

South African Society of Psychiatrists guidelines for the integration of spirituality in the approach to psychiatric practice

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Background. It was important to develop South African guidelines in view of the extent of local and worldwide religious affiliation, rapid growth of academic investigation, guidelines provided by other associations (e.g. Royal College of Psychiatrists), the South African Society of Psychiatrists (SASOP)'s own position statements on culture, mental health and psychiatry, the appropriate definition of spirituality, the need for an evolutionary and anthropological approach, the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-V)'s cultural formulation, local legislation, ongoing research, and teaching requirements.

Objective. To report on the outcome of the peer-reviewed process that was followed to draft local guidelines for psychiatric training and practice.

Methods. During 2013, comments by members of the SASOP on a framework for guidelines on the role of spirituality in psychiatry practice and training were collated and subsequently submitted to the SASOP board for approval.

Results. Guidelines were compiled in terms of: (i) integrating spirituality in clinical care and service provision; (ii) integrating spirituality in psychiatric training; (iii) ethically integrating spirituality within the professional scope of practice; and (iv) appropriate referral between psychiatrists and spiritual advisors.

Conclusions. Integrating spirituality in the approach to practice and training cannot be ignored by local psychiatrists in the multicultural, multireligious and spiritually diverse South African context.

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

Neeleman and King^[2] noted in 1993 that psychiatrists often ignore spirituality because: (i) it is considered unimportant; (ii) it is considered important but irrelevant to psychiatry; (iii) they may feel they know too little about it themselves to comment, or even to ask questions; (iv) the very terminology is confusing and hence embarrassing; and (v) there may also be an element of denial in which it is easier to ignore this area than to explore it as it is too personally challenging. Some years later, in terms of psychiatrists' own religious affiliation, Sims^[3] referred to a study of psychiatrists working in London teaching hospitals. Although only 27% reported religious affiliation and 23% a belief in God, 92% felt that psychiatrists should be aware of the religious concerns of their patients.

Since then, it has become important to establish how, within accepted professional boundaries, the role of spirituality should be incorporated appropriately into the current model for practice and

training. Curlin *et al.*^[4] found that psychiatrists are more likely (82% v. 44%) to note that religion/spirituality sometimes causes negative emotions and also more likely (92% v. 74%) to encounter religious/spiritual issues in a clinical setting. They also found that psychiatrists were less religious than other specialists, and that religious physicians were less willing to refer patients to psychiatrists.^[5] According to them, '... this suggests that the historic tension between religion and psychiatry continues to shape the care that patients receive'.

A number of South African (SA) inquiries on spirituality, psychiatry and mental health have been published since 2011, including an explorative qualitative inquiry on the views and experiences of some local academic psychiatrists on the role of spirituality in SA specialist psychiatric practice and training,^[6] interviews with a sample of Muslim psychiatrists in Johannesburg,^[7] and an investigation of SA Hindu psychologists' perceptions of mental illness.^[8]

During the 17th National SASOP Congress in September 2012, a decision was taken by the SASOP Spirituality and Psychiatry Special Interest Group (S&PSIG) (available from author), that some guidelines should be developed on how to include the role of spirituality in local specialist psychiatric practice and training appropriately. During August/September 2013, a draft document, 'Proposed Framework for Guidelines on the Role of Spirituality



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in Psychiatry Practice and Training', was submitted to the SASOP National Council for consideration, and subsequently circulated for comments to members of the SASOP, including the SASOP S&PSIG. After incorporating these comments from members, a final draft document was resubmitted to, and approved by, the SASOP Board of Directors in March 2014.

