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Perceptions of people with mental disorders regarding social support from religion and health professionals

Percepção de pessoas com transtorno mental em relação ao apoio social religioso e de profissionais de saúde

Percepción de las personas con trastornos mentales en relación al apoyo social religioso y de los profesionales de la salud

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ABSTRACT

Objective: to analyze the perception of people with mental disorders in relation to social support from religion and from health professionals.

Method: qualitative, descriptive-exploratory study, carried out with seven members of a Christian religious institution, adults and medically diagnosed with mental disorders. Data were collected through semi-structured interviews, between May and August 2021. Thematic content analysis was used.

Results: support from healthcare professionals was emphasized in relation to symptoms and their psychosocial consequences. Medication was the main aspect, despite the stigma and side effects. Religious social support was described from a perspective of affective support, learning, and the search for overcoming the issues as a way of relieving suffering.

Conclusion: the perception of people with mental disorders in relation to the support of health professionals was pervaded by the biomedical character of drug treatments in the remission of symptoms. However, religiosity/spirituality was highlighted as an important complementary factor to treatment. In this sense, the intersection between the two types of support stands out as an aspect for expanding mental health care.

Descriptors: Social Support. Spirituality. Religion. Mental Health. Mental Disorders.

RESUMO

Objetivo: analisar a percepção de pessoas com transtorno mental em relação ao apoio social religioso e dos profissionais de saúde.

Método: estudo qualitativo, descritivo-exploratório. Foi realizado com sete membros de uma instituição religiosa de vertente cristã, adultos e com diagnóstico médico de transtorno mental. Os dados foram coletados por meio de entrevista semiestruturada, entre maio e agosto de 2021. Utilizou-se a análise de conteúdo temático.

Resultados: o apoio dos profissionais de saúde foi enfatizado em relação aos sintomas e suas consequências psicossociais, aludindo à medicação como aspecto principal. Já o apoio social religioso foi descrito sob uma lógica de acompanhamento afetivo, aprendizado e busca por superação como forma de amenizar o sofrimento.

Conclusão: a percepção das pessoas com transtornos mentais em relação ao apoio dos profissionais de saúde permeou o caráter biomédico, marcado pelo tratamento medicamentoso na remissão de sintomas. Entretanto, a religiosidade/espiritualidade foi apontada como importante fator complementar ao tratamento. Nesse sentido, destaca-se a intersecção entre os dois tipos de apoio como um aspecto para a ampliação dos cuidados em saúde mental.

Descritores: Apoio Social. Espiritualidade. Religião. Saúde Mental. Transtornos Mentais.

RESUMEN

Objetivo: analizar la percepción de las personas con trastornos mentales con relación al apoyo social religioso y de los profesionales de la salud en la atención.

Método: estudio cualitativo, descriptivo-exploratorio. Se llevó a cabo con siete miembros de una institución religiosa cristiana, adultos y diagnosticados médicamente con trastornos mentales. Los datos fueron recolectados mediante entrevistas semiestructuradas, entre mayo y agosto de 2021. Se utilizó el análisis de contenido temático.

Resultados: se destacó el apoyo de los profesionales de la salud con relación a los síntomas y sus consecuencias psicosociales, refiriéndose a la medicación como aspecto principal, a pesar del estigma y de los efectos secundarios. El apoyo social religioso fue descrito bajo una lógica de apoyo afectivo, aprendizaje y búsqueda de superación como forma de aliviar el sufrimiento.

Conclusión: la percepción de las personas con trastornos mentales con relación al apoyo de los profesionales de la salud fue permeada por el carácter biomédico marcado por el tratamiento farmacológico en la remisión de los síntomas. Sin embargo, la religiosidad/espiritualidad se destacó como un factor complementario importante al tratamiento. En este sentido, la intersección entre ambos tipos de apoyo se destaca como un aspecto para ampliar la atención en salud mental.

Descriptores: Apoyo Social. Espiritualidad. Religión. Salud Mental. Trastornos Mentales.

