

# Psyche and Spirit: connecting psychiatry and spirituality

Newsletter of the Section on Religion, Spirituality & Psychiatry

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WORLD PSYCHIATRIC ASSOCIATION

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## Editorial

Welcome to the second issue of Psyche and Spirit. In order to keep our wide readership up-to-date with some important developments in Psychiatry and Spirituality worldwide, this edition covers a broad variety of topics on Spirituality and Psychiatry around the world. We start with a message from WPA

president Prof Pedro Ruiz. Several recent conferences and publications are also covered, as well as a calendar for forthcoming conferences on the field. Focusing in clinical implications of spirituality we have two papers and a recommendation for the assessment of spiritual Issues that was made to DSM-V taskforce. At the research corner, we present a brief summary of a paper assessing the validity of the Mature Religiosity Scale.

Reflecting the growing recognition of the importance of spirituality for a better healthcare, several educational initiatives have been started. The UK Government has recognized that there is much more to improving mental health services than emphasizing NHS (National Health System) modernization. Planning for service modernization and transformation is now shifting to focus on the mental health needs of the community as a whole, as well as on the needs of those who access specialist services. This move now sees spirituality as an integral part of healthcare.

One Trust outside London defines spirituality as follows: 'Spirituality is not confined to the followers of a particular religion, or of all religions. It might usefully be described as 'the essence of human beings as unique individuals - what makes me, me and you, you?' Another way of looking at spirituality is to define it in terms of what provides energy, hopefulness, direction and motivation in our lives. The identification of spirituality is part of the process of viewing people holistically.'

In relation to education many Mental Health Trusts have set up have set up spirituality projects where doctors, nurses, psychologists, clergy and service users can discuss matters related to the incorporation

of spirituality into mental health care; their aims are to enhance knowledge of spirituality among health professionals and to facilitate discourse between these professionals and clergy in various faith traditions. Some Trusts hold 'away days' which provide basic education on spirituality and health. In some areas clergy have been incorporated into mental health teams and they provide education on spirituality for other team members while at the same time having a pastoral role with service users.

Additionally two professional university courses have been established which we describe in the education section: an MSc at Durham University and a certificate at Gloucester University. These provide an in depth examination of the theoretical and clinical links between religion and students are enabled to conduct research in this area and develop their own projects. A core focus of these courses is to teach students patient- centred whole person healthcare.

The Section is very much interested in your opinion and experiences, and therefore started a survey. You will find a questionnaire in this newsletter (p. 16). We would like to urge to respond to our questions; we appreciate your willingness. We hope to be able to present the (preliminary) results in Prague, during the WPA International Congress (October 17-21). Time and again well known scholars have argued that for the area of Psychiatry and Religion to advance new models of psychiatric training and medical education need to be implemented. Otherwise clinical practice with regard to religion and spirituality will not change. Take for instance the fact in a sample of 147 outpatients with severe mental disorders 25 % of them wished the psychiatrist to address spiritual issues in their care. One out of ten participated in a 'spirituality and recovery' group (paper presented by Mohr, 2012), and at the same time very little research is available on the question whether it makes a difference in patient outcomes if a mental health professional does a spiritual assessment. In other words we need more research on assessment of the benefits of clinical activities that apply the many findings from the research on religion and spirituality.

Therefore we need to know more about your activities.

Finally we invite all our readers to collaborate with Psyche & Spirit in many different ways:

- forwarding this Newsletter to other clinicians and researchers potentially interested in Spirituality
- sending your contributions and comments to the meeting point that is described at the end of this issue
- Joining the WPA Section on Religion, Spirituality and Psychiatry. It is easy, you just need to fill the form [here](#)

Alexander Moreira-Almeida  
Simon Dein  
Peter J. Verhagen

### Message from the WPA President

As President of the World Psychiatric Association (WPA), it is indeed a real pleasure and an honor for me to send a message on behalf of more than 200,000 psychiatrists worldwide and one hundred and thirty-five WPA Member Societies from all regions of the world, representing close to 120 countries across the world.

The most important work in the WPA is conducted by its sections; in total more than 65 of them. The WPA Sections are considered the "brain and soul" of our organization, and represents quite well the topics that require to be addressed in an ongoing basis worldwide. Among them, the WPA Section on "Religion, Spirituality and Psychiatry" plays a vital role in all aspects of life. I had the unique opportunity and pleasure to participate in some of the activities and contributions of this WPA Section. Needless-to-say, I was proud of my participation, and learned enormously from it. By acknowledging my participation in this WPA Section, I am also deeply thanking the leadership of this WPA Section among the different components of the WPA. This WPA Section also produced a newsletter "Psyche and Spirit", which is a jewel within the WPA.

My congratulations to the leadership of this WPA Section and my recognition and gratitude for the leaders of this very much needed newsletter, especially Drs. Alexander Moreira-Almeida, Simon Dein and Peter Verhagen.

Cordially,

Pedro Ruiz, M.D.  
President

## News

AMERICAN PSYCHIATRIC ASSOCIATION  
165th ANNUAL MEETING • PHILADELPHIA, PA • MAY 5-9, 2012

This Convention took place in Philadelphia (USA), May 5-9, and the most important developments related to spirituality and psychiatry are described below by Dr. John Raymond Peteet, M.D, Associate Professor of Psychiatry at Harvard University.

- New APA Caucus on Spirituality, Religion and Psychiatry

A few years ago, the APA downsized by discontinuing a number of components, including the Corresponding Committee on Spirituality, Religion and Psychiatry. Last year, members interested in a forum for discussing relevant issues at the interface between psychiatry and spirituality/religion received permission from the APA to form a Caucus on Spirituality, Religion and Psychiatry, with encouragement to meet at APA national meetings and to foster communication and collaboration between meetings, e.g. by use of a listserve or a website. On May 7th, at the 165th Annual Meeting of the APA in Philadelphia the diverse group of approximately 20 psychiatrists who attended the inaugural meeting of the Caucus participated in a lively discussion of their previous experience and current interests directed toward clinical practice, training and research. Next steps include adoption of bylaws, selection of officers, and exploration of the development of a website. The Caucus will meet next at the Institute for Psychiatric Services in October, 2012 in New York, and anyone interested in joining the listserve is encouraged to contact John Peteet at [jpeteet@partners.org](mailto:jpeteet@partners.org).