1. Reasons and context for guidelines

These guidelines were developed in view of the following:

1.1 World-wide religious affiliation

The Pew Research Centre's Forum on Religion and Public Life^[9] recently published a review on the world's major religious groups in 2010. The study assembled data on the size and geographical distribution of eight major religious groups, including the religiously unaffiliated, and estimated that there are 5.8 billion religiously affiliated adults and children around the globe, representing 84% of the 2010 world population of 6.9 billion. The demographic study, based on an analysis of more than 2 500 censuses, surveys and population registers, found that worldwide, there were 2.2 billion Christians (32% of the world's population), 1.6 billion Muslims (23%), 1 billion Hindus (15%), nearly 500 million Buddhists (7%) and 14 million Jews (0.2%) as of 2010.

In SA, of the almost 85% of the total 44.8 million who self-reported in the 2001 national census to be religiously affiliated, about 80% (35.8 million) were Christian, while about 15% (6.8 million) reported themselves to be non-religious. Other major religious groups in 2001 included Muslims (1.5%), Hindus (1.2%), Jews (0.2%) and Buddhists (0.03%).^[10] However, according to polls,^[11] which measured global self-perceptions on belief, South Africans who belong to a particular religion have dropped from 83% in 2005 to 64% in 2012. These different findings, however, raise issues of definition and statistical categorisation.

1.2 Academic investigation and guidelines by professional associations

There has been focused interest in the medical literature in the role of culture, religion and spirituality in psychiatry over past the two decades in particular.^[12,13] In this context, considering practice and training guidelines for professional associations, important evidence-based and research-driven resources have already been published by others. These include the World Psychiatric Association,^[14-16] the Royal College of Psychiatrists,^[17] the American Psychiatric Association^[18] and Brazilian and Latin American professional groups.^[19]

1.3 SASOP Position Statement on Culture, Mental Health and Psychiatry

These SASOP guidelines for the integration of defined spirituality in psychiatric practice and training must, as a point of departure, be considered in the context of the existing SASOP position statement 9 on Culture, Mental Health and Psychiatry.^[20]

1.4 Defined spirituality

Spirituality, as opposed to religion or a belief system, can be defined as a progressive, individual or collective inner capacity, consciousness or awareness.^[21] It also comprises relational aspects, or connectedness, and essentially exists as a process, representing growth, or a journey. This capacity, consciousness and connectedness provide the

SASOP position statement 9 on Culture, Mental Health and Psychiatry

Culture, religion and spirituality should be considered in the current approach to the local practice and training of specialist psychiatrists. This should, however, be performed within the professional and ethical scope of the discipline, and all faith traditions and belief systems in the heterogeneous SA society should be respected and regarded equally. In the public sector domain, no preference for one particular tradition should be given over another, as a result of a practitioner or a dominant group being from the one tradition or the other. Building relationships of mutual trust and understanding will require training and health education initiatives aimed at psychiatric practitioners, their patients, carers and students, and cultural and religious practitioners whom patients and their carers may choose to consult. The protection of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, however, needs to be ensured, and all forms of abuse in this context, or neglect and delay with regard to appropriate psychiatric care, should be identified and prevented.

motivating drive for living and constitute the source from which meaning and purpose is derived.^[22,23]

This definition of spirituality can apply to psychiatrists, registrars, general practitioners and medical students as individuals or professionals, but also to their patients, family and community, as well as to the provision of mental healthcare in an institutional environment. This definition of spirituality is inclusive of mono- and pantheistic traditions, as well as of non-religious and atheistic, agnostic and secular positions and views on spirituality and religion.^[24]

When considering the proposed guidelines as discussed below, it is of importance to note that care must be taken not to oscillate in one's perspective between the constructs of 'spirituality' and 'religion', not to use these terms interchangeably, or to treat spirituality as being synonymous with religion. Much debate, for example, has been reflected in the literature on how these and related terms are to be defined. In this regard, Dein^[25] reviewed the question of whether religion and spirituality are useful terms for cross-cultural comparisons, and noted with other co-authors that:

Recent mental health literature differentiates religion from spirituality. Religion usually refers to socially based beliefs and traditions, often associated with ritual and ceremony, whereas spirituality generally refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater "whole", together with a sense of belonging and acceptance. Spirituality is expressed through art, poetry and myth, as well as religious practice. Both religion and spirituality typically emphasise the depth of meaning and purpose in life. One does not, of course, have to be religious for life to be deeply meaningful, as atheists will avow. Yet, although some atheists might not consider themselves spiritual, many do. Spirituality is thus a more inclusive concept than religion.^[26]

1.5 Overlapping territories of culture, religion and spirituality

The integration of defined spirituality in specialist psychiatric practice and training must consider the overlap that exists between the territories of culture, religion and spirituality. Definitions of each of these areas

have been alluded to earlier.^[21,27-29] Bodley,^[30] for example, defined culture as 'the learned and shared symbolic information and way of life and thought that *Homo sapiens* use to improve their survival'.

An anthropological perspective may also further assist to define the relationship between culture, religion and spirituality. While religion can be considered as a component of an integrated cultural whole, the other components of such a system are, for example, economy, politics, education and health. There is, in this context, however, an expressed need for spirituality to be distinguished and separated from religion, especially in the practice of medicine, psychiatry and psychotherapy. Frankl,^[31] for example, proposed: 'the goal of psychotherapy is to heal the soul, to make it healthy; the aim of religion is something essentially different, to save the soul'.^[31]

This is of particular importance when considering what may be appropriate content to include in undergraduate and postgraduate curricula with respect to required cultural and spiritual competencies of candidates, as well as of what constitutes appropriate and ethical psychiatric and psychotherapeutic practice, within professional boundaries.^[32] To further illustrate these practical implications is the debate on whether traditional health practice, which is imbedded in African cultural beliefs,^[33] should be regarded as a psychotherapeutic modality,^[34-36] or as a religion and spiritual practice.^[37-39]

1.6 Africa and the burden of suffering and disease

It is important specifically to note the actual context of psychiatry in Africa, which is characterised by sociocultural and tribal diversity, as well as widespread poverty, violence, suffering and death. Individuals and communities living under such circumstances are inevitably confronted with more existential and related spiritual issues and may necessarily seek to bring these to their doctors' and psychiatrists' attention. The epidemiological profile and the burden of diseases are also factors that may push such affected people to raise existential and spiritual issues. This context requires the disciplines of medicine and psychiatry to redefine themselves in order to be relevant to the people in need of appropriate services.

1.7 An evolutionary and anthropological approach

It seems appropriate to adopt an evolutionary approach to the development of religion and the neuropsychological development of abstract and symbolic thinking, ceremony and ritual, and anthropological approaches to life, death and dying, and transcendence,^[40-41] as well as take cognizance of an evolutionary approach to the development of psychopathology.^[42] This approach allows for the consideration of religion in its earliest forms and its development over time, including: the process of hominisation from 2 million - ~200 000 years ago; the development of hunter-gatherer religions (200 000 - 10 000 years ago); religions of early food producers (10 000 - 6 000 years ago); religions of early state societies with writing, e.g. in Mesopotamia, Assyria, Israel, Egypt, Greece, India, China and Central America (6 000 - 3 500 years ago); religions of systematised thought with voluntary members (3 500 years ago to the 15th century), e.g. Zoroastrianism, Greek philosophy, Hebrew prophecy, Christianity - Jesus Christ and Paul, Upanishadic thinkers, Gautama the Buddha, prophet Mohammed, Lao Tzu and Confucius; modern religion in the technological age (15th - 20th centuries), and the current postmodern era.^[29]

1.8 DSM-V cultural formulation and diagnostic categories

Both the current 5th and previous 4th revised text editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have included guidelines on how to compile a cultural formulation as part of the clinical assessment and management of patients in psychiatric practice.^[18,43] These formulations recommend the consideration of: the cultural identity of the individual; cultural conceptualisations of distress; psychosocial stressors and cultural features of vulnerability and resilience; cultural features of the relationship between the individual and the clinician; and an overall cultural assessment. The current DSM-V Cultural Formulation Interview (CFI) comprises a set of 16 questions and 4 domains of assessment: cultural definition of the problem (Questions 1 - 3); cultural perceptions of cause, context and support (Questions 4 - 10); cultural factors affecting self-coping and past help-seeking (Questions 11 - 13); and cultural factors affecting current help-seeking (Questions 14 - 16).

