Religiosity in clinical practice - some proposals

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Abstract

Unfortunately, the findings about the religiosity-health connection in most European countries are fragmentary and unsystematic. Therefore, all considerations of an integration of religiosity in psychotherapy must remain on a rather abstract level, and should be addressed very carefully to the specific situations in the context of different nationalities. Comprehensive information can only be found in the voluminous U.S publications, especially in the books published by the American Psychological Association. In these books, religious considerations in therapeutic practice are presented (Richards & Bergin, 2005). Further, applications to members of diverse religious traditions and communities (Richards & Bergin, 1999a) as well as specific perspectives of different psychotherapeutic traditions and approaches (Shafranske, 1996) are discussed. Utsch (2005) gives eleven examples of how to use religiosity in therapy as described by psychotherapists belonging to different therapeutic orientations and religious traditions.

Generally, it is important to keep in mind that psychology and psychotherapy are not ideologies and cannot make statements about the existence or non-existence of contents of religious beliefs (e.g. the belief in God) or about the "truth" of value systems and world views (Murken, 1997). It is not the truth of a patient's statement, but the psychological reality and meaning of this statement that is crucial in the psychotherapeutic process. Therefore, this reality should be explored and understood in the conjoint work of therapist and patient and therefore help patients to live more consciously and self-determined.

This article is based upon two longer reviews of the religiosity-health connection that will be published in German language this year (Klein & Albani, in press; Klein et al., in press).

Preconditions for therapeutic practice

Psychotherapy can never happen in a value-free manner. Therefore, it is necessary for psychotherapists to be aware of one's own cultural and ethnic traditions, value systems, beliefs and preoccupations, and to reflect their impact on one's therapeutic practice. This is especially important in the practice with religiosity in psychotherapy: Some therapeutic orientations continue to criticise religion in the tradition of enlightenment. This is the case with Freud's classic psychoanalysis as well as in the old paradigm of Behaviorism in the Cognitive-Behavioral Therapy (and is mainly a result of the anti-religious affect of the founders Freud, Watson, and Skinner; cf. Wulff, 1997). Interestingly, psychologists have been the least religious professional category (within university graduates) in the U.S. for a longer period of time (Ragan, Malony & Beit-Hallahmi, 1980) and are still less religious than most other U.S. Americans (Shafranske, 1996). It could be assumed that there has been – and maybe might still be - a tendency to criticise religion in European countries as well. The psychology of religion is still unpopular in many European countries (van Belzen, 1998; Murken, 2002), and an inquiry on a sample of 177 German university lecturers of psychology found that 59 % did not know any psychological investigation about religiosity (Petersen, 1993). Maybe this is a result of a competition for the "true" interpretation of human existence that affected the relationship between psychological theories and religiosity in times of a positivistic concept of science. But it might still happen in therapeutic relationships that a therapist holds the view that his "own" psychological theories are "orthodox" exclusive truths, and does not regard them as the scientifically plausible, yet hypothetical explanations that they are. Then a new competition against religious or other ideological beliefs arises. Disregarding that the basis for such beliefs then avoids the argumentative and communicative validation of a scientific consensus.

Thus, "orthodoxy" misinterpreted psychological theories are at risk to affect and to damage every consideration of a patient's value system. Such a overemphasis of the "own" religion-criticising perspective might be one reason for evangelical Christians being against psychotherapists (Worthington et al., 1996). On the other hand, patients' and psychotherapists' value systems often converge during their conjoint work (Beutler, Machado & Neufeldt, 1994). This is why insistence on and a disengagement from one's own beliefs, through self-examination, is so important in psychotherapy.

