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Community Ment Health J (2010) 46:77–86
DOI 10.1007/s10597-009-9247-y

ORIGINAL PAPER

Religion and Spirituality: How Clinicians in Quebec and Geneva Cope with the Issue When Faced with Patients Suffering from Chronic Psychosis

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Received: 2 January 2009 / Accepted: 10 September 2009 / Published online: 22 September 2009
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Abstract Spirituality and religion have been found to be important in the lives of many people suffering from severe mental disorders, but it has been claimed that clinicians "neglect" their patients' religious issues. In Geneva, Switzerland and Trois-Rivières, Quebec, 221 outpatients and their 57 clinicians were selected for an assessment of religion and spirituality. A majority of the patients reported that religion was an important aspect of their lives. Many clinicians were unaware of their patients' religious involvement, even if they reported feeling comfortable with the issue. Both areas displayed strikingly similar results, which supports their generalization.

Keywords Religion · Psychosis · Schizophrenia · Coping · Clinicians

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Introduction

Reflecting trends in Western culture in the early twentieth century, leading psychiatrists were known for their personal rejection of religious values and for constructing pathological theories that construed religion as primitive and pathological. It was often assumed that religious attitudes were inevitably the cause of phenomena such as dependence, guilt or delusions (Neeleman and Persaud 1995). Moreover, the gap between psychiatry and religion has widened over the years, partly due to psychiatry's progress in elucidating the biological and psychological causes of mental illness, which have rendered religious explanations more and more superfluous (Payman 2000).

However, in the last 10 years, studies conducted in Canada (Baetz et al. 2002), the United States (Bellamy et al. 2007; Corrigan et al. 2003) and Europe (Tepper et al. 2001) have highlighted the crucial role of spirituality and religion in patients' daily lives and in coping with their illness, notably through its role in the recovery process. One of these studies, conducted by our research group, evaluated religion in outpatients suffering from chronic psychosis and their clinicians in Geneva, Switzerland (Mohr et al. 2006). By "religion" we mean both spirituality (concerned with the transcendent, addressing the ultimate questions about life's meaning) and religiousness (specific behavioural, social, doctrinal and denominational characteristics).This study highlighted the prevalence of religious practices and spiritual coping in this patient population and the clinical significance of religion in their care. For the majority of these patients, religion instilled hope, purpose, and meaning in their lives, whereas for a minority, it induced spiritual despair. More than half of the patients reported that religion lessened psychotic and general symptoms. Religion was reported to increase social

integration or, in a minority of cases, social isolation. Religion also seemed to play a specific role in the decisions patients had made about suicide, reducing or sometimes increasing the risk of suicide attempts (Huguelet et al. 2007). It also had an impact on addiction, reducing substance use in the majority of cases (Borras et al. 2007; Huguelet et al. 2009). It fostered treatment adherence in some patients, but hindered treatment in others, depending on how the patient's religious beliefs influenced the representation of the illness (Borras et al. 2007).

Surprisingly, despite the fact that religion was an important issue for the majority of these patients, only 36% of them had discussed this issue with their clinicians, even if the majority reported feeling comfortable with the subject (Huguelet et al. 2006). Additionally, it appeared that more than half of the clinicians underestimated or were even unaware of the importance of religion for their patients. A few patients considered religion to be incompatible with treatment, and clinicians were seldom aware of such a conflict. It also emerged from this study that these clinicians had fewer religious affiliations and were less involved in religious practices than the general population, which corresponds to the findings of other studies.

The principal conclusion of this study was that spirituality and religiousness should be considered by clinicians dealing with patients with psychosis. In this perspective, the validated clinical grid constructed to assess spirituality, religiousness and religious coping among patients with severe mental disorders could be used (see Appendix and Mohr et al. 2007). This grid allows clinicians to identify patients who would benefit from developing this dimension in various domains, i.e., at the psychological level (reconstruction of identity, improved quality of life, finding meaning in life and feeling self-fulfilled in spite of the handicap), at the social level (by developing social skills and/or integrating a religious group) and for adherence to treatment (by helping patients to harmonize beliefs and care).

