WPA Position Statement on Religion and Spirituality: Research and Clinical implications

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WORLD PSYCHIATRIC ASSOCIATION
Section on Religion, Spirituality and Psychiatry
Advance Psychiatry and Mental Health Across the World

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World Psychiatry
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15: 87-88; 2016

WPA News | Free Access

WPA Position Statement on Spirituality and Religion in Psychiatry

Alexander Moreira-Almeida, Avdesh Sharma, Bernard Janse van Rensburg, Peter J. Verhagen, Christopher C.H. Cook

POSICIONAMENTO DA ASSOCIAÇÃO MUNDIAL DE PSIQUIATRIA SOBRE ESPIRITUALIDADE E RELIGIOSIDADE EM PSIQUIATRIA*

revista debates em **psiquiatria** - Mar/Abr 2018

DECLARATION POSITION DE L'ASSOCIATION MONDIALE DE PSYCHIATRIE SUR SPIRITUALITÉ LA RELIGION EN PSYCHIATRIE

Section de l'Association mondiale de psychiatrie sur la religion, la spiritualité et la psychiatrie

Declaración de la posición de la WPA sobre la espiritualidad y la religión en la psiquiatría

Actas Esp Psiquiatr 2018;46(6):242-8

VERTALING VAN HET WPA POSITION STATEMENT OVER SPIRITUALITEIT EN RELIGIE IN DE PSYCHIATRIE

بيان موقف الجمعية العالمية للطب النفسي حول الروحانيات والدين في الطب النفسي

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WPA Position Statement on Spirituality and Religion in Psychiatry

WPA Section on Religion, Spirituality and Psychiatry

The World Psychiatric Association (WPA) and the World Health Organization (WHO) have worked hard to assure that comprehensive mental health promotion and care are scientifically based and, at the same time, compassionate and culturally sensitive[1,2]. In recent decades, there has been increasing public and academic awareness of the relevance of spirituality and religion to health issues. Systematic reviews of the academic literature have identified more than 3,000 empirical studies investigating the relationship between religion/spirituality (R/S) and health[3,4].

World Psychiatry 15 (1):87-8, 2016

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In the field of mental disorders, it has been shown that R/S have significant implications for prevalence (especially depressive and substance use disorders), diagnosis (e.g., differentiation between spiritual experiences and mental disorders), treatment (e.g., help seeking behavior, compliance, mindfulness, complementary therapies), outcomes (e.g., recovering and suicide) and prevention, as well as for quality of life and wellbeing[3,4]. The WHO has now included R/S as a dimension of quality of life[5]. Although there is evidence to show that R/S are usually associated with better health outcomes, they may also cause harm (e.g., treatment refusal, intolerance, negative religious coping, etc.). Surveys have shown that R/S values, beliefs and practices remain relevant to most of the world population and that patients would like to have their R/S concerns addressed in healthcare[6-8].

World Psychiatry 15 (1):87-8, 2016

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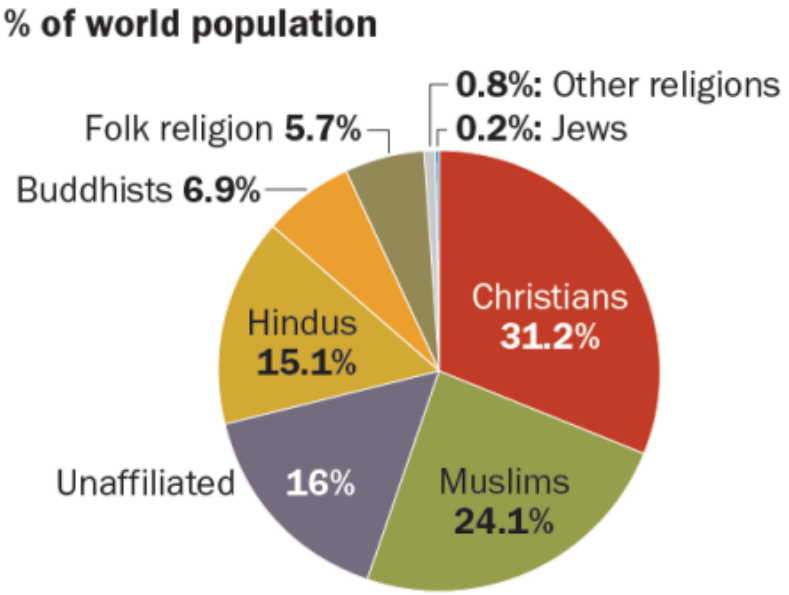
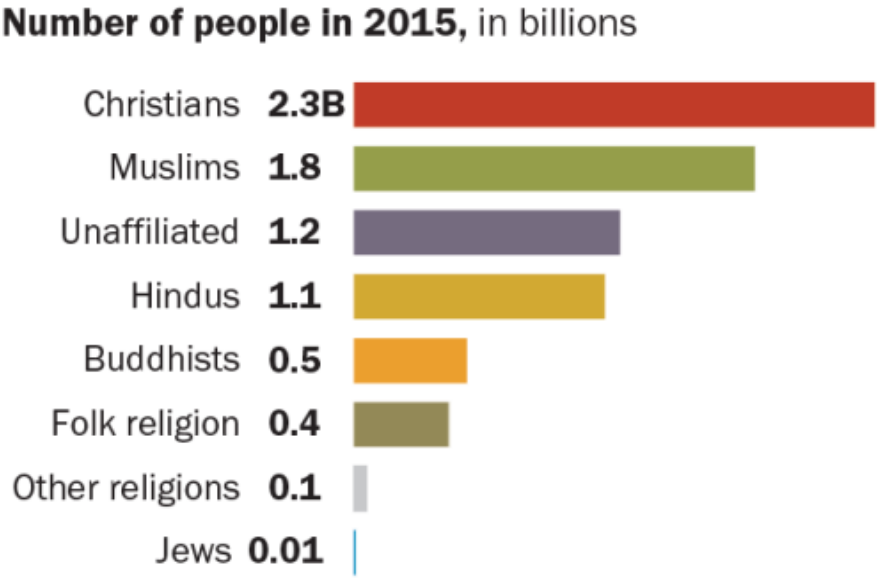
The Global Religious Landscape