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INTRODUCTION

Although the definition of health endorsed by the World Health Organization did not officially include a religious/spiritual aspect, this dimension has been increasingly more evoked in health care processes. Regarding the nomenclature used, despite distinctions from the epistemological point of view, regarding the concepts of religion, religiosity, and spirituality, a recent movement has been proposing the integrated designation "Religiosity/Spirituality" (R/S) in investigations that seek to investigate the outcomes of this dimension in health-disease-care processes. R/S encompasses both elements related to religious institutions and their dogmas and the personal way in which individuals experience said beliefs and relate with the transcendent[1]. Another moniker that has been explored of late is "ancestry", which is related with the experience of the sacred in religions of African origin, for example[2,3].

Studies about how to address R/S in health care has shown that professionals value this dimension, although they do not always have knowledge and experiences to support their actions in this regard[4–7]. Activities developed in this regard involve relaxation techniques, mediation, and practices of prayer, according with the desire of the users. They also include encouragement to reflect on ones own existence and the search for a healthier lifestyle[1,8]. Nonetheless, these practices are rarely proposed as a response to the need to include R/S in health care plans, but reflect the uncertainties and difficulties that arise from an approach which is not guided by evidence-based protocols or strategies. Furthermore, the training received by professionals is insufficient to address the topic, showing how relevant it is to share/include these aspects by other means, such as support from religious institutions themselves.

There have been relationships between R/S and mental health since mental disorders started to be understood. For a long time, the notion of madness has been discussed as something in the order of the divine. In ancient Greecy, for example, it was through delirium that a person, considered to be privileged, could access divine truths. As time passed, this perspective changed, and with it, many spiritual manifestations/expressions were associated to mental disorders[9].

It should be noted that religious intolerance and racism, especially regarding religions of African origin, have shown themselves to be important factors in regard to mental suffering. The demonization of these religions starts in the colonial period, in which the religious practices of black peoples were considered expressions of evil that should be combated. Such thoughts are part of the social imaginary, and practitioners of these religions are submitted to violence that may have consequences in the mental health of individuals[10]. These examples show important ways in which R/S crosses the field of mental health care.

Literature has emphasized that R/S can be an important protective factor and a tool to resignify health-disease-care processes. Still, it can also provoke stigma and stereotypes, especially when certain religions impose restrictions on specific health procedures, or when certain behaviors, associated with fanaticism, can interfere with health outcomes. An example are cases in which one does not resort to formal dispositives of care, nor to treatments with solid scientific evidence behind them, for religious/spiritual reasons. This can generate feelings of guilt, of going through a trial, and feeling the need to bargain when confronted with this type of suffering. However, the positive repercussions of R/S for health outcomes do stand out in national and international scientific literature[11–13].

Regarding the perception of users concerning the association of R/S with mental health, a review [1] found that this dimension has played an important role in the search for meaning during mental disorder care processes. Nonetheless, many users feel that their religious/spiritual experiences are rejected, misunderstood, or treated as pathologies in formal health dispositives, which brings to bear old psychiatric practices. These same individuals state that mental health services often do not prioritize spaces or opportunities for users to manifest their R/S, which seem to increase the fear of these users to explore this angle when receiving care from health workers, as they are afraid to be interpreted as being afflicted by some sort of mental disorder[1]. Thus, popular spaces dedicated to health, which includes spaces with a religious/spiritual nature, tend to provide a type of listening that integrates ethno-theories to formal health knowledge, in order to listen and promote a conversation between different understandings[14].

Regarding this panorama, it can be said that, although the R/S is one of the main angles of care and health promotion, with strong references described in scientific literature, further reflection regarding its role in health outcomes is still necessary, especially in order to explore settings beyond health services, and reaching different understandings regarding these relationships. Thus, it is valid to explore more closely the perception of people with mental disorders regarding the support they receive from R/S and health professionals. Are these understandings integrated? Or there are dissonances? Are these support networks integrated in the user experience?

Investigating these questions by listening to religious communities is also important, as it values ethno-theories in a decolonial perspective, without submitting these collaborators to an interpretation exclusively aligned with biomedical

knowledge, as, through history, this type of knowledge has produced asymmetries, prejudice, and discrimination around mental disorder, pushing R/S further from scientific settings. Thus, this study aims to analyze the perception of people with mental disorders regarding their social-religious support, and the support from health professionals.

METHODS

This is a qualitative, descriptive-exploratory study, whose method was designed according with the Consolidated criteria for reporting qualitative research (COREQ) guidelines to meet rigorous criteria of research. It was developed in a religious institution in a municipality in the countryside of São Paulo.

