Mental illness is often perceived by those affected and by outsiders as something that affects the mind, spirit, and soul. Religion/spirituality is often perceived as something affecting the same. Moreover, mental illnesses sometimes have similar or the same symptoms as religious/spiritual experiences and behaviour. The boundaries between psychiatric and psychological phenomena on the one hand and religious/spiritual ones on the other may therefore be especially challenged and fluid.

In their academic histories, psychiatry and psychotherapy have often distanced themselves strongly from religion and insisted on a scientific and secular worldview. For a long time, these disciplines placed religion in the neurotic/pathological corner. However, more recently, scientifically accredited therapies have taken up religious elements and psychotherapeutic training courses deal with spirituality. In addition, the interrelations between religion/spirituality and mental health have been investigated in an increasing number of academic studies (see e.g. Rosmarin and Koenig 2020). In this chapter, we ask how this development came about and how boundaries are drawn (and re-drawn) between medicine/therapy and religion/spirituality.

After a few remarks on terms, we describe the history of the relationship between religion, the fields of psychiatry, psychology, and psychotherapy, and phenomena that in today’s medical terminology are called mental illness. We concentrate on the European, especially German-speaking context, with references to the US. The mutual reception of psychotherapy and religion/spirituality in the present is to be understood in the context of a therapeutization of society. This reception is negotiated through questions of whether and to what extent
religion/spirituality should be included in psychotherapy. To conclude this first part, we present examples from Austria, Switzerland, and Germany.

In the second part, we look at two basic issues regarding the therapeutic relationship in cases where religion/spirituality is integrated into therapy: the danger of power abuse and the possibility of accepting religion/spirituality as a patient’s relevant reality. The third part of our chapter is dedicated to a specific case of entanglement between spirituality and therapy: the concept of posttraumatic growth in the context of Posttraumatic Stress Disorder (PTSD). Here, we draw from a study about the ‘Perception of Muslim Patients in Psychiatry,’ headed by Dorothea Lüddeckens (2018–2020), with a total of twenty-five interviews with therapists and nurses in a Swiss psychiatric hospital.

Psychiatry, psychology, and psychotherapy

Psychiatry as a branch of medicine deals with the diagnosis and treatment of mental disorders. In most countries, training as a psychiatrist also includes a comprehensive training in the field of psychotherapy in addition to biomedical education. After studying psychology, psychology-trained psychotherapists undergo theoretical clinical training in the field of psychotherapy. In many countries, the professional title psychotherapist is protected by law and linked to content requirements. Depending on the national legal basis, other professional groups such as chaplains can also receive psychotherapeutic training. Psychotherapy is based on the relationship between therapist and patient. It is usually conversation-based and can have very different approaches. The aim is to improve mental health and quality of life by changing the patient’s thought and behaviour patterns.

The concept of spirituality

In the context of psychiatry, psychology, and psychotherapy, the term spirituality is linked to a network of associations rather than to a single concept that is or can be related to an objectifiable and definable object. The range of meanings that this term covers encompasses: a positive relationship with oneself, with other human beings, and an encompassing connectedness; something that gives meaning and purpose; and a reference to transcendence or the sacred, generally without elaborating what is meant by these terms. These various nuances indicate that what is meant by spirituality is something that cannot be reduced to the biopsychosocial level. People who use the term spirituality usually want to refer to a reality which, in their opinion or experience, transcends the empirical realm of everyday life and the biological basis of the body: something that gives meaning. Spirituality is described as something positive and encouraging, promoting hope, and a positive worldview, and is often combined with values such as kindness, forgiveness, generosity, thankfulness, and compassion. Being spiritual often designates a person’s interest in this expanded idea of reality within and beyond the mundane as well as their ability to experience it. This may include being open to experiences perceived as dissolving boundaries, for example those of one’s own body or one’s own consciousness; experiences that show, according to a spiritual view, the interconnectivity of everything. Within the framework of New Age spirituality, these experiences are often considered to be part of an objective reality that can be measured in a scientific way, now or perhaps in the future. These spiritual, transcendent aspects of reality are not opposed to but inherent in nature. In contrast, more traditional Christian or Muslim concepts usually understand the transcendence of God as a reality that goes beyond the empirical, natural world.
A typical understanding of spirituality in psychotherapy is shown by Karin, a psychotherapist explaining Mindfulness Based Stress Reduction (MBSR) as a Buddhist practice:

MBSR . . . comes from the East, but it is really open to all communities. It is not linked to any religion. . . . It allows for a lot of openness and also has something connecting, something that doesn’t exclude people, that doesn’t reduce people to one religion, but where being human is concerned. With all feelings, all physical sensations, all suffering, all pain, all beauty. That is what is close to my heart, finding access to oneself. . . . And what I find even more exciting is that there is also a little bit of spirituality in meditation. . . . It’s like this: ‘now I feel at one [with myself, with everything?] and it’s so beautiful to come into peace like this.’ And for me that is spirituality, independent of any religion. Or—it is there in every religion. . . . It can be very spiritual. When I come to my senses . . . here with my heart, and not in my head.7

Here we see a differentiation between spirituality and religion (see Stein in this volume, Klassen 2005). Hill and Pargament criticized the ‘polarization’ and bifurcation of religion and spirituality often found in the medical context, ‘with the former representing an institutional, formal, outward, doctrinal, authoritarian, inhibiting expression and the latter representing an individual, subjective, emotional, inward, unsystematic, freeing expression’ (Hill and Pargament 2003: 64).8 This differentiation is not specific to the field of psychotherapy (see Reimer, this volume). Irrespective of the context, these kinds of (normative) differentiations, which often assign negative (and positive) aspects to religion, while spirituality is conceived as basically positive, are problematic because their implications are misleading in several ways. Institutional, formal religion may be, for example, very emotional, while subjective spirituality may be experienced in institutions. Members of religious communities and institutions may be more interested in experiences than doctrines, and in an existential search for meaning, the label spirituality is obviously associated with aspects that belong to traditional religiosity. Both concepts, religion and spirituality, are contested and interrelated and require careful handling by scholars. Therefore, due to their overlaps and entanglements in the emic and to some extent the etic discourse, to avoid misunderstandings, we will refer to religion/spirituality (as mentioned in endnote 1).

Most instruments that mental health researchers have developed to measure religiosity and spirituality9 are based on self-report scales, which is ‘understandable in that this form of measurement is common to most social sciences research and given that most psychology of religion has been conducted within a Western Protestant context that stresses religious beliefs as personal and subjective’ (Hill and Dwiwardani 2010: 332). However, as they note, relying solely on self-report measures is risky because it makes ‘the study of religion/spirituality vulnerable to bias in the form of demand characteristics and impression management.’ Furthermore, even widely used scales are often ‘religiously biased’ (2010: 332) and measures and studies often ‘have overrepresented Whites, the middle class, and, to some extent men’ (Hill and Pargament 2003: 70, 332).

**Mental illness in European history and modern psychiatry**

In ancient Europe and the Middle Ages, what is now called mental illness was often explained by means of religious concepts, such as ‘demonic obsession.’ The Arab Islamic region seems to have been the first medical facilities for the mentally ill (Dols 1992; Mitha 2020). The Muslim influence was probably also important for the founding of psychiatric hospitals in Spain in
the fourteenth and fifteenth centuries (Weiner 2008: 257). The overall situation varied greatly from place to place. Some historians assume that those who were given into the care of Christian monasteries across Europe were mostly treated with mixtures of medical (e.g. herbs) and religious therapies (e.g. exorcism rituals, prayers). Others were put on display in cages or kept in towers of city walls and later on in former plague houses (Schott and Tölle 2006: 232–235).

While religious explanations for mental illness, like demonic obsession, still prevailed in early modern Europe, this age also brought the combination of penitentiaries, workhouses, and madhouses. The eighteenth century saw reforms and new institutions: they became less purely prison-like and more therapeutic institutions (Shorter 1997: 436; Schott and Tölle 2006: 237–239).

The reformers were motivated by enlightenment ideals, while some of them had religious motives too. The Quaker Samuel Tuke, committed to the ‘York Asylum’ that had a pioneering role in England (Stanley 2010), saw medical and humane treatment, meaningful occupation, and also religion as important means of cure: ‘to encourage the influence of religious principles over the mind of the insane, is considered of great consequence, as a means of cure’ (Tuke 1813: 160). However, medicine, ‘education’ and correction (régime moral in the influential French context), ‘moral treatment and management’ in the sense of a respectful and person-oriented attitude towards the patient, rather than religion, were the focus of treatment in the York Asylum. Enlightenment ideals of reason as the core of human existence played a role in growing convictions that the mentally ill, the ‘unreasonable,’ should be healed in order to become reasonable again. The physician became the ‘knowing authority’ to whom the patient had to submit absolutely in order to be led back to reason. Foucault saw these power relations and new regimes of truth as the context within which madness as a historical category was developed. He saw the asylums as a means of exclusion from society and doctors as guardians of the interns, who protect society from madness in a context of a new paradigm of confinement, repression, and disciplining (Foucault 2006).

