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FEATURE

Clergy and Psychiatrists: Opportunities for Expert Dialogue

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Thus, insofar as it is possible--and all of us fail now and then when one of our private interests is touched upon--the psychiatrist remembers that his role is that of an expert.
--Harry Stack Sullivan, *The Psychiatric Interview* (1954, p36)

On Oct. 20, 2000, the New York Academy of Medicine, the New York Medical College and the World Psychiatric Association jointly sponsored a conference titled "Psychiatry and Religion: Friends or Foes?" The conference was oversubscribed, with standing room only for some of the more than 150 people present. Three previous presidents of the American Psychiatric Association were in attendance; two were presenters. In the course of the daylong meeting, each speaker agreed that we have to carefully proscribe our interventions in areas outside our expertise and called on clergy to do the same. The details of where to place the boundaries were left open for discussion and are still ripe for research.

Little did any of us realize that less than a year later, expert dialogue between clinicians and clergy would be crucial in the aftermath of Sept. 11, 2001 (American Red Cross, 2002).

The need for research to determine the best mode of reciprocal collaboration between clergy and mental health care professionals was made dramatically apparent after the attack on the World Trade Center. Civic leaders called upon citizens to go to their houses of worship and to seek psychological counseling. In St. Paul's Chapel--an Episcopal church that was a main place of refuge for relief workers at Ground Zero--a handwritten sign near the entrance said, "Counselor available. Please ask" (Wakin, 2001).

For the past 10 years, I have studied the process of reciprocal collaboration between clergy and clinicians. In the last five years, I have implemented pilot projects designed to examine the complementarity of religion and mental health care within the contexts of professional and vocational specialization (Milstein et al., 1999).

Clergy or Clinician

Research has consistently shown that people with emotional problems most frequently turn to clergy for help (Chalfant et al., 1990; Gurin et al., 1960; Veroff et al., 1981) and that even people with serious mental illness are as likely to contact clergy as they are to contact mental health care professionals (Larson et al., 1988). In a survey conducted less than one month after Sept. 11, approximately 60% of all the respondents said they would likely seek help from a spiritual counselor, compared to 45% of all the respondents who would likely seek help from their physician and 40% who would seek help from a mental health care professional (American Red Cross, 2002).

People do not choose these patterns of help-seeking because they are unaware of mental health care resources. Rather, they do so because they are more familiar with clergy, clergy do not charge fees and there is less stigma involved in discussing one's personal problems with clergy (Chalfant et al., 1990; Schindler et al., 1987). It is estimated that 10% of people who go to clergy with psychological problems are then referred to mental health care professionals (Mollica et al., 1986). Few studies have examined circumstances wherein mental health care professionals have made referrals to or consulted with clergy (Weaver et al., 1998, 1997).

Religion and Diagnosis

In order to collaborate, clergy and clinicians must be able to recognize those signs and symptoms that indicate a need for consultation or referral. The DSM-IV introduced a new V code, religious or spiritual problem (V62.89), which the DSM-IV Sourcebook (Lu et al., 1997) describes as a category to employ in order to explicitly differentiate psychiatric mental disorders (e.g., schizophrenia, major depression) that require clinical attention from profound personal religious concerns that are not mental disorders but may be a focus of clinical attention because of difficulty integrating these experiences into the individual's social or emotional life (e.g., mystical experience, religious doubt). A third distinct category discussed in the sourcebook is labeled pure religious problems. These are described as emotional difficulties that people have within the context of organized religion and warrant neither clinical attention nor a DSM-IV diagnosis (e.g., mourning rituals, religious doctrine).

An example of the first category (mental disorders that present with religious ideation) would be a young man with schizophrenia who has isolated himself in his room and reports seeing God talking with His angels. This person should be treated by a clinician and referred to a mental health care professional if first brought to clergy. A vignette study we conducted with rabbis and clinical psychologists found agreement on this course of action, with one rabbi exclaiming, "We go right to the emergency room!" (Milstein et al., 2000).

Examples of the second category of presenting problems consist of emotional difficulties resulting from strong religious experiences and may include mystical experiences or questions of personal faith that leave a person with troubling questions, emotional discomfort and a sense of isolation (Lu et al., 1997). Although these problems may be a focus of clinical attention, they are not mental disorders and could receive a DSM-IV diagnosis of religious or spiritual problem (V62.89). Expertise for this type of care may not belong only to psychiatry, and therefore a collaborative approach may be most appropriate.

