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*Article*

# How do Psychiatric Staffs Approach Religiosity/Spirituality in Clinical Practice? Differing Perceptions among Psychiatric Staff Members and Clinical Chaplains

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**Abstract:** The present study examined the perception of contemporary German psychiatric staff (*i.e.*, psychiatrists, psychotherapists and nurses) regarding their approach towards religious/spiritual issues in their clinical practice, and how clinical chaplains perceive attitudes and behaviors towards religiosity/spirituality of other psychiatric staff members. To answer these questions, two separate studies were conducted to include psychiatric staff and clinical chaplains. Curlin *et al.*'s questionnaire on *Religion and Spirituality in Medicine: Physicians' Perspectives* was the main instrument used for both studies. According to the self-assessment of psychiatric staff members, most contemporary German psychiatric staff members are prepared and open to dealing with religiosity/spirituality in therapeutic settings. To some extent, clinical chaplains agreed with this finding, but their overall perception significantly differs from the staff's own self-rating. Our results suggest that it may be helpful for psychiatric staff members and clinical chaplains to exchange their views on patients regarding religious/spiritual issues in therapeutic settings, and to reflect on how to apply such findings to clinical practice.

**Keywords:** religiosity/spirituality; psychiatric staff; chaplain; Germany; self-awareness

## 1. Introduction

When patients suffer from severe illnesses and mental crises, they frequently ask themselves why they have become a "victim" of such a difficult situation and why or whether they "deserve" it. It is not unusual for patients to ask existential questions and to reflect on and seek out the meaning of life [1,2]. Religious/spiritual people, in particular, try to find answers and deal with their hard times by turning to their belief systems and religious/spiritual practices, e.g., by reading the Bible or praying.

In the field of mental health, there are ambivalent attitudes regarding whether and how religion and/or spirituality should become a standard aspect of mental health care rather than being restricted to religious pastoral care. In continuity with a strong demarcation between psychiatry/psychology and religions/religious rituals in the 19th and most of 20th century [3–5], for instance, the Austrian Federal Ministry of Health on June 17th, 2014 edited guidelines for psychotherapists to (re-)establish boundaries against esoteric, spiritual and religious practices [6]. In addition to the stipulation to refrain from religious/spiritual methods and practices in psychiatric and psychotherapeutic practice, these guidelines also point to an increased yet perhaps unprofessional interest in esoteric and religious/spiritual issues in mental health practice. The mere avoidance of religious/spiritual practice in therapeutic settings does not yet resolve the question of how to perceive and deal with these issues in mental health care. Undoubtedly, religious/spiritual issues are part of the human mind and behavior in general—that is to say an object of behavioral sciences, psychiatry included—and they also play a role, for better or for worse, in the mental conditions of psychiatric patients.

In fact, there is a growing body of research and publications exploring the actual and potential role of religion and/or religiosity/spirituality in psychiatry and psychotherapy [7–11]. Research has shown that psychiatric patients sometimes indicate religious/spiritual needs during therapy [12–15]. There are patients receiving psychotherapeutic treatment who express a desire for their religious and spiritual needs to be taken into consideration by psychiatric staff members and to exercise their religious/spiritual activities without encountering prejudice. In addition, several empirical studies with psychiatric patients have found significant associations between religiosity/spirituality and mental health; e.g., depression [13,16–18], eating disorder [19], post-traumatic stress disorder [20–22] or schizophrenia [23], even though such studies have used different traits, tested various groups and accordingly shown inconsistent results. For instance, the American study of Miller *et al.* showed the protective relationship between maternal religiosity and having MDD (major depressive disorder) with $p < 0.005$ [17]. In a study with German patients, however, the depression measured by BDI (Beck's Depression Inventory) was not associated with RGH (Reliance of God's Help) [24].

Further studies have shown positive effects of religious and/or spiritual behaviors on mental health [22,25–27]. For example, the study with college-aged students in Wachholz and Pargament show that a spiritual meditation group shows significantly less anxiety in comparison to relaxation or secular group meditation (respectively, $p < 0.01$ and 0.05) [25]. Also, PPANS (positive mood; the Positive Affect Scale), but not NPANS (negative mood), showed a significant difference ($p < 0.01$). Plante (2008) was the first to distinguish between the intrinsic and extrinsic benefits of religious/spiritual behaviors: "Intrinsic benefits are benefits for the self helping to make someone a better and more well adjusted person [...] Extrinsic benefits involve advantages that are external to the self that benefit the person within community" [28]. In clinical settings, even in the era of secularized societies, various

religious/spiritual tools based on religious/spiritual principles are frequently used, not necessarily in connection with any particular religion. Well-known therapeutic approaches are 12-step programs or diverse mindfulness-based meditations, such as the MBSR (The Mindfulness-Based Stress Reduction) or MBCT (Mindfulness-Based Cognitive Therapy).

