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Nissen, Ricko Damberg; Gildberg, Frederik; Hvidt, Niels Christian

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Approaching the Religious Patient in Forensic Psychiatry, with special focus on Ethnic Minority Patients

Ricko Damberg Nissen, Frederik Alkier Gildberg and Niels Christian Hvidt
Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, Odense, Denmark

Abstract

Ethnic minority patients are overrepresented in Danish forensic psychiatry and knowledge is needed on how these patients are approached in relation to religious and cultural issues. The aim of this study was to investigate how psychiatrists in Danish forensic psychiatry approach religious ethnic minority patients. Based on interviews with psychiatrists working in Danish forensic psychiatry, the study revealed positive approach towards religious ethnic minority patients. However, unless religion features as part of the illness, the tendency is to not incorporate the patients’ religiosity in treatment, which may hinder patient empowerment and positive religious coping. The study finds that the hospital chaplain is regarded by the psychiatrists as an important part of the ward, offering the patients a ‘therapy-free room’, and expressed the desire for a more formal cooperation with religious specialists to be developed. Finally, the study finds that religious practices such as Ramadan, common prayer, and Islamic edicts on food and unlawful touch are areas where more knowledge is needed, and where a lack of consensus may cause anxiety and potential stress and conflict situations.

Keywords

Forensic Psychiatry, Religion, Culture, Ethnic Minority Patients
Patients of ethnic and cultural backgrounds other than Danish are overrepresented in forensic psychiatric wards in Denmark in comparison to the overall ethnic composition of the population (Johansen, 2005; Sundhedsstyrelsen, 2010). International research has shown that failing to understand the cultural and religious background of patients of ethnic provenance other than the majority population leads to stereotyping, and within psychiatry, research has shown that psychiatrists in general are not trained to manoeuvre in cultural complexities, though it is becoming increasingly important in a multi-cultural world (Kirmayer, Rousseau, & Lashley, 2007; Tseng, Matthews, & Elwyn, 2016; Tzeferakos & Douzenis, 2017). In relation to religious patients of non-Danish ethnic backgrounds, the situation is further muddled by the highly secularized context of Danish society, where religion has become so private that it can be difficult for the patient to bring up their religiosity, and equally difficult for the psychiatrist to address the religiosity of their patients (Borras et al., 2010; Breemer, Casanova, & Wyller, 2014; Nissen, Gildberg, & Hvidt, 2019).

Patient empowerment through involvement of individual resources is a national (and international) healthcare strategy (Danish Healthcare, 2017). In relation to religious patients, research has shown that enabling positive religious coping (Culliford, 2002; Gopalkrishnan, 2018; Pargament, Smith, Koenig, & Perez, 1998) can be a fruitful strategy (Behere, Anweshak, Richa, & Aniruddh, 2013; Saad & de Medeiros, 2012; Smolak et al., 2013). Discussions about how to approach religion and religious topics in psychiatry remains a debated area and includes both the argument that religion/spirituality should be an intrinsic part of psychiatry on the one side, and concerns about the ethical boundaries of the discipline, if addressing religion/spirituality should become standard procedure on the other side (Poole & Higgo, 2011). It has been argued that the secular setting of the hospital (incl. psychiatry) offers a pluralistic...
setting, where secular and religious discourses are intertwined in complex ways (Berger, 2015), but research has also shown that the religious aspects of patients’ worldviews are often marginalized in secular psychiatry. Cook et al. (2011) argue that the secular is in itself biased against the religious. This, in turn, may lead to miscommunication and misunderstandings, disempowering individual resources (Nissen, Gildberg, & Hvidt, 2019), and may also obstruct de-escalation strategies and instead lead to conflict and the use of coercive measures (Campinha-Bacote, 2016; Kuivalainen et al., 2017). In relation to forensic psychiatry and ethnic minority patients the situation is even more complex, especially in the meeting between Islam and various culturally/religiously based understandings of mental health and forensic psychiatry that meet in a globalized world (Hassan, Tamizuddin, & Asmer, 2017; Geferakos, Lykouras, & Douzenis, 2014). A recent study from the same forensic setting as the present study examined the use of restraint and coercive measures ‘before, during, and after’ conflict situations and showed that the markers of escalation preceding the use of coercion were characterized by, among other things, lack of communication, disrespectful communication, or miscommunication (Tingleff, 2019). All participants in the study were ethnic Danes, which points to a potential knowledge gap regarding how (religious) patients from ethnic minorities are approached in forensic psychiatry and whether misunderstanding religious or cultural traits may act as escalating triggers for conflict situations and thus a greater use of coercive measures and disempowered positive religious coping among this population.