Psychiatry has come to recognize the importance of culture as the interpretive system through which people seek answers to complex questions (Bruner, 1990; Gaw, 1993). Religion is a central aspect of nearly every culture, and clinicians need to be familiar with the "nuances of an individual's cultural frame of reference" or else they "may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture" (APA, 1994). Therefore, if people come for clinical care in response to emotional difficulty associated with a loss of faith or anger at God after Sept. 11, we are ethically obligated to understand their theological perspective from within the interpretive system of their religious beliefs and wisdom traditions (Hopkins et al., 1995). This understanding could be gained through consultation with the patients' own clergy or with another trusted clergy with knowledge of these faiths. With the patient's consent, the clinician and clergy could devise a treatment plan incorporating each profession's expertise.

Finally, the third category of pure religious problems would not receive a DSM-IV diagnosis. This category includes normal bereavement, wherein the person is grieving but not depressed, and the mourner has many religious and philosophical questions. A large part of the professional role of clergy is guiding individuals and families through the rituals--as well as the emotional trauma--of death and burial. This is an area of psychological suffering with which clergy have expertise different from that of psychiatrists, and mental health care professionals could gain knowledge from them.

Once a differential diagnosis from within the three categories has been established, a subsequent psychiatric (or nonpsychiatric) response may be considered.

Conduits to Care

Some clinicians who are co-religionist with their patients might choose to work without consultation. Some may believe that doctors and their patients should engage in religious rituals together, as part of the healing process. Although such interventions could be personally gratifying, Harry Stack Sullivan reminded us nearly 50 years ago that we should not work outside our scope of expertise. I would instead propose that we develop collaborative relationships with clergy. They are the experts in matters of religion.

Trauma, depression, bereavement, anxiety and loss of religious faith have all arisen in the aftermath of Sept. 11. We know that more than a year later, some people are only now beginning to discuss the effects of the attack on their emotional well-being (Goode and Eakin, 2002). We expect that clergy are seeing some of these signs, hearing their parishioners' symptoms and could, therefore, serve as conduits to appropriate clinical care. There may also be times when it is appropriate for psychiatrists to serve as conduits to clerical care.

Collaboration With Clergy

Since 1998, I have worked with the pastoral care and education department at the Westchester Division of the New York Hospital, Weill Cornell Medical Center, to develop outreach programs to community clergy. At the hospital, we hosted a breakfast presentation by clinicians. After telling the clergy of the different mental health care services we offered, we had them write down a paragraph describing one or more challenging congregants. Our chaplain suggested to the participants that these congregants could be found among the 2% of parishioners seeking help who use 80% of the clergy's counseling hours.

We then organized several clergy case conferences based on the diagnostic similarity of the congregants described. The associate medical director presided over three separate meetings, and we were able to offer some specific suggestions to the clergy. At the same time they provided mutual comfort to one another through dialogue they initiated. Subsequent to this outreach, several clergy made referrals to our facility. We have also been able to engage clergy in the discharge planning of some patients who are active in their congregations.

Collaboration with clergy need not be limited to institutional outreach. Individual clinicians could begin their own network of collaboration through attending the interfaith clergy meetings that are common in most communities. The key to success is to develop ongoing reciprocal interaction. Clergy are disinclined to maintain contact with clinicians who treat them as a quiescent source of referrals (Meylink and Gorsuch, 1988). Two resources that have been very helpful in our outreach are the *Mental Illnesses Awareness Guide for Clergy and Other Spiritual Leaders*, distributed at no cost (APA, 1997); and the Web site for Pathways to Promise, a nondenominational organization consisting of religious congregations who seek to increase awareness about mental illness .

Currently, at the Montefiore Medical Center Geriatric Psychiatry Clinic in the Bronx, I am the principal investigator of a study funded by the National Institute of Mental Health that explores geriatric psychiatry outpatients' opinions about collaboration between clergy and clinicians. The data from this study will help us develop Project C.O.P.E. (Clergy Outreach & Professional Engagement), a study designed to measure the salutary (or harmful) effects of interaction between patients' clinicians and their clergy. We hypothesize that the effects could include improved adherence to psychiatric care because of reduced stigma and improved clinical outcomes from increased social support.

Sept. 11 taught many lessons about how all of us are capable of working across social and professional boundaries to help the injured to heal. Research on the outcomes of reciprocal collaboration between psychiatrists and clergy is a project intended to bring disparate areas of expertise to the single goal of improved mental health.

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