Taking these elements into account, it is of increasing interest to assess how mental health care providers actually deal with religious/spiritual topics in their clinical practice. How do they approach their patients' religious/spiritual issues? According to empirical evidence, contemporary mental health specialists actually quite often encounter religious/spiritual aspects in clinical settings. Apart from pathological symptoms in the disguise of religious phenomena, they often observe positive effects from religiosity/spirituality in mental health care [29–32]. Generally, mental health specialists perceive themselves as being aware of their clients' religious/spiritual concerns. Yet, dealing with religious/spiritual matters in their clinical practice is not typically part of psychiatric staffs' "standard" repertoire, and they do not consider such issues to be their main responsibility [32–35]. For example, El-Nimr *et al.* surveyed psychiatric staffs in the UK [35] and found that (only) one quarter of psychiatrists and less than 20% of psychiatric nurses believed that psychiatrists should assess and provide spiritual care. Furthermore, over half of both groups thought that mental health professionals are not the appropriate professional group to deal with such issues. In a study by Huguelet *et al.*, only 36% of Swiss psychiatric staffs had ever discussed religious/spiritual topics with their patients [34].

While the presence of religious/spiritual factors in therapeutic settings requires further research and development, the international interest in religiosity/spirituality in mental health care, including its adequate integration into clinical practice, is increasing. In most German clinics, chaplains (or pastoral care providers) from different religious denominations are available to meet the explicit religious needs of patients (including rituals). The mutual perceptions, interactions and relationships between psychiatric staff and chaplains appear relevant, both for therapeutic processes (progress or regressions) as well as the spiritual "well-being" of patients. However, there are fewer studies dedicated to psychiatric staff, particularly in German-speaking countries, in comparison to the U.S. or other English-speaking countries. In addition, there are hardly any studies focusing on both of these mental health "specialists" [32,36], and, to our knowledge, no study that investigates the level of correspondence between the self-perception of psychiatric staff and the "outside" perception of clinical chaplains.

Therefore, within the scope of a larger research project, we aimed at surveying both psychiatric and psychotherapeutic staff members as well as clinical chaplains in the psychiatry department with regard to religiosity/spirituality in clinical practice. In particular, we addressed the following topics: How do contemporary German psychiatric staffs deal with religiosity/spirituality during therapy? How do clinical chaplains perceive the way other psychiatric staff members deal with religious/spiritual issues? Which similarities and differences exist in these perceptions?

## 2. Materials and Method

### *2.1. Respondents*

To answer the aforementioned questions, we conducted two main studies. One study focused on psychiatric staff, and the other was directed towards clinical chaplains. All participants in these anonymously conducted studies were informed about the purpose of the study (to survey their various experiences with religious/spiritual issues in treatment processes in psychiatry and psychotherapy wards). They were also assured of confidentiality and their right to withdraw at any time.

#### 2.1.1. Study with Psychiatric Staff

From October 2010 to February 2011, an anonymous survey was conducted in German university hospitals and faith-based clinics in 16 cities to explore the viewpoints of psychiatric staff in regard to religiosity/spirituality. In this study, we defined psychiatric staff as medical, (psycho-) therapeutic, nursing and also other team members (e.g., social worker, secretary) directly working with patients. A total of 32 German university hospitals and 21 faith-based clinics had been asked to take part in our study. Ultimately 21 clinics participated. The medical director of each psychiatric department distributed a paper-based questionnaire to relevant employees. A total of 404 questionnaires were returned (response rate = 24.43%; $n$ = 1654): The response rate of 11 participating university hospitals was 29.54% ($n$ = 205 of 694) and that of 10 participating faith-based clinics was 20.73% ($n$ = 199 of 960). The detailed information as well as part of results have been published in several papers [29,30,37].

For the purpose of our analysis, we focused on three occupational groups: psychiatrists, psychotherapists and nurses. A total of 330 questionnaires were filled out by these groups. An isolated response rate could not be calculated for this group, as the total number of participants from each clinic could only be obtained at the beginning of the survey. There were 312 questionnaires used for the final analysis and 18 questionnaires were not included due to incomplete responses.

#### 2.1.2. Study with Clinical Chaplains

For a comparative analysis, we conducted an anonymous survey among clinical chaplains working in psychiatry and psychotherapy departments. Among other goals, this study aimed to find out how chaplains perceive the attitudes as well as the behaviors of other psychiatric staff members towards religiosity/spirituality. First, we conducted a pilot study from November 2012 to February 2013. In the context of this pilot study, we began by locating all Catholic psychiatric chaplains in Baden-Württemberg (federal state in southern Germany). Subsequently, paper-based questionnaires were sent to these Catholic chaplains as well as their Protestant or other confessional colleagues working in the same clinics. The response rate was 59.38% (38 of 64 questionnaires).

From March 2014 to June 2014, a nationwide study was consequently conducted among all clinical chaplains who were at the time mainly working in the field of psychiatry and psychotherapy. Again, we began by first locating all Catholic psychiatric chaplains of German dioceses (beyond

Baden-Württemberg): participation was requested of 23 German dioceses[1] and ultimately 15 dioceses participated in the survey. Each diocese provided a list of all enrolled Catholic chaplains via a dedicated contact person. Then, paper-based surveys were sent to them as well as the Protestant and other confessional chaplains working in the same hospitals. Contact information of Protestant and other confessional chaplains was either provided via reference of Catholic colleagues or researched on the relevant clinic's website. The response rate was 47.39% (100 of 211 questionnaires); the response rate of Catholic chaplains was 75.28% (67 of 89 questionnaires) and that of Protestant and other confessional chaplains was 27.05% (33 of 122 questionnaires).