PewResearchCenter

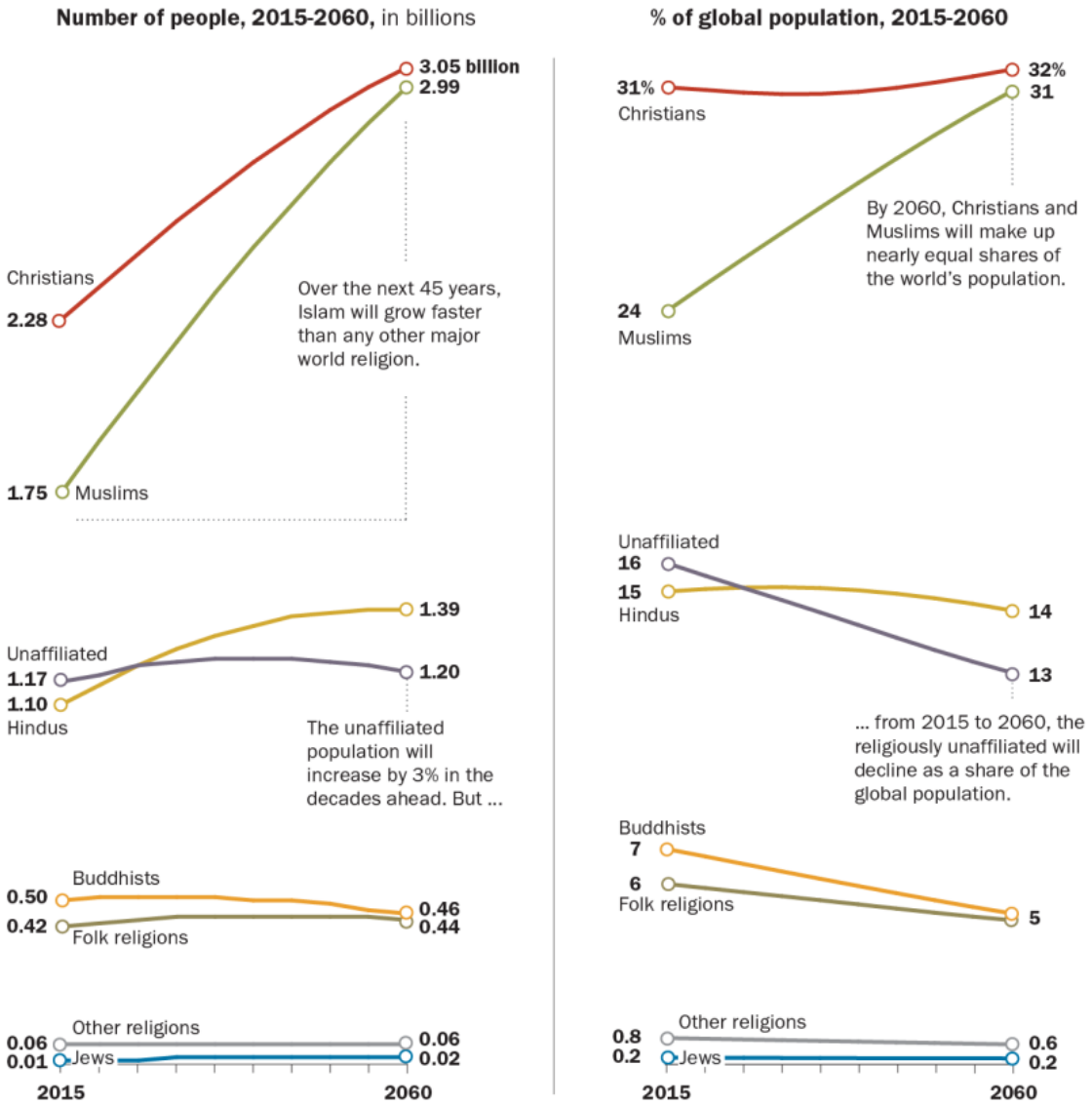
- >6 bi religiously affiliated
- 84% world population





Projected change in global population, 2015-2060

Most major religious groups are expected to increase in number by 2060. But some will not keep pace with global population growth, and, as a result, are expected to make up a smaller percentage of the world's population in 2060 than they did in 2015.



Source: Pew Research Center demographic projections. See Methodology for details.
"The Changing Global Religious Landscape"

PEW RESEARCH CENTER

Journal of Religion and Health (2019) 58:1217–1234
https://doi.org/10.1007/s10943-018-0723-y

ORIGINAL PAPER

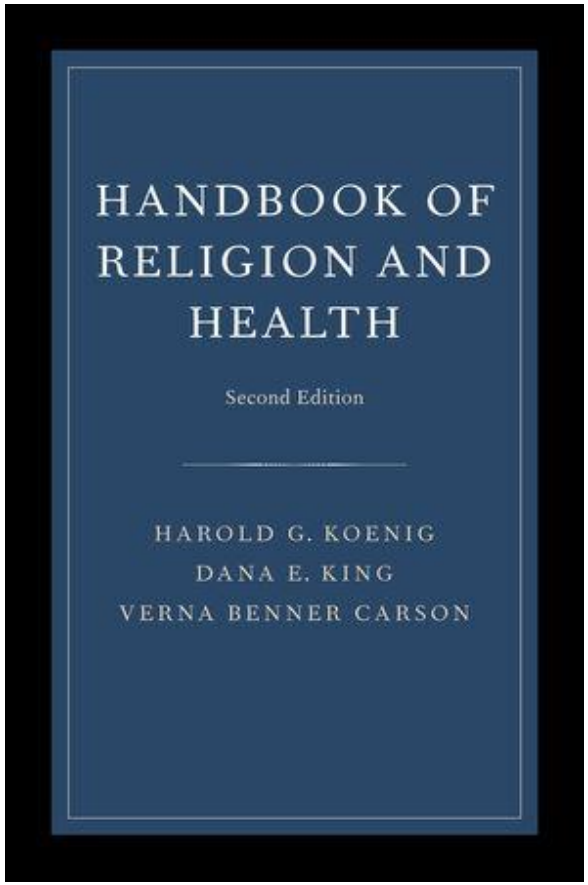
Who Does Believe in life After Death? Brazilian Data from Clinical and Non-clinical Samples

