

Religiosity, Spirituality, and Mental Health in Portugal: a call for a conceptualisation, relationship, and guidelines for integration (a theoretical review)

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Abstract: In the Portuguese research society, particularly in the mental health field, little has been done regarding religiosity, spirituality and mental health. Thus, this paper strives to stimulate the interest in this area by providing an overview of the body of research on religiosity, spirituality and mental health, highlighting the role and importance these dimensions represent in the life of many people, whether in health or mental distress and illness. A brief review of the conceptualisation of religion (religiosity) and spirituality is provided, as well as some areas of disagreement and contention. Guidelines for the integration and professional training are also included, not discarding the ethical considerations inherent in this process. Finally, reflections are offered as to why bringing religiosity and spirituality into mental health field is important, as well as some implications for clinical practice, with particular focus on Portuguese mental health system.

Keywords: Religiosity; Spirituality; Mental Health; Conceptualisation; Integration; Guidelines; Ethical challenges

Religiosidade, Espiritualidade e Saúde Mental: da conceptualização, à relação e às orientações para a integração (revisão teórica): Em Portugal, a investigação científica tem sido escassa no domínio do estudo da religiosidade, espiritualidade e saúde mental. Assim, este artigo propõe-se estimular o interesse pela área, fornecendo uma visão geral do corpo de investigação relativo a religiosidade, espiritualidade e saúde mental. Realça-se o papel e a importância que estas dimensões desempenham na vida de muitos indivíduos, quer estes sofram de doença ou mal-estar físico ou mental. É fornecido um resumo da conceptualização da religião (religiosidade) e espiritualidade, incluindo algumas áreas de desacordo e controvérsia. Incluem-se também orientações para a integração e formação profissional, tendo em consideração os aspectos éticos inerentes ao processo. Por fim, segue-se uma reflexão sobre a importância de integrar a religiosidade e a espiritualidade no campo da saúde mental, bem como algumas implicações para a prática clínica, com especial enfoque no sistema de saúde mental português.

Palavras-chave: Religiosidade; Espiritualidade; Saúde Mental; Conceptualização; Diretrizes de integração; Desafios éticos.

Portugal is predominantly a religious country tied not only to religious beliefs and practices, but also to a number of social and cultural aspects. In the last Portuguese Census, in 2012, almost 85% of the population identified as being religious, mostly Roman Catholic, and with a growing religiously diverse population representing up to 4% of Portuguese residents (INE, 2012. See Table 1). Although being a non-confessional secular state, Portugal (as a country, a society, and state) shares a particularly long and strong relationship with Roman Catholic Church (for a historical review, see Wiarda, 1994; Vilaça, 2006; Dix, 2010).

Furthermore, as a society Portugal is quite advanced in terms of religious legislation. For instance, not only does Portuguese constitution forbid discrimination in any form, but it also constitutes religious and spiritual life as a right, as portrayed in the Art 41 - *freedom of conscience, of religion and of form of worship*. More specifically in relation to health, the Portuguese State guarantees to any citizen the right to have their spiritual and religious needs understood and included when seeking for health care (Law n^o 253/2009, regulating the spiritual and religious care in hospitals and other establishments of the National Health Service).

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Table 1. Religious Identification (affiliation) of Portuguese Population at Age 15 Years and Older (based on 2011 Census)

		N. ^o	%
Religion	Portugal	8.989.849	100.00
	Catholic	7.281.887	81.00
	Orthodox	56.550	0.63
	Protestant	75.571	0.84
	Other Christian	163.338	1.82
	Jewish	3.061	0.03
	Muslim	20.640	0.23
	Other non-Christian	28.596	0.32
	Not religious	615.332	6.84
	Did not answer	744.874	8.29

Table reprinted and adapted from INE (2012, p. 530).

However, almost no research has studied this subject so far. For instance, in terms of previous work focusing on the integration of Religion and Spirituality into professional healthcare field, most of the work was conducted in nursing and end-of-life care (Caldeira, Castelo Branco & Vieira, 2011), whereas in mental healthcare research (Psychology, in particular) no academic research and publications were made, apart from a few masters dissertations (e.g. Garrett, 2010; Taranu, 2011) and the research in the context of quality of life and well-being (e.g. Pinto & Pais-Ribeiro, 2007; Gouveia, Marques & Ribeiro, 2009; Pinto & Pais-Ribeiro, 2010).

More recently a few multicultural studies, with a particular focus on minority group issues, have been conducted in an attempt to draw attention to this field (e.g. Moleiro, Silva, Rodrigues & Borges, 2009; Freire & Moleiro, 2011; Moleiro, Pinto & Freire, 2013). Yet, clearly these dimensions remain understudied in the field of mental health research in Portugal, which is also true for international research society, despite of the rapidly increasing interest in these topics (Hill & Pargament, 2003; Paloutzian & Park 2005).

This gap in research between spirituality/religion and its implication on healthcare seems paradoxical given the historical relationship between psychiatry (the dominant science focusing on mental health at the time) and religion. As a matter of fact, initially these two fields were so intertwined that mental healthcare facilities were located in monasteries and the care was provided by religious leaders (Koenig, 2009; 2012). Consequently, mental illnesses were often associated and treated as religious problems. As Koenig (2009, p. 284) refers "*the first form of psychiatric care in the United States was moral treatment, which involved the compassionate and humane treatment of people with mental illness*".