**Aim**

The aim of this study was to investigate the characteristics of how psychiatrists in Danish forensic psychiatry approach religious patients, with special focus on ethnic minority patients.
Method

The project is grounded in social constructivism (Berger & Luckmann, 1991; Nissen, Gildberg, & Hvidt, 2019) and employed a method of sequential semi-structured interviewing for data construction (Charmaz, 2006; Holstein & Gubrium, 2003). An open interview guide was constructed, informed by the following research question: What characterizes the approach of psychiatrists in Danish clinical practice regarding topics of a religious nature? The interview guide had three thematic parts: (1) the background and position of the informant; (2) the approach to religious patients; and (3) the informant’s personal worldview and the potential influence of this on their approach to patients.

The ‘first reading’ of the interviews informed subsequent interviews in a dialectic process as the informants brought up topics or themes to be pursued, followed by an inductive segment-by-segment coding to establish themes while staying close to the data (Charmaz, 2006). An explorative/abductive analysis (Johannessen, 2018; Timmermans & Tavory, 2012) led to four categories characterizing the approach to religious patients: i) ‘Religion as a negative part of the patient story’, ii) ‘Religion as a positive part of the patient story’, iii) ‘Radicalization’, and iv) ‘There are no religious patients’ (Nissen, Gildberg, & Hvidt, 2019). During the analyses, an independent main theme emerged from the data from the forensic wards meriting further investigation: ‘ethnic minority patients’ (hereafter EMP). In order to investigate this theme, a new and focused thematic research question was formulated: What characterizes the approach of psychiatrists in forensic psychiatry regarding EMP with specific focus on religious topics? Following the formulation of this ulterior research question, the data was systematically coded
and analysed anew, using the above described approach, resulting in the theme ‘Religious Orientations’ and the two subthemes: ‘Religious Specialist’ and ‘Religious Activities’.

Data Construction

The interviews were conducted in the period of August 2016 through February 2018 with psychiatrists working in psychiatric hospitals in the region of Southern Denmark with both in- and outpatient populations. 22 semi-structured interviews were conducted and 12 of these were from forensic psychiatry. Criteria for inclusion: Certified specialist in psychiatry; Physician in psychiatric residency; Employed in psychiatry in the region of Southern Denmark.

The informants were recruited in the following ways, listed here chronologically: At a weekly conference for psychiatrists at the hospital in Middelfart (N=3); Through an email co-written with the Administering Head Physician at the hospital in Middelfart (N=12); Through personal contact from the research coordinator for psychiatry in the region of Southern Denmark (N=1); Through personal contact from the Administering Head Physician (N=1); Through personal contact from the researcher (N=1); Through the Head Physician at the psychiatric hospital in Kolding and Vejle (N=2); Through personal contact from the professor of spiritual care at the University of Southern Denmark (N=2); Through a presentation at the annual conference for the psychiatrists working at the hospital in Middelfart (N=3).

The total number of potential informants recruited was 25. Three interviews were not conducted due to lack of response, bringing the number of interviews to 22. Approximately 50 persons were contacted. The exact number is unknown, as it is not known how many persons the Head Physician in Kolding/Vejle contacted. The informants were employed at the psychiatric hospital in Middelfart, the Region of Southern Denmark, the psychiatric hospital in
Vejle/Kolding, the region of Southern Denmark, and the psychiatric hospital in Odense, in the region of Southern Denmark.

Supplementary interviews were conducted with the Head Nurse, the Hospital Chaplains, and the Matron at the hospital in Middelfart, all with separate interview guides. This concluded the data construction in January 2019.

The interviews took place in the informants’ offices, except for one which took place in a small meeting room, and one which took place at the private residence of the informant. The interviews were conducted one-on-one and were recorded. Each interview lasted 42.73 minutes on average.

The number of informants from the forensic wards, and thus the focus in this article, was 12; this included 8 women and 4 men, with a mean age of 53.67, and employed as chief physicians in psychiatry (N=9), specialists in psychiatry (N=2), and resident (N=1), with 14.3 years mean work experience. 11 were ethnic Danes and one was of other ethnic background.

The informants are seen as representative of psychiatrists working in Danish psychiatry and the sample is regarded as purposive (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Patton, 1990). Data saturation was discussed in the author group and decided by the primary author (Charmaz, 2006; Johannessen, 2018). All interviews were conducted, audio recorded, transcribed, coded, and analysed by the primary author. The analyses were supplemented and given nuance by the secondary authors.