Finally, the data collected from both studies were analyzed. Of the 275 distributed questionnaires, 138 were returned (response rate = 50.18%). Due to incomplete responses, the final sample included 124 questionnaires.

### *2.2. Measures*

The main instrument used for the survey was the questionnaire from Curlin *et al.*, *Religion and Spirituality in Medicine: Physicians' Perspectives* [38]. F. Curlin and his colleagues primarily developed this instrument to measure the religious/spiritual characteristics of medical doctors, their observation/interpretation of the influence of religion and/or spirituality on patients' health, and also their attitudes/self-reported behaviors towards religion and/or spirituality in therapeutic settings. The questionnaire was developed using literature reviews and qualitative pilot studies, and tested through multiple iterations of expert panel reviews [39] More detailed information on how they developed and tested this questionnaire has been described in several papers [31,38,39].

To meet the requirements for a study in German-speaking territories, Curlin's questionnaire was translated into German (for the first time) and was slightly modified to suit the German language. This translation was then revised by a team of professionals. In 2009, a first pilot study was conducted in the department of psychiatry and psychotherapy of the University Medical Center Freiburg in Germany from December 2008 to January 2009 [40]. Based on respondents' comments, response options were modified to a 5-point ordinal scale and all questionnaire items were redesigned into statements. According to each category, all items were tested by principle component analysis as well as reliability (internal consistency) [29]. In addition, because the German term "religion" is generally limited to formal religious affiliation, we decided to use the expression "religiosity/spirituality" rather than the original terminology "religion/spirituality" in order to encompass all related subjective religious/spiritual issues. For the large part of the questionnaires, the format used in both studies was identical. In the study with the psychiatric staff, however, the meaning of the translated answer "unsure" was unclear for several respondents. According to these participants, the translated term conveyed an ambiguous meaning, such as "I have no idea" or "I am not sure", thereby leading to some confusion The number of respondents finding this term difficult was not negligible. After discussion with a team of professionals we decided that the translated answer "unsure" had to be removed from the mean analysis to ensure the accuracy of the ordinal scale. In the questionnaire of chaplains, this

[1] There are 27 dioceses in Germany. Among them, two already participated in our pilot study. Another two dioceses do not have pastoral care especially dedicated psychiatry and psychotherapy.

response option was presented separately. The remaining response options provided a 4-point ordinal scale.

In line with the aim of our analysis, we concentrated only on items concerning attitudes/ self-reported behaviors towards religiosity/spirituality in therapeutic settings. Fully described items are listed in Tables accessed in the result part.

### *2.3. Statistical Analysis*

A total of 436 questionnaires were included in the final statistical analysis. All data were analyzed with SPSS 20.0 for Windows. To test the difference between groups and variables, cross-tabulation as well as Pearson's chi-squared-test, Levene's test, *t*-test, univariate analyses of variance (UNIANOVA), in addition to Scheffé's *post hoc* test and Spearman's rank correlation were used. Significance level was set at $p < 0.05$.

All questions were set on and analyzed as a 4-point ordinal scale (from 1-definitely not true to 4-definitely true of me). The response option "unsure" was tested separately to see if there were any significant differences according to demographic characteristics.

## 3. Results

### *3.1. Characteristics of Survey Respondents*

On average, respondents were 43.15 years old (Table 1). Among the respondents, 54.4% were women. More than three-fourths of participants had a religious affiliation. Among chaplains, 65.3% were Catholic and 34.7% were Protestant (data not shown). Among psychiatric professionals, 67.6% indicated a religious affiliation[2]: 44.9% of them were Protestant and 41% were Catholic. In addition, among the psychiatric staff, 50.3% worked in university clinics and 49.7% in faith-based clinics (data not shown). The largest group of participants were nurses (33.9%) and clinical chaplains (28.4%). On average, respondents had 10.05 years of work experience in the fields of psychiatry and psychotherapy. The detailed results are described in Table 1.

**Table 1.** Characteristics of survey respondents.

| Variable | | Values (%) |
|---|---|---|
| Absolute Number | | 436 |
| Age (years) | | 43.15 (±11.64 [a]) |
| Sex | Female | 237 (54.4) |
| | Male | 199 (45.6) |
| Religious affiliation | Have a religious affiliation | 335 (76.8) |
| | No religious affiliation [b] | 101 (23.2) |

[2] This percentage is somewhat less than in the wider German population. According to "Religionsmonitor 2008", 26% of the German population has no religious affiliation [41]. The research of the EKD (*Protestant Church in Germany*) conducted in 2010 also showed that approximately 76% have a religious affiliation [42].

**Table 1.** *Cont.*

| Variable | | Values (%) |
|---|---|---|
| Occupation | Doctor | 118 (27.1) |
| | Psychotherapist | 46 (10.6) |
| | Nurse | 148 (33.9) |
| | Chaplain | 124 (28.4) |
| Work experience in occupation (years) | | 15.94 (±10.95) |
| Work experience in psychiatry (years) | | 10.05 (±8.18) |

[a] All numeric results were rounded up to the nearest hundredth; [b] Atheist, agnostic, and none.