1. Openness and thoughtfulness:
Psychotherapists are not only at risk to prejudice patients due to their own stereotypes, but they are also at risk to regard dissenting values as pathological (if a patient would do so, this would easily be seen e.g. as defence of the fear of the strange). Respect for divergent ethnic, cultural, and ideological value systems is not a question of political correctness in the sense of social desirability, but the expression of an intrinsically motivated ethical tenor in the therapeutic practice. Instead of an – utopian – neutrality, openness and thoughtfulness (Thomä & Kächele, 1997) should be implemented. This tenor includes:

- Openness of the associative and cognitive structuring – neither preoccupied nor uninformed,
- Thoughtfulness in emotion regulation – neither seducible nor inaccessible,
- Openness in belief systems – neither partial nor faceless,
- Openness for the direction of change – neither patronising nor uninterested,
- Thoughtfulness in wielding power – neither intrusive nor unempathic.

Nevertheless, it still remains possible that (limitations) of openness are indicated within and beyond the therapy when patients act extremely ruthless against themselves or against other people (Thomä & Kächele, 1997). Here, therapists have to set boundaries until the patient is able to realise and change the biases in his value system. Thus, it can be essential to persist in a well-defined viewpoint and, if necessary, to refuse or stop a therapy. Of course, therapists should give reasons for this step. They should know about their own limitations (e.g.: Can I administer the therapy of right wing extremist patients or of somebody with religious beliefs that led him to criminal acts – e.g. killing in the name of Satan?).

2. Religious and ideological expertise:
Therapists considering to integrate religiosity in their practice should aim for a "ideological expertise" (Utsch, 2005) and "cultural competence" (Sue & Lann, 2002) including a reflected, well elaborated as well as open world-view and a specific knowledge about diverse cultural, ethnic, religious, and ideological groups and their beliefs (Murken, 2003). Otherwise, authenticity in the communication about suffering, injustice, guilt, meaning or death is nearly impossible (Utsch, 2005).

3. Knowledge about religiosity's relevance:
In-service training and information about diverse value systems and beliefs is helpful (Richards & Bergin, 1999c). A detailed overview about diverse ideological beliefs and resulting attitudes towards healing, medical care, and psychotherapy can be found in Richard's & Bergin's book (1999c; see above). Basic knowledge about contents and structures of the differing beliefs is needed especially in the treatment of highly religious patients, in particular of members of specific religious denominations (New Apostolic Church, Jehovah's Witnesses) or ideological groups (Anthroposophical Societies, Rosicrucianists) (Murken, 2003). Furthermore, therapists should know about the positive and negative interplay of religiosity and mental health when applying them as resources in healing processes or for considering them in the therapeutic process as conditions that caused or supported the disease.

4. Distinguishing between religious / ideological and therapeutic service:
A reliable therapeutic consideration of value systems has to distinguish between the scientifically elaborated therapeutic methods on the one hand and spiritual services in alternative medicine and esotericism on the other (Utsch, 2005). Generally, therapists can consider religiosity, but they are usually not religious specialists, and therefore their expertise for a religious offer is clearly limited. (Handzo & Koenig, 2004).

Diagnostic investigation of religiosity

If the preconditions described above have been considered, therapists may explore a patient's religious and/or alternative value system. The goal should be to understand how a patient's ethnic traditions and culture, his beliefs, values, and practices impact his world-view and identity. It seems to be reasonable to consider and explore a patient's religiosity explicitly (Murken, 2003). 75% of U.S. American patients want physicians to also take religious issues into consideration (King & Bushwick, 1994), and 55% of the clients frequenting U.S. American counselling institutions like to talk about their religious needs while only 18% refuse this issue (Rose, Westfeld & Ansley, 2001).

Fitchett & Handzo (1998) propose a "spiritual screening" intending to investigate patients at risk to suffer from a "spiritual crisis", and to offer spiritual help to those patients. If it seems to make sense, a comprehensive exploration should be carried out (Koenig, 2002). The inclusion of the diagnostic category "religious or spiritual problem" in the DSM-IV (V62.89, Z71.8, American Psychiatric Association, 1996) illustrates the increasing sense for this issue (Turner, Lukoff, Barnhouse & Lu, 1995).

