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Article

"Religion in Psychiatry and Psychotherapy?" A Pilot Study: The Meaning of Religiosity/Spirituality from Staff's Perspective in Psychiatry and Psychotherapy

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Abstract: This study examined: (1) the spirituality of staff; (2) its relationship with staff's attitudes towards religiosity/spirituality of patients; and (3) with staff's integration of religious and spiritual contents in the patient's therapy. *Method:* An anonymous survey distributed to the staff in the department of psychiatry and psychotherapy at the Freiburg University Hospital. The main predictor variable was the spirituality of staff using DRI (*Duke Religion Index*). The main criterion variables were the relevance of religiosity/spirituality of patients and staff's attitude towards religious/spiritual contents during their therapy using the questionnaire of Curlin *et al. Results:* The spirituality of staff was 6.91 on a scale of 12.0. There was no significant relationship between variables. Staff regarded the influence of religious/spiritual contents generally positive to patients. However, the staff did not use religious/spiritual elements in their therapy methods. Frequent reasons were insufficient time/occasion and insufficient knowledge. *Conclusions:* Religious/spiritual contents have not been integrated yet in therapy methods, although they are regarded as important for patients. Further studies and discussion about religious/spiritual matters are essential for their integration into psychiatric therapies in order to overcome these inconsistencies.

Keywords: religiosity; spirituality; psychiatric staff; spiritual needs; salutogenesis; coping

1. Introduction

Anger, sadness, pressure, anxiety or depressive mood changes are typical factors determining the daily exposition to psychological stress. In such encumbered situations, religious persons turn to religion including prayers and worship in the hope to cope with their difficult situation. Positive correlation of religiosity/spirituality does find acceptance as support or potential resource with not directly affected groups. In the context of psychiatry and psychotherapy, however, this correlation is traditionally met with skepticism, as a variety of psychological disorders is connected with peculiar or exaggerated religious experiences such as hallucination or depressive sense of guilt. According to D. Wyss, it is doubtable, if there is any 'Neurosis' or 'Psychosis', in which no religious content can be observed in a distorted form [1,2].

Since the late 1980s, there has been a noteworthy increase in empirical studies dedicated to "religiosity/spirituality and health". Since then, the number of related empirical studies has continued to grow significantly. In English speaking countries, the field of research for the topic "religiosity/spirituality and health" has already become an important topic [3-5]. Numerous studies, most of them undertaken in English-speaking countries, show a significant, though weak, positive correlation between religious/spiritual contents and both physical and mental health [6-10]. However, it is not strongly surveyed yet, how staff regards the religious/spiritual contents, although their attitude has an important impact on the integration of these contents [4,11-14].

2. Objectives

In the context of a growing body of international research, though not in German-speaking countries, this study is placed in a department of psychiatry and psychotherapy of a German University Hospital. The study aims to examine the staff's self-assessment regarding their own spirituality (the main predictor variable), staff's attitudes towards religiosity/spirituality of patients according to their experiences (a main criterion variable), and staff's point of view regarding the integration of religious/spiritual contents in psychiatric therapeutic methods (a main criterion variable). Moreover, this study examines the correlation between these variables.

Taking into account the relevance given to religious/spiritual aspects for health and life quality by the WHO [2,15,16], integration of religious/spiritual resources in the therapeutic process should be discussed. Based on aforementioned objectives, three main questions guided the pilot study.

(1). How does staff in psychiatry and psychotherapy assess their own spirituality?
(2). What is the attitude of staff in psychiatry and psychotherapy towards patients' religiosity/spirituality, and what is the relationship to staff's own spirituality?
(3). How does staff in psychiatry and psychotherapy regard the integration of religious/spiritual contents in therapeutic methods, and what is the relationship to staff's own spirituality?

