Spirituality, Religion and Psychiatric Practice in New Zealand

A survey of psychiatrists in New Zealand

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Abstract

The literature on spirituality, religion and health identifies spirituality and religious belief as being important components in the recovery from mental illness (May, Muir-Cochrane, & Clare, 2005; Swinton, 2001; Turbott, 1996). This project attempted to identify by use of a questionnaire New Zealand psychiatrists’ attitudes and practice with regard to religious and spiritual issues in mental health.

This study drew on and modified previous work on the topic (Curlin et al., 2007). Three questions were asked:

1. What are the opinions and attitudes of New Zealand psychiatrists regarding religion/spirituality and mental health?
2. What factors determine a clinician’s attitude and practice, with respect to spiritual matters?
3. What factors determine a clinician’s attitude and practice, with regard to spiritual and culturally-based mental health care providers? (i.e. Chaplains and kaumatua/tohunga)

An online survey was used, and advertised in the Royal Australian and New Zealand College of Psychiatrists on-line newsletter.

The response rate was 18% of the total number of psychiatrists in New Zealand. Respondents self-selected to complete the survey, and, as such, the sample may not be representative of psychiatrists in New Zealand. The opinions and attitudes of respondents regarding religion/spirituality and mental health were found to be mixed. A number, however, whilst not necessarily professing religious and spiritual beliefs, acknowledged their importance to patients and therefore to psychiatric assessment and treatment.

The findings suggest that in New Zealand ethnicity is the single most significant factor that determines clinicians’ opinions and practices with respect to religion and spirituality. Those psychiatrists in this sample who identified as New Zealanders were less likely to believe in God, less likely to see value in religious involvement and less likely to refer patients to spiritual and cultural advisors or carers. On the other hand, psychiatrists identifying as New
Zealanders, particularly those still in training, were more likely to see value in marae involvement but were not more likely to refer Māori patients to Māori spiritual leaders.

The findings suggest further research is needed in this area of psychiatry in New Zealand using a more representative sample. This could help provide a basis for better training of psychiatrists in the religious/spiritual domain and therefore better understanding. As a result mental health consumers could receive more effective treatment modalities and outcomes.
Preface

The literature on spirituality, religion and health identifies spirituality and religious belief as being important components in the recovery from mental illness (May, Muir-Cochrane, & Clare, 2005; Swinton, 2001; Turbott, 1996). This project attempts to identify, by use of a questionnaire, psychiatrist’s attitudes and practice with regard to religious and spiritual issues in mental health in New Zealand.

This project started from a simple request in February 2006. The writer’s phone rang. The caller identified herself as a psychiatric registrar working in Hillmorton Hospital. “Several of us are wondering whether we should ask about spiritual and religious beliefs when we assess a new patient. What do you think?”, she asked. The Chaplain replied “Recent research would tend to suggest so, and even DSM IV specifically advises in the introductory notes that enquiry about culture and religion should be carried out”.

Following this conversation I was invited to attend the registrars’ journal group to comment on an article in a reputable medical journal that had raised the issue of spiritual care for those with mental illness. In the discussions that followed it became evident that these registrars were grappling with questions such as: What is spirituality? Should psychiatrists address issues of spirituality for those in their care? How can spirituality and spiritual health be assessed? How is spiritual care facilitated or provided? What interventions can be used?

It is perhaps a sign of changing times that such issues are being raised by medical professionals. Historically religion, spirituality and medicine have had common roots (Koenig, 2005), in the search for understanding and caring for human beings. However, in the last two centuries in particular they have become increasingly separated and are at times seen as being opposed to each other (Larrimore, Parker, & Crowther, 2002). Hall and Livingstone (Hall & Livingstone, 2006) contend that, in the USA at least, the steady exclusion of spirituality from health practice is founded in deep structural components of western society including colonialism, secularisation and attempts to allow space for diversity and tolerance. In many non-western cultures this division has not occurred.
In recent decades there has been an increasing trend to talk of “holistic care”. A review of nursing texts or journals will show that nearly all refer to holism in nursing care. Increasingly in the western world it is being acknowledged that spirituality lies at the heart of what it means to be human and plays a vital role in patients’ recovery from both physical and mental illness. “Holistic care” usually includes a spiritual perspective. If spirituality is a universal part of the human condition then the relationship between mental health and spirituality is of significance to every person of every culture. It becomes increasingly important as cultures intermingle. However the role religion and spirituality play in health and illness is contentious with no common agreement at present. In a multicultural society a health care provider has the task of identifying spiritual and cultural norms that may not be the same as their own, and adapt the care provided to best meet the patient’s needs.

This aspect of cultural difference has to some extent been recognised in New Zealand with the provision of Māori health workers in most health state health care settings. Unfortunately this has not been so well addressed for other ethnic groups or sub-cultures in our non-Māori population.

In designing the survey, it was proposed to replicate on a limited scale the work done at the Chicago University’s Department of Medicine (Curlin et al., 2007). That study was a very large and complex survey of many psychiatrists and general practitioners in the USA. New Zealand has its own distinctive mix of cultures. A survey of psychiatrists and trainee psychiatrists in this country would shed light on how they viewed and approached the religious and spiritual dimensions in their practice.

Permission was obtained from the Center for Health and the Social Sciences and the MacLean Center of Clinical Medical Ethics at the University of Chicago to use the instruments they developed. The two instruments (questionnaires) have been combined and adjusted to fit the New Zealand demographic.

The researcher in this study is a Hospital Chaplain. I am a Baptist Minister with an interest in spiritual care and patient wellbeing. For the purpose of this research I endeavoured to undertake scientific research in the role of a Masters Student. This research used both quantitative and qualitative methods. The analysis drew on both of these and my professional background. I thank my supervisors, Prof Doug Sellman and Associate Prof Simon Adamson for their relentless checking to reduce bias and partiality. It is relevant to note that neither of
my supervisors are practising Christians as I am. Robust discussion of spirituality and potential bias occurred throughout the project.
Acknowledgements

Thanks go to all those who have helped with the research and thesis. My primary supervisor, Professor Doug Sellman, spent many hours gently guiding and patiently encouraging me. Thank you Doug, and also Simon Adamson as my secondary supervisor. Thank you to my chaplain colleagues for their positive encouragement. To my wife Janice and daughters, Cathryn and Morgan, thank you for your patience when the house was cluttered with my papers for several years.

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Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>I</td>
</tr>
<tr>
<td>PREFACE</td>
<td>III</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>VI</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>VII</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>IX</td>
</tr>
<tr>
<td>1.0 LITERATURE REVIEW</td>
<td></td>
</tr>
<tr>
<td>1.1 SEARCH STRATEGY</td>
<td>1</td>
</tr>
<tr>
<td>1.2 HISTORICAL BACKGROUND</td>
<td>2</td>
</tr>
<tr>
<td>1.3 CULTURE</td>
<td>4</td>
</tr>
<tr>
<td>1.4 RELIGION</td>
<td>4</td>
</tr>
<tr>
<td>1.5 SPIRITUALITY</td>
<td>3</td>
</tr>
<tr>
<td>1.6 HEALTH AND RELIGION/SPRITUALITY</td>
<td>9</td>
</tr>
<tr>
<td>1.7 MEETING THE RELIGIOUS/SPRITUAL NEEDS OF THE MENTALLY ILL</td>
<td>11</td>
</tr>
<tr>
<td>1.8 RELIGION/SPRITUALITY AND PSYCHIATRY</td>
<td>15</td>
</tr>
<tr>
<td>1.9 SUMMARY</td>
<td>18</td>
</tr>
<tr>
<td>2.0 METHOD</td>
<td>20</td>
</tr>
<tr>
<td>2.1 SURVEY DISTRIBUTION AND IMPLEMENTATION</td>
<td></td>
</tr>
<tr>
<td>2.2 QUESTIONNAIRE DESIGN</td>
<td></td>
</tr>
<tr>
<td>2.2.1 The National Religious and Spiritual Psychiatric Survey (NRSPS)</td>
<td>22</td>
</tr>
<tr>
<td>2.2.2 Psychiatrists’ Opinions Regarding Religion/Spirituality</td>
<td>22</td>
</tr>
<tr>
<td>2.2.3 Psychiatrists’ Opinions Regarding Religion/Spirituality with Respect to Mental Health Problems and Clinical Practice</td>
<td>23</td>
</tr>
<tr>
<td>2.3 APPROVALS</td>
<td>25</td>
</tr>
<tr>
<td>2.4 SURVEY TRIALLING</td>
<td>25</td>
</tr>
<tr>
<td>2.5 PROTECTIONS</td>
<td>25</td>
</tr>
<tr>
<td>2.6 CONSENT</td>
<td>26</td>
</tr>
<tr>
<td>2.7 PRIVACY/CONFIDENTIALITY/STORAGE OF DATA</td>
<td>26</td>
</tr>
<tr>
<td>2.8 ANALYSIS PROCESS</td>
<td>26</td>
</tr>
<tr>
<td>3.0 RESULTS</td>
<td>28</td>
</tr>
<tr>
<td>3.1 OUTLINE</td>
<td></td>
</tr>
<tr>
<td>3.2 DEMOGRAPHICS</td>
<td>28</td>
</tr>
<tr>
<td>3.3 PSYCHIATRISTS’ OPINIONS REGARDING RELIGION/SPRITUALITY</td>
<td></td>
</tr>
<tr>
<td>3.3.1 Religion</td>
<td>30</td>
</tr>
<tr>
<td>3.3.2 Spirituality</td>
<td>30</td>
</tr>
<tr>
<td>3.3.3 Belief in God</td>
<td>30</td>
</tr>
<tr>
<td>3.3.4 Supernatural Intervention in Mental Health</td>
<td>32</td>
</tr>
<tr>
<td>3.3.5 The Value of Participation in Religious Community or Marae Participation</td>
<td>32</td>
</tr>
<tr>
<td>3.3.6 Christian Spiritual Care Providers</td>
<td>33</td>
</tr>
<tr>
<td>3.3.7 Māori Spiritual Care Providers</td>
<td>36</td>
</tr>
<tr>
<td>3.4 PSYCHIATRIC ILLNESS AND RELIGION/SPRITUALITY</td>
<td>38</td>
</tr>
<tr>
<td>3.4.1 Causality</td>
<td>38</td>
</tr>
<tr>
<td>3.4.2 Treatment</td>
<td>39</td>
</tr>
<tr>
<td>3.5 CLINICAL SCENARIOS</td>
<td>40</td>
</tr>
<tr>
<td>3.5.1 Referring Patients to a Chaplain</td>
<td>42</td>
</tr>
<tr>
<td>3.5.2 Referring Patients to a Tohunga/Kaumatu</td>
<td>43</td>
</tr>
<tr>
<td>3.5.3 Encouraging Involvement in Marae Activities</td>
<td>43</td>
</tr>
<tr>
<td>3.6 SUMMARY OF RESULTS</td>
<td>43</td>
</tr>
</tbody>
</table>
4.0 DISCUSSION

4.1 LIMITATIONS

4.1.1 Limitations in Sampling

4.1.2 Limitations in Design

4.1.3 Limitations in the Literature Reviewed

4.2 IMPLICATIONS FOR FUTURE RESEARCH

4.3 CONCLUSION

REFERENCES

APPENDICES

APPENDIX 1: THE NATIONAL RELIGIOUS AND SPIRITUAL PSYCHIATRIC SURVEY

APPENDIX 2: RESPONDENTS’ COMMENTS ABOUT CHRISTIAN AND MĀORI SPIRITUAL CARE PROVIDERS

APPENDIX 3: OTHER COMMENTS
List of Tables

Table 1  Demographic characteristics of psychiatrists surveyed, examining their opinions and attitudes towards religion and spirituality in mental health (n=116)..................................................................................................................29

Table 2  Respondents to the NRSPS, beliefs about God (n=114).................................31

Table 3  Respondents to the NRSPS, beliefs about the Christian God (n=99) ...............31

Table 4  NRSPS responses to the statement, “Participating in religious congregation provides unique psychological benefits that are not found by participating in other groups”. (n=114) .........................................................33

Table 5  The effectiveness of chaplains and other Christian spiritual care providers as perceived by respondents to the NRSPS. (n=115)..............................................................33

Table 6  The effectiveness of Tohunga, Kaumatua and other Māori spiritual care providers in helping psychiatric patients as perceived by respondents to the NRSPS. (n=116)..............................................................................................................36

Table 7  Extent of religion/spirituality as a cause of mental illness. Percentage responses by respondents to the NRSPS. (n=115)..............................................................39

Table 8  The extent to which religious/spiritual component should be included in mental health treatment. Percentage responses by respondents to the NRSPS. (n=116)..............................................................................................................40

Table 9  Percentage responses to the scenario by respondents to the NRSPS.............41

Table 10 Percentage responses to the scenario (first modification) by respondents to the NRSPS......................................................................................................................41

Table 11 Percentage responses to the scenario (second modification) by respondents to the NRSPS......................................................................................................................42
1.0 Literature Review

1.1 Search Strategy

The initial search strategy was to search online journal databases for articles on spirituality and mental health. This initial search found a very large number (in excess of 1500) that covered a wide range of issues and varied from editorial comment and opinion type articles through to serious qualitative and quantitative research. There are large numbers of articles relating to spirituality and other health issues, particularly palliative and geriatric care.

The primary search strategy was to use databases available at the University of Otago to search online for journal articles. Due to the nature of the subject matter both health and theological/religious databases were utilised. Databases searched were:

<table>
<thead>
<tr>
<th>Health Databases:</th>
<th>Theological/religious databases:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cinahl</td>
<td>Proquest Religion</td>
</tr>
<tr>
<td>Medline</td>
<td>Religious &amp; Philosophy Collection</td>
</tr>
<tr>
<td>Medline pending</td>
<td>(via Ebsco)</td>
</tr>
<tr>
<td>Embase</td>
<td>Academic Search Complete</td>
</tr>
<tr>
<td>AMED</td>
<td></td>
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<tr>
<td>PsychInfo</td>
<td></td>
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<td>Proquest 5000</td>
<td></td>
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</tbody>
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The following keywords were used in varying combinations in both sets of databases:
Spiritual; spirituality; religion; religious; mental health; mental illness; psychiatric; recovery; assessment; history, care, treatment, pastoral, intervention.

Only articles dated later than 2000 were included in an effort to limit the search to the latest thinking on the subject. In the final selection several articles from the 1990s were included due to their particular relevance. The search was restricted to those articles that were in English.
It is noteworthy that failure to search theological databases would have produced a significantly smaller selection of literature. It is the writer’s observation that to publish in only those journals limits the readership to those who already value spirituality. Many articles that seek to promote spiritual care to the medical profession unfortunately will never be seen by the intended readers.

As well as the above searches several books were read and the reference lists examined for new or relevant material. Of particular value is Koenig’s meta-analysis of the research in religion/spirituality and health (Keonig, King & Carson, 2012). Much of this material was older but is still of significance given the nature of the subject is such that time does not cause great change. There are no significant technological changes that are likely to have occurred. Use was made of the website of Duke University in the USA. Article references were also followed up.

Once the search was completed the articles collected were sorted by abstract content into question relevance. Secondary selection was then based on the type of article. Preference was given to those that were research based rather than a statement of opinion. Several literature reviews were also selected as they provided valuable insights. The final selection included only articles from peer reviewed journals. As well as these criteria the articles were submitted to appraisal based on the Dixon-Woods checklist.

1.2 Historical Background

Religion and spirituality are thought to address essentially the same issues as psychiatry (Hartog & Gow, 2005) and provide a context essential to understanding suffering, mental health and illness (Halasz, 2003). Yet the relationship between them has at times been characterised by conflict and mutual disregard (Hartog & Gow, 2005). The role that religion and spirituality can play in health and illness is still a contested issue.

Despite the popular belief that, prior to the development of modern psychiatry in the last two centuries, the mentally ill were isolated and treated with fear and neglect (Hartog & Gow, 2005) it can be shown that a history of compassionate care, grounded in both religious and civil authority, can be traced back to the first century (Koenig, 2005). However as Koenig notes, the relationship between religion and the treatment of those with mental illness has not always been
positive, particularly in western culture (Koenig, 2005, p. 39). At a practical level Bethlem Hospital in the UK has provided compassionate care for 750 years (Sims, 1999).

