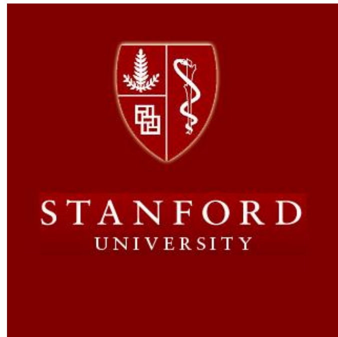

Faith, Mental Health and DSM-5

Rania Awaad, MD
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Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine

Diagrammatic Overview

Stanford Muslims and Mental Health Lab

Research

- CBPR with American Muslim Community
- Mental Health in Muslim Women
- History of Mental Health in the Muslim World
- Psychometric scales for Muslims
- Islamic Framework for Mental Health
- Culture and Religion in MH
- Social Justice and Muslim MH
- International/ Refugee MH

Psychoeducation

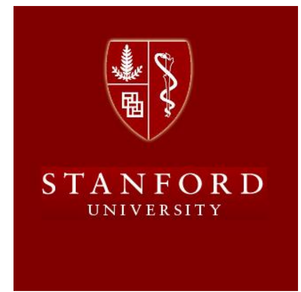
- University Level: teaching a "Culture and Religion in Psychaitry" class to Stanford residents
- Local, regional and national lectures, seminars and workshops about MH for the Muslim community
- International mental health work writting a train the trainers curriculum for PTSD in Syrian refugees and children in Gaza
- Home to the comprehensive Database on Muslim Mental health research

Mentorship & Training

- Hosts of a Monthly Meeting for Muslim Mental Health Professionals in the Bay Area
- Oversees the monthly Bay Area Muslim Mental Health Community Advisory Board meetings
- Developed and maintain a Bay Area Mental Health Emergency response team for Muslims

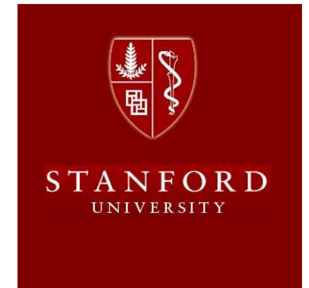
Community Partnerships

- The Muslim Community Association (MCA) in Santa Clara, CA
- Khalil Center, community wellness and counseling center for Muslims in Santa Clara, CA
- Muslim American Society- Social Services Foundation (MAS-SSF) in Sacramento, CA



Objectives

- Improved understanding of the importance of Spirituality/Religion/Moral tradition (S/R/Mt) to our patients
- Better appreciation of the impact of both positive and negative religious coping on our patients' lives
- Consistent screening for the role that S/R/Mt plays in our patients' lives and health care



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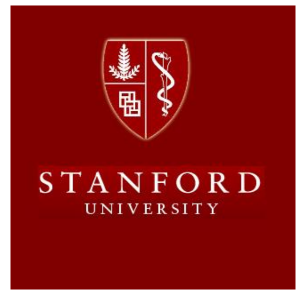
- David A. Harrison, MD, PhD @ University of Washington
- Harold Koenig, MD @ Duke University

Disclosures

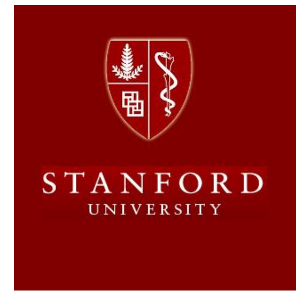
None

Psychiatrists' View of Religion



- "Religion is an illusion and it derives its strength from the fact that it falls in with our instinctual desires"—**Sigmund Freud, MD**
- "Among all my patients in the second half of life ... there has not been one whose problem in the last resort was not that of finding a religious outlook on life."—**Carl Jung, MD**
- "The essence of humanity"—**Viktor Frankl, MD**

Spiritual and Religious Beliefs: American Adults

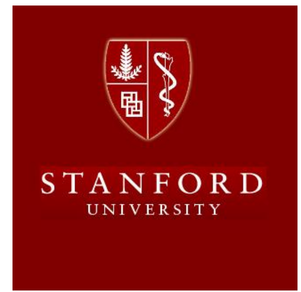


When asked: ***"Do you believe in God, Do you believe in God or in a universal spirit, or don't believe in either?"***

- 89% said they believe in God
- 89% said they believe in God or a universal spirit
- 9-10% don't believe in either

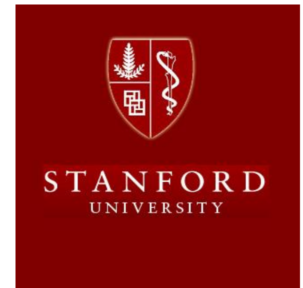
[1]"Belief in God," Gallup Poll, data collected May 14-23, 2016. Gallup Organization.

