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Religion has a Public Relations Problem: Integrating Evidence-Based Thinking into Clinical Practice

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Abstract

Religion and religious institutions receive a great deal of negative, rather than positive, attention and press. This creates an impression, for the casual observer, that religion and associated institutions are a plight on the planet. It is critically important for evidence-based research and best practices in clinical services to be well known and utilized within professional psychotherapy practice. Clinicians must be mindful of the many advantages of religious engagement for physical, mental, and community health and wellness. Psychologists, and other mental health professionals, tend to be secular and non-religious and receive little, if any, training on religious diversity that may contribute to a negative bias against all things religious. The bias may be detrimental to working with many of their clientele. This reflection addresses these issues and offers a call for a more thoughtful, balanced, and evidence-based approach of integrating religious engagement within clinical and counseling psychological practice.

Keywords: Religion, psychotherapy, religious bias, religious discrimination, evidence-based practice

The purpose of this reflection is to briefly introduce and discuss the increasing disconnect between the psychologists' and the public's perception of religion and religious institutions and the potential advantages of spiritual and religious engagement for health and wellness. Clinicians in particular should consider religion as a multicultural issue among their clientele and be mindful of evidence based research and practice that integrates spiritual and religious engagements into mental health practice. Clinicians should be careful to avoid potential bias and discrimination in working with religiously engaged people.

Religion and religious institutions have a severe public relations problem. For the casual observer and reader religion may appear to be a plight on the planet (Iannaccone, & Berman, 2006; Vardy, 2014; Whitehouse, 2019). The secular press often present stereotypes about religion and religious groups as facts (Winston, 2012). For example, while reading the secular press, one might believe countless pedophile priests, homophobic clerics, and antiabortion fanatics chronically plague the Roman Catholic Church (Henderson, 2018; McNees, 2004; Pagliarini, 1999; Plante, 2020a). One might also conclude the evangelical Protestant and non-denominational Christian churches are anti-science and opposed to modern medicine (including, most recently, COVID-19 vaccinations).

Additionally, they may believe evangelicals are closely aligned with authoritarian right-wing politics and politicians and their pastors are obscenely rich (Boas, 2016; McDermott, 2009). The secular press might have one conclude Jews chronically oppress marginalized Palestinians at every opportunity and orthodox Jews are anti-science and oppress women (Kushner, 1991; Schiffer & Wagner, 2011). The secular press often presents the view that Islamic young men cannot be trusted: they are likely to be either terrorists or at least sympathetic

to terrorist causes similarly Islamic women are always oppressed, marginalized, and often abused by their spouses and male relatives (Schiffer & Wagner, 2011; Zaal, 2012).

In general, the secular press seems to report stereotypes as facts highlighting religion and religious people, being superstitious, narrow-minded, rigid in thoughtor behavior, endorse magical, and fantasy over science, and are self-righteous about how to live one's life and make various important life decisions (e.g., Harris, 2005). Additionally, stereotypes such as religion and religious people tell everyone outside of their particular religious community to either be and think like them or face eternal damnation and more (e.g., Dawkins & Ward, 2006) are common. Of course, stereotypes are merely stereotypes but they seem to be absorbed and believed by many people as factual (Hodge, Baughman, & Cummings, 2006; McDermott, 2009). Recent contemporary examples include how evangelicals have been portrayed during the COVID-19 crisis as being anti-masks and vaccinations.

Those who maintain an affiliation with an organized and structured religious tradition and associated religious institutions in the United States and elsewhere has steadily declined in recent years perhaps due to a number of issues and influencing factors (Inglehart, 2021: Schwadel, 2010; Twenge, Sherman, Exline, & Grubbs, 2016; Uecker, Regnerus, & Vaaler, 2007). It has also been well established that only a minority of psychologists and mental health professionals, for example, are associated with any religious tradition or institution themselves (Bergin & Jensen, 1990; Shafranske & Malony, 1990). In fact, psychologists are more likely to be nonreligious, secular, and unchurched than almost any comparable (in terms of education) professional (Bilgrave & Deluty, 1998; Shafranske & Malony, 1990; Plante 2009). Thus, the general population, and psychologists in particular, appear to be increasingly secular and unengaged with religion and religious institutions.

Furthermore, psychologists, and other mental health professionals, tend to receive little, if any, training on religion or religious diversity as part of their graduate and post-graduate training and licensing processes (Plante, 2009; Shafranske, 2016; Vieten, Scammell, Pilato, Ammondson, Pargament, & Lukoff, 2013). Professional codes of ethics for psychologists and other mental health professionals state that religion and religious people should be respected and considered as part of sensitivity to and embracing diversity and multiculturalism (American Psychological Association, 2017; Young 2017). Yet, most secular professionals readily admit that they know little, from a professional training perspective, about religion and how it operates in the lives of their clientele (Pearce, Pargament, Oxhandler, Vieten, & Wong, 2019; Plante, 2009; Vieten et al., 2013). Religion is part of human diversity and multiculturalism that many clinical professionals feel free to ignore. This situation does not bode well for patients and clients who are deeply engaged with and steeped within their religious beliefs, practices, and institutions, especially when they seek services from these professionals (Pearce et al., 2019; Plante, 2009).