The ‘medicine of Enlightenment’ was still a mixture of alchemical and humoural pathological elements, but the Enlightenment also brought philanthropic ideals and the idea of social causes of disease. By the middle of the nineteenth century, it was well recognized in Europe and the USA that mental illness was actually illness and belonged under the purview of the medical profession. ‘Asylums’ or ‘retreats’ had been established with the concept of ‘humane’ and ‘moral treatment’ of the mentally ill. However, these were mostly for wealthy patients, whereas many of the public institutions were soon overcrowded. Dorothea Dix, shocked by the placement of mentally ill people in prisons and almshouses in the middle of the nineteenth century in the USA, fought for public psychiatric hospitals and medical care. In a ‘Memorial to Legislature of Massachusetts’ she describes:

In Germany, psychiatrists such as Wilhelm Griesinger (1817–1868) and later Emil Kraepelin (1856–1926) wanted to establish psychiatry as a scientific medical discipline. They dissociated themselves from ideas that based mental illness on religious causes (Kraepelin 1899: 1). Kraepelin, as Dix before him, demanded a new look at people with mental disorders. Under
the new psychiatric order of knowledge, these people went from troublemakers and sinners who had caused their own suffering and had to be punished (or at least shut away) to patients to be treated medically. For Kraepelin, the causes of mental illness lay in the cerebral cortex and, as he later admitted for delusion, the ‘processing of life experience.’ In any case, for him and his somatically oriented colleagues, the causes certainly did not lie in religious misconduct or in the influence of demonic powers.

In the history of psychiatry, there has been a critical, even negative attitude towards religion, which many attribute to the influence of Sigmund Freud. However, with Carl Gustav Jung (1875–1961) and Abraham Maslow (1908–1970) (described later), religion and positive evaluations of the religious reached psychotherapy, though not necessarily the psychiatric scene. As Hanegraaff writes, Jung

not only psychologized esotericism but he also sacralized psychology, by filling it with the contents of esoteric speculation. The result was a body of theories which enabled people to talk about God while really meaning their own psyche, and about their own psyche while really meaning the divine.

(Hanegraaff 1996: 513)

Religious concepts and practices came into today’s psychotherapy through lines that are interwoven through mutual influence or personal overlaps. After World War I, many mainstream Christian and Jewish clergy began turning to psychotherapy in the form of pastoral care (Klassen 2011). There are psychotherapeutic schools such as Jung’s Depth Psychology that are influenced by religious concepts and practices, and a new generation of psychotherapists has been influenced, for example, by the teachings of Rajneesh (Osho) and neo-shamanic practices and concepts (e.g. ‘power animals’). The transitions from a therapy that aims to strengthen individual psycho-physical wellbeing and to enable clients to deal constructively with their social environment to a therapy with religious goals are sometimes fluid. Examples of the latter are the aims of dissolving earthly ties, finding one’s ‘higher inner self,’ or being able to reach higher ‘spiritual’ levels beyond this biological life—be it in a future life after death or within this life but in contact with ‘higher’ non-empirical beings.

Transpersonal Psychology and therapy

Within the overlapping fields of New Age and psychotherapy, Transpersonal Psychology (TP) has become quite influential and has contributed to ‘Modern Psycho-Religion’ (Hammer 2001: 67ff.). However, TP, founded by the psychologist Abraham Maslow and the psychiatrist Stanislav Grof, is considered marginal within academic psychology and has given rise to controversies regarding whether it even is a legitimate part of psychology at all. TP claims to be superior to ‘materialistic’ psychology in that it includes ‘higher’ levels of consciousness and wants to scientifically explore, according to the Journal of Transpersonal Psychology, among others, ‘peak’ and ‘mystical’ experiences, the ‘transcendence of the self,’ ‘oneness,’ and ‘spiritual paths’ (Hammer 2001: 72).

Transpersonal Psychology adopts typical narratives of New Age that argue for a universal truth in all religious traditions or a spirit that permeates all matter and being. Evolution is another core concept, as seen in this quote from the influential author Ken Wilbur: ‘The course of human development—and evolution at large—is from subconscious to self-conscious to superconscious; from pre-personal to personal to transpersonal . . . from pre-temporal to temporal to trans-temporal, by any other name: eternal’ (Wilbur quoted in Combs 2013: 171). As
in other New Age contexts, ‘experience’ is given particular importance, in connection with ‘terms such as unity, transcendence of space and time, objectivity and reality, a sense of holiness, deeply positive moods, and ineffability’ (Gripentrog 2018: 251).