As the most important parameters, the centrality and the characteristic contents of a patient's religiosity should be explored (Huber, 2003). The centrality determines the efficacy of religiosity in somebody's life. If religiosity is central in his life, he will probably make political, economical, or even health related decisions due to his religious beliefs. The specific contents of somebody's religious beliefs determine the direction (where) his religiosity is leading him into: The belief in a merciful and forgiving God could be an important resource for a patient while the image of a severe, punishing divine judge might strike with awe and cause depressive symptoms. Beginning with the exploration of centrality and contents, the following questions can serve as guidelines for an exploration of religiosity (Murken, 2003; Richards & Bergin, 1999c; Weber & Frick, 2002):

What are the patient's religious and ideological beliefs and values? (contents)

What is their relevance for the patient's thoughts, feelings, and acts, for his self-perception and his relationships? (centrality)

How could their relations to specific motives and needs (self esteem, reduction of fear, social integration) be understood? What are their functions?

Is this belief system healthy? How does it impact a patient's subjective theory of his illness and the actual problems and diseases?

What are the patient's experiences with members of religious groups or with the institution „church" and its' representatives? Are there religious attachment figures?

Can the religious beliefs and / or a religious community or religious specialists serve as a coping resource? Which religious interventions could be helpful and effective, which hindering?

To what extent should the patient's religious needs and interests be considered in the treatment?

These questions may help to gather information to arrange individual therapeutic contracts and treatments for a religious patient (Worthington & Sandage, 2002).
Religious people sometimes are sceptic against psychotherapy and psychotherapists, and some members of specific ethnic and religious groups do not make use

of some health services as often as the mean U.S. population (Richards & Bergin, 1999b). Given loyalty conflicts ("May I go to a "strange" psychotherapist? Shouldn't my problems be solved in my religious community?") and feelings of guilt (May I receive help from "outside"? Doesn't there need to be a "religious" solution?"), it may be easier for some patients to search for the help of a psychotherapist belonging to the same denomination and then to engage in psychotherapy (Richards & Bergin, 1999c). On the other hand anticipated compliance can abet problematic processes of identification, e.g. if understanding and compliance are only taken for granted, but do not really exist – with the result that important issues are not addressed. Wrong identifications can cause compunctions, patients and therapists might avoid conflicts, confrontations and aggressive emotions. The therapeutic process could then be affected by misdirected respect and harmony.

Religiosity in psychotherapeutic treatment

1. Explicit integration of religious beliefs and religious services in psychotherapy:
Psychotherapists sometimes feel threatened, attacked or devaluated if patients make use of alternative (religious or non-religious) helping services due to their own value systems (pastoral caregivers and counsellors, alternative practitioners, traditional healers, etc.). Competition and rivalry in transference mechanisms and the defence of conflicts in therapeutic relationships can be reflected in such constellations, but they have to be distinguished from a patient's autonomous attitudes and behaviours. At the best, the external resources and coping strategies can be integrated in the therapy, potentially in a direct cooperation. Richards & Bergin (2005) report on conjoint prayers, meditations, Scripture readings, rituals of repenting and blessing, and co-operations with clergymen and patient's religious communities as helpful interventions for patients wanting their religiosity explicitly being integrated in the psychotherapeutic treatment. To date, there are some programs for concrete interventions integrating a spiritual dimension, e.g. in oncology (Cole & Pargament, 1999; Cunningham et al., 2000).

2. Problems – resistance, transference and counter-transference:
Particularly value systems of personal importance can be used for pseudo-disputes serving resistance tendencies and defence of menacing conflicts. E.g., a patient may argue that his faith is very important for him but the therapist does not understand (his) faith at all. Thus, a private domain which the patient wants to protect is marked – leaving the therapist outside of this sphere. Maybe this is the expression of an aggressive defence of a conscious anxiety of being influenced by the therapist's non-religious value system - which could be the anxiety of a lacking control in the therapeutic relationship on the unconscious level. Separation and narcissistic stabilisation might then be the result.

