Original article

Experience and views of academic psychiatrists on the role of spirituality in South African specialist psychiatry

Experiência e visão de psiquiatras acadêmicos sobre o papel da espiritualidade na prática e no treinamento de especialistas em psiquiatria na África do Sul

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Abstract

Background: The importance of having to consider the role of spirituality in health, mental health and psychiatry in South Africa has in particular been emphasized by recent legislation on African traditional health practice. **Objective:** The purpose of this study was to explore the views and experience of local psychiatrists regarding the role of spirituality in South African specialist psychiatric practice and training. **Method:** This study is an explorative, descriptive, contextual, phenomenological and theory-generating, qualitative investigation. In-depth, semi-structured interviews with individual academic psychiatrists affiliated to a local university were conducted as primary data source. Measures to ensure trustworthiness included credibility, transferability, dependability and confirmability. **Results:** Awareness of spirituality, "mindfulness" and an open-minded approach about spirituality should, according to participants, be facilitated in psychiatric practice and training. Six themes were identified through open coding. **Discussion:** All participants, disregarding of their own views on spirituality and religion, agreed, that under certain conditions, spirituality must be incorporated into the current bio-psycho-social approach in the local practice and training of specialist in psychiatry.

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Keywords: Spirituality, psychiatry, practice and training, qualitative inquiry, interviews.

Resumo

Contexto: A importância de ter de considerar o papel da espiritualidade na saúde, saúde mental e psiquiatria na África do Sul tem sido especialmente enfatizada pela recente legislação sobre práticas tradicionais de saúde na África. **Objetivo**: Explorar as opiniões e experiências de psiquiatras locais sobre o papel da espiritualidade na prática e no treinamento de especialistas em psiquiatria na África do Sul. **Método**: Este estudo é uma pesquisa qualitativa, exploratória, descritiva, contextual, fenomenológica e geradora de hipótese. A fonte principal de dados foram entrevistas semiestruturadas com psiquiatras filiados a uma universidade local. Para assegurar de que os dados fossem confiáveis, as seguintes medidas foram incluídas: credibilidade, transferibilidade, confiabilidade, e confirmabilidade. **Resultados**: A consciência da espiritualidade, "*mindfulness*", e uma abordagem de mente aberta sobre a espiritualidade, segundo os participantes, devem ser facilitadas na prática e no treinamento psiquiátrico. Seis temas foram identificados por meio de códigos abertos. **Discussão**: Todos os participantes, independentemente de suas próprias visões sobre espiritualidade e religião, concordaram que, sob certas condições, a espiritualidade deve ser incorporada na abordagem biopsicossocial atual na prática local e no treinamento de especialistas em psiquiatria.

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Palavras-chave: Espiritualidade, psiquiatria, prática e formação, investigação qualitativa, entrevistas.

Background

> *"As a result of the fact that human consciousness transcends materialistic explanations, psychiatry now finds itself at an important crossroad. The fostering of spirituality and well-being is crucial for psychiatry to achieve its meaning and purpose, but spirituality and well-being have been neglected because of the tendency toward materialistic reductionism."* (Cloninger)[1]

In South Africa, the need to consider spirituality, religion, culture and world view in various secular areas, such as health and mental health, has been associated with the increasing prominence allocated to the role of traditional African beliefs. This has been noted in particular in recent legislation on traditional health practice[2]. Great emphasis is, for example, placed on mental health by the Traditional Health Practitioner's Act nº 35 of 2004, defining it as a significant part of what is regarded as the traditional health practitioner's spectrum of responsibilities.

In terms of spirituality in the South African government sector it can be noted, for example, that under the auspices of the local Department of Arts and Culture, the Freedom Park heritage site as a "spiritual institution" was established in 2002. This has been undertaken with government funding as a National Legacy Project according to the National Heritage Resources Act nº 25 of 1999, as an expression and a continuation of the processes of the Truth and Reconciliation Commission[3]. The perspectives of the author(s) of a Freedom Park Trust publication on the role of spirituality in the apparently "secular" public terrain of the state, and of government, provide some light on the issue and demonstrate the importance of the definition of terminology and of what terms, such as "spiritual" and "religion", are regarded to mean in different settings[4]. These authors considered the post-1994 political implications of the definition of spirituality and religion in South Africa. African healing ceremonies are described as "cultural methods through which many societies and faith-based communities have dealt with the issue of societal pain

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and the need for regeneration" (p. 3). The document states that the use of spirituality in the context of the relations between the state and spirituality is certainly a new situation, and also describes the restoration of indigenous African forms of spirituality, following its liberation from "colonial spirituality". Colonial spirituality is described as being of a religious type and largely Christian, which in colonial states constituted a close marriage between church and state pursuing the enterprise of "conquering the indigenous epistemological space" (p. 5). The quest for independence from colonialism is also a quest for freedom from the dominance of Western forms of spirituality. The document explores the different sections of the South African constitution on this matter and concludes that South Africa has opted for a "cooperative model" between the state and religious communities[5].