The causes for ‘psychogenic disorders,’ according to Grof, can also be found ‘on the transpersonal level of the psyche,’ a deeper layer of the unconscious (Grof 2015: 105). Therapeutic methods include concepts of reincarnation, practices for the memorization of past incarnations and rituals that are seen as religious or spiritual but without being bound to specific religious traditions. TP, according to Grof, ‘employs methods that involve holotropic states of consciousness that engage levels of the unconscious generally inaccessible to verbal therapy’ (Grof 2015: 105).

‘The therapeutization of society’

This entanglement of New Age, psychotherapy, and ‘Psycho-Religion’ is situated in the wider context of the ‘therapeutization of society.’ This refers to the naturalness with which the self of the individual is addressed as something that needs attention, care, and is considered capable of improvement. The role of experiences and emotions in biographies and social interaction are the subject of unquestioned reflection and discussion, be it privately or in public. This ‘therapeutic emotional style,’ which developed in the 1920s, has become widespread in Europe, North America, and elsewhere since the 1960s. Though often the subject of scholarly and popular critique, therapeutic culture is found across TV shows and series, self-help literature, professional therapeutic contexts and corporate capitalism (Illouz 2008). This development also contributed to a decrease in taboos regarding mental illness, psychiatry, and especially psychotherapy.

Discourse on the inclusion or exclusion of religion/spirituality

The line between spirituality and mental health remains contentious at the level of both the medical establishment and the state. Peter Schulthess, the Chairman of the Swiss Charter for Psychotherapy, writes: ‘I believe that we should not mix these domains. We, as psychotherapists, must not also—at the same time—be practicing as shamans, priests or spiritual guides. These roles should be kept separate’ (2017: 20). Schulthess dissociates himself from a phenomenon that in Austria has led to many lawsuits against psychotherapists so that Austria’s Federal Ministry of Health has reacted by publishing ‘Guidelines for psychotherapists on the issue of differentiating between psychotherapy and esoteric, spiritual, and religious methods’ in 2014:

There is a clear and distinct difference between psychotherapy and all kinds of esoteric, spiritual and religious methods, such as human energetics, spiritual healing, shamanism and many others. These methods do not form part of psychotherapy. The provision of any kind of esoteric content, spiritual rituals or religious healing doctrine is strictly prohibited in all psychotherapeutic education and training.11

An even more detailed set of guidelines was published in 2018 (Weiss et al. 2018), as ‘psychotherapy is increasingly mixing with esoteric, spiritual, religious, and ideological contents and a shift of esoteric, spiritual, religious, and ideological questions of orientation and meaning into the psychotherapeutic field is taking place’ (Weiss et al. 2018: 4). In these guidelines, the ‘scientific nature’ of psychotherapy becomes the decisive criterion to legally exclude
Psychiatry, psychotherapy, and religion

Religious/spiritual content. Psychotherapy’s ‘scientific foundation,’ ‘scientific verifiability’ of recognized methods, and its ‘limits of the scientific character [as an] empirical science’ are emphasized. In contrast to religion/spirituality, psychotherapy ‘cannot give generally binding answers—in the sense of “truths”—to existential questions or even a transcendent reality’ (Weiss et al. 2018: 7).

The demand for a strict separation of psychotherapy and religion/spirituality in these guidelines is the call to consider the special need to protect patients in therapeutic relationships ‘in view of the particular situation of dependence’ (Weiss et al. 2018: 10). Especially when a person is a psychotherapist and a pastor, for example, a clear separation of roles is required: only as a pastor may one bring religion/spirituality into the relationship as a subject or action on his or her own initiative. Simultaneously treating a patient as a psychotherapist and as a pastor is not permitted. Thus, prayers or religious rituals cannot be part of psychotherapeutic treatment (Weiss et al. 2018: 13).

This official Austrian position triggered debates in Switzerland and Germany. The German Association for Psychiatry, Psychotherapy, and Psychosomatics (DGPPN) published a position paper (Utsch et al. 2016) and journals of psychotherapists’ professional associations devoted issues to the topic. Many reject the active inclusion of aspects and methods considered spiritual, by arguing that they lack scientific validity:

Research into consciousness can, with objective measurements, now investigate: the effects of changed conditions of consciousness, relaxation, distancing from self, reductions in brain and heart functioning, etc. However, the ‘correctness’ of the conceptualization of transpersonal and/or esoteric teachings cannot be verified properly in this way.

(Schulthess 2017: 17)

Not only proponents of the Austrian guidelines but also their critics argue with scientific values and concepts, that is, with claims about ‘training/education,’ a competence in ‘diagnostics’ and the ‘resource [of] spirituality’ as ‘scientifically proved’ (Signer-Brandau 2016: 25). They demand a change from the pathologization of religion/spirituality to a ‘resource’ orientation, though the risk of manipulation and abuse of ‘spiritual interventions in therapies’ is considered to be of particular concern (Signer-Brandau 2016: 25). Frequently, spirituality is also understood as a general human dimension of the ability to relate to others and interpret meaning, so that ‘spirituality in this essential sense, was a natural part of every major psychotherapy mainstream’ (Boadella 2017: 25).

