ARTICLE

Religious Barriers to Mental Healthcare

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Religion can be defined as the collection of beliefs, practices, and rituals related to the "sacred" (1). A religious group refers to a large number of people with shared spiritual values. According to DSM-5, religion is considered as part of the cultural context of the illness experience. However, shared values toward spirituality may indicate common characteristics among patient populations across different religious backgrounds. Providing culturally appropriate mental healthcare is further complicated by the fact that any one religious group may be comprised of a variety of ethnicities, socioeconomic classes, and subcultures with their own belief systems.

Religion plays an important role in American society. According to a national survey by Pew Research, more than 70% of Americans report being affiliated with a religious group, and 42% attend religious services weekly or almost weekly (2). People with persistent psychiatric disorders could rely on their religious beliefs to cope with their condition (3). In a study of 406 patients from 13 Los Angeles County mental health facilities, more than 80% of the participants reported using religious beliefs or activities to cope with daily difficulties and frustration (4). Another study using the National Comorbidity Survey data suggested that a quarter of religious people seek help from clergy as their first treatment contact for mental health problems (5). Several other studies have shown that religious involvement is associated with positive mental health outcomes (6–8).

Patients' tendencies to use religion when coping with mental health-related problems and the involvement of a nonclinical party can result in a complex model of mental healthcare delivery. The current literature regarding the interface of religion and psychiatric care primarily focuses on the outcome of the psychiatric treatments. This focus draws limited attention to religion's effect on service access and use. It is critical to understand the religious barriers to appropriate and efficient mental health delivery to different populations. The present review article focuses on potential barriers to access to mental health services among people with religious involvement. Access barriers may be grouped into three major categories: the patient level, the psychiatrist level, and the system level.

ACCESS BARRIERS

Patient-Level

The help-seeking process starts with an individual's understanding and conceptualization of psychiatric disorders (Table 1). Interpretations of psychiatric symptoms are influenced by a patient's cultural experience, which includes religious beliefs and practices. Historically, psychiatric disorders were explained by supernatural phenomenon, such as demonic possession. Today, some religious people may believe that psychiatric disorders are caused by a "weakness in faith" and that the illness can be overcome or cured through "willpower" alone, rather than by seeking professional help from the mental health system (9). For example, in one survey, 85% of African Americans defined themselves as fairly religious or very religious, and researchers have found that there is a prevalence of a belief in this population that psychiatric disorder can be overcome by heroic striving (10). For this reason, some patients with religious affiliation may avoid contacting a psychiatrist. Even after contacting a physician, patients might avoid discussing their religious concerns with the provider because of their perception that psychiatrists are not sensitive to or knowledgeable about the religion (3, 10, 11).

Similar to patients, clergy also have various beliefs about psychiatric care and the perceived need for treatment

TABLE 1. Access Barriers to Care

Patient level
Conceptualization of disease
Beliefs in religious help for mental illness
Beliefs about perceived need for treatment
Use of nonpsychiatric forms of services
Fear of challenging religious beliefs
Fear of discrimination
Psychiatrist level
Difficulty recognizing nonpathological expression of religion
Reluctance in obtaining religious history
System level
Clergy's lack of familiarity with the system
Limited referral from clergy
Limited understanding of clergy
Lack of coordination between faith-based services and formal healthcare
Reluctance of collaboration by faith-based providers

(12, 13). In a survey conducted among 204 Protestant pastors, a significant portion of the participants attributed symptoms of depression to "lack of trust in God," and they were less likely to agree with the biological nature of depressive disorders (12). Another study conducted on Muslim clergy suggested that while imams can recognize the need for psychiatric care in a hypothetical clinical vignette, they could still be reluctant to make referrals to the mental health system due to concerns about discrimination based on their religion (13). Since clergy are a key entry point for a quarter of religious people, the clergy's perceptions of psychiatric disorders can lead to avoidance of referral to mental health providers.