Traditionally priests and doctors were one and the same. With the Enlightenment, and the formalising of scientific method, physical (scientific) knowledge and spiritual knowledge were divided and eventually grew apart. Swinton (2001) provides an analysis of the cultural development of this schism. Today “religious people and psychiatrists often appear to live in two different worlds and they know that they do”, (Sims, 1999, p. 97).

Sigmund Freud, who has been referred to as the father of psychiatry and psychological medicine, had a particularly negative view of religion (Koenig, 2005, p. 25f) as did several of his contemporaries (Marks, 2006). Their views influenced attitudes in the development of psychiatry (Marks, 2006; Sims, 1999) and can still be seen by reference to “‘recurring malignant references to religiosity and religious belief”’ (Marks, 2006, p. 135) in the Diagnostic and Statistical Manual-III. However, much of the empirical data of the last 30 years has failed to support such a negative view (Keonig, King & Carson, 2012). The negative references were eliminated in the DSM-IV and a new diagnostic category, “religious and spiritual problems” was introduced along with specific instructions to consider patients’ spirituality, culture and religion.

Many writers have considered the problems of developing universally accepted definitions of religion and spirituality (McSherry & Cash, 2004; Sheridan, 1986; Swinton & Pattison, 2010; Vandenberg, 2010). Even after decades of debate and theorising, there is little consensus on how to define the terms (W. K. Mohr, 2006). Some writers even talk of “controversy and confusion” (Koenig, 2005, p. 44). In general terms “religion” refers to ordered systems of belief within a structured communal setting which people engage in. Spirituality, on the other hand, is much more individual, amorphous, intangible and subjective (Mohr, 2006; Wilding, May, & Muir-Cochrane, 2005). The relationship between culture, religion and spirituality is explored in some depth in this literature review.

Spirituality and religion are far from being discrete entities that can be considered in isolation from each other. Rather, they are complex and varied (Fleming & Evans, 2008). Religion and spirituality exist and are expressed within cultural contexts, both collectively and individually (Fallot, 2001, p. 111). Attempts to define either without wider reference to culture can lead to mis-definition and does justice to neither.
1.3 Culture

Commonly-used definitions of culture from the Encarta World Encyclopaedia and the Oxford Dictionary include: “Shared beliefs and values of group: the beliefs, customs, practices, and social behaviour of a particular nation or person…” and “the ideas, customs, and social behaviour of a particular people or society” (p. 206).

In the literature of medical science the definition of culture has been evolving and broadening and is being seen as increasingly complex. A definition by Geertz in 1973 defined culture as, “the fabric of meaning in terms of which human beings interpret their experience and guide their action” (quoted in Vandenberg, 2010, p. 240). Sheridan gives a fuller definition as;

Culture is an open, complex, systemic whole of human behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups. The essential core of culture consists of traditional ideas and values. A culture is both a product of action and conditions further actions. Culture has a function, among others, to transform the human predicament, that is, the inherent dilemmas of being finitely human in time and space, possibly in the assisting presence of a Transcendent Other. (Sheridan, 1986, p. 40).

As will be seen in the following, the intersection of and influence of culture on religion and spirituality is strong.

1.4 Religion

If culture is a natural response to the human dilemma as stated above then “religion functions substantively as a cultural answer to the dilemma of being human within the whole of reality when the whole of reality is sensed as greater than the sum of its parts” (Sheridan, 1986, p. 37). Sheridan argues that the functional actions of religion make religion very close to culture and that the two are hard to distinguish. It is unclear at times whether religion is a cultural system or culture is a religious system.
Despite this blurring of boundaries there are some features that are clearly associated with religion and that are generally accepted definitional markers. Swinton states “religion refers to a formal system of beliefs, usually centring on some conception of God and expressing the views of a particular religious group or community ... a person’s religion ... i] something that is foundational to the way in which they experience themselves and make sense of the world they inhabit” (Swinton, 2001, p. 28). Hodge sees the linking in of individuals to a moral community as being fundamental to religion (Hodge, 2006, p. 318).

The main features of religion can be summarised as the following:

Religion:
- is a community's organised system of beliefs, practices and rituals.
- is designed to increase a sense of closeness to the sacred or transcendent.
- promotes an understanding of one’s relationship to and responsibility for others living together in a community.
- may be authoritarian in terms of behaviours and the exercise of responsibilities.
- is concerned with beliefs and doctrines that among other goals seek to separate good from evil.

(Koenig, 2005, p. 44)

Sheridan considered a need to develop a working taxonomy to distinguish culture from religion. He sees religion as that part of culture that is linked to the understanding of and relationship with the Transcendent Other outside of the spectrum of human understanding alone.

Reductionism does not do justice to these concepts. Culture and religion are not distinct entities. What about spirituality?

1.5 Spirituality

The word spirituality in the English language has its origins in Christian, Jewish and Islamic early history. The Christian Bible in the first chapter speaks of the Spirit of God involved in creation and breathing life into humanity. The Hebrew root word is ‘ruach’ that is translated literally as the ‘wind of God’ or ‘breath of God’ (Goodrick & Kohlenberger, 1990). In later times as Latin became the main language of the world the Latin translation of ‘ruach’ was
‘spiritus’ from which the word spiritual is derived. So the term has a long association with religious belief.

Many problems of definition arise from this historical religious association and the modern tension between religion and science. The worldview of materialistic science is radically different to the worldview of religions derived from eastern thought (Swinton, 2001). This difference in worldview is reflected in differences in language. Verhagen discusses the problem of incommensurability, viz the inability to completely translate theories of worldviews in other’s terms. There is no mutual language as the paradigms of each worldview are fundamentally different (Verhagen, 2010). Others recognise that religious and medical-scientific views are two distinct forms of knowledge (Wagenfeld-Heintz, 2008). This distinction is seen by some as so sharp as to lead to the total dismissal of religion and spirituality in psychiatric practice. As Lawrence has said:

Those who wish to mix religion and medicine do not understand that the language of science and the language of religion are radically different. Religion and spirituality exist in the realm of poetry and the imagination, not the realm of science where medicine dwells. The rules of discourse are different. To mix the languages can be highly misleading and disruptive. Physicians who are scientists cannot legitimately incorporate “relationships with transcendent beings” into their discourse as if it were another source of data like some laboratory result. To do so is schizophrenogenic (R. J. Lawrence, 2002, p. 75).

Despite such antagonistic views many medical practitioners seek to more fully appreciate the links between medicine, religion and spirituality. The problem of definition however will never go away. However there is a growing understanding of the gulf between paradigms of religion and science. Recent writers in the field have looked to the utility of religion and spirituality as basis of definition and are arguing that scientific definition is not necessary.

Spirituality is very difficult to define, and there is little agreement about what it is. Swinton contends that it is a “highly contested concept” with definitions ranging from coherence to dissonance and disparity (Swinton & Pattison, 2010, p. 226). In medical and allied health journals and books the range of definitions is wide. Barker (2004) talks of “spirituality as a reflection of the process of change.” This definition reflects the Buddhist spirituality that
suffuses his book. In a similar vein O’Reilly (2004, p. 46) says “spirituality has been described as a maturation and change in response to life events”. McSherry (2000, p. 26) says spirituality is a “Quality that goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death”.

Lindgren and Coutsey (1995, p. 93) however specifically relate personal spirituality to God. They define spiritual support as “the perceived, personally supportive components of an individual’s relationship with God.”

Swinton has developed a concise definition: “Spirituality is the outward expression of the inner workings of the human spirit. It is a personal and social process that refers to the ideas, concepts, attitudes and behaviours that derive from a person’s or a community’s interpretation of their experiences of the Spirit” (Swinton, 2001, p. 20). Much of this definition can be said to be true of both culture and religion as terms to explain humanness. Swinton in the next paragraph developed his model further:

Spirituality is an intra, inter and transpersonal experience that is shaped and directed by the experiences of individuals and of the communities within which they live out their lives. It is intrapersonal in that it refers to the quest for inner connectivity ... It is interpersonal in that it relates to the relationships between people and within communities. It is transpersonal in so far as it reaches beyond itself and others into the transcendent realms of experience that move beyond that which is available at a mundane level.

With such a range of definitions in the literature it is little wonder that Mohr (2006) contended that spirituality outside of religion is amorphous and difficult, if not impossible to define. Other writers agree (Esther, May, Eimear, Muir-Cochrane, & Wilding Clare, 2005). Despite assertions “that the construct of religion is fairly well grounded, while that of spirituality is much more diffuse” (Blazer, 2009, p. 281) it would seem that many of the definitions developed for spirituality can be applied, in part or in full, to both religion and culture.
Given these problems of definition some argue that spirituality is irrelevant, non-existent and not worthy of study (Swinton & Pattison, 2010). The conceptual separation of spirituality and religion is a relatively recent development (Swinton & Pattison, 2010). Many researchers and authors however stress that spirituality is distinct from, and must not be equated to, religion (Mohr, 2006). Others see spirituality and religion as overlapping concepts (Mueller, Plevak, & Rummans, 2001) or synonymous (Fallot, 2001) (Kendler, Liu, Gardner, McCullough, Larson, & Prescott, 2003). Fallot bases his view on a review of literature to date whereas Kendler et al. came to their conclusion by extensive statistical analysis.

The use of quantitative tools to investigate issues of spirituality (Larson & Larson, 2003) is becoming increasingly common. The use of such analysis allows researchers to more accurately define and describe these issues. As a result many are now seeing religion as the means of expressing spirituality (Mohr, 2006). Swinton speaks of religion as being the vehicle for spirituality (Swinton, 2001, p. 23). However, issues of definition remain deeply subjective. Each researcher is influenced by their own cultural heritage.

Swinton concludes that spirituality emerges as a response to particular needs in specific situations. As such it is highly individual. In different situations and circumstances individual attempts to define or understand spirituality may modify or contradict previous definitions in different circumstances. The vagueness of definition allows spirituality to address a wide-ranging set of needs, or lacks, in a patient’s situation. Any definition will arise from, and is influenced by, the meaning or need at the time. Spirituality is not a “thick theoretical concept, but is a thin and vague construction that … is defined by its practical utility” (Swinton & Pattison, 2010, p. 232).

Curlin more formally states the need to focus on the function of religion and, by extension, spirituality, rather than engaging in an etiological debate on the meaning of words. In this way spirituality is able to:

avoid minimizing or neglecting the influence of secular traditions, empirical studies of religion and the practice of medicine would employ a functional definition of religion, in which a person’s religion is that set of intellectual and moral commitments (beliefs and values, with their related practices) that the person self-consciously endorses as his or her own worldview.
Worldviews may be substantially religious or they may be substantially secular (Curlin, 2008, p. 1119).

The problem of defining terms will continue as it reflects a clash of worldview. Western culture has become predicated on a scientific worldview that seeks to define by measurement and materiality (Swinton, 2001). Spirituality sits outside this worldview. Verhagen sees the problem as one of incommensurability. A complete translation from one worldview to the other is simply not possible. There is no neutral language that allows for full description or understanding. People use different standards for truth and rationality (Verhagen, 2010). To become intelligible to each other the world of the spirit and the world of science must continue to dialogue. Psychiatry and religion both seek the same end, the alleviation of suffering. However they are worlds apart on issues of worldview and vocabulary used to describe, explain and understand suffering and wellness (Hartog & Gow, 2005, p. 263).

Some researchers are optimistic that dialogue about definitions of spirituality is possible and will continue to evolve and change until “mutual acceptance and understanding is achieved” (Verhagen, 2010). Others however contend that a universal definition of spirituality is theoretically and culturally impossible (McSherry & Cash, 2004).

In this study the combined term religion/spirituality was used to describe the overlapping domains of religion and spirituality. This reflects the difficulties of definition and the blurred boundaries between the two domains. Such usage allows for flexibility and recognition of the changing and overlapping functions that religion and spirituality has across a wide range of individuals and circumstances. It also allows for maximum inclusivity.

1.6 Health and Religion/Spirituality

Patient-based research has established that spirituality is life-sustaining and life-enhancing for many sufferers of mental illness, to such an extent that it is described as being vital to life (May, Muir-Cochrane & Clare, 2005, p. 6). Spirituality extends to the core of who we are. Turbot quotes Lukoff et al. in asserting that “the religious and spiritual dimensions of culture are amongst the most important factors that structure human experience, beliefs, values, behaviour and illness patterns” (Turbott, 1996, p. 721). For many people the importance of these issues does not become evident until their worlds are threatened.
It seems, however, that in times of illness, what might be loosely called spiritual, meaning, and identity issues come to the fore even when religion and spirituality formally defined have not previously been of significance. (Swinton & Pattison, 2010, p. 229).

There have been a large number of studies on the relationship between religion and spirituality and health. Last century alone over 1200 such studies were conducted. (Koenig, 2012). Other papers cite 350 studies for spirituality and general health outcomes and 850 for spirituality/religion and mental health (Mueller, Plevak, & Rummans, 2001, p. 1230) (Mohr, 2006, p. 176). The majority of these studies (65-75%) have found a direct beneficial relationship between religious involvement and belief and health outcomes (Koenig, 2002). Despite such extensive writing and research, the exact nature and action of this relationship has not yet been determined. However the link is well established.

Religious people as a whole are physically healthier, lead healthier lifestyles and require fewer health services (Koenig, 2002). More specifically patients with a clear religious/spiritual base and practice are less prone to depression and other mental illnesses and are more likely to experience more successful recovery (Mueller, Plevak, & Rummans, 2001) (Larson & Larson, 2003).

Religion, can however, have negative effects. Religious people can have unrealistically high expectations of themselves (Mueller, Plevak, & Rummans, 2001, p. 1230). Other negative effects may include spiritualising issues with a subsequent lack of insight, failure to accept or comply with medical regimes, excessive guilt and/or self-condemnation (Larson & Larson, 2003, p. 42).

Despite these cautions most studies show a positive effect for up to 90% of those who seek comfort and support from religion (Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006, p. 1958). In addition Mohr shows that for up to 85% of patients with schizophrenia, religion and spirituality are vitally important to their ongoing well-being. This is consistent with other studies that show 80% of the general mental health patient population report positively about the influence of religion (Lindgren & Coutsey, 1995).
It is evident that religion and spirituality play a vital and significant role in the lives of those who experience mental illness. Many authors conclude that integrating spiritual care into mental health treatment is necessary. Not to do so would be to miss out on a therapeutic “treasure” (May, Muir-Cochrane, & Clare, 2005). Such integration takes more seriously the voiced needs and preferences of consumers (Fallot, 2001; Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006). These authors paint a very positive picture of the benefits of spirituality and religious belief.

A cautionary note is sounded by some commentators and writers that methodologies used by researchers in this area of study are flawed. Mohr contends that researchers have “failed to control for confounding variables and covariates, as well as to control for multiple comparisons using multiple statistical procedures”. She claims that “Failure to control for these factors can lead to a biased estimation of this association” (Mohr, 2006, p. 177). King and Leavey argue that much of the research is flawed both methodologically and conceptually. However they agree research into and consideration of spirituality and religion in medicine has the potential to be worthwhile and is necessary (King & Leavey, 2010). Cook maintains that King and Leavey needlessly dismiss good research (Cook, 2010).

Most research on religion and spirituality in medicine has been conducted in the USA, Canada and Britain. Most of the articles located from database searches for this study were from these countries. The only studies that have direct relevance to New Zealand are those by Turbot (1996) and Payman (2000).

1.7 Meeting the Religious/Spiritual Needs of the Mentally Ill

Some researchers have asked if it is the role of professional medical staff to meet such needs. They could be met by the patient’s faith/religious community. However many patients have become alienated from their communities because of their symptoms (Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006), or have had a bad experience with established religion (Moller, 1999). As a consequence many of this client group have unmet spiritual needs (Moller, 1999; Mueller, Plevak, & Rummans, 2001). Some suggest that mental health patients have more unmet religious and spiritual needs than do surgical or medical patients (Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006). Unmet needs are particularly relevant in a population
group that considers spirituality to be more important in their everyday lives than does the general population (Mohr, Brandt, Borras, Gillieron, & Huguelet, 2006).