In principle there is probably more scepticism about the inclusion of religion/spirituality in German-speaking secular institutions than, for example, in the US (see e.g. Curlin et al. 2007). The inclusion of MBSR and Dialectical Behaviour Therapy (DBT), both working with mindfulness awareness techniques, are minor exceptions. These are approaches that claim to be non-religious and had academic studies on their effectiveness early on. According to the Professional Association of German Psychiatrists, Psychotherapists, and Neurologists (DGPPN), professional ethics exclude ‘religious and spiritual interventions’ (Utsch et al. 2016: 6). However, the DGPPN and many professional societies recommend more attention to the issues of religion/spirituality among their patients. The German Medical Association’s official international science journal states that, ‘psychotherapists are increasingly confronted with religious and spiritual questions’ and there is an increase in the ‘spiritual or religious orientation of many psychotherapists’ (Sonnenmoser 2017: 7). Actually, some therapists mention religion and spirituality as possible topics for their therapy, for example in the list of the
Swiss professional association PsychotherapeutInnen Zentralschweiz VPZ. However, even authors who advocate for the integration of spirituality often explicitly distance themselves from Transpersonal Psychology in the sense meant by Grof.

Therapeutic relationships and abuse of power

The question of power and misuse of power is particularly challenging in psychiatric and psychotherapeutic contexts. Patients are especially vulnerable as not only their bodies but also their minds are under scrutiny. The inclusion of religion/spirituality may add to the danger of power misuse for several reasons.

First, when religious/spiritual therapists refer to (religious/spiritual) knowledge, it is generally not verifiable for the patient, because it claims to come from a ‘higher’ transcendent level. ‘A self-assessment, but also an external assessment of the psychotherapist as a shaman would be dangerous, because emotional dependencies are transcended, so to speak, and thus become unassailable’ declares Lempert (2015), a Swiss psychotherapist and teacher of Buddhist psychology and mindfulness meditation.

Second, in cases of ‘spiritual psychotherapy,’ the client’s spiritual side is also taken into consideration. On this level, patients might be even more vulnerable, as it may at the same time be a level that is difficult to grasp and potentially perceived as more existential (by both patient and therapist). Therapists can thus claim power over their patients, or patients can give their therapists power to affect not only their acute mental state but also their existential understanding. As Foucault made clear, knowledge is always connected to power. From this perspective one can say psychotherapies are informed by bodies of psychiatric/psychotherapeutic knowledge and religious/spiritual therapies are additionally informed by bodies of ‘spiritual knowledge.’ An example is the idea of a future reincarnation that depends on the patient’s ability to grow spiritually in this life (with the therapist’s support), or the acceptance of demons that allegedly can only be tamed by the supernatural power attributed to the therapist. The anticipated possible negative (or positive) existential consequences will support the therapist’s position of power.

Third, the danger that a patient is not seen as someone who has a mental illness but as someone who is this mental illness, is possibly even doubled in the field of spiritual therapy. This is the case when the therapist’s diagnosis of a person as having spiritual deficits determines the patient as a whole. Thereby, the patient is defined in his/her very being as a spiritual problem and his or her identity outside of this mental illness is negated.

Acceptance without adoption of religious concepts and practices

It is often overlooked that it is possible to both acknowledge that patients have a religious/spiritual perspective, and at the same time not to adopt the patient’s perspective and become religiously/spiritually engaged as a therapist. Acknowledging that something is an important reality for a patient does not necessarily mean that the therapist accepts it as a reality for her/himself.

An example from the addiction-therapeutic context of Thomas Lüddeckens’ clinical practice illustrates this stance. A patient reported demons possessing him. He saw and experienced the demons as external powers, part of an external evil. In his religious worldview, he found explanations for their presence. The therapist acknowledged the patient’s perspective by reassuring the patient that this situation must be very stressful for him. He invited the patient to
consider these demonic powers in the context of psychotherapy, as also part of himself, a part that wants to push back against his responsible adult ego. The demons thus became (also!) an analogy of the patient’s destructive, addictive part; they became an intra-psychic mechanism. For the therapist they were a metaphor, not a transcendent reality, however, the patient’s experience and concepts were not negated. In therapy, the religious level was thus translated into an inner-psychic one. For the client, this extension enabled him to maintain his religious interpretation and at the same time acknowledge the psychotherapist’s interpretation. While the perspective of exclusively externalized demons takes away the patient’s autonomy, the extension to an intra-psychic one gives the patient the possibility of self-responsibility in dealing with the demons. A non-religious/non-spiritual therapy can thus allow patients to maintain their religious perspectives, while at the same time being offered another perspective accessible for talk therapy.