Within the specialist medical discipline of psychiatry, the increasing role of spirituality is evident from the focus that religion and spirituality receive at international congresses such as the world congresses of the World Psychiatric Association in recent years held in Cairo (2005), Prague (2008) and Buenos Aires (2011). Current editions of both the DSM IV-Text Revision (TR), and Chapter V of the ICD-10, already advise the consideration of a service user's presentation in her or his cultural context[6,7]. In addition to a glossary of culture-bound syndromes, the DSM IV-TR proposes that a cultural formulation should be added to the assessment of service users. The DSM IV-TR makes allowance for religious or spiritual problems identified during psychiatric assessment, by including these not as a psychiatric disorder but as an "additional condition that may be the focus of clinical attention", with an allocated "V-code" of V62.82 (Religious or Spiritual Problem), or "Z71.8", as equivalent ICD-10 code. In reviews of evidence from the Latin-American literature, De Menezes Jr. and Moreira-Almeida and Moreira-Almeida and Cardeña also recently proposed features suggestive of the non-pathological nature of common spiritual experiences[8,9].

Several international authors, including Koenig, Larson, Baetz, Sims, Culliford, Verhagen, Moreira-Almeida and D'Souza, reported extensively on the role of spirituality in psychiatry[10-20]. Koenig *et al.*, provided "a rebuttal to sceptics" on religion, spirituality and medicine, while Josephson *et al.*, also addressed developments in psychiatry regarding spirituality[21,22]. Andreasen, as editor of the *American Journal of Psychiatry* at the time, stated "*We must practice and preach the fact that psychiatrists are physicians of the soul as well as of the body*"[23]. Breakey in the *International Review of Psychiatry* and Jakovljevic, in a Croatian journal, also discussed the status of religion, spirituality and psychiatry[24,25]. Boehnlein provided a retrospective and prospective view[26], and Moreira-Almeida provided an overview of the topic in a Brazilian context[18].

Turbott noted that an epistemological gap exists between religion, spirituality and psychiatry over what constitutes rational explanation and what impediment this may be to a rapprochement of these areas[27]. He referred to Halasz, who suggested an ambitious project with his proposal to "reclaim psychiatry's soul and reinstate the psyche in psychiatry" by including "the study of the soul" to the study of anatomy, biochemistry and physiology[28]. *"Rapprochement may best be achieved by increasing psychiatric awareness and knowledge of the issues, and by a willingness to embrace intellectual, cultural and religious pluralism*" (Halasz). The spiritual challenge to psychiatry, according to Halasz, is a three-way tension between "brain-less", "mind-less" and "soul-less" psychiatry.

In terms of the definition of spirituality, Culliford sets a definition of spirituality within: the context of the World Health Organisation's quality of life (WHO-QOL) domains; the facets proposed for a WHO-QOL Spirituality, Religious and Personal Beliefs (SRPB) module; and the dimensions of human experience[16]. He refers to an often quoted definition of spirituality by Murray and Zentner: "*In every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical (and mental illness), loss, bereavement and death*"[29]. In clarifying the term spirituality, D'Souza and George use an explanation of two realms of existence – the outer and the inner[30]. This is where the outer realm consists of a person's interaction with the world and the inner realm is defined as the individual's interaction with the transcendental.

In terms of studies that explored psychiatrists' perceptions about the role of spirituality in clinical practice, Morgan and Cohen in 1994 commented on the observation that spirituality was slowly gaining recognition among North American psychiatrists[31]. Sims referred to a study of psychiatrists working in London teaching hospitals: although only 27% reported religious affiliation and 23% a belief in God, 92% felt that psychiatrists should be aware of the religious concerns of their patients[15]. There was no evidence that psychiatrists' private religious beliefs had an important influence on their clinical practice, according to Neeleman and King, who noted that the reasons why psychiatrists often ignore spirituality included that: it is considered unimportant; it is considered important but irrelevant to psychiatry; and the very terminology is confusing and hence embarrassing[32]. The possible role that religion played in the relationship between a group of Dutch psychiatrists and their patients was also explored in a qualitative survey, using interviews with them on their own attitude towards religions and spirituality as data source[33].

Curlin *et al.* compared the ways in which American psychiatrists and physicians interpret the relationship between religion and health and how they would address religious issues in the clinical encounter[34]: psychiatrists are more likely to note that religion sometimes causes negative emotions and also more likely to encounter religious and/or spiritual issues in a clinical setting. Compared to the other specialists, they also appear more comfortable and have more experience in addressing religious and/or spiritual concerns. Reporting on the same survey, Curlin *et al.* found that psychiatrists were less religious than other specialists, and that religious physicians were less willing to refer patients to psychiatrists[35]. This suggests that the historic tension between religion and psychiatry continues to shape the care that patients receive.

It is in view of this observed phenomenon that spirituality seems to play an increasingly important role in the secular areas of mental health and psychiatry, that it also seemed important for local South African psychiatrists to consider from within the discipline, as to what they would judge the role of spirituality to be in specialist psychiatric practice and teaching and to reaffirm, or redefine psychiatry's relationships and boundaries with the members of the existing, or potentially extending multidisciplinary mental health team. The purpose of this study was to start the exploration of the views and experience of local psychiatrists on the role of spirituality in South African specialist psychiatric practice and training.