Spiritual and Religious Beliefs: American Adults



- **9 out of 10** of American adults say that they pray and **58%** pray daily
- Approximately **two--thirds** are members of churches or synagogues
- **40%** attend services regularly

[1]Pew Research Center, October 9, 2012



Religiosity by State, 2016

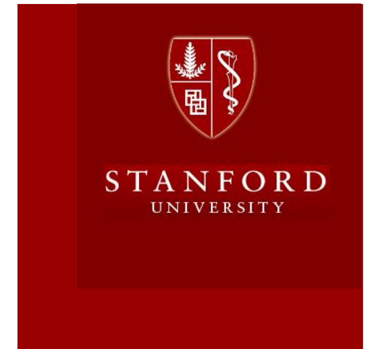
Most religious | Above average | Average | Below average | Least religious

GALLUP DAILY

Very Religious= attending weekly religious services?

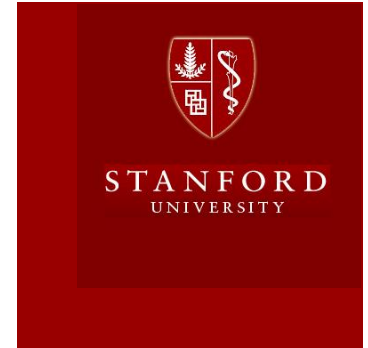
Mississippi 59%, Vermont 21%, **California 31%**

Medical Anthropology Literature (Willen et al. 2010, Willen 2013)



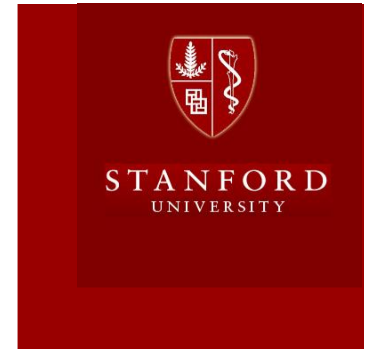
- Cultural competency initiatives must address powerful emotional valences associated with culture or risk undermining fundamental objectives
- Affective potency = "opening up a huge can of worms"
- Instructors much acknowledge their own role in deliberately cultivating vulnerability and risk, and be prepared to manage it in pedagogically meaningful and respectful ways

Medical Anthropology Literature (Willen et al. 2010, Willen 2013)



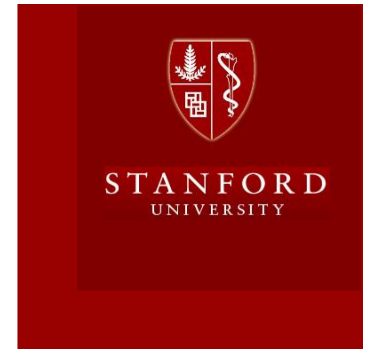
- Not “mainstream” clinicians and “other” patients: patients *and* clinicians bring cultural commitments and concerns into clinical encounters
- Most successful courses impart clinically-relevant insights and skills *while* engaging seriously with the attitudes, perspectives and biases of the clinician

The DSM-5 Outline for Cultural Formulation (p. 749-750)



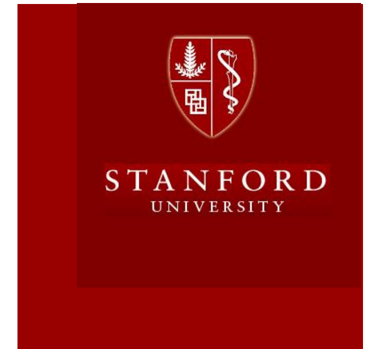
- A. Cultural identity of the individual
- B. Cultural conceptualizations of distress (Cultural explanations of the individual's illness)
- C. Psychosocial stressors and cultural features of vulnerability and resilience (Cultural factors related to psychosocial environment and functioning)
- D. Cultural features (elements) of the relationship between the individual and the clinician
- E. Overall cultural assessment (for diagnosis and care)

OCF Part A: Cultural Identity of the Individual (added in DSM-5)



- “Other clinically relevant aspects of identity may include **religious affiliation**, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.”