There is a lack of research to determine if these needs are being met in mental health services in western societies (Flannelly, Galek, & Handzo, 2005). Consumers can be at ease talking about religion and spirituality with psychiatrists (Mohr, Brandt, Borras, Gillieron & Huguelet, 2006), yet most do not receive or seek support from psychiatrists in this area of their lives (Moller, 1999) (Flannelly, Galek, & Handzo, 2005). As US study found even chaplains charged with spiritual care meet only 10-30% of patients hospitalised (Flannelly, Galek, & Handzo, 2005). These chaplain figures are based on a ratio of one chaplain per 100 beds. In New Zealand the chaplain to bed ratio is half that figure, being set at 1: 200 beds (ICHC, 2011, p. 2).

My search of the literature suggests little has been done to address the question of what spiritual interventions and care currently take place in psychiatric care. Theorists have discussed the interventions they think are appropriate, however there is wide degree of variance between them.

Some research has been carried out with consumers of mental health services to investigate what they consider important to meet their spiritual needs (Moller, 1999; MacGillivray, Thelma, & Wicks-Nicholls, 2006). A paper by Lingren and Coutesy (1995) attempted to evaluate this using experimental methods. Their results showed some benefits but they were inconclusive. The programme they adopted took an educational approach, rather than focusing on spiritual care.

Another early US study examined spiritual care by nurses working in a long-term mental health facility. It identified interventions nurses were already making and grouped them under four broad themes: being with the client, doing for the client, facilitating clients to look within and facilitating clients to look outward (Tuck, Pullen & Lynn, 1997).

It would appear that whilst most health professions agree that spiritual care is necessary and desirable, there is no agreement about who should be responsible and how it should be done. Nurses particularly support spiritual care (El-Nimr, Green, & Salib, 2004) and are trained to treat patients holistically. However, based on UK study, in their day-to-day practice they report that they feel inadequately equipped to meet patients’ need for spiritual care (McSherry
& Ross, 2002). Chaplains traditionally have been considered to be the main providers of spiritual comfort and care. McSherry and Ross argue that multidisciplinary involvement between chaplains, nurses, doctors and other allied professions is necessary. Mohr supports this view by encouraging nurses to build collaborative relationships with patients, clergy and chaplains (Mohr, 2006). Even Koenig who has written prolifically on these subjects, acknowledges that “almost no research has been done to guide ... which actions [or interventions] are appropriate” (Koenig, 2002).

Some research has been attempted to evaluate psychiatrists’ attitudes and responses to discussing spiritual issues with patients. In a UK-based study very few doctors had any training in religion and spirituality and very few GPs wanted further training (El-Nimr, Green, & Salib, 2004). Psychiatrists in the same study thought that this type of care should be assessed and provided by mental health professionals. This can be seen as a logical extension of multi-disciplinary care. The findings that psychiatrists are happier with this form of care is supported by an extensive US study (Curlin, et al., 2007). It found that, on the whole, those doctors who had a personal religious/spiritual orientation were more likely to engage with their patients at this level.

The New Zealand government has since the 1980’s adopted a policy of biculturalism which has affirmed the importance of the Treaty of Waitangi in framing our national life and institutions. Under this policy an understanding of health that is culturally sensitive has developed, particularly with reference to Māori health. Turbot points out that any consideration of Māori mental health issues ‘must acknowledge the unique cultural heritage and cultural reality in which Māori people live’ (Turbott, 1996, p. 722). He quotes the New Zealand Ministry of Health document Looking Forward. Strategic Directions for Mental Health which states; “Mental health services in the future will need to be culturally safe and able to provide treatment at a spiritual, physical, emotional and cultural level. This will apply to both mainstream mental health services and any services managed and delivered by Māori themselves” (Ministry of Health, 1994, p. 18). This document expresses clear expectations that our mental health providers should acknowledge and respond to the spiritual needs of the Māori population, if not others.

If Looking forward is to be taken seriously then mental health providers are not only charged with identifying spiritual needs, but they must also provide appropriate interventions to ensure that these needs are met.
As well as the general requirement to adhere to Treaty principles, three documents require psychiatrists to consider the religious and spiritual beliefs and needs of their patients:


   Principle 1.1 Psychiatrists shall respect a patient’s culture, ethnicity, language and religion.
   Principle 1.2 Psychiatrists shall not discriminate against patients on the grounds of age, gender, race, ethnicity, sexual orientation, disability, language, religious or political affiliation; they shall not impose their own values on patients and their families. [My emphasis]
   Principle 3.2 Psychiatric care shall involve consideration of a patient’s physical, psychological, social and spiritual wellbeing. Psychiatrists shall provide advice to patients where it is identified that care, other than psychiatric care, is needed.


   a. Consumers have Rights and Providers have Duties:
      i)  Every consumer has the rights in this Code.
      ii) Every provider is subject to the duties in this Code. [My emphasis]
   b. RIGHT 1 Right to be treated with respect
      i. Every consumer has the right to be treated with respect. (Health, 1994)
      ii. Every consumer has the right to have his or her privacy respected.
   c. Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori. [My emphasis]

3) Looking Forward Strategic Directions for the Mental Health Services. (Ministry of Health, 1994, p. 5)

This document issued by the Ministry of Health in 1994 sets out the 14 principles by which all subsequent legislation relating to mental health have to comply. Among the principles are:

- Encouraging services that enable people of any age, culture, gender or individual interest to fully participate in society.
• Improving the cultural safety of services and ensuring that services accommodate cultural differences, especially for Māori.

These three documents make it clear that psychiatrists in New Zealand have professional responsibility to be aware of and consider their patient’s religious and spiritual needs, views and circumstances. However little research has been done to see what is happening here. Payman in 2000 considered the actions of psycho-geriatricians in New Zealand. D’Souza reported in 2003 that only 11% of New Zealand patients reported that a spiritual history had been taken in their psychiatric assessments (D’Souza, 2003). Payman’s study is one of only nine published worldwide on the subject of psychiatrists’ belief and actions with regard to religion and spirituality (Cook, 2011).

1.8 Religion/Spirituality and Psychiatry

There have been very few published studies on the spiritual beliefs and attitudes of psychiatrists and how this may effect their clinical decisions (Curlin, 2008, p. 1119). A recent literature review Cook (2011) identified only nine published papers on this subject. Cook did not include a paper by El-Nimr and colleagues (El-Nimr, Green, & Salib, 2004). That asked about attitudes towards spiritual care within the clinical setting. Possible reasons for this lack of research are that spirituality and psychiatry is an area of research that evokes prejudices and stigma. Swinton notes that “Young researchers avoid the area for fear of negative repercussions on their career advancement” (Swinton, 2001, p. 42). Another limiting factor is the problem of incommensurability so work in this area is not seen as ‘hard research’.

Research so far suggests that psychiatrists are likely to be less religious and identify as less spiritual than the general population. Curlin showed that psychiatrists are less religious or spiritual than other doctors within the same population (Curlin, Lawrence, et al., 2007, p. 1825). This tendency to has been confirmed in studies in Britain and Australasia (R. E. Lawrence et al., 2006; Payman, 2000). Payman’s study in Australia and New Zealand of psycho-geriatricians showed that 43% of his respondents reported no religious affiliation, but 40% reported a belief in God. Lawrence’s study seven years later yielded similar results.

Despite the reported lack of personal belief or religious affiliation amongst psychiatrists, a number of studies suggest an openness and willingness to discuss spiritual issues with
reference to their patients (Curlin, Chin, Sellergren, Roach, & Lantos 2006). The view that spirituality and religion are positive factors in recovery stands against some of the negative stereotypes of antagonism between religion and psychiatry.

In the USA three out of four psychiatrists describe the influence of religion/spirituality as generally positive (Curlin, Lawrence, et al., 2007, p.1829). Even so, they acknowledge that in some cases religion/spirituality can be associated with anxiety, guilt or other negative emotions. This positive attitude among psychiatrists, despite a high proportion of them not holding religious beliefs, could reflect a general recognition of the observed positive effects of religion and spirituality on patients’ health.

Over 90% of psychiatrists in Curlin’s study were open to discussing and addressing their patients’ spiritual and religious needs. However, they noted that such consideration was one-sided, on the side of the patient, as the psychiatrist had to adhere to a professional non-disclosure policy. Payman also notes that non-disclosure is tightly adhered to. Although more than 90% may be open to addressing spiritual needs within the clinical encounter, such discussion is more likely to occur if the psychiatrist themselves has religious or spiritual beliefs (Curlin, Lawrence, et al., 2007).

Much of the research, five out of ten studies, has been conducted in the USA. One research study conducted in UK reported that “Non-UK respondents were more likely than UK-born respondents to see humans as made up of spirit as well as body, perhaps reflecting the greater religious emphasis in many other cultures” (El-Nimr et al., 2004, p. 168). This raises the question of transferability of findings between cultures and nations. Is what happens in the USA and UK applicable in other settings? Cook (2011) identifies trans-Atlantic cultural differences. Cook claims that the USA is a religious nation and the UK as secular. This results in a difference of language of public religious discourse. Incommensurability is not limited to religious/scientific conversation but also inter-cultural conversations.

Payman in the title of his paper asked the question, “Do Psycho-geriatricians ‘Neglect’ Religion?” This reflected the stereotype that psychiatrists ignore religion and spirituality. He concluded by saying:

Although by and large an irreligious group, Psycho-geriatricians nevertheless do consider religion to be important. In particular, most
believe that there are important links between religion and mental health and most do concern themselves with the religious issues of their patients. However, they are reluctant, for various reasons, to refer patients directly to pastoral counsellors, and most do not seek any formal or informal training in religious issues. (Payman, 2000, p. 143)

In respect of referring their patients to chaplains or other religious caregivers psychiatrists do appear to show a reluctance to do so. Lawrence et al. report that over 50% in the UK would consider patient referral and a quarter staff referral, but they note this is hardly ever done (R. E. Lawrence et al., 2006). There has been little research to test Sim’s statement in 1994 that psychiatrists ignore the spiritual dimension (Sims, 1994, p. 444). At the time he postulated five reasons for this:

   a. It is considered unimportant.
   b. It is considered important but irrelevant.
   c. Psychiatrists know too little about it.
   d. The terminology is confusing and the topic is embarrassing.
   e. Psychiatrists are in denial because it is too challenging.

Further research has produced more thoroughly grounded reasons. Curlin (2006) identified the following:

   i. Lack of time.
   ii. Concern about offending patients.
   iii. Personal discomfort in discussing religion/spirituality.
   iv. Insufficient knowledge and training.

Considering Curlin i-iv it is clear that Sim’s first two reasons: it is unimportant or irrelevant can be contested. Cook asserts ‘the growing literature gives increasingly little excuse for ignorance and belies imputations of unimportance or irrelevance’ (Cook, 2010, p. 195). The issues involved in patient spirituality are challenging and possibly embarrassing to the physician, but no more so than the intimate details of sex and relationships that psychiatrists must deal with.

The literature shows consistent calls for psychiatrists to have more training in religion and spirituality, both in the world’s main religious traditions and in the link between religion/spirituality and health (Curlin, Lawrence, et al., 2007; Payman, 2000; Sims, 1999;
Research conducted by Balboni (Balboni et al., 2012) in “End of Life” oncology settings suggests that such education in spiritual care for nurses and doctors is the major determinant of the extent and quality of spiritual care received by patients. The Association of American Medical Colleges has a series of learning objectives regarding spirituality that new graduates should be competent in (Curlin et al., 2006). They should be able to: elicit a spiritual history, apply their understanding of patients’ spirituality to appropriate clinical contexts and recognise and take into account the way that their own spirituality might affect how they relate to, and provide care to, patients.

In New Zealand *The Curriculum for Basic Training in Psychiatry of the Royal Australian and New Zealand College of Psychiatrists* (RANZCP, 2002) lists the following knowledge objectives:

‘In particular, trainees should be able to demonstrate knowledge of:

K4.8 the influence of specific factors on assessment and care of mental health problems and mental illnesses, including:

(e) Culture;

(f) Spiritual beliefs’

The requirement of knowledge of these matters implies an expectation to consider them in professional practice.

1.9 Summary

There is a well-established body of research on the importance of religion and spirituality in health, including mental health. This literature review does not claim to be comprehensive. It has focused on the beliefs and actions of psychiatrists concerning the role of religion and spirituality in their daily work. Religion and spirituality have been identified as being vital and life-giving by mental health clients. However a number of studies have suggested that patient’s spiritual needs are not always met by traditional sources. Some but not all health providers see it as their responsibility to holistically meet the needs of patients, including their spiritual needs. Others are strongly opposed to such an integration. Some regard this as an “unholy alliance” (Lawrence, 2002), rejecting it on professional grounds (Poole & Higgo, 2011). Few such studies could be found. However, there is on-going debate and contestation over the intersection of religion/spirituality and health.
Psychiatrists, despite being generally less religious than the general population and their patients, have been shown in some studies to be open to spiritual conversations with their patients. Little evidence is yet available to indicate how often and in what manner these conversations occur. The literature tends to suggest that, whilst there is growing recognition of the value and importance of religion and spirituality to sufferers of mental illness, there is still inertia acting on this in the clinical setting and a reluctance to refer patients to pastoral care-givers.

Recent research points to the inescapability of a religious and spiritual component in clinical interactions (Cook, 2011, p. 15). Whether this is addressed explicitly or remains implicit depends on the decisions and actions of the clinician. Some psychiatrists are reluctant, for various reasons to include this dimension.

This review of the literature has identified both strengths and weaknesses in the existing knowledge in this field. There is a surfeit of writing and research on the benefits of spiritual belief and practice on mental health and health outcomes. In mental health there is a vast volume of writing at a theoretical level on spiritual issues. Conversely, there is a lack of reliable data on the beliefs and practice of psychiatrists. Perceptions of the role and importance of religion and spirituality in psychiatry depends on the professional orientation and personal belief structure of each individual health professional.

These findings indicate that further research is needed on the beliefs and attitudes of psychiatrists. The dearth of such research in New Zealand leaves those in this country dependent on studies in the USA, UK and Canada. As noted above, such research may not be transferable to a small more secular South Pacific nation.

This study then seeks to explore the following main questions:

1. What are opinions and attitudes of New Zealand psychiatrists regarding religion/spirituality and mental health?
2. What factors determine a clinician’s attitude and practice, with respect to spiritual matters?
3. What factors determine a clinician’s attitude and practice, with regard to spiritual and culturally based mental health care providers (chaplains and kaumatua/tohunga).
2.0 Method

It was proposed to build on the Chicago study (Curlin, 2007), a large and complex national survey of psychiatrists and general practitioners in the USA.

The Chicago questionnaires contained several scenarios as well as demographic and personal belief questions. The questionnaire required at least 25 minutes to complete. Many of the questions were not directly transferable to a New Zealand setting due to differences in language and culture, so a survey reflecting these was designed. The length of the Chicago questionnaire and the time required to complete it was considered likely to discourage participation. The New Zealand version was considerably shorter.

Permission was obtained from the Centre for Health and the Social Sciences and the MacLean Centre of Clinical Medical Ethics at the University of Chicago to use the instruments they had developed. The two instruments (questionnaires) were combined, reduced and adjusted to reflect the New Zealand demographic.

The Chicago study elected not to attempt to define the terms spirituality and religion but rather let respondents use their own definition and understanding. Due to the issues of definition discussed above, this study took the same approach. The text of my questionnaire, The National Religious and Spiritual Psychiatric Survey (hereafter referred to as the NRSPS) is given in Appendix One.

2.1 Survey Distribution and Implementation

It is recognised that psychiatrists are a challenging group to survey (Thorpe et al., 2009). Initially a mail survey was proposed, as research indicates that high return rates can be achieved with sound appropriate implementation strategies. These have a greater influence on return rates than survey design (Brennan, 1992).
Several factors influence response rates (Edwards et al., 2002; Nakash, Hutton, Jorstaa-Stein, Gates, & Lamb, 2006; Thorpe et al., 2009). It was hoped that by using an advance notice and intense follow-up the return rate would be at least 70%, sufficient for a representative sample.

It was initially proposed to circulate the questionnaire to all psychiatrists in New Zealand registered with the New Zealand Branch of the Royal Australian and New Zealand College of Psychiatrists which had 642 members (342 Fellows, 144 affiliates and 156 Trainees). Unfortunately, the RANZCP was unable to release a list of members because of privacy concerns.