Theoretical framework adopted was the Social Capital theory, proposed by three Canadian theoreticians[15]. These authors advocate that social capital must be investigated as a social-network, since these networks are, in a way, the basis for social capital. This theory proposes analyses that involve both individual aspects and social structures, forming a link between actions and structural limits. Within this perspective, it is essential to consider not only the structural characteristics of these networks, but also the resources inherent to them[15].

The notion of social capital is formed by three elements: resources embedded in a social structure, conditions to access these resources, and use or mobilization of them by an individual in specific situations. In other words, studies based on this theory can revolve around three elements: structural aspects (incorporation), opportunity (conditions of access), and action-related aspects (use)[15].

This study considers that social support is an important aspect of social capital, involving any assistance, coming from any source. The concept of social capital, in turn, goes beyond, including aspects such as availability, satisfaction, and conditions of access. The conversation between these aspects and the context of this study is depicted in Figure 1, which was elaborated according with the Social Capital theory[15].

The study took place in a Christian religious institution with approximately three thousand members, 70% of whom are adults. The main researcher has been a part of said institution for a long time. In her experience, she got in touch with an expressive number of reports from the members of said church about the experience of being diagnosed as having a mental disorder, and the importance of religious social support to relieve the suffering they experienced, which is why this place was chosen as the setting of this study.

The institution provides collective religious practices, such as ceremonies associated with life cycle transitions, such as birth, marriage, and death; sermons and meetings in small groups, carried out in the homes of church members in order to share a message of faith, in order to generate reflections and open a space to listen about the needs of the members, which are considered and become part of the content of the prayer at the end of the meetings. These practices are opened to any audience, regardless of age group and belief.

The institution also schedules and conducts religious home visits to individuals or families under mental distress. This service, which can be requested by a person, a relative, or stem from a recognition, from members of the institution, that it is necessary, is carried out by a religious leader. It includes the listening of the person and/or their relative, aiming to transmit a spiritual reflection regarding the suffering being experienced. Furthermore, a prayer is offered to be conducted with the person, providing individualized support.

Inclusion criteria to participate in the study were: being an adult, from 19 to 44 years of age (the definition of adult in the health science descriptors[16]; being a member or attending the aforementioned institution for, at least, three months; and having some form of mental disorder, diagnosed by a physician (self-reported). The only exclusion criteria was having any disability related to auditory

Figure 1 – Synthesis of the dialogue of the theoretical framework adopted and its use in the study. Ribeirão Preto, SP, Brazil, 2023

Source: The authors, 2023.

or verbal function that would make communication unfeasible. It is worth noting that the presence of signs and symptoms of mental disorders were not considered to be exclusion criteria.

The recruitment strategy used was the snowball method[17]. Since the main researcher was a part of the institution and, as a result, had a bond with its religious leaders, she was able to identify the first participant of the study, who were in accordance with the inclusion criteria. Each participant, after the interview, was invited to suggest one or more members of the institution that they believed were in accordance with the criteria. When the researcher got in touch with eligible parties for the first time, she confirmed whether they were in accordance with inclusion criteria, invited them, and provided explanation about the research. Data collection was interrupted when data saturation was reached, that is, when new interviews stopped adding new information[18]. This strategy led to a final sample of seven participants. One participant refused because, despite being assured their participation in the study was anonymous, they did not want to expose their mental suffering. However, they collaborated with the study by indicating another member of the institution, to help continue collection until data saturation.

Data were collected by the main researcher (a nursing undergraduate) from May to August 2021. The eligible parties indicated by the participants were invited via a telephone conversation, in which they received explanations about the goals of the research, and information from the Informed Consent Form. When the participant accepted the invitation, the interview was scheduled in a place of their choosing (their homes or a private room in the religious institution itself), according to the availability of both parties involved. The number of times it was necessary to schedule with each participant varied from one to three, due to the fact that some participants were unable to finish their interview in a single meeting. Interviews lasted an average of one hour each. To ensure the anonymity of participants, they were referred to using the letter "P" followed by a number from one to seven, indicating the order in which the interviews were carried out.