One of the most prominent Portuguese examples, among many others, is São João de Deus, also named the Saint of Hospitality; the patron saint of hospitals, the sick, nurses, fire-fighters, etc. Nowadays, the legacy of this Portuguese-born soldier turned into health-care worker, is known around the world as the *Hospitaller Order of St. John of God* (HOSJG). Its presence in Portugal is under the St. John of God Institute, who provides a holistic health and social care, based on the Order's values of "*Quality, Respect, Responsibility and Spirituality*" (for historical review, please see HOSJG, 1997).

Of course, "soon" philosophers, scientists and health professionals started to see, understand and treat mental illness less with a religious approach and more with a medical perspective (Thielman, 2009). This separation was so profound that by the nineteenth century all terms and treatment related to religious issues were completely removed from the healthcare field (Thielman, 2009), religion being relegated only to hospital chaplains and clergy.

Among many authors and scientists, one of the most prominent names contributing to the state of this gap is considered to be Sigmund Freud. Freud's hostility towards religion (and other factors, of course) led most of mental healthcare professionals, including psychologists, to avoid any contacts with the concept of Religion/Spirituality for a long time (Fallot, 1998; Hill & Pargament, 2003; Nelson, 2009; Plante, 2007; Johansen, 2010; Curry & Roach, 2012; Koenig, 2012), turning it into a topic with little or no importance in the training of these professionals (Dein, 2004; Koenig, 2012).

However, times have changed. More recently, both mental health research and professionals have been claiming that religion and spirituality represent key dimensions when aiming a complete understanding of an individual (Fallot, 1998; Hill *et al.*, 2000; Tummala-Narra, 2009; Johansen, 2010); as well as having a great and positive impact on both physical and mental health, and client's therapeutic

process. It has been hypothesised that this impact is largely due to the meaning, meaning making and connection to the transcendent religion and spirituality may provide to one's life (George, Ellison & Larson, 2002; Dein, 2004; Büssing, Ostermann & Matthiessen, 2005; Park, 2005; Dein, Cook, Powell & Eagger, 2010; Koenig *et al.*, 2012); in a sense that these domains can influence one's beliefs, goals, emotions or even the core of human existence (Park, 2005).

In light of the above, the present paper aims to highlight some of the current perspectives on the relevance of religion and spirituality in mental health research and, most importantly, how to incorporate these life aspects in psychological treatment with religious and/or spiritual clients.

Therefore, this theoretical review is organised according to the current trends of research on religiosity, spirituality and mental health; discussing firstly the ambiguities and confusions surrounding the relationship between the concepts of religion, religiosity and spirituality. Then and briefly, the relationship between religion, spirituality and mental health will be addressed, focusing on the impact the former have on mental health outcomes and to the psychological treatment process. Next, and from an integrative and multicultural point of view, some guidelines will be provided, along with the ethical issues the integration of religious and spiritual issues in psychological treatment requires.

RELIGION (RELIGIOSITY) AND SPIRITUALITY: RELATIONSHIP AND CONCEPTUALISATION

When recognizing the different dimensions of "*religion*" and "*spirituality*", the understanding and definition of these phenomena is by nature complex and often these two are used interchangeably in the scientific research and clinical practice (Pargament, 1999; Zinnbauer, Pargament & Scott, 1999; Büssing *et al.*, 2005; Koenig, King & Carson, 2012). This is essentially due to a great number of different perspectives, starting points and cultural contexts, as these terms can be seen as synonymous, overlapping, or completely different concepts (Hill *et al.*, 2000; Tummala-Narra, 2009).

The ambiguity is so profound that, for some authors, religion should be considered as a broader and more general construct than spirituality (Pargament, 1999; Hill *et al.*, 2000); whereas others see religion as a component falling into an "*umbrella*", of the spirituality (Miller, 1999; Dein, 2004). As mentioned before, it is commonly accepted, though, that both religion and spirituality emphasise the depth of meaning and purpose in life, and connection to the sacred (Dein, 2004; Büssing *et al.*, 2005; Dein, *et al.*, 2010; Koenig *et al.*, 2012); where some may be "*religious and spiritual*"; "*religious, but not spiritual*"; or yet again "*spiritual, but not religious*", without dismissing those who are "*neither religious nor spiritual*" (Worthington, Kurusu, McCollough & Sandage, 1996; Koenig, George, Titus & Meador, 2004; Richards & Bergin, 2005; Saucier & Skrzypińska, 2006; Büssing, 2010).

As a matter of fact, religion and spirituality as concepts do overlap, and in some regards might also be similar (Richards & Bergin, 2005; Fisher, 2011; Hadzic, 2011; Koenig *et al.*, 2012). However, one must also acknowledge they are not identical (Zinnbauer, *et al.*, 1999) and for that reason conceptualisations that focus or are narrowed to certain aspects of religion or spirituality might not be appropriate (Saucier & Skrzypińska, 2006; Nelson, 2009).