Spero (1984) refers to the danger of disturbing transference and counter-transference processes, in particular when religiosity has a neurotic connotation for the patient, but a non-neurotic for the therapist. Spero makes proposals for religious therapists how to deal with counter-transference in psychodynamic treatment. These proposals can analogically be adapted by non-religious therapists as well. Therapists should:

- understand patients' normal and neurotic needs concerning religious beliefs and practices. Therapists should explore corresponding attitudes, e.g. the image of God and parallels to earlier parental figures (cf. Rizzuto, 1979; Thierfelder, 1998), attitudes about this life and the hereafter, and religious beliefs about coping with experiences of loss and death (cf. Dörr, 2001; Pargament, 1997).
- diagnose neurotic and immature forms of religious faith which are expressions of conflicts; distinguishing this faith from a "mature" faith which is adaptive and free from pathological impact – Lovinger (1996) postulates the following criteria of a mature faith (according to the perspective of psychotherapy; thus valuing, too (!)):
  - a sense of the religious diversity and its' contraries, ambiguity tolerance
  - personal decision for a religious membership (this includes the personal decision for staying in the community one was "born" into)
  - agreement of word and deed, of beliefs, values, and real behaviour
  - a sense and acknowledgement of one's own weaknesses and boundaries
  - respect to the religious attachments of other people
- see and analyse their own world-view from these two different angles, and recognise similarities and differences to a patient's world-views.
- be aware of the boundaries in the agreement with patients, e.g. in the differentiation whether religious beliefs are used for defence, are bondages or restrictions for the patient, or are goals which to achieve a patient will need the therapist's help.
- know about their own impulse to offer their own religious or ideological beliefs as solutions to the patient's problems. The focus of symptomatic treatment should be to understand how religious beliefs cause or abide neurotic conflicts.
- agreement in religious questions should not lead to more or less esteem. Counter-transference biases should be distinguished from religious demands for brotherly love.

3. Personal information about therapists' own religiosity:
Koenig (1994; 2002) explicitly speaks out on the therapeutic strategy if patients ask about the therapist's personal beliefs: therapists should contain their own beliefs until the importance of these issues for the patient is clearer because it only then is possible to give an adequate answer appropriate to the patients needs. Such personal information should be made with the hint that the therapist himself is searching for more mature beliefs and does not know the ultimate truth.

For highly religious patients, personal information of therapists concerning religious issues (e.g. an advance information in writing for patients about the therapist's religious values) seems to involve more positive expectations for the therapy (Worthington & Sandage, 2002). But Worthington & Sandage point out that – for such patients – important differences between the therapist's and the patient's values and beliefs can become problematical because the patients might bowdlerise their statements with regard to the therapist's position. Personal information is hindering, too, if pa-

tients have very negative stereotypes of religious people, because religious issues could be overemphasised in the therapeutic sessions while other issues are neglected. But it can be assumed that therapists in many European contexts would rather give personal information regarding a "scientific" world-view which could also be on the risk of trying to convince a patient of the truth of the therapist's own "scientific" value system. This would hold the ideological dispute dear in a way usually not indicated in therapy.

4. Exchange of information and supervision:
Richards & Bergins (1999c) called for supervision in the treatment of patients belonging to specific religious groups and in treatment using religious interventions, for mutual respect, openness and for communication between representatives of psychotherapy organisations and religious denominations. Furthermore, Shafranske & Malony (1996) demanded a specific therapeutic training concerning religious issues. The author absolutely agrees to these calls, even more for the European situation.

5. Restriction on the therapeutic job:
Giving transcendent meaning to life is not the job of psychotherapy – psychotherapy can only help patients to search seriously and with responsibility for such a meaning, e.g. if psychotherapy gives help to identify the individuals' religious or ideological questions at stake (Radebold, 2005). Searching for transcendent meaning can mislead to ask for the ultimate meaning of one's former life or for the point to one's life in the future, but to neglect present conflicts and transference problems. Here again a critical examination of a therapist's own position is necessary: Is the therapist's interest for existential questions a result of his own threat and / or catastrophic experiences?