- APA Symposium on Spiritually Integrated Clinical Psychiatric Practice and Psychotherapy

In the waning hours of the APA's 165th Annual Meeting in Philadelphia, whose theme was Integrated Care, a symposium co-chaired by Drs. Peter Verhagen and John Peteet engaged a full audience with five varied and complementary presentations. Alexander Moreira-Almeida, M.D., Ph.D. presented work in Brazil on the characteristics of individuals with anomalous spiritual experiences shared by mediums at spiritist centers. Two cases, one with co-existing bipolar disorder, illustrated the difference between these experiences and psychotic symptoms and highlighted the importance of understanding these phenomena in their own right. Walid Sarhan, M.D., as a Muslim psychiatrist from Jordan then distinguished cultural from religious beliefs and practices, and discussed three cases demonstrating the potential psychiatric implications of Muslim beliefs and practices: reliance on a sacred feeling for direction after prayer (potentially distorted by anxiety or depression); the threat presented by an Evil Eye (practiced by native healers, with resulting anxiety and paranoia); and the fear of influence by Jinn (at times requiring joint religious and psychiatric sessions to resolve). James Lomax, M.D. then presented his psychoanalytic treatment of two patients in which he helped them to treasure and explore their spiritual and religious experiences as resources. The first patient revealed an anomalous spiritual experience only after months of therapy, and the second used treatment to rework her relationship with her father after his death. John Peteet, M.D. next offered a framework for understanding the role of a therapist in providing spiritually integrated care, along with a discussion of the many challenges of doing so. Finally, Peter Verhagen, M.D. described group therapy with men who had lost their careers, in order to illustrate the operation of root metaphors in their character pathology and their movement from contractual relationships to more personal ones. Becoming able to feel valued for who they were was an important element in opening them up to spiritual and emotional growth.

The abstracts of the papers presented at this symposium follow below:

Islamic religious experiences and concepts in clinical psychiatric practice

Walid Sarhan F.R.C.Psych.

Amman –Jordan

Introduction: Islam is not merely a religion but a complete system of life, which is integrated in the culture and life of Muslims, and consequently the concepts and religious experiences are intermingled with the daily behaviors in health and sickness, and in daily psychiatric practice it is important to know these concepts and experiences, in order to reach the right diagnosis and psychotherapeutic approach.

Method: 3 cases will be presented. The first is related to guidance prayer and Sophie school of Islam, with GAD and MDE management. The second case is related to the evil eye and the black magic which interfered with the right diagnosis, the case explores the roles of jugglers, religious scholars and spell legitimate. The third case is presenting the role of jinn in Muslim patients, in the case presented, the resistance to therapy turns to be certain beliefs about jinn.

Results: The results show that the understanding of the Islamic religion was of great importance in helping these three patients, and missing that could be an obstacle to help the Muslim patients.

Conclusion: The presentation of the three cases from daily busy psychiatric practice in Amman –Jordan, an Arab Muslim country shows clearly the need for mental health professionals to take in consideration the religious and spiritual background of the patient in diagnosis and management, and it shows clearly that the professionals need to know the true Islamic teaching and the prevailing practices and concepts and whether they are accepted or not, and ethically if the professional cannot handle a case because of its religious complications he should refer the patient to another professional, or at least seek the help of a religious scholar.

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Analyzing the clinical significance of spiritual/anomalous experiences in the clinical setting

Alexander Moreira-Almeida MD, PhD

Professor of Psychiatry, Director of the Research Center in Spirituality and Health (NUPES), School of Medicine, Federal University of Juiz de Fora (UFJF), Brazil

Introduction: Spiritual experiences may be confused with psychotic and dissociative symptoms, being frequently a challenge for the differential diagnosis. On the other hand, psychotic patients frequently present a symptomatology of religious/spiritual content.

Objective: To present/discuss some criteria for the differential diagnosis between spiritual/anomalous experiences and mental disorders and show their application in actual clinical practice.

Method: Discussion of cases of patients who report spiritual experiences in the clinical setting. It will be presented cases covering different situations: a) individuals with no mental disorder presenting spiritual experiences that resemble psychotic symptoms; b) patients with mental disorders whose symptoms have religious/spiritual content; c) patients with mental disorders who also have spiritual experiences resembling psychotic symptoms. It will be discussed the clinical application and limitation of several guidelines to make the differential diagnosis between spiritual/anomalous experiences and mental disorders.

Results: There is strong evidence that psychotic and anomalous experiences are frequent in the general population and that most of them are not related to

psychotic disorders. Frequently, spiritual experiences involve non-pathological dissociative and psychotic experiences that are often related to indicators of good mental health. Some features may suggest the non-pathological nature of a spiritual experience: short duration, not having an unwilled character, lack of suffering, lack of social or functional impairment, compatibility with some religious tradition and recognition by others, absence of psychiatric comorbidities, control over the experience, capacity to perceive its unusual/anomalous character, and personal growth with the experience.

Conclusions: It is crucial to develop cultural competence and clinical reasoning to understand the person's cultural frame of reference and to analyze the clinical relevance of spiritual/anomalous experiences that may resemble dissociative and psychotic symptoms.

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#### Using Psychoanalytic Perspectives to Help Patients Benefit from Spiritual and Religious Resources

James W. Lomax, M.D.

Karl Menninger Chair of Psychiatric Education. Brown Foundation Chair of Psychoanalysis. Baylor College of Medicine, USA.

Introduction: Medical health professionals often avoid discussions about religious and spiritual matters with patients because their professional formation has not helped them to connect what they have learned as professionals with their patients' "clinical stories" about religious and spiritual experiences. This presentation provides three examples from clinical practice to illustrate how a background in psychiatry

and psychoanalysis allows a practitioner to make use of such material in order to promote growth and produce healing.