The main limitation of the study was related to the fact that the data were collected in a specific context, i.e., the Geneva/Switzerland area. Geneva is a French-speaking town in Switzerland. It is an international metropolis due to the presence of international institutions and multinational corporations. Of Geneva's 410,000 inhabitants, 45% are foreigners, with 179 different nationalities and 130 religious confessions (Campiche et al. 2004). Thus, we wished to investigate a population of patients with chronic psychosis and their clinicians who lived in a different sociocultural and religious environment. The Trois-Rivières/Québec area was chosen. Trois-Rivières has a population of 136,600 inhabitants, of whom only 1.7% are foreigners. Ninety percent of the population is Catholic (Larouche and Ménard 2001).

In addition to these parameters, Geneva and Trois-Rivières differ in terms of urban development, the influence of churches on the population and the system of care. Thus, the two areas represent specific settings where patients may use religion in different ways to cope with their illness and where the religious dimension of clinician-patient relationships may vary.

The objective of this study was two-fold:

1. A replication of the Geneva study (Huguelet et al. 2006) in a different social, cultural and clinical environment. Our hypothesis was that the same patterns would be elicited, i.e., (1) religious involvement and religious coping would be more important for patients who have chronic psychotic illness and less important for clinicians than in the general population, and (2) patients' religious practices and spirituality would be underestimated and neglected by their clinicians.
2. A more extensive evaluation of spirituality, religiousness and religious coping for clinicians in the new sample located in Trois-Rivières, Québec. The hypothesis was that clinicians were less prone to use religion and spirituality as a way to cope with life's daily difficulties, as compared with patients.

Method

Samples

Patients and clinicians from Geneva were interviewed in 2004. In Trois-Rivières, the survey was conducted between October and December 2006. We wanted to include a population of outpatients with chronic psychosis and their clinicians. Patients were adults who met ICD-10 (WHO 2002) criteria for schizophrenia or other non-affective psychoses. Diagnoses were confirmed by a review of patients' charts and the administration of the MINI (Sheehan et al. 1998). Patients whose clinical condition prevented them from participating in the interviews were excluded.

In Trois-Rivières, the patients were being treated by an assertive community treatment (ACT) team. ACT provides a comprehensive range of treatments, rehabilitation services and support services through a multidisciplinary team based in the community. Most patients feature severe symptoms and impairment that produce distress and major disability in daily functioning, which traditional outpatient management models are unlikely to alleviate. Basic characteristics of this ACT program include assertive involvement, in vivo delivery of services, an integrated team approach, staff continuity and responsibility, caseloads

with high staff-to patient ratios and brief but frequent contacts. The ACT team is comprised of five first-line social workers, eight community psychiatric nurses and ten occupational therapists who can be assisted by a psychiatrist if necessary. Patients receive supportive psychotherapy, somatic treatments, and rehabilitation.

The patients' referent clinicians were provided with information about the study. One of the authors (LB), a psychiatrist, then met with all of the 126 eligible patients and the 23 clinicians. Five patients refused to participate. The study was approved by the ethical committee of the Trois-Rivières University. All participants received detailed information about the study and gave written consent.

In Geneva, the system of psychiatric care is divided into four sectors, each treating a patient population of around 110,000. These sectors include both in- and out-patient facilities. The clinic offers long-term treatment, primarily for patients with diagnoses such as schizophrenia, bipolar disorder, severe depressive disorder and personality disorder. The multidisciplinary teams are composed of a psychiatrist in first line, who can be assisted by nurses and/or social workers if necessary. Patients receive supportive psychotherapy, somatic treatments and rehabilitation as needed. One hundred and fifty patients were randomly selected from about 200 eligible patients in order to balance feasibility and generalizability. These patients, as well as their clinicians (19 psychiatrists, 11 nurses and five social workers) were interviewed.

