The clergy's role in reducing stigma: a bi-lingual study of elder patients' views

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Social stigma associated with mental illness is a societal process whereby public attitudes toward persons with mental disorders range from stereotyping to discriminatory behaviors. As a consequence, individuals who receive care for emotional problems may not seek social support from their community out of a fear of rejection. The aims of the present study were to examine whether elderly psychiatric outpatients experience stigma in the context of interacting with their clergy and religious communities, and to identify possible interventions both to reduce such stigma and increase social support. Patients' charts in an economically, ethnically, and linguistically diverse geriatric psychiatry clinic were reviewed (n=113), and a subset of these consumers were interviewed (n=67). The data were collected using forms in English and Spanish. Patients were surveyed about the frequency of their religious participation, examples of contacting clergy for emotional help, and preferred roles they thought clergy could play in response to their emotional needs. The consumers reported an aggregate frequency of religious participation comparable to national polls of elderly in the United States. Patients reported that they infrequently discussed emotional problems with their clergy; in some cases, specifically because of stigma. When asked to rate the helpfulness of different clergy roles, the elderly consumers reported that the most helpful role for clergy would be to educate their religious congregation to reduce stigma. These data support the possibility that religious congregations could be beneficial sites for future stigma-reduction interventions.

Key words: Stigma, clergy, African-American, Latino, religion, elderly, services, mental health care

The World Health Organization has identified stigma as a primary barrier to mental health care internationally (1). The Surgeon General of the United States has made it known that this is particularly true within the country's underserved minority populations (2). Social stigma associated with mental illness is a societal process whereby public attitudes toward persons with mental disorders range from negative stereotyping to discriminatory behaviors (3), resulting in people avoiding seeking needed social support from their community for fear of rejection (4-7).

Clergy are widespread *de facto* providers of mental health services (8). They lead over 250,000 congregations across the U.S. (9), and report spending 15% of their work time counseling (10). This amounts to over 140 million counseling hours per year. The clergy's role is especially crucial in minority communities, where clergy serve both as a bridge to mental health professionals as well as a community-based reinforcement for adherence to prescribed care (11-13). The clergy's role is particularly significant among the elderly, 80% of whom are members of churches or synagogues, and 52% of whom attend services weekly (14). Studies have found a higher prevalence of depression among elderly persons who do not attend religious services (15,16), and that religious belief in the elderly is correlated with a lower prevalence and reduced persistence of depression (17,18).

Reviews of the mental health literature have called for professional collaboration between clergy and clinicians to improve the continuity and accessibility of mental health care (19-23). National mental health organizations and religious denominations have directed substantial resources to foster dialogue between the two professions (24,25). These efforts recognize that clergy represent a community-based resource that is potentially capable of improving access to, and acceptance of mental health care (26-28).

Although several surveys have investigated the views of clergy and mental health professionals regarding consultation (29-33), it is striking that no research has yet investigated the views of psychiatric patients about how to best conduct such collaboration. Such input is necessary for several reasons. The proportion of elderly consumers of psychiatric services who are affiliated with religious congregations is unknown. Neither is it known whether they seek emotional support from their clergy and religious congregations. If they do seek emotional support from their clergy, it could be provided in a variety of ways as clergy function simultaneously in many different capacities (34-36).

Six professional clergy roles, which were first delineated by Blizzard (35), continue to be used to evaluate the professional tasks of clergy (37,38). Table 1 summarizes the function of each role as described by the Joint Commission on Mental Illness and Health (28).

In order to judge the feasibility of developing a stigma-reduction intervention for religious communities, we evaluated four research questions: 1) How frequently do elderly psychiatric patients attend religious services? 2) What types of counseling are sought from clergy by geriatric patients? 3) How important is stigma reduction compared to the other possible ways clergy could respond to their emotional needs? 4) Are there group differences associated with diagnosis, ethnicity, religion, and religious participation?

Table 1 Six central roles of clergy as described in the Joint Commission Report, and how they were operationalized for the interview

Role name	Joint Commission descriptions of clergy roles (28)	Operationalization
Ritualist	Administer sacraments, conduct rites of passage (marriages, funerals...), lead worship services	Provide you sacramental, ritual, or spiritual guidance
Pastor	Serve congregants in a person-to-person relationship	Provide you individual counsel to supplement your mental health care
Preacher	Provide guidance and inspiration in a one-to-many relationship with the congregation	Engage congregation members to provide you with social support
Teacher	Direct the church's religious education program; "teach" in many less defined ways	Educate the congregation about mental illness in an effort to reduce stigma
Organizer	Participate in intra- and inter-denominational activities; be active in community affairs	Help you communicate with your clinician concerning your care
Administrator	Supervise the financial program of the church; coordinate the work of its staff	Provide you financial help for your living expenses