Method: Three cases will be presented. The first case involves an experience which is emotional and evokes a religious "cognition" that is with the intellectual and educational background of the patient, but involves a "conclusion" that he is reluctant to accept. The second case is an illustration of spirituality as an attachment phenomena in which the patient's experience of an "anomalous event" is nurtured by the therapist because of its capacity to reflect spiritual connection as healthy attachment-seeking (and not psychopathology) even though the experience, itself, is anomalous and would be considered by some individuals as paranormal and by others as a possible sign of psychopathology. The third case also relates to spirituality as an attachment phenomena, but also adds the role of "sacred objects" as what William Meissner referred to as "creative illusion formation."

Results: The reputed clinical stories involved incremental growth and healing which can occur when a mental health professional makes use of his or her own professional background to conceptualize the religious and spiritual resources of patients which produce positive health outcomes.

Conclusion: These cases illustrate the way in which respectful dialogue and exchanges between mental health professionals utilizing a psychoanalytic orientation and religious and spiritual professionals (whether from pastoral or theological backgrounds) may produce powerful synergisms to improve health outcomes of patients and better interdisciplinary dialogue.

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## Spiritually Integrated Psychotherapy

John R. Peteet, M.D.

## Spiritually Integrated Psychotherapy

Tensions between psychiatry and religion persist, but interest continues to grow in the place of spirituality in mental health, and in psychotherapy. Arguments for integrating spirituality into treatment have been based on shared worldview (Bergin), existential need (Griffith), moral distress (forgiveness promoting, 12 Step), coping (Pargament), and human flourishing (Cloninger). However, clinicians lack clear conceptual and practical guidelines for approaching patients' spiritual concerns.

Four potential approaches to spiritual concerns in psychotherapy are to: (1) acknowledge the problem, but limit discussion to its medical/psychological dimension; (2) clarify the spiritual as well as the psychological aspects of the problem, suggesting resources for dealing with the former, and considering working with an outside resource; (3) address the problem using the patient's own philosophy of life; and (4) address the problem using a shared perspective on life. Case-specific factors relevant to choosing an approach include clinical, therapist-related, boundary, transference/countertransference and ethical considerations. More general considerations include: Should spirituality inform the goals of treatment? Should clinicians provide spiritual care? Is it possible for clinicians to agree on a model for integrating spiritual and psychological approaches?

Whole person psychiatry provides a framework that can both accommodate other approaches (e.g. psychodynamic, and cognitive behavioral), and address the boundary and ethical issues involved.

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York, Routledge, 2010

Using group analytic perspectives to help patients discover spiritual relationships

Peter J. Verhagen, M.D.

GGZ CENTRAAL, the Netherlands

Introduction: Integrating spirituality and religion into mental health care, psychiatry and psychotherapy is still controversial. The role of spirituality in group psychotherapy was until recently virtually ignored.

Method: Group psychotherapy/group analysis use important frameworks with which we can learn to "see" what is happening on a spiritual level. Although religious, spiritual or anomalous experiences happen to individuals, these belong to and are members of a larger transpersonal network, which a group is equipped to study. Cases will be presented in order to explain the concept of the so-called "invisible group". Another helpful tool will be introduced also: individuals and communities tend to perceive their spiritual relationships as analogous to the various human relationships with which they are familiar. This notion provides an important aid for understanding the structure of different basic forms of spirituality. Looking at spirituality in that way we can discover inherent opportunities for therapeutic progress. The cases will also illustrate this recognizable aspect of spirituality.

Results: Participants will recognize the importance of the two tools presented and illustrated and gain some understanding of the dynamics of spirituality in group psychotherapy. This might stimulate psychiatrists and psychotherapists to develop a more open professional stance when engaging patients on religious, spiritual and/or anomalous experiences.

Conclusion: Without an adequate framework we can keep spiritual experiences to ourselves, try to share them with others who may share with us their similar experiences, or we push them to the back of our minds. However, if the experience is important it is urgent to find a frame of reference for dealing with it. Group psychotherapy/group analysis offer such a framework. In general, studies clearly indicate that outcomes can be enhanced by integrating spiritual/religious elements into therapy, and that this can be done by religious and non-religious therapists alike. The growing appreciation for the clinical

importance of religion/spirituality in psychiatry and psychotherapy requires continued examination and research. Careful and thoughtful clinical case description is of utmost importance to stimulate this trend.

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This was a very successful congress held by the World Association of Cultural Psychiatry in March 2012 at Barbican in London. There was an afternoon devoted to religion and health held at St Paul's Cathedral: 'Culture, Spirituality & Psychopathology: integrating clinical and theoretical perspectives'. Chaired by Professor Goffredo Bartocci from Rome, it was attended by about 100 people and included a number of international speakers who spoke on diverse topics: Spirit Possession (Quinton Deely); Current Controversies in Research in Spirituality and Health (Simon Dein); Religion and Belief From an Asian Perspective (Wen Shin Tseng) and The Divine Placebo (Armando Favazza) among others. This was a highly successful event. There were also several popular symposia on spirituality and psychiatry in the main conference ([www.wacp2012.org](http://www.wacp2012.org)).



The third European Conference on Religion, Spirituality and Health (ECRSH) took place on May 17-19, 2012, at the university hospital in Bern/Switzerland. The conference gathered experts from 23 European and foreign countries including South America, Australia and New Zealand. The main topic was spiritual care, a holistic and interdisciplinary approach in clinical medicine emerging from palliative care. Prof. Eckhard Frick from the Ludwig-Maximilians

University in Munich, professor of spiritual care, presented the Bern Lecture on "Spiritual Care – how does it work?". In contrast Prof. Harold Koenig from the Duke University Medical Center in Durham spoke on "Spiritual care in the United States – research, understanding and practice". Eight additional keynote lectures, symposia, free communications and posters covered a broad range of topics on religion, spirituality and health. Below some main issues are outlined and discussed:

#### 1. Definitions and meaning of spirituality

Considering the topic of spiritual care, there is discussion concerning the meaning of the term "spiritual". For some experts spiritual is equivalent to human and therefore includes every human behaviour, as for others spirituality needs to be related to the transcendent (Zinnbauer, 1997). In health sciences anthropological definitions of spirituality are predominant (Baier, 2006). Spirituality is understood as a distinct human dimension expressing itself as spiritual needs and struggles.