Residents Responses: R/S/Mt?



Resident Responses: DSM-5 Formulation

Cultural Identity

- Jewish culture; survival/fear/danger present and need for vigilance
- East coast transplants
- Education valued above money/power

white
middle class
"American"

- Korean
- family oriented
- Christian / successful
- educated

- Jewish American
- Both 1st gen American & ancestors came on Mayflower
- East coast/west coast
- Eccentric
- Middle class

- upper middle class
- European American
- nuclear family (Ø divorce)
- Christian
- professionals/academic
- stay @ home mother, father provides for family

- Jewish, feminist, hippie, Islander "BOI" Texan, eccentric, choose your "family" from friends

- Irish Catholic American, Pittsburgher (Yinzer)
Bicoastal

Cultural Conceptualizations of Distress

anxiety & stress
relationship conflict, arguments

crying
saying I need help
complaining
expressing emotions + talking about emotions

Avoidance
& communicating
Acting out

↓$
sick
hysterics
isolation

crying, 'falling apart'

Anxiety, crying, showing insecurity; emotion-based thinking instead of intellectualization

emotional
emotive externalizing
Not emotive internalizing
somatization
Physical

Resident Responses: DSM-5 Formulation

Features of Vulnerability/Resilience

- financial, status, marriage, family

R: relationships especially family, partners, close friends & being able to communicate, seek support from this community

- vulnerable - alone, friends or family, financially insecure
- resilient - pushing through, giving up

Vulnerable: isolation, lack of support

Resiliency Meant: Overcoming struggles, pulling yourself up after getting knocked down
"Putting on Your Big Girl Panties & Dealing with it"

Vulnerable: Loss of control

R: caring for family, showing success via education, handling stress calmly

V: Reactivity; emotionality; feeling unsure

Finances/resources/education.

Social support ⟷ spirituality/religion ⟷ independence

Flexibility ↕ Rigidity

Acceptance — rejection/change

Vulnerable: overwhelmed, unable to deal with everyday life, needing help.
Resilience: able to face challenges

R: close nuclear family ties, communicating, proactive, seeking help together as family, overcoming struggles, education

V: Avoidance, social isolation, being spread too thin outside fam unit, religious extremism

Cultural features Between Indiv. & Clinician

- older generation — doctor tells pt what to do, pt. follows recommendations — paternalism
- younger generation — patient centered care, doctor makes suggestions, pt may or may not follow — autonomy

- Clinician as expert, patient as following orders
- clinician as superior, unquestioned, idealized
- Clinician as authority — patient as subservient; Not allowed/expected for pt. to ask questions

being a pt means your sick, vulnerable or things are out of control

Call my Dr. "Dr. So & So" (respect)
idealize physicians like Dr. Quinn, Medicine Woman
romanticize being a good doctor by television depictions

Doctors as consultants - take or leave it
Though also idealized/romanticized.

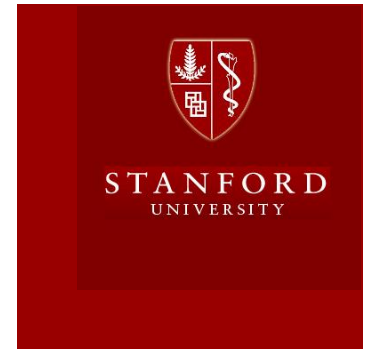
AUTONOMY ⟶ PATERNALISM

identification closeness / distance; fear shame

12 Supplementary Modules

- Patient–Clinician Relationship
- School-Age Children and Adolescents
- Older Adults
- Immigrants and Refugees
- Religion, Spirituality, and Moral Traditions