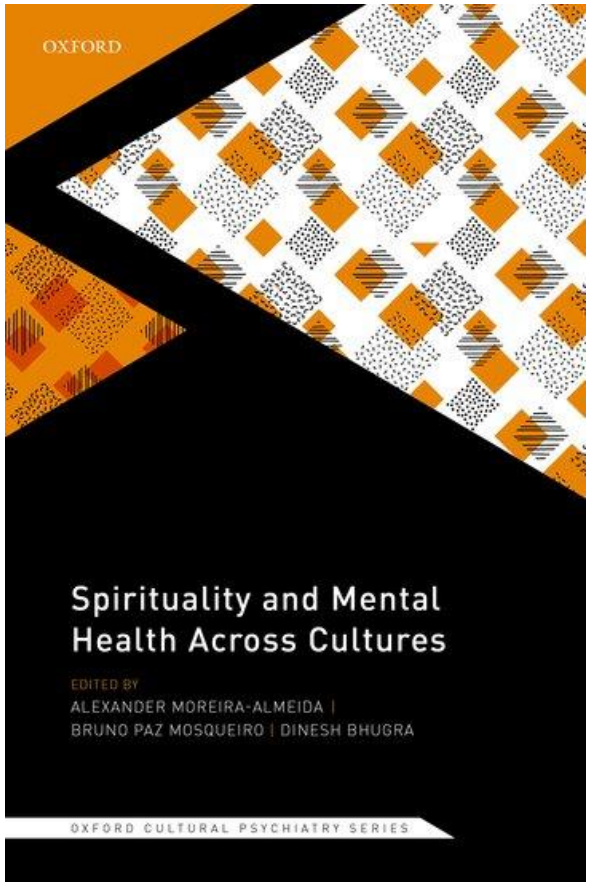
Cristiane Schumann Silva Curcio[1] · Alexander Moreira-Almeida[1]

"To believe that something of us remains after the death of physical body"	Odds ratio (95% CI)
To believe in something beyond matter	**8.3 (3.2–21.4)**
Educational level	
None	
Elementary school	1.4 (0.6–3.05)
High school	**2.8 (1.2–6.5)**
Graduation or more	**4.2 (1.6–11.2)**

Relevance

- Tousands of empirical studies on S/R and health

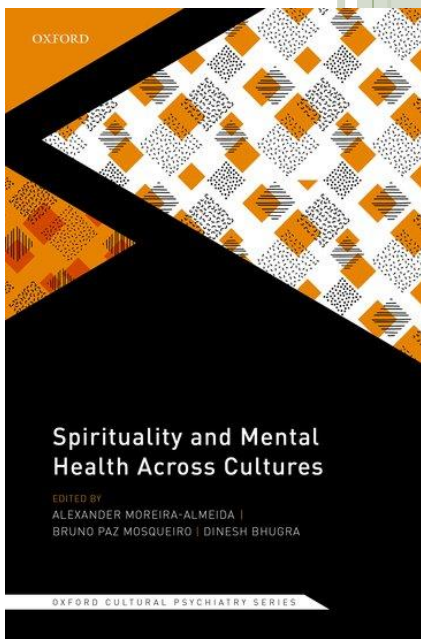




Have any impact on mental health?

- ↑ R/S mostly associated with:
  - ↓ General mortality
  - ↓ Depression
  - ↓ Suicidal behavior
  - ↓ Substance use/abuse
  - ↑ Quality of life, wellbeing and human flourishing

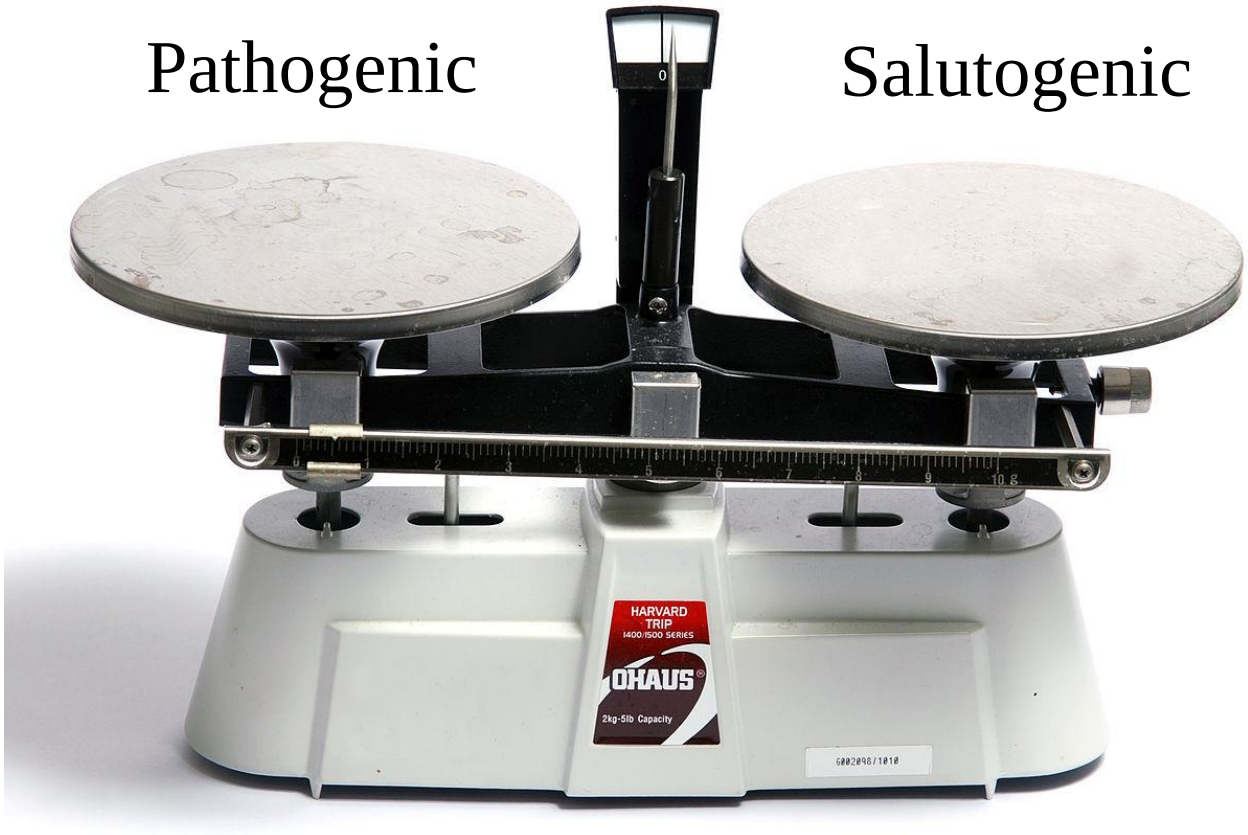
- Negative impacts
  - Negative religious coping
  - Extrinsic religiosity
  - Conflicts about treatments



BIO-PSYCHO-SOCIO-SPIRITUAL APPROACH

Pathogenic

Salutogenic



BIPOLAR DISORDERS
AN INTERNATIONAL JOURNAL OF PSYCHIATRY AND NEUROSCIENCES

Bipolar Disord 2013: 15: 385–393

BIPOLAR DISORDEI

Original Article

Religiosity, mood symptoms, and quality of life in bipolar disorder

Religious disagreement toward the treatment, n (%)	50 (30.7)
Interference in the treatment by the religious leader, n (%)	38 (23.3)

