

Pastoral Care of the Mentally III

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A. Why study this topic?

In pastoral ministry, we will meet parishioners with mental disorders. In some cases, the normal techniques we use, based on the Gospel (e.g. willingness to help) and human development (e.g. unconditional positive regard), will not be beneficial to the client but could reinforce the difficulties caused by her condition. We need to learn how to recognise such conditions and offer appropriate pastoral care.

This paper is based on one book, *A Minister's Handbook of Mental Disorders* by Joseph W. Ciarrocchi, which is written for ministers of pastoral care in the Judeo-Christian traditions. Its first three chapters make general points: the importance of knowledge of this subject area by pastors; different schools of thought on what causes abnormal behaviour; and how to take a clinical profile of a patient in a standard form which could be referred on to mental health professionals. The remainder of the book consists of six chapters, each of which deals with a particular group of mental illnesses.

Each of the behavioural schools of thought is associated with, and gives the methodology for, a different type of counselling. For more information on these areas, I recommend *A Practical Approach to Counselling* by Margaret Hough, which gives a concise and user-friendly introduction to seven main varieties of therapy; or for more detail, Windy Dryden's *Handbook of Individual Therapy*. If you need to refer a patient on to psychiatric care, Sarah Cheston's *Making Effective Referrals* suggests how this can be made a positive part of the healing process.

In this paper, I will focus on the six areas of mental conditions listed, and my concern will be to summarise *symptoms* and *pastoral care*. The book also lists pharmaceutical treatments which can be offered in each case, and a range of counselling responses based on the different schools of counselling. Be warned that in the context of the book and this paper, many terms in mental illness (e.g. schizophrenia) are umbrella terms which cover a lot of underlying conditions rather than well-defined syndromes.

For linguistic simplicity, I will refer throughout to the pastor as *he*, and the parishioner receiving pastoral care as "the client", and as *she*.

B. General Points and Terminology

It is important to make a distinction between guilt and shame, according to Ernest Kurtz, author of *Shame and Guilt*:

Guilt results from a failure of *doing*, and the Christian tradition offers means of forgiveness and repentance to work through guilt.

Shame results from a failure of *being*. Self-acceptance and recommitment can overcome shame.

In several classes of mental illness, Ciarrocchi refers to **psychotic symptoms**: this term refers to hallucinations (false perceptions) and delusions (false beliefs).

C. A Concise Guide to Mental Illnesses and their Pastoral Implications

(i) Depression

Most life trials result in a mild depression which falls short of **clinical** depression: essentially depression is just "feeling down". But sometimes trials can push someone into clinical depression - "the common cold of mental illness" - which we need to recognise, as well as identifying those parishioners who suffer with a regular cycle of depression. The intensity, duration and consequences of a "down" period distinguish mild from clinical depression. There are two classes of symptoms, so-called "vegetative" symptoms which are physical, and "cognitive" symptoms of thought and behaviour.

Symptoms

"Vegetative Symptoms"

insomnia (at start, middle or end of sleep cycle)

- or tiredness despite sleeping 10-14 hours per day

loss or increase of appetite

low sex drive

aches and pains

constant fatigue

slow-motion

"Cognitive Symptoms"

inability to concentrate

thoughts of death (self-inflicted or imagined accidents)

choosing isolation

not enjoying normally pleasurable activities

psychotic symptoms (hallucinations and delusions)

Depression may present itself in a pastoral context as guilt, or perhaps as a sense of injustice through perceiving oneself to have been "wronged".

Pastoral Strategies:

1. **Refer the *severely* depressed.** - i.e. in cases of suicidal thoughts, psychotic symptoms or persistent vegetative symptoms. When you do so, stay in touch with the client and the health care provider
2. You may need to help the client adjust to a hostile world and/or help explain the condition to family/friends/workplace, especially in the case of referral.
3. Help the client resolve interpersonal disputes (marriage counselling, workplace issues, teaching problem-solving skills).
4. Be supportive while the client is undergoing a role-transition - reduce stressful triggers (especially be aware when you have control over their parish activities).
5. Supply positive religious beliefs and spiritual images to supplant false ones, e.g. overcome zealous perfectionism with the image of Jesus taking a rest. See Rebecca Propst's *Psychotherapy in a Religious Framework*.
6. 15% of ***seriously*** depressed people commit suicide. Pastors should not be afraid to ask whether clients have thought about suicide - exploring the subject will not implant the idea in the minds of those not contemplating it.