#### 2. Religion and spirituality as coping resources

Religion and spirituality have been found as powerful resources in coping with mental illness and physical disease (Koenig, 2001). God can be understood as an attachment figure promoting secure attachment behaviour. An impressive example has been presented by Franco Bonaguidi from Pisa/Italy. He examined patients undergoing liver transplantation and found that the more religious had a three times higher survival rate than the less or none religious (Bonaguidi, 2010).

#### 3. Implementation of spiritual care

Spiritual care in clinical practice is an interdisciplinary approach including and integrating all health disciplines as established in palliative care. This approach is based on an extended psychosocial model (Hefti, 2011) and can be applied to all medical specialities from family medicine to cardiology, surgery, gynaecology and psychiatry. To challenge the professional's attitude towards spiritual care Prof. Frick quoted FitzGibbon: "If a nursing practice

procedure is mishandled, the worst that can happen is that the patient dies; if a spiritual care procedure is missed, it can mean the eternal death of the soul" (FitzGibbon, 1951). This thought provoking view underlines the importance of the spiritual dimension and the need for training basic competencies in spiritual care. A core competence is taking a spiritual history using a person centred approach. Specific resources supporting a spiritual history are the SPIR interview or a newly developed spiritual distress assessment tool (Monod, 2012)

For further information please visit our post-conference website offering pdf and audio files of many of the presentations ([www.ecrsh.eu](http://www.ecrsh.eu), see programme). In addition we point to the newly published book with selected contributions of the first and second European Conference ([www.rish.ch](http://www.rish.ch), see shop) and the newsletter of the European Network of Religion, Spirituality and Health ([www.rish.ch](http://www.rish.ch), see newsletter) that keeps you informed about new topics, projects, publications and conferences.

René Hefti, M.D.

Scientific and organizing committee of ECRSH  
Research Institute for Spirituality and Health/  
Switzerland

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#### **International Juan José López Ibor Award granted to Prof. Srinivasa Murthy**

The third edition of this prestigious award has been granted a board member of the WPA Section on Religion, Spirituality & Psychiatry, Prof. Srinivasa Murthy. The total award amount of €40,000 was donated by him to the [Association for Mentally Challenged](http://www.fundacionlopezibor.es) that develops programmes towards empowering families of persons with intellectual disability in Bangalore, India. The award will be granted in Prague during the International Congress of the World Psychiatric Association, 17-21 October 2012, when Prof. Murthy will deliver a lecture. [www.fundacionlopezibor.es](http://www.fundacionlopezibor.es)

#### **Symposium on Spirituality and Health: a Person Centered Model of Care.**

Geneva April 2012

This Plenary Symposium was organised by Christina Puchalski (Washington) and took place at the Fifth Conference on Person Centered Medicine held in Geneva April 2012, and organised by the International College of Person Centred mmedicine (ICPCM). The prominence given to this session, chaired by Manuel Dayrit ( Director, of WHO), was symbolic of the wider interest in these matters than ten years ago. Christina Puchalski first outlined her model of incorporating spirituality in to a patient's treatment plan- in collaboration with a Board certified chaplain an expert in spiritual care. Robert Vitallio, Director of Caritas, focussed on the Catholic Church commitment to assist the vulnerable, whilst recognising that the other World Faiths shared many these values. He described specially the lessons learned from working with people suffering from HIV/ AIDS. My presentation 'Religious and Secular Counselling: relevance of Faith, the need for science

and the variety of Values' considered the uncertain boundaries between Religious/ Christian Counselling and so called secular counselling. I suggested that health professional when working in secular settings may benefit from knowledge of the spiritual images derived from Faith Tradition such as the Wounded Healer ,the Journeying Companion and the Good Shepherd.

Finally, Elvira Dayrit gave a moving and personal account of the value of her Christian faith to coping with Cancer; and Andrew Miles ( Editor, with Juan Mezzich, of the new International Journal of Person Centered Medicine) summarise what had been not only a seminal but also a 'germinal' session.

Members of the Section may like to know that the new Journal can provide an opportunity for publication in this field and that the website of the College of Person Centered Medicine also gives details of future activities.

John Cox Vice Chair, WPA Section on Religion Spirituality and Psychiatry.

### **Spirituality, Eastern traditions and Western therapies in enhancing patient centred care**

Prof. Russell D'Souza  
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The world is becoming a truly post-modern society, a place where we are learning to incorporate uncertainty in our view of the world. The absolute is giving way to the relative; objectivity to subjectivity; function to form. In the modern view of the 20th century, seeing was believing; in the post-modern world of the turn of the century, believing is seeing. Conviction yields to speculation; prejudice to a new open-mindedness; religious dogma to a more intuitive, inclusive spirituality. Even the concept of God receives a changed emphasis, from the materialist's 'out-there' being, to a spirit that is more intimately part of us (1).

The historical split between "facts" and "values"; science and religion is being reconsidered. There has been the recent shift away from dichotomies such as

therapy/spirituality, science/religion towards a both /and syntheses in the "New Science" and spirituality. The "Cartesian anxiety" and dualism that has dominated western thought in the last 300 years is now less apparent, and science is more inclusive of different paradigms (2).

Spirituality is a concept globally acknowledged. However, attempts to reach a consensus regarding its nature have not often met with success. In discussing spirituality, one is really discussing the ways in which people fulfil what they hold to be the purpose of their lives. Spirituality can encompass belief in a higher being, the search for meaning and a sense of purpose and connectedness. There can also be a wide overlap between religiosity and spirituality.