Methods

This study was an explorative, descriptive, contextual and phenomenological qualitative investigation, where in-depth, semi-structured interviews with individual academic specialist psychiatrists affiliated to a local South African university were conducted as the primary data source.

As noted in the increasing number of qualitative studies published in specialist medical literature, qualitative methods have been incorporated as an accepted approach in the process of gathering information and establishing the context of evidence in the larger framework of formal health and health systems research efforts[36,37]. Culliford also identified this paradigm for research in psychiatry and mental health moving beyond positivism, which includes qualitative research approaches such as participant observation and phenomenology, using data such as unstructured in-depth interviews[16]. Chibeni and Moreira-Almeida remarked on the scientific exploration of "anomalous" psychiatric phenomena and recommend that exploring the "unknown" in psychiatry – such as the relationship between spirituality and mental health – may warrant a broadened perspective of inquiry that includes qualitative investigation[38].

Epistemological framework

A constructivist paradigm assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create methodologies) and a naturalistic (in the natural world) set of methodological procedures[39]. In terms of this description, a constructivist position was adopted in the approach to this study, as it was undertaken from a relativistic ontological viewpoint (realities are apprehendable in the form of multiple, intangible mental constructions), with a subjectivist epistemology (findings are created as the investigation proceeds) and with a naturalistic set of methodological procedures (constructions can be elicited and refined through interaction between and among investigator and respondents).

Ethical measures

Ethical clearance for this study was granted by the ethics committee of this local university in 2007. Informed consent for participation from individual participants was obtained separately. In addition, the organized profession, as represented by the South African Society of Psychiatrists through its regional structures, was informed about the intent, scope and results of the study.

Sampling

A purposeful sample for the interviews was drawn from a current group of local academic specialist psychiatrists as the primary target group. These psychiatrists were all appointed to the Division of Psychiatry at the University of the Witwatersrand in Johannesburg, and in clinical positions at sites within the academic complex serving the University. These facilities serve a dense, diverse urban population in the southern part of Gauteng Province and included general secondary and tertiary hospitals with acute psychiatric units, as well as specialist psychiatric hospitals and regional community psychiatric services. At the time of the study, about 40 local psychiatrists were attached to the services from which the sample was drawn. Prospective participants were approached in a purposeful manner and although, as a qualitative inquiry, the sample was not regarded as representative of the whole group, an attempt was made to include participants from different faith traditions including an atheistic or agnostic perspective, as well as from across different age and gender profiles.

Data collection

As primary data source, in-depth semi-structured interviews were conducted with this group of local academic psychiatrists to gain in-depth knowledge about their experience of and view on the role of spirituality in specialist psychiatry practice and training[40]. Basic data on the demographic and professional profile of each participant was collected by means of a short biographical questionnaire completed by all participants. Participants were presented with one open-ended question: *"What is your experience of and view on the role of spirituality in specialist psychiatric practice and training?"* During the actual interviews, concepts were explored and elaborated on only through non-directive techniques such as reflecting, paraphrasing, clarifying and summarizing. Participants' responses were documented, analyzed and compared. Each interview was audio-taped and transcribed. Interviews were conducted until data saturation was reached, which was regarded as the point at which no new elements from the subsequent interview content were identified.

Data analysis

Open coding was used for the analysis of the thematic content of the interviews, and refers to the creation of certain categories pertaining to certain segments of text and is aimed at expressing data and phenomena in the form of concepts[41]. Apart from the investigator (first author), a second independent coder was requested to analyse the interview transcripts. Themes were not identified in advance, but derived from the interview data. The final categories of concepts and themes from the interviews were considered during consensus discussions between the investigator and the second coder, and were only confirmed after consensus was reached. No computer software programs were used in the analysis of the data. Key quotations from the interviews were included in the narrative interpreting the data, to provide a chain of evidence that the provisional identified concepts were derived from and grounded in the interview content.

Measures to ensure trustworthiness

Appropriate measures of trustworthiness in qualitative inquiry, such as credibility, transferability, dependability and confirmability as described by Lincoln and Guba, was considered in this investigation[42]. To this purpose, triangulation and reflexivity (field notes) were included as measures in this study. Field notes were compiled to reflect on the particular circumstances of, and impressions about each interview[39].

Results

Interviews were conducted in English and no problems were experienced with the articulation of concepts or with language. Two psychiatrists declined to participate, without providing particular reasons. Only one interview per participant was conducted and the duration of the interviews on average was about 1.3 hour per interview. After thirteen interviews, no new elements were identified from the interview content and the data was considered to be saturated.

The participants' age ranged from 33 to 71 years, six were men and seven were women. Participants' professional experience after qualifying as psychiatrists ranged from two to 29 years and they were mostly employed at the time as senior and principal psychiatrists. Their stated personal religious or spiritual identification included: discontinued religious ties, with currently only spiritual interests; being raised in an organized religious context, but with no current religious or spiritual affiliation or interest; continued serious and even strict organized religious affiliation with active participation; continued organized membership with extended spiritual orientation or awareness; continued identification with original religious and cultural background, but currently with a more general spiritual awareness; and an inclusive more internalized spiritual orientation, with no previous particular traditional religious adherence.

