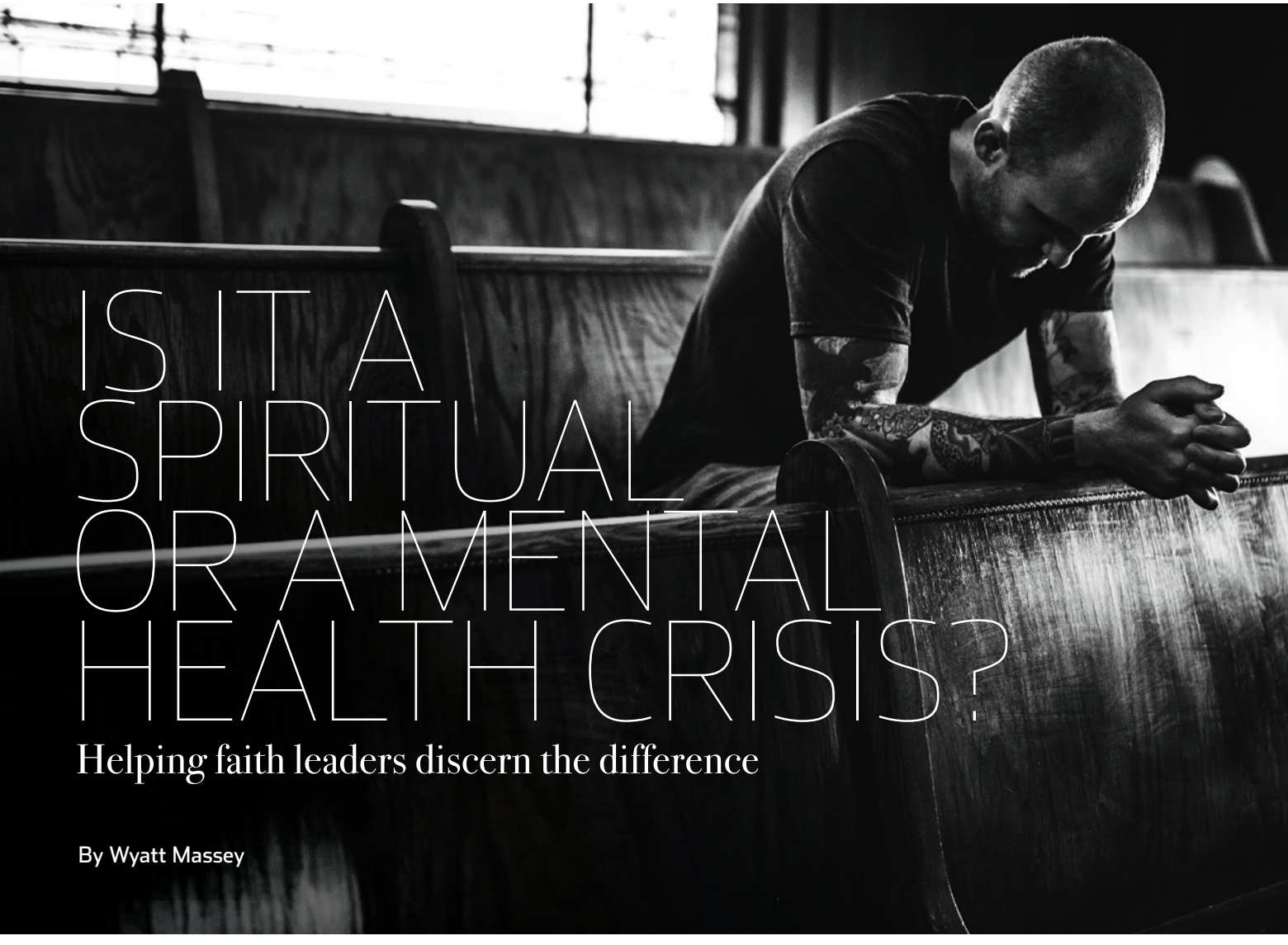

IS IT A SPIRITUAL OR A MENTAL HEALTH CRISIS?

Helping faith leaders discern the difference

By Wyatt Massey

People who are more religious report better mental health and a higher quality of life. They also experience lower rates of suicide—perhaps because of the sense of wellness and community religion provides. Sometimes, though, prayer is not the only answer to personal psychological struggles, and religious leaders must be able to identify when someone needs professional help.

