Dealing with Religiosity and Spirituality in Psychiatry and Psychotherapy[1]

Position Paper of the German DGPPN Task Force

(German Association for Psychiatry and Psychotherapy, Psychosomatics and Neurology)

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Background

Cultural diversity is increasing in society, especially because of migration and the differentiation of social environments. Consequently, psychiatric-psychotherapeutic care of patients with diverse backgrounds has to be sensitive to cultural and religious factors (Kizilhan 2015). In the USA religious and spiritual competencies are already described for psychiatrists and psychotherapists (Morgan & Sandage 2016; Vieten et al. 2013). It is also the case in Germany that patients with mental illness expect their psychiatrists and psychotherapists to have a holistic perception of their life situation, including its existential, spiritual and religious dimensions (Best et al. 2015; Curlin et al. 2007; Huguelet et al. 2011; Lee et al. 2015). A recent exploratory study in Germany surveyed the significance of existential issues for coping with illness in 30 patients at a behavioural therapy outpatient clinic. It was found that directly addressing and immediately processing existential topics in therapy was relevant for treatment (Grober et al. 2016).

We encounter patients who believe in ghosts, pray compulsively, or have eschatological expectations. Practitioners who lack understanding for a patient's cultural and religious characteristics risk unknowingly violating religion-specific taboos and boundaries. Therefore, at the point of psychiatric diagnosis, differential diagnosis and evaluation of medical history factors like religiosity and spirituality (R/S) should be considered. This attention to spiritual factors within psychiatric evaluation is necessary in particular with the following constellations: e.g. in patients showing suicidal tendencies, religious delusions, depressive guilt and post-traumatic disorders.

Clarification of terminology and connotations: Whereas the term **religion** generally refers to any religious community with its shared traditions of rituals and texts (e.g. Christianity, Judaism, Islam, Buddhism, Hinduism) **religiosity** refers to the personal aspects and life practice of religion beyond any institutional affiliation or ritual. **Spirituality** is often used as an umbrella term in health sciences. It refers to a personal search for the sacred, for connectedness or self-transcendence, which specifically includes worldviews outside of institutionalized religions (Bucher 2014; Pargament 2013). The term **existential** refers to boundary situations, to the experience of illness and death and its specific questions which might be crisis of meaning, reviewing one's life, or transcendence (La Cour 2012; Schnell 2016).

The Islamist terrorist attacks on 9/11 in the USA caused a new, intense debate about the place of religion in modern society also among secular psychotherapists in Germany (Kühn et al. 2010). A constructive dialogue between religious and secular ways of meaning giving is needed in a pluralistic society. From a cultural science perspective, Straub (2016) recently

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differentiated that in our time the conflict line that is mostly significant in society is no longer between religious believers and unbelievers, but between people who have reflected and integrated their worldview into their identity structure and those who have a totalitarian structure.

Meaning can be found through a secular or a religious-spiritual worldview. Meaning is built on interpretative components out of subjective values. Until now, these aspects have received too little attention in psychotherapy (Flassbeck & Keßler 2013; Frey 2016). Through the dissemination of mindfulness-based approaches psychiatrists and psychotherapists have started to reflect differently on psychotherapeutic values and their ethics (Grossman & Reddemann 2016). For the purpose of adequately addressing R/S the therapist´s values and basic assumptions as well as the implicitly mediated values within the respective psychotherapy should be reflected on.

Within the professional discussion on the inclusion of R/S in psychiatric-psychotherapeutic treatment one can find the following viewpoints: While some authors recommend spiritual treatment methods, i.e. the inclusion of R/S interventions on the basis of empirical evidence (Anderson et al. 2015); others, like the Austrian Ministry of Health warn against boundary transgressions and the abandonment of scientific standards and forbids esoteric content, spiritual rituals and religious methods in psychotherapy (Österreichisches Bundesgesundheitsministerium 2014). Because the assessment of R/S in psychiatry and psychotherapy is highly dependent on the cultural context, the DGPPN has set up a task force to create a position paper on R/S in psychiatry and psychotherapy and to promote a discussion on the topic within the German health care system. One aim of the position paper was to adopt the international discussion of this topic to the German situation. The composition of the Task Force ensures that it is balanced in terms of denomination/religion, cultural background, occupational groups and gender aspects.

Today the criticism and disease mongering of R/S, which prevailed in science in earlier years, is no longer appropriate. This critical attitude, however, should not be replaced indiscriminately by an idealization of the field. Psychiatry and psychotherapy can make an important professional contribution to the formulation of criteria for healing and harmful aspects of R/S.