Overview of content

Disregarding of their personal position on religion and spirituality, all participants concurred that spirituality can't be ignored in the practice and teaching of specialist psychiatry. Awareness of spirituality, "mindfulness", or an open-minded approach towards spirituality should be facilitated in specialist psychiatric practice and training. Participants had diverse views and experiences on the role of spirituality in psychiatry, but all stated that spirituality should be considered in current specialist practice and training. Their views were influenced by their personal attitudes towards spirituality and religion and by their trained academic world view of medical science and of patients.

Participants believed that spirituality refers to an individual process towards meaning and being, while religion refers to the social and organized aspects of faith traditions. The importance of clear ethical and professional boundaries in specialist psychiatric practice was highlighted, as was the fact that the personal views of psychiatrists on spirituality and religion should not be enforced in any way by them on each other, or on their patients. Psychiatrists were not regarded as having a primary role as spiritual workers themselves. Yet the importance of the incorporation of an in-depth exploration of spirituality and religion and the meaning thereof, for individual users in the history taking and clinical interviewing of routine psychiatric assessments was identified.

In the training of psychiatrists, it was advised that awareness of spirituality and its relevance to specialist psychiatry, as well as the knowledge and skill of individual trainees in assessing and identifying

the place of spirituality in the management of users' mental health care should be facilitated. This may also warrant the re-orientation of the teachers in psychiatry, concerning the place of spirituality in specialist practice.

The referral of users to relevant spiritual workers on an individual basis was preferred when indicated, according to users' individual needs. Concerns were however raised, about time and resource constraints. Closer, more regular and perhaps also more formal collaboration by local individual psychiatrists and also by the organized profession of psychiatry, with the spectrum of relevant spiritual workers was proposed. But participants were generally very tentative about how this collaboration should be approached or implemented.

Main themes from the content

After consensus was achieved about their description and order, six final categories of concepts were confirmed. These were: "personal and professional orientation"; "spirituality and religion as a reality"; "scope and boundaries; routine mental state assessment and health care"; "awareness, knowledge and skill of trainees"; and "referral and collaboration".

Personal and professional orientation towards spirituality

To orientate themselves as individuals towards the concepts of spirituality and religion from a personal perspective was often the initial step and a practical way for participants to respond to the research question:

> *"I think the first thing for me is that there is a difference for me between spirituality and being religious, and I think that's where my starting point would be when considering these questions. Spirituality is sort of an understanding of where the specialist – or I would say 'my' – mindset is with regard to my own belief systems and also where I am in my own space".*

Several participants orientated and associated themselves personally with having a spiritual rather than a religious position, while others have orientated from a religious position, or from not having a spiritual or religious position at all. The personal motivation for choosing psychiatry as a career, and psychiatry as a discipline that has unique inter-relatedness with spirituality, was reflected on.

The failure to address spiritual or religious issues in their own training was referred to several times by different participants:

> *"But in terms of actual postgraduate training, and in fact even undergraduate training, it's not incorporated in any way. So I think that that in itself is lacking and on top of that I think it's probably maybe the most neglected part because, I mean one sees, the more you encounter patients over the years, the importance of spirituality".*

To review the philosophical reasons why the dimensions of "science" and "religion" have been separated in the first place, may also be informative. The strict (Western) definition of what is scientific and people's subjective fears and uncertainties about matters of faith may be part of these reasons:

> *"I think what psychiatry in particular has... because it's been regarded for so long, because we didn't have tests and this sort of thing, it was regarded so long as a sort of – not fictitious – but a slightly suspicious branch of medicine. You know, with the psycho-analysts making interpretations and this sort of thing, and so, psychiatrists fought so hard to say: 'Look, we're part of medicine, we're part of hard science, we also use double-blind trials and this sort of thing...', so I think it's been a particular fight within psychiatry itself".*

Spirituality and religion as a reality for practitioners and users

According to participants, the reality of a spiritual dimension in the current practice of psychiatry should be acknowledged. The differentiation between spirituality and religion may however not always be clear. But exploring, as a psychiatrist, the role of both in a person's life, was regarded as important:

> *"I think one needs to make a real clear definition on what spirituality means, because many people equate spirituality with religion. Spirituality, I suppose, also has a lot to do with one's tradition, with putting one's thoughts together, spending a lot of time with yourself and a lot of introspection. I think there's a definite role for that and I think that's what spirituality is".*

At the same time, specific stereotypes about people (White, Muslim, African etc.) continue to exist, in Africa and elsewhere. In South Africa it may be more difficult and important not to judge a situation from a stereotypical perspective. In the complex South African society it is essential to have adequate awareness and skill to accommodate, understand and respect different backgrounds in order to interpret symptoms and to make diagnoses:

> *"... you've got to judge mental illness in the context of what the beliefs or practices in the community are. So I suppose one has to have an understanding of what those beliefs and practices are, in order in the context of that, to judge whether their behavior or their functioning is in fact functional or not".*

Participants felt that, although it may still be easier to maintain a division between the bio-psycho-social and the spiritual dimensions, it is more important to achieve a wholistic view of users and mental health care. Spirituality is central in the transcendence of difficult life situations, such as chronic illness and death, confirming, for participants, the applicability of a balanced four-dimensional bio-psycho-socio-spiritual model:

> *"I have a paradigm which I give to my patients and tell them that perhaps we need to look at balance in our lives and the balance is like having the wheels of a car balanced; there are four wheels and there are four areas".*

It may therefore be appropriate, especially if a systems approach is adopted, to extend the current bio-psycho-social model to include spirituality as an additional, fourth dimension of care:

> *"It is inconceivable if you take a systems approach not to bring in the spiritual aspect of thing... inconceivable." "Perhaps I've just always believed and maybe this is a very idiosyncratic thing of my own, but if you don't understand the person's relationships and sexual life and their value system and any religious aspects of their life, then you don't know the patient".*

Scope and boundaries of professional specialist psychiatric practice

It was evident from the interviews that ethical aspects of what is appropriate and acceptable as a health worker in declaring one's personal position about religion and spirituality are important. A psychiatrist's (or other health worker's) own position and views towards spirituality and religion should not impact on other colleagues' or on users' position on the matter, nor on the professional assessment of users, or on appropriate clinical management decisions. It is appropriate to set and maintain proper boundaries in this regard:

> *"Now I think that it's most important that psychiatrists don't impose their own belief system upon the patient." "I think herbalists and traditional healers are the same as Jewish people or Catholics or Muslim and that's a worldview. And those worldviews can be quite... if you get a medical intern wearing the burka with only the eyes showing, I mean that's a very physical manifestation of a worldview".*

Participants concurred that there seems to be no primary role for the psychiatrist to attempt to be a spiritual or religious adviser within the context of a professional psychiatric consultation. The appropriateness of interventions should be clearly established, monitored and reviewed by, for example, professional bodies.

Spirituality and religion in routine mental state assessment and health care

Considering the place and role of religion and spirituality in the lives of users, it should be part of the routine clinical assessment and management, whether a psychiatrist in his or her personal capacity would consider religion or spirituality important or not:

> *"But the other thing that I think we really need to ask people is their religious history – where they've come from, what they've done, what part they've had in it, where have they been".*

Questioning should not only be a superficial screening, but an adequate understanding must be achieved of words and phrases used in their context. Language barriers should therefore also be taken into account:

> *"So that even perhaps if as a psychiatrist you don't have a particular faith, I believe it's important that you give that space to your patient to explore that area and whether their faith or their road to spirituality is of assistance to them in nurturing that, or if it's hindering them... to get them to question that..."*

Religious-cultural background also influences the way in which symptoms and problems are presented and the content thereof. Individuals with proven psychiatric disorders will often lose their insight when they default on medication, resulting in the recurring of symptoms such as mania and delusional thought content:

> *"So my experience with spirituality... I mean, I think often with patients who are manic or psychotic it becomes more difficult if the delusions have a spiritual context. So I suppose people are more tolerant of delusions or unusual beliefs if they have spiritual content. It's plausible. But I still think the bottom line is whether the person is functioning or not".*

Many mental health care users may consult a religious worker/leader in the first instance and may only later be referred for a psychiatric assessment. Psychiatry may generally still be regarded as unfamiliar territory by more traditional or conservative religious groups. Users may present with unclear symptoms and may interpret these from their cultural perspective, but may actually be in need of psychiatric care, especially when they have experienced a loss in functionality. A helpful approach may be to collaborate with family and particularly spiritual workers to address the stigma of, and misunderstanding about psychiatric conditions:

> *"I think with any kind of spirituality where it becomes an issue, is when maybe the patient or the family get into conflict between their particular beliefs and the psychiatric treatment that's offered and given... and I think that to ignore it (the stigma of and misunderstanding about mental illness) is often not helpful, because you may end up with people leaving treatment that they really need".*

The experience of the conflict between a traditional African understanding and the scientific knowledge about the cause of HIV/AIDS, with the associated stigma, may also be used as a model to understand and describe the differences in approach that may exist towards psychiatry and mental health:

> *"I was reading a book... about HIV in the Eastern Cape and why people don't actually go for testing... and (the author) looks at some of the... areas behind how people cope or adapt to the old worldview... how they kind of incorporate the traditional healing... so it's a way of incorporating your worldview and your traditions within the face of modern medicine without losing face".*

It would also be important to allow enough space for these other worldviews about mental health, and for people not to "lose face" while they have to come to terms with the reality of psychiatric conditions.

Awareness, knowledge and skill of trainees in psychiatry regarding spirituality

Through openness and awareness, a competent psychiatrist should appropriately identify a presenting spiritual problem and refer accordingly, while still operating within her or his own professional frame of reference:

> *"I think you could say people in training in psychiatry – more than any other group in medicine – need to understand the person's background and their spiritual beliefs in that context".*

Basic knowledge and information about main spiritual and religious themes should be included in the training of psychiatrists, but in particular an awareness and understanding of the reality and importance of a spiritual dimension in psychiatric practice should be established:

> *"Maybe in some form of... I don't know, religious studies, maybe not so much even... not concentrating on any particular religion but maybe a more sort of broader understanding of religion and mankind, of the different religious faiths and their different understandings of things in the world".*