However, the RANZCP was able to publish a one page notice and web link in their online New Zealand members’ newsletter bulletin. It was therefore decided to use an advertised online survey. Survey Monkey was selected as an appropriate tool as it is readily accessible, relatively cheap and trusted. Survey Monkey also enables the downloading of data in suitable formats for data analysis.

Online surveys generally have a lower rate of return than mailed paper surveys (Nulty, 2008) or any paper survey. As mailing of the survey was not possible, it was accepted that an advertised online survey would have significantly lower returns than the posted survey originally planned.

There are limited strategies to increase the return rates for online surveys. The following strategies were used:

- The notice in the newsletter was written by a named senior academic (Professor Doug Sellman) from the University of Otago to give authority to the project (Evans & Mathur, 2005).
- Use was made of an Internet Survey Service (Survey Monkey) to structure the questionnaire and collate the responses (Wright, 2006).
- The survey was relatively short, relevant and varied. Taking less than ten minutes to complete.

Low return rates are the most cited shortcoming of online surveys. Others are that respondents are volunteers only. Such samples are not necessarily representative of the sample population. Those with strong views are more likely to respond, compared to those who are more neutral or uninterested. Little can be done to overcome this problem. Second
there is the possibility of multiple responses from one person. Survey Monkey is structured and has systems in place to prevent this, identifying IP addresses and using a personal identifier for each respondent.

2.2 Questionnaire Design

2.2.1 The National Religious and Spiritual Psychiatric Survey (NRSPS)

Questions were adapted from the Chicago instruments to provide an interesting and varied series of questions and scenarios with multi-choice answers. As well as quantitative data, provision was made for qualitative written replies in two questions and there was an opportunity to make further comments at the end. Including both quantitative and qualitative responses can yield “the most fruitful empirical research regarding religion and medicine” (Curlin, 2008). Questions on demographic and personal belief were similar to the Chicago survey. Where appropriate the questionnaire used the same categories as used by the official New Zealand census on ethnicity, religion and gender.

Limiting the number and length of questions meant some compromises. The section on demographics asked respondents to indicate religious affiliation and belief in God, but did not include a measure of their religiosity. Curlin argues at least one or preferably two such measures should be included (Curlin, 2008). A specific question relating to belief in the Christian God was included as census figures reveal Christianity is still the major religion in New Zealand.

2.2.2 Psychiatrists’ Opinions Regarding Religion/Spirituality

For reasons stated above, no definitions of spirituality or religion were given in the questionnaire. Two questions asked how religious and how spiritual psychiatrists considered themselves to be. These were taken from the Chicago survey.

Further questions from the Chicago survey and census questions were used to identify the religious/spiritual beliefs of psychiatrists.
2.2.3 Psychiatrists’ Opinions Regarding Religion/Spirituality with Respect to Mental Health Problems and Clinical Practice

Respondents were asked if they were of the view that religious and spiritual issues played a causative role in the development of mental illness, and whether they saw a place for a religious/spiritual component in the treatment of such illness. Respondents were asked these two questions in relation to six psychiatric disorders: mood disorders, psychotic disorders, substance use disorders, anxiety disorders, eating disorders and personality disorders. The scale for their response was: Not at all, A little, Somewhat, or A lot.

Two further questions were taken from the Chicago survey concerned psychiatrists’ perceptions of the benefits of participation in religious congregational life and the effectiveness of chaplains and other spiritual care providers. Two further questions reflecting the New Zealand context were added on the benefits of marae participation and the effectiveness of tohunga, kaumatua and other Māori spiritual care providers. These gave an important point of comparison.

The Chicago survey included several scenarios. Curlin (2008) considers such scenarios to be more informative than questions about what physicians are likely to do in practical settings. In consultation with Professor Sellman the following scenario was developed for the New Zealand context, based on the Curlin survey.

A 42-year-old woman presents to her GP for the third time in five months. She complains of difficulty sleeping, loss of appetite, irritability, loss of meaning in life and feeling “down” but not suicidal. She reports problems with her marriage and problems at work. She exercises regularly. Physical examination is unremarkable except for a sad affect, and routine investigations are normal. She is open to “anything” the doctor thinks will help.

Given this limited information, if asked for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient):
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not very likely</th>
<th>Not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Prescribe an antidepressant medication</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
<tr>
<td>9.2</td>
<td>Refer to a psychologist</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
<tr>
<td>9.3</td>
<td>Refer to a counsellor</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
<tr>
<td>9.4</td>
<td>Refer to a chaplain</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
<tr>
<td>9.5</td>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
<tr>
<td>9.6</td>
<td>Encourage her to get more involved in her religious community</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
<td>□️</td>
</tr>
</tbody>
</table>

The two questions that followed modified this scenario to include a religious perspective and a cultural perspective.

Q10. In further conversation the doctor reveals that the patient is a Christian who attends church services.

If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (*Assume all strategies are available and financially feasible for the patient*).

Q11. Instead of being Christian, the doctor reveals that the patient is Māori and attends her local marae.

If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (*Assume all strategies are available and financially feasible for the patient*):

- The following modifications were made to accommodate Māori cultural norms.
  - 11.4 Refer to a kaumatua/tohunga
  - 11.6 Encourage her to get more involved in her religious community

Structuring the question in this way gave respondents an opportunity to show how they might modify their treatment according to a patient’s beliefs and cultural practices.
A question on what might discourage psychiatrists from discussing religion/spirituality in the clinical setting was taken from the Chicago survey.

Five questions were included on qualifications, years in practice and any training received in religion/spirituality. The aim was to assess if training or time in practice was associated with individual perspectives to do with religion and spirituality and also to find out how much training in spirituality and religion there is for psychiatrists. It identified those who were still in training as a sub-group within the sample.

Demographic questions made up the balance of the questionnaire.

2.3 Approvals

This research was approved by the Otago University Board of Graduate Studies in Health Science. The Upper South B Regional Ethics Committee advised that, according to their guidelines, an Ethics Committee review was not required for this study. Consent to select and adapt items from the Chicago questionnaires was granted.

2.4 Survey Trialling

The survey was given in written form to four psychiatrists in Christchurch for piloting purposes. Each was able to complete the survey in less than ten minutes. After trialing several minor adjustments and corrections were made. The survey was then uploaded to Survey Monkey and tested by two further psychiatrists. Further minor corrections to the wording were made.

2.5 Protections

As noted, Survey Monkey has inbuilt systems to block multiple responses by identifying individual IP addresses. If a person is determined to give multiple responses there is little protection against them using multiple IP addresses or other people’s computers and IP
addresses. In order to log on and complete the survey a code number was required. This code was made available on the RANZCP online newsletter to members in New Zealand.

2.6 Consent

Consent was assumed to be implicit in the clinician’s completion of the questionnaire. A covering letter gave details of the research and provided contact details. (See Appendix One)

2.7 Privacy/Confidentiality/Storage of Data

Survey Monkey identifies the completed questionnaires by a number. It includes an IP address only as a tool to identify attempted repeat responses. No names, email addresses or readily identifiable markers were asked for. Raw data are stored as SPSS files on the researcher’s personal computer. No recorded data or final results identified the clinicians.

2.8 Analysis Process

At the end of the data collection period the survey was closed and all response data were downloaded from Survey Monkey in SPSS format. Response frequencies, percentages and descriptive statistics were obtained. A series of Chi-square analyses of contingency tables were undertaken to identify the statistical significance or not of the relationship between variables. For the purposes of analysis, ordinal data were transformed into binary categories, typically at the point that allowed for the most sensible and even division of the sample. Throughout p<0.05 was used as the level of statistical significance, reflecting the exploratory nature of this study.

Binary logistic regression analyses were run using the independent and dependent variables identified as significant by the Chi-square analysis.

The demographic variables analysed as potential determinants of religion/spirituality and aspects of clinical practice were: gender, age, ethnicity, religious belief, stage of training and training received in religion/spirituality.
A thematic analysis of written responses was undertaken. A sample of these comments has been included in the results to provide clarity and augment the quantitative statistics. For a full record of the written comments see Appendix 2 and 3.
3.0 Results

3.1 Outline

This chapter presents the results of the NRSPS conducted in New Zealand in 2012. The questionnaire was designed to answer three research questions:

- What are the opinions and attitudes of psychiatrists regarding religion/spirituality and mental health?
- What factors determine a clinician’s attitude and practice with respect to spiritual matters?
- What factors determine a clinician’s attitude and practice with regard to spiritual and cultural mental health care providers? (chaplains and kaumatua/tohunga)

The chapter opens with a description of the respondent group’s basic demographic data, followed by three sections. Firstly, the respondent’s opinions and attitudes about religion and spirituality, including belief in God, supernatural intervention in health, the value of religious/cultural involvement and religious and cultural care providers, also respondents’ identification of factors which might limit their enquiry about such issues. Secondly, responses about the role of spirituality and religion in the causality and treatment of mental illness. Finally, responses to a clinical scenario to elicit responses indicating likely referral actions.

Demographic factors identified as significant determinants of various aspects of religious/spiritual attitudes and clinical practice are identified sequentially in the results. The chapter closes with a summary of results.

3.2 Demographics

116 responses were received. Out of a potential sample of 642, this represents an 18% return rate. Of the 116 responses, 73 were male, 39 female and one identified as transgender. Three respondents did not answer the demographic questions (see Table 1). The age of respondents was collected by use of decade ranges. Age ranged from 20 to over 70. The median age for both male and female was the 40–49 years decade. There were no significant differences in age according to gender or ethnicity.
The majority of respondents identified as having European ethnicity, 46.5% of New Zealand origin and 39.5% of other European origin. Other European also included the Americas, South Africa, European and Baltic/ex-Soviet states. Seven identified as Asian, four as Chinese and three Indian. The sample did not reflect the ethnic distribution of the New Zealand population, in particular there were no Māori or Pacific Island respondents. 78% of respondents were qualified specialist psychiatrists and the remaining 22% were still in training. 26% said they had received training in religion and spirituality and of those 70% indicated they had received between 1 and 200 hours. The median was eight. Four received over 100 hours, six between 10 and 100 and eleven under ten hours. Nine gave no indication of the number of hours received.

Nearly half (48.6%) declared they had no religious affiliation. Of those who did, Christians comprised the largest group at 38.5% of the total sample and Buddhists (2.8%), Hindus (3.7%) and ‘Other’ (3.7%) made up the small minorities.

Table 1  Demographic characteristics of psychiatrists surveyed, examining their opinions and attitudes towards religion and spirituality in mental health (n=116)

<table>
<thead>
<tr>
<th>Respondent Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>39</td>
<td>33.6</td>
</tr>
<tr>
<td>Qualified specialist Psychiatrist</td>
<td>91</td>
<td>78.4</td>
</tr>
<tr>
<td>Formal training in religion/spirituality</td>
<td>30</td>
<td>25.8</td>
</tr>
<tr>
<td>FRANZCP qualified</td>
<td>77</td>
<td>66.3</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European/Pakeha</td>
<td>53</td>
<td>46.5</td>
</tr>
<tr>
<td>Other European</td>
<td>45</td>
<td>39.5</td>
</tr>
<tr>
<td>Asian</td>
<td>8</td>
<td>6.9</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>6.9</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No religion</td>
<td>53</td>
<td>48.6</td>
</tr>
<tr>
<td>Christian</td>
<td>42</td>
<td>38.5</td>
</tr>
<tr>
<td>Buddhist</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>Hindu</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>Object to answering question</td>
<td>3</td>
<td>2.8</td>
</tr>
</tbody>
</table>

1  Fellow of the Royal Australian and New Zealand College of Psychiatrists
3.3 Psychiatrists’ Opinions Regarding Religion/Spirituality

3.3.1 Religion

In answer to the question “to what extent do you consider yourself a religious person?” almost half (47.4%) said they were not religious at all. 11.2% identified as being highly religious and the balance were almost evenly split between moderately religious (21.5%) and slightly religious (19.8%). Those who identified as New Zealand European/Pakeha were more likely to be “not religious at all”, with 53% indicating so ($\chi^2=25.004$, df=9, p=.003, n=114). Conversely those who identified as Other European and Asian were more likely to identify as highly religious with 22.6% as opposed to a New Zealand census percentage of 1.8%.

3.3.2 Spirituality

Respondents tended to identify themselves as spiritual rather than as religious. Just over half (55.1%) said they were either very or moderately spiritual compared with a third (32.5%) who declared themselves to be very or moderately religious. No significant differences were found for any of the determinant variables analysed.

3.3.3 Belief in God

Belief in God by respondents varied considerably and is recorded in Table 2. Questions in this survey did not elicit responses about the meanings of God. One third (33.3%) said they did not believe in God and the next largest group was at the other end of the continuum with a quarter (24.6%) saying they had ‘no doubt’ that God really exists. Those who did not identify as New Zealanders were more likely to believe in God ($\chi^2=7.449$, df=1, p=.006, n=113).

The 2x2 contingency table comprised those identified as New Zealanders or those who did not and those who believed to some extent in a personal God or those who did not (see Table 2).
Table 2  Respondents to the NRSPS, beliefs about God (n=114)

<table>
<thead>
<tr>
<th>Belief</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t believe in God</td>
<td>38</td>
<td>33.3</td>
</tr>
<tr>
<td>I don’t know whether there is a God and I don’t believe there...</td>
<td>19</td>
<td>16.7</td>
</tr>
<tr>
<td>I don’t believe in a personal God but I do believe in a Higher power</td>
<td>13</td>
<td>11.4</td>
</tr>
<tr>
<td>I find myself believing in God some of the time but not at others</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>While I have doubts I feel that I do believe in God</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>I know God really exists and have no doubts about it</td>
<td>28</td>
<td>24.6</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>100.0</td>
</tr>
</tbody>
</table>

A further question explored more specifically belief in the Christian God. The responses to showed a greater bipolarity. About a quarter (26.2%) had no doubt the Christian God exists and just over half (53.5%) stated that the Christian God does not or is highly unlikely to exist. Those who did not identify as New Zealanders were nearly three times more likely to indicate belief that the Christian God exists at 49.0%, compared with 17.0% of those stating New Zealand ethnicity ($\chi^2=11.213, df=1, p=0.001, n=99$) (See Table 3). 17 respondents did not answer this question. The 2x2 contingency table comprised of those who “identified as New Zealanders” or those who did not, and those who believed in a greater than 50/50 probability of the Christian God existing, or not (see Table 3).

Table 3  Respondents to the NRSPS, beliefs about the Christian God (n=99)

<table>
<thead>
<tr>
<th>Belief</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No doubt He exists</td>
<td>26</td>
<td>26.2</td>
</tr>
<tr>
<td>Very high probability He exists</td>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>Quite a high probability He exists</td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>50/50 that He exists or does not exist</td>
<td>4</td>
<td>4.0</td>
</tr>
<tr>
<td>Quite a high quite high probability He does not exist</td>
<td>3</td>
<td>3.0</td>
</tr>
<tr>
<td>Very high probability He does not exist</td>
<td>17</td>
<td>17.2</td>
</tr>
<tr>
<td>No doubt He does not exist</td>
<td>35</td>
<td>35.4</td>
</tr>
<tr>
<td>Don’t know what I believe</td>
<td>7</td>
<td>7.1</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
<td>100</td>
</tr>
</tbody>
</table>
3.3.4 Supernatural Intervention in Mental Health

Over half of respondents (54.0%) disagreed with the statement that supernatural beings intervene in a patient’s health. 29.2% believed that such interventions occur, with the balance (16.8%) undecided. Those who did not identify as new Zealanders were more than twice as likely to believe in supernatural intervention (63.3%) compared with those who identified as New Zealanders (26.9%) ($\chi^2=16.032$, df=1, p=.000, n=112). The 2x2 contingency table comprised those who identified as New Zealanders and those who did not and those who had a positive belief in supernatural intervention in patient health and those who did not.

3.3.5 The Value of Participation in Religious Community or Marae Participation

Two separate questions addressed the attitude of psychiatrists to participation in a religious congregation and marae participation. Almost half (47.3%) the respondents agreed that participating in a religious congregation provided unique psychological benefits not found by participating in other groups. 29.0% disagreed and 23.7% were undecided. (See Table 4).

It was beyond the scope of this survey to identify or examine these advantages. However, the responses indicated that a number of respondents did consider that some unique benefits can be gained from religious and/or cultural based community involvement. Female respondents were almost twice as likely to regard religious congregational involvement as advantageous with 65.7% agreeing ($\chi^2=7.209$, df=1, p=.007, n=110) compared with 38.8% of their male counterparts. The 2x2 contingency table comprised those who were male or female and those who agreed or strongly agreed with the statement: “Participating in a religious congregation provides unique psychological benefits that are not found by participating in other social groups”.

