Approaching Religiously Reinforced Mental Health Stigma: A Conceptual Framework

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Religious reinforcement of mental health stigma is a widespread obstacle to treatment. Understanding its principal causes—fundamentalist thinking, communal bonding, misattribution of psychopathology, traditional beliefs and healing practices, and adverse experiences with secular providers—is a prerequisite to effective mitigation. This requires a sensitive search for common ground, efforts to work within community values, attempts to address both psychiatric and spiritual concerns, and educational interventions tailored to these challenges. Addressing religious reinforcement through collaboration between providers of psychiatric and spiritual care requires further study.

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Religiously reinforced stigma toward mental illness is an obstacle to effective treatment worldwide (1, 2). Examples include competition from traditional healers, the use of prayer rather than medication for depression, and exorcisms performed for psychosis. We distinguish here several sources of the problem—fundamentalist thinking, communal bonding, misattribution of psychopathology, cultural and religious beliefs and practices, and adverse experiences with secular providers—to highlight their differing implications for intervention. By virtue of their availability, most examples and literature cited pertain to American Christianity.

Fundamentalist Thinking

Fundamentalism has come to be understood as a way of thinking marked by authoritarianism and intolerance for ambiguity ("nonquesting") that transcends particular religious and political traditions (3). It has been associated with prejudice, perhaps because fundamentalists are more susceptible to uncritically accepting racial and ethnic stereotypes endorsed by authorities, such as clergy. Studies have found that religious fundamentalism correlates more with stigma against mental illness than does orthodox Christian belief (4), and higher levels of religious fundamentalism are associated with greater preference for religious rather than psychological help seeking (5). An example of a fundamentalist approach to mental illness is the Biblical Counseling (formerly nouthetic counseling) movement, which, in contending that truth can be known literally only through revelation in scripture, rejects mainstream psychology and psychiatry as humanistic, secular, and antithetical to Christianity (6). Fundamentalist, highly literal interpretations of scripture are often reflected in positions on gender roles, divorce, substance use, and domestic violence (7).

For example, a woman with complex PTSD, nightmares, and hypersensitivity to suspected abuse was encouraged to think about her symptoms as demonic in origin and to tell negative thoughts to "go back to the pit of hell."

Given the need felt by fundamentalists to operate within a closed cognitive system, and the challenges they can present in accepting treatment, Aten et al. (7) have suggested that mental health professionals evaluate their own attitudes; sensitively explore their patients' rigid beliefs; collaborate with community gatekeepers including clergy, and respect the potential for religious belief to foster recovery.

The Role of Tribalism

Tribalism is a pervasive feature of human society that can find expression in religious contexts. Strong social bonds formed though sharing a faith or a cause can encourage a sense of security among trusted "kin," altruistic care for fellow members of the faith group, expectations of fairness of the community, and a deep foundation for one's identity (8, 9). By the same token, tribal, or what Griffith and Griffith (9) called "sociobiological" religion, can mobilize mistrust, scapegoating, and stigmatization of outsiders perceived as different or threatening (8). For example, congregations may counsel, sanction, or "disfellowship" individuals with mental illness or substance use disorders because their appearance or behavior deviates from the group's norms. Members can

experience pressure to pursue spiritual rather than secular interventions for problems such as depression. An African-American youth described her church's response to her efforts to seek help as follows (10), "Cause they'll tell you, they'll tell you [sic] 'Oh, we wouldn't judge you on that blah, blah, blah, blah, blah,' and then they come right back around and they judge you on it and they're doing the same thing."

Similarly, members of (spiritually oriented) 12-step programs can experience sanction for seeking professional help outside of the group, and high-demand groups such as the Church of Scientology can be overtly antagonistic to psychiatry.

As with fundamentally oriented believers, it is often useful for communally stigmatized patients to find providers who have credibility within their spiritual tradition—ideally, those who are trusted by their particular community. Models for doing so include church-based mental health clinics, spiritually oriented mental health or 12-step programs such as Celebrate Recovery (https://www.celebraterecovery.com/), networks of community providers of the same faith, and active interdisciplinary referral and consultative relationships.

Education of faith communities and leaders can also help to break down perceived boundaries and stigma. A helpful resource is *Mental Health: A Guide for Faith Leaders* (https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership), prepared by the Mental Health and Faith Community Partnership of the American Psychiatric Association. It can also be helpful for faith leaders to talk openly about their own emotional struggles and experiences with seeking help and how their tradition reaches out to those who have been alienated ("welcomes the stranger").