Table 3. Multivariate analyses of the relationship between religious involvement items and quality of life domains, controlling for sociodemographics[a]

		Quality of life (beta standardized)			
Coordinate axes	N	Physical (p-value)	Psychological (p-value)	Social (p-value)	Environment (p-value)
Organizational religiousness	163	0.100 (0.231)	0.124 (0.126)	−0.038 (0.653)	0.010 (0.904)
Private religiousness	163	−0.006 (0.942)	0.134 (0.096)	0.025 (0.765)	0.114 (0.155)
Intrinsic religiousness	163	**0.224 (0.009)**	**0.365 (0.000)**	**0.241 (0.005)**	**0.314 (0.000)**
Positive religious coping	161	0.164 (0.051)	**0.216 (0.002)**	0.127 (0.131)	**0.178 (0.028)**
Negative religious coping	161	−0.123 (0.141)	**−0.182 (0.025)**	−0.134 (0.110)	−0.097 (0.229)

	n (%)	Depression OR (CI)
Organizational religiousness		
Low	59	1
High	108 (64.7)	0.67 (0.29–1.51) p = 0.33
Private religiousness		
Low	33	1
High	134 (80.2)	0.85 (0.32–2.24) p = 0.74
Intrinsic religiousness		
Low	27	**1**
High	140 (83.8)	**0.19 (0.06–0.57) p = 0.003**
Positive religious coping		
Low	31	**1**
High	133 (81.1)	**0.25 (0.09–0.71) p = 0.01**
Negative religious coping		
Low	135 (82.3)	1
High	29	2.36 (0.82–6.80) p = 0.11
Religious affiliation		
Catholic	90 (53.6)	**1**
Evangelical	48 (28.6)	1.27 (0.50–3.23) p = 0.61
Other	10 (6.0)	—
None	20 (11.9)	**4.21 (1.22–14.52) p = 0.023**

Religiosity, depression, and quality of life in bipolar disorder: a two-year prospective study

André Stroppa,[1] Fernando A. Colugnati,[2] Harold G. Koenig,[3,4] Alexander Moreira-Almeida[1]

Table 2 Effect of religious characteristics at T1 on QoL and clinical outcomes at 2-year follow-up (T2) (n=158)

Religious characteristics	Mania		Physical QoL		Mental QoL		Social QoL		Environmental QoL	
	Beta	95%CI	Beta	95%CI	Beta	95%CI	Beta	95%CI	Beta	95%CI
Organizational religiosity	-0.30	-1.40 to 0.80	1.40	-4.75 to 7.55	2.30	-3.64 to 9.63	-0.60	-7.66 to 6.45	3.10	-2.10 to 8.31
Private religiosity	-0.21	-1.37 to 0.96	-0.16	-6.79 to 6.46	0.87	-6.29 to 8.04	-1.20	-8.80 to 6.39	-0.70	-6.31 to 4.95
Intrinsic religiosity	0.61	-2.53 to 3.74	3.01	-5.18 to 11.20	7.78	-1.00 to 16.56	5.99	-3.36 to 15.34	**9.56**	**2.76 to 16.36**
Positive religious coping	0.54	-0.60 to 1.69	**10.17**	**4.22 to 16.11**	**13.41**	**7.10 to 19.73**	**10.46**	**3.60 to 17.33**	**11.15**	**6.22 to 16.07**
Negative religious coping	**4.09**	**0.63 to 7.54**	-21.10	-43.31 to 1.10	**-28.10**	**-51.96 to -4.22**	-25.35	-50.78 to 0.07	**-20.45**	**-39.26** to **-1.64**
Disagreement of leader	-0.09	-1.24 to 1.06	-2.12	-8.93 to 4.70	0.28	-7.09 to 7.66	-0.01	-7.88 to 7.76	0.24	-5.55 to 6.04
Interference in treatment	-0.29	-1.49 to 0.91	-1.05	-6.30 to 8.41	1.99	-5.95 to 9.94	2.22	-6.20 to 10.64	1.22	-5.02 to 7.47
Religious affiliation*										
Evangelical Christian	-0.47	-1.70 to 0.76	-0.72	-7.72 to 6.28	-1.14	-8.69 to 6.41	-2.28	-10.31 to 5.75	-2.07	-7.95 to 3.82
Other	2.14	-0.24 to 4.52	-9.73	-24.09 to 4.62	-13.58	-29.07 to 1.91	-16.61	-33.08 to -0.12	**-15.13**	**-27.20** to **-3.06**
None	-1.18	-2.99 to 0.63	-9.07	-19.21 to 1.07	-9.21	-20.15 to 1.74	-1.87	-13.52 to 9.76	-7.07	-15.60 to 1.46

Revista Brasileira de Psiquiatria. 2018;40:238–243
Brazilian Journal of Psychiatry

Religion as a protective factor against drug use among Brazilian university students: a national survey

Fernanda Carolina Gomes,[1] Arthur Guerra de Andrade,[1,2,3] Rafael Izbicki,[4] Alexander Moreira-Almeida,[5] Lúcio Garcia de Oliveira[1,2]

Rev Bras Psiquiatr. 2013;35:029-037

Table 5 Multivariate regression analysis for consumption of alcohol, tobacco, marijuana and at least one illicit drug (other than marijuana) in the last 30 days among Brazilian university students.

	Alcohol (n = 11,907)			Tobacco (n = 12,145)			Marijuana (n = 12,060)			Other drugs (n = 11,603)		
	OR	CI 95%	p-value	OR	CI 95%	p-value	OR	CI 95%	p-value	OR	CI 95%	p-value
Religion												
FR	1.00	-	-	1.00	-	-	1.00	-	-	1.00	-	-
NFR	2.52	2.08-3.06	< 0.001	2.83	2.09-3.83	< 0.001	2.09	1.39-3.14	< 0.001	1.42	1.12-1.79	< 0.01

Association between religiosity and happiness in patients with chronic kidney disease on hemodialysis

Authors
Janaína Siqueira[1]
Natália Maria Fernandes[1]
Alexander Moreira-Almeida[1]

Table 2 Linear regression between religiosity and sense of coherence with happiness (adjusted for clinical and laboratory variables)

	Variable	BETA Coefficient	95% Confidence Interval	*p*
Model 1	Organizational religiosity	0.42	-0.11 to 0.95	0.11
Model 2	Private religiosity	**0.53**	0.01 to 1.06	**0.04**
Model 3	Intrinsic religiosity	**0.48**	0.18 to 0.79	**0.002**
Model 4	Sense of coherence	**0.11**	0.09 to 0.15	**< 0.0001**

Adjusted for: age, gender, education, comorbidity, dialysis time (years) and hemoglobin (g/dL), Kt/V (adequacy index in dialysis), and PTH (parathyroid hormone-pg/mL) Statistically significant results ($p < 0.05$) are in bold.