With regard to the question about the value of marae involvement and participation, over two thirds (68.9%) of respondents agreed that participating in a marae community provides Māori with unique psychological benefits that are not found by participating in other social groups. 15.5% strongly agreed and 53.4% agreed. Only 4.3% disagreed or strongly disagreed and 26.7% neither agreed nor disagreed. Those currently being trained ($\chi^2=5.395$, df=1 p=.020, n=116) and identifying as New Zealanders ($\chi^2=4.606$, df=1, p=.032, n=114) were the most significant factors in a psychiatrist holding positive beliefs about marae involvement. The
data were transformed to binary 2x2 contingency tables as also done for religious community involvement (i.e. those who Agree and Strongly Agree compared to other respondents).

### Table 4 NRSPS responses to the statement, “Participating in religious congregation provides unique psychological benefits that are not found by participating in other groups” (n=114)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>12</td>
<td>10.5</td>
</tr>
<tr>
<td>Agree</td>
<td>42</td>
<td>36.8</td>
</tr>
<tr>
<td>Neither Agree nor Disagree</td>
<td>27</td>
<td>23.7</td>
</tr>
<tr>
<td>Disagree</td>
<td>23</td>
<td>20.2</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>10</td>
<td>8.8</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>100</td>
</tr>
</tbody>
</table>

### 3.3.6 Christian Spiritual Care Providers

The effectiveness of chaplains and other spiritual care providers was rated favourably by just over half of the psychiatrists (55.6%). Only 6.9% selected “ineffective” options and the balance indicated that they had no experience or interaction in this area. (see Table 5)

### Table 5 The effectiveness of chaplains and other Christian spiritual care providers as perceived by respondents to the NRSPS (n=115)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very effective</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Effective</td>
<td>59</td>
<td>51.3</td>
</tr>
<tr>
<td>Neither effective nor ineffective</td>
<td>17</td>
<td>14.8</td>
</tr>
<tr>
<td>Ineffective</td>
<td>6</td>
<td>5.2</td>
</tr>
<tr>
<td>Very ineffective</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Have had no experience to date</td>
<td>12</td>
<td>10.4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>12.2</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>100</td>
</tr>
</tbody>
</table>
Of those who identified as New Zealanders, two thirds (67.3%) gave chaplains high ratings compared with only half (47.5%) for those who did not so identify ($\chi^2=4.46$, df=1, $p=.035$, n=113). The 2x2 contingency table comprised those who identified as New Zealanders and those who did not and those who rated chaplains as effective and very effective or not (See table 5). 12.2% of respondents selected “other”. It is not possible from the comments given to define this group.

Although there was a range of views expressed in the written comments, there was some agreement. Nearly all responses identified chaplains as the most commonly encountered religious/spiritual personnel in mental health settings. The comments about them were mostly positive. Some psychiatrists, however, recorded negative experiences with chaplains.

There was agreement that spiritual care should be provided to those who ask to receive it. Some suggested such spiritual care can have positive therapeutic value for those patients who are receptive.

[It] can be very helpful when indicated clinically, and patients are receptive to such an approach. It can provide the clinician with important insights into the coping, and meaning some patients attribute to their illness and their lives in general within their religious/spiritual framework, and inform therapeutic interventions. I have worked with chaplains in mental health settings and can only speak highly of their ethical standards and respect for patients’ religious/spiritual worldviews. They fill a significant void in helping clinicians see the “whole” person in their context.

(R111, Male, Non NZ European, Christian).

If spiritual matters are important to the individual then in my opinion offering spiritual support via access to a Chaplain for example usually provides comfort.

(R20, Female, Non NZ European, No religion).

On the other hand some respondents suggested that religious support should not be forced on patients. Some believed that for those who did not share the chaplain’s faith or belief such care and contact could be therapeutically damaging.
[Religion/spirituality] is a basic human right and can assist in building therapeutic rapport. But if not important to individual should not be forced upon them.

(R20, Female, Non NZ European, No religion).

Religious patients may be helped by those within their own faith, for others it’s irrelevant and contraindicated.

(R103, Female, Non NZ European, objected to giving religious belief)

May have deleterious consequences; depends on so many factors.

(R90, Non NZ European, Objected to giving gender or religion).

Clearly not all chaplains are of equal effectiveness when it comes to ability or value to the patient.

Negative responses focused on boundary issues and chaplains’ lack of training or support for the medical decisions made by clinicians. Clearly the respondents viewed some chaplains as better or more suitable than others. Personality, training and being prepared to cooperate with clinicians and clinical teams are regarded as being essential.

My experience has been of chaplains as an integral part of the team in hospital, and more recently in community. Well-trained chaplains are very effective but not all spiritual care providers are of the same calibre and some can be counterproductive, for example if they discourage the taking of medication. As a member of the team the chaplain is also able to address staff spiritual issues/needs and so contribute indirectly as well as directly to patients’ treatment and care.

(R27, No other information provided).

It absolutely depends on their personality and the way they use their belief systems to engage and support people. I have worked with some chaplains who were absolutely superb but they tended to have a very pragmatic faith and engaged at a spiritual level with people’s pain and suffering, not at a religious level.

(R91, Female, New Zealand European, Pantheist).
Providing [chaplains] are well trained and offer support where requested, not advocate for involvement where not wanted. I have found in most instances this has worked well.

(R102, Male, Non New Zealand European, Christian).

Although there were few direct criticisms and some complaints about chaplains, it was clear that differences between chaplains in their levels of training, theological position and practice and personality affected how respondents regarded them. Concern was expressed about boundary issues, lack of training or support for the medical decisions made by clinicians and the possibility of intrusion on those patients who didn’t want the services of a chaplain or Christian spiritual care provider. One respondent noted that the issue of chaplain effectiveness is “too dependent on the individual qualities of the chaplain, therefore, reliability/quality control is an issue”.

3.3.7 Māori Spiritual Care Providers

The effectiveness of tohunga/kaumatua and other Māori spiritual care providers was rated favourably by over half of the respondents (54.3%). Only 2.6% thought them “ineffective” and the balance were either indifferent or had had no experience or interaction with them, as can be seen in Table 6.

Table 6 The effectiveness of Tohunga, Kaumatua and other Māori spiritual care providers in helping psychiatric patients as perceived by respondents to the NRSPS (n=116)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very effective</td>
<td>7</td>
</tr>
<tr>
<td>Effective</td>
<td>56</td>
</tr>
<tr>
<td>Neither effective nor ineffective</td>
<td>15</td>
</tr>
<tr>
<td>Ineffective</td>
<td>2</td>
</tr>
<tr>
<td>Very ineffective</td>
<td>1</td>
</tr>
<tr>
<td>I have had no experience to date</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
</tr>
</tbody>
</table>
Three quarters (75.5%) of respondents who identified as New Zealanders considered kaumatua/tohunga to be effective or very effective compared to under two fifths (37.7%) of those who did not identify as New Zealanders ($\chi^2=16.361$, df=1, $p=0.000$, $n=114$). The data were transformed and analysed in the same manner as for Christian spiritual care providers. The 2x2 contingency table comprised of those who identified as New Zealanders and those who did not, and those who rated kaumatua/tohunga as effective and very effective or not (See Table 6).

There were fewer comments on this question compared with those on Christian spiritual care providers. Most agreed that Māori spiritual care providers provided a valuable link to the patient’s family/whānau and the wider Māori community and care providers.

*I am uncertain if you count Pukenga Atawhai as Māori spiritual care providers - they are the only people I have had experience with therefore my comment is rating the effectiveness of the PA in our system of care. The major help the Pukenga Atawhai provides is enabling good communication with families and helping with misunderstandings and developing a good working relationship with the family and making appropriate links to Māori health and cultural providers.*

(R75, Female, Asian, Christian).

*I have experienced effective and supportive Māori spiritual care providers. What works well for patients and the clinical team is the situation where the Māori spiritual care provider works with the team for the benefit of the patient - but also for the benefit of team members. In this context I have seen important referrals made. On the other hand if there is no relationship with the team there is a risk of having a confrontational situation which is counter-productive.*

(R27, No other information provided).

Respondents stated concerns that any involvement has to be in the context of cooperation with the clinical care team.
Often very effective and helpful, often neutral, on occasion (though rare) can be harmful if care is not coordinated with MHS and conflicting/contradictory messages are given.

(R4, Male, Asian, No religion).

One respondent commented, “No idea - have only ever met one Māori”. It would seem this person had only been in New Zealand a short time.

As with Christian spiritual care providers, respondents experience varied widely. Some respondents expressed a desire for spiritual care providers to work closely with the clinician. Māori in this role were seen as being able to provide a link to family. Respondents did not associate chaplains or Christian care workers with such a function.

3.4 Psychiatric Illness and Religion/Spirituality

This section explores respondents’ views on the role of religion/spirituality in the causality and treatment of psychiatric illness. Two questions specifically addressed this. They were: “Please indicate the extent to which the following conditions you consider are generally caused by religious/spiritual issues?” and “To what extent should treatment for the following conditions generally include a religious/spiritual component?”

Their views on six disorders were elicited: mood disorder, psychotic disorder, substance use disorder, anxiety disorder, eating disorder and personality disorder.

3.4.1 Causality

There was a range of opinion among the respondents on whether or not religion/spirituality was a causative factor in mental illness. The tendency overall was towards the “Not at all” or “A little” rather than the “Somewhat” or “A lot”. Of the six disorders, mood and anxiety disorders were regarded as the most influenced by religion/spirituality. About 37% of respondents choose “Somewhat” or “A lot” for these two disorders (see Table 7).
Table 7  Extent of religion/spirituality as a cause of mental illness. Percentage responses by respondents to the NRSPS (n=115)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Not at all %</th>
<th>A little %</th>
<th>Somewhat %</th>
<th>A lot %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>21.7</td>
<td>41.7</td>
<td>33.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>46.1</td>
<td>41.7</td>
<td>10.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>32.2</td>
<td>42.6</td>
<td>19.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>21.7</td>
<td>40.9</td>
<td>32.2</td>
<td>5.2</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>39.1</td>
<td>43.5</td>
<td>13.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>40.0</td>
<td>35.7</td>
<td>19.1</td>
<td>5.2</td>
</tr>
</tbody>
</table>

No demographic variables were found to be significant determinants of the results for religion/spirituality as a cause of mental illness, for any of the disorders surveyed.

3.4.2  Treatment

There was a range of opinion among the respondents with an overall tendency towards the “Not at all” and “A little”, rather than the “Somewhat” or “A lot” responses (see Table 8). Between 17-27% of respondents indicated that a spiritual/religious dimension should “not at all” be included in treating any of the disorders. However, 2-8% chose “A lot”. The cumulative percentages in support of the inclusion of a spiritual/religious component within treatment is very similar for mood (40.2%), substance use (44.3%), anxiety (40.7%) and personality (39.6%) disorders. The percentage for psychotic disorders (24.1%) and eating disorder (32.6%) were lower but not statistically different.

No demographic variables were identified as significant determinants of the results for whether or not a spiritual/religious component should be included in treatment for any of the disorders surveyed.
Table 8  The extent to which religious/spiritual component should be included in mental health treatment. Percentage responses by respondents to the NRSPS (n=116)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>17.2</td>
<td>42.2</td>
<td>35.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>26.7</td>
<td>49.1</td>
<td>22.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>16.5</td>
<td>39.1</td>
<td>36.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>19.0</td>
<td>41.4</td>
<td>32.8</td>
<td>6.9</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>24.3</td>
<td>42.6</td>
<td>30.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>21.6</td>
<td>38.8</td>
<td>35.3</td>
<td>4.3</td>
</tr>
</tbody>
</table>

3.5  Clinical Scenarios

Scenarios were used to investigate whether or not respondents would be more or less likely to refer their patients to spiritual and cultural mental health care providers if their patients had identified themselves as religious or Māori.

The questionnaire used a standard clinical scenario based on the Chicago study. The respondent was asked to indicate what therapeutic actions they were likely to recommend. The clinical scenario was subsequently modified in two further scenarios in order to establish if practice intentions were likely to change if the patient had strong religious convictions or belonged to a particular ethnic and cultural group (Māori).

The initial scenario was as follows:

A 42-year-old woman presents to her GP for the third time in five months. She complains of difficulty sleeping, loss of appetite, irritability, loss of meaning in life and feeling “down” but not suicidal. She reports problems with her marriage and problems at work. She exercises regularly. Physical examination is unremarkable except for a sad affect, and routine investigations are normal. She is open to “anything” the doctor thinks will help. Given this limited information, if asked for your opinion, how likely would you be to recommend that the GP do each of the following for this
patient (Assume all strategies are available and financially feasible for the patient).

The results are as follows.

### Table 9 Percentage responses to the scenario by respondents to the NRSPS

<table>
<thead>
<tr>
<th></th>
<th>Very likely %</th>
<th>Somewhat likely %</th>
<th>Not very likely %</th>
<th>Not at all likely %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to a chaplain</td>
<td>0.0</td>
<td>9.0</td>
<td>47.7</td>
<td>43.2</td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>47.4</td>
<td>40.4</td>
<td>11.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Encourage her to get more involved in her religious community</td>
<td>5.4</td>
<td>17.1</td>
<td>43.2</td>
<td>34.2</td>
</tr>
</tbody>
</table>

In the first modification the respondent was given the following further information: In further conversation the doctor reveals that the patient is a Christian who attends church services. If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient).

The results are as follows.

### Table 10 Percentage responses to the scenario (first modification) by respondents to the NRSPS

<table>
<thead>
<tr>
<th></th>
<th>Very likely %</th>
<th>Somewhat likely %</th>
<th>Not very likely %</th>
<th>Not at all likely %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to a chaplain</td>
<td>25.2</td>
<td>55.0</td>
<td>12.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>46.0</td>
<td>40.7</td>
<td>11.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Encourage her to get more involved in her religious community</td>
<td>31.0</td>
<td>52.2</td>
<td>13.3</td>
<td>3.5</td>
</tr>
</tbody>
</table>
In the second modification the respondent was given the following further information: Instead of being Christian, the doctor reveals that the patient is a Māori who attends her local marae. If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient).

The results are as follows.

### Table 11 Percentage responses to the scenario (second modification) by respondents to the NRSPS

<table>
<thead>
<tr>
<th></th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not very likely</th>
<th>Not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to a Tohunga or Kaumātua</td>
<td>35.8</td>
<td>46.8</td>
<td>13.8</td>
<td>3.7</td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>47.2</td>
<td>43.5</td>
<td>8.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Encourage her to get more involved in her marae community</td>
<td>40.9</td>
<td>51.8</td>
<td>6.4</td>
<td>0.9</td>
</tr>
</tbody>
</table>

In keeping with the aims of this study the scenarios were designed to identify trends about whether or not psychiatrists would refer their patients to religious and cultural care providers. These will now be discussed.

#### 3.5.1 Referring Patients to a Chaplain

For the first scenario no-one ticked the “Very likely” box. Only 9% indicated that they might refer to a chaplain. When those who were “somewhat likely” or “very likely” were compared with those “not very likely” or “not at all likely”, no differences could be identified with respect to any of the demographic variables.

Those who did not identify as New Zealanders were almost three times more likely (34.5%) to refer a patient to a chaplain than those who did (12.5%). ($\chi^2=5.270$, df=1 p=.022, n=110). The 2x2 contingency table comprised of those who identified as New Zealanders and those who did not and those who indicated “somewhat” or “very likely” to refer as opposed to those who indicated “not very” or “not at all likely” (see Table 10).
Ethnicity was the only significant determinant of whether or not a respondent would “Encourage her to get more involved in her religious community”. Those who did not identify as a New Zealander were 2.5 times more likely to encourage a patient to get more involved in their religious community than those born and trained in this country ($\chi^2= 8.514$, df=1, $p=.004$, n=112). 42.3% of those who did not identify as New Zealanders indicated they were “somewhat likely” or ‘very likely” to encourage such involvement compared with only 16.9% of New Zealanders.