Both populations of patients had lasting, severe mental disorders; however, in Geneva, patients were being treated in an ambulatory clinic, as they adhered to the traditional treatment proposed. First-line clinicians differed in that, in Geneva, most of them were psychiatrists whereas in Trois-Rivières, they were all paramedical therapists. In any event, the patient's referent clinician was the one who interviewed. In Trois-Rivières, since these patients often tend to refuse to meet a doctor, they see their referent clinician once to three times a week and a psychiatrist at most once every 3 months. It can also be noted that there is a shortage of psychiatrists in this region of Quebec. In Geneva, patients are in contact with their clinician (a psychiatrist or paramedical therapist) on average once a week.

Comparisons between affiliations, private and collective religious practices, and the importance of religion in patients, clinicians, and the general population were based on sociological surveys (Campiche et al. 2004; Larouche and Ménard 2001).

Measures

Socio-demographical and clinical characteristics (age at illness onset, main diagnosis, comorbidities, number and duration of hospitalizations) were recorded from the patient's medical file and from a diagnostic interview (Mini International Neuropsychiatric Interview (Sheehan et al. 1998). The Positive and Negative Syndrome Scale (Kay et al. 1992) and the Clinical Global Impression (NIMH 1978) were administered. Psychosocial adaptation was evaluated with axis V of the DSM-IV (APA 1994).

To assess religious coping in this population of patients suffering from psychosis, we used a clinical grid that we developed and tested on patients who were interviewed in Geneva. This grid has been described in detail elsewhere (Mohr et al. 2007). Elements of this assessment are detailed in the Appendix. The clinical interview explores the patients' spiritual and religious history, their beliefs, their private and group religious activities, the importance of religion in their daily lives, the importance of religion as a means of coping with their illness and its consequences, and the synergy versus incompatibility of religion with psychiatric care. Additionally, the salience of religiousness (i.e., the frequency of religious activities and the subjective importance of religion in daily life), religious coping and synergy with psychiatric care were quantified by the patient by means of a visual analogue scale.

The subjective importance of religion was also assessed, in terms of its centrality, with Huber's centrality scale (Huber 2007). Centrality is highly correlated with the religious self-concept and the everyday consequences of personal religion. The more central religion is, the more it can influence the person's experience and behavior.

Clinicians were asked about each patient's compliance, religion, religious coping with illness, and the synergy between religious practice and treatment. Clinicians were also questioned about the ease with which they discussed religion with their patients.

Clinicians in Geneva were only questioned about their own religious affiliation, their private and public religious practices and the salience of spirituality in their daily lives. In addition to these dimensions, clinicians in Trois-Rivières were also questioned about the importance of religion as a means of coping with life's daily difficulties, using the same spiritual assessment grid as for patients (Mohr et al. 2007). The centrality of religion in clinicians' lives was assessed with Huber's centrality scale as well (Huber 2007).

Statistical analysis

Data were analyzed with SPSS version 15. A principal component analysis with varimax rotation was used to reduce the various aspects of religion explored in the interview (frequency of religious practices, private or group, subjective importance of religion) to a smaller number of factors (components). Distribution-free

univariate statistics were used to compare the variable distributions between groups (chi-square, Wilcoxon rank test, Kruskal–Wallis test). Kendall's tau b rank correlations were used to assess relationships between religion and clinical variables.

Results

Sociodemographic and clinical characteristics of the patients included in the study are summarized in Table 1. Despite the fact that the two populations had similar characteristics for diagnosis, substance misuse, history of suicidal attempts and psychosocial adaptation, patients in Québec were more severely ill (i.e., they displayed more symptoms and more of them lived in halfway houses). Their characteristics are representative of those of patients treated in these ACT programs.

In Québec, five social workers, eight community psychiatric nurses and ten occupational therapists were recruited for the study, as the first-line clinicians of 35, 42, and 40 patients respectively. Gender and age distributions were equivalent across professions (35% male, average age of 45 ± 9). As in Geneva, no significant differences were found for spirituality and religious practices among clinicians by profession, age or gender. In Geneva, the psychiatrist first-line referents were younger than the Trois-Rivières clinicians (35 ± 6 years); whereas the average age of nurses and social workers in Geneva was the same as that of their counterparts in Trois-Rivières (46 ± 5 and 46 ± 11 years, respectively).

