Appendix

Areas of intervention related to religion/spirituality suggested by psychiatrists during supervision sessions for 28 patients [a]
(out of the 42 patients in the spiritual assessment group [b])

	Level of importance [c]			
Areas of intervention	**+**	**++**	**+++**	**Total**
Support positive coping	6	9	2	17
Work on identity, values	3	4	0	7
Differentiate delusion from faith and work on it	0	4	1	5
Mobilisation towards clergy, chaplain or religious community	1	1	2	4
Work on negative coping	1	2	0	3
Work on representations of psychiatric disorder and treatment	1	1	1	3
Total	**12**	**21**	**6**	**39**

[a] Ten patients have more than one domain suggested.
[b] There is no prescription for 14 patients.
[c] Levels of importance are: "likely helpful", "needs some monitoring over time" (+), "Subject of importance" (++), and "major issue in the patient's life, in care or in the therapeutic relation" (+++).

Examples of interventions based on the six areas

Supporting positive religious coping was the intervention more often suggested (17 cases). For instance, a psychiatrist involved in the care of a patient who tried to use prayer as a way to cope with anxiety was suggested to work with the patient to use this resource in a more optimal way (patient 1.3). A woman with paranoid schizophrenia was confronted with important marital and social problems. Religion appeared as a way to give sense to her life when facing all her problems. Yet her religious worldview was tainted by some elements likely to entail problems, such as unfounded guilt feelings. This warranted work by the psychiatrist aiming at preventing a switch to negative religious coping (patient 4.08).

Work on identity and values was suggested in 7 cases. For example a 41 years old patient with paranoid schizophrenia featured persistent positive symptoms, in the context of a massive identity disturbance. Religion appeared to be of major importance in his life, thus the patient was given information on how to reappropriate this important part of his identity (patient 1.16).

For 5 patients, ***delusions with religious content*** appeared to be difficultly detectible from patients' faith, thus needing further work both in terms of assessment and helping patients to cope with such symptoms. A 47 years old married male with schizophrenia believed that his wife, with whom he was in conflict, was possessed by the demon. This made him wish to kill her. Yet spiritual assessment showed that he used religion as a way to master his violent drives against her. He went to church every Sunday seeking support from his priest. He described that religion helped him overcome his violent drives, and that it prevented him from committing aggression against his wife. His psychiatrist was suggested to revise his medication, and to work on this marital conflict while restructuring delusional thoughts. Thus it appeared necessary to suggest three interventions, i.e. to foster positive coping, to encourage the patient to get support from the priest and to work on delusion which was embedded into his faith (patient 2.17). Another patient, a 35 years old male diagnosed with paranoid schizophrenia and had a previous history of suicidal attempts was convinced that he would be tortured by a devil after his death. He had spoken with a monk who apparently

comforted him from such concerns. Work on this delusion, probably related to guilt, was suggested in order to help this patient overcome this painful experience (patient 5.02).

Mobilization was suggested in four cases. For example a 50 years old female patient with schizophrenia was involved in a harmful relation with her boyfriend (sexual and financial abuse). Despite investing in her catholic faith, she had no contact with religious peers or clergy. Supervision led advice the patient to meet a chaplain, notably to balance the influence of her boyfriend (patient 1.10).

Work on negative coping was suggested in 3 cases. For instance, a 57 years old woman with schizophrenia was frequently beaten by her husband. She was told that her faith led her to accept this situation. Religion was both positive and negative in terms of coping. Supervision suggested working on negative coping, which was considered to leading the patient to an inappropriate fatalism (patient 3.03).

Work on representations of psychiatric disorder and treatment was suggested in 3 cases. A 30 years old patient with schizophrenia had persistent complaints about his medication (clozapine) and wished to discontinue the treatment. Among other reasons, he reported that neuroleptics made him stop believing. The patient's desire to stop medication (which was not known before this spiritual assessment) could then be part of the discussion when the patient showed non compliance with treatment (patient 1.09). Conversely, another patient (42 years old male with schizoaffective disorder) had an explanatory model of his disorder as God's will, though accepting well his treatment. Supervision suggested to carefully monitor his convictions in the context of a pattern of unstable and persisting symptoms (patient 3.04).