Prior to the interviews, the informants were informed about the topic of the interviews and the researcher’s academic credentials and background. The informants all signed written consent to participate. Transcripts were not provided to the informants for comments or corrections. There were no relationships between the interviewer and the informants prior to the interviews.
The researcher’s credentials as an anthropologist are considered adequate to conduct the interviews and the research process. Ethical approval was granted by the Danish Data Protection Agency and the regional research ethics committee.

Results and Discussion

The analysis established the theme ‘Religious Orientations’ and two subthemes: ‘Religious Specialist’ and ‘Religious Activities’. These are presented and discussed in the following.

Religious Orientations

Yes, I have religious patients, Christians, Muslims, and sometimes Buddhists.

(Informant 17).

The theme ‘Religious Orientations’ relates to the religious orientations of the patients mentioned in the data: Asetro (Norse mythology), Buddhism, Christianity (protestant and Catholic), Hinduism, Islam, Jehovah's Witnesses, and Judaism. The spiritual concepts of ‘the Third Eye’ and ‘Chakras’, originating in the Hindu and Buddhist traditions, were mentioned, as was ‘The Heart of the Sun’, which is a spiritual community located in the vicinity of Odense, Denmark. The most commonly mentioned religious orientations were Christianity, Islam, and Jehovah’s Witnesses.

Generally, the data show that religious EMP are approached the same as religious ethnic Dane patients (Nissen, Gildberg, & Hvidt, 2019). According to the data, the approach is to respect the religious worldview of the patient and to enquire about it as a conversational topic in relation to the therapeutic alliance, motivational support (Biglow, 2012; Griffith, 2008), and activities
of daily life (ADL) (Mlinac & Feng, 2016) as aspects of patient empowerment and patient-centred care (Castro, Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016; Dixon, Holoschitz, & Nossel, 2016). From this perspective, adhering to a religious orientation is regarded as a positive aspect of the patient ‘story’. The informants build the therapeutic alliance by conversing about a topic that is not illness-related and thus learns about their patients’ values, social network, cultural background, and religious beliefs, at times leaving their personal convictions aside, at times including aspects of their personal worldview (religious or secular) as part of building the therapeutic alliance.

I have had many conversations with patients about religiosity where I in no way have mentioned my personal values, religiosity or lack thereof. But if someone asks me then I answer honestly that I am not religious, that I don’t believe in God. I have experienced some good dialogues from this, without it becoming something like ‘I believe in this and you are wrong’. It’s more like agreeing that we have different perspectives on the world, and this open and honest approach is actually a quite important moment, very vulnerable and valuable, and gives a good relation. (Informant 18).

Research supports an open and positive approach to religious worldviews and supports enquiring further about it, if invited, as fruitful in a cross-cultural context to become familiar with other cultural and religious understandings of mental health (Dixon, Holoschitz, & Nossel, 2016; Kirmayer, Rousseau, & Lashley, 2007; Tzeferakos & Douzenis, 2017). The data confirms this as an important part of the approach also to the religious EMP, to get to know the patient and make the patient know that important religious aspects of the worldview are being heard and included, which is important to religious patients in general (Coyle, 2001; Moreira-Almeida, Koenig, & Lucchetti, 2014; Sørensen, 2007). This approach supports patient empowerment (Burau, Carstensen, Lou, & Kuhlmann, 2017; Castro, Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016;) and moves into a patient-perspective care (Carey, 2016). In relation to religious EMP this could be argued as a ‘culture-sensitive – worldview-oriented/integrating care’ that could attempt to address and include the underlying cultural
assumptions and structures of the patient worldview, religious or secular. In this way an open
and inclusive approach to religious patients in general helps to focus on areas of importance to
the patient, areas where special considerations of the religious orientation, cultural background,
or social context need to be taken into account when formulating treatment plans. This supports
the therapeutic alliance, empowering positive religious coping and assisting in reducing stress
and anxiety by creating a predictable environment for ADL (Grillon et al., 2008; Grupe &
Nitschke, 2013), it can also act as a pre-emptive strategy for locating stressors and triggers in
relation to conflict and coercive measures (Gildberg, Bradley, Fristed, & Hounsgaard, 2012;
Haines, Brown, McCabe, Rogerson, & Whittington, 2017; Tingleff, 2019).

However, this is the initial approach of the informants and there is a clear tendency in the data
revealing that they rarely pursue further communication about the religious worldview unless
it is part of the illness or a negative influence in relation to treatment, such as refusal of
medication, blocking the treatment, or as part of an illusion.

