The Role of the Pastor in Community Mental Health

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THE last two decades have shown tremendous increase in the actual cooperation of clergy with all the mental health professions. The increase of clinical pastoral education which brings about the actual working relationship in institutional settings of clergy with psychiatrists, psychologists, social workers, and nurses has done much to bring about mutual respect for the problems and contributions of each profession. The changing attitude of psychiatry was well expressed in the presidential address of Dr. Finley Gayle delivered to the American Psychiatric Association in 1956.

> If healing and the forgiveness of sin could be always neatly separated, with neither having anything really significant to do with the other, the problem might be a minor one . . . But that health and the release of feelings of guilt are intimately related, there can be little doubt . . . We need to recognize the big motion toward a religious solution of many human difficulties. (**American Journal of Psychiatry**, 1956)

Many clergymen who are interested primarily in the counseling dimension of the parish are seeking their advanced training at universities through departments of psychology, sociology, and social work. This too is bringing about an encounter and dialogue which opens avenues to increased willingness toward cooperation on the part of these other professionals with the clergy.

The insurgence on a large scale of the mental health clinic and the idea of community mental health has brought clergy and mental health professionals together in working cooperation as never before. We must recognize that this unity is still not the relationship that it should and could be from either side. Quite often the clergy are totally overlooked in the development of mental health facilities for the community. At other times he may be involved but be as uncertain of his role as are the other professionals about his role. On the other side of this coin are those instances where the clergyman has been the primary instigator and supporter of developing mental health programs.

It could be extremely easy for us clergy to assume the attitude that emotional disturbance is out of our range of operation and so when we encounter individuals within the church who are emotionally disturbed we could refer them to the mental health professionals. There are many clergy who function on this basis. This stand avoids several significant issues. First of all, there is the practical problem that professional help may not be available. This may be due to several factors, among them the lack of availability, especially in the west where professionals are clustered in the metropolitan areas and only on occasion do teams go into the outlying communities. Another problem is the over-all lack of professionals. There are only about 15,000 psychiatrists in our country, and when we add to this the psychologists and social workers who are involved with psychotherapy, we quadruple that figure, which is still insignificant when one considers a total population of 200,000,000 accompanied by the estimate that one of every four individuals will need professional help with emotional problems. A third factor

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is that a person is seldom in isolation, but has significant interpersonal relationships. Unless the clergyman refers everyone involved with the patient, he will not avoid his responsibility. Finally, referring the patient does not alleviate our relationship to him as a child of God and as Mediator for God we can never escape this responsibility.

Several dimensions of the clergyman's role can be recognized in the above statement. Let us categorize these in three areas, the theological, the sociological, and the psychological. On the theological level, the pastor is the recognized representative of the living Christ through his functional role within the life of the church and as such he is considered the mediator of the Good News of God to man. As representative of God's message to all mankind he is concerned, not only with those in his parish, but those in his community as well. This moves us to the second dimension which is the sociological. Here the pastor becomes a mediator between the person and his community or society. He helps to interpret what is meaningful within society that aids the person in the achievement of his highest potential. On the psychological dimension, the pastor is the mediator of the personal love and concern of God for man as a unique being. The pastor brings the Word of God to bear on each individual man where he is and where his needs are being presented. At this level, the pastor represents the fellowship of the church as well as his personal concern and God's love. The pastor can translate the individual and group needs through the rituals of worship and sacrament and thus bring the Good News of God into relationship with persons.

When we are talking about the clergyman's concern for community mental health, we are assuming that all three of the above dimensions are underlying his approach. There may be more stated emphasis upon the psychological and sociological, but this is because the clergyman is speaking from the total context of his role as religious representative (theological). With this viewpoint in mind, let us explore in more detail the roles of the clergy in community mental health.

Perhaps the most significant position which the clergyman serves on the mental health team is that of community consultant. He will most likely have the greatest numerical contact with people in the community than do other members of the team. Not only is the pastor involved with the members of his parish, but has broad contact with other members of the community, some of which belong to other parishes and some who are unchurched. There is another important factor in this and that is that the clergyman has contact primarily with those members of a community who are in relatively functional mental health. Other members of the team are most likely to encounter the community through individuals who are primarily disfunctional or suffering mental disturbance. The pastor thus may provide a corrective to distortions and concerns that come primarily from dealing day after day with pathology. He can in this way provide a balance for the team.