### 3.5.2 Referring Patients to a Tohunga/Kaumatua

Two demographic factors were identified as being significant determinants as to whether a psychiatrist would refer a patient to a tohunga or kaumatua. They are those who were not yet fully qualified ($\chi^2=8.282$, df=1, $p=.004$, n=109) and those who did not identify as a New Zealander ($\chi^2=6.052$, df=1, $p=.014$, n=109). Those who identified as a New Zealander appear to be less likely to refer than their overseas-born colleagues. Only 24.5% indicated likely referral compared with 47.2% for their overseas-born colleagues. 60.0% those still studying indicated likely referral compared with 28.5% of those fully qualified.

### 3.5.3 Encouraging Involvement in Marae Activities

Gender was the only variable identified as having a significant influence on the decision to encourage the fictional patient to be more involved in her marae community ($\chi^2=7.432$, df=1, $p=.006$, n=107). Women were twice as likely to do this at 58.3%, compared with 30.9% of their male counterparts.

### 3.6 Summary of Results

The sample was 18% of the targeted population. Of these respondents 48% identified as non-religious whilst 55% of respondents declared themselves to be spiritual. Belief in God by respondents varied greatly. However, those who identified as being of New Zealand ethnicity were less likely to believe in God.
There was a range of opinion on the role that religion/spirituality plays in the causation and treatment of mental health issues. 54% of respondents rejected the idea that supernatural beings intervene in patient health, whilst 30% believed in such interventions.

47% of the respondents agreed that participation in a religious congregation provides unique psychological benefits that are not found by participating in other groups. 29% disagreed. Similarly, 69% agreed that participation in a marae community provides Māori with unique psychological benefits that are not found by participating in other groups. 5% disagreed. It was beyond the scope of this study to identify and analyse these advantages.

56% of the respondents rated the work of chaplains and other Christian spiritual care providers as being effective in helping psychiatric patients. 7% rated their work as ineffective. 63% of respondents rated the work of Tohunga, Kaumatua and other Māori spiritual care providers as effective in helping psychiatric patients with only 3% rating them ineffective.

Apart from psychiatric trainees, who were more likely to refer patients to a tohunga/kaumatua than fully-trained psychiatrists, respondents not identifying as New Zealanders were more likely to refer patients to chaplains or tohunga/kaumatua.

Female respondents were more likely than their male counterparts to encourage involvement in Christian congregational activities and marae involvement.
4.0 Discussion

Increasingly health practitioners acknowledge that there is an undeniable religious and spiritual component in clinical interactions (Cook, 2011, p. 15). Whether this is addressed explicitly or remains implicit, depends to a large extent on the actions of the clinician. This study aimed to identify the main factors in New Zealand that significantly influence the clinical decisions of psychiatrists in relation to religious and spiritual matters.

Many medical practitioners seek to more fully appreciate the links between medicine, religion and spirituality. However there is a growing understanding of the gulf between paradigms of religion and science. Religious and medical-scientific views are two distinct forms of knowledge (Wagenfeld-Heintz, 2008) resulting in incommensurability, viz the inability to completely translate theories of each worldview into the other’s terms. There is no easy dialogue as the language of science and the language of religion are radically different. (R. J. Lawrence, 2002,) This study did not attempt to define terms; rather it left interpretation and definition to the respondents. Each has answered according to their own understanding and position.

This study has found the most significant factor influencing psychiatrists’ beliefs and clinical responses to religion and spirituality is the country they were born in. The country of origin (New Zealand or elsewhere) significantly influenced their religious and spiritual beliefs and consequently the way they responded to these in the clinical setting. The psychiatrists who identified as New Zealanders were less likely to believe in God, less likely to see value in religious involvement and less likely to refer their patients to spiritual and cultural advisors or carers. While psychiatrists who identified as New Zealanders, particularly those still in training, were more likely to see value in marae involvement, it did not follow that they were more likely to refer Māori patients to Māori spiritual leaders.

In the area of religion and spirituality both the professional and personal domains need to be considered. While the findings give us a better picture of the beliefs, perceptions and practices of psychiatrists in this country, the response rate of 18% means the sample cannot be regarded as representative. The findings are therefore tentative and provisional.
Respondents saw ‘religion’ and ‘spirituality’ in quite different ways. One respondent stated, ‘I think I know what “religion” is. But I’m not sure what “spirituality” might be’. 52% described themselves as “not being at all” religious, but 87% described themselves as being spiritual. This suggests that spiritual is regarded as a broader term. Further research is needed on the 13% who described themselves as not spiritual at all, in particular how they might view the search for meaning, transcendence and the issues commonly understood as being part of the spiritual experience and quest. That psychiatrists perceive themselves in terms of spirituality, rather than organised religion, has been established in a number of international studies (Curlin, Odell, et al., 2007). The official census figures for New Zealand indicate that in 2006, 34.7% of the population stated they had no religion. The percentage of psychiatrists on this survey who identified as having no religion (Not religious at all) is somewhat higher. This is in line with overseas indications that psychiatrists are less religious than the general population (Curlin, Lawrence, et al., 2007). Recognising that self-selection can result in biased samples, it is possible that significantly more than half of all psychiatrists in this country may be “not religious at all”. It is beyond the scope of this study to establish whether psychiatrists are less religious than the general population or to find reasons for this.

Turbott (1996) found that consumers are increasingly seeking out psychiatric professionals who are of similar belief, gender, age and worldview. They want a therapist who speaks the same language. If psychiatrists are indeed less religious and/or spiritual than the members of society as a whole, then consumers may not necessarily find the care they seek.

Studies in the USA have shown that a psychiatrist’s personal religious and spiritual belief is a determinant of practice actions (Curlin et al., 2006). This New Zealand study (NRSPS) confirmed that psychiatrists with strong religious or spiritual beliefs were the most likely to view religious and spiritual factors as playing a causal role in mental illness and these should be taken into account in treatment.

Religious/spiritual factors were seen as having the strongest influence on mood and anxiety disorders (mood 38.5%, anxiety 37.7%). After them came substance abuse (25.2%) and personality disorders (24.3%) and least influenced were eating disorder (17.4%) and psychotic disorders (12.1%). Given the limited scope of this study, it was not possible to establish reasons for this. However, a number of factors may come into play. Mood and anxiety disorders are sometimes seen as having religious causes, in particular feelings of guilt, low self-esteem and unworthiness are seen as stemming from the doctrines of sin and judgement.
within Christianity. Few respondents thought that religious/spiritual factors played a role in psychotic illness despite anecdotal evidence suggesting that religious delusions are not uncommon for those with a psychotic disorder.

Given these findings, particularly for mood and anxiety disorders, there is a good case for enquiry about spiritual matters and formal spiritual assessment to be a routine component of psychiatric assessments as is recognised by the relevant policy documents quoted in the literature review. As has been seen however, D’Souza in 2003 reported that only 11% of a sample of patients surveyed reported a spiritual history being taken in their psychiatric assessments. Psychiatrists in that study reported they only occasionally took a spiritual history and that time 94% said they had received no appropriate training (D’Souza, 2003). The NRSPS has shown that 30% of the sample had received some training in religion and spirituality. However, the survey did not reveal what this training was. A recent New Zealand study has argued that inaccurate assessment of Māori can lead to misunderstanding, misdiagnosis and mistreatment (Adamson, Sellman, Deering, Robertson, & de Zwart, 2006). The same could be said of any person who holds beliefs and values (religion/spirituality) different from the clinician. There is a good case that cultural and/or spiritual assessment, geared toward the beliefs and values of the individual, should be offered to all consumers of mental health services.

Analysis of evidence from the ‘other comments’ section of the questionnaire showed that respondents generally considered that the patient’s religious and spiritual beliefs should be part of their assessment process. However, most said that they do ask about religious and spiritual matters. One respondent commented “It’s a really important area and is often overlooked, both in training and in practice” (R4, female, Christian, other European) D’Souza also found that from a patient’s perspective such enquiry rarely occurs. This gap in perception between patients and clinicians merits further investigation. Respondents cited lack of time as the most common reason for not asking, followed closely by fear of offending patients and their own lack of knowledge. Only 25% of respondents identified discomfort in discussing these issues as a barrier to asking. Responses in the NRSPS are similar to trends and attitudes identified in other countries (Curlin, Odell, et al., 2007; El-Nimr et al., 2004).

In considering possible barriers to addressing religion or spirituality in clinical practice, psychiatrists were less likely to cite general discomfort or to be concerned about offending patients. Psychiatrists and other
physicians had similar reports of being inhibited by insufficient time, insufficient knowledge/training, and concerns about disapproval from colleagues. (Curlin, Lawrence, et al., 2007, p1830).

If patients have concerns to do with religion and spirituality it would seem that some time should be allowed for these. Is lack of time being used as a convenient excuse for other factors not identified? Such a question cannot yet be answered. This study was able to corroborate some of Balboni’s findings that, in end of life circumstances, training in spiritual care for doctors and/or nurses, was the major determinant of the extent and quality of spiritual care received by their patients (Balboni et al., 2012).

This study, although limited in scope, has shown that only a minority (a quarter) of psychiatrists believed that religion and spirituality had no relevance to their practice. This may not reflect the views of psychiatrists as a whole. A larger sample may show that an even higher percentage of psychiatrists consider religious and spiritual issues to be irrelevant. New Zealand’s high degree of secularity and lack of public discourse on religious matters may be factors in psychiatrists’ silence. Fear of offending patients may also play a part. This could go some way to accounting for differences with the USA and UK.

More respondents considered religious/spiritual influences positively in treating psychiatric disorders than those who saw them as causative factors. A significant percentage of the respondents thought that a religious and spiritual dimension should be included in the treatment of mental disorders. The percentages were: substance use 44.3%, anxiety disorders 40.7%, mood disorders 40.5%, personality disorders 39.6%, eating disorders 33% and psychotic disorders 24.1%. However, overall the tendency was towards a response of “Not at all” or “A little”. On the whole respondents did not think they should make religious and spiritual interventions in the treatment of psychiatric illness.

The literature review identified from the patient’s point of view some, of the beneficial effects that religion and spiritual belief may have. Psychiatrists also may take a pragmatic approach to accepting these benefits. An additional factor is the influence of the Recovery Model of care. In this model spirituality and belonging are seen as necessary for recovery (Recovery Competencies for New Zealand Mental Health Workers, 2002). One respondent commented “There is a deep yearning and reflection in a lot of our patients for spirituality and a search for greater meaning in their lives. This approach has contributed to the recovery and coping of a
good number of my patients who hold such belief, which I am supportive of’ (R109, male, Christian, Other European). It has been outside the scope of this study to identify beneficial advantages or to identify which religious or spiritual tools, therapies or actions might be considered appropriate for recovery. However a positive view of religion and spirituality in treatment complements the already widely-used recovery model for patient health. Furthermore recovery often uses the language of spirituality:

…a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.


Kelly and Gamble (2005) argue “It is not inappropriate to speak of recovery in the terms of a spiritual process”. The recovery model has been championed by consumers of mental health services. The same consumers (patients) have been shown to value spirituality and religion (Mohr, Brandt, Borras, Gillieron & Huguelot, 2006). As psychiatrists adopt the recovery model they will increasingly be challenged to acknowledge the role that the religious and spiritual dimension plays in patients’ health.

That “substance abuse disorders” were rated at 43% to merit religious/spiritual treatment interventions, the highest for any disorder, may reflect the widely-known work of Alcoholics Anonymous and Twelve Steps Programs which acknowledge the need for help from a Higher Power or God for recovery. There were low levels of support for religious/spiritual involvement in psychotic disorders. Qualitative comments suggest that this could make psychotic delusions and beliefs worse rather than better. Such suggestions are tentative and await a larger study in New Zealand.

About half of the psychiatrists in the sample held that participation in religious congregations provided psychological benefits not found by participating in other groups. Female respondents were twice as likely to view this positively. Only 8% strongly disagreed, suggesting little negative attitude towards religious involvement. Not all churches are seen as equal. As one respondent suggests, “Some church environments are very helpful and supportive, some judgmental and counterproductive” (R77, female, Christian, NZ Pakeha).
Further research is needed to identify advantages or disadvantages that could be gained by membership and participation in these and other groups such as sports groups, exercise groups and professional groups.

Most respondents identified chaplains as the main Christian care providers. Slightly more New Zealand-born and trained psychiatrists gave positive responses than those who did not identify as New Zealanders. Respondents noted chaplains’ ability to meet needs which the psychiatrist could not, to consider the whole person, help with coping and making meaning in difficult circumstances and provide comfort and support in times of crisis. Generally chaplains were seen to have good ethical standards.

Those who had reservations and made critical comments thought that religious helpers could be counter-productive, particularly if they proselytised and/or did not support the multi-disciplinary team programme. From the comments it is possible to identify five factors that make a good chaplain:

1. Individual personality
2. They need to be pragmatic
3. They must provide spiritual not religious support generally
4. They need good training in spiritual care and mental health and
5. They need to be part of therapeutic team

Reasons not to refer patients to chaplains are similar to those found elsewhere: fear of proselytising, coercion, non-support of treatment modalities and the lack of adequate training in mental health (R. E. Lawrence et al., 2006; Payman, 2000).

With regard to the question of the value of participation and involvement in marae activities, 69% of the respondents agreed that Māori who participate in a marae community gained unique psychological benefits not found by participating in other social groups. 15.5% strongly agreed. Only 3.2% disagreed and 26.7% neither agreed nor disagreed. The most significant factors in whether a psychiatrist held strong positive beliefs about marae involvement were being still in training and identifying as a New Zealander. As in the discussion about religious congregational involvement the same questions as to what the benefits are, or if they could be gained by involvement in other groups, apply here.
These younger respondents have trained at a time when the majority culture in New Zealand society started to recognise the Māori culture and to actively use Māori models of health delivery and treatment to improve Māori health (Ministry of Health Health, 1994). Marae involvement and the practice of Māori culture is not necessarily linked to formal religion. However, Christianity continues to have an influence on Māori culture as practised in most marae in New Zealand in the twenty-first century.

The role of kaumatua and tohunga in the treatment of mental illness in New Zealand was viewed positively by 80% of the respondents identifying as New Zealanders in the NRSPS. The comments showed good and bad experiences. Some respondents expressed a desire for spiritual care providers to work more closely with the clinician and treatment team. Māori in this role were seen as being able to provide a link to family. Respondents did not see chaplains or Christian care workers as providing such a link.

The qualitative responses showed that, whoever provides spiritual care, should ideally have some working relationship with the psychiatrist or multi-disciplinary team.

Little research in New Zealand to date has documented and assessed the practices of psychiatrists in referring patients to spiritual or cultural care providers. The responses to the scenarios have given a glimpse into their intentions. They suggest that if a patient has a religious orientation or specific cultural background (Christian and Māori in this instance) then the psychiatrist may or may not treat them in a manner that reflects their belief and/or culture.

Those holding religious beliefs are more likely to be referred to a chaplain or minister and to be encouraged to get more involved in their religious congregation. This study has shown that such referrals were strongly influenced by the respondent’s ethnicity and gender. A respondent who did not identify as a New Zealander, that is one who was more likely to be born and trained overseas, was twice as likely to refer religious patients to a chaplain or minister, and 2.5 times more likely to encourage more involvement in their religious congregation. These same respondents were more likely to believe in God generally, the Christian God specifically, and supernatural intervention in health. However, the higher appreciation of religious congregational involvement by female respondents did not translate into a higher referral rate, which has significant implications for patients. If patients are
religious and prefer a psychiatrist with similar beliefs, this study suggests they may have to actively seek out those who have been born and trained overseas.

El-Nimr (2004) has shown that those who identified as non UK ethnicity were more likely to see people as spiritual, compared with those born and trained in Britain. The UK is more secular than the USA. Census statistics show that New Zealand is more secular than the UK and most western countries (D’Souza, 2003; Stirling, Furman, Perry, Canda, & Grimword, 2010). This greater level of secularity and non-religiosity is reflected in both mental health professionals and in training programmes in this country. Psychiatrists born and trained in New Zealand may be more secular and less religious compared with their overseas counterparts and therefore less likely to refer patients to chaplains and other spiritual care providers. As a corollary an increased emphasis on religion and spirituality is needed in New Zealand-based training programmes in psychiatry. This would help raise the levels of awareness of locally trained clinicians towards those of their overseas counterparts.