In addition, we examined demographic differences between the respondents, particularly in terms of their occupation. A significant difference was found between different occupations (Table 2). Via Scheffé's *post hoc* test, we found that clinical chaplains differed significantly from other professions with regard to age and professional work experience. With regard to religious affiliation, as could be expected, there was also a significant difference between chaplains and psychiatric staff, while among other psychiatric staff (*i.e.*, excepting chaplains) there was no significant difference. In psychiatric fields, nurses had the longest experience, significantly different from psychiatrists and psychotherapists (respectively $p < 0.01$).

**Table 2.** Demographic differences between professional groups.

| | | **Psychiatrist (*N* = 118)** | **Psychotherapist (*N* = 46)** | **Nurse (*N* = 148)** | **Chaplain (*N* = 124)** | ***P*** |
|---|---|---|---|---|---|---|
| Age (years) | | 38.78 (± 7.96) | 35.50 (± 8.90) | 39.78 (± 11.41) | 54.16 (± 7.61) | <0.001 [a] |
| Sex (%) | Women | 45.8 | 73.9 | 70.9 | 35.5 | <0.001 [b] |
| | Men | 54.2 | 26.1 | 29.1 | 64.5 | |
| Religious affiliation (%) | No... | 28.8 | 34.8 | 34.5 | 0.0 | <0.001 [b] |
| | Have... | 71.2 | 65.2 | 65.5 | 100.0 | |
| Work experience in occupation (years) | | 10.56 (±8.01) | 9.12 (±8.62) | 17.75 (±11.79) | 21.42 (±9.52) | <0.001 [a] |
| Work experience in psychiatry (years) | | 8.24 (±7.55) | 7.10 (±7.07) | 12.39 (±8.79) | 10.08 (±7.66) | <0.001 [a] |

[a] Results of UNIANOVA; each eta squared size is $\eta^2 = 0.368$ (age); $\eta^2 = 0.187$ (work experience) and $\eta^2 = 0.055$ (work in psychiatry); [b] Results of Pearson; s square test.

### *3.2. Psychiatric Staff's Attitudes and Self-Reported Behaviors Regarding Religiosity/Spirituality in Clinical Settings*

#### 3.2.1. Attitudes towards Religiosity/Spirituality

Among the psychiatric staff, almost 80% of respondents found it appropriate to ask patients about religion and/or spirituality, and nearly 90% found the discussion of religious/spiritual issues appropriate when patients address such topics. At the same time, it was considered inappropriate by 72.8% that staff members share or talk about their own religious/spiritual backgrounds. Concerning

prayer with patients, more than 55% of respondents considered it absolutely unsuitable. Detailed information is provided in Table 3.

**Table 3.** Psychiatric staff's attitudes and self-rated behaviors regarding religiosity/spirituality.

| Questionnaire Items | Values (%) [a] | | | | |
|---|---|---|---|---|---|
| | **Definitely True of Me** | **Tends to Be True** | **Tends Not to Be True** | **Definitely Not True** | **Unsure** |
| Attitudes | | | | | |
| In general, it is appropriate for *psychiatric staff* to inquire about a patient's religion and/or spirituality. | 116 (37.2) | 130 (41.7) | 35 (11.2) | 14 (4.5) | 17 (5.4) |
| In general, it is appropriate for *psychiatric staff* to discuss religious/spiritual issues, when a patient brings them up. | 159 (51.0) | 121 (38.8) | 17 (5.4) | 4 (1.3) | 11 (3.5) |
| In general, it is appropriate for *psychiatric staff* to talk about his or her own religious beliefs or experiences with a patient. | 8 (2.6) | 60 (19.2) | 112 (35.9) | 115 (36.9) | 17 (5.4) |
| In general, it is appropriate for *psychiatric staff* to pray with a patient together. | 9 (2.9) | 27 (8.7) | 74 (23.7) | 175 (56.1) | 27 (8.7) |
| Behaviors [b] | | | | | |
| *I* listen carefully and empathetically. | 229 (73.4) | 74 (23.7) | 5 (1.6) | 0 (0.0) | 4 (1.3) |
| *I* try to change the subject in a tactful way. | 11 (3.5) | 44 (14.1) | 143 (45.8) | 93 (29.8) | 21 (6.7) |
| *I* encourage patients in their own religious/spiritual beliefs and practices. | 72 (23.1) | 152 (48.7) | 36 (11.5) | 11 (3.5) | 41 (13.1) |
| *I* respectfully share *my* own religious ideas and experiences. | 13 (4.2) | 42 (13.5) | 106 (34.0) | 139 (44.6) | 12 (3.8) |
| *I* pray with the patient. | 9 (2.9) | 17 (5.4) | 49 (15.7) | 229 (73.4) | 8 (2.6) |
| *I* refer patients to chaplains. | 100 (32.1) | 160 (51.3) | 25 (8.0) | 9 (2.9) | 18 (5.8) |
| It's not *my* responsibility. | 19 (6.1) | 36 (11.5) | 87 (27.9) | 150 (48.1) | 20 (6.4) |

[a] N = 312 (psychiatrists, psychotherapists and nurses); [b] Preceded by "when religious/spiritual issues come up in discussions with patients."