Religious characteristics

Religious practices and the spirituality of patients, clinicians and the general population in Trois-Rivières and Geneva are described in Table 2. In Trois-Rivières, the religious affiliation was similar in patients, clinicians and the general population. Most of the subjects belonged to the Catholic Church, like the general population. In contrast, in Geneva, religious affiliations were very different between patients, clinicians and the general population. Indeed, although most of the general population belonged to traditional Swiss Christian churches (Protestant or Catholic), the patients in the study were more likely to mention Pentecostal churches, non-Christian religions, minority religious movements (for example esoterism, spiritism, Christian Science, Scientology, or Ufology) or double religious affiliations (for example both Muslim and Christian, or both Buddhist and Christian). Moreover, 47% of the clinicians in Geneva claimed to be without religious affiliation, as compared to 9% in the general population and 18% in the study's patients.

In Trois-Rivières, no significant differences were found between group religious practices and the importance of spirituality in daily life for patients, their clinicians or the general population. However, the patients had significantly more individual religious activities than the clinicians and the general population.

In Geneva, more differences were found in religion between patients, clinicians and the general population. Indeed, for patients, spirituality was more important in their daily lives and they had more individual religious practices than the general population. Moreover, these measures were lower for the clinicians than the general population. Yet despite these differences, patients and clinicians had the same frequencies of group religious practices.

In Trois-Rivières, the principal components analysis used to examine the frequency of private and group religious practices and the subjective importance of spirituality yielded a solution with two factors for patients. The first explained 64% of the variance and included individual religious practices with the subjective importance of spirituality; the second explained 26% of the variance and included group religious practices. Thus group religious activities were weakly correlated with spirituality (Kendall tau b = .23) and frequency of individual religious practices (Kendall tau b = .27). For the clinicians, the principal components analysis yielded a solution with only one factor that explained 66% of the variance. Indeed, for clinicians, group and individual religious activities were correlated (Kendall tau b = .55). These results replicate the Geneva findings, where the stronger salience of spirituality among patients was not linked to increased group religious practices.

In order to deepen our understanding of the varieties of spirituality and religiousness among patients and clinicians, additional data collected only in Trois-Rivières are presented in Table 3. The clinical interview may be used in various populations to elicit the importance of religion to cope with daily difficulties, either linked to the illness (for patients) or other daily difficulties (for clinicians). For both patients and clinicians, religion was very important in providing meaning to life, in coping with life difficulties, in giving meaning to these difficulties, in gaining control or in obtaining comfort, with no statistically significant differences.

However, despite an overall score measured by the Huber centrality scale that was the same, religion was more likely to occupy a central position in patients' lives than clinicians' (28 vs. 4%). For almost all clinicians, religion was of some importance in their lives, but in a subordinate position. Examining the various subscales in detail showed that patients were more convinced of the existence of God, a supernatural power and a life after death (ideological

Table 1 Sociodemographic and clinical characteristics of 221 outpatients with chronic psychosis in a study comparing spirituality and religiousness in Quebec and in Switzerland

		Geneva	Trois-Rivières	
		%	n	%
		100	121	
Gender*	Male	73	71	59
	Female	27	50	41
Ethnicity*	Caucasian	80	119	98
	Arab	8	0	0
	African	8	0	0
	Asian	4	0	0
	Caribbean	0	1	1
	Amerindian	0	1	1
Marital status*	Single	81	80	66
	Married	7	5	4
	Divorced	12	36	30
With disability funding*		86	117	97
Living*	Alone	49	63	52
	In a halfway house	21	45	37
	With family	30	13	11
Diagnosis	Paranoid schizophrenia	62	71	59
	Hebephrenic schizophrenia	8	9	7
	Undifferentiated schizophrenia	12	8	7
	Schizoaffective disorder	17	33	27
	Psychotic disorder NOS	1	0	0
History of suicide attempts		47	48	40
Current comorbidity	Substance misuse	23	19	16
	Nicotine dependency	63	73	60
Clinical global impression scale**	Slightly ill	33	29	24
	Moderately ill	34	65	54
	Severely ill	33	26	21
Subjective quality of life rating	Unhappy	17	19	16
	In-between	40	33	27
	Happy	43	67	55
Hospitalizations	Median number	6	5	
	Median duration (months)	5	7	
		Mean	Mean	SD
Age (years)**		39 ± 10	48	14
Duration of illness (years)**		16 ± 11	21	13
Psychosocial adaptation: global assessment of functioning score		56 ± 14	55	7
Positive and negative syndrome scale score	Positive symptoms**	13 ± 5	14	5
	Negative symptoms**	12 ± 6	18	5
	General symptoms**	23 ± 5	31	7
	Total score**	48 ± 11	63	13