Although religious content and context have to be considered in all psychiatric assessments and diagnostic formations, the DSM-V also allows for the use of a V-code - V62.89 (Z65.8) Religious or Spiritual Problem - to document the fact when religion or spirituality may be the focus of clinical attention and has determined the presentation of a patient. The DSM-V also includes a glossary of cultural concepts of distress, such as ataque de nervios, dhat syndrome, khyâl cap, kufungisisa, maladi moun, nervios, shenjing shuairuo, susto and taijin kyofusho.

1.9 Legislation and policy

Traditional medicine was originally recognised by the World Health Organization, as part of the Alma-Ata in 1978. The African Union has recently developed a 'Plan of Action' on traditional medicine for 2011 - 2020. Current relevant legislation includes:

- the South African Constitution, Act No. 108 of 1996, which ensures: freedom of religious belief, expression and association; and freedom from discrimination and coercion on the grounds of religious belief, expression and association by the state^[44]
- the National Health Act No. 61 of 2003^[45]
- the Traditional Health Practitioners Act No. 22 of 2007 (THPA).^[46]

According to the THPA, traditional philosophy refers to indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs, and uses of traditional medicines, communicated from ancestors to descendants or from generation to generation, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.

1.10 Research on spirituality and psychiatry

Research on culture, religion, spirituality and psychiatry is ongoing.^[47] Topics explored include preventive and epidemiological aspects. Methodologies of research address specific ethics requirements, protocol design, and additional qualitative and mixed methods.^[48,49] Research funding priorities should probably be reconsidered in view of culture, religion, spirituality and the significant impact of world views on adherence to psychiatric medication and treatment and on pathways to care, for example. Such research findings must be translated into appropriate mental health policy and advice, and used to update practice and teaching guidelines.

1.11 Teaching and training

In SA, psychiatry has been practised and taught for some time now within a broader multidisciplinary context in the field of mental health, with Engel's^[50] biopsychosocial model as the paradigm for psychiatric practice and for undergraduate medical and postgraduate resident training. However, SA psychiatry as a specialist medical discipline must also, in terms of the teaching and training of psychiatry, bridge the multicultural, multireligious and spiritually diverse reality in which everyday practice occurs.^[51-54]

2. Practice guidelines for SA specialist psychiatry

These guidelines are therefore provided in terms of:

- Integrating defined spirituality in clinical care and in-service provision and use, by practitioners and patients, in their own lives and in terms of their professional therapeutic relationship
- Integrating defined spirituality in the training of local undergraduate and postgraduate students in psychiatry
- Ethical integration of defined spirituality within the professional scope of practice
- Appropriate referral of patients and collaboration between psychiatrists and spiritual/religious advisors.

2.1 Integrating defined spirituality in clinical care and service provision by practitioners and patients

2.1.1 Psychiatrists

(1) Activities related to psychiatrists' own incorporation of the role of defined spirituality in their individual lives and practice may include the development of their own skills, knowledge and attributes as a practitioner and teacher, as well as doing research.

A framework for what to consider regarding practitioners' *orientation in terms of spirituality and religion in psychiatry* may include:

- considering definitions and terminology critically
- acknowledging developing phases of spirituality
- increasing personal awareness, consciousness and mindfulness
- acquiring competence in teaching, training and mentoring on integrated approaches
- engaging in practical exercises and continuing professional development (CPD) regarding the development of personal spirituality.