Obviously, this ambiguity and confusion has a great impact on the credibility and understanding of research and practice in this area (Koenig, 2009), leading for instance to: limited or otherwise too broad definitions of religion and spirituality, which results in a loss of their idiosyncratic characteristics (Zinnbauer, *et al.*, 1999; Hill *et al.*, 2000); different forms of polarisation of religion and spirituality, the former being institutional/negative/harmful and the latter individualistic/positive/beneficial (Pargament, 1999; Zinnbauer *et al.*, 1999; Hill & Pargament, 2003; Pargament, 2007; Smith, 2007; Mutter & Neves, 2008); and pathologization of religious and spiritual beliefs/practices in diverse or minority contexts (Frame & Williams, 1996; Fallot, 1998; Lukoff & Turner, 1998; Tummala-Narra, 2009; Adams, 2012).

Concerning this tendency for religious and spiritual pathologization, it is crucial to emphasise the weight a Western conceptualisation has put on this process of isolating, analysing, and defining both religion and spirituality (Smith, 2007). Indeed, Western conceptions of religion and spirituality have a tremendous impact on defining acceptable forms of approaching these concepts, with a particular interest in the realm of mental health; and undoubtedly a considerable progress has been made in this field.

However a complete discussion of this conceptual history, as important as it is, is beyond the purposes of this article (for extended discussions please see Fallot, 1998; Zinnbauer *et al.*, 1999; Hill *et al.*, 2000; Hill & Pargament, 2003; Smith, 2007; Koenig, 2009). Thus, this paper presents some of the most significant and recent inputs in this field, highlighting that special care must be taken to properly conceptualise these two multidimensional concepts.

Religion (Religiosity)

One of the leading definitions of religion is provided by Argyle and Beit-Hallahmi (1975 as cited Argyle and Beit-Hallahmi, 2014). These authors define religion as “*a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power*” (p. 6); This definition by nature emphasises the substance of religion, focusing primarily on institutionalised beliefs, emotions, practices, and relationships of individuals that are clearly related to the *institutionalised* sacred (Fallot, 1998; Pargament, 1999; Zinnbauer, *et al.*, 1999; Richards & Bergin, 2005; Lindridge, 2007). Pargament (1997, as cited in Pargament, Magyar-Russell & Murray-Swank, 2005) also defined religion as “*a search for significance in ways related to the sacred*” (p. 32), highlighting that the sacred here should be understood in a broader sense, rather than only limited to the traditional concepts of higher powers, divinity or God (Zinnbauer *et al.*, 1999).

More recently, Koenig and colleagues suggested a more comprehensive definition of religion in an attempt to bridge, for instance, the gap between western and eastern traditions. Therefore, for these authors religion represents a “*multidimensional construct that includes beliefs, behaviours, rituals, and ceremonies that may be held or practiced in private or public settings, but are in some way derived from established traditions that developed over time within a community*” (Koenig *et al.*, 2012, p.45).

Moreover, religion has connection to other dimensions, such as a search for personal goals (i.e. meaning and purpose in life and good physical health) as well as having a social function (i.e. sense of belonging and closeness to others) (Zinnbauer *et al.*, 1999; Johansen, 2010). Accordingly, *religious life*, *religiosity* or *religiousness* involve participation in a set of beliefs, rituals, and activities such as attending religious and church services, scripture reading, prayer, meditation, among others (Fallot, 1998; Haynes, 2009).

Spirituality

Compared to religious studies, the interest and research on spirituality are much more recent, yet there are numerous and diverse findings. In the health context across different fields, studies have been conducted in an attempt to define and distinguish spirituality from religion. Nonetheless, perhaps researchers might still be using personal definitions of spirituality, typically based on their own understanding of this dimension (Hadzic, 2011).

Also, spirituality is progressively being used to refer to the individual's subjective aspect of religious experience (Hill & Pargament, 2003). Therefore, research and society in general, have been witnessing a growing movement of its usage, shying away from the institutionalization of their beliefs (religion) toward its individualization. Therefore more and more individuals identify themselves as being “*spiritual, but not religious*” (Zinnbauer *et al.*, 1999; Miller, 2003; Saucier & Skrzypiąska, 2006; Winslow & Wehtje-Winslow, 2007; Baetz & Toews 2009; Büssing, 2010), i.e. those who are “*committed to the spiritual dimension of life, but not be identified with any specific religion*” (Miller, 2003:150).

Accordingly, spirituality is widely defined as a universal human trait (Lindridge, 2007; Winslow & Wehtje-Winslow, 2007; Fisher, 2011) leading an individual towards knowledge, meaning, purpose and hope (Büssing *et al.*, 2005; Smith, 2007; Winslow & Wehtje-Winslow, 2007), in an ultimate goal to find, transform and relate to the transcendent or sacred (Pargament, 1999; Nelson, 2009). To highlight that this journey may or may not include participation in a religious faith/community (Hill & Pargament, 2003; Koenig *et al.*, 2004). And as Koenig *et al.* (2012, p.46) added, it “*also extends beyond organized religion (and begins before it)*”.

