Mental Disorders Prevention and the Clergy

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The recent NIMH report on priorities for prevention research both expanded the
definition of prevention, and recommended that a greater variety of participants and
methodologies be used (1). This presentation will describe the potential effectiveness of
collaboration with clergy and their congregations as a locus for prevention research. There
are over 300,000 clergy working with religious congregations in the United States (2).
Surveys of the general population have found that people with emotional difficulties initially
seek help from clergy more frequently than from mental health professionals or primary care
physicians (3, 4). Clergy report spending an average of 15% of their working time providing
help to persons who seek counsel (5). The multiple professional roles of clergy mirror the
NIMH prevention categories: clergy understand the normative context of people's
experience (Universal), they—and their congregations—are sources of social and emotional
support (Selective), they are de facto gatekeepers to professional mental health care
(Indicated) and they could provide community reinforcement for adherence to treatment
(Relapse & Comorbidity). Recent research has demonstrated that a sample of clergy and
mental health professionals could distinguish mental disorders, which require clinical
intervention, from religious problems, which do not need to be the focus of clinical
attention, and further indicated that they might be willing to make collaborative referrals (6).

The NIMH also recommended a developmental approach to prevention research. The
clergy follow the lives of some congregants from birth, through school years, to marriage
and at times until death. This longitudinal relationship brings clergy in contact with people
at times of transition that often include those serious stressors which are identified as placing
people at risk for mental disorders (e.g. job loss, divorce, natural disaster, bereavement, raising
children). This report will recommend ways to work with clergy, as well as to empower and
measure the effectiveness of their naturally occurring social support systems.

Three diagrams follow. The first diagram is adopted from the NIMH diagram entitled,
*Level of Risk and Proportion of Population Receiving Preventive Interventions, with Illustrative Examples*
(1). In this diagram the proportion of the population receiving the intervention is shown by
the area of the rectangle, the level of risk of impairment to the population receiving the
intervention is shown by the level of shading. The proportion of the population targeted is
therefore progressively smaller across Universal, Selective, Indicated, and Relapse &
Prevention, while the level of risk is progressively greater. The second diagram, *Mental
Disorders Prevention and the Clergy* is designed to provide public health examples of the role of
clergy across these prevention categories.
The third diagram, *Clergy: A Mental Health Perspective* has been used in outreach programs with local clergy and lay congregation leaders. This single sheet has allowed us to visually and conceptually describe a hierarchy of mental health needs of persons in their communities. It begins with a recognition of the mental health support provided by the clergy and their congregations, and recognition that these normative relationships do not require the presence of clinicians. The increased darkening represents increasing severity. The switch from statements to questions, as well as of font color from black to white in the third box represents situations that should involve contact with mental health care providers. We found that changing the size of the boxes was more confusing than informative. Therefore, each box has remained a uniform size. The message of when to collaborate is communicated by the shading, the font color and the content of the boxes.

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**References**

1. National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research: Priorities for Prevention Research at NIMH. Rockville, MD, National Institute of Mental Health, 1998
5. Weaver AJ: Has there been a failure to prepare and support parish-based clergy in their role as frontline community mental health workers: a review. The Journal of Pastoral Care 1995; 49(2):129-47
National Institute of Mental Health
Level of Risk and Proportion of Population Receiving Preventive Interventions

UNIVERSAL

Targeted to a whole population.

SELECTIVE

Mental illness risk is higher than average.

INDICATED

High risk with minimal symptoms not meeting DSM-IV.

RELAPSE and COMORBIDITY

Risk for relapse or comorbid complications.
## Mental Disorders Prevention and the Clergy

### Universal

Clergy and religious congregations can facilitate the maintenance of individuals’ mental health through providing persons with the context and coherence of a caring social community, encompassed by a shared religious language.

**Context:** clergy interact with congregants **across their lifespan** both when they are and when they are not having problems.

**Coherence:** religious communities provide comfort, support and meaning which may help persons avoid experiencing mental disorders or regain their sense of belonging if they do.

### Selective

In response to **Major Stressors** (e.g. job loss, divorce, natural disaster, bereavement, raising children), religious communities may help individuals to prevent more serious dysfunction through:

- Social Support of the Congregation
- Enaction of Community Rituals
- Reinforcement of Religious Coping Beliefs
- Brief Clergy Counseling

### Indicated

- Clergy and religious congregations could note if, in response to stress, individuals demonstrate a deterioration of functioning (i.e. Bereavement can lead to **Major Depression**).
- If they have a collaborative relationship with mental health care providers, they can intervene to initiate professional assessment and, if necessary, treatment for the suffering individual.

### Relapse and Comorbidity Prevention

Clergy and congregations can help persons identified with mental disorders by facilitating **adherence** to treatment that is necessary to prevent the recurrence of mental illness. Such support can also reduce the co-occurrence of comorbid symptoms and help reduce family burden.
Clergy: A Mental Health Perspective

**What You Already Do**

YOU interact with congregants both when they are, and when they are not, having problems.

YOU provide comfort, support and meaning, which can minimize the effects of mental health problems.

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**How You Already Help**

In Response to **Stress** *(job loss, divorce, natural disaster, bereavement, raising children)*

You Provide:

- Religious Coping Beliefs and Rituals
- Social Support of the Congregation
- Counsel

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**What More May Need To Be Done?**

**Response:** to Stigma

**Initiation:** of Mental Health Assessment and Treatment.

**Collaboration:** with Mental Health Care Providers

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**Now What?**

**Support:** to Families of Persons with Mental Health Problems.

**Reintegration:** Into the Congregation.

**Adherence:** to Mental Health Treatment Plan.

**Prevention:** of Relapse and Possible Harm to Self or Others.