It should be emphasised that considering the assessment of spirituality in a clinical practice setting, practitioners should be cognizant of the definition of spirituality as being distinct to religion, and be aware that it refers to an interrogation of a person's sense of connectedness, value and meaning, which may, or may not, include a particular religion or traditional belief system as a component.^[26]

(2) Activities related to the incorporation of the role of defined spirituality in terms of practitioners' professional relationship with their patients may include the implementation of clinical guidelines on training and treatment, or service guidelines of health programmes regarding relevant norms and standards.^[55]

A framework for what to consider in terms of the *reality of spirituality and religion for practitioners and patients* may include:

- incorporating a religious and spiritual history, and assessing

patients' spiritual needs during routine clinical assessments,^[56,57] where spiritual needs refer to needs and expectations to find meaning, purpose and value in life

- evaluating the cultural-religious context of patients' clinical presentation
- identifying the role of religion and spirituality in psychiatric disorders (e.g. psychotic, mood, anxiety and substance use disorders), as well as managing psychopathology related to religion and spirituality
- incorporating spirituality in clinical healthcare programmes appropriately, such as health promotion, and curative and palliative care
- identifying appropriate ways of incorporating defined spirituality in child, adolescent,^[58,59] and old-age psychiatry^[60]
- establishing physical structures and procedures in health facilities, regarding appropriate space and opportunity, dietary and other requirements, referral arrangements and general ethical conduct
- advocating for resource allocation to allow for integrative, comprehensive care
- engaging in practice-orientated research.

2.1.2 Patients

Activities related to patients' own incorporation of the role of defined spirituality, in the context of the therapeutic relationship between them and their doctor, include: communication during clinical assessments and interventions (history-taking, examination, discussion, and referral and liaison), as well as user advocacy and support programmes.

A framework for what to consider in terms of the *routine assessment of spirituality and religion in psychiatry* may include considering:

- objective, evidence-based perspectives of the role of culture, religion and spirituality in the causes, clinical assessment and management of illness
- relevant research.

2.2 Integrating defined spirituality in the training of local undergraduate and postgraduate students in psychiatry^[52]

Activities related to students' incorporation of the role of defined spirituality may include: curriculum development; the recruitment and selection of appropriate students in psychiatry, especially postgraduates; structured teaching using courses, lectures, tutorials or seminars; and the assessment and evaluation of skills, knowledge and competency. Once again, when introducing an approach to the assessment of spirituality in a training setting, students and teachers should also be cognizant of the definition of spirituality as being distinct to religion, and that it would refer to an interrogation of a person's sense of connectedness, value and meaning which may, or may not, include a particular religion or traditional belief system as a component in this.^[26]

A framework for what to consider in terms of the *training of spirituality in psychiatry* may include the following:

2.2.1 Undergraduate medical student requirements^[52]

- Assess the role of spirituality as part of routine history-taking and clinical examination by referring to, for example, the FICA model (F: Faith and belief; I: Importance/influence; C: Community; A: Address/action in care).^[61]

- Use the following patient-led communication techniques competently in dealing with patients' spiritual issues regarding:
 - discussing diagnoses, test results and treatment implications
 - breaking bad news and bereavement
 - listening skills, contemplation, self-reflection and mindfulness.
- Refer patients appropriately to spiritual ministers.
- Manage the scenario of the death or dying of a patient.^[62]

2.2.2 Postgraduate registrar in psychiatry requirements^[52]

In a broader context for postgraduates, cultural and transcultural topics may often be included in the field of social psychiatry, in addition to other areas such as: public health policy and health systems; preventive psychiatry; comorbidity; human rights and coercion; and migration and mental health.