3. Design and Methods of the Study

To answer the aforementioned main questions, this study was composed of three parts:

(1) The spirituality of staff. The concept of spirituality has been increasingly used and is usually understood as the inner attitude towards life related to the transcendent. There is a host of different attempts to operationalize spirituality and religiosity [3,17], without arriving at satisfactory solutions yet. In this study, for pragmatic reasons, spirituality, as an increasingly popular term, is assumed to be intrinsic religiosity according to Allport and Ross [17]. According to them, extrinsic religiosity is a tool to fulfill a wish like security, sociability, or self-justification. In this sense, people "use" their religions, whereas intrinsic religiosity is inner motivated and internalized, so that people "live" their religions and try to live according to the beliefs and prescriptions of their religions. Accordingly, spirituality in this study is measured with DRI (*Duke Religion Index*) [18], which is a strongly accepted instrument to measure religiosity (both extrinsic and intrinsic religiosity) [18-20], especially for high reliability and validity though we would concede and state a lack of sophisticated differentiations. The DRI consists of five items; three of them measure the intrinsic religiosity through an ordinal scale (5-Likert Scale). In this pilot study, the reliability (internal consistence) of the three questions about spirituality was Cronbach's $\alpha = 0.819$.

(2) Staff's attitudes towards religiosity/spirituality of patients; and

(3) the integration of religious and spiritual contents into the therapies;

both (2) and (3) were measured using the questionnaire of Curlin *et al.*. He and his research team constructed these questionnaires based on several pilot studies; they were tested via multiple iterations of expert panel review [11]. The questions regarding attitudes towards religiosity/spirituality of patients were categorized into *positive* and *negative influence*, and the questions regarding staff's point of view in relation to the integration into therapy were divided into *attitudes* and *behaviors.*

These main instruments were translated into German and improved through comments by a team of professionals. Additionally several master students answered the translated version prior to this pilot study. An anonymous survey was distributed to the staff in the department of psychiatry and psychotherapy of the Freiburg University Hospital from December 2008 to January 2009. Staff in this study was medical, psychotherapeutic, and nursing staff working directly with patients.

The study was analyzed using SPSS 15.0 for Windows. UNIANOVA was used for the differentiation of various groups according to the spirituality (gender, occupation and religion). The correlation between variables was analyzed through the (one tailed) Spearman-Rho-correlation test.

4. Results [1]

The response rate was 44.16% (87 of 197), of which 86 questionnaires could be analyzed. One questionnaire was returned almost empty and therefore not included in the analysis.

The average age of the staff was 41.5 years (range 24–58 years). Among the staff 56.8% were women and 43.2% men. Nursing staff was 44.7%, 21.2% doctors, 12.9% psychotherapists, and 21.2% from other professional groups, for example music therapists, social workers or physiotherapists. The

[1] The discrepancy $N < 86$ is possible, as missing values are not listed in the table.

average work experience was 16.4 years for staff of the psychiatric and psychotherapeutic field. Protestant were 34.9% of staff and 32.5% were Catholic. 26.5% said that they have no confession.

(1). How does staff in psychiatry and psychotherapy assess their own spirituality?

The spirituality of staff is 6.91 (SD = 3.02) on a scale of 12.0 (the highest possible score[2]). The answers of each question are described in the following Table 1.

Table 1. Staff's intrinsic religiosity[3] (*N* = 86).

Category Intrinsic religiosity	**Answers (%)**				
	Definitely true of me	Tends to be true	Unsure	Tends not to be true	Definitely not true
Experience	16 (18.6)	24 (27.9)	11 (12.8)	20 (23.3)	15 (17.4)
Philosophy	15 (17.4)	30 (34.9)	2 (2.3)	20 (23.3)	19 (22.1)
Practice	12 (14.0)	30 (34.9)	3 (3.5)	19 (22.1)	20 (25.6)

There was no significant difference of spirituality between occupations or between religions by UNIANOVA (Table 2). However, a significant difference between men and women was shown (p = 0.022). The spirituality was on average 7.56 by women and 6.00 by men.

Table 2. The extent of intrinsic religiosity**.**

	Category	***N***	**Mean**	**SD**	***p***
Total	Total	86	6.91	3.02	-
Occupation	Doctors	18	6.50	2.43	0.372[4]
	Psychotherapists	11	6.36	3.26	
	Nursing staff	38	6.71	3.06	
	Other professional groups	18	8.00	3.34	
Gender	Women	46	7.56	3.00	**0.022**[5]
	Men	35	6.00	2.93	
Religion	No confession	22	5.77	2.84	0.212[6]
	Catholic	27	7.44	3.16	
	Protestant	29	7.06	2.92	
	Other confessional groups	5	7.80	2.77	

(2). What is the attitude of the staff in psychiatry and psychotherapy towards patients' religiosity/spirituality?