It is crucial that they do so. About 8 percent of Americans report symptoms of depression, but less than a third receive treatment for it, according to a study reported last year by JAMA Internal Medicine.

In a mental health survey in 2015, "severe psychological distress" over the previous 30 days was reported by 3.6 percent of U.S. adults, up from 2.4 percent in 1999. And between 1999 and 2014 the U.S. suicide rate steadily increased, from 10.5 per 100,000 people to 13.0—20.7 among men and 5.8 among women. During that timeframe, the suicide rate for women rose by 45 percent, compared with 16 percent for men.

Faith leaders received training in spotting mental health problems at a recent summit organized by the New York Commission of Religious Leaders. Around 200 faith leaders and laypeople gathered at the Sheen Center for Thought & Culture in New York City on Feb. 13 to learn

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about mental health awareness, suicide prevention and pastoral wellness from mental health researchers and advocates.

In confronting this vast national challenge—more than 42 million Americans suffer from some form of mental illness each year—pastors are on the front lines of both spiritual and physical care, Cardinal Timothy Dolan said during a press conference at the summit. "One of the things churches can do, one of the things communities of faith can do, is create a climate of trust, security, safety, where people really feel they're at ease to speak from the heart, from the soul," he said.

Rabbi Joseph Potasnik underlined the need for mental health training for clergy, saying the faith community has been silent for too long on the subject. "We would talk openly about different ailments," he told summit participants. "But when it came to mental health, we were somewhat on the silent side."

Locating the source of the strain between religious leaders and mental health care providers means going as far back as the Enlightenment. In the 18th century, science redefined mental illness as an issue to be addressed medically rather than spiritually. But religious individuals can still feel stuck when a doctor's advice contradicts that of a religious leader, and clergy felt their role in treatment was sometimes undermined by the mental health professionals, according to a study of relationships between the church and the mental health community.

That antagonistic relationship started to thaw in the 1980s as both groups recognized how a coupling of spiritual and medical support provided more holistic treatment to individuals. Groups like the Archdiocese of Chicago's Commission on Mental Illness emerged in the mid-1990s to provide educational resources about mental illness. Deacon Tom Lambert of Chicago founded the group and later the National Catholic Network on Mental Illness, which assists church leaders about how to support people facing mental health challenges in their congregations.

Chirlane McCray, first lady of the City of New York, told the summit participants that faith leaders play an important role in connecting people to mental health services, since some people may be more willing to talk to a priest than see a psychiatrist. In 2015 Ms. McCray helped launch a comprehensive mental health plan for the city, ThriveNYC. The plan aims to encourage discussion about mental illness and to close treatment gaps. More than 500 New Yorkers from 160 faith-based organizations have been trained in "first aid" for mental health through the program, she said.

"A faith leader can do so much in helping a person feel comfortable in talking about what's plaguing them, what's making them feel uncomfortable, and help them get to the right type of care," Ms. McCray said.

Dr. David Ginsberg, a clinical professor and vice-chair of the New York University Department of Psychiatry, taught the audience of faith leaders how to administer the Columbia Suicide Severity Rating Scale, which identifies the likelihood of self-harm and the level of intervention urgency. Removing means of self-harm and directly asking individuals about suicidal thoughts are important intervention tactics, he said.

Dr. Jamila Codrington, a clinical supervisor at Astor Services for Children and Families in Rhinebeck, N.Y., described in detail the warning signs of mental illness in children and adolescents, among them declining performance in school, avoiding friends and feelings of hopelessness. Poverty, abuse, the death of a loved one and stress over immigration status are all risk factors for adolescent mental health problems, Ms. Codrington said, and children must be cared for differently than adults.

Many young people "express their reality, perceptions and experiences through play," she said. "Compassion and active listening—those two things can be done by anyone."

Yet the good work of clergy should not come at the cost of personal health, said Dr. Derek Suite, sports psychiatrist and founder of Full Circle Health. The overwhelming nature of caregiving can lead to decreased compassion and burnout, he said, which is why leaders should make sure they have a community of counsel for times of need.

"We can have life and death before us," Mr. Suite said. "The risk that you all face, and we all face, as caretakers is that our senses get overloaded."

Clergy should also make sure they are sleeping enough and eating healthily, too. Observing the sabbath can be one of the most difficult things for clergy to do because of the workload demands of religious life, he added.