(1) Knowledge

- Definition of concepts and terminology
- Overview of the history of the relationship between religion and science, e.g. the original 'split' between religion and psychiatry, and indications of a recent rapprochement^[63]
- Current inclusion of spirituality in diagnostic systems
- Relevant theories and related models such as those by Cloninger,^[1] Vaillant,^[64] Anandarajah,^[65] and Koenig^[66]
- Psychodynamic and other theories of consciousness^[67]
- Relevant schools of thought on the philosophy of psychiatry, as well as nosology and phenomenology in psychiatry
- Principles of evolutionary psychiatry
- Sociological and anthropological views on religion and spirituality^[68]
- Comparative overview of different faith traditions and belief systems relevant to health and mental health (including monotheist, polytheist and atheist traditions)
- Evidence of the saliency of spirituality and religion
- The role of spirituality and religion in psychopathology
- Bibliographies.

(2) Attitude and skills

- Inclusion of spirituality in clinical assessment (history-taking, in-depth interviewing, diagnostic formulation),^[69] including elaborating on an individual's strengths, vitality, motivation and sense of worthiness and belonging
- Appropriate interventions (e.g. referral to identified religious/spiritual advisors) and professional practice (e.g. adhering to guidelines on ethics and boundaries)
- Preparing and discussing case studies
- Personal growth and development of students and of teachers as mentors
- Ability to self-reflect and practise mindfulness.

(3) While the curricula for the SA College of Psychiatrists' diploma and specialist fellowship qualifications are currently being reviewed and blue-printed, the existing FC Psych (SA) Part I examination requirements already advocate an integrated approach to the neurosciences and behavioural sciences section. The Part I syllabus has thus been including a component on 'Sociology and social anthropology relevant to mental health and illness' in terms of

which in-depth knowledge of these subjects is not required, but candidates should be familiar with the main terms and concepts relevant to psychiatry. Among others, these were specified to include an understanding of:

- the nature and dynamics of family and kinship systems in various ethnic groups in SA, in particular the dynamics of the African family with special reference to the nature of parental authority, sibling rivalry and conjugal relations. Attention should be paid to the changes taking place in these relationships
- concepts of mental health and illness in distinct ethnic groups in southern Africa, including causation, the system of witch beliefs, pollution beliefs, the role of ancestors, etc.
- healing practices in distinct ethnic groups, including the role of indigenous healers and diviners
- culture-bound psychiatric syndromes, local and worldwide: their identification and treatment.

The requirements on cultural competencies in the current Part II examination may possibly be expected to be included in the one paper on special psychiatry (which covers: child and adolescent; old-age psychiatry; mental handicap; forensic; community; cultural; ethics; and research issues), and possibly also in the standardised, single exit oral and clinical examinations.

2.3 Ethical integration of defined spirituality within the professional scope of practice

To begin, a look at what the role of spirituality in a clinical medical and psychiatric care context should not be. In a professional clinical setting, the doctor or medical student is not responsible for the provision of spiritual care as can be expected from a spiritual advisor. Clinicians should not be performing spiritual (or religious) activities, or providing spiritual (or religious) interventions to patients, or their families, in a clinical medical setting. Clinicians should not use the clinical encounter with patients to exert personal religious or non-religious views to patients who may find themselves in vulnerable and unequally powered situations in this context.

Psychiatrists, general practitioners and medical students should rather be considering spirituality in the holistic context of a biopsychosocial-spiritual approach to healthcare, where the primary role of the clinician remains within the professional boundaries of a competent medical practitioner, and psychiatrists are responsible for the diagnosis, treatment and rehabilitation of medical and psychiatric conditions. The appropriate referral to an identified, qualified spiritual advisor from a particular faith tradition or belief system, on request of the patient or family, may rather be incorporated in this implied multidisciplinary attitude towards the comprehensive management of health, illness and disease.

Apart from the development of appropriate practice guidelines for psychiatrists in public and private practice, activities related to the ethical integration of spirituality within the professional boundaries and scope of practice may include CPD on the topic of culture, religion and spirituality such as conference presentations, seminars and lectures and the establishment of an organised system of peer review.