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2 In the analysis of spirituality (intrinsic religiosity in DRI), the translated answer *„unsure"* was removed, to ensure that ordinal scale could remain after a German translation. Therefore the highest possible score in the German version is 12,0, not 15,0 as in the original version DRI.

3 For better readability, the questions are categorized in the table. Questions: 1) *Experience:* In my life, I experience the presence of the divine (*i.e.*, God). 2) *Philosophy:* My religious beliefs are what really lie behind my whole approach to life. 3) *Practice:* I try hard to carry my religion over into all other dealings in life.

4 N = 85, F = 1,058, df = 3, p = 0.372, η^2 = 0.038

5 N = 81, F = 5,501, df = 1, p = 0.022, η^2 = 0.065

6 N = 83, F = 1,533, df = 3, p = 0.212, η^2 = 0.055

For the psychiatric staff religious/spiritual issues are generally prevalent. 76.5% answered that their patients mention religious/spiritual issues such as God, meditation or prayer (Table 3). Only 6.3% responded that religiosity/spirituality has negative influence on health, and 5.1% concluded that religiosity/spirituality has no influence. The majority of staff stated that religiosity/spirituality helps patients to cope with illness and suffering (90.3%) or gives a positive state of mind (89.1%). Following comments were taken from the free text input section; *"It [religiosity/spirituality] is important for certain patients"*, *"Initiative from patients would be supported"* or *"I am sure, that it could be good for religious patients, if one prayed with them, when it is their wish."*

Table 3. Staff's attitude towards patients' religiosity/spirituality (*N* = 86).

Factor	Categories	Answers	Frequency (%)
Inquire[7]	-	Rarely or never	20 (23.5)
		Sometimes	60 (70.6)
		Often or always	5 (5.9)
Positive influence	health[8]	Positive	29 (36.7)
		Negative	5 (6.3)
		Equal	40 (50.6)
		Has no influence	4 (5.1)
	coping[9]	Rarely or never	8 (9.8)
		Sometimes	60 (73.2)
		Often or always	14 (17.1)
	help[10]	Rarely or never	9 (10.8)
		Sometimes	67 (80.7)
		Often or always	7 (8.4)
	support[11]	Rarely or never	32 (39.0)
		Sometimes	47 (57.3)
		Often or always	3 (3.7)
Negative influence	Increasing[12]	Rarely or never	24 (29.3)
		Sometimes	56 (68.3)
		Often or always	2 (2.4)
	Refusing[13]	Rarely or never	55 (67.9)
		Sometimes	26 (32.1)
		Often or always	0 (0.0)
	Avoiding[14]	Rarely or never	53 (65.4)
		Sometimes	28 (34.6)
		Often or always	0 (0.0)

[7] Question: How often have your patients mentioned religion/spirituality issues such as God, Prayer, meditation, the bible, *etc.*?

[8] Question: Is the influence of religion/spirituality on health generally positive or negative?

[9] Question: Religion/spirituality helps patients to cope with and endure illness and suffering.

[10] Question: Religion/spirituality gives patients a positive and hopeful state of mind.

[11] Question: How often have your patients received emotional or practical support from their religious community?

[12] Question: Religion/spirituality causes guilt, anxiety or other negative emotions that lead to increased patient suffering.

[13] Question: Religion/spirituality leads patients to refuse, delay or stop medically indicated therapy.

[14] Question: How often have your patients used religion/spirituality as a reason to avoid taking responsibility for their own health?

The correlation between the extent of staff's spirituality and each item of *inquire, positive influence (except "health")* and *negative influence* was analyzed, but there was no significant correlation.

(3). How does staff in psychiatry and psychotherapy regard the integration of religious/spiritual contents in therapeutic methods?

Staff's attitudes toward religious/spiritual contents and during the therapeutic process showed certain diversity (Table 4). 80% of staff found it, in general, appropriate to inquire about a patient's religiosity/spirituality, and 76.5% already did so. When patients bring up religious/spiritual issues, 91.7% consider it generally appropriate to discuss them with their patients. However, 54.2% refused to talk about their own religious/spiritual ideas and experiences, and 96.4% of staff denied encouraging patients to engage in concrete religious activities, especially praying. Nearly 90% found it, in general, inappropriate to pray together with patients and only 3.6% have prayed with their patients.

