis times (2), Often (3), and Always (4). The first question pertained to the participants’ inclination to discuss spiritual issues (meanings and concepts in their lives) with their psychiatrist or psychologist. The second question explored their willingness to have their psychiatrist or psychologist inquire about spiritual issues (meanings and concepts in their lives). The third question examined their receptiveness to their psychiatrist or psychologist inquiring about religious matters. The fourth question aimed to determine which areas (religion, spirituality, and the existence of God in life) were relevant to the work of a psychiatrist or psychologist. The participants were afforded the opportunity to select multiple options in response to this question.

Data collection

During the second phase of the study, data were gathered from the targeted study population, which consisted of patients referred to the outpatient clinic of Iran Psychiatric Hospital and the Tehran Institute of Psychiatry. The diagnosis of mental health disorders was established by a qualified psychiatrist utilizing the diagnostic criteria outlined in the DSM-5. The participants completed the questionnaire independently, with the researcher available to provide clarification if needed. It is important to note that the participants had the autonomy to select their preferred answer options, and the researcher abstained from any interference in this decision-making process.

Participants

Adult outpatients diagnosed with non-psychotic mental health disorders who sought care at the psychiatric clinics affiliated with the Iran University of Medical Sciences comprised the study population.

Inclusion criteria

The inclusion criteria for the study participation encompassed individuals between the ages of 18 and 65 years old, having a major psychiatric disorder, having good hearing, who provided informed consent to partake in the research.

Exclusion criteria

The exclusion criteria for the study encompassed individuals who exhibited any of the following

conditions: current acute psychosis, presence of an acute physical disorder, unstable medical condition, dementia or other cognitive impairment, substance or alcohol addiction, and lack of literacy.

Ethical considerations

Ethical approval was obtained from the Ethics Committee of the Iran University Medical Sciences under the reference number IR.IUMS.REC.1398.107. Subsequently, the study subjects provided their informed consent to participate in the research. The patients were assured that their identities would remain anonymous within the questionnaire, and their decision to participate or decline involvement, as well as their responses, would not impact their ongoing treatment process. Written informed consent was obtained from all the study subjects, signifying their voluntary agreement to participate in the study after being provided with relevant information.

Statistical analysis

Descriptive statistics, including measures such as mean and frequency, were employed to present and summarize the study's findings. To assess the reliability of the questionnaire, Cronbach's Alpha test was conducted. The distributions of the quantitative variables were evaluated using the Kolmogorov-Smirnov test. The data obtained from the study were subjected to various statistical analyses, including the one-sample t-test, independent samples t-test, analysis of variance (ANOVA), and Pearson correlation. These analyses were undertaken to examine the relationships, differences, and associations within the collected data. The data were anayzed using SPSS 16.

Results

Descriptive findings

A total of 368 patients participated in the study comprising 168 females and 200 males. The mean age of the study subjects was 37.61±11.50 years, as indicated by the mean±standard deviation (SD). The majority of the study population had been diagnosed with bipolar and related disorder and depressive disorder, accounting for more than half of the participants. Table 1 presents the demographic characteristics of the study subjects.

The answers of patients to questions

Table 2 presents the frequency of answers and mean±SD scores for each question based on the responses provided by the patients. Comparing the score of question 1 with a hypothetical mean of 3 revealed a significant difference, indicating that the mean score of question 1 was significantly lower than the representative median score. Conversely, the mean scores of questions 2 and 3 were significantly higher than the hypothetical mean of 3. No statistically significant associations were found between the participants' educational level, type of diagnosis, gender, and their scores obtained from the questionnaire.

The Pearson correlation analysis revealed significant correlations between the scores of the study questions. Specifically, question 1 exhibited a significant positive correlation with question 2 ($r=0.504$, $p<0.001$) and question 3 ($r=0.294$, $p<0.001$). Additionally, a positive correlation was observed between question 2 and question 3 ($r=0.555$, $p<0.001$). Regarding question 4, the responses were distributed as follows: 23 (6.30%) for religion, 153 (41.60%) for spirituality, and 97 (26.40%) for the existence of God in life.

The relationship between the answers and sociodemographic variables

The analysis conducted did not reveal any significant relationship between gender and the main variables of the study. However, it was found that patients with higher levels of education expressed a greater desire to include spiritual issues (Q1) in their psychiatric assessment. Additionally, the patients who had stable employment displayed a stronger intention to incorporate religious issues (Q3) into their psychiatric assessment, as presented in table 3.

The comparison of answers to questions based on diagnosis is presented in table 4.

As the above Table shows, there is no statistical difference between different diagnoses in terms of the need and desire to integrate spiritual dimensions.

