Brazilian Journal of Psychiatry
bjp
Revista Brasileira de Psiquiatria

Braz J Psychiatry. 2021 Jul-Aug;43(4):424-429
doi:10.1590/1516-4446-2020-1106
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SPECIAL ARTICLE

Religiosity and spirituality in psychiatry residency programs: why, what, and how to teach?

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Objective: To propose a core curriculum for religiosity and spirituality (R/S) in clinical practice for psychiatry residency programs based on the available evidence.
Methods: After performing a review of studies on the implementation of R/S curricula and identifying the most commonly taught topics and teaching methods, an R/S curriculum was developed based on the most prevalent strategies, as well as recommendations from psychiatric associations, resulting in a fairly comprehensive R/S curriculum that is simple enough to be easily implemented, even where there is a shortage of time and of faculty expertise.
Results: The curriculum is a twelve-hour course (six 2-hour sessions). The topics include: concepts and evidence regarding R/S and mental health relationships, taking a spiritual history/case formulation, historical aspects and research, main local R/S traditions, differential diagnosis between spiritual experiences and mental disorders, and R/S integration in the approach to treatment. The teaching methods include: classes, group discussions, studying guidelines, taking spiritual histories, panels, field visits, case presentations, and clinical supervision. The evaluation of residents includes: taking a spiritual history and formulating an R/S case. The program evaluation includes: quantitative and qualitative written feedback.
Conclusions: A brief and feasible core R/S curriculum for psychiatry residency programs is proposed; further investigation of the impact of this educational intervention is needed.

Keywords: Curriculum; religiosity; spirituality; residency; psychiatry

Introduction

According to the World Health Organization, approximately 10% of the world's population suffers from mental disorders.[1] This high prevalence has posed the challenge of how to improve the prevention and treatment of mental disorders and how to foster mental health. In recent decades, religion and spirituality (R/S) has emerged as a relevant factor; thousands of studies have provided solid evidence that R/S has a considerable impact on mental health. This impact is usually positive, reflecting lower prevalences of depression, substance use/abuse, and suicide as well as decreased general mortality and higher levels of well-being, social support, and quality of life.[2,3] However, some expressions of R/S may be associated with unfavorable health outcomes, such as depression, obesity, low adherence to treatment, and even acts of oppression and violence.[3] The World Health Organization has come to consider R/S as a dimension of quality of life.[4] The associations between R/S and mental health acquire even greater implications for global public health in light of the fact that most of the world's population ($>$ 84%) has some religious affiliation.[5]

Based on this evidence, national psychiatric associations have created sections and published recommendations about the importance of dealing with R/S in clinical practice. For example, associations in Brazil, Canada, Germany, India, the United Kingdom, the United States, and South Africa have all published statements, and these were summarized in 2016 by the World Association of Psychiatry's Position Statement on the importance of including R/S in research, training, and clinical practice in psychiatry.[6] However, despite such recommendations, this theme has scarcely been addressed in psychiatry residency programs (PRP),[7,8] and the evidence has not been translated into the clinical care of patients, despite evidence that patients would generally like to have R/S addressed in clinical encounters.[9] Surveys of mental health professionals have indicated the main reasons why R/S has not been routinely addressed in clinical practice, with a lack of training being among the most frequently cited.[10,11]

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Submitted May 06 2020, accepted Jul 10 2020, Epub Oct 23 2020.

How to cite this article: de Oliveira e Oliveira FHA, Peteet JR, Moreira-Almeida A. Religiosity and spirituality in psychiatry residency programs: why, what, and how to teach? Braz J Psychiatry. 2021; 43:424-429. http://dx.doi.org/10.1590/1516-4446-2020-1106

Surveys have found that mental health professionals tend to be less religious than their patients, constituting what has been called a "religiosity gap."[11-13] This lower religiosity among mental health professionals seems to be at least partially related to some anti-R/S bias and a pathologizing of R/S in professional training, especially among those whose training was less recent.[11-13]

Thus, despite awareness of this issue and willingness to change psychiatry training, many PRP coordinators and faculty may not know how to introduce such training. Some barriers include a superficial knowledge of the subject, a lack of time, fear of proselytizing or a nonscientific approach, and the challenge of adding yet another topic to a very full PRP curriculum.[10,11] A further limitation noted in a recent review of PRP R/S curricula is that the considerable diversity among curricula makes comparing initiatives very difficult. This report specifically addresses these limitations by reviewing the available evidence[10] and proposing a practical core curriculum that is straightforward, fairly comprehensive, and easy to implement, even by faculty without extensive experience in R/S and psychiatry. Such standardization would allow different programs to compare their findings, including evaluations by residents.