Spirituality, Religion, and Moral Traditions

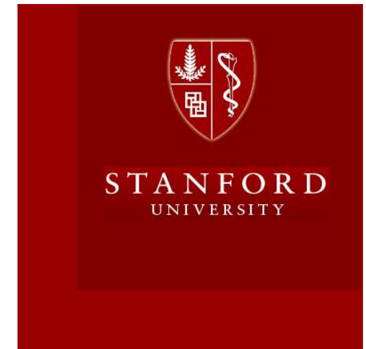


- Spiritual, religious, and moral identity (1-4)
- Role of spirituality, religion, and moral traditions (5-8)
- Relationship to the [PROBLEM] (9-12)
- Potential stresses or conflicts related to spirituality, religion, and moral traditions (13-16)

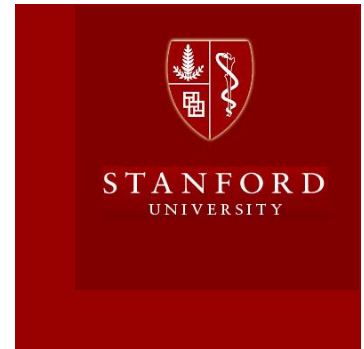
Rationale for this module: WPA Position Statement

- " A tactful consideration of patient' s religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking."
- An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered an essential components of both psychiatric training and continuing professional development."

Rationale for this module: WPA Position Statement

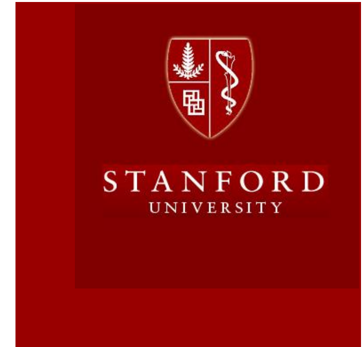


- "Psychiatrists should not use their professional position for proselytizing for spiritual or secular worldviews. Psychiatrists should be expected always to respect and be sensitive…"
- "Psychiatrists… should be willing to work with leaders/members of faith communities, chaplains and pastoral workers…"



Spirituality

- "A dimension of human experience related to the transcendent, the sacred, or to ultimate reality. It is closely related to values, meaning and purpose in life. It may develop individually or in communities and traditions." (WPA Position Statement)



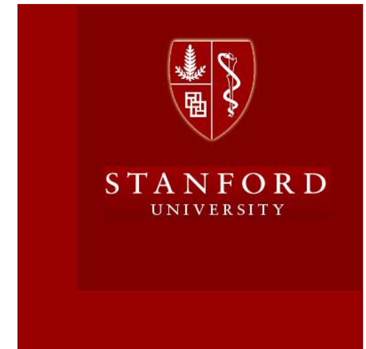
Religion

- "The institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group." (WPA Position Statement)

Moral Traditions

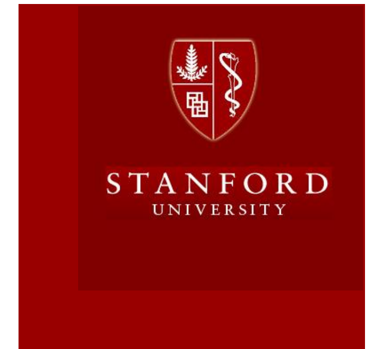
- " A system of moral reasoning and practice, akin to a worldview, typically connected to principles of spiritual and religious traditions yet often experienced as a secular and philosophical guide for ethical behavior and a 'good' life." (Lewis-Fernandez, p. 90)

Spiritual, religious, and moral identity



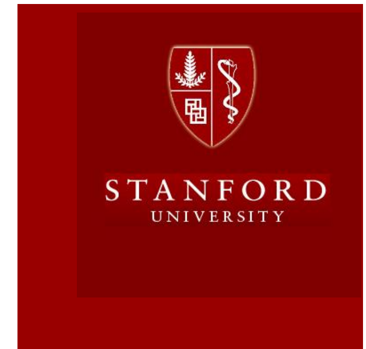
- Do you identify with any particular spiritual, religious or moral tradition?
- Do you belong to a congregation or community associated with that tradition?
- What are the spiritual, religious or moral tradition backgrounds of your family members?
- Sometimes people participate in several traditions. Are there any other spiritual, religious or moral traditions that you identify with or take part in?

