

S. Res 205 Legislative Bill - Mental Health

Milagros Valencia

SWK 460/770

Professor Mark Jennings

November 2nd, 2021

The original paper *The Pew Versus the Couch: Relationship Between Mental Health and Faith Communities and Lessons Learned from a VA/Clergy Partnership Project*, authors Steve Sullivan, Jeffrey M. Pyne, Ann M. Cheney, Justin Hunt, Tiffany F. Haynes and Greer Sullivan all give emphasis to the historical relationship between religion and mental health and its identity of commonality, conflict, controversy and distrust. Further attention is given to this complex relationship which clinicians and clergy are seeking to holistically meet the needs of people in clinics, churches and communities services are being provided to. The objective of the paper is to briefly discuss the relationship history and the important areas of disagreement and contention. A brief case study in VA/Clergy partnerships in rural Arkansas identified practical tensions which concluded with a framework of three models for understanding how most faith communities perceive mental health and should offer opportunities to overcome tensions between the two, “the pew” and “the couch.” (p.1268) Although there is more research and collaboration needed to de-escalate “long standing tension” that has rooted in biblical understanding between spirituality and mental health - religion and medical science conclusively may overlap. Progress in the education and training of social workers understand the need for the spirituality context in the treatment of mental health illnesses. I agree with S.Res.205 legislative bill, which identifies statistical data of discriminatory, disparity and social determinants in the black population that contributes to poor health outcomes and shorten life expectancy. Further, addressing the need for inclusive spiritual care and mental wellness of an individual is believed to be necessary and I believe an update to the bill should include specifying faith-based community and mental health care initiatives.

#### Historical Identity of Spirituality and Medical Science

While religion and psychiatry use different vocabularies and methodologies to understand human experiences, their goals overlap and are often congruent. For example, both religion and mental health services seek to provide emotional well-being and emphasize the importance of relationships for their parishioners or clients (Levin and Chatters 1998). Humans are fundamentally bio-psycho-social-spiritual

beings (Sulmasy 2002). Emphasis is given to “proper understanding” of spirituality and its integral part of the human condition and they point out the philosophical underpinnings of religion and psychiatry are similar and both can be conceptualized as frameworks to understand the describe “the human experience and human behavior.” (Boehnlein 2000, p. xvi.) The author identifies the “long-standing” relationship between religion and psychiatry across the world’s major religions (Kinzie 2000). There are many cultures that religious healing and rituals are conducted that have been functioning in medical traditions or as alternative practices. There is evidence that individuals have looked for care from both medical providers and spiritual leaders. An example is the Buddhist and Hindu traditions: patients often seek care from Western-trained clinicians after seeking guidance from religious elders or gurus. These spiritual leaders are akin to a chaplain or pastoral counselor in a Western setting and listen to and offer advice to individuals experiencing emotional and psychological distress (Josephson and Peteet 2004). Historically christianity has been the major source of social services like providing medical care, counseling, schooling, culture and philosophy. We know that religion can play a major role in helping patients cope with the stress of all sorts of illnesses or cares of life. Regardless of one’s religious tradition, coordinated spiritual and mental health care are important to holistic treatment. (1268)

### Conflicts Between the Pew vs the Couch

One area of discussion of concern is the unawareness of mental health providers knowing how to address the spiritual needs of their clients. Clergy are untrained in how to address many of the mental health needs of practitioners. Conscious dismissal of each practice brought about the conflict. Mentioned is the historical acknowledgement of healthcare being synonymous with spiritual care (Magner 2005). After the cathedral, within the town's hospital formulated. The current perspective on clergy and mental health tensions are surrounded in these three variables: Trust, Stigma and Knowledge. Historically, the dispute between the Pew and the Couch conflict emerged during the rise of Enlightenment thinking and the subsequent Darwinian and Freudian revolutions, which raised the debate between matters of the soul, mind, and body (Reed 1997). Thus, the struggle between the pew and the couch dates back to the

Enlightenment period of the 17th and 18th centuries when scientific and rational theories began to explain the world (Bristow 2011). Prior to that point, it was difficult to distinguish religion, spirituality, and medicine. Illness was understood in a spiritual context until the beginning of the Enlightenment or Age of Reason (circa 1650–1700). The rise of modern science, medical explanations for behavior, and the fields of psychiatry and psychology drove a wedge between the church and science with regard to mental health in particular and resulted in increased tension. With the Enlightenment and the development of the scientific method, a gradual territorial struggle began between the religious and the scientific communities that had tremendous impact on the nature and delivery of healthcare. The institutionalization of medicine and what Foucault (1973) refers to as the “medical gaze” fundamentally changed the explanation of emotional distress from a religious one to a medical one, as the Cartesian dualism of biomedical philosophy separated the mind and body and the individual became subject to the expert knowledge of those in positions of power. (1270)