Ideally, the patient’s religious beliefs already provide a religious resource of their own. Another therapist described such a case: ‘He [the patient] himself argues with much of what his mother had told him about devil and angels. For him, the devil is now the addicted part, the angels the adult part, who strengthen him and support him on his abstinent path. He now reads the Koran here in the clinic as well.’

**Posttraumatic stress disorder**

The treatment of PTSD is an example of the extent to which religious/spiritual aspects are included in the psychiatric context. Since the beginnings of psychiatry as a medical discipline in the late nineteenth century, the discipline has been concerned with the effects of extreme events such as war, torture, natural disasters, or extreme violence to the human psyche. Triggered by the devastating effects of the two great wars of the twentieth century, the experiences of survivors of the Nazi death camps and the consequences of sexualized violence, the field of psycho-traumatology experienced great scientific and therapeutic interest in the second half of the twentieth century.

The clinical picture of PTSD was first recorded in 1980 in DSM-III and it was first listed in the WHO’s diagnostic manual ICD 10 in 1989. In the current WHO Diagnostic and Statistical Manual, ICD 11, the clinical picture of PTSD is described as follows:

- a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat.

Today a large number of evidence-based treatments for PTSD are available. They address primarily or exclusively clinically observable symptoms from the areas of remembrance, avoidance, and hyperarousal. There is no indication in these therapeutic methods of the need to include religious/spiritual topics or to use elements from religious practice in the therapy. The rationales behind the individual procedures are more or less neurobiological or cognitive-behavioural.
Spirituality/religion and PTSD


A review of quantitative studies on the connection between religiosity and psychological outcomes after trauma (Kucharska 2020) shows that the terms religion and spirituality refer to very different constructs, making a comprehensive interpretation of the studies difficult. Other difficulties are related to the different types of trauma and cultural contexts.

Pargament et al. (2000) developed a popular construct of positive and negative religious coping that encompasses, for example, seeking religious meaning and religious appraisals of a negative event. Positive coping might be connected with a belief in a supportive, consoling God, while negative coping with the belief in a punishing God. An example from our research was a young man who did not come out as gay because of his religious socialization. His therapist explained:

what he showed to the outside world was very different from what he felt, which led to the fact, as the patient himself said, that the addictive drug served to maintain this structure. . . . There are always patients from different faiths and they are often very stuck in inner images.22

Another therapist said ‘addiction is connected with shame and sin . . . religion makes it difficult [for this patient] to be transparent with regard to his addiction.’23

There is a very clear finding in all studies that for war-traumatized patients religion leads to less severe symptoms. The data are less clear for victims of natural disasters or sexual violence. Overall, positive associations between religiosity/spirituality and different types of mental disorders have been demonstrated. However, negative religious coping is associated with worse psychological outcomes (Bryant-Davis et al. 2015; Weber and Pargament 2014).

Shattered assumptions

‘Traumatic life events shatter our fundamental assumptions about ourselves and our world’ (Janoff-Bulmann 1992: 169). During traumatic events, people experience extreme feelings of helplessness and loss of control. Extreme physical pain and being flooded with negative feelings can damage one’s own physical and emotional integrity,24 while one’s concept of oneself, others, and the whole world can be questionable. Basic convictions that were believed to be safe (people are generally good, I am safe, there is justice, good prevails, etc.) can be lost. These changes were described in detail by psychologist Ronnie Janoff-Bulman (1992). In her opinion, the goal of trauma therapy lies in ‘recovery.’ This does not mean the restoration of the state before the traumatic event, but a positive adaptation of the self and worldview to the posttraumatic reality. This in turn requires an integration of the traumatic experience into one’s own biography. Janoff-Bulman (1992: 172) sees, ‘(1) the victim’s ability to tolerate arousal and distressing emotions; (2) . . . to creatively rework and reappraise the powerful new “data” and (3) the support of close, caring others’ as decisive factors that enable recovery. In her
perspective, positive coping with traumatic events can lead to far-reaching changes for those affected:

Trauma survivors no longer move through life unmindful of existence. . . . They have made their peace with the inevitable shortcomings of our existence and have a new appreciation of life and a realization of what is really important. . . . The trauma survivor emerges somewhat sadder, but considerably wiser.

(Janoff-Bulman 1992: 175)

Janoff-Bulman does not use the terms religious or spiritual, but the changes she observes contain elements that subsequent authors put into a spiritual context.