New Zealand-born respondents and those still in training in this country had a higher appreciation for Māori cultural and religious factors than, respondents not identifying as New Zealanders. However, the latter were 1.8 times more likely to refer Māori patients to kaumatua and tohunga. This was surprising given the recognition and incorporation of Māori culture and belief into the mainstream health and teaching in New Zealand over that last three decades. Those respondents who were currently in training were, however, more than twice as likely to refer patients to a kaumatua or tohunga.

In the bicultural journey in this country, psychiatrists and other health professionals have increasingly recognised the unique and different facets of Māori culture, religion and spirituality. They have also given greater recognition to ethnicities and cultures. This is evidenced by the cultural training content in the Royal Australian and New Zealand College of Psychiatrist’s current Training Curriculum in Basic Psychiatry (RANZCP, 2002). However this study has shown that not all psychiatrists recognise the advantages of marae involvement and the value of Māori spiritual leaders. Indicated levels of likely referral are not high.

As the racial and religious mix in New Zealand continues to become even more diverse, mental health professionals will be challenged to recognise and take into account different cultures and religious/spiritual orientations in much the same way that Māori have been
recognised. The current training provided in religious and cultural issues would then need to be broadened to include all medical professionals, so that all are equipped to understand the relevant religious, spiritual and cultural factors.

As Lawrence et al. noted ‘Clinicians do appear to consider referring individual patients to spiritual advisors and to show a potential “willingness” to integrate spiritual care in patients treatment plans and carers’ support’ (Lawrence et al., 2006). However, it needs to be asked how much of this willingness is translated into action and how much is the spiritual component of patients either ignored or given only token acknowledgement. As stated by Curlin, psychiatrists would benefit from increased training and a greater awareness of the need to consult with pastoral and theologically trained colleagues (Curlin, Lawrence, et al., 2007).

4.1 Limitations

There were two main limitations in this study, sampling and design.

4.1.1 Limitations in Sampling

The implementation method of the study (advertised online, self-referring questionnaire) resulted in a potential severe limitation in representativeness of the sample, given a low (18%) response rate. It is known that those with an interest in, or holding strong opinions about, a topic are more likely to respond to a survey run in this manner. Although it is impossible to know how biased the sample was, it is reasonable to assume there is some.

The lack of Māori/Pacific respondents was also a limitation for research in a New Zealand context. It was therefore not possible to determine if Māori and Pacific psychiatrists have a particular perspective on these questions. Further research would need to proactively seek out Māori and Pacific psychiatrists to ensure participation.
4.1.2 Limitations in Design

The need to have a questionnaire that could be completed in less than ten minutes resulted in design limitations.

There were limited internal checks and balances. One question covered each type of information sought. Such a lack of internal checking means that nuances of thought and belief may have been missed. One or two measures of respondent religiosity could have resulted in a better understanding of how religious/spiritual beliefs influence psychiatrists’ actions and practice.

Several respondents stated they found it hard to answer generalised questions about religion and spirituality. They made comments such as:

*Hard to answer questions on mental health spirituality link in general because this is so very individually determined.*

*Difficult to use such a general questionnaire for this topic as the care/advice/services you may get involved in are highly individualised to the patient, their beliefs, their problems and their presentation.*

*This questionnaire is too simplistic to cover a sensitive and complex topic and answers would vary so much depending on multiple factors relevant in individual cases.*

*Some of the questions above depend on context. Some church environments very helpful and supportive, some judgemental and counterproductive.*

These comments point to the shortcomings of “short” surveys that rely on such generalised comments.

A small number of respondents questioned what they saw as an implicit view of organised religion and particularly Christianity: Comments included:
I appreciate it is hard to put together a survey about this topic but I felt there was an overly heavy emphasis on Christian spirituality and organised religion which made it very hard to answer your questions meaningfully as a Buddhist. Many of my patients and colleagues have spiritual and existential concerns which are not at all related to specific religious groups or practices.

As discussed the questionnaire was designed in this way as census figures that show Christianity is still the majority religion and cultural background of most people in this country (Census, 2009). While it is increasingly secular and multicultural New Zealand society has itself evolved out of Christianity (Geering, 1999). In a questionnaire of this size it was not possible or practical to include questions and clinical scenarios to cover the world’s major religious traditions. That deserves a much larger study.

Referral intentions were measured by reference to a single progressive clinical scenario. The use of multiple scenarios would have allowed for more internal checks and resulted in more indicative results across arrange of situations. However scenarios can only provide an indication of respondent’s self-reported intentions to refer a patient or take other clinical action. Without reference to specific real-life cases it is not possible to know the extent to which such intentions might translate into clinical practice. The scenario modifications indicated that the patient could be Christian or Māori. These are not mutually exclusive but options were limited due to the design restraints of the questionnaire.

4.1.3 Limitations in the Literature Reviewed

Only papers written in English were reviewed. This may have resulted in a cultural bias. Those cultures and religions whose native tongue is not English may have valuable insights that have been missed.

4.2 Implications for Future Research

This research has a number of implications for current clinical practice. Given the limited scope these remain tentative. More in-depth research is required in the practice of psychiatry where it touches matters to do with religion and spirituality. A more comprehensive survey of a wider sample of psychiatrists practising in New Zealand would need to include measures of
religiosity and have a greater range of questions to allow internal checking. Wider data collection methods could be used, such as case note analysis and semi-structured interviews.

Other areas of research might include:

a. What are the perceived unique psychological benefits of congregational and/or marae involvement? Can these benefits be gained from involvement in other types of groups?

b. If 46% of the respondents in the sample were found to be open to the possibility of supernatural intervention in patient’s mental illness. What might this mean for practice interventions?

c. Why do female psychiatrists seem more likely than male psychiatrists to see psychological benefit in religious congregational involvement?

d. What differences are there between training programmes in New Zealand and other countries? What changes could be incorporated into New Zealand training programmes?

Concerns to do with religion and spirituality are fundamental to being human. When psychiatric theory and practice are able to more fully take these into account those who endure the pain of mental illness will be treated more holistically. Both psychiatry as a profession and patients will benefit.

4.3 Conclusion

This study sought to answer three research questions:

- What are opinions and attitudes of New Zealand psychiatrists regarding religion/spirituality and mental health?
- What factors determine a clinician’s attitude and practice, with respect to spiritual matters?
- What factors determine a clinician’s attitude and practice, with regard to spiritual and culturally based mental health care providers (chaplains and kaumatua/tohunga).

In the NRSPS the opinions and attitudes of psychiatrists regarding religion/spirituality and mental health were found to be mixed. A number acknowledged the importance of these issues to patients and therefore to psychiatric assessment and treatment. Such
acknowledgement does not necessarily translate into practice. Lack of time, lack of understanding and boundary issues were among the factors identified that limit the implementation of spiritual discourse in the therapeutic setting. Good base education during undergraduate study and relevant up-to-date professional development would better equip clinicians for their task/work.

This study is the first to suggest that in the area of religion/spirituality in New Zealand ethnicity is the single most significant factor that determines clinician’s assumptions and practice. In particular it impinges on whether or not they are likely to refer patients to spirituality or culturally based mental health care providers (i.e. chaplains and kaumatua/tohunga). The psychiatrists in this sample who identified as New Zealanders were less likely to believe in God, less likely to see value in religious involvement, and less likely to refer a patient to spiritual and cultural advisors or carers. However they and particularly those still in training, were more likely to see value in marae involvement. This did not translate into being more likely to refer Māori patients to Māori spiritual leaders.

This study suggests psychiatry in New Zealand could benefit from further research in religion and spirituality in psychiatric practice. Such further research could provide understanding that will form a basis for advancements in the training of psychiatrists and the on-going development of psychiatric practice in a multicultural society. Increased understanding by psychiatrists of the role of religion and spirituality and their benefits, will result in better treatment modalities and outcomes for mental health consumers.
References


Interchurch Council for Hospital Chaplaincy. (May 2011). Snippets from the ICHC Executive Committee meeting. *Chaplaincy Messenger, 12*.


63
Appendices
Appendix 1

The National Religious and Spiritual Psychiatric Survey
THE NATIONAL RELIGIOUS AND SPIRITUAL PSYCHIATRIC SURVEY

Dear Doctor

Thank you for your interest in this anonymous survey of psychiatrists and psychiatric trainees about religion and spirituality in clinical practice. The questionnaire should take less than ten minutes to complete.

It has been adapted from a USA national study of medical practitioners completed by Dr Farr Curlin of the University of Chicago (American Journal of Psychiatry 2007; 164:1825-1831).

The survey has been approved by the University of Otago and the New Zealand Health and Disability Ethics Committee.

If you have any concerns or further queries about this research please don’t hesitate to contact either myself (butwy131@student.otago.ac.nz) or Professor Doug Sellman (doug.sellman@otago.ac.nz<mailto:doug.sellman@otago.ac.nz>) my research supervisor.

Thank you very much for your assistance.

Yours sincerely

Wyatt Butcher
Master of Health Sciences Student
University of Otago, Christchurch
1. To what extent do you consider yourself a religious person?
- [ ] Very religious
- [ ] Moderately religious
- [ ] Slightly religious
- [ ] Not religious at all

2. To what extent do you consider yourself a spiritual person?
- [ ] Very spiritual
- [ ] Moderately spiritual
- [ ] Slightly spiritual
- [ ] Not spiritual at all

3. In general, to what extent are the following conditions caused by religious/spiritual issues?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. In general, to what extent should treatment for the following conditions include a religious/spiritual component?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Please indicate how much you agree or disagree with the following statement:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in a religious congregation provides unique psychological benefits that are not found by participating in other social groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Please indicate how much you agree or disagree with the following statement:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in a marae community provides Māori with unique psychological benefits that are not found by participating in other social groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. How would you rate the effectiveness of the work of Chaplains and other Christian spiritual care providers in helping psychiatric patients?

- Very effective
- Effective
- Neither effective nor ineffective
- Ineffective
- Very ineffective
- have had no experience to date
- other

Other (please comment)
THE NATIONAL RELIGIOUS AND SPIRITUAL PSYCHIATRIC SURVEY

8. How would you rate the effectiveness of the work of Tohunga, Kaumātua and other Māori spiritual care providers in helping psychiatric patients?

☐ Very effective
☐ Effective
☐ Neither effective nor ineffective
☐ Ineffective
☐ Very ineffective
☐ I have had no experience to date
☐ Other

Other (please comment)

9. Consider the following clinical scenario: A 42-year-old woman presents to her GP for the third time in five months. She complains of difficulty sleeping, loss of appetite, irritability, loss of meaning in life and feeling “down” but not suicidal. She reports problems with her marriage and problems at work. She exercises regularly. Physical examination is unremarkable except for a sad affect, and routine investigations are normal. She is open to “anything” the doctor thinks will help. Given this limited information, if asked for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient):

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not very likely</th>
<th>Not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe an antidepressent medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to a psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to a counsellor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to a chaplain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage her to get more involved in her religious community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. In further conversation the doctor reveals that the patient is a Christian who attends church services. If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient):

<table>
<thead>
<tr>
<th>Action</th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not very likely</th>
<th>Not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe an antidepressant medication</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a psychologist</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a counsellor</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a chaplain</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Encourage her to get more involved in her religious community</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

11. Instead of being Christian, the doctor reveals that the patient is Māori who attends her local marae. If asked again for your opinion, how likely would you be to recommend that the GP do each of the following for this patient (Assume all strategies are available and financially feasible for the patient):

<table>
<thead>
<tr>
<th>Action</th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not very likely</th>
<th>Not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe an antidepressant medication</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a psychologist</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a counsellor</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Refer to a Tohunga or Kaumātua</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Encourage her to get more involved in meaningful relationships and activities</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>Encourage her to get more involved in her marae community</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>
THE NATIONAL RELIGIOUS AND SPIRITUAL PSYCHIATRIC SURVEY

12. Do any of the following discourage you from discussing religion/spirituality with patients? (Tick all that apply)
   - [ ] General discomfort with discussing religious/spiritual matters
   - [ ] Insufficient knowledge/training
   - [ ] Insufficient time
   - [ ] Not relevant to normal psychiatric treatment
   - [ ] Concern about offending patients
   - [ ] Concern that my colleagues will disapprove
   - [ ] Other
   Other (please comment)

13. Have you had any formal psychiatric training regarding religion/spirituality in clinical practice?
   - [ ] Yes
   - [ ] No

14. If Yes to 13, approximately how many hours?

15. Are you a qualified specialist psychiatrist?
   - [ ] Yes
   - [ ] No

16. If Yes to question 15 do you have the FRANZCP qualification?
   - [ ] Yes
   - [ ] No

17. How many years have you been practicing psychiatry (including psychiatric training years)?

18. Do you think God or any other supernatural being ever intervenes in patients’ health?
   - [ ] Yes
   - [ ] No
   - [ ] Undecided
19. Which one of the following statements best describes your beliefs about God? (ISSP 1993)

- I don’t believe in God
- I don’t know whether there is a God and I don’t believe there is a way to find out
- I don’t believe in a personal God but I do believe in a Higher Power of some kind
- I find myself believing in God some of the time but not at others
- While I have doubts I feel that I do believe in God
- I know God really exists and have no doubts about it

20. What is your religion? (NZ Census 2006)

- No religion
- Christian
- Buddhist
- Hindu
- Muslim
- Jewish
- Other
- Object to answering this question

Other (please specify)

21. If Christian, please indicate your denomination

22. If Christian do you consider yourself evangelical?

- Yes
- No

23. Which one of the statements best describes your belief in the Christian God?

- No doubt He exists
- Very high probability He exists
- Quite a high probability He exists
- 50/50 that He exists or does not exist
- Quite a high probability He does not exist
- Very high probability He does not exist
- No doubt He does not exist
- Don’t know what I believe
THE NATIONAL RELIGIOUS AND SPIRITUAL PSYCHIATRIC SURVEY

24. Your Gender?
   ○ Male
   ○ Female
   ○ Transgender

25. Your Age Group?
   ○ < 20
   ○ 20-29
   ○ 30-39
   ○ 40-49
   ○ 50-59
   ○ 60-69
   ○ 70+

26. Your main ethnicity?
   ○ NZ Māori
   ○ NZ European/Pakeha
   ○ Other European (Australian, English, Dutch, Scottish, etc) (please specify below) Samoan
   ○ Tongan
   ○ Other Pacific (please specify below)
   ○ Asian (please specify below)
   ○ Other (please specify below)
   ○ Specific ethnicity

27. Are there any final comments you would like to make about “religion and spirituality in psychiatry”?

Page 8
THANK YOU FOR YOUR PARTICIPATION
PLEASE ENCOURAGE OTHER COLLEAGUES TO DO THE SAME
Appendix 2

Respondents’ Comments About Christian and Māori Spiritual Care Providers

The comments have been grouped according to the theme and topic. All comments are in the respondents’ own words. Spelling and grammar have been corrected. Respondent number, gender, religious belief and ethnicity are given (NB. Some respondents did not provide all demographic details).

1.1 Comments on chaplains and other Christian spiritual care providers

1.1.1 Chaplains working with patients

[Chaplains] can be very helpful when indicated clinically and patients are receptive to such an approach. It can provide the clinician with important insights into the coping and meaning some patients attribute to their illness and their lives in general within their religious/spiritual framework, and inform therapeutic interventions. I have worked with chaplains in mental health settings and can only speak highly of their ethical standards and respect for patients’ religious/spiritual worldviews. They fill a significant void in helping clinicians see the whole person in their context.

(R109, male, Christian, other European)

[It] depends completely on the individual and their situation.

(R102, male, atheist, African)

Depends very much on the patient, what they are wanting from a chaplain and the chaplain [sic]. Very difficult to generalize. Also difficult to generalize [from] the above questions - some patients will greatly benefit and some not.

(R92, female, Christian, other European)

Each patient presents individual challenges and pathways for recovery, so for all these questions a general statement is challenging to make as for some the impact of their spirit/religious beliefs is fundamental to their illness/recovery - for others a minor part - but always gets a consideration.

(R85, male, no religion, NZ Pakeha)

If patient religious.

(R63, male, no religion, NZ Pakeha)

Can be very effective when it is in line with the patient’s own views and needs.

(R58, female, Buddhist, NZ Pakeha)

Can vary between very effective and directly damaging. Question probably needs to be bidirectional in its phrasing. Just like therapy, it depends on the individuals, their ways and their circumstances.

