

## **The Interface between Religion/Spirituality and Mental Health**

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Religion/spirituality (R/S) and psychiatry share a long and complex history. Western medicine originated in an era when illness represented disfavor from the gods, healing involved gaining favor from the divine, and priests had unique roles as healers. During the Middle Ages, the first hospitals developed in monastic communities, and nuns served as nurses. With the Enlightenment came empiricism and reductionistic explanation, which led to major shifts in the Western view of the self and of the human condition. Freud's militant atheism, and the ascendancy of neurobiology later deepened the split between R/S and psychiatry.

Mutual suspicion persists. A religious figure recently acknowledged that psychiatry and psychology have made useful contributions, but warned that "much of those disciplines are built on a faulty worldview and must be (at least partly) rejected." (1) In a 2013 telephone survey of a representative sample of 1,001 Americans about mental illness, thirty-five percent of respondents (and 48% of Evangelical, fundamentalist, or born-again Christians) agreed with the statement, "With just Bible study and prayer, ALONE, people with serious mental illness like depression, bipolar disorder, and schizophrenia could overcome mental illness." (2) For their part, many mental health professionals, who as a group are much less religious than the general public, suspect religion of being judgmental, masochistic, homophobic, misogynistic, and monolithic.

Yet in recent decades interest has grown in the relationship between R/S and health: Twelve Step spirituality is widely valued. Psychoanalysts such as Rizzuto have revised Freud's understanding of faith. Mindfulness has become mainstream. Palliative Medicine includes spiritual care among its goals. Research has burgeoned into the effects of religion on health (e.g. via positive and negative "religious coping"), and into the neurobiology of spiritual experience. The Joint Commission mandates routine spiritual assessment, reflecting greater appreciation for the role of R/S as a risk or protective factor. Most patients surveyed want R/S included in therapy. Courses, papers, journals and books in this area have proliferated, many sponsored by interest groups within mental health organizations such as the American Psychological Association, the Royal College of Psychiatrists and the World Psychiatric Association. Seven doctoral programs in clinical psychology now exist within Christian universities. And while psychiatrists are less religious than physicians in other specialties, Curlin et al. (3) found in a national survey that they are more likely to say it is appropriate to ask patients about spiritual concerns (93% vs 53%) and that they do inquire (87% vs. 49%).

Given these developments, how can religious communities and mental health professionals collaborate to reduce the emotional suffering and the stigma of mental illness, and address patients' R/S needs? Consider briefly some conceptual and practical aspects of this challenge.

Psychiatry and R/S both aim to enhance human flourishing, understanding this to involve the development of adaptive capacities (for example to be reflective, and regulate emotion), a solid identity, realistic hopes, meaningful activities, authentic relationships, a mature moral life and a balance between autonomy and respect for authority. However, they differ in emphasis and role, with R/S placing greater emphases on growth and transformation toward full functioning than on critical thinking about diagnosis and treatment of disorders, as well as greater emphasis on relationship to the Transcendent and one's community than on individual mastery as means toward these ends.

From a practical perspective, mental health practitioners differ widely in how they implement their theoretical frameworks, ranging from the individualistic Rational Emotive Therapy of the atheist Albert Ellis to the spiritually sensitive or integrated CBT of David Rosmarin and others, to the theistic integrative psychotherapy of LDS psychologists Scott Richards and Allan Bergin. Religious communities also engage in a wide variety of practices aimed at integrating emotional and spiritual approaches such as healing presence by chaplains, pastoral counseling and psychotherapy, spiritual direction, inner healing prayer and group programs such as Celebrate Recovery or Living Waters.

Yet regular interaction between mental health and spiritual care professionals remains the exception rather than the rule. During one month, 60% of the oncology patients seen in psychiatric consultation at my institution were also known to a chaplain, but no communication took place between the two disciplines. Relatively few seminaries or Clinical Pastoral Education (CPE) curricula devote time to the care of major mental illness, despite the fact that clergy are often the first professionals approached by many individuals with mental health and family problems. Conversely, a minority of psychiatric residency training programs include training in addressing the clinical significance of R/S.

There are good reasons to be concerned about this lack of communication and collaboration. Communities which view spiritual and psychiatric interventions as competing alternatives can discourage much needed medication and therapy. Mentally ill individuals are sometimes not only stigmatized and misunderstood but mistreated, as when a bipolar patient is physically restrained or ejected, or a woman with a trauma history is restrained by male clergy during an exorcism. Conversely, religious individuals discouraged by therapists from participating in faith communities stand to miss out on opportunities to understand their narrative as part of a larger story, enhance their relationship with a forgiving God and supportive others, or finding ways to give back.

Various models of communication and collaboration have recently emerged. Examples include a mental health clinic in a Coptic church on Staten Island; a psychologist accepting regular referrals from an orthodox rabbi in New York, a list serve of Christian therapists used to facilitate referrals in greater Boston; a web-based course on mental health and substance abuse for South Asian pastors; and recent conferences for mental health and spiritual care professionals sponsored by a mental health center in Vermont, by the New Jersey Psychiatric Association, by Saddleback Church in California, and by a consortium of entities in Toronto and Houston.

The diversity of mental health and R/S communities, and the complexity of the interface between them suggest the need to: (1) learn from existing models what has worked well and why; (2) develop practical (case based) approaches to engaging learners in various settings about both the challenges which mental illness presents for R/S communities (e.g. recognizing depression), and those which religious individuals encounter in treatment (e.g. integrating spiritual and psychiatric perspectives on the treatment of their depression); and (3) engage key institutions to promote best practices.