METHODS

The study was conducted at the Geriatric Psychiatry Outpatient Clinic of the Montefiore Medical Center of the Albert Einstein College of Medicine in the Bronx, New York. This clinic provides services to economically, ethnically, and linguistically diverse elders. All patients are over 60 years old and 27% are monolingual Spanish speaking. Patients were recruited for the study when they came for their regularly scheduled appointments. Clinicians described the study to each of their patients and sought consent for participation. Both new and returning patients were asked to participate in the study. Patients could consent to a chart review or a chart review and interview. The study was approved by the Institutional Review Boards of the Albert Einstein College of Medicine, and The City College of the City University of New York.

The English and Spanish versions of the consent and interview forms were developed simultaneously, using back-translation and decentering protocols (39,40). They went through four iterations of translation and back-translation using a team of four bi-lingual translators. The decentering process allowed changes in both the English and Spanish versions of the forms to most closely match our intended meanings. Latinos who required Spanish forms and to be interviewed in Spanish represented 22% of the total sample, and 65% of all Latinos surveyed. Results are presented in English. Spanish versions of the survey are available from the author upon request.

A total of 141 patients were asked to participate in the study, 86% consented to both a review of their chart and an interview, and 10% to a chart review alone. Interviews could not be conducted in 42 cases: 8 patients died, 7 were unable to schedule an interview due to poor health, 8 were unreachable, 8 completed treatment before a telephone number could be obtained for an interview, and 11 completed treatment before an interview could occur. All patients who were contacted finished the interview. European-Americans were significantly more likely to consent to a chart review alone, Protestants and persons affiliated with a church or synagogue were significantly more likely to consent to a chart review and an interview.

Data were collected between July 2000 and August 2003. The chart review collected information on each patient's ethnicity, gender, age, and diagnosis. All patients in the Geriatric Clinic had completed a Religious Practice and Clergy Roles in Psychiatric Care form as part of the demographic background information in their medical chart. Patients were asked their religious preference and the frequency of their religious participation. In the interview, patients were asked to tell of an instance that they thought of contacting the clergy for help with an emotional problem, whether they contacted the clergy, and the outcome. They were then asked to describe the helpfulness of the six possible clergy actions in response to their emotional needs (Table 1). All answers were transcribed for qualitative analysis. Strauss and Corbin's grounded theory and conceptual ordering (41) qualitative analysis techniques were employed to cluster and label the patients' transcribed

Table 2 Patient demographics

Independent variables	Total (N=113)	Chart only (N=46)	Chart and interview (N=67)
Age (years)			
Range	61-94	64-93	61-94
Mean (SD)	77 (8.08)	78 (8.13)	76 (7.93)
Gender (%)			
Female	89	90	88
Diagnosis (%)			
Major depression or dysthymia	54	52	57
Anxiety disorders	19	19	19
Psychotic disorders	16	21	13
Due to a general medical condition	5	4	5
Bipolar disorder	2	0	3
Adjustment disorder	3	2	3
Substance use disorder	1	2	0
Ethnicity (%)			
European-American**	49	62	39
Latino	31	24	37
African-American	17	12	21
Southeast Asian	1	2	0
Other	2	0	3
Religion (%)			
Catholic	54	56	52
Protestant*	20	10	27
Jewish	20	27	15
Other	4	2	6
No religion	2	4	0
Church/synagogue attendance			
Affiliated (at least yearly) ***	73	58	84
Weekly or more	41	38	44

Significantly different in persons whose charts were only reviewed vs. those who were also interviewed: *p<0.03; ** p<0.02; *** p<0.01

Table 3 Religious services attendance*

	Categories		
Diagnosis	**Major depression (N=57)**	**Anxiety disorders (N=21)**	**Psychotic disorders (N=18)**
Mean (SD)	2.8 (1.4)	2.9 (1.5)	2.2 (1.1)
Ethnicity ***	**Latino (N=34)**	**African-American (N=18)**	**European-American (N=54)**
Mean (SD)	3.5 (1.3)	3.0 (1.1)	2.2 (1.3)
Religion**	**Catholic (N=59)**	**Protestant (N=22)**	**Jewish (N=22)**
Mean (SD)	2.9 (1.4)	3.1 (1.3)	2.1 (1.2)

*5=More than once a week; 4=Every week or so; 3=Every month or so; 2=Once or twice a year; 1=Never
**p<0.03; ***p<0.001 (ANOVA)

responses according to the meaning and importance of clergy participation in the continuity of their mental health care.