Discussion

The study findings demonstrate that approximately half of the participants agreed that there is a need to integrate spiritual aspects into their psychiatric assessments. However, more than half of them

Table 1. Demographic characteristics of the study subjects

Categories	Number	Percent	Total
Gender			
Male	168	44.8	365
Female	200	58.3	
Education			
High school	128	35.1	365
Diploma and above	237	65	
Occupational status			
Unemployed or housewife	234	63.6	368
Employed	124	33.7	
Hospitalization history			
Yes	155	42.1	368
No	213	57.9	
Number of visits			
Once	88	23.9	368
More than once	280	76.1	
Diagnosis			
Depressive disorder	86	23.7	363
Anxiety disorders	36	9.9	
Subestance-related and addictive disorder	35	9.6	
Bipolar and related disorder	89	24.5	
Schizophernia spectrum and other psychotic disorder	52	14.3	
Obsessive-compulsive and related disorder	32	8.8	
Others	33	9.1	

Table 2. Frequency and answers of the questions

Questions	Not at all	Sometimes	In times of crisis	Often	Always	Mean±SD	One sample t-test*
Q1: Do you need your psychologist or psychiatrist to ask you questions about spiritual/religious issues?	56	142	54	49	63	2.78±1.33	0.002
Q2: Would you like your psychologist or psychiatrist to ask you questions about spiritual issues?	28	77	43	72	148	3.63±1.38	0.001
Q3: Would you like your psychologist or psychiatrist to ask you questions about religious issues?	47	92	41	60	126	3.34±1.48	0.001

* Comparison of the mean score of each question with score of 3. ** There were 4 and 2, missing for Q1 and Q3, respectively.

Table 3. The relationship between study questions and sociodemographic variables

		Q1: Do you need your psychologist or psychiatrist to ask you questions about spiritual/ religious issues?	Q2: Would you like your psychologist or psychiatrist to ask you questions about spiritual issues?	Q3: Would you like your psychologist or psychiatrist to ask you questions about religious issues?
Gender	Male	2.78±1.26	3.72±1.30	3.43±1.45
	Female	2.78±1.40	3.58±1.43	3.43±1.50
T-test		0.973	0.310	0.970
Education	High school	2.76±1.32	3.39±1.43*	3.36±1.48
	Diploma and above	2.77±1.34	3.71±1.36	3.26±1.48
	Post graduate	2.91±1.38	4.08±1.16*	3.67±1.39
ANOVA		0.809	0.015	0.301
Occupational status	Unemployed or housewife	2.82±1.39	3.55±1.39	3.17±1.51
	Employed	2.77±1.29	3.72±1.36	3.49±1.43
T-test		0.717	0.244	0.040
Hospitalization history	Yes	2.76±1.32	3.68±1.36	3.36±1.48
	No	2.84±1.38	3.48±1.45	3.30±1.48
T-test		0.638	0.233	0.745

Table 4. The comparison of answers to questions based on diagnosis

Diagnosis	Q1	Q2	Q3
Depressive Disorders	2.95±1.39	3.65±1.29	3.31±1.47
Anxiety Disorders	2.97±1.23	4.22±1.05	3.61±1.50
Subestance-Related and Addictive Disorders	2.91±1.38	3.57±1.31	2.97±1.44
Bipolar and Related Disorders	2.43±1.30	3.56±1.45	3.36±1.52
Schizophernia Spectrum and Other Psychotic Disorders	2.70±1.34	3.25±1.55	3.15±1.50
Obsessive-compulsive and Related Disorder	2.94±1.39	3.81±1.40	3.71±1.37
Others	2.85±1.25	3.76±1.41	3.48±1.52
ANOVA	0.164	0.069	0.375

expressed willingness to include spiritual and religious aspects in their assessments. This suggests that although patients may not perceive a necessity for integrating spiritual or religious aspects, they are open to their inclusion. No significant relationships were observed between the participants' perceived

need or inclination towards incorporating spiritual and religious aspects into psychiatric assessments and their type of diagnosis, education level or gender.

Among the questions posed, patients considered the topic of spiritual aspects in life as most relevant (40% of the patients), while the question related to religious aspects received the least attention (only 6% of the patients). The assessment of spiritual aspects, particularly the presence of God in their lives, was rated as average by the participants.

It is noteworthy that Iranians traditionally seek guidance from clerics regarding their religious matters. This cultural context may explain why the patients in our study perceived the question about religious aspects as less relevant to the work of a psychiatrist or psychologist. However, despite this perception, they expressed a positive attitude towards their mental health professionals asking about these issues. This could be attributed to the belief held by many patients that addressing higher aspirations beyond themselves can contribute to sustaining hope, purpose, and meaning in their lives (17).