Methods

In order to propose a curriculum, we analyzed original studies (including case reports) that described and investigated experiences of teaching R/S in PRP. These studies were selected from a previous systematic review that we conducted about R/S training in PRP.[10] The following databases were searched: EMBASE, PubMed, Cochrane, PsycArticles, PsycINFO, LILACS, and SCOPUS. The English search terms were: (spiritual* AND psychiatr*) OR (religio* AND psychiatr*) AND (residency OR resident*) AND (educa* OR train* OR teach* OR instruct* OR curricul*). The Portuguese and Spanish terms were: (espiritual* AND psiqui*) OR (religio* AND psiqui*) AND (residente OR residência) AND (educ* OR formación OR ensino OR instruc* OR curric*). There were no date restrictions. Papers not published in English, Portuguese, or Spanish were excluded. Only one paper was excluded due to language, an Iranian study written in Arabic.[10]

Two researchers selected papers directly relevant to the study's objective; disagreements were resolved by consensus and consulting the other authors. Full articles were retrieved as necessary for in-depth analysis. The references of the selected papers were also searched in Google Scholar and Web of Science to find other papers that might satisfy the inclusion criteria. To investigate "gray literature," we contacted at least one author of the selected papers by e-mail for additional information and references. Further details of this systematic review can be found elsewhere.[10]

The eleven selected studies[13-23] were evaluated according to the following seven categories: residency year in which the intervention was implemented, course coordinator/faculty teaching methods, topics covered, evaluation tools and results (for the curriculum, residents, and patients), R/S competencies addressed, and recommended bibliography.

The proposed curriculum was defined through a combination of the following criteria: the most prevalent findings from the above-mentioned curriculum categories, recommendations from previous guidelines, and the authors' clinical and teaching experience in the R/S area (all of the authors are psychiatrists whose interests, training, and academic productivity are focused on this issue). Two of the three authors have substantial academic experience with R/S, having lectured about and taught courses on R/S for medical students and psychiatry residents, including presentations in international psychiatry congresses. Both of these authors have chaired sections on R/S and psychiatry in national psychiatric associations (in Brazil and the USA), and one chairs the World Psychiatric Association Section on R/S.

Results

Except for three of the included studies, the residents were in the third year,[15,18,20] and at least one psychiatrist mentioned the profile of the coordinators.[13-15,18,22] A total of 31 methods and 23 different topics were found in the categorized results.[10] The residents' assessment was summative and formative, quantitative and qualitative. The assessment of both the curricula and the residents was predominantly qualitative. There was a great diversity of bibliographical references (34 books and 20 different articles). Further details and discussion of the results can be found elsewhere.[10]

Discussion

Proposed curriculum

This main aim of the curriculum is to provide residents with basic competencies (knowledge, skills, and attitudes) to address R/S in their routine clinical practice. This 12-hour core curriculum consists of six 2-hour meetings (Box 1) that include the following topics: methods, evaluation methods, who should deliver the content, and basic references, which, of course, can be further developed and expanded. The reading recommendations were simplified to facilitate implementation and increase interest; a vast bibliography can also be recommended[24] in addition to the references of articles included in this review. The references should be provided in advance to facilitate prior reading by the residents.[2,6,25-35]

To systematize the supporting evidence for the proposed curriculum in a practical way, we present our findings by answering the main questions: Why teach an R/S curriculum? What should be taught? How? When? Where? Who could teach? What competencies should be developed? What are the most common challenges, barriers, or limitations? The "why" has been answered by the rationale presented in the Introduction, and the remaining questions will be answered in the following sections.