Braz. J. Nephrol. (J. Bras. Nefrol.) 2019;41(1):22-28

The effect of religiosity during childhood and adolescence on drug consumption patterns in adults addicted to crack cocaine

Alexandre Rezende-Pinto, Alexander Moreira-Almeida, Marcelo Ribeiro, Ronaldo Laranjeira and Homero Vallada

$N = 531$

Table 3 Logistic regression between religious history and severity of crack cocaine consumption

Variable (total scores)	Age at onset (before 18 years), odds ratio (95% CI)	Greatest consumption (>10 crack cocaine rocks), odds ratio (95% CI)	Total craving (CCQ-Brief score >28), odds ratio (95% CI)
Global religious history, first × fourth quartile	**0.50 (0.28–0.90)**	0.67 (0.36–1.25)	0.52 (0.26–1.06)
Religious history (frequency and participation) at 8–11 years of age, first × fourth quartile	**0.56 (0.32–0.98)**	0.91 (0.48–1.69)	0.81 (0.43–1.52)
Religious history (frequency and participation) at 12–14 years of age, first × fourth quartile	0.65 (0.38–1.11)	0.81 (0.45–1.48)	**0.42 (0.21–0.84)**
Religious history (frequency and participation) at 15–17 years of age, first × fourth quartile	**0.53 (0.32–0.88)**	**0.46 (0.27–0.76)**	**0.50 (0.26–0.98)**
Global religious frequency, first × fourth quartile	**0.30 (0.16–0.56)**	**0.48 (0.26–0.88)**	0.64 (0.31–1.32)
Global religious participation, first × fourth quartile	0.77 (0.46–1.30)	1.12 (0.66–1.90)	**0.42 (0.22–0.79)**

BJPsych open | BJPsych Open (2018) 4, 324–331. doi: 10.1192/bjo.2018.25

WPA Position Statement on Spirituality and Religion in Psychiatry

WPA Section on Religion, Spirituality and Psychiatry

Both terms, religion and spirituality, lack a universally agreed definition. Definitions of spirituality usually refer to a dimension of human experience related to the transcendent, the sacred, or to ultimate reality. Spirituality is closely related to values, meaning and purpose in life. Spirituality may develop individually or in communities and traditions. Religion is often seen as the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group[3,8].

World Psychiatry 15 (1):87-8, 2016

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WPA Position Statement on Spirituality and Religion in Psychiatry

WPA Section on Religion, Spirituality and Psychiatry

Regardless of precise definitions, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders and the patient's attitude toward illness should therefore be central to clinical and academic psychiatry.

1. A tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking.

World Psychiatry 15 (1):87-8, 2016

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A preliminary survey on the religious profile of Brazilian psychiatrists and their approach to patients' religiosity in clinical practice

Maria Cecilia Menegatti-Chequini, Juliane P.B. Gonçalves, Frederico C. Leão, Mario F.P. Peres* and Homero Vallada*

Attitudes regarding religion/spirituality in clinical practice	Total *n*= 484 (%)
Do you consider it important to integrate patient's religion/spirituality in clinical practice?	371 (76.8)[b]
Barriers to address religion/spirituality with patient:[c]	
None	195 (40.3)
Fear of exceeding the role of the doctor	146 (30.2)
Lack of training	108 (22.3)
Lack of time	79 (16.3)
Do you consider it important that the issues of religion/spirituality are included in medical training?	340 (71.1)[b]
How often do you enquire about patients' religious/spiritual issues?	
Frequently	220 (45.5)
Occasionally	168 (34.8)
Rarely	67 (13.9)
Never	28 (5.8)

BJPsych Open (2016)
2, 346–352. doi: 10.1192/bjpo.bp.116.002816

Barriers to integrate R/S in clinical practice

Table 3 Attitudes regarding religion/spirituality in clinical practice of Brazilian psychiatrists (statistical analysis of the respondents from a total number of 484 participants)

	Religious affiliation			
Attitudes regarding religion/spirituality in clinical practice	Total *n*= 484 (%)	Without *n*=158 (%)	With *n*=326 (%)	Adj. OR[a] (95% CI)
Do you consider it important to integrate patient's religion/spirituality in clinical practice?	371 (76.8)[b]	91 (57.6)	280 (86.1)	4.33 (2.75–6.81)*
Barriers to address religion/spirituality with patient:[c]				
None	195 (40.3)	81 (51.3)	114 (35.0)	0.47 (0.32–0.70)*[d]
Fear of exceeding the role of the doctor	146 (30.2)	27 (17.1)	119 (36.5)	2.82 (1.75–4.54)*[d]
Lack of training	108 (22.3)	25 (15.8)	83 (25.5)	1.91 (1.15–3.17)*[d]
Lack of time	79 (16.3)	21 (13.3)	58 (17.8)	1.46 (0.84–2.53)[d]
Do you consider it important that the issues of religion/spirituality are included in medical training?	340 (71.1)[b]	80 (51.3)	260 (80.7)	4.14 (2.69–6.36)*[d]

BJPsych Open (2016)
2, 346–352. doi: 10.1192/bjpo.bp.116.002816

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

Fabrício H.A. **de Oliveira e Oliveira**,[1] John R. **Peteet**,[2,3,4] Alexander **Moreira-Almeida**[1]

Braz J Psychiatry. 2021 Jul-Aug;43(4):424-429

Box 1 Core religion and spirituality curriculum for psychiatry residency programs

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

Taking Spiritual History in Clinical Practice: A Systematic Review of Instruments

Giancarlo Lucchetti, MD,[1,2,3#] Rodrigo M. Bassi, MD,[2] and Alessandra L. Granero Lucchetti, MD[2,3]

Explore 2013; 9:159-170.