Medical science gained power over the body resulting in the devalued and alienated aspect of spiritual medicalization for many faith based communities. Many of the churches were threatened by the rise of psychiatry and psychology to the biblical understanding of the human condition (Powlison 1993) The mentality of the language imposed faith community disregards previous contributions made from church involvement in the wellness and overall care of individuals and communities. An example of the Couch attitude toward the Pew is noted, ‘Modern psychiatry is as anti-Christian, dangerous and satanic as evolution’ (The Interactive Bible, n.d.). In this quote we see how psychiatry is linked to evolution and viewed as part of the modern attack of science on religion. Antagonism in the relationship between the couch and the pew is not limited to the church. Science, in general, and the fields of psychiatry and psychology, in particular, have done their fair share of demonizing religion. (1271) The degrading language toward the church by those in the mental health profession reveals how deeply anti-religious sentiment is historically embedded in the beliefs of many of those who seek to treat mental illness. (Pargament and Saunders 2007).

These historical events caused mental health providers a reluctance to engage in spiritual and religious perspectives with their clients resulting from these historical events. (1270)

The history of discrimination, social injustices and disparity that gives attention to this bill is stated. The 117th Congress 1st Session permits by governing legislations to be heard for the population being affected by the bill.

### **S. RES. 205**

Promoting minority health awareness and supporting the goals and ideals of National Minority Health Month in April 2021, which include bringing attention to the health disparities faced by minority populations of the United States such as American Indians, Alaska Natives, Asian Americans, African Americans, Hispanics, and Native Hawaiians or other Pacific Islanders.

## **IN THE SENATE OF THE UNITED STATES**

May 11, 2021

Mr. Cardin (for himself, Mr. Scott of South Carolina, Mr. Booker, Mr. Rubio, Mr. Menendez, Mr. Boozman, Ms. Cortez Masto, Mrs. Capito, Ms. Hirono, Mr. Cramer, Mr. Wyden, Mr. Braun, Mr. Van Hollen, Mr. Brown, Mr. Markey, Mr. Padilla, and Mr. Sullivan) submitted the following resolution; which was considered and agreed to

### **RESOLUTION**

Promoting minority health awareness and supporting the goals and ideals of National Minority Health Month in April 2021, which include bringing attention to the health disparities faced by minority populations of the United States such as American Indians, Alaska Natives, Asian Americans, African Americans, Hispanics, and Native Hawaiians or other Pacific Islanders.

- Whereas the origin of National Minority Health Month is National Negro Health Week, established in 1915 by Dr. Booker T. Washington;
- Whereas the theme for National Minority Health Month in 2021 is “Vaccine Ready”;
- Whereas the Department of Health and Human Services has set goals and strategies to enhance and protect the health and well-being of the people of the United States;
- Whereas a study by the Joint Center for Political and Economic Studies, entitled “The Economic Burden of Health Inequalities in the United States”, concludes that, between 2003 and 2006, the combined cost of health inequalities and premature death in the United States was \$1,240,000,000,000;
- Whereas African American women were as likely to have been diagnosed with breast cancer as non-Hispanic White women, but African American women were about 40 percent more likely to die from breast cancer than non-Hispanic White women between 2012 and 2016;
- Whereas African American women lose their lives to cervical cancer at more than twice the rate of non-Hispanic White women;
- Whereas African American men are 70 percent more likely to die from a stroke than non-Hispanic White men;
- Whereas Hispanics are twice as likely as non-Hispanic Whites to suffer from end-stage renal disease caused by diabetes, and are 30 percent more likely to die of diabetes, than non-Hispanic Whites;
- Whereas the HIV diagnosis rate among Hispanic men is more than 3 times the HIV diagnosis rate among non-Hispanic White men;