There is now awareness across multi disciplines of the importance that spirituality and religiosity has for many patients. This has led to suggestions and research in relation to validating the incorporation of aspects of spirituality and religiosity into multi-disciplinary assessments and interventions for patients with psychological and physical illness (3). In an Australian survey a large majority of patients wanted their therapist to be aware of their spiritual beliefs and needs. About two thirds (68.7%) of respondents believed that their spiritual beliefs helped them to cope with psychological pain (4).

The treatment of psychiatric disorders has improved with the introduction of many medications and psychotherapy techniques which show benefits in randomised controlled trials. However these benefits of treatments are moderate and incomplete. This is seen from frequent drop-outs, relapse and recurrence of illness.(6) The inadequacy of these available treatments result in persistent residual symptoms of disease and distress, as well as low levels of life satisfaction and well-being in most patients with mental disorders. The absence of life satisfaction and positive emotions is a major problem, because the current evidence suggests the absence of positive emotions is more predictive of subsequent mortality and morbidity than the presence of negative emotions (7). We see there is little evidence of any improvement in life satisfaction and positive emotions from the introduction of psychotropic drugs and or

manualized forms of psychotherapy from 1950 to present time (8).

There is now growing evidence showing it is possible to improve well-being in general populations as well as with patients with most mental disorders. Therapies that have incorporated the blending of philosophy, the practice and the spiritual venerable time known, eastern wisdom and cutting edge western sciences have now been found to give dynamic results. These effective methods of intervention focus on the development of positive emotions and the character traits that underlie well-being, as has been described in positive approaches to philosophies of life, psychology and psychiatry. Evidence is there from randomized controlled trials of these therapies using cognitive exercises to achieve acceptance, hope, meaning and purpose along with behavioural exercise of meditation and rituals to enhance well-being and happiness in patients with mental disorders (9). These therapies have also shown enhanced well-being in samples of student and volunteers (10). These methods use the best of eastern and western traditions to achieve improved well-being, increased positive emotions and reduced negative emotions.

Therapies using western scientific operative structured modules which incorporate eastern concepts, that offer the practice of catalytic sequences of spiritual exercises, such as meditation, silence of the mind, giving and receiving, cause and effect, reflecting and seeking purpose in life, have been able to demonstrate the enhancing of the character traits associated in enhancing well-being (5). This is seen with increasing the character of self-directedness, through the strengthening of the sense of hope and mastery, with increasing the character of cooperativeness, through kindness and forgiveness and with increasing the character of self-transcendence through increased awareness and finding meaning greater than oneself (5,9). There is now evidence that exercising and strengthening of these three character traits of the Temperament Character Inventory can result in increased scores on the personal well-being index scale (6).

Understanding the concepts of happiness in Eastern cultures and Western cultures is useful. In the western cultures positive hedonic experiences of happiness are associated with personal achievement, whereas in eastern cultures happiness is associated with social harmony (11). Similarly western traditions emphasis is on 'doing' oriented toward rewards (12) while eastern traditions focus on continuous excellence of 'being' that is associated with stable character traits. Happiness as a trait and can be cultivated by specific yoga practices. It represents a deep sense of well-being and a reduced vulnerability to outer circumstances (13).

### Conclusion

With new advances on understanding the biological and neuroscience influences of eastern models of meditation, yoga, mindfulness and its impact from gene expression and epigenetics to structural expressions from imaging studies there is an argument to study and incorporate these evidence based best practises of eastern traditions, blending in with western scientific therapies, to get the ultimate desired best outcomes for patients and general populations which we work with.

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### The Biopsychosocial Model and Spiritual Life

This paper was presented as a poster at the 24<sup>th</sup> Annual Meeting of the Association for the Advancement of Philosophy & Psychiatry, Philadelphia, PA, USA. May 5 & 6, 2012

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#### Question I

Do we need a new definition of health? According to the WHO definition health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The WHO definition has never been changed although it has been criticised for several reasons. One theme in this criticism is the meaning of the word 'complete'. Experts tend to move from the present static formulation to a more dynamic one 'based on the reliance or capacity to cope and maintain and restore's one's integrity, equilibrium, and sense of wellbeing'. Health is formulated as the ability to adapt and to self manage. [1].

#### Question II

Do we need a renewed biopsychosocial model (BPS)? In a sense the biopsychosocial model parallels the

WHO definition of health since in a BPS formulation the psychiatrist/therapist seeks the mental health problems and their solution in three dimensions of human functioning. The authors of the aforementioned dynamic formulation of health still suggest the same three domains of health: physical, mental and social.

#### Question III

Do we need to extend the BPS model by adding a fourth dimension: spiritual life? Although not specified in the definition of health WHO stated that spiritual life might affect quality of life by helping people cope and self manage with difficulties in their lives by giving structure, ascribing meaning, and providing a sense of greater well-being.

#### Starting point

The BPS model was/is primarily used in clinical practice as a non-reductionist approach to mental disorder [2, 3]. However, the model is not clear about how these three (or four?) dimensions relate. Are they just levels of increasing complexity, as George Engel seems to suggest? Do they have their own language and methods?

#### Objection I

The BPS model lacks an integrative framework and does not explain how these levels or domains work together.

#### Objection II

The BPS model is not open to meaning-centered aspects of illness and health [4].

#### Counter-argument

It is possible to reformulate the BPS model such that it is open to religion and spirituality and that it integrates empirical findings at the interface of psychiatry and religion. A reformulation along these lines would integrate the spiritual dimension in clinical practice and would allow the use of spiritual resource in coping with illness and in managing one's problems. Research on 'psychiatry and religion' does suggest that spirituality/religion can be helpful for persons

with physical and mental disorders and that the correlations found cannot be explained by or reduced to other psychosocial variables.