In the comparative analysis according to profession, particularly the nursing and medical staff showed a significant difference regarding the question of whether it is appropriate for staff members to share their own religious beliefs or related experiences (via the *post hoc* test; the highest possible score with 4.00,[3] *m* of nurses = 2.03 ± 0.90 *vs.* *m* of psychiatrists = 1.71 ± 0.73; $p = 0.009$). With regard to prayer with patients, the *post hoc* test again showed a significant difference between nurses and psychiatrists ($p < 0.001$) as well as psychotherapists ($p = 0.001$). The mean of each item as well as each occupational group is reported in Table 4.

[3] In the mean analysis, the answer "unsure" was removed to ensure the nature of an ordinal scale in our German version. We tested for significant differences in regard to demographic characteristics (age, sex, occupation, religious affiliation, work experience and work in psychiatry) and the response "unsure". Only one significant difference was found: Younger participants tended to reply with "unsure" when asked whether it is generally appropriate to discuss religious/spiritual issues with patients ($p = 0.013$).

**Table 4.** Psychiatric staff's self-reported attitudes and behaviors regarding religiosity/spirituality.

| Questionnaire Items [a] | Psychiatrist | Psychotherapist | Nurse |
|---|---|---|---|
| Attitudes | | | |
| In general, it is appropriate for *psychiatric staff* to inquire about a patient's religion and/or spirituality. | 3.17 ± 0.80 | 3.38 ± 0.65 | 3.12 ± 0.88 |
| In general, it is appropriate for *psychiatric staff* to discuss religious/spiritual issues, when a patient brings them up. | 3.45 ± 0.61 | 3.69 ± 0.47 | 3.37 ± 0.74 |
| In general, it is appropriate for *psychiatric staff* to talk about his or her own religious beliefs or experiences with a patient. | 1.71 ± 0.73 | 1.77 ± 0.75 | 2.03 ± 0.90 |
| In general, it is appropriate for *psychiatric staff* to pray with a patient together. | 1.27 ± 0.49 | 1.32 ± 0.57 | 1.84 ± 0.94 |
| Behaviors [b] | | | |
| *I* listen carefully and empathetically. | 3.75 ± 0.45 | 3.83 ± 0.38 | 3.68 ± 0.53 |
| *I* try to change the subject in a tactful way. | 1.84 ± 0.78 | 1.64 ± 0.61 | 2.05 ± 0.81 |
| *I* encourage patients in their own religious/spiritual beliefs and practices. | 3.18 ± 0.65 | 3.19 ± 0.74 | 2.91 ± 0.80 |
| *I* respectfully share *my* own religious ideas and experiences. | 1.59 ± 0.72 | 1.53 ± 0.66 | 1.99 ± 0.95 |
| *I* pray with the patient. | 1.13 ± 0.36 | 1.09 ± 0.29 | 1.64 ± 0.92 |
| *I* refer patients to chaplains. | 2.94 ± 0.72 | 2.90 ± 0.77 | 3.47 ± 0.58 |
| It's not *my* responsibility. | 1.76 ± 0.83 | 1.53 ± 0.74 | 1.79 ± 1.01 |

[a] Response categories are: 1 = definitely not true, 2 = tends not to be true, 3 = tends to be true, 4 = definitely true of me; [b] Preceded by "when religious/spiritual issues come up in discussions with patients".

### 3.2.2. Self-Reported Behaviors Regarding Religiosity/Spirituality

Nearly all respondents (97.1%) indicated that they listen carefully and empathetically to patients' religious/spiritual concerns, when these issues come up in the conversation (Table 3). This response corresponds strongly with professionally desired behavior. About 75% reported to not shy away from such topics. Furthermore, nearly 72% indicated that they encourage their patients to practice their religious/spiritual activities. A percentage of 83.4% of psychiatric staff members recommend patients to clinical chaplains. Approximately 79% of respondents, however, preferred not to share their own religious/spiritual backgrounds. About 90% did not find it appropriate to engage in prayer with patients (73.4% found it absolutely inappropriate).

Among the staff, nurses were most inclined to change the subject when patients addressed religious/spiritual topics (Table 4). Especially in comparison to psychotherapists, the nursing staff showed a significant difference (of the highest possible score 4.00[4], *m* of nurses = 2.05 ± 0.81 *vs.* *m* of

[4] Again, the answer "unsure" was not included in the analysis of the mean. According to sex, occupation, religious affiliation and work experience in psychiatry, no significant difference was found. According to age, some significant differences were found: younger participants tended to be unsure whether they listen carefully, change religious/spiritual themes, encourage their patients to practice patients' religiosity/spirituality or share staff's own religious/spiritual backgrounds (respectively $p < 0.05$). Furthermore, participants with less work experience in their

psychotherapists = 1.64 ± 0.61; $p = 0.01$). Again, the nursing staff was the most reluctant to encourage religious/spiritual practical activities. Particularly compared to psychiatrists, their mean differed significantly (*m* of nurses: 2.91 ± 0.80 *vs. m* of psychiatrists: 3.18 ± 0.65; $p = 0.019$). However, nurses were the most willing to suggest patients visit chaplains and the least reluctant to share their own religious beliefs or pray with patients, when compared to other groups (at least $p < 0.01$).