A second major function which the clergyman serves on the mental health team is in the area of prevention. The Joint Commission Report on Mental Health and Illness concluded that the major function of the clergy and the church is in the area of prevention. Aiding individuals and families toward the development of maximizing their potential as individuals and families should be our goal. However, in order to do this at the most significant levels, the pastor will need the insights and assistance of other members of the team. Those members who have specialized knowledge of individual growth and development, those who understand the needs and problems of the family,

those who recognize the pressures of citizenship, job, recreation, etc. Let me provide you an example of such a cooperative program. A psychiatrist at a local Mental Health Center and members of his team have recognized this need for cooperation with the clergy as a means of prevention. The first phase of the program which was developed was to bring into the hospital setting a group of clergymen. He divided them into three small groups through which lecture, discussion, and action could be maximized. Their individual pastoral skills were increased. Their awareness of community resources was enhanced. Above all, their awareness of significant educational tasks for the church became clarified. The second phase of this program will see the mental health professionals going into the churches of these clergymen in order to discover the specific needs of each church and then to work with the committees within these churches to put into operation plans of action aimed at increasing mental health. The team feels that the church can reach various levels of people and problems where it can be a positive influence that other mental health professionals cannot, and that psychiatrists and others need to help the church do a better job in developing programs to meet the realistic needs of people. The team plans to serve as advisors to the programming in such areas as parent education, children's work, the problems and needs of adolescents, marriage and family education, the aging, and especially in helping the clergymen learn to deal more effectively with crises areas that are continually emerging within the life of the church. This is one approach in the area of prevention. Essentially, the clergyman and church have been performing this role in one way or another since its beginning, but the complexities of our society necessitate this need for more cooperation between clergy and the mental health experts who have significant contributions to make in terms of a more total understanding of our task.

A third function the clergyman serves is as a referral resource. The clergyman has at this disposal a huge team: his parishoners. Few clergymen have adequately utilized the numerous resources available within their membership. A variety of non-professional functions could be served by this group. So very often in planning the disposition of a case by the hospital or clinic staff we are thwarted by the lack of resources available or known to us. A job may be needed. A home to live in on a temporary basis. A friend to talk with for support. Someone to help care for a family while a mother regains her strength and confidence. A ride to and from the clinic. I could extend this list on and on.

I beleive that we are not permitting our members to really witness that they are the people of God at work in the world when we fail to utilize their individual and collective resources for the good of the fellowship and mankind at large.

I served as an associate pastor in a church where this was in operation. A twelve member advisory board was established to assist the pastors in working with the people and problems they confronted. It was composed of a physician, a lawyer, a social worker, a public health worker, a housewife, a teacher, an insurance man, a judge, two business men, and a representative of the young adults, and young marrieds. This group then attempted to establish the resources available through other members of the church. They then met on call as a group or in part with the pastor, to advise and aid him in dealing with the person coming to him for help. The pastor no longer needed to have all the answers or know all the resources himself but could draw upon those of his members. The faith and witness of the one seeking help and the helpers were both strengthened through this united effort.

There is a second dimension in this area of referral that goes the other

direction. The pastor, unlike most other professionals in the community, has ready access to most of the homes in the community, both those of his members and many of those who are not. If he is adequately carrying out his pastoral care function, he will be visiting in homes, offices, businesses, restaurants, and even in his church groups. The sensitive pastor will have his radar in operation and will be open to picking up the clues which people throw out to him that so often are cries for help. He will move in and attempt to open this up more directly when that seems advisable or may consult other family members to see what reactions he gets from them. At any rate he is keeping a temperature check on people and when he feels it is getting too high he has the authority and position to do some clarifying of what is going on. A result of this may be that the individual or individuals will come to him for counseling or other assistance. One very important result of this action may be early referral to mental health resources. We know that early referral is often a significant key to treatment of emotional illneses. Again the pastor may need assistance from mental health team members in learning to recognize the signs of emotional disturbances. I hope that you are all familiar with Tom Klinks, little pamphlet "Clergyman's Guide to Recognizing Serious Mental Illness."

The fourth function of the clergyman on the mental health team is through his own counseling and pastoral care of his members and constituants. The Joint Commission on Mental Health and Illness found that 42% of all individuals seeking help with emotional problems went to their pastor first, which was the largest figure for any counseling source. This indicates that whether the pastor likes it or not he is on the front line and must be capable of responding to this presented human need. The major problem that was presented to the clergyman related to marriage conflicts. This is undoubtedly a natural outgrowth of the religious or sacramental nature of marriage. At the same time, it is increasingly being recognized that marital counseling is an extremely complex process requiring the highest level of skill and insight. It is unlikely that most ministers have the training necessary to do the job required in a majority of these cases. This would be true for many of the other problems which are brought to him. However, it may be necessary for him to handle the case for any number of the reasons we examined earlier. The pastor will feel more comfortable in his counseling role if he has consultative help readily available to him. Here again the resource of the mental health team comes into operation.