* Chi-square, $P < .05$; ** Wilcoxon rank test, $P < .05$

dimension) and more often felt that God was close, wanted to speak and intervened in their lives (experiential dimension) than clinicians. Yet patients gave less importance to a religious community (ritual dimension) than clinicians.

Clinicians' assessment of patients' religiousness

Clinicians' assessments of patients' religious characteristics in Trois-Rivières and in Geneva are summarized in Table 4. Across the sample, clinicians in Trois-Rivières

Table 2 Spirituality and religiousness among outpatients with schizophrenia, clinicians and the general population in Geneva and Trois-Rivières

	Geneva patients n = 100		Geneva clinicians n = 34		Swiss general population n = 1561	Trois-Rivières patients n = 121		Trois-Rivières clinicians n = 23		Trois-Rivières general population n = 136600
	N	%	N	%	%	N	%	N	%	%
Religious affiliation[a]										
Christians	62	62	16	47	89	110	91	22	96	87
Catholic	38	38	12	35	51	105	87	22	96	87
Mainline Protestant	11	11	3	9	37	1	1	0	0	1
Pentecostal Churches	13	13	1	3	1	4	3	0	0	0
Judaism, Islam, Buddhism	8	8	1	3	1	1	1	0	0	3
Other religion	12	12	1	3	1	2	2	0	0	3
No affiliation	18	18	16	47	9	7	6	1	4	6
Participates in group religious activities										
Never	56	56	20	59	10	71	59	7	30	22
Each year	11	11	7	21	63	20	17	11	48	53
Each month to each day	33	33	7	21	27	30	25	5	22	25
Participates in individual religious activities[b]										
Never	26	26	19	56	10	23	19	3	13	22
Occasionally	22	22	9	26	51	28	23	17	74	53
Each day	52	52	6	18	39	70	58	3	13	25
Importance of spirituality in daily life[c]										
No or some importance	23	23	14	41	26	28	23	6	26	5
Important	18	18	6	18	23	10	8	4	17	51
Very important to essential	59	59	14	41	51	83	69	13	57	44

[a] Christian versus other religion versus no affiliation: Geneva patients versus Geneva clinicians ($c^2(2) = 12.5$, $P < .01$); Geneva patients versus Quebec patients ($c^2(2) = 25.67$, $P < .00$); Geneva clinicians versus Quebec clinicians ($c^2(2) = 14.6$, $P < .00$)

[b] Geneva patients versus Geneva clinicians: Wilcoxon W = 1555, $P < .01$: Quebec patients versus Quebec clinicians: Wilcoxon W = 1177, $P < .01$; Quebec clinicians versus Geneva clinicians: Wilcoxon W = 848.5, $P < .05$

[c] Geneva patients versus Geneva clinicians: Wilcoxon W = 1779, $P < .01$

and in Geneva tended to underestimate the importance of religion for their patients. The Trois-Rivières clinicians were only found to be more accurate than those in Geneva with respect to religious affiliation, probably because Trois-Rivières is predominantly Catholic.

Clinicians reported discussing religious issues with their patients in 36% of cases, as in Geneva, although they claimed that they felt at ease when speaking about spirituality in 92% of cases (93% in Geneva).