**Posttraumatic growth**

Tedeschi and Calhoun (1996, 2004a) developed the concept of posttraumatic growth (PTG) in relation to their observation that some people talked about a changed relationship with themselves and the world after severe traumatic events. They described five dimensions of growth: 1) relating to others; 2) new possibilities; 3) personal strength; 4) spiritual change; and 5) appreciation of life (Tedeschi and Calhoun 1996). The questionnaire they designed to measure these dimensions also includes two specific items on religion/spirituality: ‘A better understanding of spiritual matters’ and ‘I have a stronger religious faith.’ Since they do not specify what is meant by ‘religious faith’ and ‘spiritual matters,’ the answers only provide information about the patients’ self-assessment within the framework of their own understanding of these terms.

PTG can be the result of a successful trauma integration, similar to the recovery described by Janoff-Buhlman. However, it should be distinguished from concepts like resilience.

In contrast, posttraumatic growth refers to a change in people that goes beyond an ability to resist and not be damaged by highly stressful circumstances; it involves a movement beyond pretrauma levels of adaptation. Posttraumatic growth, then, has a quality of transformation, or a qualitative change in functioning, unlike the apparently similar concepts of resilience, sense of coherence, optimism, and hardiness (Tedeschi and Calhoun 2004a: 4).

PTG is, as Tedeschi and Calhoun emphasize, ‘not simply a return to baseline—it is an experience of improvement that for some persons is deeply profound.’ This improvement may be experienced in the ‘domain of spiritual and existential matters,’ even by non-religious individuals (Tedeschi and Calhoun 2004a: 6). According to the authors, the therapist’s task should be to gently support this process and they are aware that this may mean a new field of activity in therapeutic work:

Clinicians must feel comfortable and be willing to help their patients process their cognitive engagements with existential or spiritual matters and generally respect and work within the existential framework that patients have developed or are trying to rebuild in the aftermath of a trauma.

(Tedeschi and Calhoun 2004b)

The entanglement between PTG and religion/spirituality is manifold: ‘although spirituality may not be directly linked to a decrease of pain, it may have a unique impact in providing a
framework through which painful experiences may be more easily borne’ (Galea 2014: 7). And Schultz et al. (2010) find:

Positive psychology has fostered increased interest in forgiveness and posttraumatic growth, two ways in which individuals may respond following significant interpersonal transgressions. Each has been related to positive health outcomes, and both have strong ties to religion and spirituality.

(112)

Inducing religious coping and ‘spiritual strength’

The following therapeutic programme, called ‘Trauma-focused Spiritually Integrated Intervention for Veterans Exposed to Trauma,’ can be understood as an example of induced religious coping. The American psychologist Jeannette Irene Harris and her team designed a specific type of group intervention to address religious strain and enhance religious meaning making for military trauma survivors (Harris et al. 2011: 425). They based their therapy on a large number of studies that associate a positive correlation between a particular form of spirituality and an improved outcome in terms of PTSD symptoms: ‘Those who view their spirituality, faith community, and/or Higher Power as sources of support, validation, and acceptance are more able to make healthy meanings and recover than those who don’t’ (Harris et al. 2011: 425).

The intervention is explicitly aimed at people that see themselves as religiously or spiritually oriented. The programme understands itself as interreligious and non-missionary. The goal of the eight-session group intervention is to reduce symptoms of PTSD. The aims are to train ‘participants to make the best use of their preexisting faith resources to manage trauma’s impact,’ and ‘to assist survivors in recognizing and resolving spiritual concerns that can contribute to distress’ (Harris et al. 2011: 427).

In the first meeting the participants share their ‘religious histories’ and try ‘to identify individual spiritual development goals.’ Sessions two and three ‘involve experiential and written prayer exercises, designed to establish open communication with a Higher Power.’ Participants are introduced to the methodology/technique of a ‘prayer log’ or ‘meditation log.’ Experiences of prayer and meditation are shared and those present, members and leaders of the group ‘respond with their perceptions of how a Higher Power (or Tao, Universe, or equivalent concept for non-theists) might respond to the prayer/meditation’ (Harris et al. 2011: 427). The theme of the fourth session is the discussion of the question of theodicy, why God allows evil and thus also the traumatic events and experiences of the participants. The fifth session seeks to improve one’s own prayer/meditation practice; sessions six and seven deal with forgiveness and conflict resolution. The final session discusses the experiences of the participants during the therapy, ‘progress on individual spiritual goals, and planning for continued personal spiritual development’ (Harris et al. 2011: 428).