One-way analysis of variance (ANOVA) was used to examine differences in mean frequency of religious attendance on each of three independent variables on which participants were classified: diagnosis, ethnicity, and religious denomination. Participants were grouped into three categories within each independent variable. The least significant difference (LSD) test was used to make post-hoc comparisons between the three categories within each independent variable, if the omnibus *F* was statistically significant.

Multivariate analysis of variance (MANOVA) was used to examine differences in participants' mean ratings of the helpfulness of six clergy roles for potentially responding to the patients' emotional needs. The six roles were arranged in order for the analysis, to form a Helpfulness Hierarchy based on their average ratings. Trend analysis was then conducted to test whether there was a significant linear change in the magnitude of the ratings across the six roles. Paired t-tests were used to compare differences between specific roles.

RESULTS

Characteristics of the study sample are shown in Table 2**.** Seventy-three percent of all the geriatric patients were affiliated with a church or synagogue and 41% attended weekly. Among those we interviewed, 84% were affiliated and 44% attended weekly. These data are comparable to the national statistics, which found that 80% of elderly are affiliated and 52% attended weekly (14).

Table 3 reports the mean frequency of religious attendance. The overall mean of 2.8 represents almost monthly attendance at religious services. Latinos reported the highest average rate of attendance of more than once a month. European-Americans attended religious services significantly less often than either Latinos or African-Americans, and Jews reported the lowest average rate of attendance of about yearly.

Table 4 examines the association between diagnosis, ethnicity and patient's mean ratings of the helpfulness of each of the six clergy roles in responding to their emotional needs. MANOVA revealed significant differences among the six roles regardless of diagnosis or ethnicity. A significant linear trend was also found, with helpfulness ratings decreasing in magnitude from Stigma Reduction (highest) to Financial Help (lowest). Diagnosis and ethnicity categories did not influence helpfulness ratings and no interaction effects were found.

Table 5 shows that significant differences were found among the six roles regardless of religion or frequency of religious attendance. A similar significant linear trend was found in each analysis, in which helpfulness ratings decreased in order from Stigma Reduction (highest) to Financial Help (lowest). No main effects or interactions were found.

Figure 1 shows the Helpfulness Hierarchy reported by 49 persons who were affiliated with a church or synagogue. As noted above, a significant main effect and a significant linear trend were found across roles. No significant differences were found between the helpfulness of stigma reduction and sacramental guidance. There was a significant difference between stigma reduction and social support, the next role in the hierarchy. There was also a significant difference

Table 4 Helpfulness of six clergy actions in response to patients' emotional needs*

Clergy roles	**Diagnosis categories****						**Ethnicity categories****					
	Major depression (N=31)		**Anxiety disorders (N=12)**		**Psychotic disorders (N=8)**		**Latino (N=20)**		**African-American (N=13)**		**European-American (N=23)**	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Stigma reduction	3.2	1.0	2.9	1.2	2.6	1.1	3.4	1.1	3.4	0.9	2.7	1.2
Sacramental guidance	3.0	1.0	2.6	1.3	2.5	1.1	2.9	1.0	3.3	0.6	2.3	1.2
Engender social support	2.5	1.3	2.4	1.4	2.5	1.1	2.8	1.3	2.6	1.1	2.0	1.2
Individual counsel	2.5	1.2	2.3	1.3	1.6	1.1	2.5	1.1	2.6	1.2	2.0	1.3
Collaborate with clinician	2.5	1.1	1.8	1.0	1.8	1.2	2.4	1.3	2.5	1.0	1.8	1.0
Financial help	2.1	1.4	1.9	1.2	1.6	1.2	2.3	1.3	1.6	1.0	2.0	1.4

* 4=Very helpful; 3=Somewhat helpful; 2=Not very helpful; 1=Not at all helpful
** Main within subject effect; within subjects linearity test: p<0.001

Table 5 Helpfulness of six clergy actions in response to patients' emotional needs*

Clergy roles	Religion categories**						Attendance categories**					
	Catholic (N=31)		Protestant (N=14)		Jewish (N=9)		Monthly (N=33)		Yearly (N=15)		Never (N=10)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Stigma reduction	3.2	1.0	3.3	0.91	2.3	1.3	3.3	1.0	2.3	1.12	2.5	1.4
Sacramental guidance	2.7	0.9	3.1	1.14	2.1	1.4	3.1	1.0	2.7	0.88	1.4	0.7
Engender social support	2.6	1.2	2.8	1.37	1.6	1.1	2.6	1.3	2.5	1.12	1.6	1.1
Individual counsel	2.3	1.1	2.6	1.22	1.9	1.4	2.6	1.2	2.2	1.08	1.4	0.8
Collaborate with clinician	2.2	1.1	2.3	1.27	1.8	1.2	2.5	1.1	1.9	1.16	1.3	0.5
Financial help	2.2	1.3	1.8	1.19	1.3	1.0	2.2	1.3	1.5	1.12	1.7	1.1