### Theory

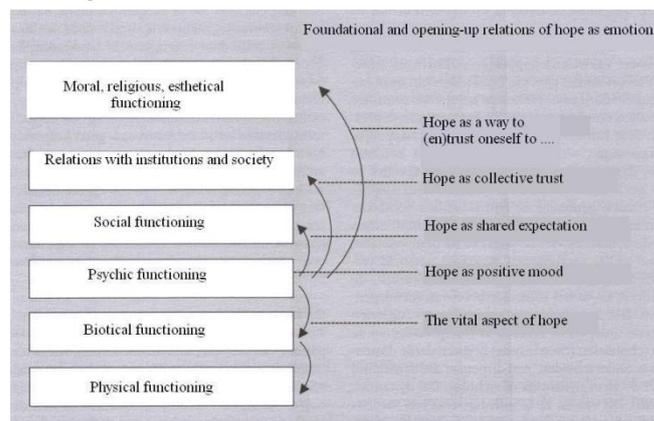
(Based on the systematic philosophy of the Dutch philosopher Dooyeweerd.) Human functioning can be analyzed as a structural whole, in which substructures are interwoven without loss of their relative independence. The structural whole has its own internal destination. Human emotions as part of the psychic substructure prepare for an immense diversity of acts and act-like behaviours. This preparing for is called 'anticipation'. So anticipation refers to the reflection of elements of the higher functions within human emotional life, which as such is part of the psychic structure. So, emotional life is co-determined by analogical moments which anticipate the higher functions of the structural whole. Feelings as trust and hope can be interpreted as feelings that anticipate faith (spiritual life). As such, as feelings, they remain within the boundaries of emotional life. However, the words 'trust' and 'hope' may denote other events, acts of trust or hope, acts that bear witness of our confidence in somebody or in a certain state of affairs [5].

### Hope

Hope is an affective disposition, which expresses itself in a variety of ways. In a weaker sense it means something like positive expectation, having confidence in the future. Hope is reaching out to what is not yet there, in the anticipation of something positive to come. The opening-up of feeling leads to more concrete expectations, which include a cognitive dimension. These expectations are not merely private, they may be shared with other people, explicitly or implicitly. The psychic sphere is opened up to the social, to the level of institutions and society and finally to the realm of meaning, morality and aesthetics.

If emotional life opens up to these higher levels of functioning, they are no longer just expressions of the self. They become social by attuning to the wishes, feelings and interests of others around us. Each of the

higher levels adds another connotation to the feeling (see Figure).



### Mental illness

What are called anticipatory moments seem to be atrophied in mental illness, e.g. depression. In depression the psychic structure is 'closed'. The anticipation of spiritual life is blocked, but also of social life and of trust in collective structures.

### Therapy

Based on this approach therapy does not need to be straightforwardly spiritual in the sense that spiritual interventions are needed in order to provide a really integrative therapy. Integral treatment primarily means: being sensitive for the dimension of opening-up (anticipation), especially the opening-up of the psychic dimension toward higher levels of functioning (social, institutional, spiritual). It also means: establishing reinforcers (all kind of stimulating factors) for this anticipatory movement.

### Conclusion

The refinement we propose is based on a view on human functioning as structural whole, in which substructures are interwoven. Each 'lower' substructure is encompassed by the next, higher substructure, the structural whole encompassing them all. Each encompassed or underlying substructure functions in a foundational sense within the higher substructure. Each substructure is qualified by the function which is used to denote them. The structural whole is open to a wide variety of functions including spiritual life [6]. This approach allows us to formulate a new answer to what might be meant by

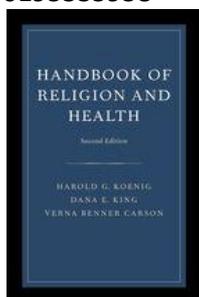
the word 'complete' in the definition of health because it offers an integrative framework (Objection I) and it is open to meaning centered-aspects of illness and health (Objection II), and open to spiritual life.

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#### New Releases

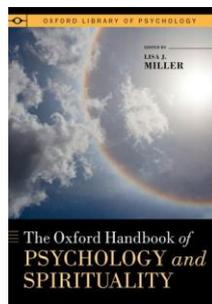
[Handbook of Religion and Health, 2<sup>nd</sup> Edition](#). Harold Koenig, Dana King, Verna B. Carson. Hardcover: 1192 p. Oxford University Press, 2012, ISBN: 978-0195335958



The second edition of the Handbook of Religion and Health has just been released. By providing a comprehensive and rigorous review of empirical studies on religion and health performed through 20th Century, the first edition became classic essential reading in the field. This second edition complements

the first by providing a review of studies performed since 2000.

[The Oxford Handbook of Psychology and Spirituality](#). Edited by Lisa J. Miller. Hardcover: 640 pages. Oxford University Press, 2012, ISBN: 978-0199729920.



This volume, composed by contributors from different areas (psychology, medicine, and physical and biological sciences) makes the case for a "postmaterial spiritual psychology".

[Asian Journal of Psychiatry](#): Spirituality and psychiatry: Special series. It starts at Volume 5, Issue 2, June 2012. It includes more than 20 short papers of leading authors in the field from all continents. Prof. Russell D'Souza, MD is the guest editor.

#### Research corner

Mature Religiosity Scale. Validity of a New Questionnaire

*European Journal of Mental Health* 7, June 2012, 57–71.

Margreet R. de Vries-Schot, Joseph Z.T. Pieper & Marinus H.F. van Uden

In order to validate a new questionnaire, the Mature Religiosity Scale (MRS), it was presented to a sample of 336 persons, of which 171 were parishioners and 165 outpatients of Christian mental health clinics. A first version of this questionnaire was designed by studying both psychiatric/psychological and theological literature. This version was, according to the Delphi-method, presented to a panel of 49 experts, 25 of whom were psychologists and psychiatrists and 24 pastors/theologians. By incorporating their opinions and ideas, a new version of the questionnaire was developed. Consensus was attained regarding 23 criteria in a second round. Using

factor analysis, 21 of these 23 criteria could be clustered, in three factors with the labels 'Orientation to higher values out of a sense of inner freedom', 'Trust in God pervades the entire life', and 'Responsibility for fellow humans and creation'. In these three factors, all individuals' three possible relationships are present, namely with themselves, with God and with their fellow humans, as can be seen in the Biblical Golden Rule.