As an additional question, we asked psychiatric staff members about their experience with chaplains in clinical settings (data not shown). Of 312 participants, 83.3% reported having encountered chaplains in clinics, and the remaining 16.7% did not have any experience with them. In addition, having an experience with chaplains was significantly dependent on the occupation. More than 90% of the nursing staff and about 85% of psychiatrists reported having experience with chaplains. In contrast, only 52.2% of psychotherapists had ever come across chaplains in their clinical experience ($p < 0.001$).

### *3.3. Clinical Chaplains' Assessment of Other Staff's Attitudes as Well as Their Behaviors Regarding Religiosity/Spirituality in Clinical Setting*

#### 3.3.1. Attitudes towards Religiosity/Spirituality

Clinical chaplains perceived that psychiatric staff members *occasionally* regard it as appropriate to inquire or discuss religion and/or related topics. Each reply of occupational groups was slightly in the middle between *tends to be true* and *tends not to be true*, as mean scores were shown around 2.5 of 4.00. In comparison to psychiatric staff's self-assessment regarding these two questions (*i.e.*, inquiry and discussion), the perception of chaplains was significantly less positive (respectively $p < 0.001$; *cf.* Table 4). Particularly psychiatrists and psychotherapists indicated a strong tendency to discuss religious/spiritual issues with patients when patients address such topics. In contrast, chaplains rated the attitudes of psychiatrists and psychotherapists rather moderately. Based on subgroups of chaplains (age, sex, work experience in occupational field, work in psychiatry), chaplains' assessments of psychiatric staff's attitudes were not significantly different.

Concerning issues about sharing one's own religious/spiritual backgrounds and praying with patients, clinical chaplains assessed the attitudes of nurses most positively. In general, clinical chaplains' observation was not significantly different from other psychiatric staff's self-rated assessment. Only one significant difference was found: Clinical chaplains perceived nursing staff to have a more positive attitude towards sharing religious/spiritual background than the nurses themselves indicated (2.26 *vs.* 2.03; $p = 0.023$).

#### 3.3.2. Behaviors Regarding Religiosity/Spirituality

According to chaplains, psychiatric personnel tend to listen carefully and empathetically when religious/spiritual themes are brought up, but not to a strong extent (Table 5). Chaplains reported that psychiatric staff members *occasionally* encourage their patients to practice religious/spiritual activities

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occupational field seemed to be unsure whether they encourage their patients to practice religious/spiritual activities or share staff's own religiosity/spirituality (respectively $p < 0.05$).

and usually refer patients to visit chaplains. By and large, clinical chaplains found that the nursing staff of a clinic has the most positive behavior towards patients' religiosity/spirituality.

**Table 5.** Chaplains' assessment of other psychiatric staff's attitudes and self-reported behaviors regarding religiosity/spirituality in clinical settings.

| Questionnaire Items [a] | Psychiatrist [b] | Psychotherapist [b] | Nurse [b] |
|---|---|---|---|
| Attitudes | | | |
| In general, it is appropriate for *psychiatric staff* to inquire about a patient's religion and/or spirituality. | 2.44 ± 0.66 *** | 2.52 ± 0.69 *** | 2.69 ± 0.70 *** |
| In general, it is appropriate for *psychiatric staff* to discuss religious/spiritual issues, when a patient brings them up. | 2.59 ± 0.77 *** | 2.67 ± 0.71 *** | 2.84 ± 0.68 *** |
| In general, it is appropriate for *psychiatric staff* to talk about his or her own religious beliefs or experiences with a patient. | 1.81 ± 0.73 | 1.80 ± 0.71 | 2.26 ± 0.71 * |
| In general, it is appropriate for *psychiatric staff* to pray with a patient together. | 1.37 ± 0.70 | 1.28 ± 0.56 | 1.84 ± 0.81 |
| Behaviors [c] | | | |
| *I* listen carefully and empathetically. | 2.73 ± 0.62 *** | 2.85 ± 0.49 *** | 2.99 ± 0.47 *** |
| *I* try to change the subject in a tactful way. | 2.47 ± 0.77 *** | 2.45 ± 0.72 *** | 2.26 ± 0.59 * |
| *I* encourage patients in their own religious/spiritual beliefs and practices. | 2.58 ± 0.74 *** | 2.57 ± 0.70 *** | 2.82 ± 0.60 |
| *I* respectfully share *my* own religious ideas and experiences. | 1.77 ± 0.69 | 1.73 ± 0.66 | 2.34 ± 0.68 ** |
| *I* pray with the patient. | 1.29 ± 0.53 * | 1.25 ± 0.46 * | 1.86 ± 0.83 * |
| *I* refer patients to chaplains. | 3.32 ± 0.61 *** | 3.16 ± 0.64 * | 3.48 ± 0.55 |
| It's not *my* responsibility. | 2.98 ± 0.94 *** | 2.94 ± 0.89 *** | 2.68 ± 0.83 *** |

[a] Response categories are: 1 = definitely not true, 2 = tends not to be true, 3 = tends to be true, 4 = definitely true of me; [b] In comparison to psychiatric staff's self-assessment (described in Table 4): * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; [c] Preceded by "when religious/spiritual issues come up in discussions with patients".