RELIGIOSITY, SPIRITUALITY AND MENTAL HEALTH: ROLE AND IMPACT

As mentioned above, it has been long since religious and spiritual issues were considered to be completely outside of the mental health domain, to where it stands currently. In the meantime, these two dimensions were pathologized; considered to have a strong and negative effect on mental health and psychosocial functioning; *depathologized*; considered to have a slight, but positive impact on mental health; to what are believed today to be key dimensions in many peoples' lives, with practical and important repercussions on therapeutic outcomes (for extended knowledge on the relationship between religion, spirituality and mental health, see Lukoff & Turner, 1998; Johansen, 2010).

Some developments in the mental health field have contributed to the changed interest in religion and spirituality, which are reviewed here, so the current standpoint of the relationship between these dimensions can be understood and supported.

Research regarding religion, spirituality, and health (either physical or mental) is currently being much more encouraged and included in the literature, not exclusively but, in the fields such as: medicine, neuroscience, epidemiology, and psychology.

Starting from a developmental perspective, there is little doubt that religion and spirituality play an important role in the development across the human life span (Levenson, Aldwin & D'Mello, 2005). Therefore, innumerable models and theories have been developed in an attempt to cover and explain how, across the human life span, one sees oneself in relation to what is considered to be divine or transcendent (Dowling & Scarlett, 2005). Most of the work in this field has been done concerning the importance religion and spirituality has for adaptation in later life; however, lately the interest also covers early life, including childhood, adolescence and middle adulthood (Levenson, *et al.*, 2005).

Concerning the relationship between religion, spirituality and health, most of the work involves studies on mental health, and again the majority shows a positive and strong relationship between these dimensions. Specifically, it seems that religious and spiritual people tend to present better indicators of physical and psychological well-being, in that they present lower rates of physical illnesses and psychological disorders, such as depression, suicide, anxiety, substance abuse, marital problems (Koenig, 2000, 2001; Cohen & Koenig, 2004; Büssing *et al.*, 2009; Johansen, 2010; Koenig, 2012).

Also, they seemed to present a greater sense of social support (Fallot, 1998; Koenig, 2000, 2001, 2012; Baetz & Toews, 2009); and experiencing much more positive emotions and acts, such as happiness, hope, optimism, meaning and purpose, altruism, gratitude and forgiveness (Hackney & Sanders, 2003; Cohen & Koenig, 2004; Baetz & Toews, 2009; Rosmarin, Krumrei & Pargament, 2010; Koenig, 2012). These positive connections seem to be closely linked to lifestyle habits, social support and coping strategies (e.g. prayer, meditation and religious rituals) often inherent to religious and spiritual daily life (Nelson, 2009; Johansen, 2010; Curry & Roach, 2012; Koenig, 2012).

There also seems to be a positive association between the onset and/or worsening of psychopathological symptoms and increased importance of religion and spirituality in the life of many patients/clients (Baetz & Toews, 2009; Gockel, 2011). Other studies indicate that, in psychological distress and suffering, religious clients tend to recover faster with better outcomes when mental health professionals seek the integration of their clients' religious beliefs and practices (Fallot, 1998; Aukst-Margetić & Margetić, 2005; Curlin *et al.*, 2007; Baetz & Toews, 2009). This might be in response to clients' wishes that their religion or spirituality be included in psychological treatment (Miller, 1999; Knox, Catlin, Casper & Schlosser, 2005; Martinez, Smith & Barlow, 2007; Hodge, 2011^a).

However, it is important to highlight that not all studies have found a positive relationship between religion, spirituality and mental health, and these should also be taken into account. Some researchers have indicated, for instance, that negative/harmful emotions such as dissatisfaction or anger towards God and/or a congregation and sense of guilt may arise; or yet a strict religious background or membership correlate with impaired mental health (Fallot, 1998; Cohen & Koenig, 2004; Lindridge, 2007; Baetz & Toews, 2009; Hadzic, 2011; Curry & Roach, 2012). It also seems true that when understood, used or manipulated in an unhealthy way, some religious and spiritual beliefs and practices may result in worse mental health and neurotic behaviour (Cohen & Koenig, 2004; Curry & Roach, 2012). For instance, among patients with obsessive-compulsive disorders (or even individuals in nonclinical samples), it is not uncommon to find beliefs or fear of sin/God, and consequently the use of daily practices such as church attendance or pray numerous times per day to try to neutralise or decrease levels of distress (Abramowitz *et al.*, 2002; Cohen & Koenig, 2004; Williams, Lau & Grisham, 2013).

Accordingly, the research and professional challenge here may require not only the recognition of the positive and negative impact that religion and spirituality might have on mental health, but most importantly the understanding of how this impact occurs; how it can be used as a resource; how it can be challenged; and how it can be integrated accurately into therapeutic settings, thus benefiting the client, the therapeutic relationship and the therapeutic process as a whole.