Now, validity and reliability were studied by including other questionnaires, among them the Spiritual Well-Being Scale (SWBS), the Duke Religion Index, the Religious/Spiritual Coping (RCOPE) and the State-Trait Anxiety Inventory (STAI). The results indicate that 16 items of the questionnaire make up one factor with good internal consistency, which is measured by Cronbach's alpha (.92). This factor was used as the Mature Religiosity Scale in this study. Out of correlations with other validated scales and correlations with characteristics of known groups this scale proved to have good validity.

The Mature Religiosity Scale is suitable for use in both mental healthcare and pastoral care. It is designed and validated for these two groups, giving direction to professional communication about faith and meaning of life.

#### Mature Religiosity Scale (MRS)

The items are presented in a sequence of highest to lowest factor loading

,809	I have the idea that I entrust myself more and more to God
,802	My religion supports my sense of self-esteem and identity
,787	Knowing God's love is fundamental for my life
,766	The meaning and significance of my life is in my relationship with God
,757	The experience of God in my life motivates me to decide for the good, also if this is difficult
,715	I believe sincerely, not mainly out of obligation or fear
,701	In times of trial and tribulation I trust in God
,676	I am willing to be accountable to God and my fellow humans about my way of life
,647	My faith is oriented to values that transcend physical and social needs
,645	Out of my sense that God loves human beings, I pursue to love my fellow man
,621	My faith influences all areas of my life
,599	The development of my personality and my faith influence

	each other mutually
,561	As a person I am only fully complete in a relationship with God
,547	For me, praying for and doing justice belong together inextricably
,513	I pursue higher values such as love, truth and justice
,447	My sense of self-esteem is connected to who I am and not so much to what I have

Margreet de Vries-Schot, MD PhD, psychiatrist and theologian, GGz Centraal Ermelo, the Netherlands; [vriesschot@kpnmail.nl](mailto:vriesschot@kpnmail.nl).

### Recommendation for the Assessment of Spiritual Issues at DSM 5

The proposal bellow was submitted to the DSM 5 taskforce by Alexander Moreira-Almeida, a member of WPA section on Religion, Spirituality and Psychiatry.

The category "Religious and Spiritual Problems" (V62.89) describes basically religious problems, but essentially no spiritual problems. It could include reference to spiritual experiences (SE) that, although often similar to psychiatric symptoms (often psychotic and/or dissociative), causing distress and leading to help-seeking behavior, are not related to mental disorders. These SE are specific types of spiritual problems that may be focus of clinical attention but are not due to mental disorders. This inclusion would have several advantages:

- include a spiritual aspect to "Religious and Spiritual Problems"
- stimulate better awareness about this issue
- reducing the occurrence of iatrogenic harm from misdiagnosis
- stimulate research in this much needed topic

Considering that spiritual and religious beliefs and experiences can affect mental health and the way patients cope with distress and mental disorders, and also that healthy SE may present characteristics similar to those of dissociative and psychotic symptoms, it is good practice to inquire about patients' spiritual and religious background, beliefs, practices, and experiences.

During assessment, the psychiatrist should be able to determine if religion/spirituality is important in the life of his patient. A brief spiritual history is necessary to become familiar with the patient's religious beliefs, as they relate to decisions about medical care, and to understand the role religion plays in coping with illness or causing stress, and to identify spiritual needs that may require consideration. Four basic areas should be remembered when taking a spiritual history:

- 1) Does the patient have any spiritual beliefs that might influence health care?
- 2) Is the patient a member of a supportive spiritual community?
- 3) Does the patient use religion or spirituality to help cope with illness - or is it a source of stress, and if so, in what way?
- 4) Does the patient have any troubling spiritual question or concerns?

It is also crucial to develop cultural competence and clinical reasoning to understand the person's cultural frame of reference and to analyze the clinical relevance of experiences that may resemble dissociative and psychotic symptoms. Clinicians must become aware that most people reporting anomalous, psychotic, or dissociative experiences do not actually have psychotic or dissociative disorders (Moreira-Almeida & Cardena, 2011). Certain features, although not necessarily present or sufficient on their own, are suggestive of the non-pathological nature of such experiences. We have reviewed the criteria that have been proposed in the literature to make the differential diagnosis between healthy SE with psychotic and dissociative experiences and mental disorders that may resemble SE (Moreira-Almeida & Cardena, 2011). There is an urgent need for more studies in the subject and for more empirical tests of the proposed criteria. However the criteria summarized below can help clinicians to assess the clinical significance of SE. There is no absolute criterion, it is possible to cite counter examples for each of them, however they may be very useful in provide some base to perform a culturally sensitive and judicious clinical reasoning. The more elements

present, generally speaking, the less likely is the experience to be psychopathological.

Guidelines to assess the clinical significance of spiritual, psychotic, or dissociative experiences:

- Absence of psychological suffering, of social and occupational impediments: the individual does not feel disturbed by the experience he/she is having; it does not impair the individual's relationships and activities. However, if the person does not have a cognitive framework that makes sense of the experience it may cause distress and a sense of alienation.

- Absence of psychiatric co-morbidities: absence of other mental disorders or symptoms suggestive of mental disorders besides those related to SE. Regarding psychotic experiences, although there may be reports of hallucinations, unusual beliefs and other anomalous experiences, there is a lack of negative or disorganization symptoms.

- There is a discerning attitude about the experience that includes the capacity to perceive its unusual/anomalous character and the insight that it may not be shared by others. Healthy people having anomalous experiences are often reluctant in talking about them.

- Compatibility with some spiritual tradition: experiences might be understood within the concepts and practices of some established spiritual or religious practice, even if it is not the person's or local tradition.