The script for the interview was previously elaborated by the researchers, including questions about participants' sociodemographic profile (sex/gender, age, occupation), medical diagnosis ("What is the diagnosis/diagnoses received?"), treatment ("Are you being treated?") If so, for how long? What type of treatment, pharmacological, psychotherapic, or both? Was there any improvement since treatment began? If so, how long after it started?", the health care provided by the professionals involved ("How is the assistance provided by the health workers involved in your treatment?"), connection with the religious institution ("How long have you been a member of the religious institution?"), the support provided by the institution and its potential effects on the treatment ("How do you feel about the support that the religious institution provides? Does the support that the religious institution provide contribute to the treatment? If so, how?"), and the difference between these types of support ("What is the difference between the support provided by the institution and by health professionals?"). The script was tested in three pilot interviews, with people from a similar Christian religious institution, after which it was adjusted to be used with the participants of the current study.

Regarding reflexivity, an important criteria in qualitative research, the fact that one of the researchers is a member of the institution facilitated the process regarding her entry into the institution and a more contextualized understanding of the phenomena. Nevertheless, it may have led to some interpretation bias, and, in this regard, the participation of the supervisor, expert in mental health and not a part of the phenomena, provided valuable aid in the search for interpretation that could be considered impartial.

Interviews were recorded, transcribed, and analyzed using the thematic content method, following the steps proposed by Bardin (2016)[19], which are pre-analysis, material exploration, and data treatment. In the pre-analysis stage, the corpus was read multiple times, in order to organize the material and recognize the ideas. Then, in the exploration phase, guided by the theoretical framework and the objective of the study, registration units were singled out. Each unit received a code (a short name to illustrate the idea proposed in the excerpt). Then, these codes were listed, and grouped into subcategories according to their similarity; these, in turn, were grouped into categories. In the treatment stage, through data inference, the results were synthesized, which led to the regrouping of the categories under three major topics: 1) The course of life and determinants of mental suffering; 2) Mental disorder and treatment; and 3) Spirituality as complementary to treatment. The analysts were triangulated[20], that is, two researchers carried out the coding separately. Then, they conferred, in order to find the convergences and specificities of their interpretations. After a discussion with the wider group of researchers, the list of codes was adjusted, and the grouping proceeded, carried out, from this point on, by both analysts.

The project was approved by the Research Ethics Committee of the Nursing School of Ribeirão Preto, part of the Universidade de São Paulo, under opinion nº 4.649.273/2021 and Certificate of Submission to Ethical Appreciation:

40977520.5.0000.5393. All ethical precepts for research with human beings proposed by Resolution 466/2012 were followed, including the signing of the Informed Consent.

RESULTS

Participants were from 31 to 41 years old. Five were single, five were women, three self-declared as black or *pardas* (a Brazilian nomenclature for mixed color), all self-declared a diagnosis of depression, and five had another disorder, such as panic or anxiety (Table 1).

The narrative of the participants had a chronological aspect, regarding their perception of their mental health. The first category presents aspects related to the period before the disorder was installed and/or diagnosed; the second, is related to the manifestation of the disorder itself and the search for treatment; and the third emphasizes the role of spirituality as complementary to the treatment. Chart 1 shows the code tree and respective topics and categories.

The course of life and determinants of mental suffering

Participants described aspects of their life histories that pointed out important risk factors for the development of mental disorders, especially violent episodes and traumatic childhood events:

> *I was raised by my maternal grandparents, I had an uncle, my grandmother's brother, he liked me very much but I was molested by him* (P6).
>
> *I was the one he [father] attacked the most, verbally, physically, he beat me, punched me, beat me, he was very aggressive* (P3).

These circumstances were marked by negative feelings and difficulties to accept help, as the participants described:

> *...I felt like, that I wasn't loved by anyone, that I wasn't important, that I wouldn't be missed by anyone* (P3).
>
> *Since I rejected help I was in a very complicated situation, a really very serious case of depression* (P5).

Experiences that led to an accumulation of disappointments and losses through life were reported as potential explanations built by the participants in the face of mental suffering:

> *These are things that marked my life, so that was only adding up* (P6).