(R56, male, pagan, NZ Pakeha)
The prescriptive terms of this survey do not allow for my views from Q 3 onwards. Religious patients may be helped by those within their own faith, for others it’s irrelevant and contraindicated.

(R101, female, other European)

The spiritual dimension is often not understood by persons themselves who have no religious experience. Hence it is not considered by therapists, particularly the effect of prayer and the possibility of miracle in the Christian faith in the action of Jesus as part of his healing mission started 2000 years ago and continue to time immemorial.

(R51, female, Christian, Asian)

If spiritual matters are important to the individual then in my opinion offering spiritual support via access to a Chaplain for example usually provides comfort, is a basic human right and can assist in building therapeutic rapport. But if not important to individual, should not be forced upon them.

(R18, female, no religion, other European)

An awful lot depends on the degree of buy in from the patient, and on the personality of the chaplain.

(R4, female, Christian, other European)

Many of these questions are a little too absolute for my liking. I think for some people spiritual issues, and addressing these, are critical, whereas for others they are not relevant.

(R54, male, no religion NZ Pakeha)

It can dependent on the individual patient and their worldview.

(R40, Christian female, no religion NZ Pakeha)

Depending on the needs and religious views of the patient.

(R37, male, no religion, other European)

They are only effective if the patient is that way inclined.

(R29, male, no religion, NZ Pakeha)

1.1.2 Comments relating to Chaplains and their training

Difficult to comment on as their work is often not visible.

(R19, female, Christian, NZ Pakeha)

Depending entirely on the person and openness of the Chaplain etc.

(R41, Christian, NZ pakeha)

Though as with health care and associated care-givers it does also depend on the skills of the individual.

(R11, female, no religion, NZ Pakeha)

Too dependent on the individual qualities of the chaplain, therefore, reliability/quality control is an issue.

(R22, male, Christian, other European)
Providing they are well-trained and offer support where requested, not advocate for involvement where not wanted. I have found in most instances this has worked well.

(R100, male, Christian, other European)

It absolutely depends on their personality and the way they use their belief systems to engage and support people. I have worked with some chaplains who were absolutely superb but they tended to have a very pragmatic faith and engaged at a spiritual level with people’s pain and suffering, not at a religious level.

(R89, female, pantheist, NZ Pakeha)

Can be helpful but very variable, some spiritual counsellors are not well-trained and fail to recognize transference etc.

(R83, female, no religion, NZ Pakeha)

Two roles. One is in meeting the religious needs of those with an inclination that way. Other is as a neutral and kindly person to talk to.

(R62, male, no religion, NZ Pakeha)

My experience has been of chaplains as an integral part of the team in hospital, and more recently in community. Well-trained chaplains are very effective but not all spiritual care providers are of the same calibre and some can be counter-productive, for example if they discourage the taking of medication. As a member of the team the chaplain is also able to address staff spiritual issues/needs and so contribute indirectly as well as directly to patients’ treatment and care.

(R27)

Often very effective and helpful, sometimes neutral, on occasion (though rare) can be harmful or even very harmful; especially radical/fundamentalist/ultra-conservative groups.

(R2, male, no religion, Asian)

1.1.3 Comments on the variability of chaplains’ effectiveness

Some but little experience with working with support people from people’s churches with varying level of effectiveness. Generally with young people who are only loosely connected with spiritual care providers.

(R73, female, Christian, Asian)

Can be effective, when appropriately used.

(R39, female, no religion, NZ Pakeha)

Variable effectiveness.

(R35, male NZ Pakeha)

May have deleterious consequences; depends on so many factors.

(R88)
1.2 Comments on the Effectiveness of Tohunga/Kaumatua and Other Māori Spiritual-Care Providers

1.2.1 Effectiveness for the patient

Has been effective for some patients.  
(R94, male, no religion, other European)

If patient has strong Māori cultural history.  
(R63, male, no religion, NZ Pakeha)

Depends on the beliefs of the patient.  
(R62, male, no religion, NZ Pakeha)

As above, it depends on the patient. Some are helped; others are not, depending on their views and wishes.  
(R58, female, Buddhist, NZ Pakeha)

Can be helpful or detrimental. Depends on the diagnosis.  
(R57, female, no religion, other European)

As above if important to individual, a helpful adjunct!  
(R18, female, no religion, other European)

Again though does depend on the individuals and groups involved.  
(R11, female, no religion, NZ Pakeha)

Could be effective or not effective at all. It depends on many factors: patient's diagnosis, personality, beliefs.  
(R7, female, no religion, other European)

1.2.2 Comments on the effectiveness of tohunga and kaumatua

I haven’t had much direct experience of Tohunga but the involvement of Kaumatua has made a big difference to both the service user and their family.  
(R89, female, panthieist, NZ Pakeha)

Varies from helpful to very unhelpful.  
(R74, female, no religion, other European)

I am uncertain if you count Pukenga Atawhai as Māori spiritual care providers. They are the only people I have had experience with therefore my comment is rating the effectiveness of the PA in our system of care. The major help the Pukenga Atawhai provides is enabling good communication with families and helping with misunderstandings and developing a good working relationship with the family and making appropriate links to Māori health and cultural providers.  
(R73, female, Christian, Asian)

Can be effective, when appropriately used.  
(R39, male, spiritual, NZ Pakeha)
Variable effectiveness.  

(R35, male, Unitarian, NZ Pakeha)

It forms part of the picture.  

(R29, male, no religion, NZ Pakeha)

1.2.3 Comments on the need for liaison with the Multi-disciplinary team

I have experienced effective and supportive Māori spiritual care providers. What works well for patients and the clinical team is the situation where the Māori spiritual care provider works with the team for the benefit of the patient but also for the benefit of team members. In this context I have seen important referrals made. On the other hand if there is no relationship with the team there is a risk of having a confrontational situation which is counter-productive.

(R27)

Often very effective and helpful, often neutral, on occasion (though rare) can be harmful if care is not coordinated with MHS and conflicting/contradictory messages are given.

(R4, male, Asian, no religion)
Appendix 3

Other comments

In the respondents’ own words.
The comments have been grouped according to theme and topic. The comments received were generally positive. Respondent number, gender, religious belief and ethnicity are given. (NB. Some respondents did not provide all demographic details)

1.3 Positive comments on the inclusion of religion/spirituality in clinical practice

This is an exciting area I have been exploring for years and the research is stimulating and confirming the general beneficial effects of religion, spirituality and mental health as is evidenced by the involvement of psychiatric academics (e.g. Koenig and others) and the Australian National Conferences on spirituality and health in recent years. There is a deep yearning and reflection in a lot of our patients for spirituality and a search for greater meaning in their lives. This approach has contributed to the recovery and coping of a good number of my patients who hold such belief, which I am supportive of. The spiritual dimension of our being on the whole is crucial, I believe, to a balanced and fulfilling life.

(R109, male, Christian, other European)

I think religion can be very helpful to people and is a fascinating part of human culture.

(R26, male, no religion, NZ Pakeha)

The illegal status of entheogens is the main religious persecution of our time. Spiritual aspects of mental illness are dismissed as psychosis, instead of used as part of understanding of it. There is a spiritual dimension in all life and all people in particular that is neglected in our society which is dominated by material concerns. This denial of, and making laws against, the spiritual is leading humanity into deep trouble with the environment and each other leading towards our self-destruction as a race.

(R13, male, all religions, other European)

I would conceptualize religious beliefs as similar to cultural and philosophical beliefs, if these are relevant to the patient and the patient’s context, they can be very helpful in engagement and offering support; however the concepts by themselves have little to add to good practice.

(R8, male, no religion, other European)

I do endeavour to inquire into religious beliefs but this rarely leads to any useful outcome.

(R61, male, Christian, NZ Pakeha)

I would look for the opportunity to tackle the spiritual dimension, but would not force a patient to do so.

(R31, male, Christian, NZ Pakeha)
No doubt we should enquire about and attend to spirituality in psychiatry as it is vital to understand this aspect of patients’ lives. What gives them meaning, hope and helps transcend their difficulties.

(R95, female, no religion, NZ Pakeha)

Like sexuality, spirituality and religion are personal matters with lots of baggage, but we probably do our patients a disservice by not discussing them more.

(R108, male, Christian, other European)

1.4 Negative comments on religion/spirituality

I consider the growing laxity re boundaries of expertise in this regard a grave threat to psychiatry and our patients.

(R116, male, no religion, other European)

Religion/spirituality is not evidence-based medicine. There is a real risk that well-meaning doctors could end up proselytizing, inducing guilt trips and all sorts of un-therapeutic mayhem. It is fine to suggest patients see the religious/spiritual guide of their choice, but not to see it as medicine.

(R58, female, Buddhist, NZ Pakeha)

Despite my Christian background, I regard all religion as a form of approved social delusion. However, I feel no need to proselytize my views.

(R21, male, no religion, other European)

1.5 Comments that religion/spirituality in psychiatry is neglected

Much more research is needed to break down the barriers to including a spiritual aspect in therapy. This will take some courage from researchers to explore ways to most effectively do this.

(R114, female, no religion, other European)

It’s an area that has been neglected for so long, but is relevant to the core human issues. It should be incorporated as part of the holistic approach to psychiatric treatment.

(R103, female, Christian, other)

An understudied area, with inadequate clinical guidelines, but very important to individual patients and their families; and ignoring it impairs clinical treatment.

(R100, male, Christian, other European)

I think religious and spiritual aspects of people’s lives are not assessed and utilized in day-to-day clinical practice. I feel including these can have a much greater positive impact on people’s mental health esp. for ones who are religious in their beliefs.

(R98, male, Hindu, Asian)

Needs more education and discussion. Also around philosophy, e.g. I am an absurdist. Lots of my patients are having existential crises.

(R81, female, no religion, other European)
Religion and Spirituality also includes a vast number of people who are involved in the occult, witchcraft and Wicca as well as Freemasons. Black magic, voodoo and makutu (as practiced in Māori culture) are important aspects to know about a person’s belief structure to tease out appropriate instructions and approaches for patients. One should have a working knowledge of most religious beliefs (including Judaism and Islam) in order to understand if one’s beliefs are socially normal. A person may have religious ideas that are peculiar to their psychosis and which disappear entirely when they are treated. Without the concept of a personal creator, questions of meaning are irrelevant. Therefore (given that humans are meaning-making machines) the issue becomes one of constructing a satisfying and constructive life in the absence of perceived external guidelines. The literature is clear that 90% plus of patients are intensely interested in spiritual matters but doctors don’t enquire and worse are castigated by their colleagues if they discuss these matters with patients. Those undergoing surgery are often thinking of the possibility of death. A viewpoint can be effectively neutral but extremely helpful (to an extent we are required to be chameleons.) Those who do not believe in God may have an entirely correct perception if they have never experienced or met God. The trick is to gently explore a patient’s beliefs and tailor treatment accordingly. I will be lecturing on this topic shortly to colleagues and training registrars. All of us are confronted with the essential mystery of our existence which is a puzzle whichever view you subscribe to. In its broadest sense exploring spirituality is exploring those issues and views that the patient holds most dear and deeply.

(R53, male, Christian, NZ Pakeha)

It’s a really important area and is often overlooked, both in training and in practice. While I understand surveys such as this are difficult to put together, much of the answer to several questions is, depends on the patient!

(R4, female, Christian, other European)

I am glad that your survey high-lighted an area often neglected and I know in England you can be disciplined for suggesting faith can help with healing the mind and body. I hope your research could help.

(R51, female, Christian, Asian)

It is important, but my experience is that it is generally neglected.

(R16, male, no religion, NZ Pakeha)

### 1.6 General comments on spirituality

Spirituality can be theistic or non-theistic.

(R90, male, Christian, other European)

I think I know what “religion” is. But not sure what "spirituality" might be.

(RR71, Male, no religion, other)

A comment re meditation as a spiritual tradition /practice, with an evidence base for improving psychological well-being in both sick and healthy people as well as connecting people to their own spirituality.

(R50 male, no religion, NZ Pakeha)
1.7 The value of church community

Some of the questions above depend on context. Some church environments are very helpful and supportive, some judgmental and counterproductive. Not a lot more training in NZ on spirituality in Māori context cf. religious.

(R77, female, Christian, NZ Pakeha)

In question 11 if Pukenga Atawhai are counted as spiritual care providers then the answer is very likely for referral to Māori provider. Using the concept of cultural safety I would say 20 years ago psychiatric training was culturally unsafe for Christians as we were constantly told to keep our beliefs to ourselves and were given the distinct impression that people who believed in God were wrong and bordering on delusional. I think this position has softened somewhat over time. I think also the lack of knowledge about the safety or not of people’s various churches and lack of knowledge re their appropriate supervision makes advice in this area difficult. Some churches have been abusive and damaging to some patients. With the PA we know at least they are part of a system that has peer supervision and are part of the treating team.

(R73, female, Christian, Asian)

Religious congregation provides a unique psychological experience, I think this experience can range from helpful to harmful.

(R35, male, Unitarian, NZ Pakeha)

1.8 Comments on Individual variability

Hard to answer questions on mental health spirituality link "in general" because this is so very individually determined.

(R99, male, Christian, NZ Pakeha)

The rules of cognitive psychotherapy apply.

(R104, transgender, Christian, NZ Pakeha)

The issue re spiritual aspect is not so much diagnostic but [an] individual’s beliefs and values

(R48, male, Christian, NZ Pakeha)

I guess I assess its relevance to the presenting problems on a case-by-case basis, together with an assessment of the person’s other coping strategies. As a powerful organizing principle in people’s lives, I tread around religious beliefs with caution. Having converted from Christian to devout atheist myself, I’m aware of the turmoil such a shift in perspective can cause, but I’m also aware that a switch the other way could have significant healing potential...

(R94, male, no religion, other European)

1.9 Critical comments about the questionnaire

I appreciate it is hard to put together a survey about this topic but I felt there was an overly heavy emphasis on Christian spirituality and organized religion which made it very hard to answer your questions meaningfully as a Buddhist. Many of my patients and colleagues have spiritual and existential concerns which are not at all related to specific religious groups or practices. It is good to see some interest in this area, esp. as the college ethical guidelines include attention to our patients, spiritual welfare in our remit.

(R113, male, Buddhist, other European)
Good luck in your study! Defining religion and spirituality might help in answering your survey. As a Buddhist I do not consider myself religious but partly spiritual if that makes sense. Again, good luck!

(R110, male, Buddhist, Asian)

Note error in Q26 Samoan presumably deserves its own category.

(R102)

Difficult to use such a general questionnaire for this topic as the care/advice/services you may get are highly individualized to the patient, their beliefs, their problems and their presentation.

(R92, female, Christian, other European)

I think that spirituality and religion must be separated out to make this work meaningful.

(R89, female, pantheist, NZ Pakeha)

This questionnaire is too simplistic to cover a sensitive and complex topic and answers would vary so much depending on multiple factors relevant in individual cases.

(R88)

Perhaps it's the way of such questionnaires. It is far too categorical, and by lumping tends to reduce ideas to the absurd e.g. God and religion. Left q3 unanswered on purpose.

(R56, male, pagan, NZ Pakeha)

I thought the design of the questionnaire increased the chance of bias. For example, I changed some of my answers after reading the Māori questions that followed.

(R43, male, no religion, NZ Pakeha)

The questionnaire has a somewhat typical American yes/no flavour, and is very un-nuanced. It does not give any definitions of religion and spirituality.

(R41, Christian, NZ Pakeha)

I think religion should be differentiated from spirituality. I have thoughts on how to improve the questionnaire. Some of the questions are hard to answer fully or specifically.

(R39, male, spiritual, NZ Pakeha)

For question 3 and 4, if you had asked to what extent these things COULD relate to spiritual or religious things, I would have answered a lot to both of these questions uniformly.

(R31, male, no religion, NZ Pakeha)

As a retired psychiatrist I have answered the first part of this questionnaire and then realised it was probably not relevant for your research as I have not practised for many years. I wish you well in your research, it's an important topic.

(R25)

I found the wording of some of these questions difficult (e.g. q23). None of the statements really fits for me. It would be more helpful to ask about Yeshua/Jesus and his role in history and impact on my life currently, belief and experience of Holy Spirit etc.

(R6, female, Messianic Jewish, other European)