The foremost mentioned barriers in integrating religious/spiritual practices with patients were insufficient time (22.4%) and insufficient knowledge (21.1%). Among "other reasons" (30.6%) privacy was the most frequent answer. Moreover, therapeutic neutrality is stated by doctors and psychotherapists, and assumed reservations by supervisors are stated by nursing staff as other frequently mentioned barriers. Some open comments were; *"An expert training would be good"*, *"I think, it is good, but I don't practice it"*, *"My work as doctor should be ideologically neutral"* or *"I have already often noticed [it] and it is a pity, that there are so few possibilities for religious patients in the clinic."*

The correlation between the staff's spirituality and each item of *behaviors* was analyzed (Table 5). Since items of *attitude* were based on a nominal scale, their correlation could not be analyzed. Besides the correlation with the sum of items could not be analyzed, as items have different possible answers. A significant correlation was found with the item *sharing* (r_s = 0.236, p = **0.015**). That is, the more spiritual the psychiatric staff, the more they tend to share their own religious ideas and experiences with patients.

5. Discussion

Contrary to the widespread assumption that staff of psychiatric clinics has low to no spirituality, empirical studies published in English speaking countries showed that staff is more spiritual or religious, as could generally be expected [11-14]. According to Baetz *et al.* the intrinsic religiosity of the Canadian psychiatrists had a mean of 13.9 of 15.0 (SD = 1.9) using DRI in its original version. Curlin *et al.* surveyed the American psychiatrists among whom only 22% indicated their spirituality to be low [11]. This pilot study conducted in Freiburg leaned in the same direction, indicating the psychiatric staff's opinion about their own spirituality to be *not* low.

According to our pilot study, the psychiatric staff believes that religiosity/spirituality plays an important role for patients. However, there is evidence that religious/spiritual contents are seen to be taken with care and precaution, as religious/spiritual contents could also cause psychiatric problems or aggravate already existing ones. About 70% of the surveyed people commented, that religiosity/spirituality can cause anxiety, guilt, or another negative emotion. The survey of Curlin *et al.*

showed a similar tendency (63%). Differently from the answer of psychiatrists, only 40% of the non-psychiatrist physicians agreed with this statement ($p < 0.0001$) [11].

Table 4. Staff's point of view regarding the integration of religious/spiritual contents (N = 86).

Factor	Categories	Answers	Frequency (%)
Attitude	Inquiry[15]	Usually or always appropriate	68 (80.0)
		Usually or always inappropriate	17 (20.0)
	Discussion[16]	Usually or always appropriate	77 (91.7)
		Usually or always inappropriate	7 (8.3)
	Dialogue[17]	Never	20 (23.5)
		Only when the patient asks	31 (36.5)
		Whenever the staff senses…	34 (40.0)
	Pray	Usually or always appropriate	10 (12.7)
		Usually or always inappropriate	69 (87.3)
Behaviors	Frequency[18]	Rarely or never	19 (22.4)
		Sometimes	43 (50.6)
		Often or always	23 (27.1)
	Encouraging[19]	Rarely or never	20 (23.8)
		Sometimes	44 (52.4)
		Often or always	20 (23.8)
	Sharing[20]	Rarely or never	45 (54.2)
		Sometimes	34 (41.0)
		Often or always	4 (4.8)
	Issues[21]	Rarely or never	57 (68.7)
		Sometimes	24 (28.9)
		Often or always	2 (2.4)
	Pray together	Rarely or never	81 (96.4)
		Sometimes	3 (3.6)
		Often or always	0 (0.0)
Barriers[22]	Insufficient time		19 (22.4)
	Concern about offending patients		9 (10.6)
	Insufficient knowledge		18 (21.1)
	General discomfort with discussing religious matters		3 (3.5)
	Concern that my colleagues will disapprove		12 (14.1)
	Others		26 (30.6)
	Nothing		8 (9.4)

[15] Question: In general, is it appropriate or inappropriate for a physician to inquire about a patient's religion/spirituality?

[16] Question: In general, is it appropriate or inappropriate for a physician to discuss religious/spiritual issues, when a patient brings them up?

[17] Question: When, if ever, is it appropriate to talk about his or her own religious beliefs or experiences with a patient?

[18] Question: How often do you inquire about a patient's religion/spirituality, when a patient suffers from anxiety or depression?