... well, we are not to be judges of what is the right or wrong thing to believe, that
would be horrible if we suddenly were to do that, that is not the intention. But in
reality, there are grey areas where we have to choose for the patient, and when they
make that decision for a person who is obviously psychotic, the patient still have to
fulfill the criteria if he is a danger to himself or others, or if there is reasonable chance
for a worsening of the health condition (before they can restrain the person).
(Informant 17, my parenthesis).

In these situations, it is, as illustrated, a careful balance of separating what it seen as healthy
religious aspects from delusional aspects of a worldview. The approach is to move to behaviour-
and perception or reality-corrective care (Gildberg, Bradley, Fristed, & Hounsgaard, 2012),
including the potential use of coercive measures. By focusing on religion as a negative aspect
of the patient story, the religious aspect of the worldview has a tendency to be pathologized.
Taking into account a secular bias against religion inherent to the setting of psychiatry (Cook,
Powell, Sims, & Eagger, 2011; Nissen, Gildberg, & Hvidt, 2018), the positive religious part of
the worldview becomes something that both patient and psychiatrist feels that ‘we don’t talk about’ (Coyle, 2001; Lakdawala, 2015; Nissen, Gildberg, & Hvidt, 2019). This is supported by the finding expressed by informants in our data that the majority of patients on the forensic ward are diagnosed on the psychotic spectrum, and religion is often entangled in related delusions. From this perspective, the religious is regarded as a delusional aspect of the patient’s worldview, and it was generally expressed by our informants that this was seen as illness-related behaviour, clearly distinct from a ‘normal’ religious worldview that the patient may have.

Research shows that it can be difficult to differentiate between normal and pathological delusional religious convictions (Chidarikire, 2012; Pierre, 2001), even more so in relation to religious EMP who may have different understandings of mental health/illness (Jimenez, Bartels, Cardenas, Daliwal, & Alegria, 2012; Tzeferakos & Douzenis, 2017). The data supports this, with informants expressing that it is difficult to incorporate different cultural or religiously-based understandings of mental health.

Just like a woman we had, a Muslim woman, who wouldn’t take the medicine and then they had a necromancer come home to them and remove it (the demon), and that lasted for years. I mean we have to respect that. Then the demon returned, but that could also have happened with medicine. (Informant 6, my parenthesis).

Whether there is a possibility to approach underlying cultural factors as a way to understand the patient’s experienced needs (Ruyter, 2014) and include these in the formulation of treatment plans is controversial and largely depends on the majority cultural context. The findings of Jones, Kelly, and Shattell (2016) regarding patients juxtaposing and blending explanatory frameworks (religious and secular/scientific) in order to interpret their own situation, complicate the situation further. In multicultural and postsecular times (Habermas, 2008), where the need for psychiatry to have a strong secular identity is very important, blurring
boundaries and discourses could potentially be inviting idiosyncrasy into psychiatry (Nissen, Gildberg, & Hvidt, 2018).

Informant: She thought she was possessed by a demon, and we are paying attention to if this is a culturally based acceptable thing, then it is less bizarre, and in some East African countries it is normal that strife can lead to a curse being cast and then you have a demon hanging around until you have it cleansed out again. If I understood you right, then you asked if it could be useful to have a white dressed witch doctor to cast out these demons?

Interviewer: Or somehow approach it through the underlying cultural… (the informant cuts in).

Informant: I don’t think we should do that. I wouldn’t object to the relatives doing it, unless I see a danger in it and as long as it isn’t substituting the treatment that I think is the correct one. I wouldn’t recommend it. I think that would be dishonest to my own professional grounding and another value is to defend credibility, decency and honesty. (Informant 15, my parenthesis).

It is clear from the data that informants are grounded in the scientific and secular context of psychiatry and are very conscious of the outlined situations, careful not to accept a patient’s theologically-grounded understanding of psychosis or include it in treatment. Neither do the informants see it as part of their jobs to act as cultural experts or religious specialists. The data support that involving a religious specialist like a chaplain or imam is a possibility to address cross-cultural situations. Language barriers also complicate the situation of understanding/misunderstanding underlying cultural traits further (Bowen, 2015; Ohtani, Suzuki, Takeuchi, Uchida, 2015), making it difficult for the psychiatrist to determine whether the included parties (patient, relatives, and staff) are in mutual understanding and hence can reach an agreement on the treatment plan.

