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COMMENTARY

Integrating religious faith into patient care

COMMENTARY ON… THE ROLE OF FAITH IN MENTAL HEALTHCARE†

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†See pp. 419–425, this issue.

SUMMARY

We examine Foreman's assertion that assessing, addressing and utilising a patient's faith is warranted. After a brief background, we examine when faith-integrated therapy is indicated, the need for training, an example of such a therapy, and what to do when the faith of the therapist conflicts with that of the patient. Also emphasised is the need for a clear definition of terms.

DECLARATION OF INTEREST

None

Foreman (2017, this issue) examines the controversial issue of assessing, addressing and perhaps even utilising a patient's faith as part of professional mental healthcare. He is to be commended for taking hold of this tiger by the tail and trying to tame it through a sensible and rational approach. This commentary is intended to expand on some of the author's points. We introduce this commentary by resetting the stage. While it might seem quite progressive and novel to be including the patient's faith in their mental healthcare, what is revolutionary when considered across the entire span of human history is the modern-day practitioner's exclusion of faith. Indeed, avoiding or ignoring the patient's faith is something new, occurring only during recent times as mental healthcare has become more rational and interior-focused. For millennia, people dealt with stress, loss, suffering and even mental illness through religious beliefs, rituals and support within religious communities. This is especially true for members of minority religious groups in the UK such as Islam, where the first person that the patient sees for mental health problems may be a religious healer (since mental health problems are often viewed as having a spiritual aetiology).

One of Foreman's most important points is that 'simply avoiding faith-related values in therapy […] is not sufficient' and we may add that it could even ignore resources that might be used to advantage. There is a rapidly expanding evidence base (Koenig 2012) demonstrating that religious beliefs/practices are often associated with good mental health and psychological resilience (and only occasionally with psychopathology). The growing number of clinical trials that demonstrate efficacy for faith-based approaches is also supported (Ross 2015).

When is a faith-integrated therapy indicated?

Foreman provides a practical approach for deciding whether a faith-integrated therapy is indicated by asking:

1 Is faith important to the patient (determined by a 'spiritual history')?
2 Can the patient's faith be utilised to facilitate coping (or is it a barrier in that regard)?
3 Are the faith beliefs/values of therapist and patient shared?

We wonder, though, whether question 3 is necessary. Recall that treatment focuses on the beliefs and values of the patient, not those of the therapist. Even when beliefs and values are shared, differences are likely that, if not acknowledged, can cause conflict. Whether a faith-integrated therapy is considered or not, all therapists must be able to perform an objective assessment of the patient's faith resources and liabilities, and provide treatment that is consistent with and respectful of those beliefs.

Addressing practitioner bias and training

Foreman also notes that most practitioners need formal training to keep their own faith beliefs, values and attachments (religious and secular) from interfering with their assessment and use of the patient's faith in treatment. 'Patient-centred' healthcare requires that mental health professionals acknowledge and reflect on their own biases in order to create a safe and neutral space where patients can work through their problems. This is especially true when the therapist's

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beliefs and values are different from or conflict with those of the patient. Good Medical Practice guidelines (General Medical Council 2013: para. 54) emphasise that 'You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress'. A significant proportion of patients seeking, being recommended or undergoing therapy in mental health settings is vulnerable. Therefore, psychiatrists must observe this guidance or otherwise risk action being taken against their registration. Suspending one's own beliefs and values in order to enter the world of the patient is indeed difficult, and requires substantial training and reflection when addressing deeply personal issues such as faith. There may be times when the patient's faith is so different from the therapist's that the therapist cannot ethically support the patient's faith and may be unable (because of deeply held values) even to refer the patient to someone who provides treatment from that perspective. In that rare instance, the only option is to avoid religious issues entirely and provide therapy from a secular perspective.

In other cases, instances where a faith-integrated therapy is indicated (i.e., one that utilises the patient's faith as a resource for achieving treatment goals) and is preferred by the patient, then the therapist must be trained in that method, obtain ongoing consultation from experts in the patient's tradition, or be willing to refer the patient to someone with the necessary training. One such treatment is a religiously integrated form of CBT (RCBT) for depression (Pearce 2015). A study of RCBT (with specific versions for Christians, Jews, Muslims, Buddhists and Hindus) showed that it reduced depressive symptoms to much the same degree as secular (conventional) CBT (Koenig 2015a). In that study, religiosity at baseline interacted with treatment group ($P<0.05$) such that reduction in depressive symptoms with RCBT was particularly strong for highly religious patients; the highly religious also tended to be more adherent to RCBT than to conventional CBT. Resources for applying this approach (including therapist manuals and workbooks) are readily available (e.g. from the Center for Spirituality, Theology and Health at Duke University, USA: https://spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals).

Faith and QoL

Foreman also suggests that faith is more relevant to quality of life (QoL) than to psychopathology, and we strongly agree with him. In a study of patients with major depression, we found that, although religiosity was unrelated to depressive symptoms, there was a striking positive correlation with positive emotions (Koenig 2014). Furthermore, in the clinical trial described above, RCBT tended to be more effective in increasing optimism than in decreasing depressive symptoms (Koenig 2015b).

A note on terminology

Finally, we comment on Foreman's use of language. Terms such as 'faith', 'religious belief', 'spirituality' and even 'values' are often used interchangeably (which admittedly we do as well). None of these terms (with the exception of values) has been defined in the literature in a way that clearly distinguishes one from the other. This presents a special challenge when conducting research on spirituality and mental health. Such lack of clarity has resulted in confusing spirituality with mental health itself, resulting in the inclusion of mental health indicators in measures of spirituality, thus ensuring a positive relationship with mental health (Koenig 2008). Better definitions and more consistent use of terms, then, would greatly facilitate communication about these issues.

In conclusion, this fine article will further the discussion of a factor that is dear to the hearts and minds of many patients and deserves to be brought back into mental healthcare.

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