(ii) Manic-Depression

"Manic-depression" is a condition where a client experiences both depression, as described above, and periods of "mania". The condition is also known as "bipolar disorder", as distinct from depression alone, sometimes called "unipolar disorder". The two conditions are collectively known as *mood disorders*.

Manic-depression can follow a cyclic pattern, e.g. a repeated pattern of mania-normal-depressed-normal; but all conceivable combinations of manic, normal and depressed phases are possible. The manic experience of euphoria makes the client unlikely to seek help during this phase.

Symptoms

Depression as above; mania as follows:

euphoria (initially appearing as just infectious good nature)

expansive tendencies: believing you have extreme mental/physical powers, or taking on the identity of a powerful personage

high energy levels: extreme work; fidgeting; sleeplessness; impulsive behaviour; intense telephone calls for no good reason or at unsociable hours

irritability, especially in the face of obstacles

poor judgement,

decreased appetite,

neglect of personal hygiene/grooming,

high sex drive.

Pastoral Strategies:

As for depression, particularly noting the need to support families, whether compulsory or voluntary treatment has been sought by the client.

(iii) Anxiety

Symptoms

Anxiety is manifested in any or all of three areas:

behavioural: trembling, shaking, pacing, twitching eyelids, avoidance, difficulty sleeping, stuttering, hand-wringing....

subjective: dread, feeling tense, feeling things are unreal, fear of death/seizure/madness, dizziness, tight chest, irritability, constant worry. (*We rely on the client's self-reporting for knowledge of these.*)

physiological: rapid heartbeat, sweating, nausea, butterflies in the stomach, shortness of breath, clammy hands, dry mouth, lump in throat, difficulty swallowing, hot or cold flushes, tingly hands or feet, seeming numbness.

Certain forms of anxiety are associated with fear of being in public spaces from which it is hard to escape (*agoraphobia* is not only fear of BIG spaces, but narrow public ones too). Some people organise their lifestyle so as to stay in familiar surroundings. Church can be such a setting.

Phobias (intense fears) may manifest in the form of "shy young people" who can't enter the social scene easily.

Pastoral Strategies:

Chronic (constant) anxiety can be countered by encouraging faith and trust in God. Lifestyle changes (more leisure and down time) may help. If the anxiety is rooted in some past trauma, let the client speak at her own pace, never try to coax out more details.

For agoraphobics and shy young people, church social events can be a safe environment to try new social behaviours and overcome fears - the pastor may need to challenge the client's perfectionism or fear of "what others think". Notions of trusting on God, of being loved by God despite our sinfulness, may help.

Prayer/meditation can help reduce anxiety.

Achieving "integration" is of therapeutic benefit. In practice, according to Rebecca Propst, this means:

- i) becoming aware of the client's spiritual beliefs which increase or decrease her anxiety - false gods, lesser needs, low priorities, despair;
- ii) the pastor must challenge some of these automatic beliefs, and replace them with more nourishing beliefs foundational to Christianity;
- iii) the client must monitor daily anxiety and employ these revised beliefs to reduce stress.

(iv) Schizophrenia

Schizophrenia is a broad term covering a number of psychotic conditions, i.e. major delusions, hallucinations and disorganised behaviour; it is not always, or even often, experienced as a consciously "split personality". It tends to strike young people from late adolescence to their early twenties, and prevents them from achieving social or occupational orientation. Two thirds of schizophrenics are unable to sustain regular employment and normal relationships.

Symptoms

delusions over one's ability to influence the thoughts of others, or giving particular persons or events a particular significance (e.g. a TV report is about the client herself);

incoherent conversations - loose associations of sentences, coining new words, losing train of thought, returning to a single idea, persistent rhyming;

hallucinations, usually auditory - voices may be disparaging or obscene (making client reluctant to admit them to pastor), and may command immoral actions including killing of self or others;

affective responses which are blunted, absent or inappropriate (e.g. amusement at past tragedy);

loss of sense of self: feeling of experiencing one's body from an outside perspective, or union with other people or objects;

inability to carry out willed desires;

autism: lack of sensitivity to social cues and others' personal space;

behaviour problems: lack of table manners or personal hygiene;

motion problems: immobility with or without awareness of one's surroundings; odd mannerisms and facial expressions, shuffling and repeated hand movements.