Instruments' Attributes	FICA	HOPE	SPIR	ACP	CSI	FACT	RCP	Stoll	PCSQ	JCAb	FDM	Kuhn
Mean time for application, min	4-5	5-6	10-15	3-4	3-4	6-7	20-25	10-15	7-10	3-4	15-20	5-6
Memorability	✓	✓	✓	—	✓	✓	—	—	—	—	—	—
Religious affiliation	✓	✓	✓	—	✓	✓	✓	—	—	✓	✓	—
Religious attendance	—	—	—	—	—	—	—	—	—	✓	—	—
Negative aspects of religion	—	—	✓	—	✓	✓	✓	—	—	—	✓	✓
Spirituality meaning	✓	✓	✓	—	—	✓	✓	✓	—	✓	✓	✓
Influence of spirituality on life	✓	✓	✓	✓	✓	✓	✓	✓	—	✓	✓	✓
Influence of Spirituality on illness	✓	✓	✓	✓	—	✓	✓	✓	—	✓	✓	—
Religious rituals and practices and their influence on treatment	✓	✓	✓	—	✓	—	✓	✓	—	✓	—	—
Religious Coping	✓	✓	✓	✓	✓	✓	✓	✓	—	✓	✓	✓
Religious Support	✓	✓	✓	✓	✓	✓	✓	✓	—	—	✓	—
Medical practices not allowed	✓	✓	✓	—	—	—	—	—	—	—	—	—
Spiritual experiences	—	—	—	—	—	—	—	—	—	—	—	—
Dealing with Terminal events	✓	—	✓	—	—	—	✓	—	—	—	—	—
Option to discuss religious issues	✓	✓	✓	✓	✓	✓	✓	—	✓	✓	—	—
Option to refer to religious leader/chaplain	✓	✓	—	✓	✓	✓	✓	—	✓	—	—	—
Validation	✓	—	—	—	—	—	—	—	—	✓	—	—
Internet Site Available	a	—	—	—	—	a	a	—	—	—	—	—
Credibility (Support literature)	a	a	a	a	a	a	—	a	a	a	a	a
Score of each instrument	13	11	12	6	9	10	11	6	2	9	7	4

WPA Position Statement on Spirituality and Religion in Psychiatry

WPA Section on Religion, Spirituality and Psychiatry

2. An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.
3. There is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications. These studies should cover a wide diversity of cultural and geographical backgrounds.
4. The approach to religion and spirituality should be person-centered.

World Psychiatry 15 (1):87-8, 2016

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REVIEW ARTICLE

Clinical implications of spirituality to mental health: review of evidence and practical guidelines

Alexander Moreira-Almeida,[1] Harold G. Koenig,[2] Giancarlo Lucchetti[1]

Revista Brasileira de Psiquiatria. 2014;36:176–182

- Patient centered, not prescribing, not imposing
- Ternary awareness: physical, mental and spiritual aspects of human beings
- Clinicians explore his/her own worldview and history on R/S issues
- Open-minded approach with genuine interest and respect by patients' beliefs, values and experiences

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Journal of Religion and Health
https://doi.org/10.1007/s10943-021-01345-z

ORIGINAL PAPER

Religion-Adapted Cognitive Behavioral Therapy: A Review and Description of Techniques

Marianna de Abreu Costa[1] · Alexander Moreira-Almeida[2]

Table 2 Summary of interventions

	Techniques	Description
Initial therapy session	Psychoeducation about symptoms and mental health disorders	Discussion about religious theories for the causation of symptoms and disorders. Information provided about the impact of R/S on mental health
	Psychoeducation about CBT model	Explanation about the relationship between thoughts, behaviors, and emotions using R/S content
Motivational strategies		Use R/S content to motivate clients to engage in treatment
	Religious activities	Explicitly encourage private religious activities (e.g., praying, reading religious texts, meditating) and religious community activities (e.g., religious services, engaging in charity), and R/S activities as homework tasks. These activities are used for behavioral activation
Behavioral intervention	Coping strategies	Encouraging clients to cope using positive R/S strategies (e.g., secure relationship with God, sense of spiritual connectivity with others) and reducing the use of negative R/S coping strategies (e.g., viewing God as punishing or abandoning them, being unable to forgive)
Life values		Motivating clients to act according to their R/S values (e.g., forgiveness, generosity, altruism, compassion)
Cognitive intervention	Cognitive restructuring	Modifying distorted automatic thoughts and beliefs using R/S content
	Religious imagery modification	Combining cognitive restructuring with systematic desensitization. Clients are encouraged to imagine a depressive image while also imagining themselves coping using a R/S perspective

Note. R/S religious or spiritual

Self-Directedness Predicts Quality of Life in Individuals with Psychotic Experiences: A 1-Year Follow-Up Study

Letícia Oliveira Alminhana[a] Miguel Farias[c] Gordon Claridge[d]
C. Robert Cloninger[e] Alexander Moreira-Almeida[b]

Psychopathology 2017;50:239–245

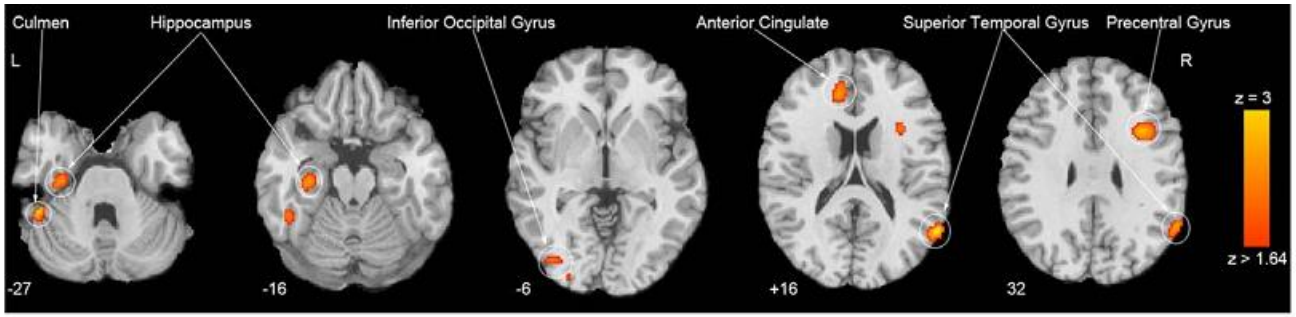
Table 2. Hierarchical regression predicting each domain of quality of life (QoL) at time 2 ($n = 90$)