Dr. Edgar Draper, a Methodist ministter who became a psychiatrist, and who spends a good deal of his time developing programs of cooperation between psychiatrists and clergy, believes that consultation in this area needs to be looked at from four possibilities. He points out beforehand that consultation is often mistakenly heard by a psychiatrist as a request for taking over a case and management of a patient, which is not always so. This tends to be one reason that clergymen are rather reluctant to consult a psychiatrist. It would seem that clarifying the communication would be a goal here rather than a withdrawal from or refusal to use the consultative relationship. This communication will most likely be enhanced through cooperation of clergy on mental health teams.

The first level of consultation Dr. Draper proposes is where the pastor is asking the psychiatrist or mental health professional for a diagnostic evaluation of the patient without assumption of treatment responsibility. Most pastors who do much counseling, especially in larger cities, readily develop a relationship with a psychiatrist to whom they feel they can refer a

patient for evaluation and receive from the psychiatrist his diagnosis and his suggestions for treatment, either by the pastor or through referral.

Secondly, consultation may mean a communication of opinion without a diagnostic examination of the patient himself. Here the pastor will talk with the psychiatrist about the patient. This is especially true if some problem arises in the course of counseling or the pastor seems baffled as to what is happening or where the goals of treatment are not being achieved.

A third level of consultation may be sought by the pastor as a means of supervision of his counseling work. I know of two psychiatrists in Denver who meet on a regular basis with a small group of clergymen for group consultation of their counseling cases. I do both individual and group consultation where clergymen present case material, portions of tape recordings, discuss their own feelings and anxieties, the questions they have about the cases, and community resources. I in turn have a regular consultation with a psychiatrist or psychologist about my own work or any sticky problem that may arise in pastoral consultations.

The fourth level of consultation which Dr. Draper deliniates consists of the psychiatrist teaching a regular clinical case conference for the clergy. This is somewhat like the third level but is more a didactic orientation and lasts only for a brief period of time, whereas supervision is an ongoing process. This level reaches a large group of clergy and may provide impetus for continuing education and supervision of his counseling work.

When the pastor is working at this cooperative level with other mental health professionals he is usually more willing to increase the number of parishioners he could see and also is more willing and capable of carrying them through to completion of their treatment needs.Uncertainty of his own skills and question as to depth of treatment need tend to be two factors which keep clergymen from being willing to assume more depth involved counseling cases. When consultation is available and the pastor feels the support of colleagues these factors diminish. The result, as it relates to community mental health, is that the pastor is able to handle more and varied types of emotional problems and thus potentially reducing the case load for psychiatrists and clinics so that more time can be devoted to the serious and deeply involved emotional illnesses.

A fifth function which the clergyman has on the team is as a functional member of the clinic or hospital organization. This function is perhaps the latest to emerge at a direct counseling level, although it has been present for many years in the hospital setting through the clinically trained chaplain who is a recognized member of the healing team. In the last few years, several private and state mental health organizations and clinics have recognized the value of providing training in depth for local clergy while at the same time the clergyman provides a service to the clinic as a member of the staff.

I recently served as consultant to a state mental health clinic in Texas which was in the process of developing such a cooperative program. The following plan of operation was proposed which is somewhat typical of what has been done in other situations. The clinic would provide service and training opportunity for the clergy at three levels. The first level would be that of consultation on any or all the levels discused above. A working relationship would be sought through which clergymen would feel comfortable in contacting the clinic to provide consultation at whatever level was needed. The second level would be an ongoing training program for clergymen offered by the clinic. This would be a twice monthly meeting for one afternoon. A staff mem-