Table 1 – Distribution of participants according to sociodemographic characteristics (n=7). Ribeirão Preto, SP, Brazil, 2021

p*	Age	Sex	Color	Marital status	No. of children	Educational level	Profession	More than one diagnosis
1	38	F†	Black	Single	0	Complete higher education	Social worker	No
2	34	F	*Parda*	Married	2	Complete high school	Cook	Yes
3	41	F	White	Married	1	Incomplete higher education	Housekeeper	No
4	35	M‡	Black	Single	2	Incomplete higher education	Train conductor	Yes
5	31	M	White	Single	0	Complete higher education	Teacher	Yes
6	38	F	*Parda*	Single	3	Incomplete high school	Unemployed	Yes
7	35	F	White	Single	0	Post-graduation	Psychiatric nurse	Yes

*Participant; †Female; ‡Male

We dated for four years, so the end of the relationship had a strong emotional effect (P4).

Mental disorder and treatment

The intensity of the suffering caused by the mental disorder was described considering he prejudice perceived in the daily life and in interpersonal relationships:

[The depression] was really deep, literally, I wouldn't leave my house, I wouldn't leave my room, everything closed, everything dark and accumulating. I'd get things to eat and hoard food containers, cups(P4).

I got away from everyone, I didn't want to see anyone, I didn't want to talk to anyone... I didn't work, didn't sleep, barely took care of the house, didn't take care of my daughter or my husband (P3).

In addition to these losses, fear and suicidal ideation were also pervasive in the statements:

I was about to explode and when I found myself attempting suicide (P2).

Since I was little I had this thought, suicidal ideation (P7).

Being away from the religious institution was described by some as one of the consequences of the suffering caused by the mental disorder, and the search for treatment was one of the main options to care for this condition:

I spent two years away from the religious institution, two years, due to this really, really strong depression(P3).

I went to the psychologist at first, and then to a psychiatrist (P5).

Six of the participants sought assistance in the private network (P1, P2, P3, P4, P5, P7) and one in the public network (P6). According to the report, the health care received was not considered satisfactory by most participants:

I didn't like the way I was treated so I didn't look for anyone else... I gave up, actually [...] if the doctors had more empathy with the patient... they could help better, more effectively, I believe (P3).

He didn't want to know if I was well, he didn't want to listen to me, he didn't ask: But are you well enough to stop taking the drug? No! He just said I had to stop and that was it... he didn't pay attention or showed concern (P2).

I think health professionals could be more empathetic (P7).

Psychotropic medicine was perceived as an important and effective help, impacting on the control of the acute symptoms of mental disorders and enabling the performance of activities of daily living:

I think that medication would be needed to help my symptoms, yes, because it wasn't just affecting the emotional side, but even my daily chores (P2).

I have to take medicine, if I don't, I freak out, I go crazy, I do things that the next day I may be tied to the hospital bed not knowing what I did (P6).

Still, participants also stressed how challenging it is to live with the side effects and stigma associated with the use of these drugs:

I started to feel very sick, I got all the side effects you read about in the package insert (P7).

It's really bad, your feet get cold, your heart speeds up and it seems that you'll be short of breath, you feel that you will die [... i used to follow the the treatment to a T, but then I stopped doing it ...] because I heard a lot that people who took these drugs wew crazy, that I was crazy (P6).

Spirituality as a complement to treatment

The idea of God as an important supporting force was pervasive in the statements of the participants. They also emphasized the role of the religious institution as a mediator of this relationship, in a movement of approximation and connection:

I used to get in touch with God already..., I'm sure that's why I'm still standing (P1).

I didn't know how to get close to God... so the religious institution was a bridge (P4).

Feelings such as filling in the emptiness, not being alone, and relief were reported as effects promoted by the religious institution:

The more I participated in the meetings, the more I got involved, it was kind of liberating, it filled in the gaps, the emptiness (P4).

They'd call me a lot, they came to my home, they didn't give up on me, so for me it was very, very important (P3).

[After the religious practice] I have a whole new life, I don't have problems, I don't think about problems (P6).