Box 1 Core religion and spirituality curriculum for psychiatry residency programs

Lesson 1[2,6]	
Topic	**Introduction to R/S in Psychiatry (2 h)**
	Part 1: Introduction – Historical context and conceptual and research aspects
	Part 2: WPA Position Statement
Teaching method/facilitator	Part 1: Theoretical lesson – Preceptor or invited speaker (1 h)
	Part 2: Group discussion about the WPA Position Statement (1 h)
Evaluation method	Short individual essay about the experience at the end of the lesson (up to 20 lines). Suggested question: What personal and professional knowledge did you obtain from this lesson?
Lesson 2[26,27]	
Topic	**Taking a religious and spiritual history, and bio-psycho-socio-spiritual formulation of the case (2 h)**
Teaching method/ facilitator	Pairs of residents take each other's spiritual history using the Faith and Belief, Importance, Community, Address in Care tool (30')
	Presentation of a report (written and oral) of how the collected R/S data could be relevant to clinical evaluation and treatment. Suggested questions: Which R/S resources, stressors or interventions are present in the history? How they could influence the diagnosis or the formulation of the treatment plan? (30')
	Group discussion by the residents and preceptors (1 h)
Evaluation method	Evaluation of the presented report and participation in group discussion
Lesson 3[28,29]	
Topic	**Historical and research aspects: R/S and Psychiatry (Science and Religion) (2 h)**
Teaching method/facilitator	Didactic session presented by residents (article and videos) (1 h)
	Group discussion including residents and preceptors (1 h)
Evaluation method	Presentation of the lessons
	Participation in the discussions
Lesson 4[30]	
Topic	**Main global and/or local religious traditions (2 h)**
Teaching method/facilitator	Panel (in 2 parts):
	Part 1 (residents): Oral report by the residents of their impressions of their visits to religious centers* and/or Alcoholics Anonymous groups (1 h)
	Part 2 (guests): View of religious leaders of the interface between R/S and mental health (1 h)*
	*Include the most prevalent R/S groups in the region
Evaluation method	Written account of their experience at the end of the panel
Lesson 5[31,32]	
Topic	**Differential diagnosis: R/S experiences and psychopathology**
Teaching method/facilitator	1) Case presentation (residents or preceptors) and group discussion (2 h)
Evaluation method	Written account of the case/participation in discussion
Lesson 6[25,33-35]	
Topic	**Integration of R/S into treatment (2 h)**
Teaching method/facilitator	Didactic session by the residents (1 h) + group discussion of cases (current or recorded cases) (1 h) OR
	Group discussion about the article (1 h) + Clinical supervision (or supervision during the consultation) for outpatients or inpatients seen by residents (1 h)
Evaluation method	Presentation of articles by the residents (theoretical lesson)
	Bio-psycho-socio-spiritual integration in the formulation of the cases in writing

R/S = religion and spirituality; WPA = World Psychiatric Association.

What should be taught and what competencies should be developed?

The topics and teaching methods should be focused on developing R/S competencies by residents in order to help them address these issues in clinical practice. Box 2 describes the competencies to be developed to guide curriculum development in PRP. This box can also be used as a reference to create different methods of evaluation and/or self-evaluation before and after the intervention, e.g., as a checklist of competencies with scores from 1 to 100. We recommend providing this list of competencies to the residents before the program begins to inform them of the learning expectations.

In a broader context, R/S can be included among cultural competencies.[36] According to the World Psychiatric Association Position Statement,[6] psychiatrists are expected to know how to take an R/S history and allow room for its inclusion in patient care in an ethical and person-centered manner. Psychiatrists should also understand the cultural interface between psychiatry and religious leaders, members, and communities, establishing dialogue and reciprocal referrals for the benefit of each patient. In a continuum from prevention to treatment, these professionals should be prepared to formulate a differential diagnosis that includes cultural, religious, and spiritual experiences and psychopathology, as well as to formulate a treatment plan from a bio-psycho-socio-spiritual point of view. This approach includes evaluating positive and challenging aspects from the religious, spiritual, or secular realms, such as risk or protective factors in the life of each of their patients. They should

Box 2 R/S competencies for psychiatry residents (adapted from Grabovac, Clark & McKenna[16])