- Whereas the HIV diagnosis rate among Hispanic women is 4 times the HIV diagnosis rate among non-Hispanic White women;
- Whereas, in 2018, although African Americans represented only 13 percent of the population of the United States, African Americans accounted for 42 percent of new HIV diagnoses;
- Whereas, in 2018, African American youth accounted for an estimated 51 percent, and Hispanic youth accounted for an estimated 27 percent, of all new HIV diagnoses among youth in the United States;
- Whereas, in 2016, Native Hawaiians and Pacific Islanders were 1.6 times more likely to be diagnosed with HIV than non-Hispanic Whites;
- Whereas, in 2018, Native Hawaiians and Pacific Islanders were 2.5 times more likely to be diagnosed with diabetes than non-Hispanic Whites;
- Whereas Native Hawaiians and Pacific Islanders are 10 percent more likely to die from cancer than non-Hispanic Whites;
- Whereas, although the prevalence of obesity is high among all population groups in the United States, 48 percent of American Indian and Alaska Natives, 51 percent of Native Hawaiian and Pacific Islanders, 48 percent of African Americans, 45 percent of Hispanics, 37 percent of non-Hispanic Whites, and 12 percent of Asian Americans older than 18 years old were obese (not including overweight);
- Whereas Asian Americans accounted for 30 percent of chronic Hepatitis B cases, and non-Hispanic Whites accounted for 13.5 percent of chronic Hepatitis B cases;
- Whereas of the children diagnosed with perinatal HIV in 2017, 65 percent were African American, 9 percent were Hispanic, and 14 percent were non-Hispanic White;

- Whereas the Department of Health and Human Services has identified heart disease, stroke, cancer, and diabetes as 4 of the 10 leading causes of death among American Indians and Alaska Natives;
- Whereas American Indians and Alaska Natives die from diabetes, alcoholism, unintentional injuries, homicide, and suicide at higher rates than other people in the United States;
- Whereas American Indians and Alaska Natives have a life expectancy that is 5.5 years shorter than the life expectancy of the overall population of the United States;
- Whereas African American women die from childbirth or pregnancy-related causes at a rate that is 3 to 4 times higher than the rate for non-Hispanic White women;
- Whereas African American infants are 3.8 times more likely to die due to complications related to low birth weight than non-Hispanic White infants;
- Whereas American Indian and Alaska Native infants are more than twice as likely as non-Hispanic White infants to die from sudden infant death syndrome;
- Whereas American Indian and Alaska Natives have an infant mortality rate twice as high as that of non-Hispanic Whites;
- Whereas American Indian and Alaska Native infants are 2.7 times more likely to die from accidental deaths before their first birthday than non-Hispanic White infants;
- Whereas sickle cell disease affects approximately 100,000 people in the United States, occurring in approximately 1 out of every 365 African American births and 1 out of every 16,300 Hispanic births;
- Whereas 10.9 percent of Native Hawaiian and Pacific Islanders, 6.3 percent of Asian Americans, 8.8 percent of Hispanics, 8.7 percent of African Americans, and 14 percent of

American Indians and Alaska Natives received **mental health** treatment or counseling in the past year, compared to 18.6 percent of non-Hispanic Whites;

- Whereas the 2019 National Healthcare Quality and Disparities Report found African Americans and American Indians and Alaska Natives receive worse care than non-Hispanic Whites for about 40 percent of quality measures, Hispanics and Native Hawaiians and Pacific Islanders receive worse care than non-Hispanic Whites for 33 percent of quality measures, and AAsian Americans received worse care than non-Hispanic Whites for nearly 30 percent of quality **measures**;
- **Whereas nearly 30 percent of reported COVID–19-related cases are among Hispanics** compared to less than 50 percent comprising non-Hispanic Whites;
- Whereas nearly 3.5 times more American Indians and Alaska Natives, 2.9 times more Hispanics, and 2.8 times more African Americans were hospitalized due to COVID–19 compared to non-Hispanic Whites;
- Whereas significant differences in social determinants of health can lead to poor health outcomes and declines in life expectancy; and
- Whereas community-based health care initiatives, such as prevention-focused programs, present a unique opportunity to use innovative approaches to improve public health and health care practices across the United States and to reduce disparities among racial and ethnic minority populations: Now, therefore, be it

***Resolved,*** That the Senate supports the goals and ideals of National Minority Health Month in April 2021, which include bringing attention to the health disparities faced by minority populations in the United States, such as American Indians, Alaska Natives, Asian Americans, African Americans, Hispanics, and Native Hawaiians or other Pacific Islanders.

## References

- S.Res.19 – 117th Congress (2021-2022): A resolution recognizing January 2021 as “National Mentoring Month”. (2021, January 28). <https://www.congress.gov/bill/117th-congress/senate-resolution/19>
- Sullivan, S., Pyne, J.M., Cheney, A.M. *et al.* The Pew Versus the Couch: Relationship Between Mental Health and Faith Communities and Lessons Learned from a VA/Clergy Partnership Project. *J Relig Health* 53, 1267–1282 (2014). <https://doi.org/10.1007/s10943-013-9731-0>