Additional concerns among religious people may arise when they need inpatient level of care. In an observation study conducted at SUNY Downstate Hospital, Orthodox Jewish patients at the psychiatric inpatient unit experienced difficulties while following ward milieu due to conflicts with religious practice. For example, inability to pray at accustomed times exacerbated the anxiety of religious patients (14). For an outpatient treatment such as psychotherapy, nonreligious therapists can integrate religious components into their treatment; however, patients might have fears that the therapist will challenge their religious beliefs. This can be a barrier for patients who seek long-term treatments like psychotherapy (15).

Psychiatrist-Level

It is also important to note how psychiatrists relate religion and health. Clinicians' views of religion can shape how they interact with their patients (16) (Table 1). In a national survey, it was found that psychiatrists were less likely to be religious compared with nonpsychiatry physicians (15). Although psychiatric care promotes better understanding of patients' beliefs, patients still report difficulty finding a psychiatrist with an understanding of their religious beliefs. This can be especially prominent in religions with a relatively low percentage of psychiatrists within the population (2).

KEY POINTS/CLINICAL PEARLS

- More than 70% of Americans report being affiliated with a religious group.
- A quarter of religious people seek help from clergy as the first contact for mental health.
- Religious beliefs continue to be an important part of individuals' attitude toward seeking psychiatric care.
- Clinicians can use the HOPE questionnaire to assess patient's religiosity.

Psychiatrists frequently encounter patients with pathological expressions of religion, such as religious delusions (17). Psychiatrists may have difficulty separating normal and pathological expressions of religiosity, which becomes a barrier to understanding their patients. In an interview study, psychiatrists reported discussing religion with their patients in only 36% of cases, although they reported feeling comfortable talking about religion in 93% of the cases (3). None of the clinicians initiated the topic themselves. Patients in the same study reported avoidance of talking about their spirituality, especially when it overlapped with their positive psychotic symptoms. In the same study, psychiatrists discussed community resources of the religion with their patients but had difficulty discussing the subjective experience of their patients' religiosity.

System-Level

While religiosity and spirituality in American society have increased (2), there has been an increase in the use of nonpsychiatric forms of mental health services and a decrease in the use of psychiatric services (5). Because clergy are often the first entry point to mental health for religious people (5, 18), it is important to understand the role of religious institutions in service delivery. Despite the fact that use of clergy for mental healthcare is associated with good outcomes (19), we have limited understanding of the structure of faith-based service delivery. A cross-sectional survey found that counseling provided by clergy has low frequency, even for individuals with serious psychiatric or substance use disorders (5). In addition, coordination between faith-based services and formal healthcare has often been lacking (Table 1). A survey on clergy suggested that faith-based providers were found to be reluctant to collaborate with formal health services due to several reasons, including lack of demand from their community, financial limitations, and lack of specialized training (20). Even among clergy who have a willingness to refer an individual to a mental health provider, the lack of familiarity with the mental health system may remain a barrier (13).

IMPLICATIONS

The goal of this review was to raise awareness of access barriers to mental health treatment for religious people. Several barriers were identified and categorized according to patient, psychiatrist, and system levels. It is important for clinicians to be aware of these barriers and seek ways to educate themselves, their patients, and the community about the role of religion in mental health delivery. Different interventions can be used to overcome these barriers, especially at the psychiatrist level, such as assessing and understanding patients' beliefs and collaborating with clergy (17).

Assessing religious beliefs is now a standard part of psychiatric history. There are different protocols for how to assess patients' religiosity. One of them is the HOPE questionnaire [sources of **H**ope, **O**rganized religion, **P**ersonal spirituality and practices, **E**ffects on medical care and end-of-life issues], a protocol for asking patients questions about spirituality (21). The HOPE questionnaire could be a good guideline for residents. It is critical to understand

and discuss how patients shape their responses based on their religiosity. A psychiatrist should be aware of the obstacles and opportunities with regard to the religion-related issues during the interview. By understanding potential barriers at different levels, we can build individual and system-level approaches to improve mental health service delivery.