Knowledge	**Residents must show understanding of the following topics:** 1. Historical and demographic aspects of religious/spiritual beliefs in different patient populations[2,28,29] 2. Research on the relationship between religious/spiritual beliefs and physical and mental health[2,28] 3. Psychodynamic aspects involving religious and spiritual issues in psychotherapy (e.g., transference and countertransference)[33,34]
Skills	**Residents must show competence in the following areas:** 1. Taking a religious/spiritual history[2,26] 2. Incorporating bio-psycho-socio-spiritual elements into the understanding of the patient, reflected in the diagnosis and treatment plan[2,27,31,32,35] 3. Identifying how their own religious/spiritual beliefs can impact their formulation of the case, the diagnosis, and treatment plans[25,27,33,34] 4. Recognizing and working on transference and countertransference reactions[33,34] 5. Deciding when it is appropriate to refer a patient to or consult with chaplains, spiritual leaders, or healers[30]
Attitudes	**Residents must show the following skills:** 1. Awareness of patients' religious and spiritual experiences, the impact that these experiences have on their identity and worldview, and biases that could influence patient treatment[25] 2. Respect for and acceptance of the diversity of cultural and religious experiences[25]

also be able to identify interventions that can include R/S practices for the patient's benefit, ranging from reading, prayer, attending religious services, groups, or other religious organizations to voluntary activities, meditation and relaxation activities, relevant television or radio programs, etc. (Box 2).

The 11 reviewed curriculum sections covered 23 R/S topics, of which the eight most frequent were taking a spiritual history; transference and countertransference/self-knowledge; pastoral counseling/chaplaincy; definitions of R/S and other topics; psychotherapy, theology, and spirituality; differential diagnosis between spiritual and psychopathological experiences; historical aspects of psychiatry, science, and religion; and transcultural psychiatry. Thus, the proposed curriculum covers most of these topics, focusing on these competencies as succinctly and efficiently as possible so that excessive information or references do not prevent its effective implementation in PRP (Box 1).

How should this curriculum be taught?

The reviewed papers described 31 teaching methods, and we based our proposal on the most common ones to increase its effectiveness: didactic sessions, case presentations, discussion groups, clinical supervision, seminars/workshops, and conferences/lectures.[10,37] Some reports found that group interventions with the residents' personal subjective involvement (e.g., yoga, meditation, mindfulness, sharing subjective experiences, participation in a retreat) seem to be significant in their personal development.[13-15,17,21,22] Residents requested an emphasis on topics that would most closely address their patients' needs.[14]

When should this curriculum be taught?

The majority of the articles presented a curriculum spread over several semesters of coursework[13-16,18,19,22,24] or were more concentrated initiatives[17,20,21,23] involving residents from different years. Some may defend the importance of the residents' prior clinical experience to better take advantage of the curriculum's content and discussion. In contrast, an argument can also be made in favor of earlier training to reduce resistance toward R/S and enhance doctor-patient relationships. In light of the findings, we believe that it is generally advisable to provide R/S training somewhere in the middle of the residency course (e.g., in the second year of a 3- or 4-year program). Due to the other teaching demands during the residency program, we have proposed a feasible minimum study load to avoid overloading the faculty and residents: a minimum curriculum of 12 hours, with six two-hour sessions. We suggest this as a mandatory minimum study load, although optional modules can be added according to the demands of the local culture or the profile and interest of the residents and preceptors.

Who should teach this curriculum?

The majority of the coordinators and faculty in the included studies were psychiatrists, with some involvement by presbyters,[13] theologians,[22] or a committee to develop and supervise the curriculum and its implementation.[13] Some studies reported that the course was offered by a multidisciplinary team including seminary professors, psychologists, and psychiatrists.[16,17,20] We propose that the course be coordinated by one psychiatrist,[13-15,18,22] who may or may not share teaching duties with another member of the multidisciplinary team[14,16,17,20] or even regularly teach the residents.[18,21] It also seems appropriate to invite speakers to address needs related to specific themes. The purpose of this article is to encourage situations in which preceptors associated with interested residents are able to manage a minimum curriculum without necessarily being experts in this area.

How should this curriculum be evaluated?

The evaluation can cover the course itself and its impact on residents and patients.[22] Only three studies involved a patient evaluation dimension,[18,19,21] with only one[19]

objectively evaluating the course's impact on patients, a process that had numerous limitations. This lack of evidence about the effects of such R/S curricula on patients should encourage efforts to develop new evaluation methods.[18,19,21] This may occur concurrently with or, more likely, after implementation of the curriculum.