By comparison, in fact, chaplains assessed other psychiatric staff member's behavior significantly less positively than the staff itself. For example, the psychiatric staff strongly agreed that they listen carefully and empathetically when patients address religious/spiritual issues (around 3.80 of 4.00). In contrast, clinical chaplains are more skeptical in this regard (the lowest result for psychiatrists with $m = 2.73$; the highest scores for nurses with $m = 2.99$). In addition, chaplains perceived that all subgroups of the psychiatric staff do not generally consider their patients' religiosity/spirituality to be part of their professional responsibility. In strong contrast, however, psychiatric staff personnel do believe that they are responsible for these topics. Finally, chaplains perceive a significantly lower level of readiness on the part of psychiatrists and psychotherapists to refer patients to the chaplain. Chaplains also had a significantly more negative perception regarding the psychiatric staff's encouragement of patients in their religious/spiritual beliefs and practices. These latter differences were not present for nurses.

Regarding other psychiatric staff's behaviors, chaplains reported significantly different perceptions depending on different characteristics, e.g., how long they had worked in the field of psychiatry.[5] For instance, clinical chaplains who had more years of experience replied more frequently that psychiatrists and psychotherapists do not regard religiosity/spirituality as their responsibility ($r = 0.259$ and $r = 0.276$) and that nursing staff refers patients to them ($r = 0.200$).

## 4. Discussion

The present study examined how contemporary German psychiatric staffs (*i.e.*, psychiatrists, psychotherapists and nurses) perceive their approach to religious/spiritual issues when such topics arise in therapeutic settings. Moreover, we also investigated how clinical chaplains perceive other psychiatric staff member's attitudes and behaviors regarding religiosity/spirituality. Both perceptions are confronted with each other in this study.

Overall, psychiatric staff in our survey reported that they are considerably open to religion and/or spirituality when brought up by their patients. The majority of psychiatric staff members are ready to listen and discuss such topics with their patients. This does not differ remarkably from other studies' results [38]: in Curlin *et al.*'s study, 97% of psychiatrists considered it appropriate to discuss religious/spiritual issues when patients want. Despite such positive attitudes towards religious/spiritual issues, the personnel's self-assessment showed that they do not work proactively on religious/spiritual issues, and they engage even less in religious/spiritual activities with their patients. Respondents showed a particularly negative attitude towards prayer with patients, finding it generally inappropriate. Psychiatric staffs in other countries share this viewpoint and in part were even more strongly against it. For example, according to Curlin *et al.*, 94% of American psychiatrists rarely or never prayed with patients [38].

Interestingly, chaplains' perceptions differed significantly from the psychiatric staff's self-reports. Clinical chaplains agreed that psychiatric staff members neither reject nor ignore religious/spiritual issues when their patients want to address such topics in therapeutic settings. However, chaplains had significantly different perceptions than the psychiatric personnel themselves, especially regarding questions like whether these issues are part of the psychiatric staff's professional responsibility and how they actually care by listening carefully and empathetically. Similar skepticism is also found in their rating of the psychiatrists' and psychotherapists' readiness to refer patients to the chaplains for religious/spiritual issues. These differences suggest that there may be a need to improve both communication and cooperation between psychiatric staff and clinical chaplains. This may become especially valuable when psychiatric staff members perceive their own limited competence in this regard, or a need and obligation to remain neutral towards religious/spiritual issues in order to avoid unprofessional behavior develops.

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[5] According to subgroups (age, occupational work experience and work experience in psychiatry) there were several significant correlations ($p < 0.05$). Via Spearman's 2-sided rank correlation, the following associations were found; age with the question "psychiatrists listen carefully and empathetically ($r = 0.196$)," "psychiatrists/psychotherapists refer patients to chaplains ($r = 0.206$/$r = 0.236$)" and "psychotherapists pray with the patient ($r = -0.219$)"; or the question "nurses refer patients to chaplains" was associated with chaplains' age and work experience in psychiatry ($r = 0.234$/$r = 0.190$).

Appropriate ways to deal with religious/spiritual issues may vary from person to person. Previous findings show that there are different needs among different groups of patients and it is important to find ways to approach such topics sensitively. Although it is important that a psychiatric staff is open and willing to integrate religious/spiritual issues and practices into its clinical practice, psychiatric methods of patient care with religious/spiritual or even esoteric methods should not be replaced. According to the results of our study, psychiatric staffs do consider religious/spiritual issues or their patients' religious/spiritual needs as part of their responsibility. The question remains how they can adequately deal with these issues and needs of their patients. There are various ideas on how to adequately integrate religiosity/spirituality into therapeutic settings, such as implicit and explicit integration, or spiritual care [43–46]. A first step, as frequently emphasized, may be a religious/spiritual assessment or to take a religious/spiritual history, which usually takes 2–5 min [47]. Such an assessment can enable psychiatric staff to recognize patients' religious/spiritual resources and difficulties. However, this is not yet a common practice in psychiatric fields. Patients' religious affiliation or related information is usually entered into the file by nurses [14].