ber of the clinic would be regularly in charge of this training but could call upon other staff when appropriate. This training would include lectures, technique training, group consultation, and other services as these emerged from the voiced needs of the group. A maximum of ten clergy would be involved at a time in courses to run over a period of six to nine months, at which time a new group would be formulated. The third level would be to provide extensive and depth training for two clergymen over a period of one year. At this level two clergymen would be selected each year to become a part of the clinic staff. Each pastor would give fifteen hours of his time a week to the clinic in which he would be dealing with clinic cases. In return, he would be a regular part of the staff, have individual supervision of his work, and be given training in individual, marital, group and family counseling. This may seem like a lot of time and involvement, but in the long run both the church and the community and clinic would benefit. We know from the experience of other counseling oriented disciplines that significant amelorative therapy cannot be adequately learned when there is not involved a clinical orientation accompanied by individually oriented supervision. This has been a major lack in the preparation of the clergy for the pastoral counseling side of his work and with a few exceptions is still a missing ingredient in most seminary programs. It would seem most logical for this supervised training to take place "in the field" so to speak, much as social work supervision has been done for years. The minister as an integral part of the community mental health clinic staff would appear to be in a unique position to receive this training. When looked at realistically, the staff reaction of time involvement is diminished when it is recognized that actual patient-staff contact through service is increased through this additional staff. Also this trained minister will serve the community and the clinic after his year of training both through direct service to people in need and as a vital and qualified resource for referral.

Sixth and final function relates to broad educational opportunities.

During the last ten years or so, a number of programs have been developed on a cooperative basis by mental health clinics and ministerial associations. Dr. Ed Draper and Dr. Granger Westberg have been involved in several of these and have recently published a book reporting their experiences entitled **Community Psychiatry and the Clergy.** I would highly recommend that you read this brief report to stimulate some thinking on the part of your clinic and ministerial associations.

I have found over the past year, as I have lectured and talked with clergymen, that the most pressing need they feel they have in regard to continuing education is for some short but loaded courses or seminars in the area of pastoral care and counseling. Several of these have been developed and are in operation throughout the country, but we need many more to meet the need. I would like to share with you two examples of the type of program that can be developed. The program offered by the Institute of Mental Health of St. John's University at Collegeville, Minnesota, was designed to facilitate the effective cooperation between psychiatry and religion. They conduct three seminars a year for a period of one week each. A typical group consists of about fifty pastors, priests and rabbis. The format is somewhat as follows: Two lectures are given daily, at the beginning of the morning and afternoon sessions, followed by a period devoted to questions from the audience. The assembly then breaks up into four discussion groups, each with a faculty member as leader, in which issues and principles presented by the lecturer are discussed in detail with illustrative

material derived from the experience of the clergymen.

In the evening, panel discussions are conducted by the faculty, during which there is always audience participation. The subjects are usually chosen by the clergymen, and are always varied: growth and development, character formation, ways in which values are transmitted, social and cultural influences affecting behavior and accomplisment, anxiety, the significance of symptoms, the nature of mental and emotional disorders, alcoholism, marital problems, depressions, sexual disorders, suicide, neuroses and psychoses. The theory and practice of pastoral counseling is always a relevant subject. Theological questions are avoided by common consent, psychiatrists and psychologists having no competance in this area, and valuable time may be lost when ministers push their own hidden theological agendas.

These programs have been in operation for over ten years and are viewed as dynamic and significant by those pastors in attendance. The psychiatric staff also believes that they learn and grow as much as do the students.

The second example may be found closer to home. This is the bi-annual seminar for physicians and clergy which is held at the YMCA Camp at Estes Park. This is sponsored by the University of Colorado Medical Center and the Colorado Medical Society. The original conference dealt with general counseling concerns of the physician and clergy. Out of this conference grew the theme of the conference for this year which will focus upon mariage and family counseling and which will be expanded to five days. Mornings will be devoted to lectures and case materials presented by nationally recognized authorities in the field. The afternoons will be spent in small group discussion where physicians and clergy may share their experiences. A major contribution of these conferences is the development of a new level of understanding and respect betwen the two professions. This results in a greater willingness to develop good working relationships in the home community between the clergy and the physician.* As significant as these programs are, they are still not sufficient to meet the demand. Ministerial associations, community clinics, and even local churches are going to have to survey their needs and instigate programs that will meet these demands.

In drawing this lecture to a conclusion, let me say that it has been my hope to stimulate some thinking on the part of both the clergy and the clinic staff present, in terms of some possible steps that could be taken toward greater cooperation and functioning. Perhaps I have planted a seed or two, thrown out some challenges, and maybe even threatened you a bit—I hope so. Just let me add a word of caution. Move slowly, don't expect everything to come about overnight. Make sure that communication is clear on both sides. But for the sake of the community, do communicate and do move no matter how slowly that move may be.

* The Estes Conference for Physicians and Clergy will next be held June 16-20, 1969 and the focus will be upon Crisis Counseling.