The Role of Religion in Mental Health

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Vocatus atque non vocatus Deus aderit (Bidden or not bidden, God is present). Delphi Oracle. Sentence carved above Carl Jung's door at his house in Kusnacht, Switzerland.

No topic should be forbidden when it comes to mental health. Religion and spirituality (R/S) are no exceptions. According to Gallup, 64% to 87% of Americans believe in God [1]. Asking about R/S should be part of every psychiatric assessment. Just like practitioners ask about depression and panic, stress and hobbies, sexuality and intimacy, financial and work issues, among others, they should ask about R/S issues.

R/S and Psychiatry have had a difficult relation. Freud boasted about being "an infidel Jew" and called religion a collective delusion. Much has changed since then. As a Psychiatry Fellow, 25 years ago, I was taught at Memorial Sloan-Kettering Cancer Center to respect my patients' spiritual beliefs, to inquire about them and to be comfortable working with Chaplains.

Talking about the role of Religion, the Massachusetts General Hospital's book of Consult/Liaison Psychiatry says that "ignoring religious content risks omitting an important element of the psychotherapeutic armamentarium" [2]. This may reflect the perhaps more relevant role of R/S in Consult/Liaison Psychiatry, where patients face, frequently, big existential issues. However, the World Psychiatric Association, in its official statement on R/S says that "spirituality and religion are concerned with the core beliefs, values and experiences of human beings [3]. 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." In the same statement a number of recommendations follow, including things like "a tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes

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be an essential component of psychiatric history taking." The document also talks about the need to include R/S competencies in the training of Residents.

An important question on this topic is how Religion and Spirituality are defined. It is not easy to find a good consensus. In 1998 Duke University opened the "Center for Spirituality, Theology and Health," under the leadership of Dr. Harold Koenig. For the sake of practicality, I will use the definitions put forth by him in the book "Religion and Mental Health" [4]. Religion there is defined as "a set of beliefs, practices and rituals related to the transcendent, where the transcendent is that which relates to the mystical, supernatural or God in Western religious traditions, or to Brahman, Ultimate Truth, Ultimate Reality, or practices leading to Enlightenment, in Eastern traditions. (It) may also involve beliefs about spirits, angels or demons. Usually religion involves specific beliefs about life after death and rules to guide personal behaviors and interactions with others during this life. Religion is often organized and practiced within a community, but it can also be practiced alone and in private, outside of an institution, such as personal beliefs about and commitment to the transcendent and private activities such as prayer, meditation and scripture study." Regarding Spirituality Koenig says that "it is distinguished from its consequences (human values, moral, meaning, purpose, peace, connectedness, feelings of awe and wonder) by its link to the transcendent. The transcendent is that which is outside of the self, and yet also within the self, and in western traditions is called God, Allah, HaShem or a higher power and in Eastern traditions is called Ultimate Truth or Reality, Brahman, the Dharma or Budda."

R/S can play a positive or negative role when it comes to mental health. Among the positive, it may be associated with better coping, resilience, higher sense of meaning, and good mental health overall. Among the negative, religious beliefs may be incorporated in the psychopathology of the patient. About a third of schizophrenic patients suffer from religious delusions when psychotic. For bipolar disorder patients, the rate is 15 to 22% [5]. Religious hallucinations are also common.

Although traditionally Catholic, Hispanics with an interest in R/S issues have been open, more and more, to others' faiths and ways of believing when it comes to how to relate to the transcendent or sacred. It is not uncommon to find Hispanic patients that have embraced or frankly converted to non-Catholic Christian denominations ("Protestantism"), Buddhism, atheism (often times with an emphasis more on values and principles), Judaism, and others. It is not common (in my experience) to see Hispanic patients that convert to the Muslim faith.

Some of the main topics encountered in the literature about Hispanics, religion, and mental health include things like mental health stigma in Latinos, their use of religion for coping with stress, the possible protective role of religion in Latinos, the use of religion to increase access to mental health in Latinos and other minorities, etc.

In terms of protection from mental health problems, Meyers et al. looked at the data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) regarding religiosity, race, and alcohol use behaviors in the United States [6]. Frequency of religious attendance was inversely associated with alcohol use disorders. The association was more robust in Blacks than in Whites or Hispanics, but it also happened in the latter two groups.