Only three clinicians reported feeling ill at ease with some of their patients. None of the clinicians initiated discussions of the topic themselves, as in Geneva. Clinicians gave the following reasons for not discussing this topic: other vital priorities (clinical symptomatology, food, housing, money) to be discussed with patients (most of them living in a rather precarious situation), lack of time (39%), lack of knowledge or feeling insufficiently prepared to assess the patient's case in order to approach the subject without disturbing the patient (22%), and not being aware that spirituality could be a resource for patients, thus leaving it unexplored (26%).

A minority of patients (6%) perceived a conflict between religion and psychiatric care (medication and/or the clinician's support). But the clinicians of only two patients experiencing this struggle were aware of it. Patients in Geneva were more likely to feel that there was a conflict between their religion and psychiatric care than patients in Québec (19 vs. 6%, $X^2 = 10.37$, df 1, $P < .001$). Nevertheless, clinicians in both areas were equally unaware that this was a problem for their patients.

Discussion

This study showed, as we expected, that religion was important for the majority of patients suffering from psychotic illness in Trois-Rivières. Indeed, patients were characterized by a high level of spirituality, which served

Table 3 Subjective importance of religion in daily life and in coping with the daily problems in a study comparing spirituality and religiousness among 121 outpatients and their 23 clinicians in Trois-Rivières (Québec)

	Patients		Clinicians	
	n = 121		n = 23	
	Mean	SD	Mean	SD
Subjective importance of religion[a]				
In your day-to-day life	6.5	3.3	5.7	3.0
To give meaning to your life	4.9	4.1	4.3	3.3
To cope with your illness	5.7	3.6	5.3	3.6
To give meaning to your illness	2.7	3.8	2.9	3.2
To gain control of your illness	3.7	3.7	2.8	3.1
To gain comfort	5.6	3.7	5.4	3.1
To get support from a community	1.5	3.1	0.9	2.6
Huber centrality scale[b]				
Intellectual (cognitive interest)	5.0	3.6	5.1	1.7
Devotional (prayer)	7.2	4.3	6.3	3.2
Ideological (level of conviction in religious beliefs)*	10.8	2.1	9.9	2.7
Ritual (church attendance, importance of community)*	3.3	3.3	3.8	1.5
Experiential*	6.5	4.6	4.3	3.0
Total score[c]	32.9	15.3	29.3	9.4

Centrality categorization**	n	%	n	%
Central	34	28	1	4
Heterogeneous	64	53	20	87
Marginal	23	19	2	9

[a] Subjective importance range from 0 (not important at all) to 10 (essential)

[b] Scales range from 0 (not important at all) to 12 (essential)

[c] Total score range from 0 (not important at all) to 60 (essential)

* Test Wilcoxon W, $P < .05$

** $X^2 = 9.69$, df 2, $P < .01$

as an important coping mechanism to deal with their illness across all socio-cultural and religious contexts. Overall, these results confirm the findings of the other studies carried out in Europe (Neeleman and Lewis 1994; Kirov et al. 1998) and in North America (Tepper et al. 2001; Kroll and Sheehan 1989).

Religiosity: patients versus clinicians

Contrary to our expectations, patients and clinicians in Québec were far closer in their spirituality and religiousness to the general population than in Geneva. Clinicians featured the same degree of affiliation as their patients and the general population. They stressed the importance of religion in their lives and in dealing with difficulties and participated in group religious practices as frequently as their patients. These findings could be related to the fact that the Catholic Church plays a central role in Quebec, and religious values continue to occupy an important place in people's lives. Despite the similarities in religious affiliation and overall importance of religion between patients and clinicians in Québec, our data highlight divergent ways of experiencing religion. For people living with chronic psychotic disorders, religion often becomes central in their lives, but, at the same time, social impairments hinder religious practices with other people. For clinicians, religion seems to be an interest among others.