Restriction on the therapeutic job also includes the observation of the "exclusion of transcendence" (Flournoy, 1903; Wulff, 1997) in the therapeutic treatment. Whether – and if yes: how – God or another transcendent power does impact the therapeutic process is unanswerable by methods of scientific knowledge. In respect of questions about religious truth therapists can only be dialogue partners in the conversation about faith or religious and spiritual quest.

At the end, a very sensible consideration and a very careful assessment of value systems (whether religious or not) in psychotherapeutic relationships should be emphasised. Disputes about the role of religiosity and value systems in therapy last since the days of Sigmund Freud (Bergin, 1980; 1985; Ellis, 1980) and affect the situation until today (e.g. Koenig et al., 2000; Sloan et al., 2000). The own value systems impact the positions which is inevitable in therapeutic relationships, too. But in a time of growing variety and relevance of religiosity, although sometimes only present in implicit forms (Schnell, 2004), a particular thoughtfulness is needed. The fragmentary research does not facilitate this job. Therefore, a comprehensive and integrative psychological and psychotherapeutic consideration of the diverse forms of religiosity and world-views is a challenge of high priority for the future.

Constantin Klein
kleinc@rz.uni-leipzig.de

Literature

1. Bergin, A. E. (1980). Psychotherapy and religious Values. Journal of Consulting and Clinical Psychology, 48, pp. 75-105.
2. Bergin, A. E. (1985). Proposed Values for Guiding and Evaluating Counseling and Psychotherapy. Counseling and Values, 29, pp. 99-116.
3. Beutler, L., Machado, P. P. & Neufeldt, S. A. (1994). Therapist Variables. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change (5 ed., pp. 229-269). New York: John Wiley & Sons.
4. Cole, B. & Pargament, K. (1999). Re-creating your Life: a spiritual/psychotherapeutic Intervention for People diagnosed with Cancer. Psycho-Oncology, 8, pp. 395-407.
5. Cunningham, A., Edmonds, C., Phillips, C., Scoots, K., Hedley, D. & Lockwood, G. (2000). A prospective, longitudinal Study of the Relationship of psychological Work to Duration of Survival in Patients with metastatic Cancer. Psycho-Oncology, 9, pp. 323-339.
6. Dörr, A. (2001). Religiosität und psychische Gesundheit. Zur Zusammenhangsstruktur spezifischer religiöser Konzepte. Hamburg: Kovac.
7. Ellis, A. (1980). Psychotherapy and atheistic Values: A Response to Bergin. Journal of Consulting and Clinical Psychology, 48, pp. 635-639.
8. Fitchett, G. & Handzo, G. (1998). Spiritual Assessment, Screening and Intervention. In J. Holland (Ed.), Psycho-Oncology. (pp. 790-808). New York: Oxford University Press.
9. Flournoy, T. (1903). Les principles de la psychologie religieuse. Archives de Psychologie, 2, pp. 33-57.
10. Handzo, G. & Koenig, H. G. (2004). Spiritual Care: whose Job is it anyway? Southern Medical Journal, 97, pp. 1242-1244.
11. Huber, S. (2003). Zentralität und Inhalt. Ein neues multidimensionales Messinstrument der Religiosität. Opladen: Leske & Budrich.
12. King, D. & Bushwick, B. (1994). Beliefs and Attitudes of hospital Patients about Faith Healing and Prayer. The Journal of Family Practice, 39, pp. 349-352.
13. Klein, C. & Albani, C. (in press). Religiosität und psychische Gesundheit. Eine Übersicht über Befunde, Erklärungsansätze und Konsequenzen für die klinische Praxis. Psychiatrische Praxis, 33.
14. Klein, C., Brähler, E., Decker, O., Blaser, G. & Albani, C. (in presss). Religiosität und Spiritualität – Wertsysteme im Kontext therapeutischer Beziehung. In M. Hermer & B. Röhrle (Hrsg.), Handbuch der therapeutischen Beziehung. Beziehungsgestaltung, Bündnisprobleme, Kontexte. Tübingen: DGVT-Verlag.
15. Koenig, H. G. (1994). Aging and God: Spiritual pathways to mental Health in midlife and later years. New York: Haworth.
16. Koenig, H. G. (2002). Spirituality in Patient Care: Why, How, When and What. Templeton: Foundation Press.
17. Koenig, H. G., Nicklin, D. E., Kaufman, A. S., Hite, R. W., Cameron, J. R., Hall, D. E., et al. (2000). Medicine and Religion (correspondence). New England Journal of Medicine, 343, pp. 1339-1342.
18. Lovinger, R. J. (1996). Considering the religious Dimension in Assessment and Treatment. In E. A. Shafranske (Ed.), Religion and the clinical Practice of Psychology (pp. 327-364). Washington: APA.
19. Murken, S. (1997). Ungesunde Religiosität - Entscheidungen der Psycholo-