RELIGION, SPIRITUALITY AND MENTAL HEALTH: AN INTEGRATIVE VIEW

It is important to highlight that this paper does not serve as a preparation or as a training manual for mental health professionals when working with religious people or religious matters in therapy. Rather, it should be seen as a "*wake-up call*" or another helper (*so to speak*), guiding mental health professionals to search and define what to do prior to beginning working with these issues. Therefore, hereinafter some guidelines to an accurate integration of religious and spiritual issues in therapy found in literatures will be provided, followed by the ethical issues in achieving this accurately.

Standing from an integrative point of view, Psychotherapy and Religion/Spirituality seem to share similar purposes, despite using different logics, methods, and strategies. Fundamentally, these worlds try to emphasise the importance of self-knowledge (resources, responsibilities and difficulties); promote the acquisition of strategies to deal with the guilt and shame; guide the search for solutions to personal conflicts; seek to answer the questions of purpose and meaning of life, among others (Corey, 2001; West, 2004). Nonetheless, getting these two worlds together appears to be a complex and ethically challenging

process (Martinez *et al.*, 2007; Smith, Bartz & Scott Richards, 2007), starting with the clarification and definition of the boundaries between a religious and spiritual sensitive psychotherapeutic intervention from a spiritual care or counselling (Miller & Thoresen, 1999).

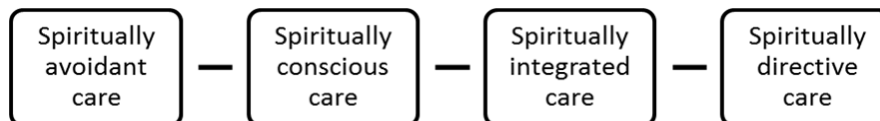
As mentioned earlier, international academia and professionals have been striving to demonstrate how important religion/spirituality can be in the life of many people, which lead to the understanding of its effects on health, emphasising both the advantages and disadvantages for mental health status. Nowadays, the focus has shifted towards understanding what role religion and spirituality play when integrated into therapeutic settings. It was not surprising to witness a rising tide of hypotheses, theories, researches and studies in the last years, concerning the development and integration of religious and spiritual perspectives and interventions into the mainstream of psychological practice (Richards & Bergin, 2004).

In Portugal, however, these dimensions are still poorly examined in its related scientific fields, intensifying the gap between research and practice. Few studies were conducted in mental health field researching religion and spirituality and to date no training programme (graduate or post-graduate) guides mental health professionals on how to integrate these issues into clinical practice. An important step, though, was taken by The Order of Portuguese Psychologists (OPP, 2011) presenting religion as one of the dimensions to be taken into consideration when “*practice is aimed at minority populations, psychologists seek to obtain professional and scientific knowledge in order to intervene abiding by the ethics and efficiently, adapting their intervention to factors associated with sex, age, sexual orientation, gender identity, ethnicity, cultural origins, nationality, religion, language, socioeconomic level, capacity, or others*” [section 5.6. cultural minorities].

Following this path, a small qualitative study was conducted by Freire and Moleiro (2011), which found that participants (members of religious minority groups) perceived religiosity/spirituality as a dominant factor in their lives. Even though they expressed openness and positive representations of the psychologists’ work, this was not considered to be a first help-seeking option, since all participants agreed the primary help would be either within their family or their religious community (leaders and other members).

These steps raise a few questions related firstly to the fact that Portuguese society is predominantly religious and Catholic, being religious minority groups represented only by 4% of the population. Furthermore, as presented above, one must argue with the importance and impact religion and spirituality have on people’s life and therapeutic processes (for a discussion see Koenig, 2012; Vieten, Scammell, Pilato, Ammondson, Pargament & Lukoff, 2013). What is certainly not known, so far, is what role religion and spirituality play on life and work of Portuguese mental health professionals. Or again the importance and impact religious and spiritual issues have when integrated into therapy.

In contrast to the Portuguese context, many studies have been conducted worldwide. As a matter of fact, international contributions range from approaches where religion and spirituality can be integrated (or not), to a continuum of spiritual care, as advanced by Saunders, Miller and Bright (2010). These authors conceived integration of a patient’ spiritual or religious beliefs and practices – SRBP (credits to Saunders *et al.*, 2010) from: *spiritually avoidant care*, where the mental health professionals avoid issues related to a patient’s SRBP, even if the patient indicates a need or desire to discuss them; to a *spiritually conscious therapy* as a respectful and sensitive way of determining the impact that religious and spiritual matters have on the patient and the patient’s problems; whereas *spiritually integrated care* focus on patients’ SRBP, without explicitly seeking the maintenance or transformation of those; and finally *spiritually directive psychotherapy* where the goal of therapy is to help a patient resolve psychological problems either by maintaining or transforming SRBP (Saunders *et al.*, 2010; Figure 1). To highlight that, the latter three approaches differ not only in content, but also on the level of the competence needed and ethical concerns inherent to each type of care.



Note: Figure reprinted from Saunders *et al.* (2010).

Figure 1. Continuum of spiritual care in psychotherapy.