The course itself should ideally be evaluated both at the end and after each lesson. Qualitative and/or quantitative feedback should be given by both the preceptors and the residents. Some studies have used questionnaires for this purpose.[16]

Residents can be evaluated formatively (e.g., through supervisor feedback), summatively (through quantitative instruments, such as questionnaires), and qualitatively (through oral and/or written accounts of their experiences in this area and the impact of these experiences on their training).[37,38] Evaluations can be conducted at the end of the program or at the end of each lesson. It is recommended that the evaluation process be guided toward the development of the R/S competencies (Boxes 1 and 2). If the evaluation process must be simplified, we recommend using only one evaluation at the end of the course, in which each resident produces a written bio-psycho-socio-spiritual formulation of an actual patient they have seen. This formulation should also discuss the implications for treatment, including, if possible, R/S-integrated interventions appropriate to the specific patient.

How can possible challenges, barriers, and limitations be overcome?

The reported initiatives were generally well accepted and evaluated positively by the residents. Nearly half of the articles mentioned no problems or barriers encountered during curriculum implementation.[17-20,23] When reported, the most relevant problems were initial resistance by the residents[15,16,22] and preceptors,[13,21] tension among the residents[14,15] and conflicts with their own faith; tension between the residents and the preceptors (residents' fear of disapproval by the preceptors),[13,14] and tension among the preceptors themselves, for example, regarding the extent of the literature.[13,14] The main limitations concerned research-related issues[13,16,18,20-23] and were less directed toward the content, such as complaints by the residents about lack of time.[14]

Individual supervision can help overcome conflicts between residents and patients. Discussion groups and group supervision for residents regarding their own R/S experience could decrease intra- and interpersonal tension and encourage residents to overcome it.[13] Presenting robust research evidence, proper professional boundaries, and an emphasis on a person-centered approach can help overcome institutional and personal barriers (e.g., fears regarding a non-scientific approach, proselytizing, prejudices etc.). Restricting mandatory references to a minimum will help prevent stress due to overloading the faculty and residents.[13] Individual feedback and discussion groups – formal or informal – among residents and faculty may help reduce tension throughout the process. Having more than one faculty member involved in the course may help broaden the range of approaches and minimize resistance to a perceived "hidden agenda."[15] In contrast, too many faculty members could jeopardize identification with the process and its continuity.[13]

Modifications to the proposed curriculum

If the course must be condensed into a single session, we suggest a summary of Lessons 1 and 2 (maximum duration of 4 h): a brief introductory presentation on the theme taught by the preceptor (30 min) + group discussion by the residents about the position statement (45 min) + interval (15 min) + pairs of residents taking each other's spiritual history (15 min each), with a subsequent written bio-psycho-socio-spiritual formulation of the case by the residents (15 min) and a succinct oral presentation of each formulation by the residents (1 h 30 min – up to 10 min for each resident); a written evaluation of the program (positive and negative points and suggestions for future initiatives); and final considerations (15 min).

At the other end of the spectrum, if more time is available and there is a greater interest in R/S – in terms of research, teaching, or clinical applications – by the faculty and/or residents, then complementary modules could be explored in accordance with local needs and interests. Modules for further development could include addiction, palliative care, human development, R/S in the care of specific groups (e.g., the elderly, women, LGBT, the homeless, and inmates),[24] positive psychiatry (the science of well-being, happiness, etc.),[39] integrative psychiatry (integration with alternative and complementary therapies),[40] and transpersonal psychiatry.[41]

Conclusions

Although there is sufficient evidence to corroborate the inclusion of R/S in clinical practice in conformity to the recommendations of psychiatric associations and other stakeholders in mental health care, a lack of training is one of the main barriers to such an initiative. The evidence from previous experiences regarding R/S curricula in PRP is limited and very diverse. As a result, this curriculum was designed to provide the minimal competencies needed for proper patient care in a simple, comprehensive, and easy-to-implement way that does not require extensive human or material resources.

This curriculum covers the most relevant topics and uses teaching methods that are commonly applied and are easy to implement. From a pedagogical perspective, this proposal can, of course, be improved, and it should be adapted, if necessary, to the cultural context in which it is implemented. Complementary modules can also be added (or removed) according to local needs.

In an attempt to integrate teaching, research, and clinical practice, further studies are recommended to test the impact of this proposal on both residents and patients. In such studies, we suggest the use of larger samples, control groups, and short-, medium-, and long-term pre- and post-test evaluation of both the residents and patients, as well as minimally standardized

questionnaires when no validated instruments are available to measure the impact of the intervention.

Disclosure

The authors report no conflicts of interest.

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