gie? In G. M. Klinkhammer, S. Rink & T. Frick (Hrsg.), Kritik an Religionen. Religionswissenschaft und der kritische Umgang mit Religionen (pp. 157-172). Marburg: Diagonal.
20. Murken, S. (2002). Religionspsychologie in Deutschland. Eine Bestandsaufnahme. Wege zum Menschen, 54, pp. 185-196.
21. Murken, S. (2003). Die Bedeutung von Religiosität und Spiritualität für die Behandlung von Patienten in der psychosomatischen Rehabilitation. In S. Murken, H. Rüddel & U. Laux (Hrsg.), Spiritualität in der Psychosomatik. Konzepte und Konflikte zwischen Psychotherapie und Seelsorge. CD-ROM Dokumentation der Tagung am 21./22. September 2003 in Bad Kreuznach: http://www.psychology-of-relgion.de/deutsch/aktuelles/cd_f.htm.
22. Pargament, K. I. (1997). The Psychology of Religion and Coping. Theory, Research, Practice. New York: Guilford.
23. Petersen, K. (1993). Persönliche Gottesvorstellungen. Empirische Untersuchungen. Entwicklung eines Klärungsverfahrens. Ammersbek: Verlag an der Lottbek.
24. Radebold, H. (2005). Förderung von Kreativität und Spiritualität - eine Aufgabe der Psychotherapie Älterer ? In P. Bäurle, H. Förstl, D. Hell, H. Radebold, I. Riedel & K. Studer (Hrsg.), Spiritualität und Kreativität in der Psychotherapie mit älteren Menschen (pp. 305-312). Bern: Huber Verlag.
25. Ragan, C. P., Malony, N. H. & Beit-Hallahmi, B. (1980). Psychologists and religion: Professional factors and personal belief. Review of Religious Research, 21, pp. 208-217.
26. Richards, S. P. & Bergin, A. (Eds.) (1999a). Handbook of Psychotherapy and Religious Diversity. Washington: American Psychological Association.
27. Richards, S. P. & Bergin, A. (1999b). Religious Diversity and Psychotherapy: Conclusions, Recommendations, and Future Directions. In S. P. Richards & A. Bergin (Eds.), Handbook of Psychotherapy and Religious Diversity (pp. 469-489). Washington: American Psychological Association.
28. Richards, S. P. & Bergin, A. (1999c). Toward Religious and Spiritual Competency for Mental Health Professionals. In S. P. Richards & A. Bergin (Eds.), Handbook of Psychotherapy and Religious Diversity (pp. 3-26). Washington: American Psychological Association.
29. Richards, S. P. & Bergin, A. (2005). A Spiritual Strategy for Counseling and Psychotherapy. Washington: American Psychological Association.
30. Rizzuto, A.-M. (1979). The Birth of the living God. A psychoanalytic Study. Chicago: University of Chicago Press.
31. Rose, E. M., Westfeld, J. S. & Ansley, T. N. (2001). Spiritual Issues in Counseling: Clients beliefs and Preferences. Journal of Counseling Psychology, 48, pp. 61-71.
32. Schnell, T. (2004). Implizite Religiosität. Zur Psychologie des Lebenssinns. Lengerich: Pabst.
33. Shafranske, E. P. (Ed.) (1996). Religion and the clinical Practice of Psychology. Washington: American Psychological Association.