The therapeutic approaches mentioned earlier have established themselves in an American context that is much more open to religion and the vague concept of spirituality than is the case in Western European societies. It also shows that religion as a positive resource for society and individuals is more naturally recognized than in many European contexts. Since for many Americans religion and spirituality are positive concepts, therapies that connect to these (vague) concepts find a high level of acceptance. The need to draw boundaries between
religion/spirituality and other public spheres of society is also seen less in the USA than in Europe.

Conclusion: from ‘bio-psycho-social’ to ‘bio-psycho-social-spiritual’ model

Since the beginning of academic psychiatry, psychiatrists have mostly distanced themselves from religious explanatory patterns and practices or were even fundamentally negative towards religion. The purely biological disease model of the young academic psychiatry was expanded by the psychological aspect in the 1920s, and the social and societal aspects were added in the 1950s and 1960s. The bio-psychosocial model, still in use today, has recently been extended again with the integration of a spiritual perspective. This bio-psycho-social-spiritual model is often seen as holistic and is classified in different ways. It is either considered a relapse into an unscientific view of mental illnesses, or as a necessary extension of an otherwise reductionist understanding of humanity, disease, and health. Due to the development of an increasingly patient-oriented approach it can be assumed that the inclusion of religion/spirituality might follow as logical next step to psychotherapy if spirituality/religion is an important issue for the patients themselves.

The history of psychiatry and psychology has led to boundaries being drawn between these medical and therapeutic fields and religion. One consequence of this is that religion/spirituality was and still is often overlooked as a relevant aspect of patients’ lives and their medical histories. At the same time, as we have seen, the boundaries remain controversial. Therapies that actively integrate religion/spirituality into the therapeutic relationship and practice are becoming increasingly relevant. However, the more explicitly transcendent aspects are included, the stronger the criticism of unscientificity and potential abuse of power.

Notes

1 In this chapter, spirituality is understood as an emic category of the field. In some academic contexts, however, the term spirituality is understood as an academic category, distinguished from religion. In order to avoid misunderstandings, we will speak of religion/spirituality in this text when we refer to concepts associated with both, religion and spirituality.
2 In some contexts, it is more common to speak of clients.
3 My thanks go to the cooperation of Beatrix Göcking, Lilo Ruther, and Barbara Zeugin.
4 See also Streib and Hood (2016).
5 Religion is often attributed with negatively evaluated aspects, such as fundamentalism.
6 From a neuroscientific or psychopathological point of view, these experiences are seen as neurologically explainable and describable states of consciousness.
7 Interview by Ruther and Zeugin, December 2018. The English translations from the German/Swiss German original of this and the following Interview quotes were translated by the authors.
8 However, this polarization can also be found in non-medical contexts.
9 For a review of these measurement instruments see Hill and Dwiwardani (2010).
10 Tuke saw a great ‘advantage’ in ‘treating the patient as much in the manner of a rational being, as the state of his mind will possibly allow’ (Tuke 1813: 158).
12 For Germany, see Utsch 2018.

DGPPN = Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde.

So, for example, the World Psychiatric Association (WPA), (Utsch et al. 2016).

By ‘knowledge’ we do not mean to ascribe truth to it. ‘Knowledge’ refers here to something that is seen or acknowledged as ‘knowledge’ in a certain context. Psychiatric as well as spiritual knowledge is produced by discourses and can be historicized and politicized.

Interview by Ruther, December 2018.

15 DGPPN = Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde.


17 By ‘knowledge’ we do not mean to ascribe truth to it. ‘Knowledge’ refers here to something that is seen or acknowledged as ‘knowledge’ in a certain context. Psychiatric as well as spiritual knowledge is produced by discourses and can be historicized and politicized.

18 Interview by Ruther, December 2018.

19 DSM=Diagnostic and Statistical Manual of Mental Disorders.


22 Interview by Ruther, December 2018.

23 Interview by Ruther, December 2018.

24 Emotional integrity is a multifaceted concept. It encompasses the ability to admit one’s own feelings and beliefs, independent of the opinions of others, the congruence of one’s own feelings, thoughts and their expression.

25 If trauma integration succeeds, the traumatic experience is integrated into one’s own life story in such a way that it can be understood as part of the biography and is not perceived as a permanently present burden and disturbing factor.

26 ‘Religious strains may include feeling alienated from one’s Higher Power, shame, guilt, or fear related to sin or perceived sin, expectations of punishment or abandonment from a Higher Power, or difficulties in relationships with leadership or peers in a faith community. Religious strain has been related both to poorer mental health outcomes and to higher levels of PTSD symptoms in trauma survivors’ (Harris et al. 2011: 427). See also Exline et al. (2000).

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