Ai et al. investigated the association between childhood abuse, cultural factors, and lifetime substance use disorder (LT-SUD) among Latinas nationwide [7]. Religious attendance at a weekly level was negatively related to LT-SUD. The authors concluded that "religious attendance may have potential protection for Latinas."

Kirchner and Patino looked into religiosity in a sample of 295 Latino immigrants to Spain (63.1% of them were women) and found that religiosity was correlated with less depression, but only in women [8]. In women also, "the sense of spiritual fulfillment had mediating value in buffering the relationship between stress and depression symptoms." They conclude, naturally, that it is difficult to determine what part of the protection was due to religion and what part to social support received in the religious community.

Access to Mental Health Care in Latino immigrants is known to be significantly lower, compared with non-immigrant Latinos and non-Hispanic Whites. Faith Based Organizations (FBO) have been considered for helping this situation. According to the Department of Health and Human Services, one in four people with mental health concerns turn to faith leaders before they seek help from clinical professionals. Dalencour et al. report on 947 individuals from the Community Partners in Care Study, to see if they received depression care (determined by interview) in six FBOs in Los Angeles [9]. Sixty percent of the patients attended a religious place. Of those, 39% received depression services. The patients that used FOB mental health services had significantly higher mental health needs than those who did not use those services. This included prior diagnosis of depression, mania, or psychosis. Younger patients were more likely to use the services and to be African Americans and non-US born Hispanics. Due to the stigma associated with Mental Health in the Hispanic community, in general, many patients don't request or receive care. Frequently, in my experience, Hispanic patients are seen only when the situation can no longer be hidden like, for instance, in case of a suicide attempt, an episode of mania or psychosis, a panic attack that makes the patient go to the ER thinking they are having a heart attack, etc.

Another concern that Hispanic patients voice is that seeing a mental health provider (or just going to see a primary care provider), and having to register in a clinic, may come to haunt them back later as a problem with immigration services, if not with a quick detention on the spot followed by a speedy deportation.

Due the above two factors, efforts to "recruit" Hispanic patients into clinics that provide even virtually free care often times don't achieve much, and are met with frustration on the part of the staff in those clinics.

What could be some of the basic recommendations for providers that want to include R/S in their mental health practice?

1. Deal with your own issues first.
2. Elicit a thorough spiritual history.
3. Respect and support the patients' beliefs.
4. If necessary, challenge those beliefs.
5. Prayer with patients.
6. Consider working with a Chaplain.

1. I have heard Residents (and other practitioners) say that "we are not supposed to talk religion with our patients." Or that religion and politics should be left out of the therapeutic encounter. I agree that talking about politics is almost never helpful in psychiatric treatment. But R/S is different. Statements like the one from the World Psychiatric Association quoted above can do a lot to change that perspective. Residents and seasoned practitioners need to have a good understanding of how they perceive the themes of R/S, God, faith, and prayer. And to understand that patients have their own positions. Most importantly they need to understand that this areas need to be respected and explored regardless of our own beliefs or lack of.

   R/S also affect health providers. An interesting recent article published in the JAMA Journal of Psychiatry in May of 2020 found that religious attendance in almost 65.000 US nurses was associated with lower risk of death from despair [10].
2. Elicit a thorough spiritual history, including religious background and spiritual experiences throughout life (childhood, adolescence, adulthood). Determine how religion has been used to cope with life stressors. Any positive or negative experiences with religion should be recorded as well as religious beliefs and activities. As recommended by Koening, the response on the part of the patient that he is not spiritual should not stop a gentle exploration of the past. If the patient shows resistance to the topic, it is better to drop the subject. But especially when the patient engages in psychotherapy, the topic should be revisited at a later point, when the therapeutic alliance is more solid.
3. Respect and support the patients' beliefs. Respect, regardless of what they generate in you, in terms of countertransference, is important to the patient. And respect regardless of any degree of psychopathology you may perceive in those same beliefs. Take initially a more neutral exploratory stand, before deciding if they need to be supported or not. A great example of respect for religion in psychotherapy is in the book "Schopenhauer's Porcupine," by Deborah Anna Luepnitz, PhD. [11]. In Chap. 2 she describes the case of an 11-year-old Orthodox Jewish girl, daughter of a Rabbi, who presented with brittle diabetes (presumably due to psychological issues) that is beautifully and respectfully treated by a Catholic Psychologist.
4. If the beliefs are maladaptive, they need to be gently challenged. This is a touchy endeavor. It is better to do it once a therapeutic alliance has been established, and some progress in therapy in other areas has been achieved. A beautiful example of challenging spiritual beliefs is in the book "Love's Executioner" by Irvin Yalom, in the chapter "If rape was legal…" [12].
5. Prayer with patients. This is acceptable, if done with common sense and some basic requirements. The patient should initiate the request, the provider should have a good understanding of the patients' religious background and psychiatric diagnosis, both patient and provider should (ideally) share the same religious background, and the provider should have a clear understanding of what the prayer is for.