Clinicians facing patients' religiosity

It is interesting to note that although religiosity seemed to be important for the clinicians in Trois-Rivières, they tended, as in Geneva, to underestimate or neglect this dimension. Their knowledge of their patients' religious activities and the importance of religion in patients' lives was inaccurate: patients' group religious practices were correctly identified in half the cases, whereas individual religious practices were identified for only one-third. The reasons given by the clinicians in Trois-Rivières are the same as those given in Geneva (Huguelet et al. 2006) and in the literature (Neeleman and Persaud 1995; Greenberg and Witztum 1991; Shafranske 1996; Lukoff et al. 1995; Crossley 1995): they believe they lack the skills necessary to evaluate this dimension; they are afraid of weakening or provoking a relapse in the patient ("open door to madness"); they lack the time to investigate this dimension or they believe that it is not their job to do so but that of an almoner, church worker or other spiritual counsellor.

During the study, several strategies were put forward by Quebec clinicians who worked with some very religious patients on a daily basis: cooperating with the patient's

Table 4 Clinicians' awareness of their patients' religious practices and spirituality

	Geneva				Trois-Rivieres			
	Patients		Agreement		Patients		Agreement	
Variable	N	%	N	%	N	%	N	%
Religious affiliation*				49				75
Christianity	121	61	68	56	107	88	87	81
Catholic	77	39	43	56	102	87	86	84
Protestant	20	10	8	40	1	1	0	0
Pentecostal churches	24	12	17	71	4	3	1	25
Other religion	41	21	19	46	4	3	1	25
No affiliation	37	19	10	27	6	5	0	0
Group religious practices				48				48
Yes	93	47	43	46	49	42	16	33
No	106	53	52	49	68	58	40	59
Individual religious practices				35				39
Yes	148	74	48	32	96	82	40	42
No	51	26	22	43	21	18	6	29
Importance of religion in daily life				47				41
Important to essential	151	76	77	51	91	78	43	47
Of no or some importance	48	24	17	35	26	22	5	19
Importance of religion in coping				43				38
Important to essential	120	60	46	38	85	73	34	40
Of no or some importance	79	40	39	49	32	27	11	34
Incompatibility of religion and medication	28	14	11	39	6	5	1	17
Incompatibility of religion and clinician support	20	10	1	5	5	4	1	20

* Chi-square, $P < .05$

Quebec clinicians included eight nurses and 15 health professionals for 42 and 75 patients, respectively

Geneva clinicians included 19 psychiatrists, 11 nurses, five social workers for 98, 71 and 30 patients, respectively

spiritual mentor to reduce the patient's resistance, examining the therapist's own religious attitudes to modify counter-transference feelings and, for the majority of them, acquiring knowledge of the patient's religion to better distinguish religious beliefs from delusion or obsessive–compulsive symptoms when interviewing patients. Indeed, clinician reports suggested that normative religious experiences could be easily mistaken for symptoms of psychopathology. Greater knowledge of these kinds of religious experiences and phenomena might help them, they said, to determine which behaviors or attitudes should be considered. They also made it clear that including religious and spiritual issues in current training programs would be a worthwhile endeavor.

Patients' religiosity and psychiatric treatment

In contrast to patients in Geneva, very few patients perceived a conflict between psychiatric care, medication and spirituality. We have no firm evidence to interpret this finding, yet this may be due to the fact that clinicians and patients in Trois-Rivières belong to the same religious affiliation and that, with a common cultural and religious background, their views on illness and the world in general are more similar. Additionally, in view of these patients' lack of resources and the privileged contact they have with the ACT team-referent—for some, their only contact during the week—they may be less prone to find that their beliefs and the treatment proposed are incompatible. In Geneva, patients felt more antagonism towards treatment, probably on account of the large diversity of religious faiths, each with its own representation of illness and treatment. Religious patients were also more likely to be suspicious of secular therapists and therapy. This is particularly true for patients belonging to fundamentalist or minority religious movements, which are less frequent in Trois-Rivières than in Geneva. Such movements do indeed tend to be antagonistic towards psychotherapy, which is

considered to be incompatible with their systems of spiritual healing (Bobgan and Bobgan 1989). Some attitudes and kinds of behaviors encouraged during psychotherapy (in particular cognitive-behavioural therapy) may enter into conflict with or otherwise go against the precepts and teachings of such movements. For example, the idea of focusing on your own needs, taking care of yourself and seeking self-fulfilment may go against some of their beliefs which, on the contrary, encourage the individual to think of others, to be wholly at the service of others and the community, with suffering and self-sacrifice seen as salutary. Taking medication may also come into conflict with the belief systems of certain religious groups for the same reasons that they find certain forms of psychotherapy inacceptable.