For this reason, training programs addressing religious/spiritual issues should be conducted (more) regularly and with more specific content. In Germany and Europe, only few such training programs are available [48–50]. Accordingly, many psychiatric staff members do not have the possibility of participating in such a training program [29,50]; in a national study with German psychotherapists, more than 80% of respondents had rarely or never participated in such a program. Nevertheless, 62.5% of the therapeutic practitioners indicated that they would find training programs with religious/spiritual topics to be beneficial. Furthermore, the differences in perception between psychiatric staff and clinical chaplains suggest that these professional groups should become more aware of the role of the other and find ways to learn more about the way of thinking and attitudes of the other, to discuss these issues as well as to cooperate more effectively. Training programs with both professional groups may be one possibility to promote such interdisciplinary communication and cooperation. This might facilitate innovative interdisciplinary teamwork for the benefit of the patients above all, but also for all staff in psychiatry and psychotherapy, clinical chaplains included. In our study, the majority of psychiatric staff members reported that they refer their patients to clinical chaplains when confronted with religious/spiritual matters of patients. In contrast, the majority of psychiatrists in the UK (72%) had not suggested visiting chaplains or religious/spiritual advisors [14]. Chaplains as professional specialists for religious/spiritual issues can be considered an important resource for "holistic" patient care. Interestingly, the results of our study indicated that nurses were the least reluctant group to share their own religious/spiritual belief or experiences, or even to pray with patients together. This difference could perhaps be a result of nurses' more frequent contact with patients. In addition, this difference could originate from the different roles of psychiatric staff for patients, *i.e.*, for nurses especially as caregivers. Or does this difference reveal a varying level of competence or professional training between these groups?

In professional training programs it is common practice to undergo a self-assessment as well as an assessment by fellow trainees under the supervision of experts on specific issues (e.g., sensitivity). Based on the feedback of supervisors and other trainees, clinical staff can identify how consciously they deal with certain topics and learn how to work in a professionally appropriate manner while also being aware of and monitoring for potential prejudices [30]. In this sense, self-observation as well as

self-experience concerning religious/spiritual issues should be developed and encouraged within training programs to improve psychiatric staff member's understanding of their attitudes towards religiosity/spirituality. Such measures are preconditions for competent neutrality and abstinence with regard to patients' religious/spiritual issues, whether needs, resources or problems.

In spite of our findings, this study has a number of limitations that should be considered alongside the results. First of all, minor content differences due to the translation of English into German cannot be ignored. In our translation, we accounted for different cultural and religious backgrounds between the USA and Germany and agreed on them with the author (Curlin). In the German version, the translated term of "unsure" was removed from the mean analysis, as it conveyed an ambiguous meaning. This implies some loss of information and a limitation in the analysis of the data obtained. Although Curlin's questionnaire has been used frequently, there is still a need for further formal validation of the instrument.

Secondly, some caution is necessary when generalizing these results to other populations of psychiatric and psychotherapeutic staff, even within Germany. First of all, the sample for the study among the psychiatric staff was limited to psychiatry and psychotherapy departments of university hospitals and faith-based clinics in Germany. Furthermore, the response rate among the psychiatric staff is relatively low with 24.43% of the hospitals ready to participate. In fact, the response rate for both university and faith-based clinics equally shows that only one-fourth of our targeted groups showed enough interest in religious/spiritual issues to dedicate some time to filling out the questionnaire (without other incentives) This may have skewed the results, as respondents could be a biased sample group and not representative of all German psychiatric staffs.

Similarly, the sample for the study among clinical chaplains was limited to chaplains belonging to Catholic German dioceses as well as their colleagues in other denominations. Other confessional chaplains ultimately showed a very low participation rate in comparison to Catholic chaplains. One possible explanation is that most of the Catholic chaplains were informed via their dioceses even before the survey, whereas other confessional chaplains were not. This shows a structural deficit in the sampling, and perhaps also varying levels of preparedness of both groups, and could possibly further skew the findings.

Third, additional studies are required, such as exploring the psychiatric staff's observation of how clinical chaplains deal with religious/spiritual issues. Finally, the patients themselves need to be asked how they perceive the care provided by different professional groups in regard to religiosity/spirituality. Such studies are underway and will allow for an even better picture and understanding of the opinions of all groups involved. This will help to implement and improve more interdisciplinary work in this field for the benefit of the patients. Notwithstanding the already growing range of research, further studies are needed to explore whether, which and how religiosity/spirituality and its adequate integration into therapeutic processes affects therapeutic outcomes.

## 5. Conclusions

In conclusion, this study finds that most contemporary German psychiatric staffs are open and willing to deal with religiosity/spirituality in therapeutic settings. To some extent, clinical chaplains agreed with this finding, but their assessment differed significantly from the staff's own self-rating in

some regards. In the light of these results, we suggest that psychiatric staff and clinical chaplains should be provided with more opportunities to participate in interdisciplinary teamwork on religious/spiritual issues in therapeutic settings. Moreover, both psychiatric staff and clinical chaplains must reflect on their own attitudes and on how to apply such findings in clinical practice in order to provide more personalized patient care.

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**Author Contributions**

In the research group of Baumann, Lee and Baumann designed this research, in cooperation with the dept. of psychiatry and psychotherapy of Freiburg university hospital, incl. Zahn. Mainly Lee collected data. Supervised by Baumann, Lee analyzed the data, outlined and wrote the first version of this article. Baumann and Zahn discussed and commented. All authors read and approved the final version improved by Lee and Baumann.

**Conflicts of Interest**

The authors declare no conflict of interest.

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