An Overview and Introduction to Caring for Clergy

By

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This afternoon we will concisely present some of the main issues we have encountered in the evaluation and treatment of clergy over three decades. We hope this will be a beginning to something that will continue as an ongoing dialogue.

I. Our background—started in early 1990s at Menninger, 2001-2011 the Baylor Clinic, 2011 The Gabbard Center

II. "Impossible profession"-Clergy are expected to be all things to all people :

Priest, preacher, teacher, leader, CEO, fundraiser, mediator, business administrator, counselor, friend, confidante, problem-solver, surrogate parent…

The notion of surrogate parent brings in the issue of transference—the idea that one experiences authority figures as parents. Priests and bishops bear an even heavier transference burden that has spiritual overtones because they are viewed not only as parental but also as Godlike. Parishes thus have unrealistic expectations of priests just as a diocese can have unrealistic expectations of bishops.

To satisfy the expectations, clergy may work themselves to a point where they have no time for themselves, reminiscent of the novelist Walker Percy's comment: "Some people miss their lives like others miss airplanes."

III. Definition of impairment—inability to work with reasonable skill because of mental or physical illness that adversely affects cognitive or perceptual skills or due to abuse of alcohol, controlled substances or recreational drugs.

IV. Findings from our own data: 70 Episcopal clergy evaluated by our team over 20 years—Not a random sample of Epis priests, but a group of individuals referred for evaluation because of difficulties. Included 11 bishops and 59 priests. Published in 2011 Journal of Pastoral Care and Counseling.

A. 17% had alcohol or substance abuse
B. 56% had depression or mood disorder/bipolar
C. 11 % cognitive disorder
D. 11% anxiety disorder
E. Other diagnoses included problematic personality traits and true personality disorders
F. Priests with the above diagnoses were not necessarily impaired.
    a. Some clergy with depression or substance use disorders are impaired and unable to function, while others are able to function well with treatment
    b. Goal is to catch the problem early and treat before the disorder rises to the level of impairment

G. An important finding from our study was the high prevalence of mentalizing problems. Mentalizing is usually defined as the capacity to put one's mind in another's mind and discern how that person may feel differently than oneself. In other words, many clergy had difficulty in understanding how they came across to others and why others were reacting to them the way they were. In simple terms, they were oblivious to the impact they had on others.

V. Recognizing early signs-most psychiatric conditions are treatable so early detection is key

A. Burnout

- "State of fatigue or emotional depletion brought about by adherence to a professional role that has failed to produce expected rewards"
- "An erosion of the soul" --Maslach & Leither, 1997
- Similar to other helping professions: physicians, therapists
- Automatic pilot, despair
- Decreased sense of calling
- Exhaustion

B. Substance abuse /chemical dependency—DSM 5 diagnositic manual collapses abuse and dependency into one category—substance use disorder

- 8-10% of population manifests some form of alcohol abuse;

-18% of Americans will have a substance use disorder at some point in their lifetime

-Excessive use on occasion is not alcoholism

-Denial is pervasive—virtually no one thinks they have a problem with alcohol or drugs

Warning signs: erratic behavior, irregular hours, calling in sick, sleepiness, doesn't remember conversations, repeated falls or injuries, unusual irritability, drinking at lunch, drinks more than others at social functions, denial in spouse or in co-workers who "see but don't see". The British psychoanalyst Wilfred Bion noted that all groups fall into various basic assumptions. One of those is dependency on the leader. Yet while they are dependent, they also resent the leader and may unconsciously wish for his/her downfall. Hence sometimes the "seeing but not seeing" is because of an idealized transference to the leader, but sometimes it is also an unconscious destructive wish to see the leader, whether bishop in a diocese or priest in a parish, self-destruct.

C. Depression

-Stigma prevents some from seeking help

-Some see it as a character flaw rather than an illness

-Sadness may or may not be present in depression

-Signs: social withdrawal, insomnia, decreased appetite, decreased energy, decreased pleasure, pessimism, hopelessness, suicidal thoughts, difficulty concentrating, anger and irritability.

-While most are afraid to ask about suicidal thoughts, doing so may save a life

-Depression may result from a "perfect storm" of genetic tendency, overwhelming stress, life phase, and lack of coping strategies.

-80% of depression can be successfully treated with medication and/or psychotherapy

D. Cognitive disorder, including Alzheimer's and other dementias

-Problems in memory, thinking and behavior

- Must be severe enough to disrupt daily life

-Forgetting names and words periodically is normal aging

- Not knowing where one is or why one is there is more typical of dementia

-Problems in planning and completing tasks: can one still balance the checkbook?

-Withdrawal from work or social life

-Poor judgment

VI. Treatment—when planning treatment, one must assess who is impaired and who is able to function at work with a treatment plan, and realize there is a continuum in terms from individuals who can work effectively while being in treatment to those who cannot work in any capacity even with treatment.

VI. Treatment (G)

A. Medication—antidepressants may take 3 or 4 weeks to work so that one cannot immediately return to work if severely depressed. It may be necessary to wait until the medication "kicks in".

B. Psychotherapy
We recommend treatment tailored to the individual. Outpatient, inpatient, individual and family depending on the condition and seriousness.

C. Different approaches to chemical dependency—The most recent edition of Gabbard's Treatments of Psychiatric Disorders reflects the diversity of treatments available.
A trend in alcoholism and substance abuse treatment is to use a variety of treatments depending on what's best for the particular patient. AA works for some but not for others. One size does not fit all. New research has developed medications that are helpful as adjuncts, individual therapies specifically tailored to substance use disorders, such as motivational therapies, cognitive therapies focused on relapse prevention, dynamic therapies, group therapies, family therapies, and network therapies. Combining treatments may be the most common strategy today.

D. Another recommendation we often make is oversight or supervision in the work setting. It's increasingly hard to put this in place because many churches don't have something equivalent to an associate rector position where supervision is built in.

VII. Monitoring and Follow-up: with alcoholism and drug abuse, no one is "cured". An alcoholic or drug abuser is recovering rather than recovered. The pervasiveness of self-deception and deception of others in substance abuse is striking—it is a disorder of hidden-ness.

Inherent in substance use disorders is a component of shame. Both individual and systemic. Particularly in a church context, living life in a way that is closely observed, shame about what others will think of the priest can contribute to the secrecy and hidden-ness. Inherent in shame is an acute sense of humiliating exposure to others who are judging you. This feature can be highly prevalent in a diocese or parish.

VIII. Take home points

If you suspect a colleague has a problem:

A. Don't do nothing
B. Don't keep concerns to yourself
C. Consult with colleagues
D. Seek help from mental health professionals

It is a Sisyphean task that all of us face in identifying and helping clergy with emotional problems and substance abuse. No one can do it perfectly. We need to avoid harsh judgment of ourselves and colleagues who are struggling. As one priest once said, "We clergy are like candles—we give light to others but we burn out."

If you have questions or need further information, contact us by email:

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