Conclusion—clinical implications

Our study entails some limits. For example, both areas in which this study took place are situated in "Western" parts of the world. Although characterized by some differences (e.g., kinds of affiliations), they share many cultural similarities. Thus, replication studies are warranted in other parts of the world (e.g., developing countries, areas inhabited essentially by non-Christian populations). Also, the different clinical contexts in the two areas (ambulatory care vs. ACT) may have led to differences both in terms of patients' typology and the kind of approach. Yet our relatively similar results give some support for a generalization of our findings, i.e., that a specific psychiatric setting such as ACT does not seem to influence the way clinicians consider religion.

Yet to our knowledge, the present study is the first to report qualitative and quantitative data on religious coping in clinicians caring for patients with psychosis in two distinct areas. These results underline the fundamental need to assess the spiritual beliefs and religious practices of patients with psychosis and to highlight the positive and protective factors as well as the negative and stress factors that religion engenders in their care. Recording the patient's religious history by means of specific evaluation tools (e.g., devised on the basis of data gathered by the present study) should be included in the initial psychiatric evaluation. The questionnaire applied by one of the present authors (LB) during our research in Trois-Rivières and perfected by the research group seems to have been a practical tool for the Trois-Rivières clinicians for approaching the subject with their patients. In the light of these findings, clinicians should, if necessary, include the religious dimension in the treatment program of patients for whom religion is important in their daily lives and in coping with their illness. In particular, issues such as illness and treatment representation, positive and negative spiritual coping and ways to use religion/spirituality as a means of recovery should be tackled. However, clinicians must never lose sight of the therapeutic context and be aware of any possible counter-transference, which may occur more easily if the patient and psychiatrist come from different religious backgrounds (Propst et al. 1992). Clinicians must also ensure that they do not impose their religious viewpoint on the patient, who is often in a vulnerable position. Psychotherapy sessions are not appropriate settings for debates on the truth or falsehood of religious doctrines. Spiritual assessment could also provide an avenue for increased dialogue between mental health professionals and chaplains.

In any event, the importance of training in religious issues lies in cultivating an attitude of curiosity about patients' beliefs and in seeking out and encouraging those elements of religion that are likely to promote recovery and prevent relapse (Levin 1994).

Further studies could be envisaged to investigate the best way to raise clinicians' awareness of this dimension and to encourage them to collaborate with the clergy.

It would also be useful to gain a better understanding of how to integrate the positive components of religion in the care of patients suffering from psychosis and how religion could be better used as a resource in therapy. Finally, randomized studies of patients could be carried out to examine the impact of religious interventions in patients suffering from psychotic disorders.

Acknowledgments This study was supported by investigator-initiated grant 325100-114136 from the Swiss National Science Foundation and by the Société Académique de Genève. Dr Huguelet reports receiving research funding from Janssen Pharmaceuticals and Eli Lilly. Dr Borras reports receiving investigator-initiated research funding from Bristol-Myers-Squibb. Other authors report no potential conflicts of interest or financial support.

Appendix

Religious and Spiritual Assessment

Religious/Spiritual history
Family background
Religious education
Significant changes in religious beliefs or practices
Effect of the illness upon Spirituality and/or religiousness
Current spiritual/religious beliefs and practices
Religious preference
Spiritual beliefs
Private religious practices
Organizational religious practices
Support from religious community

Appendix continued

Subjective importance of religion:
in day-to-day life
to give meaning to life
Subjective importance of religion to cope with the illness
to give meaning to the illness
to cope with symptoms
to get comfort
coping style (self-directing, deferring or collaborative)
Synergy of religion with psychiatric care

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