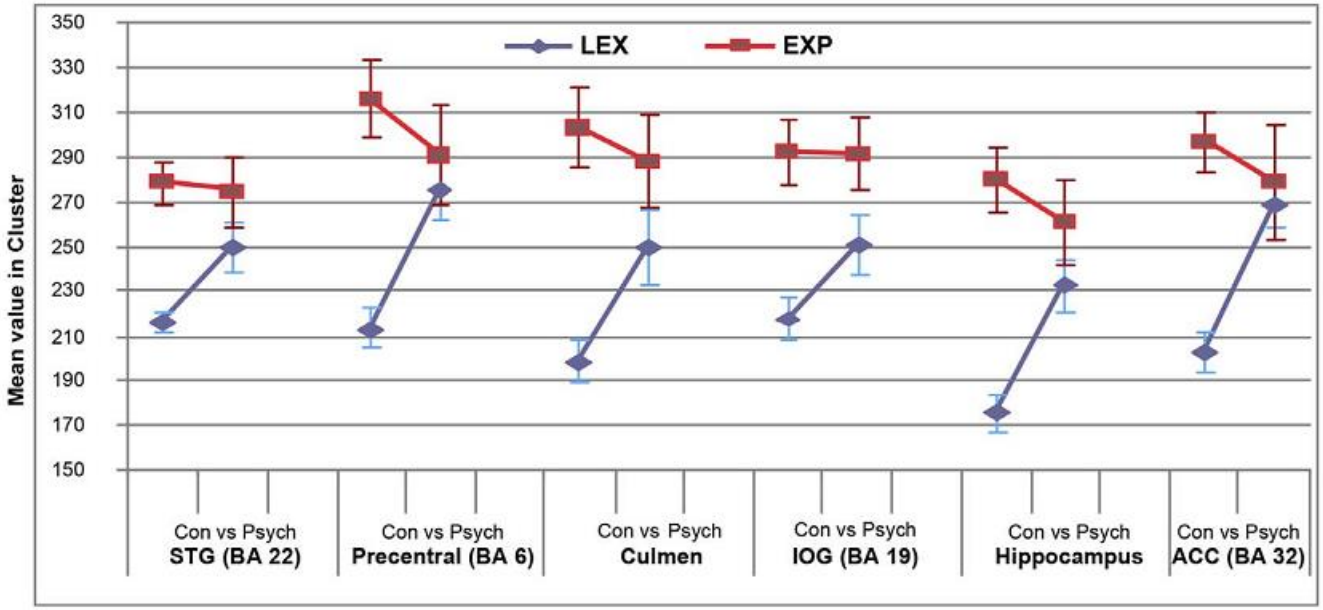
	Physical QoL		Psychological QoL		Social QoL		Environmental QoL	
	β	*t*	β	*t*	β	*t*	β	*t*
R^2_{Adj}	0.12		0.19		0.17		0.09	
Sex	−0.045	−0.378	−0.045	−0.388	−0.042	−0.356	−0.029	−0.240
Age	−0.258	−2.095*	0.096	0.811	−0.164	−1.374	−0.164	−1.309
Novelty seeking	−0.216	−1.386	0.026	0.172	−0.255	−1.691	−0.057	−0.361
Harm avoidance	−0.368	−2.315*	−0.092	−0.604	−0.191	−1.239	−0.166	−1.030
Reward dependence	−0.095	−0.684	−0.082	−0.617	0.120	0.895	0.094	0.669
Persistence	0.059	0.418	−0.135	−1.006	−0.244	−1.794	0.017	0.116
Self-directedness	−0.003	−0.015	0.390	2.074*	0.219	1.149	0.141	0.707
Cooperativeness	0.063	0.425	−0.107	−0.757	−0.016	−0.111	0.038	0.255
Self-transcendence	0.011	0.077	0.078	0.596	0.051	0.384	−0.091	−0.653
Unusual experiences	−0.115	−0.766	−0.014	−0.094	−0.166	−1.139	0.054	0.352
Cognitive disorganization	−0.038	−0.232	−0.310	−1.962*	−0.129	−0.808	−0.191	−1.139
Introverted anhedonia	−0.035	−0.268	−0.070	−0.556	−0.059	−0.468	−0.097	−0.731
Impulsive nonconformity	0.108	0.627	0.143	0.869	0.196	1.174	0.084	0.479

OPEN ACCESS Freely available online November 2012 | Volume 7 | Issue 11 | e49360 PLOS ONE

Neuroimaging during Trance State: A Contribution to the Study of Dissociation

Julio Fernando Peres[1,2,3]*, Alexander Moreira-Almeida[4], Leonardo Caixeta[5], Frederico Leao[3], Andrew Newberg[1,2,6]