Basic assumptions

- R/S are regarded as anthropological universals (Luckmann 2002; Meindl & Bucher 2015). Religiosity and spirituality are part of being human and should be acknowledged in the context of a holistic view – regardless of the possible influence of R/S on health outcomes (Koenig 2008, 2012) or on the efficiency of therapeutic interventions.
- R/S are identity-forming in both the patient and the psychiatrist/psychotherapist. This is evident especially in existential crises and boundary situations, but also in moments of purposefulness and life phases of existential indifference (Schnell 2016).
- In psychotherapy, R/S should be perceived and appreciated as personal systems of meaning and culture-forming influencing factors (Utsch et al. 2014). For reasons of professional ethics, psychiatrists and psychotherapists are obliged to respect their

patients regardless their age, sexual orientation, social position, nationality, ethnic origin, religion or political conviction.

Present research

When reviewing the English-language literature on the relationship between religiosity and psychotherapy (e.g. Anderson et al. 2015; Goncalves et al. 2015; Lim et al. 2014; Ross et al. 2015) it is noticeable that R/S is often seen as a modular component of psychotherapy itself (e.g. in the context of behaviour therapy [BT]/cognitive behaviour therapy [CBT]). Most of the research has been performed in the USA. As R/S can only be analyzed within the cultural context of individuals, the results cannot simply be transferred to the European situation; our own research is urgently needed in Europe to add to the small amount of European data. Unlike in the USA, in the German-speaking world there is a great deal of caution regarding spiritual interventions in psychotherapy. Exceptions can be found within Buddhist-meditative elements in mindfulness-based therapies (Anderssen-Reuster 2011; Anderssen-Reuster et al. 2013; Harrer & Weiss 2016).

A great deal of research exists, particularly from English-speaking countries, on the relationship between R/S and health (Koenig et al. 2012). Despite all the attention that many studies on spiritual interventions have paid to methodology, it is noticeable that the authors attribute the therapeutic effects to the impact of faith rather than to psychological mechanisms. Therein lies a fundamental bias. Criticism of this aspect has also been raised in the USA (Sloan 2006; Sloan et al. 2000). We therefore need psychiatric and psychological models of association to explain why R/S can act as a resource or a stress factor (Murken 1997; Schowalter & Murken 2003).

The risk of improper boundary transgression and encroaching behaviour by the therapist in spiritual psychotherapy modules is discussed more intensively in Europe than in the USA (Galanter et al. 1990). Even though the importance of existential issues is recognized in psychotherapy, some questions remain open. For example, is giving meaning the task of psychotherapeutic *interventions* (Hardt & Springer 2012)? How far the psychiatric-psychotherapeutic *support* of the patient can go in his or her existential, religious and spiritual search? What professional boundaries are necessary and meaningful to protect the freedom of the patient *and* the practitioner?

It is becoming clear that religious and spiritual topics in psychiatry and psychotherapy have not yet been adequately evaluated, researched and communicated in a training context. These factors are even more important because, besides the classical religions, a mushrooming psycho-spiritual counselling market has emerged that includes some questionable offerings (Brentrup & Kupitz 2015; Murken & Namini 2008). Quite a lot of patients are looking for a spiritual teacher – the guru question is an important subject in psychotherapy (Caplan 2011).

The many guidelines written specifically on R/S show the important role of R/S in English-speaking psychological and psychiatric professional associations (Cook 2013; Galanter et al. 1990; Moreira-Almeida et al. 2015; Peteet et al. 2006).

As people with mental illness often turn to the head of their religious community, the **American Psychiatric Association** (2016) has launched the “Mental Health and Faith

Community Partnership" and set up a working group which has written a guiding manual for the spiritual leaders and ministers of religious organisations on how to properly deal with mental illness.

The Section "Religion, Spirituality and Psychiatry" in the "**World Psychiatric Association**" **(WPA)** works on these issues and publishes its results on its own website as well as in a regular newsletter (WPA, 2015). Recently the WPA published a position paper on how to deal with R/S (Moreira-Almeida et al. 2015). As empirical evidence has shown, R/S affects the prevalence (especially of depression and dependence disorders), diagnosis (distinctions between spiritual experiences and mental illness) and treatment (inclusion of spiritual needs) of mental illnesses, the WPA recommends that its members pay greater attention to these issues.

Over the last 15 years the **American Psychological Association (APA)** has published over a dozen textbooks on the psychology of R/S. It also publishes findings related to psychological aspects of religion and spirituality in the journal "Psychology of Religion and Spirituality." In addition, two years ago the APA started publishing the quarterly journal "Spirituality in Clinical Practice," which presents scientific reports of spiritually-oriented clinical interventions (http://www.apa.org/pubs/journals/scp). Pargament and colleagues (Pargament et al. 2013) have published a two-volume APA handbook that summarizes the current state of knowledge.