[19] Question: I encourage patients in their own religious / spiritual beliefs and practices, when religious / spiritual issues come up in discussions with patients.

[20] Question: I respectfully share my own religious ideas and experiences, when religious/spiritual issues come up in discussions with patients.

[21] Question: I try to change the subject in a tactful way, when religious/spiritual issues come up in discussions with patients.

[22] The subjects had multiple possibilities for their response.

Table 5. Correlation between staff's behaviors and spirituality.

	Categories	**Spirituality**	
		r_s	p
Behaviors	Frequency	0.057	0.302
	Encouraging	0.053	0.313
	Sharing	0.236	**0.015**
	Issues	-0.095	0.194
	Pray together	0.058	0.300

The integration of religious and spiritual contents into psychiatric therapeutic methods seems difficult, especially incorporating "prayer", which is the most frequently mentioned religious/spiritual practice by patients [21,22]. It rarely plays a role in therapeutic action, as this pilot study and other empirical studies have shown [11,14]. Inquiring about patients' confession or religious background, like "spiritual history", can encourage the usage of such a resource [23,24]. Elements of "Vipassana-meditation" in dialectical behavior therapy are used without greater attention to its Buddhist roots [25].

In therapeutic settings one of the important aspects seems to be professional neutrality, which could be opposed to the salutogenesis use of religious/spiritual contents in the therapeutic process. In this pilot study a notable number of the respondents mentioned that religious/spiritual contents should not be integrated in the therapeutic process because of the importance of the aforementioned professional neutrality and the protection of patient's privacy. Other private domains such as job, friends, sexuality, or hobbies, which are not normatively neutral either, are, however, incorporated "neutrally". What is the reason for this difference?

As a major reason we assume that staff shows some behavior insecurity when it comes to dealing with religious/spiritual issues though there is a certain awareness in regarding related activities and resources. Improved curricula of psychiatry and psychotherapy trainings can reduce the staff's uncertainty and insecurity and help to integrate religious/spiritual aspects in psychiatric therapeutic processes [4,13,26], including an adequate understanding of professional neutrality. Promoting interdisciplinary teamwork between professionals of clinical pastoral care and psychiatric staffs could help to improve the integration of patients' religious/spiritual needs, as can be seen in palliative care medicine [21,26,27].

In spite of the aforementioned results and discussions, this study has certain limits. First of all, the staff's spirituality was measured by DRI according to the intrinsic religiosity concept of Allport and Ross, even though spirituality and intrinsic religiosity, strictly speaking, are not the same. Thus, three items of the DRI are not completely sufficient for precisely measuring spirituality. Secondly, it is possible that the German questionnaire has minor content differences, as it is a translation of the English original. In general, one must also consider that the results of this pilot study only cover a limited geographical area, as it was undertaken only at the Freiburg University Hospital. In future studies, these limitations should be improved in order to achieve more exact results, which can be generalized to a larger public.

6. Conclusions

According to empirical studies published in English (speaking countries), therapists do not incorporate patients' religious/spiritual backgrounds into therapeutic processes [28]. This seems to be valid for German speaking countries as well [29].

It is needless to say that, in medical settings, understanding all dimensions of a person is important. It seems only natural, however, to include religious/spiritual issues, because a person as a whole can only be understood by looking at the physical, mental, social and also spiritual dimensions [2,6,15,16].

After having been successfully sensitized for multifactoral, bio-psycho-social ways of thinking in psychiatry and psychotherapy, it is now a task to achieve an equal acceptance for religious/spiritual needs. More and more empirical studies have shown a weak but positive correlation between religiosity/spirituality and mental health [6-10,21]. However, an exact explanation about such correlations and more accurate observations of religious/spiritual needs and resources are needed.

This pilot study has shown, that staff in psychiatry and psychotherapy neither regard religious/spiritual contents as a potential risk factor (any more) nor pathologically. However, religious/spiritual contents are still not proactively incorporated into therapy. Properly trained staff can acknowledge, respect, and even appreciate patients' religious/spiritual needs. The positive consideration of staff in psychiatry and psychotherapy about religious/spiritual contents, which has been shown in this pilot study, matches the viewpoint of the WHO regarding the meaning of religiosity/spirituality for therapy, coping and patients' life quality.

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