34. Shafranske, E. P. & Malony, H. N. (1996). Religion and the clinical Practice of Psychology: a Case for Inclusion. In E. P. Shafranske (Ed.), Religion and the clinical Practice of Psychology (pp. 561-586). Washington: American Psychological Association.
35. Sloan, R. P., Bagiella, E., VandeCreek, L., Hover, M., Casalone, C., Hirsch, T., et al. (2000). Should Physicians Prescribe Religious Activities? The New England Journal of Medicine, 342, pp. 1913-1916.
36. Spero, M. (1984). Psychotherapy of the religious Patient. Springfield: Charles C. Thomas Publishing Ltd.
37. Sue, S. & Lann, A. G. (2002). Cultural and demografic Diversity. In J. C. Norcross (Ed.), Psychotherapy Relationships that work. Therapist Contributions and Responsiveness to Patients (pp. 401-422). New York: Oxford University Press.
38. Thierfelder, C. (1998). Gottes-Repräsentanz. Kritische Interpretation des religionspsychologischen Ansatzes von Ana-Maria Rizzuto. Stuttgart: Kohlhammer.
39. Thomä, H. & Kächele, H. (1997). Lehrbuch der psychoanalytischen Therapie. Band 2: Praxis (2. Aufl.). Berlin, Heidelberg, New York, Paris, London, Tokyo: Springer.
40. Turner, R. P., Lukoff, D., Barnhouse, R. T. & Lu, F. G. (1995). Religious or spiritual Problem. A culturally sensitive diagnostic Category in the DSM-IV. Journal of Nervous and Mental Disease, 183, pp. 435-444.
41. Utsch, M. (2005). Religiöse Fragen in der Psychotherapie. Psychologische Zugänge zu Religiosität und Spiritualität. Stuttgart: Kohlhammer.
42. van Belzen, J.A. (1998). Errungenschaften, Desiderata, Perspektiven – Zur Lage der religions-psychologischen Forschung in Europa, 1970-1995. In C. Henning & E. Nestler (Hrsg.), Religion und Religiosität zwischen Theologie und Psychologie (pp. 131-158), Frankfurt/M.: Peter Lang.
43. Weber, S. & Frick, E. (2002). Zur Bedeutung der Spiritualität von Patienten und Betreuern in der Onkologie. In T. München (Hrsg.), Manual Psychoonkologie (pp. 106-109). München: Zuckschwerdt.
44. Worthington, E. L., Kurusu, T. A. & McCullough, M. E. (1996). Empirical Research on Religion and psychotherapeutic Processes and Outcomes: A 10-year Review and research Prospectus. Psychological Bulletin, 119, pp. 448-487.
45. Worthington, E. L. & Sandage, S. J. (2002). Religion and Spirituality. In J. C. Norcross (Ed.), Psychotherapy relationships that work. Therapist contributions and responsiveness to patients (pp. 383-400). New York: Oxford University Press.
46. Wulff, D. M. (1997). Psychology of Religion. Classic and contemporary (2 ed.). New York: Wiley.

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Editorial board: René Hefti, Franz Fischer, Maria Teschner.

Research Institute for Spirituality and Health
Weissensteinstrasse 30
CH-4900 Langenthal
Switzerland
Tel. +41 (62) 919 22 11
Fax +41 (62) 919 22 00
info@rish.ch
www.rish.ch