Previous research conducted on psychiatric patients has consistently indicated a propensity to incorporate spiritual and religious aspects into therapeutic interventions (9,13,17). For instance, a study conducted in Bosnia and Herzegovina on Muslim patients with mental health disorders demonstrated that both religious and secular patients expressed a significant need for spiritual support during their treatment. This study emphasized the importance of considering spiritual aspects in the treatment of individuals with mental health disorders and recommended the inclusion of spiritual assessment. However, it is worth noting that this study did not differentiate between various dimensions such as spiritual, existential, inner peace, and social aspects of care (16).

Our findings align with previous research indicate that individuals with higher levels of education tend to exhibit a greater inclination towards incorporating spiritual aspects into their evaluation. A study has demonstrated that educated individuals possess more knowledge about spirituality, resulting in a more favorable attitude towards it (18). Moreover, educated individuals tend to have a higher propensity to incorporate spiritual practices into their daily lives compared to those with lower levels of education. Another study revealed that educated older adults, through studying religious texts, can expand their intellectual capacity, leading to a heightened sense of purpose (19). Although the study populations of the aforementioned studies differ from ours, their results provide insights into why educated patients displayed a greater willingness to include spiritual aspects in their assessment.

The results represent that patients who were employed exhibited a greater inclination to include religious aspects in their assessment. This finding is consistent with previous studies that have shown a positive relationship between employment and a favorable prognosis among individuals with mental health disorders. It has been observed that patients who have jobs tend to have better cognitive function and a higher quality of life compared to those who are unemployed (20).

Although our findings did not reveal a direct relationship between the history of hospitalization and the number of visits with the tendency to include spiritual and religious aspects in psychiatric assessment, it is important to consider the potential factors that may influence this relationship. Spiritual issues can often involve internal conflicts that individuals may associate with feelings of shame and negativity, leading to initial hesitations in discussing them during the early stages of treatment. However, as the therapeutic alliance between the patient and therapist strengthens over subsequent treatment sessions, patients may develop a greater willingness to open up about these spiritual concerns. It is worth noting that patients with a history of hospitalization may have had a closer and deeper relationship with their therapist during their hospital stay, which could contribute to a more comfortable environment for discussing spiritual matters (21). The integration of spiritual dimensions in the treatment of psychiatric patients has been proposed in various studies. One such approach is biopsychosocial therapy, which recognizes the importance of addressing spiritual aspects in addition to biological and psychological factors. This approach suggests that the assessment of spiritual dimensions should be included as part of the psychological evaluation for hospitalized patients. By considering the spiritual aspects of individuals' lives,

healthcare professionals can provide more holistic and personalized care, taking into account the unique beliefs, values, and coping mechanisms related to spirituality. This integrated approach aims to enhance the overall well-being and recovery of psychiatric patients. The physician-patient relationship and the spiritual needs of the patient are indeed interconnected and can influence each other in a two-way manner. When a strong therapeutic relationship is established, patients often feel more comfortable expressing their spiritual needs and concerns. This open and trusting environment allows them to discuss spirituality-related issues with their healthcare providers (22).

The significance of patients' attention to spiritual matters in the context of mental health has long garnered interest (8,13,23), with patients often leading the way in broaching such topics with their therapists. Glavas *et al* assert that while therapists are inclined to address spiritual concerns only if raised by their patients, a minority of therapists proactively incorporate spiritual issues into their practice (16,24). This tendency can be attributed, in part, to the inadequate emphasis on spiritual aspects of care in the training of psychiatrists and psychologists (25). Moreover, Iranian Muslim patients tend to perceive religious matters as less pertinent to the domain of psychologists and psychiatrists, as they consider the responsibility for addressing such issues to lie primarily with clerics, who serve as the authoritative figures on religious affairs in Iran (26).

Limitations

The main limitation in the study was the lack of a specific and valid questionnaire to assess the level of willingness of psychiatric patients to integrate spiritual dimensions in their psychological evaluations. The sample size of this study was limited and the data was gathered from one site in Tehran.

Conclusion

This study highlights a positive inclination among Iranian mental health patients toward integrating spiritual and religious dimentions into their psychological evaluations. However, more studies are needed to generalize this result to the entire Iranian society. Nonetheless, due to the limited prevalence of such integration by specialists, patients have experienced a diminished perception of its necessity. Consequently, we advocate for psychiatrists to take this matter into consideration as an important aspect of patient care. Furthermore, we propose conducting additional research based on the obtained results, specifically focusing on assessing the perspectives of psychologists and psychiatrists regarding the incorporation of spiritual and religious elements in patient evaluations. Additionally, we recommend undertaking a study aimed at developing a standardized scale and guideline for the systematic implementation of this assessment approach.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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