Examples of the latter three approaches range from those grounded and tailored on religious foundations, i.e. Buddhist (Nauriyal, Drummond & Lal, 2006); Christian (Jones & Butman, 1991); Islamic (Dwairy, 2006); targeting specific religious or ethnic groups i.e. Jews (Rosmarin, Pargament, Pirutinsky & Mahoney, 2010); Mormons (Martinez *et al.*, 2007; Lyon, 2013); Latinos (Cervantes, 2010); African-

Americans (Frame & Williams, 1996; Constantine, Lewis, Conner & Sanchez, 2000); Asians (Hall, Hong, Zane & Meyer, 2011; Leong & Kalibatseva, 2011); targeting specific psychological disorders, i.e. depression (Agishtein *et al.*, 2013; Pearce & Koenig, 2013); alcoholism and drug abuse (Hodge, 2011^b; Lietz & Hodge, 2013); eating disorders (Kristeller & Hallett, 1999; Marsden, Karagianni & Morgan, 2007); founded on specific psychotherapeutic approaches, i.e. spiritually modified cognitive therapy (Hodge, 2006); religiously oriented cognitive behaviour therapy (Robertson, Smith, Ray & Jones, 2009); religious cognitive-emotional therapy (Rajaei, 2010); mindfulness-based cognitive therapy (Fresco, Flynn, Mennin & Haigh, 2011); Christian cognitive behavioural therapy (Pearce & Koenig, 2013); developed from the new forms of therapy such as spiritually or religiously *integrated, oriented, or accommodative* psychotherapy (McCullough, 1999; Pargament, 2007; Sperry, 2012; Ripley *et al.*, 2014); or again coming from the multicultural counselling field (Hage, Hopson, Siegel, Payton & DeFanti, 2006; Savage & Armstrong, 2010; Hall *et al.*, 2011); among many other contributions.

Following the multicultural perspective and for the purpose of this paper, interventions aiming to provide specifically a *spiritual counselling or direction* are not covered. This includes all interventions aiming to: train religious and spiritual professionals (e.g. chaplains or religious leaders) with knowledge of psychology, psychotherapy or counselling; or the training of mental health professionals to exclusively work with religious and spiritual issues [*not discarding or questioning their value*]. Thus, a multicultural perspective of integration of religious and spiritual issues into clinical practice will be discussed below.

Multicultural Perspective

Although religion and spirituality are only explicitly outlined under the non-discrimination; boundaries; and assessment affairs of APA², APA³ and ACA⁴'s code of ethics, a remarkable step was taken in 2003, when a set of 6 extensive guidelines on multicultural education, training, research, practice, and organizational change for Psychologists were presented (APA, 2003). These guidelines intended to guide psychologist's work "*in the midst of dramatic historic socio-political changes in U.S. society*" (APA, 2003, p.377), and therefore help professional society embrace *multiculturalism* and *diversity* into psychological settings.

However it is relevant to highlight that this absence of spiritual and religious reference can be also found within European code of ethics, being the Croatian (2004); British Psychological Society (2009); and Portuguese Order of Psychology (2011) the few mentioning religion or spirituality (information retrieved from <http://ethics.efpa.eu/ethics-around-europe> on November 14th, 2014).

Another ground-breaking step was the work of the "*Spirituality and Psychiatry Special Interest Group*" (SPSIG), a group within The Royal College of Psychiatrists (United Kingdom), that recently published the "*Recommendations for psychiatrists on spirituality and religion*" (Cook, 2013). These recommendations are included in the discussion segment later on.

According to the new edition of ACA's code of ethics (ACA, 2014, p.20) a multicultural or diversity counselling "*recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts*". From this point of view a [multi]culturally competent mental health professional must, first of all, be aware of his/her own cultural background, as well as its client's cultural background. Most importantly, this professional must acquire specific knowledge and skills to accurately and effectively attend to client's needs and expectations (Sue, Arredondo & McDavis, 1992; Arredondo *et al.*, 1996; Hage *et al.* 2006; Metzger, Nadkarni & Cornish, 2010; Vieten *et al.*, 2013; ACA, 2014).

However and once again, the Association for Multicultural Counseling and Development (AMCD), involved in the task force to develop the guidelines on multicultural issues, initially focused only on the 5 major cultural/ethnic groups of the United States, namely African/Black, Asian, Caucasian/European, Hispanic/Latino and Native American or indigenous group (Sue *et al.*, 1992; Arredondo *et al.*, 1996).

Nonetheless, later works and in a much broader definition, understanding and view of a person, other dimensions were introduced in order to include age, sex/gender, sexual orientation, spiritual/religious identification, among others (APA, 2003; Hage *et al.*, 2006; Metzger *et al.*, 2010; Vieten *et al.*, 2013). This inclusion allowed the emergence of new trends in the practice of psychology, such as psychological practice with older adults (APA, 2009; 2013); with girls and women (APA, 2007); with lesbian, gay and bisexual clients (APA, 2011) and the endorsement by ACA of the competencies for addressing spiritual and religious issues in counselling, as multicultural issues into clinical practice (Association for Spiritual, Ethical and Religious Values in Counseling [ASERVIC], 2009).