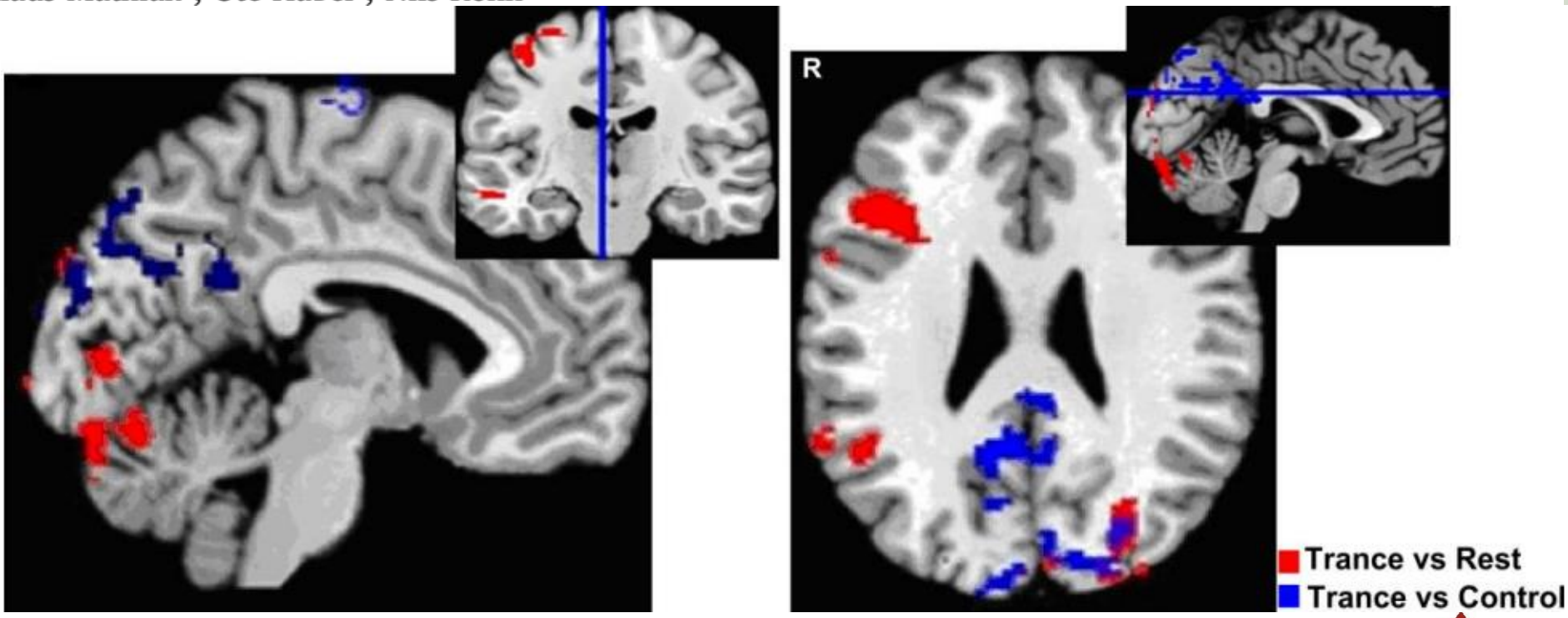
266 (2017) 101–107

Psychiatry Research: Neuroimaging

journal homepage: www.elsevier.com/locate/psychresns

Neural correlates of psychotic-like experiences during spiritual-trance state

Alessandra Ghinato Mainieri[a,b,c,*], Julio Fernando Prieto Peres[d], Alexander Moreira-Almeida[c], Klaus Mathiak[a], Ute Habel[a], Nils Kohn[a,e]



Can the *DSM-5* differentiate between nonpathological possession and dissociative identity disorder? A case study from an Afro-Brazilian religion

Romara Delmonte BSc[a,b], Giancarlo Lucchetti, MD, PhD[b], Alexander Moreira-Almeida, MD, PhD[b], and Miguel Farias, BSc, MA, DPhil[a]

JOURNAL OF TRAUMA & DISSOCIATION
2016, VOL. 17, NO. 3, 322–337

Ninety Years of Multiple Psychotic-Like and Spiritual Experiences in a *Doctor Honoris Causa*

A Case Report and Literature Review

Rodolfo Furlan Damiano, MD, Liliane Machado, MD,† Alexandre Andrade Loch, PhD,‡§ Alexander Moreira-Almeida, PhD,|| and Leonardo Machado, PhD¶*

J Nerv Ment Dis 2021;209: 449–453

Ninety Years of Multiple Psychotic-Like and Spiritual Experiences in a *Doctor Honoris Causa*

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Rodolfo Furlan Damiano, MD, Liliane Machado, MD,† Alexandre Andrade Loch, PhD,‡§ Alexander Moreira-Almeida, PhD,|| and Leonardo Machado, PhD¶*

[*J Nerv Ment Dis* 2021;209: 449–453]

- Estudo de casos paradigmáticos
- Entrevista psiquiátrica com Divaldo Franco
- Desde 4 anos EA continuamente
- Vida extremamente produtiva
- Não tinha: desorganização cognitiva, retraimento afetivo e dificuldades para manter as atividades diárias.
- Encontrou grupo religioso que o acolheu e o ajudou a fazer sentido de suas experiências

Differential diagnosis between non-pathological psychotic and spiritual experiences and mental disorders: a contribution from Latin American studies to the ICD-11

Alexander Moreira-Almeida,[1] Etzel Cardeña[2]

Revista Brasileira de Psiquiatria • vol 33 • Supl I • mai2011 • **S34**

- absence of psychological suffering
- absence of social and occupational impairment
- experience has a short duration, and does not have an unwilled, invasive character in the individual's daily activities
- capacity to perceive its unusual/anomalous character
- compatibility with some religious tradition
- absence of psychiatric co-morbidities
- control over the experience
- personal growth with the experience

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WPA Position Statement on Spirituality and Religion in Psychiatry

WPA Section on Religion, Spirituality and Psychiatry

5. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers, and others in the community, in support of the well-being of their patients, and should encourage their multi-disciplinary colleagues to do likewise.
6. Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental health care.
7. Psychiatrists should be knowledgeable concerning the potential for both benefit and harm of religious, spiritual and secular worldviews and practices and be willing to share this information in a critical but impartial way with the wider community in support of the promotion of health and well-being.

World Psychiatry 15 (1):87-8, 2016

religionandpsychiatry.org

The contribution of faith-based health organisations to public health

Cristiane Schumann, André Stroppa and Alexander Moreira-Almeida

International Psychiatry Volume 8 Number 3 August 2011

COMMENTARY

WILEY ASIA-PACIFIC PSYCHIATRY Official journal of the Pacific Rim College of Psychiatrists

Partnerships for interdisciplinary collaborative global well-being

Uriel Halbreich MD[1] | Thomas Schulze MD[2] | Michel Botbol MD[3] | Afzal Javed MD[4,5] | Roy Abraham Kallivayalil MD[6] | Suhaila Ghuloum FRC Psych[7] | David Baron DO[8] | Alexander Moreira Almeida PhD[9] | Michael Musalek MD[10] | Wai Lun Alan Fung MD[11] | Avdesh Sharma MD[12] | Allan Tasman MD[13] | Nikos Christodoulou MD[14] | Siegfried Kasper MD[15] | Gabriel Ivbijaro PhD[16,17]

Asia-Pacific Psychiatry. 2019;**11**:e12366.

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Reasons for integrating R/S and MH

- Most of the world's population has R/S
  - Usual coping strategy
- R/S impacts health
- Address R/S impacts prognosis
- Patients want clinicians address R/S
- Component of an integral patient's assessment
- Recommended by medical/health organizations

Revista Brasileira de Psiquiatria. 2014;36:176–182

WHAT DO RELIGION OR SPIRITUALITY MEAN?

"In summary, in respect to the evidence available and to the R/S beliefs, behaviours and values of most of the world's population, it is not only appropriate but a scientific and ethical responsibility to integrate R/S in clinical care and public health"

Moreira-Almeida & Bhugra, 2021

Nupes

NÚCLEO DE PESQUISA EM ESPIRITUALIDADE E SAÚDE

Nupes

TV Nupes
15 mil inscritos

www.youtube.com/nupesufjf

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64 mil visualizações • há 6 anos
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Distinção entre experiências espirituais e transtornos...
32 mil visualizações • há 5 anos

A mente além do cérebro - Prof. Dr. Alexander Moreira...
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omo Jung compreende a spiritualidade humana?
mil visualizações • há 5 anos

O surgimento da Sociologia e a Religião - Prof. Dr. Dmit...
9,8 mil visualizações • há 6 anos

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Espiritualidade e dor crônica - Dr. Mario Peres
8,2 mil visualizações • há 6 anos

Is it possible to change our personality? How? / É...
7,9 mil visualizações • há 7 anos

Lançamento do portal do Projeto Allan Kardec
7,8 mil visualizações • Transmitido há 11 meses

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Many Thanks!

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