Chart 1 – Code tree. Ribeirão Preto, SP, Brazil, 2021

Topics	Categories	Subcategories	Codes
1) The course of life and determinants of mental suffering	Life history	Significant childhood moments	Difficulties in childhood
			Childhood responsibilities
			Sexual violence perpetrated or attempted during childhood
		Pre-diagnostic feelings	Not being a priority
			Loneliness, emptiness
			Difficulties getting help
			Difficulties opening up
		Problems experienced before diagnosis	Family problems and disappointments
			Death, threats, and losses
			Abuse at work
			History of depression
			Accumulation of disappointments
			Separations
2) Mental disorder and treatment	Mental suffering	Mental disorders	Mental disorders
		Manifestations of mental disorders	Manifestations of the disorder
			Removal from the religious institution or religious activities
			Suicidal ideation or suicide attempts
	The role of health professional care	Professional health care	Professional care
			Search for help
		Frustration with the care from the health professional	Frustration with care
			Fear of being frustrated
			Lack of empathy in assistance
	Drug treatment	Pharmacological treatment	Medication
			Side effects
		Stigma	Stigma

Chart 1 – Cont.

Topics	Categories	Subcategories	Codes
3) Spirituality as a complement to treatment	The role of the religious institution	The role of faith	The role of faith
		Religious support	Relief and responses
			The religious institution and religious practices
			Feelings of confidence
			Being embraced by the religious institution
			Effects of the religious support
			Different religious institutions
	Group support	Other support	Friend support
			Family support
		Being welcomed in professional care and in the religious institution	Being welcomed by the professional and the religious institution
			The role of medicine and of the religious institution
		Proposals for health care professionals and religious institutions	Professional partnerships and the religious institution
			Knowledge about religion
	Reflection	The process of recovery	Return to religious activities
			Difficulties coming back
		Learning	Learning
			An example of overcoming obstacles

In general, the religious institution was seen as an important complement to the treatment, especially due to its affective reception:

> *I got help from both sides, from the physician, through our conversations and the medication, and from the religious institution, because of the love, the embracing you need at that moment. ...Mentally, physically, the medication helped me not to feel those things I was feeling, that panic, those symptoms. But that good feeling of being welcomed, embraced, cared for, that I got from the religious institution* (P2).
>
> *I think it was the whole, the help from the religious institution coupled with the help from the health professional, I think it was essential for me* (P4).

When the religious institution did not embrace the participants as they expected, a certain frustration and feelings of abandonment were noted:

> *There was a certain negligence on their part, regarding getting to know my situation, how serious it was, some people visited me once in two years and never came back, some leaders... that were my direct superiors in the hierarchy of the institution* (P5).

Participants suggest there should be a dialogue between these instances, since both are part of care, and, in their perception, it would be important for professionals to understand the role of the religious institution and vice versa:

> *I think there should be meetings between professionals in this field, such as psychologists and psychiatrists, and some members of the religious institution. I think this partnership should happen, to discuss some topics and exchange information* (P4).
>
> *If health workers understand a bit of this religious side, a little more than its superficial aspect, than the basic, I think this could help them understand much better some clinical frameworks, some people, and to find an answer, a medication or good orientation* (P5).

DISCUSSION

Although the sample was heterogeneous regarding sociodemographic aspects, three out of the five women in the research declared to be black or *parda*. The ethnicity/color aspect is a social sign of differences, and these populations often have an unequal access to health when compared to their white counterparts[21]. Considering the intersections in these groups, black women are affected not only due to vulnerabilities that are common to all women, such as the overload of social roles, gender discrimination, and exposure to violence (physical, psychological, patrimonial, sexual), but also by different types of racism (structural, institutional, religious, cultural, environmental). This imposes upon these women even more struggles and difficulties in their daily lives, and in their conditions of life and health[22,23]. Regarding mental disorders, the black population has been historically submitted to exclusion, isolation, and marginalization, being the population most commonly forced into asylums[24]. In this regard, the concept of mental health *quilombos* (a term related to the struggle against slavery) , which understands the psychiatric reform from a decolonial perspective, and does not separate anti-racist struggles from anti-asylum struggles[24]. It is extremely important to consider ethnicity/color both in mental health care, provided by health workers, and as a criterion to identify scientific research, since racism is a determining factor for mental suffering.

Regarding risk factors reported by participants, the findings corroborate literature about the development of mental disorders [25–27]. Among traumatic events, deceptions and losses, such as the end of relationships and the death of people who may have had an important role in their lives, leading to the (un)availability of informal social support resources, may be considered an important factor related to the availability of social capital.