A framework for what to consider in terms of the *scope and boundaries of spirituality in psychiatry* may include:

- considering accepted definitions and using appropriate terminology
- achieving appropriate cultural, religious and spiritual competency to provide such integrated care
- avoiding actual religious or spiritual practices and interventions as part of clinical intervention and remuneration
- referring appropriately to, and collaborating with, identified cultural/religious/spiritual advisors and professionals
- taking cognizance of an appropriate approach to diagnostic formulation and categories
- achieving cultural, religious and spiritual competency in psychotherapy
- adhering to arrangements regarding medical aid cover and insurance benefits
- incorporating focused health education of patients and their families on evidence-based psychiatric practice.

2.3.1 Ethical questions to consider

The following ethical questions may continue to receive further attention during routine CPD opportunities:

- When and why should the topic of culture, religion and spirituality even be considered?
- How to respond to the extent to which culture, religion and spirituality play a role in health and other secular areas?
- What policy on the role of spirituality and its application exists in other sectors, such as education?
- Considering its observed significant role and place in the community, how should culture, religion and spirituality appropriately be accommodated in mental health and psychiatry?
- What would be an inappropriate role of spirituality in mental health and psychiatry considering accepted professional boundaries?
- What are the consequences of the overlapping social, cultural and religious domains?
- If provided definitions are applied, should the African traditional belief system rather be considered a religion?
- Why do only the African traditional belief system and related health practices currently seem to play such a prominent role in the SA healthcare sector?
- How should the goal of an equal approach and level of support to all religious traditions and belief systems in the SA healthcare sector be achieved?
- Are cultural and self-help practices encouraged by default as a result of the non-availability of formal health resources in under-resourced or rural areas?
- Must the incorporation of spirituality in an integrated, comprehensive healthcare approach be a requirement for the accreditation of healthcare facilities?
- Would the adoption of the concept of secular spirituality in a postmodern era be a practical approach to follow?

2.4 Appropriate referral of patients and collaboration

between psychiatrists and spiritual/religious advisors^[70]

If the role of defined spirituality has to be added to the dimensions of the existing model of teaching and practice to constitute a biopsychosocial-spiritual approach, the question becomes pertinent

of how religious or spiritual advisors (such as Christian pastoral care workers, imams, rabbis, traditional healers, or other religious and alternative healthcare practitioners) should be appropriately considered in terms of the existing multidisciplinary team of clinical workers.

It should also be noted here that, currently, it appears as if different faith traditions are not considered equally in terms of their role in the formal health sector. African traditional health practice, for example, currently seems to be awarded a disproportionately large space in this regard, with a controlling council having been legislated and constituted for it.^[44,68] Traditional healers in various scenarios have formally been elected to clinic committees, hospital boards, district health committees, and provincial and national advisory structures. Also, certain alternative health practitioners, such as Ayurveda, Chinese medicine and Unani-Tibb practitioners are already included in the Allied Health Professions Council of SA.^[68,72] However, while there is a long tradition of pastoral care counselling services and courses in SA, including postgraduate qualifications in practical theology, separate professional status for Christian pastoral care workers still has to be achieved.^[68,73]

In a scenario where, on an organised basis, more active engagement between psychiatrists and religious or spiritual advisors is considered, activities related to the collaboration between psychiatrists and religious/spiritual advisors may include: more structured communication between the representatives of these groups and SASOP, for example; exploring referral arrangements in a geographical catchment area context at facility or district level; and establishing educational forums on mental health and for advocacy for patients with psychiatric conditions.^[68]

A framework for what to consider in terms of the *referral and collaboration on spirituality in psychiatry* may include:

- clarification of agendas
- confirming of definitions and terminology (including 'spiritual professional')
- considering the role of culture, religion and spirituality in the community
- establishing perspectives of particular faith traditions or belief systems on health and mental health
- advocating evidence-based management of serious psychiatric conditions (risk factors, symptoms, diagnoses, treatment) to spiritual advisors/workers and to patients and families
- promoting compliance and outcome, while preventing stigma of psychiatric treatment.

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