*4=Very helpful; 3=Somewhat helpful; 2=Not very helpful; 1=Not at all helpful
** Main within subject effect; within subjects linearity test: p<0.001

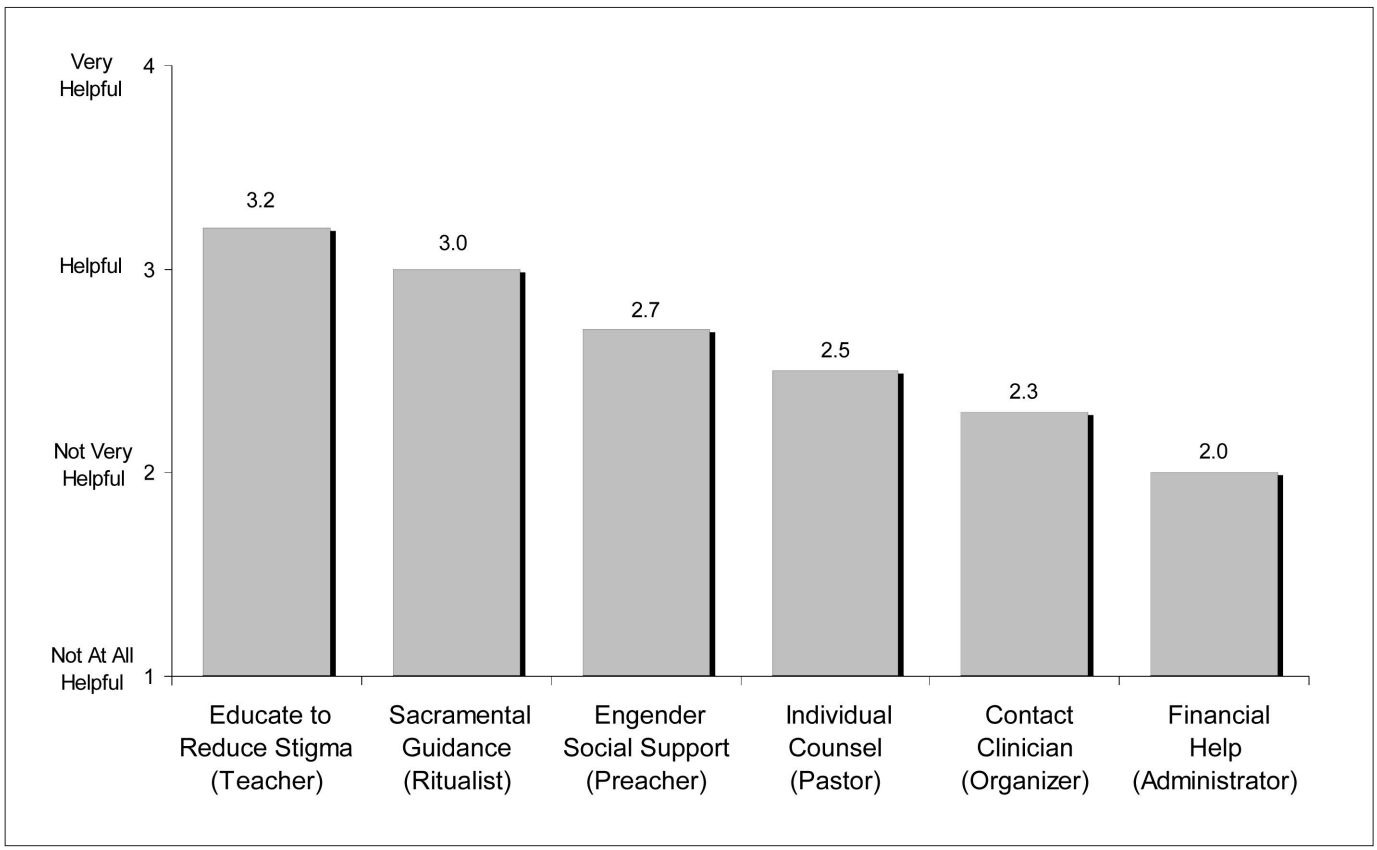

Figure 1 Helpfulness Hierarchy reported by persons affiliated with a church or synagogue (N=49). Reduce stigma > Social support: p<0.01; Sacramental guidance > Social support: p<0.04

between sacramental guidance and social support. Even though most study participants had low economic resources, financial help was viewed as the least helpful role.