CONCLUSIONS

For a substantial part of the population, religious beliefs continue to be an important part of an individual's attitude toward seeking psychiatric care. As psychiatrists, we should be aware of both the opportunities and barriers for patients with religious involvement to receive appropriate care. In particular, understanding religiosity and its effect on service use suggests that we need to build new approaches to improve the service delivery to patients who have religious involvement and coordinate with the faith-based services. From a research standpoint, there is a strong need to understand faith-based factors that may improve access to mental healthcare.

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The author thanks Osman M. Ali, M.D., and Adam Brenner, M.D., for their feedback and suggestions.

REFERENCES

1. Koenig HG: Research on religion, spirituality, and mental health: A review. Canadian Journal of Psychiatry 2009; 54:283–291
2. Pew Research Center, May 12, 2015, "America's Changing Religious Landscape" available at http://www.pewforum.org/files/2015/05/RLS-05-08-full-report.pdf
3. Huguelet P, Mohr S, Borras L, et al: Spirituality and religious practices among outpatients with schizophrenia and their clinicians. Psychiatr Serv 2006; 57:36–372
4. Tepper L, Rogers SA, Coleman EM, et al: The prevalence of religious coping among persons with persistent mental illness. Psychiatr Serv 2014; 52:660–665
5. Wang PS, Berglund PA, Kessler RC: Patterns and correlates of contacting clergy for mental disorders in the United States. Health Serv Res 2003; 38:647–673
6. Koenig HG, George LK, Peterson BL: Religiosity and remission of depression in medically ill older patients. Am J Psychiatry 1998; 155:536–542
7. Bosworth HB, Park KS, McQuoid DR: The impact of religious practice and religious coping on geriatric depression. Int J Geriatr Psychiatry 2003; 18:905–914
8. Mohr S, Huguelet P: The relationship between schizophrenia and religion and its implications for care. Swiss Med Weekly 2004; 134:369–376
9. Leong FT, Kalibatseva Z: Cross-cultural barriers to mental health services in the United States, in Cerebrum: the Dana Forum on Brain Science. New York, Dana Foundation, 2011
10. Snowden LR: Barriers to effective mental health services for African Americans. Ment Health Serv Res 2001; 3:181–187
11. Lee HB, Hanner JA, Cho SJ, et al: Improving access to mental health services for Korean American immigrants: moving toward a community partnership between religious and mental health services. Psychiatry Investig 2008; 5:14–20
12. Payne JS: Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. Community Ment Health J 2009; 45:355–365
13. Ali OM, Milstein G: Mental Illness recognition and referral practices among imams in the United States. J Muslim Ment Health 2012; 6(2)
14. Sublette E, Trappler B: Cultural sensitivity training in mental health: treatment of orthodox Jewish psychiatric inpatients. Int J Soc Psychiatry 2000; 46:122–134
15. Curlin FA, Odell SV, Lawrence RE, et al: The relationship between psychiatry and religion among US physicians. Psychiatr Serv 2007; 58:1193–1198
16. Curlin FA, Lawrence RE, Odell S, et al: Religion, spirituality, and medicine: psychiatrists' and other physicians' differing observations, interpretations, and clinical approaches. Am J Psychiatry 2007; 164:1825–1831
17. Koenig HG: Religion and mental health: what should psychiatrists do?. Psychiatr Bull 2008; 32:201–203
18. Harris KM, Edlund MJ, Larson SL: Religious involvement and the use of mental health care. Health Serv Res 2006; 41:395–410
19. Hay JC, Wood L, Steinhauser K, et al: Clergy-laity support and patients' mood during serious illness: a cross-sectional epidemiologic study. Palliat Support Care 2011; 9:273–280
20. Dossett E, Fuentes S, Klap R, et al: Brief reports: obstacles and opportunities in providing mental health services through a faith-based network in Los Angeles. Psychiatr Serv 2005; 56:206–208
21. Anandarajah G, Hight E: Spirituality and medical practice: using the HOPE questions assessment a practical tool for spiritual assessment. Am Fam Physician 2001; 63:81–89