Misattribution of Psychopathology

It is sometimes difficult to separate psychiatric symptoms from religious beliefs, and it is easy to imagine instances in which the psychiatrist, patient, and religious community disagree about what labels to use. Examples include patients with bipolar disorder believing they are being directed by God, patients with depression believing they have committed an unpardonable sin, or patients with obsessive-compulsive disorder feeling guilty of imagined sexual indiscretions. As Pargament (11) has pointed out, immature ways of coping can also be expressed in constricted spiritual beliefs and practices, such as beliefs in a God who can only judge and punish, or an emphasis on caring for others to the exclusion of self-care.

For example, an engineer with an obsessional personality style whose passivity in his marriage led to a divorce believed God was calling him to suffer rather than stand out for his achievements.

Clinicians should approach psychopathological misattribution sensitively, addressing their dynamic and pathological sources of distress without unnecessarily challenging the individual's faith, although at times they may need to be direct, for example in insisting on needed medication. When differentiating cultural and normative religious expression from psychopathology is challenging, consultation and collaboration with members of the patient's faith community can be helpful, and the patient's family of faith can become an important ally in fostering insight and adherence to treatment.

Traditional Ways of Understanding

Faith communities in certain subcultures may rely on traditional cultural ways of understanding and dealing with depression, psychosis, or addiction, referring for guidance to accounts of healing found in the scriptures (10, 12). They may draw on these to address depression as a lack of faith, substance use disorders as sinful choices, psychosis as possession, or disability as punishment. Before or instead of standard mental health treatments, they may employ prayer, exorcism, or pastoral counseling to heal.

As an example, a woman who became very anxious after the birth of her third child was encouraged by her church community to rely on God rather than on medication or psychotherapy to identify her family's "generational sins" and pray them away.

Clinicians who encounter patients using spiritual practices should appreciate the potential intrinsic value of these practices and the community support they may represent, while being alert to potential harms, such as delays in needed care, physical and emotional trauma from exorcism, and internalization of shame for falling short of their own or others' expectations. A range of attitudes toward healing is often present within a single religious tradition, providing opportunities for a variety of educational interventions.

Adverse Experiences With Secular Providers

Although less religious than physicians in other specialties, most psychiatrists describe themselves as spiritual or religious and manage the relationship between religion and psychiatry with little overt conflict (13). The examples here highlight the few instances in which religiously themed conflict occurs and the outcome is unsatisfactory. For example, patients may not only suspect secular clinicians of sharing the antireligious attitudes of Freud, but also decide these suspicions have been confirmed if they feel they are, for example, told they are "too religious," encouraged to engage in premarital sexual activities, or asked to consider divorce before they feel ready to do so.

In their study of Christians in secular psychotherapy, Cragun and Friedlander (14) quoted a participant who felt her faith was being questioned as legalistic and unreasonable. "I had been seeing this counselor for a while and it [faith] came up and I sort of got the message of, 'Do you ever think that Christianity is part of the problem or contributing to your depression?' And I was like, 'What do you mean?' And she was like, 'Well, sometimes fundamental Christians

have all these rules to follow, and we can never measure up to that. Is that part of the problem?'"

Negative experiences in secular therapy encourage perceptions that "much of those disciplines are built on a faulty worldview and must be (at least partly) rejected" (15). Instead, clinicians need to show that they respect that the patients' beliefs and values are important to them, even if they do not share them, and at times facilitate referral to clinicians who share the patient's tradition or system of values. Collaborative care with mutual learning offers the potential to reduce future adverse experiences.

Conclusions

Disentangling the sometimes overlapping reasons for religiously reinforced stigma is important for addressing them effectively. For example, educational interventions may need to be directed toward faith leaders, group members, and those who have experienced disappointing encounters with mental health professionals.

An ethical challenge in dealing with religiously reinforced stigma is balancing respect for patients' religious or spiritual beliefs and practices with clinicians' concerns for their well-being and the therapeutic goal of fostering independence of thought. Given the complexity of these issues, attention to transference and countertransference in working with religious patients becomes important.

Most mental health clinicians lack formal training in religion and spirituality, but guidance is available, including on how to inquire about the sources of help individuals have sought (such as folk healing, religious or spiritual counseling, or other forms of traditional or alternative healing) (9, 11, 16). Much more work is needed to identify and study the effectiveness of models for working with faith leaders, congregations, and religious individuals to modify religiously reinforced mental health stigma.

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