It is worth noting that the availability is essential for professional care, since being available often determines the time dispended with the person and, consequently, the deepening of their life issues, development of bonds, and affection, something that participants of this research mentioned as an important factor. However, the limitations of context of care must be respected, which, due to their organization, may limit availability. Furthermore, regarding nursing theories, unavailability is an essential measure to build a therapeutic relationship[28].

Other elements mentioned were episodes of physical, psychological, and sexual violence, in childhood or adolescence. Half the other mental disorders experienced in adult life originate in adolescence, a crucial phase of life, since many adverse experiences start in this period and continue into adulthood, when they become chronic, a relationship demonstrated in international literature[29,30].

Participants mentioned loneliness, emptiness, and feelings of being unimportant as things they experienced before the diagnosis of mental disorders, as pointed out in a previous study on the subject[31]. Resisting help, which can be related to difficulties to mobilize support networks (access conditions) and to the satisfaction with the support perceived in previous experiences, was pervasive in the statements of the participants of this study. This corroborated a research in which users, despite recognizing the importance of resorting to assistance, preferred to attempt finding a solution individually, without people or religion,. since they felt weak and with no autonomy when they thought they needed help[31].

There were prejudice in daily life, interpersonal relationships, fear, and risk of suicide, confirming psychosocial consequences described in literature, regarding mental disorders[25,26]. When it comes to suicide, a study with people being treated in two Centers for Psychosocial Care (CAPS) in Paraná, found that factors such as low educational level, the female gender, non-adherence to treatment, and a worse perception of quality of life were associated with a history of suicide attempts[32]. Previous reviews also found that suicide

was ten times more likely in people with mental disorders as opposed to healthy people. It also found a relationship between suicide attempts and different types of disorders, such as personality disorders, anxiety, and depression[33]. Health workers must pay close attention to factors already identified in literature, in order to attempt to prevent cases in the attention carried out.

Being distant from the religious institution was mentioned as a consequence of the mental distress caused by the mental disorder. This can suggest, on one hand, difficulties asking for help, as mentioned above; on the other, it is possible to interpret that his attitude, especially as symptoms are starting, is a way to not show the vulnerabilitis in this social context. This type of behavior suggests attitudes related with escaping or avoidance, related not only to the symptoms, but also to the social, family, and cultural contexts, which may make the search for health challenging, involving both the access conditions and the availability and satisfaction with the social support available, as indicated by a study carried out in another population[34].

This can be related with the fear of the person with mental disorders being discriminated due to the stigma, since their condition can be interpreted, in some religious contexts, as a sign of weakness, lack of faith, or as a trial. Although none of these factors were mentioned by the participants of this study, previous research by the Pakistani Psychiatric Research Center mentions the ambiguous role of R/S, which can support treatment or the stigma itself, by giving a religious etiology to these disorders. This factor is related to the cultural and social context in which the individual lives[35].

National and international studies emphasize the stigma as a relevant barrier to adherence to treatment, both in drug treatments and in regard to the possibility of discussing one's mental health condition with one's peers, since confinement, exclusion, and segregation have historically been imposed upon people with mental disorders, and have reverberated in society due to fear, prejudice, and misinformation, on which the stigma of this condition is based[36,37].

In this study, the main care mechanism used by the participants when their suffering was manifest was the search for medical and drug treatments. Regarding drug treatments, studies have pointed out that it is a dynamic process, which includes meanings, choices, hope, and suffering. This is why the perception of users regarding the use of psychotropic drugs is a complex experience, since, while these drugs help the remission of the symptoms, they can also have side effects that interfere in several aspects of their lives – including the stigma they suffer, especially if the side effects become a problem in their workplace[37,38].

When it comes to medical treatment, participants reported, in general, low satisfaction, disagreeing with the results of a study developeped with the users of a CAPS from a region in Minas Gerais[39]. This highlights the importance of studying different locations, since the participants may not feel free to state their dissatisfaction with the service that houses the study, even with all ethical guarantees of anonymity. Considering satisfaction as one of the aspects of the concept of social capital, this low satisfaction with the medical treatment is opposed to a greater satisfaction with the religious support that was related with the recognition of the welcoming and the affection that was received. For the participants in this research, relationships factors and empathy were essential for the perception of satisfaction with both formal and informal support.