Role of spirituality, religion, and moral traditions



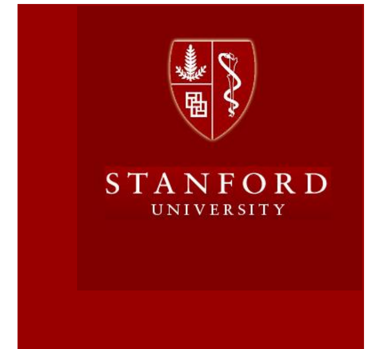
- What role does [R, S, Mt] play in your everyday life?
- What role does [R S, Mt] play in your family, family celebrations or choices in marriage or schooling?
- What activities related to [R, S, Mt] do you carry out in the home, for example, prayers, meditation, or special dietary laws?
- What activities do you engage in outside the home related to [R, S, Mt] , for example, attending ceremonies or participating in a [CHURCH, TEMPLE OR MOSQUE]? How often do you attend? How important are these activities in your life?

Relationship to the [PROBLEM]



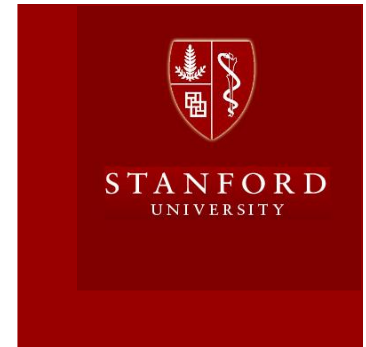
- How has [R,S, Mt] helped you cope with your [PROBLEM]?
- Have you talked to a leader, teacher or others in your [R,S, Mt] community, about your [PROBLEM]? Have you found that helpful?
- Have you found reading or studying books of [R,S, Mt], or listening to programs on TV, radio, the internet to be helpful?
- Have you found any practices related to [R,S, M t], like prayer, meditation, rituals, or pilgrimages to be helpful to you in dealing with [PROBLEM]?

Potential stresses or conflicts related to spirituality, religion, and moral traditions



- Have any issues related to [NAMES of S, R, Mt] contributed to [PROBLEM]?
- Have you experienced any <u>personal challenges or distress</u> in relation to your [NAMES of S, R, M t] identity or practices?
- Have you experienced any <u>discrimination</u> due to your [NAMES of S, R, M t] identity or practices?
- Have you been in <u>conflict with others</u> over spiritual, religious or moral issues?

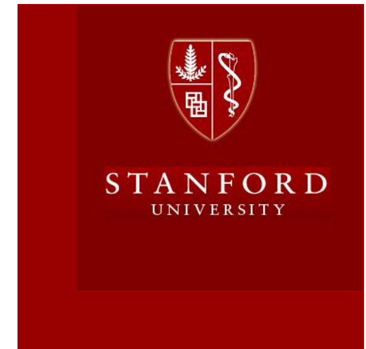
Other Conditions That May be a Focus of Clinical Attention (V Codes)



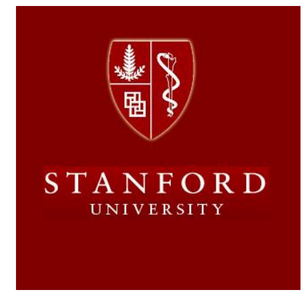
"The conditions and problems listed in this chapter are not mental disorders." (p. 715)

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- Religious or Spiritual Problems

V62.89 Religious or Spiritual Problem



- "This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organized church or religious institution." (p. 725)

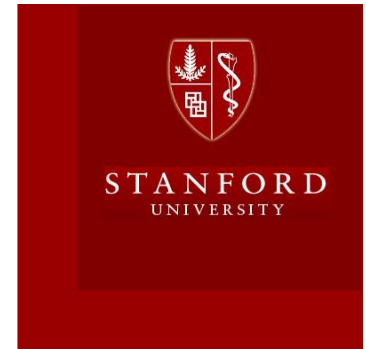


Causes of Personal Discomfort with R/S/Mt Inquiry:

- Avoidance of feelings of professional incompetence
- Fear of being asked about one's religious affiliation
- Recollection of personal encounters with religion that were aversive
- Internalized professional stigma towards religion

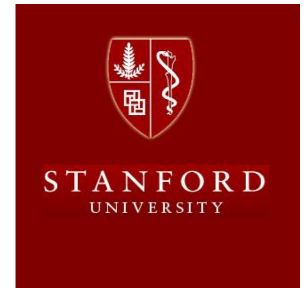
[1]Adapted from: Griffith JL. Managing Religious Countertransference in Clinical Setting. Psychiatric Annals: Mar 2006; 36:3 pg 196–204.