Interview data revealed that respondents (n=67) demonstrated a wide range of views both for contacting and not contacting clergy for assistance. The majority (64%) had not contacted their clergy for emotional problems, and 40% attributed this to a professional boundary between clergy and mental health care providers indicating that emotional problems are the concern of clinicians. Sixteen percent attributed their hesitancy to stigma-related discomfort in revealing emotional problems to clergy. Among the 36% who had contacted clergy, 3% speak with their clergy often about a range of emotional problems, and another 10% limited their clergy counseling to their concerns about death and dying.

Qualitative results revealed many concerns with regard to patients discussing their mental health problems with their religious leaders. One person did not want to inform the minister: "I wouldn't want him to know... That's not good... Right away people think you're crazy". Another person described the need for distinct professional boundaries to assuage personal concerns: "I speak to clergy about family problems and problems concerning religion maybe once or twice a month. I won't talk to clergy about hearing things because he will think that I am crazy...". A third person was explicit: "I feel stigma, I don't like to be different to other people".

DISCUSSION

The geriatric psychiatric patients in our sample attended religious services on par with national averages. Yet, they were reluctant to discuss their mental health problems within their religious communities. Many of these concerns reflect attributes of stigma (3,4,6,42). When given a choice, elderly patients chose stigma-reduction and sacramental care as the most important emotional support they could receive from their clergy. This was consistent across diagnostic, ethnic, religion, and religious attendance categories. Rather than an expectation of person-to-person counseling (pastor role), or frequent collaboration with mental health professionals (organizer role), the recommendation to clergy is mainly to provide sacramental guidance (ritualist role). This represents an opportunity of less burden to clergy as patients would prefer to receive their clinical care from clinicians (43).

The results from this study confirm that religious congregations could be productive sites for future community-based mental health and stigma reduction interventions. Facilitation of a stigma-reduction education program developed by clinicians – and combined with culturally appropriate referral resources provided to the clergy – would require little time commitment on the part of clergy compared to collaboration on the care of individual congregants (25,27,43,44). As Latino and African-American patients attend religious services frequently, religious congregations could serve as a good locus for outreach to underserved minorities (13,45).

Mental health professionals who promote stigma-reduction education programs within religious congregations may open a new avenue to improve mental health care. A successful stigma-reduction education program could be helpful in two ways. First, such a program would help promote social support for those congregants who receive mental health care, but avoid discussing their emotional needs out of fear of discrimination (4,7). Second, lower stigma could promote the use of professional mental health care services through self-referral or referral by clergy (1).

Research has compared different types of community-based interventions to reduce stigma, and found that the most effective method of attitude change is through contact with a peer who has mental illness, particularly in a setting encouraged by shared leadership (46). A program located in a church, synagogue or mosque, encouraged by clergy, and led by a member of the congregation who has experienced mental illness would exemplify such a program. Materials to plan this intervention are available (47).

This study has shown that these elderly psychiatric patients preferred that clergy not function as clinicians. However, it is limited in that it asked opinions of geriatric patients in one clinic. Although the patients had diverse backgrounds, all had already found professional care and overcome the stigma of seeking such care. Further research to confirm this study's findings will be necessary among people who may need care, but have not yet sought help.

The necessary purpose of clergy and clinician collaboration is so that each work primarily within their scope of expertise (43). As experts in matters of religion, clergy can educate clinicians about religious resources and values salient to their patients. As experts in mental health care, clinicians could use this education to develop and deliver direct care as well as stigma-reduction education programs appropriate to diverse religious congregations. Through this reciprocal professional relationship, clergy and clinicians could increase both access and adherence to mental health services, improving the continuity of mental health care (48,49).

The data provided by the geriatric consumers surveyed for this study confirm the need to confront the stigma that leads to discrimination (3). This stigma appears to restrict the social interactions of persons who receive mental health care (4,5,7). Stigma may also affect persons' adherence to mental health care (50), or hinder other persons from accessing necessary care (1,2,8). The most effective mode of stigma reduction is accomplished among fellow members of the same communities (4,5,46). A church, a synagogue, or a mosque are each such communities (27,31,51,52). The study's respondents expressed a desire to have interventions that would reduce stigma in their own religious congregations, while maintaining professional distinctions between their clergy and their clinicians (43). Researchers must now foster the community partnerships necessary to develop empirically-validated stigma-reduction and collaborative care programs, which could subsequently be disseminated to the more than 250,000 religious congregations in the United States (9), and beyond.

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