Interested candidates and practitioners can from there build on this basis through more individual reading and development. Incorporating applied anthropology and systems theory into the basic training of psychiatrists may be appropriate:

> *"I think that anthropology would have a lot to offer in a broad cultural, spiritual sense. I think they should have a course in anthropology, making people aware of what... could be useful. I think that might be more useful and maybe even a course in comparative religions might be useful but that's just all kind of theoretical. It should just be a sensitizing thing".*

It was regarded to be essential, that candidates should be taught how important the interpretation of a specific clinical history and presentation in terms of a person's values and beliefs are:

> *"I think in the first place the first thing would be to try and impress upon new entrants to psychiatry how important these sides of the patients' lives are likely to be to them... and to make them aware of that if they weren't aware before".*

It is also important to avoid a superficial "ticking-of-boxes" type of questioning. The latter should be learnt first-hand from observing more senior experienced teachers demonstrating this approach in their interviewing of patients:

> *"In fact one way of doing it could be through like mentorship programs and things like that as opposed to formal teaching and training, but that in itself also poses difficulties and problems in terms of finding... a suitable mentor..."*

Participants regarded the capacity to self-reflect is an important attribute of a competent psychiatrist and achieving it should be part of the training of a specialist. It should be an objective for the training of psychiatrists to facilitate freedom, openness and the space to discuss personal positions on spirituality and religion with registrars during their training:

> *"I mean the parallels I see are very clearly when they now talk about mindfulness in developing mindfulness in psychotherapy. There's very much the same approach in meditation practices in spirituality. And I think that what is important is to allow trainees the opportunity to explore and to realize the importance of reflection in a way that is not threatening to them".*

Referral and collaboration between psychiatrists and spiritual workers

It may be difficult and logistically challenging to organize the liaison between specialist psychiatrists and spiritual workers into formalized

referral systems, or to integrate them generally into the existing multi-disciplinary mental health care team:

"To me spirituality is something separate from health-workers as a parallel thing. I don't think you are going to create a job in a hospital, because then you need to create... then I must hire an Anglican minister and a Muslim and a Jew and a traditional healer, all to work in the hospital. But why... they aren't health-workers?"

Defining the relationship between psychiatrists and spiritual workers as a parallel process alongside each other, may still be the most practical approach, while acknowledging that health workers themselves may be from different worldviews and backgrounds, but responsible for their particular area of work in the first place:

"I think tradition goes both ways. We could teach them about psycho-education, they could teach us and I think... dialogue, for example, just even (between) psychiatry and medicine in this hospital we are so divided. And just opening up those channels of communication could really, really improve the situation. So by opening up dialogue with different people of different ideas..."

The interface with spiritual workers presents the opportunity and challenge, to: establish a mutually informative collaboration where psychiatry has achieved a presence, acceptance and acknowledgement; and at the same time confront and correct misperception and stigma in more fundamentalist religious perspectives where necessary:

"You know I think we were able to say: 'Look, we don't like it when you do this and this...' and they (would) say: 'We don't like it when you tell our patients not to come visit us', and that sort of thing... I think you have a much better chance of getting a decent working relationship and try also to weed out some of the not so good practices on both sides. I don't think we are perfect either..."

Previous experiences or perceptions, however, are still the basis for continued ambivalence and conflicting views and feelings that psychiatrists have about how to interact practically with spiritual workers on the care of users:

"I mean, what I'm trying to say is, accommodating spiritual beliefs to the extent of disadvantaging them from the benefits of other interventions (is a problem). And yet one needs to balance that with not being imposing and, you know, basically describing to people what they should be believing and practicing. It's a delicate balance".

Knowledge of psychiatry and the benefits of, for example, pharmacological and psychological interventions should also be promoted amongst different groups of spiritual/religious workers. Dialogue between the organized profession of psychiatry and organized spiritual/religious workers may be a starting point:

"So I think it's a matter of engaging with them (traditional healers) and I think that one can engage at a systemic level with societies, councils, and practitioner groups in terms of trying to look at standards of care and referral systems. And I think what would be necessary would be a lot of education on both sides, you know".

Discussion

As a general comment on the experience with this study, it can be noted that defining terminology, specifically of what exactly "spirituality" and "religion" would mean in the discussion, proved to be one of the most challenging elements of this investigation. It was, for example, during all the interviews necessary for participants' to clarify these concepts in order to further formulate their answers to the question about their views and experience of its role in clinical practice. It was also the experience with this study that, although spirituality was specifically intended as the focus and concern from the outset, religion inevitably also became part of the discussion.

After defining its meaning, participating academic psychiatrists at this local South African university, however, disregarding of their own personal views on spirituality and religion, generally agreed that spirituality must be incorporated into the current approach to the local practice and training of specialist psychiatry. It should be done though, according to them, within the professional and ethical scope of the discipline, while all faith traditions and belief systems should be respected and regarded equally. This view seems to align with the relevant ethical and legal aspects involved as, for example, reported on by Braghetta *et al.*[43]. Yet, the daily demands of service delivery to multi-cultural and multi-religious South African communities often in under resourced settings, have been referred to by most of the interviewees as a limitation to effectively incorporate the role of spirituality in routine clinical practice.