Inquires by the patient about the provider's S/R/Mt Background



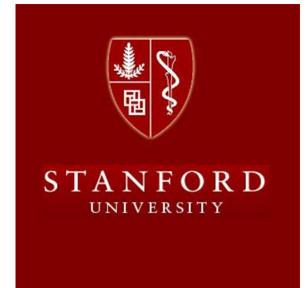
- Examples of two different perspectives:
  - "Spirituality and religion is an important part of my life. Tell me more about the role it plays in your life."
  - "Spirituality and religion is not an important part of my life at this time but I have come to value its importance for my patients. Tell me more about the role it plays in your life."

Patient-Initiated Prayer



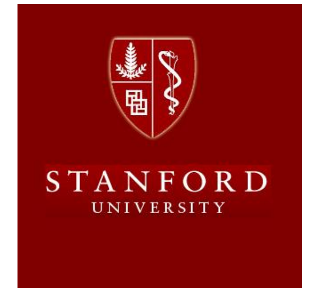
- Pray if your are comfortable; know the patient's R/S/Mt well
- Invite the patient to say a prayer
- Listen respectfully
- Offer a chaplain

Provider-Initiated Prayer



- In general, it should be **very uncommon**
- Need to know the patient's S/R/Mt background well enough to know your initiative will be welcomed
- Should be the same religious background as the patient
- **Always have to consider issues of coercion!**

Transference to Providers



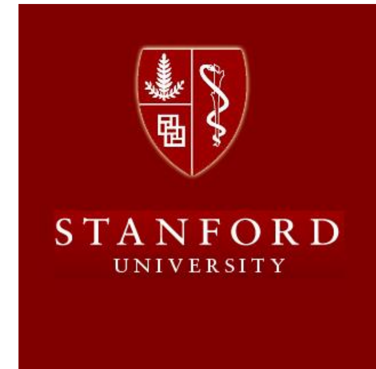
CHAPLAINS

- "Am I going to die?"
- Fear of being converted
- "Holy person"
- Acceptance

PSYCHIATRISTS

- "Am I crazy?"
- Fear of being committed
- Anti--religious
- Stigma of mental illness

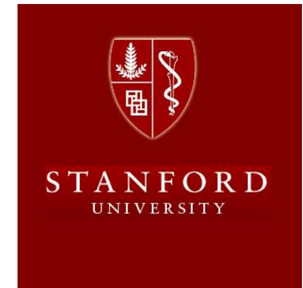
Religious Countertransference Definition



- "Religious countertransference refers to a emotional response by a clinician toward a patient's religious language, beliefs, practices, rituals, or community that can diminish the effectiveness of treatment"

[1]Griffith JL. Managing Religious Countertransference in Clinical Setting. Psychiatric Annals: Mar 2006; 36:3 pg 196–204

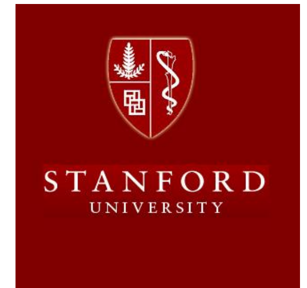
Religious Countertransference : Management



- Self--reflection and awareness
- Approaching the patient with curiosity, empathy and respect
- Self--education about spiritual care
- Working collaboratively with a spiritual care provider
- Transfer of patient to another provider

[1]Adapted from: Griffith JL. Managing Religious Countertransference in Clinical Setting. Psychiatric Annals: Mar 2006; 36:3 pg 196–204.

Spiritual Care- what can psychiatrists offer?



- At a minimum, inquire about the patient's S/R/Mt, i.e., perform a biopsychosocial--spiritual assessment.
- Consider exploring psychotherapeutically affect laden issues brought up in the spiritual history, i.e., spiritually focused psychotherapy.
- Consider referrals to Chaplains, Clergy, Pastoral Counselors, or Spiritual Directors.

SPIRITUALLY INTEGRATED PSYCHOTHERAPY

Understanding and Addressing the Sacred

Kenneth I. Pargament

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