Lab to Smartphone

Collaboration Between Child and Adolescent Psychiatrists and Faith Leaders: Is There a Path Forward?

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Recent media exposure has given many Americans their first glimpse into the hidden world of conversion therapy, where homophobia wears a therapeutic mask. Though psychiatry is historically implicated in the origins of conversion therapy,[1] many psychiatrist-advocates, working through groups like AACAP, are now working to end it.[2] Various religious groups from around the country have also started to repair the harm done by advocating for policy change.[3,4] Still, the ongoing promotion and practice of conversion therapy by some faith-based groups in the United States has led many child and adolescent psychiatrists to be wary of collaboration with faith groups in general. While many religious communities recognize the harm of practices such as conversion therapy, it remains an example of the many barriers that hinder cooperation between child and adolescent psychiatrists and some religious organizations in the United States.

At the same time, the potential benefit of collaboration between mental health professionals and faith leaders has been recognized for decades.[5] Organized religion is a foundational source of values, hope, and kindness for millions of people, and has been shown to be a protective factor for major public health problems like suicide.[6] Further, many individuals seek out religious leaders for assistance with mental health problems.[7] Across the nation, psychiatrists and faith leaders are engaged in serving the same individuals and families and working towards similar goals. It is paramount, then, that psychiatrists develop methods of collaborating with religious communities.

In a recent study involving both rural mental health professionals and clergy, members of the 2 groups developed a wide range of bold ideas for a cooperative path forward.[8] Mental health stigma was identified as a major issue within religious communities, and suggestions were made for ways that psychiatrists and clergy could collaborate to create educational interventions that break down stigma in different settings. This joint education could also reach to areas such as mental health first aid courses, mental health training for clergy and community members, as well as specific education on current issues such as the opioid crisis. One especially bold idea was the establishment of concrete and simple referral systems that clergy could utilize to find effective and economical mental health resources in their communities. This public health intervention, coupled with the investment of resources from both groups, could have a substantial impact on underserved communities as a whole.

Interventions of this size and scope would require substantial coordination. These efforts have potential to be especially helpful in overcoming systemic barriers that prevent some Americans from accessing quality mental health care, however, and may be aided by renewed motivation to fight the systemic racism that creates these barriers. Virtual or in-person meetings between psychiatrists and other mental health professionals with local faith leaders would be an effective first step. While the investment of time is not a trivial request for psychiatrists or faith leaders, the benefits would extend to both groups as well as the community at large. Psychiatrists would greatly benefit from gaining a better understanding of the communities surrounding their patients and may experience increased feelings of reward from their service to these groups. Faith leaders may develop relationships with psychiatrists

through personal interaction which could build trust and familiarity when members of the community are in need of mental health services. Especially for the underserved and communities of color, enhanced connection between the psychiatric community and faith leaders could be a powerful means to erode long-standing barriers that have prevented many individuals from obtaining the quality mental health care that they deserve. This notion of "mutual burden reduction" could also be an effective method of fighting burnout for two groups that experience this frequently in their service to others.

This type of collaboration may seem challenging, and one easily wonders how much participation could be generated, especially among groups that have harbored distrust for each other for many years. Many who have tried, however, agree there is much that can be gained. Psychiatrists may doubt the willingness of clergy members to collaborate with mental health institutions and practitioners, but research indicates that, in fact, faith leaders are significantly more interested in such a collaborative model than mental health professionals.[8] Thus, it may be that we, the psychiatrists, are the group who will require more encouragement. The first step may be for psychiatrists to educate one another about the need for this cooperation and potential benefit of various interventions. The process of building trust may be challenging, and it will require motivated parties on both sides to create effective conversations.

While it is certainly true that many psychiatrists find their clinical and religious ideas to be in harmony personally, differences of belief may present difficult waters to navigate in discussions with religious groups. Participants must acknowledge that personal beliefs differ greatly. The vision and mission of collaboration must be outlined clearly in order to maintain focus on common hopes for the benefit of the community. Specific barriers must be identified and named in creating authentic trust. Conversion therapy, racism, and harms inflicted by psychiatry are good examples of topics that cannot go unaddressed in meaningful conversations about faith and mental health. These types of conversations may feel uncomfortable, but they will ensure that all participants have a clear understanding of expectations for collaboration and therefore greater trust as a whole. After a solid foundation has been laid, the next step to building trust will be performed through active service to the community. This may include in-person meetings for community education, sharing resources, and establishing referral systems. Each investment in public service performed as one coalition will tangibly solidify the base upon which further cooperation can be built.

Psychiatrists and faith leaders are both engaged in what many consider a "calling" rather than a career. Both callings require devotion to service and carry with them great responsibility for the care of their communities. Both are also currently tasked with helping the mental health crisis that America now faces. Collaboration between these groups has enormous potential benefit for people with mental illnesses across the country. The path forward is rocky, as modern issues like conversion therapy create uncertainty and distrust. It is possible, however, to move one step at a time in the direction of healing our communities together.

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