With regard to African traditional health practice in particular it can be noted that, following the official acknowledgement in the 1970's of traditional healers' possible role in primary care by the World Health Organization, the use of alternative health practices has in many instances been encouraged and incorporated by authorities into formal health services as a strategy to address health needs. This has, however, often been the case in under-resourced rural populations with few formal health services at their disposal. In an overview of psychiatric services in Africa, Odejide *et al.*, discussed and contextualized the extended practice of African traditional medicine and syncretic churches as part of local health systems[44]. Okasha in his review of psychiatric services in Egypt, for example, not only acknowledged the practice of alternative therapies, but stated that traditional and religious healers have a major role to play in primary psychiatric care[45].

In a review of the South African medical literature until 2004 on the documented interface of alternative health practice with formal mental health care in South Africa, a prominent question that was often discussed in the past regarding African traditional health practice, was whether the work done by traditional healers should in fact be regarded as a religion, having spiritual attributes and functions, or rather as a modality of psychotherapy[46]. From the experience from this study, it had to be concluded though that applying the clarified definitions for "religion" and "spirituality" to the local African traditional belief system and practice, that African traditional health practice better fits the description of a religion with spiritual content, than that of a "psychotherapy" or, for that matter, an empirical health or biomedical intervention.

Subsequent to 2004, a number of local authors have further contributed to the discourse. Robertson, for example, reported on three separate studies which were carried out among Xhosa-speaking Africans in Cape Town[47]. He pointed out that there was no evidence that indigenous healers provided a more holistic treatment than psychiatrists, or that they concerned themselves at all with their clients' social circumstances. The South African Medical Association (SAMA), also representing specialist disciplines (especially state employed specialists), published a review of the work of a previous task team on the collaboration between traditional healers and South African medical practitioners, aiming to inform local decision-makers, professionals and non-governmental organisations on the relation between African traditional healing and the Western biomedical systems in South Africa[48]. Based on the principle that the patient is pivotal in the health care equation and that traditional health practitioners play an important role in Africa, SAMA expressed the view that some degree of cooperation between the two systems is desirable. The protection, however, of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, needs to be ensured and all forms of abuse in this context, or neglect and delay with regard to appropriate psychiatric care, should be identified and prevented.

A particular limitation of this South African study as an explorative qualitative inquiry is that its findings can't be generalized

to any other setting, as it does not even set out to be quantitatively representative of the group of psychiatrists from which the sample was drawn. This inquiry, however, was the first investigation of South African academic psychiatrists' views on the role of spirituality in psychiatry. Despite its explorative nature and qualified findings, it may contribute though to the growing discourse locally and internationally on the implications for psychiatry, of the role of religion and spirituality in the lives of the people with whom psychiatrists in cross-cultural multi-religious contexts deal with daily as patients, or as family members of patients. This study will have to be followed up by a more comprehensive quantitative survey amongst all South African psychiatrists, of their views on this topic in order to provide more representative conclusions.