² American Psychological Association (2010)

³ American Psychiatric Association (2013)

⁴ American Counseling Association (2014)

It is important to highlight, however, that this status was not earned only under the multiculturalism agenda. As a matter of fact, for the past four decades the APA's 36th Division, Society for the Psychology of Religion and Spirituality, has been promoting discussions aiming to understand the significance religion and spirituality have in people's lives and in the Psychology field. The Division latest achievement was the publication of APA's Handbook of Psychology, Religion, and Spirituality (2013), a two-volume handbook, introducing the most comprehensive analysis of the current state of the psychology of religion and spirituality⁵.

SPIRITUAL AND RELIGIOUS COMPETENCIES: GUIDELINES FOR INTEGRATION

First things first: one must acknowledge that it is not necessary (or even possible) for mental health professionals to be specialists in all range of religious and spiritual perspectives represented in one society. As a matter of fact, even though, professionals' personal religious and spiritual views can serve as important components for expertise (meaning these views can influence their assessment of their patient's spiritual and religious issues, as well as the decision as to whether the use of religious and spiritual interventions is relevant), these are not sufficient or even necessary conditions for the competence (Plante, 2007; Gonsiorek, Richards, Pargament & McMinn, 2009; Gockel, 2011).

As behavioural scientists, expertise must be achieved through learning and training, therefore promoting (*multi*)culturally sensitive competencies may represent an effective way to achieve an accurate integration (Miller & Thoresen, 1999); in addition, of course, to an adequate education and ongoing training.

Therefore, it is important to highlight that this processes should always be conducted in a clinically and ethically competent manner with no exceptions. A psychologist, for instance, should always "*provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience*" (APA, 2010:5). It means not only are mental health professionals encouraged to become competent when working with religious and spiritual clients and issues, but are also compelled to act in accordance with the ethical guidelines in the field.

The development of religious and spiritual competencies might, above all, strengthen the therapeutic relationship between mental health professionals and their patients; as well as allowing these professionals to be in a better position to distinguish the religious and spiritual issues (healthy and unhealthy beliefs, practices and behaviours) from psychopathology (Knox *et al.*, 2005; Hage *et al.*, 2006; Johansen 2010; Savage & Armstrong, 2010; Vieten *et al.*, 2013).

With the increasing evidence that mental health professionals needed knowledge and skills to become competent in the area of spirituality and religion in therapy, ASERVIC, a division of ACA, convened a summit on spirituality aiming to discuss ideas on how to incorporate religious and spiritual issues into psychological treatment process (Miller, 1999). As a result, a set of 9 competencies were proposed to Accreditation of Counselling and Related Educational Programs (CACREP), which later on were revised (Cashwell & Watts, 2010) and endorsed by the ACA. This new version of ASERVIC's guidelines for addressing spiritual and religious issues in counselling comprises now 14 competencies, divided into 6 categories. These competencies were firstly validated using a factor analysis research (Robertson, 2010) and more recently revisited by Reiner and Dobmeier (2014)⁶ and revised by Dailey, Robertson & Gill (2015).

The ASERVIC' steps towards integration of spiritual and religious issues into clinical practice appear to be an important driving force. Consequentially it led (directly or indirectly) to new forms of competencies and integration, as outlined by Savage and Armstrong (2010). These authors presented a multicultural model (attitudes/values; knowledge; skills) based on ASERVIC' list of spiritual and religious competencies for psychotherapists. This chapter is so comprehensive (and recommendable) that it incorporates not only a rich amount of literature review and case vignettes illustrating "real" cases in therapy, but also (and most importantly) an extensive resource of practical guidelines supporting mental health practitioners. For instance, they provide important recommendations on how to assess, diagnose and conceptualise a case through multicultural and religious/spiritual perspectives, as well as suggestions and resources to develop spiritual and religious skills through self-assessment and training activities.

More recently, Vieten and colleagues (2013) published the "*Spiritual and Religious Competencies for Psychologists*", a set of basic spiritual and religious competencies, based on attitudes, knowledge, and skills, in an attempt to overcome the lack of guidelines empirically validated or ultimately to be used in

⁵ For more info please visit: <http://www.apa.org/pubs/books/4311506.aspx>

⁶ For your knowledge please go to ACA or ASERVIC' web page to download the document.

policy changes (Vieten *et al.*, 2013). Therefore, these competencies might be another important resource guiding the mental health professionals in “*determining how and when to actively include religious or spiritual interventions into psychotherapy for those clients who request it and requires proficiency, rather than basic competence*” (Vieten *et al.*, 2013, p.138). However, what one must acknowledge as groundbreaking is the fact that these competencies were designed not only to help mental health professionals to provide care to those in need (e.g. religious and/or spiritual clients), but it also prepares mental health professionals to attend those clients lacking religious or spiritual involvement⁷.

Ethical considerations

Most of the mental health ethical guidelines (if not all) have as main assumption the respect and non-discrimination for the client as a person: a multicultural person (Steen, Engels & Thweatt, 2006; Plante, 2007; Hathaway & Ripley, 2009; APA, 2010; Barnett & Johnson, 2011; Rosenfeld, 2011; Cook, 2013; APA², 2013; ACA, 2014). However, most of them go beyond that.