In the multi-cultural and globalized context, international research has shown that forensic patients generally score higher on religiosity and spirituality scales than the general population (Mela et al., 2008). In Danish forensic psychiatry this should be considered in relation to the growing number of EMP, also reflecting the secular setting and that psychiatrists are recruited
from the ethnic majority population in mind. In this project 11 out of 12 informants were ethnic
Danish (the last informant was from another Northern European and secular country), which
may impact their understanding of and approach to EMP. There are countries, such as Pakistan,
where forensic psychiatry is developing, learning from Europe and North America, and vice
versa there may also be valuable knowledge that could help psychiatry in a secular setting to
understand a religiously based understanding of mental health in forensic psychiatry (Hassan,
Tamizuddin, & Asmer, 2017). The Cultural Formulation Interview provides a framework for
psychiatry to approach cross-cultural illness explanatory models and for empowering patient-
centred care (Kirmayer, Rousseau, & Lashley, 2007; Lewis-Fernandez & Aggarwal, 2013). It
is presently under evaluation in a Danish psychiatric hospital for implementation in Denmark
(Lindberg, Johansen, Kristiansen, & Lohman, 2018; Skammeritz, Lindberg, Mortensen,
Norredam, & Carlsson, 2019).

There is a tendency in the data to classify EMP as Muslims, and to identify Muslims as a
uniform group without much reference to geographical, ethnic, cultural, or national origin,
except in wide terms such as the Middle East. A few informants mention differences between
Muslims from various parts of the Middle East and a few distinguish between Shia and Sunni.
Christian and Hindu patients from the Middle East and North Africa are also mentioned.
Research has shown that the tendency to classify EMP as one group through an essentialist
understanding of both culture and religion is often employed as a part of daily work (Johansen,
2005). This blocks deeper understanding of the various different religious worldviews and
cultural backgrounds of patients, and may again hinder the therapeutic alliance and patient
empowerment. It is clear that working with trust- and alliance building and pre-emptive
strategies such as small-talk (Gildberg, Bradley, Fristed, & Hounsgaard, 2012) is made difficult
in the cross-cultural encounter and the essentialist understanding of culture and religion
increases the risk of medication errors (Bowen, 2015; Ohtani, Suzuki, Takeuchi, & Uchida, 2015). Informants in our dataset underline this situation, as religious and cultural topics are rarely brought up at staff conferences or meetings except as a negative part of the patient story, such as in relation to obstructing treatment or presenting safety concerns. Nevertheless, informants express confidence about manoeuvring in cultural and religious differences and that experience, common sense, empathy, and a rational approach goes a long way in the cross-cultural encounter.

Religious orientation in relation to suicide is a recurring topic in the data and Islam and Catholicism in particular are referred to as indicators in relation to suicidal patients.

If I know that they are really convinced Christian or Muslim, then I ask, in relation to suicide, because if you for instance are a practicing Catholic or Muslim, then it is not acceptable to commit suicide and that is a fact that plays a part. (Informant 10).

The forensic ward has an overall approach that includes an obligatory daily evaluation of all patients in relation to suicide and suicidal tendencies. This evaluation is based on a set of instructions outlined in ‘Selvordsvurdering Fem-Trin’ (SEFE-T) (Region Syddanmark, 2017) and the ‘Columbia Suicide Severity Rating Scale’ (C.SSRS) (Posner et al., 2011).

The approach to suicide evaluation is characterized by some informants, as exemplified in the above quote, to include religious orientation as one among other indicators in the evaluation of the potential for a suicidal patient to move from ideation to attempt. In this way, religious orientation may be used as an intervention to convince the patient to not take action on their suicidal tendencies. An example is an informant asking the patient about how Allah would view suicide, thus invoking the ‘divine dignity of humans’ in Islamic traditions (Marzband, Hosseini, & Hamzehgardeshi, 2016) and the criminalization of ‘self-murder’ in Islamic law (Tzeferakos & Douzenis, 2017) as a simultaneous deterrent, de-escalation strategy, and motivational
support. In this way the informants work with empowering, positive religious coping, pre-empting behaviour-corrective care or restraint. A recent review of the literature in relation to de-escalation strategies as pre-emptive alternatives to seclusion and restraint shows that the evidence regarding positive strategies is limited, especially when ethnic differences are taken into account, thus calling for more research in this area (Gaynes et al., 2017). According to research, religious beliefs and values may influence suicidal tendencies, but the manner and extent of the influence is widely debated (Mellor & Freeborn, 2011; O’Reilly & Rosato, 2015). Another review shows inconsistent results in the literature and illustrates that both suicide and religion are complex matters and the relationship between the two depends on a variety of factors, such as religious orientation, local and individual variations, and social and cultural backgrounds. It is suggested that religious affiliation may not be protective against suicidal ideation but is likely to be protective against attempts (Lawrence et al., 2016). More research is needed to understand the relationships at work and the potential positive and negative impact of religion on suicidal patients (Lawrence, Oquendo, & Stanley, 2016).