Pastoral Strategies:

Unlike most other forms of mental illness, schizophrenia does not respond well when treated by verbal means (counselling) alone. Indeed, intensive psychotherapy can make a schizophrenic more prone to relapse. The only effective verbal intervention is education in interpersonal skills (conversation, polite conventions, job interviews, assertiveness). Role play exercises can assist here, and it may be beneficial for a pastor to give feedback privately about inappropriate behaviour; a modicum of praise for positive interaction may be in order too.

Pastoral care must walk a tightrope between overengagement provoking such a relapse, and underinvolvement, which can collude with the client's demise into total social withdrawal. ***Do not challenge their heterodox religious positions, nor engage in heated discussion of theology or politics.*** Religious symbols and rituals will speak to them more effectively than rational debate, and can help communicate the message that God loves and accepts them in their pain and confusion. The Church may be able to provide a quiet place for prayer and reflection, and perhaps even some non-stressful voluntary work.

Criticism and over-involvement by family members can also encourage relapse; pastoral care of the family of a schizophrenic should encourage tolerance with a degree of disengagement. Family members may need to be reminded to continue to have their own social lives, and to give private space to the schizophrenic member. Families may need encouragement when the care they must provide is taxing, but also reassurance against any guilt that they may have "caused" their relative's schizophrenia.

Schizophrenia by its very nature prevents its sufferers speaking in the political arena. The Church's concern for social justice gives it a role in advocacy.

(v) Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) may be a minor factor in one's psyche and merely a cause of anxiety; or it may be a *Personality Disorder* in which case it has a major impact on lifestyle.

Symptoms

perfectionism (workers who reject forms not filled in correctly);
inability to see the big picture / preoccupation with trivia;
religious extremism - everything must be done by the book;
lack of sense of humour (except sarcasm);
work gives their only satisfaction - they are lost without it.

OCD may manifest in religious acts, perhaps with "magical" thinking e.g. "the plane didn't crash because I prayed every 5 minutes". It may also appear in the form of scrupulosity. In the parish, OCD sufferers may volunteer for the difficult jobs, work diligently - but be hard to get on with because of rigidity; they espouse moralism rather than morality, and may fear adapting faith to the times for fear of compromising the truth.

Pastoral Strategies

OCD sufferers are unlikely to seek help themselves, but an authority figure (e.g. their parish priest) presiding over a conflict situation may steer them thus - the conflict may be interpersonal, or arise from having to adapt to new systems of working, or from a changing theological culture. The gifts of OCD sufferers can be used to give detailed attention to a project - but pastors must beware of betraying boredom or getting drawn into intellectual arguments.

Good counsel for overcoming OCD is to suggest changing rigid patterns e.g. new driving routes, or setting goals of mediocrity for certain task - the pastor or counsellor should then help the client to work through the anxiety arising. For confessional scrupulosity, an appropriate and traditional penance is to direct the penitent not to confess too often, nor to go to other priests.

(vi) Other Personality Disorders

Personality is a catch-all term for one's regular patterns of behaviour. A **personality disorder** exists where these patterns result in distress to the subject and/or dysfunctional behaviour.

"Random selection suggests that personality disorders will exist in typical synagogues and congregations. The role they play in clergy burnout needs investigation ... I refer to this group of disorders as saboteurs of community ... the basic stance of empathy, charity and unrequited giving common to most religious professionals actually creates a barrier for effective management of [such] individuals."

Passive-Aggressive Personality Disorder - a consistent response of seeming to welcome proposals for action but choosing to go slow, complain or otherwise hinder the project (committee work, liturgical change, etc.) they have apparently accepted. Sufferers may temporarily conform to earn good will, but very soon try to re-assert their autonomy: they vacillate between finding affirmation through others and through asserting their own autonomy. Invitations to speak their mind will result in little response until the questioner is out of earshot, when they feel free to complain. They prefer to communicate by written and electronic means rather than face-to-face.

Pastors and counsellors may try to act directly to insist the client overcome their passive resistance. Alternatively, the client may be met with equal passivity and be confronted with a lack of authority to resist. Care must steer between a running battle and leaving the client unguided. Training in assertiveness and communication skills may help the client to express disagreements more constructively. When a passive-aggressive parishioner is hampering a particular situation (e.g. by tardiness or whinging), the best form of confrontation is to describe their obstructive behaviour objectively, followed by a general question asking whether they have some hidden problem which is responsible for this behaviour. **Do not** confront the client with motives of hurting the team - even if this is the case, it will provide feedback that their strategy is working.