The **British "Royal College of Psychiatrists"** regularly offers further education on these issues through its special interest group "Psychiatry and Spirituality," which now includes over 3,000 members. Materials and information about meetings are provided on a dedicated website (Royal College of Psychiatrists 2016). The group has presented a consensus paper on dealing with R/S (Cook 2013). This paper states that members are obliged to respect and be sensitive to the religious or spiritual affiliations of their patients. Clinicians should not offer religious or spiritual rituals as a substitute for professional treatment methods. On the other hand, attention is drawn to the role of positive spirituality in coping, which can be used to convey hope and meaning.

Similar initiatives are also currently being developed in Germany. Nevertheless, Germany has a great need to catch up on research, teaching, training and clinical work.

Recommendations of the DGPPN Task Force

1. ***Intercultural competence.*** Because culture influences R/S, a patient's individual health and disease concepts should be explored in a way that is sensitive to culture and religion. This includes the ability of the therapist to change perspectives. The Cultural Formulation Interview (CFI), which was developed within the framework of the DSM-5 (APA 2013), has proven to be useful in this context. Culture- and language-related misunderstandings should be resolved.

2. ***Spiritual history.*** When taking the psychiatric-psychotherapeutic history, information on values and religious and spiritual convictions, rituals, affiliations and their relevance in the patient's life should be recorded (Frick et al. 2002).

3. ***R/S in the treatment plan*.** The practitioner should be able to recognize R/S as a resource and/or stress factor for patients and, if necessary, to integrate it into the treatment strategy.
   This also is necessary if the practitioner is areligious or has a worldview different from the patient. Hence, the patient's view of R/S and his or her respective valuations have to be understood and taken into account in the treatment plan. It is often necessary to examine existential questions even with patients without a religious/spiritual attachment. The acceptance of a patient's R/S convictions may have to be limited if there is a risk to self or others.

4. ***Boundary violations based on R/S motives.*** The therapeutic relationship and therapeutic treatment in institutions requires clear rules. If these are broken because of religious or spiritual convictions (e.g. religious zealotry/fundamentalism), the patient has to be confronted with the applicable rules as part of the reality principle. Depending on the setting (clinic, inpatient acute psychiatry, practice, etc.), differentiated interventions are necessary to protect or re-establish boundaries.

5. ***Professional boundaries.*** Psychiatrists and psychotherapists have committed themselves through their professional ethics to work within the spectrum of methods of their profession. Therefore, religious or spiritual interventions are excluded. This exclusion is a meaningful and necessary self-limitation. It must nevertheless be ensured that therapy provides a space for the patient's R/S. The Task Force considers it essential that German-speaking psychiatry and psychotherapy give greater consideration to R/S than heretofore.

6. ***Diversity management.*** Facing a vivant market of diverse psychospiritual offerings and their sometimes questionable promises and framework conditions, the task force recommends that the ideological background of a healing method should be transparent, that professional and scientific standards should be maintained and that an approach should be taken that is sensitive to culture and religion.

7. ***Neutrality.*** The practitioner should remain religiously neutral in a respectful way but be open to a possible transcendence as it relates to the patient. A distinction should be made between psychiatric and psychotherapeutic treatments on the one hand and pastoral care and spiritual guidance on the other. Both should remain separate. In many cases, however, collaboration in the interest of the patient can be useful. For this purpose it is helpful if chaplains improve their basic knowledge about psychiatry and psychotherapy.

8. ***Basis in the therapeutic relationship.*** The question of the interaction and fit between the patient's and practitioner's basic attitudes towards R/S are to be reflected on in self-exploration. The prerequisite for this reflection is that psychiatrists and psychotherapists know and critically reflect on their own worldview. The phenomena of transference and countertransference are particularly important in the context of R/S. During reflection, self-exploration and supervision special consideration must be given to the area of tension between the ideological neutrality and religious or spiritual self-declaration of the psychiatrist and psychotherapist as well as questions of truth and values.

9. ***Training, further education and continuing education.*** Psychiatric, psychotherapeutic and psychosomatic training, advanced training and continuing education must be improved both in terms of the basic knowledge of religious and worldview questions and in particular with regard to opportunities for self-exploration. Competencies in R/S-related attitudes, knowledge and skills should be trained and developed. Corresponding learning goals should be integrated into medical training and further education regulations.

10. ***Research.*** Research on the significance of world views and of models for giving meaning as a burden and resource in the German-speaking world is useful and necessary. An interdisciplinary dialogue between psychology of religion, theology and psychiatry, psychotherapy and psychosomatics is desirable and necessary. The following research topics appear to be important, among others: (1) perception of patients' R/S needs, (2) R/S as a barrier to treatment and (3) cooperation between health professions and pastoral care offerings.

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