Religious Specialists

The subtheme ‘Religious Specialist’ refers to the hospital chaplain and imam. The hospital chaplain is present on the ward once a week. There is no imam affiliated with the hospital.

We have a chaplain connected to the hospital. I don’t know if we have access to an imam. (Informant 4).

The expression of the informants is that the chaplain has an important job in offering patients confidential conversation with a trustworthy ‘outsider’, not necessarily only with religious patients and not necessarily only regarding religious topics. The informants express that there
is no formal cooperation with the chaplain and that there is only a general knowledge about the daily work of the chaplain. Some informants have referred a patient to the chaplain and some have talked with the patients about the chaplain as part of the therapeutic alliance. The chaplain is seen as being able to offer more attention to the conversational aspect and so-called ‘small talk’, whereas the informants have to be more focused on the medical aspects of diagnosing and medication and treatment plans. In this way, the informants see the chaplain as an important supplement, offering a ‘therapy-free room’. This is confirmed by the chaplains.

It is a clear expression in the data that the informants trust the chaplain even though they do not have much contact. This trust is based in the knowledge that the chaplain is an employee, and in the shared Christian and Danish backgrounds of both the chaplain and the informants. Referring a patient to a chaplain outside the hospital is considered more difficult for security reasons, but also because familiarity and trust between such professionals has to be ascertained first. The establishment of a more formal cooperation between the chaplain and the psychiatrist is clearly expressed in the data as a potentially fruitful possibility. This is also supported by one of the chaplains. Research supports that providing opportunities for interdisciplinary teamwork in a psychiatric setting can be useful for all included parties (Cook, 2010; Lee, Zahn, & Baumann, 2015). However, it is also clear from the data that this would be very difficult to implement. The informants mention violations of patient-chaplain trust and confidentiality as undermining the patient-chaplain relationship, and ethical considerations are also an area of concern. This is supported by one of the hospital chaplains who sees patient-chaplain confidentiality as the most important aspect of the chaplain’s job. The chaplain explains that s/he is sometimes the most recurring and stable figure for a patient. Stability in personnel is supported by research as an important aspect in relation to the therapeutic alliance, patient empowerment, and avoiding conflict (Lakdawala, 2015). By offering the patient the possibility
to talk in confidentiality without ‘the system breathing down their neck’, the chaplain may assist in reducing stress and anxiety, potentially reducing psychotic episodes, conflict, and the use of coercive measures. Knowledge of the influence and potential of these aspects of the chaplains’ work in forensic psychiatry is limited, though research has shown that long-term incarceration can lead to ‘searching for meaning in life’, ‘longing for a new identity’ (including religious conversion), ‘identity crisis’ etc. (Thomas, Wollm, Winder, & Abdelrazek, 2016), all areas where chaplains have expertise.

It is a clear expression by the informants and the chaplains that EMP often want to talk with chaplains, including non-Christian patients. Sometimes Muslim patients prefer to talk with the chaplain instead of an imam. Statements in the data in relation to imams are conflicting, reflecting a lack of knowledge of the role and function of imams. Ambiguous feelings are expressed regarding being willing to invite an imam to the forensic ward but uncertain how to go about doing so. An issue mentioned in the data in this regard is the problem of building trust before the imam can be invited, which is complicated by general distrust influenced by public debate.

Before I would have an imam on the ward, I would have to feel really secure about what he was doing. He would have to work really hard to convince me, I would have to know him personally. What I need the most is to have access to a person who in relation to Islam and Muslims, and from the intention of not inciting or making people more religious, could talk with Muslim patients. I think there is a need for that, and I have no prerequisites in that area. (Informant 5).

This is supported by the chaplain, who recommends establishing contact with an imam at the organizational level, so that all ward personnel would know that there is a known and trusted imam to contact. The data support the need for including imams in high-security hospitals as the Muslim patient group is growing and the resources allocated to this are often limited; more research on the interplay between various faiths and the role of religious specialists is needed.

There are no other religious specialists mentioned in the data.
Religious Activities

The subtheme ‘Religious Activities’ relates to religious ceremonies, prayer, religious literature, symbols and artefacts, Islamic dietary laws, and includes Islamic edicts on unlawful touch.

The general expression in the data in relation to Christian ceremonies refers to the chaplain, who leads ceremonies at Christmas and Easter. The informants regard this as a positive part of ADL that does not present any problems. The general approach is to support this in relation to the therapeutic alliance, ADL, and as a positive religious coping strategy. It is also expressed that EMP (Muslims) sometimes participate in Christian ceremonies. This is supported by the hospital chaplains.