For instance, in their paper, Steen and colleagues (2006) presented four topics addressed in the ACAs’ code of ethics as a basis to explore the ethical challenges associated with integration of religious and spirituality matters into counselling. They highlighted the need for a mental health professional to be firstly aware of his/her own beliefs about religion and spirituality, by questioning how those beliefs might affect their work; and ensuring that he/she does not affect clients (Steen *et al.*, 2006; Cook, 2013). For instance, proselytism (in an attempt to convert a client to engage or leave a religious or spiritual faith/community) is one practice involving ethical issues that need to be considered.

This issue was recognised to be particularly difficult to deal with, in cases when a mental health professional is either actively involved in a particular religious tradition or holds anti-religious and anti-spiritual beliefs, risking falling into some ethical pitfalls (Plante, 2007). For instance, one might fail to recognise the potential harm of specific religious and spiritual beliefs and practices or overestimating them by pathologising these beliefs and practices (Vieten *et al.*, 2013).

Additionally, Plante (2007) proposed the RRICC model (that stands for Respect, Responsibility, Integrity, Competence, and Concern), composed by five main virtues considered to be common to the different professionals codes of ethics. The importance of a mental health professional being proactive in overcoming the lack of adequate training for graduate and postgraduate programme is one of the virtues highlighted. Plante also cites Richards and Bergin’s recommendations, such as the need for mental health professionals to: stay informed about the research in this area; attend workshops and seminars; seek for appropriate supervision and consultation; and personally learn about the religious and spiritual traditions of their clients. Subsequently, these recommendations are encouraging mental health professionals not to avoid working with religious and spiritual issues due to the lack of adequate training, or doing so inappropriately, since many resources are available to start becoming competent in this area.

However, this leads to another important issue concerning service provision *only* within the boundaries of ones’ competence, as APA (2010) established. When confronted with a religious and spiritual client or a client’s wish to discuss religious and spiritual issues and problem, a mental professional should not proceed with the work when feeling uncomfortable, unprepared or holding negative feelings towards client’s religiosity and spirituality, risking being more harmful than helpful for the therapeutic relationship and the client. Nevertheless, termination and/or referring to another professional are not supported by ACA (2014) when the reason being simply conflicting views, since mental health professionals are expected to be respectful and non-discriminator. Therefore, recommendations are made in the following respects: seek for collaboration with a religious adviser, i.e. religious leader, clergy or chaplains; seek for consultation/supervision with a more competent mental health professional; or ultimately refer and/or terminate the therapeutic relationship (Miller, 1999; Steen *et al.*, 2006; ASERVIC, 2009; Cook, 2013; Vieten *et al.*, 2013; ACA, 2014).

CONCLUSION AND IMPLICATIONS FOR CLINICAL PRACTICE

International academics and professionals have been working to advance the research on mental health, religion and spirituality. Portugal, however, might not hold equivalent standards concerning the research and proper integration of religious and spiritual issues into clinical practice. Much is unknown so far. Nonetheless, some researches focusing on multicultural aspects is being developed; OPP, in 2011, included religious and spiritual issues as a cultural minority characteristic that need to be considered; and overall Portugal, as state is advancing in terms of legislation.

Furthermore and following the Law nº 253/2009 on the spiritual and religious care in hospitals and other establishment of the National Health Service a practical manual was developed “*Manual de Assistência*

⁷ These competencies are available in the paper or by requesting directly from the authors

Espiritual e Religiosa Hospitalar" (manual for the spiritual and religious care in hospital settings), and as the Directorate-General of Health presents:

"With this tool, health professionals have an advantage to develop an indispensable therapeutic complement to care with patients. Moreover, everyone realize the therapeutic dimension of spirituality. The religious and spiritual support is essential to the healing and caring of a patient."
(Quotation retrieved from <http://www.dgs.pt/?cr=21645>)

This represents a ground-breaking step. However, this step was taken by the "*Grupo de Trabalho Religiões e Saúde*" (Religions and Health Working Group) in an attempt to make Portuguese chaplaincy more "*multicultural*"; and although it concerns health (mental) professionals as it promotes collaboration with religious advisers, it is not confined to mental health integration of religious and spiritual issues. For instance, it does not offer recommendations on how to use the information provided and again it appears to rely "*only*" on the respect and non-discrimination assumption. Also, other questions are yet to be answered: are, health (or mental) professionals aware of these techniques and opportunities of collaboration and its use? How have these had impact on professional work, therapeutic relationships and clients? Is there a need to go further? Here we would say inevitably: of course.

To sum, this paper strived to demonstrate, not only the need to acknowledge the importance of religion and spirituality in people's lives, but also how important it could be when properly integrated and worked through in clinical practice. By showing how much has been done internationally, this paper intended to provide mental health professionals an opportunity to consciously "*choose*" to engage in integration of religious and spiritual issues into therapy, choosing to go as far as one think might be suitable for his/her practice. And this might be by engaging in approaches that explicitly integrate religious and spiritual issues, or legitimately eschew them by providing a spiritually and culturally sensitive care (Vieten *et al.*, 2013). What is definitely not adequate to the standard required in mental healthcare is to "*deny*" a proper care by avoiding these issues to be part of a client's therapeutic process or to merely refer them to other professionals or domains claiming: "*this is no longer my jurisdiction*".

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