It may be a commonly held belief among secular professionals that religion is bad but spirituality might be good (Pargament, 1999; Sjö, 2012). Spirituality, experienced through mindfulness, yoga, nature walks, and so forth seem to be a positive thing in the minds of many (Arthington, 2016). Spirituality, in this way, is viewed as personal and individualistic with no oppressive structures or leaders telling anyone what to do and how to do it (Plante, 2009, 2016; Walach, 2017). Mindfulness and yoga have become extremely popular and readily accepted by the secular community (Plante, 2016; Sun 2014; Walach, 2017). Such approaches and interventions come from traditional and eastern religious traditions and communities including Buddhism and Hinduism (Newcombe & O'Brien-Kop, 2020; Shonin, Van Gordon, & Singh,

2015). Religious associations are minimized while the secular aspects are maximized (Burnett, 2011; Plante, 2016; Sun, 2014).

Lost in the media presentations about so many of the negative elements of religion and religious institutions is any of the positive contributions of religious engagement to mental, physical, and community health and well-being (Gebauer, Sedikides, & Neberich, 2012; Mochon, Norton, & Ariely, 2011). Physical and mental health benefits of engagement in religious communities, community support, helpful spiritual and religious rituals, ceremonies, and traditions associated with many major life events (e.g., births, coming of age, marriages, deaths), church-sponsored soup kitchens, homeless shelters, and international relief services all do not make headline news (Vardy, 2014; Whitehouse, 2019). The worst of what religious institutions and their representatives do often demand headlines while the quiet and less dramatic positive elements of religious institutions and their leaders tend to be ignored (Iggers, 2018). This reality has enormous implications for clinical work among mental health professionals and their clients who may be tempted to overlook the positive and focus on only the negative when it comes to religious influences and their various activities and service offerings (Hodge et al., 2006; Whitehouse, 2019; Winston, 2012).

For example, religious communities offer many services that people in need might benefit from and many of the services are completely free (Botchwey, 2007; Cnaan, Boddie, & Kang, 2005; McLeigh & Taylor, 2020; Schwartz, Warkentin, & Wilkinson, 2008). Religious institutions frequently offer various 12-step group programs and support groups for people struggling with multiple types of problems or stressful life events (Cnaan et al., 2005; Schwartz et al., 2008). Many religious groups and institutions offer community social services like food pantries, homeless shelters, medical screenings, spiritual direction, retreats, and pastoral

counseling services. Religious institutions often run non-profit medical and psychiatric hospitals as well as primary and secondary schools. Religious liturgical services often provide lovely music, community engagement, education, and ongoing contemplation and meditation opportunities.

Research over many years has also demonstrated that religious engagement is associated with a variety of positive both physical (Pargament, 2002; Park, 2007; Saad, Daher, & de Medeiros, 2019) and mental (AbdAleati, Zaharim, & Mydin, 2016; Weber & Pargament, 2014; Whitehead, 2018) health outcomes. Improvements include less depression, anxiety, suicidality, substance abuse, marital discord and divorce as well as longer and a healthier life when assessing all-cause mortality and other important health outcomes (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Saad et al., 2019). Religious engagement helps people cope with many difficult medical conditions such as cancer and heart disease as well (Cummings & Pargament, 2010; Plante, 2018).

So, what are the clinical implications for those in mental health fields working with clientele from religious communities or those who are actively engaged with religious beliefs and practices? First, clinicians certainly should not assume religious engagement by their clients is problematic, unhelpful, or pathological. They also should not overlook this part of their client's identity, culture, and influence in their lives. They should consider religion as they would any other form of diversity and multiculturalism (American Psychological Association, 2017). Religious engagement, institutions, and clerics can be a source of great harm and negative impacts should not be overlooked. However, they can also be a source of great support and assistance and thus should be regularly consulted with when appropriate and with client permission (Plante, 2009).

Second, clinicians should be careful not to let their personal biases, viewpoints, and critical views about religion, religious leaders, and religious institutions tarnish their views of spiritual and religiously involved clients. Clinicians may maintain discriminatory and prejudicial views of some, or even all, religious organizations, institutions, and clerics and the bias can easily seep into their professional clinical work. Clinicians should be vigilant about their own potential perspectives and how they might negatively influence their clinical work (Plante, 2009, 2013; Shafranske & Malony, 1990). They must be mindful, both ethically and clinically, of any potential discrimination, prejudice, and implicit bias that they may experience (Campbell, Vasquez, Behnke, & Kinscherff, 2010; American Psychological Association, 2017).

Third, clinicians might wish to work collaboratively with clerical and other religious personnel to help better coordinate care of their patients, including encouraging the utilization of appropriate religious support services (Plante, 2013, 2020b). Finally, clinicians may wish to obtain training on the psychology of religion and religion as multicultural and diversity issues. This can be accomplished with regular continuing education workshops and programs as well as scholarly and applied reading and professional consultation with specialists (Plante, 2020b). Clinicians should, and typically do, take their code of ethics seriously (American Psychological Association, 2017; Campbell et al., 2010). The professional ethics codes refer to religion in terms of diversity and thus considers religion as one of many different aspects of multiculturalism that therefore must be respected and supported. For psychologists, as an example, this notion is well articulated in Principle E of the Code of Ethics. It states: “Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and

socioeconomic status and consider these factors when working with members of such groups" (American Psychological Association, 2017. Principle E).

Thus, psychologists should consider religion in similar ways that they might consider issues related to gender, gender identity, race, ethnicity, and so forth. To do otherwise would be to violate this vital section of the ethics code.

For the most part, religion and religious engagement can be beneficial for people and help them with whatever life troubles they may experience that bring them to the attention and services of mental health professionals. While there are certainly notable exceptions, research and best clinical practices has well identified ways that religious engagement can be a source of support, consolation, and assistance with physical, mental, community, and other challenges in life and living. The public relations challenges of the religious world and society would lead the casual reader to think otherwise, but evidence-based clinical science and practice informs us that religion and religious engagement can be a very positive influence in the lives of many. Mental health professionals should take note and act accordingly.

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