The general expression in relation to Islamic religious activities refers to Ramadan, the five daily prayers (salat), and the Friday common prayer.

The general expression in the data in relation to Ramadan is that it mostly presents a problem when it stands in the way of treatment, when patients refuse medication during the sunup to sundown fast period during the 30 days of the holiday.

Refusing to take medicine is always a problem around Ramadan. (Informant 10).

The general approach is to try to convince the patients to take medicine during Ramadan, using coercive measures and forced medication if necessary. This conflict appear, of course, because the secular approach to medicine is the highest priority for the informants, where the observant Muslim patient may place religious adherence first and therefore refuse medication during fasts. This is in concordance with the data: the religious argument against medication during fasts is acknowledged but overruled. Research has shown that it is important to manage and plan any
medical changes as part of ADL, both in relation to reducing stress and potential conflict situations, and in relation to enabling positive religious coping (Grindrod & Alsabbagh, 2017; Marzband, Hosseini, & Hamzehgardeshi, 2016). There are approaches that are in concordance with Islamic Law on how to take medication during Ramadan, taking both the type of diagnosis and the individual cultural-religious interpretations of religious laws into account. However, there are also knowledge gaps on how to adjust medication safely while accommodating religious, cultural, and medical concerns and more research is needed (Grindrod & Alsabbagh, 2017).

Praying is acknowledged in the data as a positive activity. There is no consensus of knowledge, however, on where the Islamic common prayer is to be performed, as illustrated in these three statements.

They can’t do that (common prayer). (Informant 4, my parenthesis).

I don’t know whether they can do that (common prayer). (Informant 12, my parenthesis).

They must do that (common prayer) in the common room, or in a conversation room. (Informant 10, my parenthesis).

This points to a potential area of distress where different instructions may be given depending on who is consulted. With a few exceptions, it is the expression that the informants do not partake in prayers themselves. It is seen as highly inappropriate and overstepping professional boundaries. This is anchored in ethical concerns. For the informants, who are themselves religious, this concern also includes potential proselytizing and keeping the ‘private religious persona, separate from the ‘professional secular persona’.

I am religious myself, and maybe it helps them (patients) to pray, but I am afraid to, how can I put this, to force something on the patient. You know, I am an authority and I have to be very careful with what I suggest. So, I can listen for what helps them, and if it helps to pray, well then support that, but I do not suggest it, that is not part of my job, because I am a physician. But this asymmetry is there, if I start to say that I think it is a good idea if you pray, then I am sort of proselytizing, and that is not part
of my job, as I see it anyway. I have to be with people no matter where they are (mentally), and not try and move them in a specific religious direction or way to handle their religious beliefs. I think that is outside my role. (Informant 8, my parenthesis).

Praying with patients has been both suggested (Koenig, 2008) and argued as breaching professional boundaries in international literature (Cohen, 2018; Cook, Powell, Sims, & Eagger, 2011; King & Leavey, 2010; Poole & Higgo, 2011), reflecting different understandings of the role, place, and potential of religion in USA and European contexts (Berger, Davie, & Fokas, 2008).

The general expression in relation to religious literature is to see it as a positive activity unless it is obviously excessive, self-harmful, or creates a suspicion of potential radicalization.

Informant: I had a Muslim woman who was very psychotic and so self-destructive that we had to restrain her, and what made her calm was reading the Koran sitting in her bed, so we allowed that. (Informant 15).

The general approach is to support it as a positive part of ADL and to enquire about it as part of the therapeutic alliance and motivational support. In this way, the approach is to move back and forth between supporting ADL, patient empowerment, and positive religious coping on one side, and behaviour and perception/reality-corrective care on the other side. Informants express that the evaluation on when religious activities such as reading sacred texts moves from normal to harmful behaviour is mostly reflected in catatonic or repetitive behaviour, self-harming, aggressive missionary behaviour, or when a patient becomes intensely interested in religious literature, in which case potential radicalization is also considered.

The general expression in relation to religious symbols and artefacts, such as the tesbih or rosary, is to refer to them as either a positive aspect of the patient’s life and ADL or in relation to them as potential weapons. The distinction between what is and is not a potential weapon is a case-by-case decision made by the psychiatrist and other staff members. The approach is
characterized by balancing safety concerns and conflict management on one side, and seeing
them in relation to stress reducing activities, positive religious coping, and supporting ADL on
the other side. A recent review of the literature on religious activities among Muslim
populations shows that religious activities and adherence to Qur’anic teachings reduces stress
and anxiety and increases mental health, and that clinicians should be aware of this also when
encountering Muslim patients who are less religious and who may misinterpret Islamic
teachings (Koenig & Shohaib, 2019). The data does not mention the hijab, niqab, or burqa.
The general expression in the data in relation to Islamic dietary laws is that it does not represent
a problem.