6. Consider working with a Chaplain. Any provider that believes that R/S are important issues when working in mental health but that does not feel well prepared or comfortable to deal with them, can refer the patient to a Chaplain, one that is ideally known to be able, in turn, to work with the provider (and not, for instance, recommend to the patient to stop taking psychiatric medication in order to let God heal him). Just like providers have specialists they feel more comfortable referring patients to for consultation, the same can be said of working with Chaplains.

Two personal vignettes may be worth mentioning briefly:

I was once called to see a 10-year-old Hispanic girl from Central America who came to the USA for treatment of osteosarcoma. The prognosis was grim and her mother (a highly educated person) was told from the beginning and in no uncertain terms. In fact, the girl died about a year later. The reason for the consult was that the mother expressed that if her only daughter was going to die despite receiving treatment she might as well "just kill her and then kill myself." I worked with that mother during that year. Two days before dying, the girl (who had dealt with the whole situation with nothing but grace, courage and no psychiatric issues) was telling me still that she "knew" that God was going to save her. For her mother, in psychotherapy for depression, the issue was not so simple. She was not particularly religious but she was open to the inclusion of the topic in therapy, at times. She felt challenged by her daughter's faith and found a degree of comfort in it. She was also able to speak about issues like feeling abandoned by God. In the end, she was able to accept her daughter's death with some sense of peace and she abandoned the idea of suicide. I followed her from a distance for at least four more years and she remained well adjusted to her loss and to life.

I was asked to see a 9-year-old boy from South America, who was battling a neuroblastoma. His case had a very poor prognosis. His father was a Physician and his mother a Psychologist. There were 3 more siblings involved, two older than the patient and one younger. I tried to work with this family as best as I could, but it felt up the hill for me, despite having excellent supervision. At some point I spoke with the father about their faith. He said they were Catholic. They said it was difficult to go to Mass because being with their son was a 24/7 duty plus Mass in English was "not the same." I offered to get them a Spanish speaking Priest, but the father declined, politely but firmly so I dropped the issue. The day the patient was dying, I stopped by to visit him. As I was arriving I noticed that he was totally alone in his room except for his mother, who was by the door, in a chair, quietly praying the Rosary. I spent some time with them. After a while, the father pulled me aside and told me that this was perhaps "the" moment to get that Priest if I could. I had recently become acquainted with a Priest from Spain that was spending some time in the city, and I went to his Church to tell him about the situation. He quickly went back with me to the Hospital and administered the last rites to my patient, with the whole family (and me), present. At the time I was agnostic, but I treasure the memory of that moment.

Conclusion

Religion and Spirituality need to be included in the psychotherapeutic encounter with Hispanic patients. The old antagonism between Psychiatry and Religion is weaning. For those interested in learning more about this, there are plenty of resources out there.

As we have discussed in this chapter, Psychiatry is changing its approach to R/S issues. Religion, in turn, is changing its approach to mental health. As an example, in a visit that American Psychiatrists paid to the late John Paul II, he told them:

"The meeting affords me a welcome opportunity to express the church's esteem of the many physicians and health care professionals involved in the important and delicate area of psychiatric medicine…. By its very nature your work often brings you to the threshold of human mystery. It involves sensitivity to the tangled workings of the human mind and heart, and openness to the ultimate concerns that give meaning to people's lives. These areas are of the utmost importance to the church, and they call to mind the urgent need for a constructive dialogue between science and religion for the sake of shedding greater light on the mystery of man in his fullness" [13].

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