Paranoid Personality Disorder - in which the client is paranoid, with a general expectancy that others intend to threaten or demean them, but without the additional symptoms of other disorders. Paranoid personalities may seek refuge in churches or other religious groups, which they regard as "safe havens", but can be disruptive because of their extreme concern and vigilance for religious orthodoxy.

If people with paranoia become pastoral clients, they do so because of what they judge to be external problems (with their spouse, children, etc.). The pastor must proceed slowly, win the trust of the client, and find a balance between not justifying the paranoia by offering frequent challenges, yet offering appropriate criticism. Such negative feedback must be offered calmly and directly, so the client knows exactly what the pastor thinks; and it may help if the pastor vocalises his willingness to spend time building up trust. A useful article on the subject has been written by Jesuit psychiatrist William Meissner.

Avoidant Personality Disorder - when fear of judgement or rejection severely limits the client's social participation, even though she desires social interaction. Sufferers may be good team players yet refuse leadership or limelight roles. They may become dependent on their counsellor or pastor.

Such dependency may be utilised to encourage the client to take more risks in safe social settings (e.g. church functions, as we saw in the case of shy anxiety). Pastoral care must balance between pushing too quickly and overprotective paralysis. Clear boundaries must be set so that the client's dependence does not become unhealthy attachment; and thought must be given to terminating the working relationship, best by progressively increasing intervals and so "weaning" the client.

Dependent Personality Disorder - when a person feels lost if not cared for by others, or needs a decision maker to submit to. Classic cases are the widower lost without a wife, or the submissive wife who defers all major decision to the husband, even to the extent of staying in abusive partnerships. Sufferers are prone to depression following loss and grief, as they lack the robustness to "bounce back" in due course.

Clients may become highly dependent on their pastor, who is torn between satisfaction that the client seeks help and anguish that this help is never sufficient. Intimating one's own limitations increases the client's sense of "being a burden to everyone". Similar techniques help here as help in the *Avoidant* case; challenging the sense of helplessness, or assertiveness training, may be effective; marriage counselling for the couple may help the dominant partner to see the inadvisability of accepting too much responsibility.

Other Personality Disorders - Chapter 9 of Ciarrocchi gives quite concise descriptions of a number of other personality disorders in addition to those listed above. A photocopy of the whole chapter is appended, giving brief treatments of schizoid, schizotypal, histrionic, narcissistic, borderline and antisocial (or psychopathic) disorders.

D. Addiction and Sexual Dysfunction

Two chapters in Ciarrocchi consider addiction and sexual difficulties. It is perhaps not obvious that they are categories of mental illness, but they are treated as such here.

(i) Addiction

The spiritual approach to all forms of addiction is exemplified by the 12-step process associated with Alcoholics Anonymous and related groups (see books by Ernest Kurtz). The process asks participants to identify a "higher power" whose nature is not specified but which Christians can associate with God.

Most addictions have serious impact on the families and family support groups (AlAnon, GamAnon etc.) are also important.

Pastoral carers are at risk of *countertransference*, i.e. losing their objectivity over clients with addiction problems. If the pastor has experienced addiction in his own family, he is likely to judge the client harshly; if he himself is a recovering addict, he may well be too tolerant of the client's failings. Many cultures have a certain level of prejudice against addicts which can also prevent the pastor from displaying a non-judgmental, accepting attitude of unconditional positive regard.

(ii) Sexual Disorders

While Ciarrocchi's book covers the *philiias* concisely, I won't treat those here because they were covered thoroughly by Fr Pat McHugh's Sexuality course. It does claim that a highly prohibitive religious attitude to sex is correlated with paraphilia in general, which ought to sound a cautionary note even while we take refuge in the data that celibacy is, if anything, correlated with a *reduced* tendency to paedophilia.

The book also treats of problems of sexual function within marriage. Religious taboos on sex can contribute to sexual dysfunction - and specifically, in women, may be a contributory factor to a *vaginismus*, a vaginal muscle spasm which can prevent intercourse altogether. On the other hand, good spirituality helps marriage: studies have shown that sexual satisfaction is increased when the couple pray together.

Good sexual intercourse also depends on each partner learning what their spouse enjoys and finds comfortable; again, religious taboos might disincline partners from speaking of such things. It is important for men to appreciate that women often need to be "warmed up" with love-talk before they are quite comfortable with physical contact; and for women to overcome cultural shame at enjoying sex but to speak to their husbands of what they find works for them.

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