The search for private care, in this study, is associated with the profile of the sample, with most people providing this type of assistance already. It should be noted that participants were not asked about whether they sought assistance in the public health system, such as in the CAPS. It stands out that the CAPS is a territorially- and community-based service, that attends all those who seek it, and aims to provide care to the population with mental health issues by encouraging their autonomy, and avoiding asylum-related reasoning. Despite their potential, these services face difficulties regarding their work process, associated with the financial resources they receive and the infrastructure available for treatment, which mean that a large portion of the population is not attended[40]. Thus, the need to expand the psychosocial health care, emphasizing primary care, stands out, in order to ensure the effective access of the population that needs it.

The participants mentioned spirituality as a complement to the treatment, corroborating previous research that suggest that the religious institution is a place where beliefs, faith, and spirituality are exercised; the care, by, giving hope, is a way to change their lives, and, consequently, their health framework[11,12]. In the context of mental disorders, health strategies based on R/S aim to provide the subject with the possibility of connecting to the sacred and the transcendent. This can allow resignifying the disease, rediscovering the meaning of life and of investment on the care for oneself and the others[11,12].

Despite all these positive aspects, one participants mentioned not having a good experience regarding the expectations they had for the religious institution, in regard to their mental health condition. In this case, the participant may not have felt embraced as the others, as they did not receive the attention they expected, or even felt stigmatized. Spiritual care is based on interpersonal relationships, on the companionship of one's peers, in sensitive listening, conversation, bonds, and affective hospitality[4]. These practices may not have been made available by the members of the institution mentioned, or were operationalized in such a

way that the participant did not perceive them as accessible, considering his mention of a visit they received from the leaders of the isntitution, which is an offer of social support (conditions of access).

Although noticed as complementary in the perception of participants, these different types of support were not integrated. This shows a conflict that is pervasive in the relationship between formal health systems and popular ones, or, also, between science and R/S, suggesting that these support network can suggest different understandings of the mental health issue. However, from an integrative perspective, they should embody a humanized care, focused on a subject that is already fragmented by the process of suffering[11,14]. Therefore, this study signals that both support services could attempt to increase their role, in such a way that they can be integrated as sources of both tangible and emotional support, since this would make help more effective and contribute to overcome the dichotomized logic of the biomedical model.

Regarding the limitations of the study, the use of a single data collection technique prevented result triangulation. Future research should include the discourse of religious leaders, and even that of relatives belonging to the same institutions, allowing spaces for different reference points related to mental health. It should also be noted that, since the main researcher is part of the religious institution in which the study was carried out, there is the possibility of an interpretation bias. Although this choice allowed easy access to the participants, in addition to the fact that the participant was sensitive to religious-spiritual markers when listening, can also have, as an effect, the social desirability effect, which, in this study, may have influenced the fact that the references to religion in mental suffering were eminently positive. This point was made explicit as the main reflexivity factor.

Another important limitation that should be noted is the fact that, in addition to the fact this study was developed in a specific, Christian religious institution, the participants, in most cases, sought mental disorder treatments in the private network. Thus, further research should include other religious branches, as well as the diversification of health services, among which the public network is included.

Nevertheless, the main contribution of this study is the fact it enables a reflection about how much people, even those associated to religious institution, still see the biomedical perspective as hegemonic when confronted with mental health problems. Furthermore, the findings show R/S can strengthen stigmas or contribute to/complement treatments, due to the fact it promotes support through listening and affection. In this regard, an important recommendation, that corroborates public policies that guide mental health services, is effectively welcoming patients more affectionately, considering not only technical aspects, and addressing the issue of R/S, while exploring and considering the social capital of users. Finally, this study invites those in the health field to invest more in training that considers the importance of R/S in health care, for intersectoral and inclusive articulation that considers community leaders – including religious ones.

FINAL CONSIDERATIONS

In the perception of people with mental disorders, religion occupied a more subjective and fluid role, pervaded by the logic of embracing and afection. They showed satisfaction with informal social support, and the availability of this resource among members of the institution. Health workers, in turn, provided a more objective and tangible form of care to reduce the manifestations and consequences of mental disorders, focusing on the search for medical and drug treatments. In general, drug treatment could be understood here as the elimination of symptoms, while religious support could be understood as overcoming the experience of suffering. This highlights the intersection between these two types of care as an important aspect of the expansion of mental health care.

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