Well, we all stand in line in the cafeteria and then we have our ‘no pork’ and what
have you. This represents no problem. (Informant 13).

Besides being a somewhat stereotyping classification, this quote illustrates that the Islamic
dietary laws are exclusively associated with the prohibition against eating pork. This is solved
by making non-pork products available. To what degree the other available products have been
treated according to Islamic dietary laws (halal) is unknown, however, as the food comes from
an external kitchen (Matron Interview, Head Nurse Interview). Informants did not express that
patients have raised concerns about this. This is supported by the hospital chaplain. However,
halal is a constitutive element of Islamic law (Mukherjee, 2014) and other food products that
are not in a state of purity are also considered haram (forbidden), and this uncertainty can
therefore represent a situation of potential stress for patients.

The general expression in the data in relation to the Islamic edicts on physical contact with a
person of the opposite sex who is unmarriageable (mahram) is to respect it and not get offended.
This is primarily mentioned by female informants. Some informants enquire about it further in
relation to the therapeutic alliance.
I have asked, if they won’t shake hands for example, then instead of just feeling offended, I ask why and then get an explanation that this is based on respect, respect for me, and then we handle it in a different and very good way. (Informant 10).

At times, it is not possible to respect this boundary because of safety concerns, conflict situations, and available staff. In these cases the patients have to respect the hospital rules. It is expressed that this rarely leads to conflict even though it is a safety concern, especially considering that these situations primarily occur at times when staff is low in numbers, such as at night time. The edicts regarding unlawful touch place the Islamic tradition in opposition to and in potential conflict with the Danish secular tradition of handshaking as the general practice of greeting: this is an area of public debate, and the approach in the data of respecting this without taking offense potentially illustrates the influence of the public debate and might suggest a potential misinterpretation of Muslim behaviour, seeing it as a culturally-based sign of insult or oppression instead of based on religious practice. This kind of misunderstanding can lead to cultural stereotyping and generalizing about groups of people (Kirmayer, Rousseau, & Lashley, 2007), for instance EMP in forensic psychiatry. In a medical setting such as psychiatry the influence of public debate on the clinical setting can lead to a biased empathy and suppress a more nuanced and relational understanding of culture, religion, and ethnicity, obstructing and obscuring the approach, and disempowering potential positive cultural or religious coping and the therapeutic alliance (Snowden, 2003).

Conclusion

This study shows that the general approach to religious EMP in Danish forensic psychiatry is initially the same as to the ethnic Danish patient. This approach sees religion (and culture) as
relevant information in relation to the therapeutic alliance, ADL, empowerment, and positive religious coping.

However, the tendency is to not actively include religion/culture unless it is somehow part of the ‘problem’. This may neglect religious aspects that are important in relation to patient empowerment and positive religious coping. This oversight may instead lead to culturally-based misunderstandings that could act as escalating triggers preceding conflict, violence, and the use of coercive measures. It is clear from this study that there is a gap between the growing number of EMP in forensic psychiatry that places an increasing demand for the psychiatrist and other staff to be able to act as ‘cultural experts’ and an inability for the psychiatrist to fill this role at anything but a superficial level.

The study shows that the religious specialist could be more prominent in relation to all religious patients and that a formalized cooperation between areas of expertise could assist in locating religious or cultural aspects of importance to the patients. This is complicated, however, by the position of confidentiality that the chaplain holds in relation to the patients and in relation to Muslims in particular, as there is no formal contact with an imam within the ward and more research is needed on cooperation between psychiatrists and outside religious experts. The establishment of formal contact with an imam is thus recommended.

With the growing number of Muslim patients in Danish forensic psychiatry, it is also recommended that the situation around Islamic religious traditions like Ramadan, common prayer, and Islamic dietary laws be addressed, as it would assist to improve predictability, support ADL, make medical adjustments, and accommodate safety concerns. Again, a lack of knowledge about the ethnic, cultural, religious background of the patients may hinder patient empowerment and positive religious coping, and instead make way for miscommunication that
could lead to potential conflict and the use of coercive measures. To what extent these phenomena are connected is not known and more research is needed.

**Declaration of interest**

The authors declare no conflict of interest.

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