Greater challenges await ahead. Even though the incidence of depression and psychological distress is about the same for all racial groups, white Americans were more than twice as likely as African-Americans and Hispanics to receive treatment. Low-income and minority communities are at an increased risk from untreated mental health problems because the psychological effects of long-term stress from financial problems or discrimination can be passed from one generation to another.

A greater worry looms as talk of the repeal of the Affordable Care Act continues in Washington. That could mean that 1.3 million people with serious mental illness and 2.8 million people struggling with substance abuse would lose health care coverage, according to the Center on Budget and Policy Priorities.

Wyatt Massey, O'Hare fellow at **America**.
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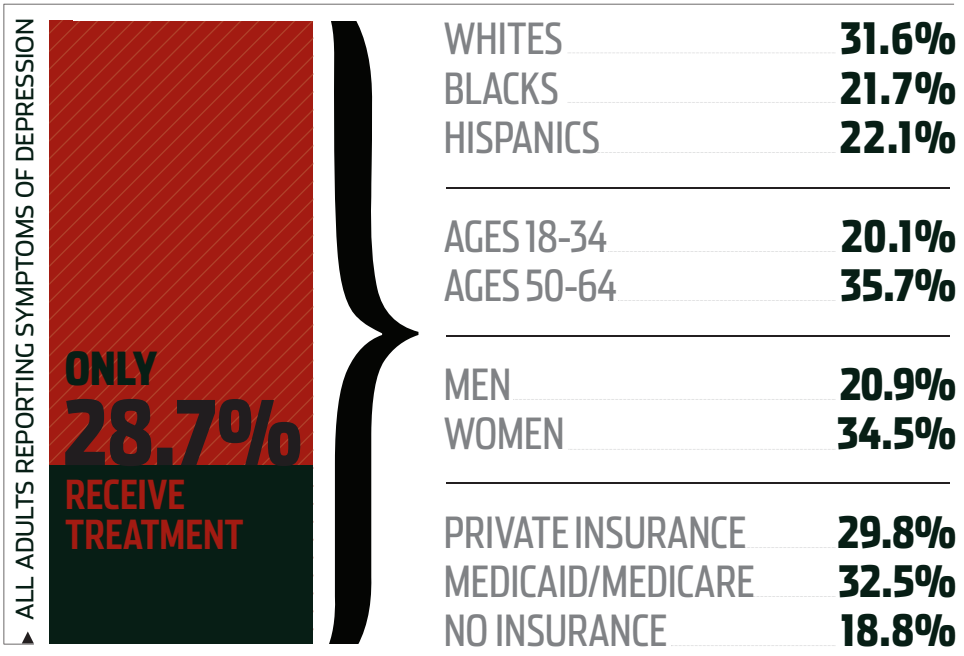
MENTAL HEALTH IN AMERICA

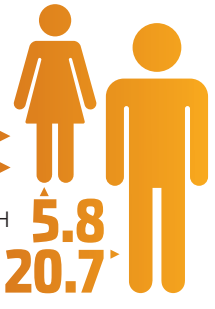
LIKELIHOOD OF SEEKING AND RECEIVING TREATMENT FOR DEPRESSION



25.7% OF ALL ADULTS AGES 18-64 SUFFER FROM MENTAL ILLNESS OR DRUG ABUSE

SUICIDE RATE (PER 100,000 AMERICANS)

1999:10.5
2014:13.0



SUICIDE IS THE 10TH LEADING CAUSE OF DEATH IN THE U.S.; **SECOND-LEADING CAUSE OF DEATH AMONG THOSE AGE 10-35**

SPENDING

IN 2013 THE UNITED STATES SPENT

$69.7B TREATING MENTAL HEALTH

45% WAS SPENT ON PRESCRIPTION MEDICATION

Sources: "Treatment of Adult Depression in the United States," by Mark Olfson, Carlos Blanco and Steven C. Marcus, JAMA Internal Medicine, August 2016, based on responses to Medical Expenditure Panel Survey, 2012-13 (8.4 percent of adults screened positive for depression based on self-reported symptoms); reported incidence of mental illness or drug abuse from MACPAC analysis of National Survey on Drug Use and Health, 2010-12; suicide rates from the Centers for Disease Control; cost data from Medical Expenditure Panel Survey, Agency for Health Care Research and Quality.