A Conception of the Interface Connecting Faith and Mental Health

Clark S. Aist, Ph.D.
Former Director of Chaplain Services and Rehabilitation Services
Supervisor of Clinical Pastoral Education, Saint Elizabeth's Hospital
Washington, DC

The interface between faith and mental health has a long and complex history. For many centuries, disorders of the mind were regarded as maladies caused by spiritual forces and thus came under the purview of sanctioned religious authorities. Through much of the 20th Century, relations between faith communities and mental health disciplines were strained by mutual suspicion and at times antagonism. This was fueled significantly by Freud's famous characterization of religion as a "universal neurosis" as well as by reactionary tendencies among some religious groups to discourage therapeutic treatment. In recent years, however, attitudes have shifted appreciably, both in the field of mental health as well as within communities of faith.

I will first address the mental health side of the interface boundary. Beginning in the early 1980s, a sharp increase of interest in positive linkages between spirituality and psychological functioning has been widely observed. This interest was motivated by several factors: (1) to overcome predominantly negative views about psychiatry held by "religiously committed" people; (2) to address a tendency among mental health professionals to underrate the significance of religious faith to patients, perhaps related to a lower level of religiousness among this group than found in the general population; and (3) to accommodate mandates to offer clinical care appropriate to patients' cultural identity, including their heritage of faith. It is of note that during this period American Psychiatry was undergoing a landmark transition from theory driven psycho-dynamic understandings of mental disorders to a more scientific, neuro-biological orientation.

Responding to these concerns, a substantial body of research was developed (and continues at an accelerated rate) by psychologists and psychiatrists assessing the therapeutic value of religion and spirituality in restoring and maintaining emotional and mental well-being. These studies have included the benefit of such variables as belief in God, capacity to forgive, hopefulness, regularity of religious participation, mindfulness, surrender to a higher power, and various modalities of meditation and prayer—among many others. Investigators have also explored the contributions of "belief" to psychic life, the intrinsic-extrinsic spectrum of religious beliefs as well as the discrete elements of well-being conveyed by religiousness such as self-regulation, attachment and connectedness, emotional comfort, a sense of meaning and self-transcendence. Some studies have also taken into account the potentially destructive role of religiousness such as provoking violence or exacerbating guilt. Of particular interest are studies investigating ways the human brain mediates, structures and is restructured by spiritual activity, suggesting perhaps a neuro-anatomical foundation for spirituality. Mention should also be made of the extraordinary contribution of first-person recovery narratives in reshaping how mental disorders are understood and treated and in illuminating the value of religious and spiritual factors in the recovery process.

The over-all goal of this research is to develop therapeutic approaches that are more sensitive and accommodating to the religious convictions and practices of patients. This together with partnerships with organizations such as NAMI and sponsorship of events like the annual Oskar Pfister Award and Lecture represent some of psychiatry's contributions to the interface between mental health and faith.

We now turn to the second side of the interface to consider the contributions of faith and faith communities to mental health. As noted earlier, care for persons with mental illnesses was for centuries carried out by faith communities in ways sometimes benign but more often laced with superstition and, by today's standards, outright brutality. In time as individuals with mental disturbances became wards of the state and their care supervised by physicians, the religious community moved to more supportive roles like providing charitable visits and opportunities for worship at mental hospitals, the treatment modality of choice.

Today the vast majority of persons diagnosed with a mental illness live in the community—mostly on their own but at times in supervised care facilities or on the streets. Except in rare cases, inpatient care is relatively brief and focused primarily of stabilization and early return. This change in mental health service delivery presents community congregations with unparalleled opportunities to offer an array of recovery sustaining services in an environment of social and spiritual support and acceptance. The need for such services is compelling. Congregations of faith bring people together to relate the resources of their fellowship, beliefs and ritual celebrations to their problems of daily living—especially those that raise ultimate concern such as guilt, meaning and mortality. If a congregation is demographically representative, one in four of its families will have a member living with a mental disorder. Committed congregations can provide individuals and families touched by mental illness a place to belong, to connect and share, to experience hope and spiritual validation, to maximize their potential for recovery—in short, a safety net of care and support. Another resource of faith congregations is the community's projected image of them as places where help can be found. Over half the people seeking help for crises in living turn first to leaders of faith—more than to any other helping profession. This places clergy in a crucial gate-keeping role to assess when a crisis requires mental health intervention.

The larger truth, however, is that for most religious congregations the possibilities described above are only potential. Most services of worship are silent about the mental and emotional problems among those present. They are not lifted in prayer or sermons, nor mentioned in social hour conversations. This conspiracy of silence serves to perpetuate the stigma associated with mental health conditions.

Congregations face a number of barriers in moving from possibility to fulfilling their potential as an effective resource for mental health. Three are significant: (1) clergy are not equipped to integrate contemporary concepts of mental and behavioral health into their interpretations of faith, their concepts of human dilemmas, and their strategies of pastoral intervention; (2) engaging in faith-based mental health ministry requires of everyone involved a degree of self-transparency and awareness of one's own mental and emotional vulnerabilities; and (3) for a congregation to be "open and welcoming" to persons facing various levels of mental and psychological distress requires focused leadership, collective intentionality, education and planning.

Fortunately there are a number of denominational and interdenominational resources available to offer competent assistance with this process. The most important resource, however, may lie within the congregation itself, namely some individual or family member currently struggling with a mental illness who has the courage to share their pain and ask why in this congregation there is "no balm in Gilead" for their suffering.

On a final note, perhaps the question should be asked: "Why is this endeavor important?" Is there a larger, even transcendent vision that moves us toward these goals? Could it be that no one can be whole unless everyone, however broken, has a place at the table of humanity before God? Is there a dignity and meaning to all illness that deserves respect? Can we, in the words of Paul Ricoeur, "allow it to aid us in bearing our own precariousness, our own vulnerability, our own mortality?"