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Editorial

Challenges to welcoming people with mental illnesses into faith communities

Patrick W. Corrigan

Summary

Faith communities are important to the psychiatric care of people with mental illness. I distinguish the effects of two principles of becoming welcoming communities: compassion, in which the community accommodates members with mental illnesses so they are fully included, and dignity, which rests on the essential worth of everyone.

Keywords

Stigma and discrimination; social deprivation; human rights; ethics; rehabilitation.

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Patrick Corrigan is Distinguished Professor of Psychology at the Illinois Institute of Technology. His research examines mental illness, substance use disorder and the effects of stigma on recovery.

As we better recognise the role of social inclusion in recovery, differing arenas outside the traditional psychiatric service system have emerged as agents in this journey. One such venue is faith communities, a group of people organised around a common set of religious or spiritual beliefs. These might be informal communities, *ad hoc* groups that gather for shared 'spiritual' purpose, or more formal organisations with a well-defined creed, clergy and history. In this editorial, I summarise efforts to promote welcoming communities, describing programmes that guide congregation members to include peers with mental illness in their communities. In the process, I recognise a possible tension in welcoming goals: promoting compassion versus dignity. The purpose of this paper is to highlight some considerations in this complex relationship so that people with mental illness are better able to fulfil personal inclusion goals in faith communities. The timeliness of this issue is highlighted by the relatively recent statements by both the Royal College of Psychiatrists[1] and the World Psychiatric Association[2] on psychiatry and religion. Statement goals were to outline psychiatrists' consideration of the role of religion in mental healthcare.

How might faith communities better welcome people with mental illness?

There is some research that shows formal clergy providing pastoral counselling can promote mental health gains,[3] although guidelines also suggest clergy should refer community members with more challenging mental health issues to trained professionals.[4] The focus of this paper, however, is benefits of faith communities when they promote social inclusion to people with mental illness. What should members of these communities do to welcome people with mental illness into their congregation? Social inclusion is the first principle for justice efforts to enhance opportunities for all disenfranchised groups: people of colour, people with low incomes and people with mental illnesses. People with mental illnesses are able to fulfil health and wellness goals when they can become fully involved in the real-world settings in which these goals are realised, including work, education, health, community and faith communities. Accommodations may better facilitate full social inclusion; reasonable accommodations often call for day-to-day assistance or changes to a role or environment that will enable, for example, employees to do their jobs despite having mental illness. The necessity for such accommodations extends to other settings where social inclusion is sought, including faith communities. This may require educating community members about how mental illnesses may limit full participation in their group, and what accommodations specific to these might facilitate community inclusion goals.

Two types of curricula have emerged to educate faith communities on accommodating members with mental illness. Mental Health First Aid is an example of the first type: having evolved out of the psychiatric services community, it is a well-developed and evaluated curriculum that teaches people how to be good helpers by recognising signs and symptoms of mental illnesses and learning listening skills when a person is in need. It has specifically been adapted for faith communities (https://www.mentalhealthfirstaid.org/population-focused-modules/faith-and-spiritual-communities/). The second type came out of interfaith communities. The Companionship Model, for example, focuses less on symptoms that prevent people from fully participating in the community and more on what congregation members can do to fully include them (www.thecompanionshipmovement.org). The Sanctuary Course is a similar approach from Canada (www.sanctuarymentalhealth.org). It teaches church members that companionship is built through hospitality, neighbouring, sharing the journey, listening and accompaniment.

Common to both approaches is the aim to build compassion and mercy as a vehicle for fully including someone, a noble goal in many faith communities. The Qur'an describes Allah as the most merciful Lord. Buddhism has the *bodhisattva*, Guanyin, the pinnacle of mercy and compassion. The New Testament recounts miracles of Jesus, who showed mercy to the sick, healing those with leprosy, paralyses and blindness. With compassion, a community is better able to accept the person with mental illnesses into its fold. Unfortunately, there may be a risk to compassion: it may unintentionally threaten dignity and interfere with social inclusion.

Social inclusion is undermined by stereotypes about people with mental illnesses that lead the public to excluding them from their community.[5] Hence, erasing the effect of stigma becomes a public health priority. One approach is education programmes that promote mercy and compassion. Programmes like these that especially focus on symptoms (e.g. 'People do not choose to have psychotic symptoms') may unintentionally exacerbate stereotypes of differentness, 'a diseased person is broken and unlike me'. Compassion may bleed into pity, which combines feeling sorry for someone with compelling need to intervene. One study showed possible ill effects of pity, namely that those with mental illnesses who were pitied by peers reported having less personal

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empowerment and more hopelessness.[6] The faith helper role may intensify a one-down position between a congregation member and the individual with mental illness. In addition, education generally is not seen as an effective method of challenging stigma. Strategies that seek to increase public knowledge about mental illnesses being a brain disorder make stigma worse, fostering the idea that mental illness is hard-wired and inescapable.[7]

Instead of compassion, advocates often focus on dignity to decrease the harmful effects of stigma; they frame mental illnesses as a part of one's identity worth respecting rather than hiding. In this light, welcoming is anchored in a different principle of many faith groups: the inherent worth of individuals. Dignity permeates the creed of many faith groups. Religions recognise the sanctity of individuals in themselves, whether this is a consequence of being of God ('So God created humanity in God's image, in the image of God, God created them.' [Genesis 1:27]), or as representation of the Divine ('The human body is the temple of God.' [Rig Veda]). People should be respected as humans in themselves, without expectations. As an analogy, consider welcoming efforts extended by some faith communities toward international refugees. Pity is risky; instead, the dignity of refugees is recognised as authentic in itself. A goal of non-refugee church members is to stand with them as allies by acknowledging and respecting who they are as they wish to identify themselves. Hence, the expectation for the faith community is to stand with the person with mental illness.

This may be a conundrum for communities welcoming people with mental illness. On one hand, community members seek to promote accommodations (through compassion) so the person with mental illness may be fully included into one's faith community. This may be risky because relationships developed on helping can lead to unintended hierarchies: healers are one-up compared with patients. Compassion may clash with the other goal of welcoming: respecting the inherent dignity and worth of the person. In this case, solidarity with the person, and not a helping relationship is what is sought. Solidarity rests on the recognition and celebration of difference.[8] People with mental illness may be different because of their experiences. This replaces the shame of mental illness with pride. Personal narratives of pride may include examples of life that represent fortitude and tenacity. People with mental illness may choose to come out with their mental illness as a whole and authentic person.

Moving forward

There are challenges to being welcoming faith-based communities. Faith communities should seek to include people with mental illnesses as peers whose membership is of worth to the community in itself. I may unintentionally be suggesting a split between communities; that, for example, faith communities are separate from healthcare and rehabilitation programmes. To move forward on the issues discussed herein we need to more accurately recognise the overlap between these groups; for example, psychiatrists and other mental health providers are often active members of faith communities themselves. Balancing compassion and dignity are even more meaningful tasks at this intersection.

Finally, a word of caution to faith communities: they must distinguish welcoming from proselytising.[9] Neither role is necessarily wrong. However, confusion between them can undermine the outlined herein. Communities and providers need to be mindful of the potential risks of dual roles.

Patrick W. Corrigan, PsyD, Department of Psychology, Illinois Institute of Technology, Illinois, USA.

Correspondence: Dr Patrick W. Corrigan. Email: corrigan@iit.edu

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Declaration of interest

None.

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