- Control over the experience: the individual is capable of limiting his/her experience to the right time and place for its occurrence, for instance, within a ritual rather than at work or school. The experience has a short duration, happens only occasionally, and does not have an unwilling, invasive character in the individual's consciousness or daily activities. There are some experiences that may have a long duration but can be seen as a stage within the previous spiritual development of the person. In many cases the control over the experience may develop only after some time, often after some formal training in a spiritual tradition

- The experience promotes personal growth over time: improvements in the personal, social, and professional life of an individual. It is directed towards self-integration and helping others.

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### Calendar of events

#### October 2012

- 1-4 [VII Latin American Conference on Science and Religion](#). Rio de Janeiro, RJ, Brazil. Promoted by Pontifícia Universidade Católica do Rio de Janeiro and University of Oxford.
- 10-13 [XXX Brazilian Congress of Psychiatry](#). Natal, RN, Brazil. Symposium on "Assessing Spirituality in Psychiatric Patients". It will cover genetics, epidemiological and clinical aspects related to psychiatry and spirituality.
- 17-21 [WPA International Congress](#). Prague, Czech Republic. Two contributions by the section: a symposium and a workshop. Also a section meeting will be held.

#### November 2012

- 5-7 [1st International Conference on Cultural Psychiatry in Mediterranean Countries](#). Tel Aviv, Israel. Sponsored by the WPA Transcultural Psychiatry Section. It will include sessions on religiosity and spirituality.

### Meeting point

Dear Colleagues,

In the section of Religion, Spirituality & Psychiatry, we have great interest in communicating with our colleagues besides our website.

You are all invited to send your opinions about unmet needs in psychiatric teaching, training, and care concerning religion and spirituality, difficulties faced during practices, stories from different cultures and future research plans to improve our understanding of the links between psychiatry and spirituality as well as mental health care.

I am sure you will assist us in this coming effort by sending your contributions and comments.

Prof. Nahla Nagy

Secretary Section Religion, Spirituality & Psychiatry  
[nahlanagy64@yahoo.com](mailto:nahlanagy64@yahoo.com)

### Religion, Spirituality and Psychiatry Survey

#### Importance of the topic

There is emerging scientific evidence that religion/spirituality may impact positively on mental health and wellbeing (Koenig 2009, Verhagen et al 2010). Religious coping has been found to be common in those suffering with mental health problems. Activities such as prayer and reading the Bible have been found to be prevalent in individuals with severe enduring mental illnesses including those with major depressive illnesses, and may be associated with reduced symptoms (Bosworth, Park, McQuoid, Hays and Steffens, 2003).

What are the implications for psychiatrists? There has been recent interest in psychiatrists' attitudes towards religious /spiritual enquiry in clinical practice (Dein et al 2010). Although results are conflicting there is some evidence that mental health professionals are becoming less reluctant to ask their clients about these topics. Additionally recent studies suggest that incorporating religious aspects into therapy with religious clients may improve outcomes (Pargament, 2007). Thus failure to incorporate religious/spiritual aspects into the consultation and treatment may disadvantage clients.

Finally, in terms of training, Kozac et al. (2010) note that there is a trend towards integrating the teaching of cross-cultural issues related to spirituality and religion into medical education and that this is particularly evident in psychiatric residency programmes.

Based on the above, the WPA Section on Religion, Spirituality and Psychiatry Executive committee would like to explore current attitudes and practices in religion and psychiatry. This survey aims to assess the attitudes and experience of members of the WPA in relation to religion/spirituality in patient care. The

results will be used to inform future teaching and research in this area. Please take few minutes to answer the following questions relating to residency training, continuous education, clinical practice and research.

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**You will find the SURVEY on the website of the Section: [www.religionandpsychiatry.com](http://www.religionandpsychiatry.com).**

**Please, return your answers and comments to the secretary of the section: [nahlanagy64@yahoo.com](mailto:nahlanagy64@yahoo.com)**

## SURVEY

### Demographics

1. Age
2. Gender
3. WPA position/section
4. Country of origin
5. Religious background
6. Resident specialist
7. Duration of psychiatric practice
8. Sub speciality

9. Place of work public/ private/ hospital/ clinic/ city/ rural

### Residency

Should religion /spirituality be part of postgraduate psychiatric residency training?

Did you personally have any teaching on religion/spirituality in your postgraduate training?

Please give details

Does your own residency programme include any training in religion/spirituality? If so what is included and how much time is devoted to it?

What changes should be included in the residency programme?

### Continuous education

Should religion/spirituality be part of continuous education?

Have you personally had any training in religion/spirituality as part of your continuous education?

What aspects of religion/spirituality should be included in continuous education?

### Clinical Practice

Do you encounter patients with religious/spiritual presentations in your psychiatric practice?

Please give examples.

Should religious/spiritual issues be discussed with patients during the clinical consultation?

Do you personally discuss religion/spirituality with patients?

What aspects of religion/spirituality should be discussed during the clinical consultation?

Should psychiatrists pray or perform rituals with their patients?

Why or why not?

In what percentage of your consultations are religious/spiritual issues discussed?

Do you consider that discussing religious/spiritual issues with patients can have a positive impact on their wellbeing?

In what way(s)?

Do you consider that discussing religious/spiritual issues with patients can have a negative impact on wellbeing?

In what way(s)?

Do you personally use therapeutic interventions with religious/spiritual content in your clinical practice?

Please give examples.

### **Research**

Are you involved in any research on religion/spirituality in the psychiatric context?

Please give examples.

What aspects of religion/spirituality and psychiatry should be the focus of research?

## **Join the Section**

### **Join the WPA Section on Religion, Spirituality and Psychiatry!**

If you are a clinician or researcher working with mental health and have an interest in spirituality, you can become a member of our section. It is free and would allow you to be in touch with peers that share your interests. Some benefits:

- You will be kept posted on the latest developments in Spirituality and Psychiatry around the globe!
- Possibility of contributing to the discussion and improvement of the understanding, scientific research, and clinical integration of spirituality in mental health care
- Networking with researchers and clinicians from all over the world

To join us it is free and easy, you just need to fill the form [here](#).