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Declaration of interest

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Authors' note

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References

1. Cloninger CR. The science of well-being: an integrated approach to mental health and its disorders. World Psychiatry. 2006;5(2):71-6.
2. Traditional Health Practitioners Act (nº 35 of 2004). Cape Town: Government Printer, Government Gazette. Nº 29034, 21 July 2006.
3. Freedom Park Index. [Online] Available from: http://www.freedompark.co.za/cms/index.php. Accessed: 9/9/2009.
4. Freedom Park Trust. Spirituality and the Secular State: a preliminary perspective. Pretoria. PO Box 2710, Pretoria, South Africa 0001; Date unknown.
5. The Constitution of the Republic of South Africa. (Act nº 108). Pretoria: Government Printer; 1996.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders-IV-TR. 4th ed. Washington, DC: APA; 2003.
7. World Health Organization. International Classification of Disease. 10th ed. Geneva: WHO; 1992.
8. De Menezes Jr A, Moreira-Almeida A. Differential diagnosis between spiritual experiences and mental disorders of religious content. Rev Psiq Clín. 2009;36(2):75-82.
9. Moreira-Almeida A, Cardeña E. Differential diagnosis between non--pathological psychotic and spiritual experiences and mental disorders: a contribution from Latin American studies to the ICD-11. Rev Bras Psiquiatr. 2001;33(Suppl 1):S29-36
10. Koenig HG. The healing power of faith: science explores medicine's last great frontier. New York: Simon and Schuster; 1999.
11. Koenig HG. Religion, spirituality and psychiatry: a new era in mental health care. Rev Psiq Clín. 2007;34(Suppl 1):5-7.
12. Koenig HG, McCullough ME, Larson DB. Handbook of religion and health. New York: Oxford University Press; 2001.
13. Larson DB, Pattison EM, Blazer DG, Omran AR, Kaplan BH. Systematic analysis of research on religious variables in four major psychiatric journals, 1978-1982. Am J Psychiatry. 1986;143(3):329-34.
14. Baetz M, Larson DB, Marcoux G, Jokic R, Bowen R. Religious psychiatry: the Canadian experience. J Nerv Ment Dis. 2002;190(8):557-9.
15. Sims A. The cure of souls: psychiatric dilemmas. Int Rev Psychiatry. 1999;11:97-102.
16. Culliford L. Spiritual care and psychiatric treatment: an introduction. Adv Psychiatr Treat. 2002;8:249-261.
17. Verhagen PJ (ed.). Religieuze psychopathologie. Tilburg: KSGV; 2007.
18. Moreira-Almeida A. Spirituality and health: past and future of a controversial and challenging relationship. Rev Psiq Clín. 2007;34(Suppl 1):3-4.
19. Moreira-Almeida A, Koenig HG. Retaining the meaning of the words religiousness and spirituality: a commentary on the WHOQOL SRPB group's "a cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life". Soc Sci Med. 2006;63(4):843-5.
20. D'Souza R. Incorporating a spiritual history into a psychiatric assessment. Australas Psychiatry. 2003;11(1):12-5.
21. Koenig HG, Idler E, Kasl S, Hays JC, George LK, Musick M, et al. Religion, spirituality, and medicine: a rebuttal to sceptics. Int J Psychiatry Med. 1999;29(2):123-31.
22. Josephson AM, Larson DB, Juthani N. What's happening in psychiatry regarding spirituality? Psychiatr Ann. 2000;30(8):533-41.
23. Andreasen NC. Diversity in psychiatry: or, why did we become psychiatrists? Am J Psychiatry. 2001;158(5):673-5.
24. Breakey WR. Psychiatry, spirituality and religion. Int Rev Psychiatry. 2001;13(2):61-6.
25. Jakovljevic M. Current status of religion and spirituality in psychiatry. Psychiatr Danub. 2005;17(3):138-40.
26. Boehnlein JK. Religion and spirituality in psychiatric care: looking back, looking ahead. Transcult Psychiatry. 2006;43(4):634-51.
27. Turbott J. Religion, spirituality and psychiatry: steps towards rapprochement. Australas Psychiatry. 2004;12(2):145-7.
28. Halasz G. Can psychiatry reclaim its soul? Psychiatry's struggle against a despirited future. Australas Psychiatry. 2003;11(1):9-11.
29. Murray RB, Zentner JP. Nursing concepts for health promotion. London: Prentice Hall; 1989.
30. D'Souza R, George K. Spirituality, religion and psychiatry: its application to clinical practice. Australas Psychiatry. 2006;14(4):408-12.
31. Morgan PP, Cohen L. Spirituality slowly gaining recognition among North American psychiatrists. Can Med Assoc J. 1994;150(4):582-5.
32. Neeleman J, King MB. Psychiatrists' religious attitudes in relation to their clinical practice: a survey of 231 psychiatrists. Acta Psychiatr Scand. 1993;88:420-4.
33. Fiselier JA, Van der Waal AE, Spijker J. Psychiater, patient en religie: meer dan coping alleen. [Psychiatrist, patient and religion: more than simply coping]. Tijdschr Psychiatr. 2006;48:383-6.
34. Curlin FA, Lawrence RE, Odell S, et al. Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. Am J Psychiatry. 2007;164(12):1825-31.
35. Curlin FA, Lawrence RE, Odell SV, Chin MH, Lantos JD, Koenig HG, et al. The relationship between psychiatry and religion among U.S. physicians. Psychiatric Serv. 2007;58(9):1193-8.
36. Brown C, Lloyd K. Qualitative methods in psychiatric research. Adv Psychiatric Treat. 2001;7:350-6.
37. Mohr S, Brandt P, Borras L, Gillieron C, Huguelet P. Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. Am J Psychiatry. 2006;163:1952-9.
38. Chibeni SS, Moreira-Almeida A. Remarks on the scientific exploration of "anomalous" psychiatric phenomena. Rev Psiq Clín. 2007;34(Suppl 1):8-15.
39. Denzin NK, Lincoln YS. The discipline and practice of qualitative research. In: Denzin NK, Lincoln YS (eds.). Strategies of qualitative inquiry. 2nd ed. Thousand Oaks: Sage; 2003. p. 35.

40. Kvale S. The Qualitative Research Interview: a phenomenological and a hermeneutical mode of understanding. JPP. 1983;14:171-96.
41. Flick U. An introduction to qualitative research. 3rd ed. Thousand Oaks: Sage; 2006. p. 296-300.
42. Lincoln YS, Guba EG. Naturalistic inquiry. London: Sage; 1985.
43. Braghetta CC, Lucchetti G, Leão FC, Vallada C, Vallada H, et al. Ethical and legal aspects of religious assistance in psychiatric hospitals. Rev Psiq Clín. 2011;38(5):189-93.
44. Odejide AO, Oyewunmi LK, Ohaeri JO. Psychiatry in Africa: an overview. Am J Psychiatry. 1989;146(6):708-16.
45. Okasha A. Focus on Psychiatry in Egypt. Br J Psychiatry. 2004;185:266-72.
46. Janse van Rensburg AB. A changed climate for mental health care delivery in South Africa. Afr J Psychiatry. 2009;12(2):157-65.
47. Robertson BA. Does evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies. S Afr Psychiatry Rev. 2006;9(2):87-90.
48. South African Medial Association. Bridging the gap. Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa. Pretoria: SAMA; 2006.