PC(USA) MINISTER SURVEY

Mental Health

Jashalund Royston, MA
Susan Barnett, PhD, MSSW
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RESEARCH SERVICES

Why conduct a survey of all PC(USA)ministers? Why now?

Research Services regularly receives questions from members, congregational staff, mid councils, and PC(USA) leaders about ministers that cannot be answered with the data that available to us. As data was not available, I decided that a survey should be developed to answer many of these questions and asked Perry Chang, PhD to lead this work. This report is one portion of what has been learned, yet many new questions have been formed. New surveys will follow focusing on clergy of color, retirement, bi-vocational ministry, commissioned ruling elders, and "part-time" ministers.

The success of this first ever survey of Presbyterian Church (U.S.A.) minister would have been far less if not for the support our many partners. Here are just a few of them.

- Call to Health, the Board of Pensions' wellness program that offered points toward the minister's wellness goal for participation.
- Presbyterian Publishing Company offered a discount for a future purchase for all who completed the survey.
- Communication's staff from the Office of the General Assembly, Mission Agency, and Presbyterian Foundation who wrote several stories that included the survey link.
- Office of the General Assembly Mid Council relations staff that regularly promoted the survey in its newsletters.
- Several denomination-wide committees that shared the link with their constituencies.
- Members of the all-agency data group who regularly meet to discuss and improve data and data reporting for PC(USA) and open doors for new partnerships.

Throughout this process ministers expressed their gratitude that these questions were being asked and that they are long overdue.

Susan Barnett, PhD, MSSW
Director, Research Services
Administrative Services Group
Presbyterian Church (U.S.A.)

Overview

The PC(USA) Minister Survey was a massive 110-question survey which fielded from September to November of 2019. Invitations were sent by postcard to all ministers for whom we had an address. In addition, an email invitation was sent to all PC(USA) congregations for whom we had an email. The survey was also one of the Board of Pensions' Call to Health challenge.

23% of the denomination's 19,243 ministers (n=4,507) responded to the survey.

On the 10th anniversary of *Comfort My People*, the 223rd General Assembly funded a two-year mental health initiative to be in the Presbyterian Mission Agency (PMA). The mental health questions in the minister survey were designed in collaboration with PMA staff and are part of a larger study of mental health across PC(USA). The questions focus on four areas: awareness, training, ministry, and self-care. After those questions, ministers were given an opportunity to share any additional comments about mental health in their setting. This report provides an overview of minister's responses to the question, "What else would you like to share about mental health in your setting?"

Several ministers contacted Research Services to ask how the data would be reported. All data is reported in aggregate. While quotes are included, they are anonymous.

Table of Contents

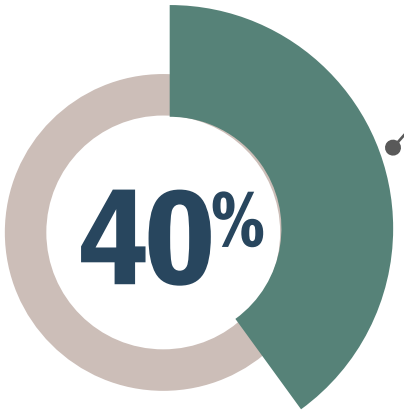
Awareness

Ministers rated their capabilities for responding to different mental health concerns such as a person considering suicide or a community-wide crisis. Overall, 46% said that they are less than capable of responding to these mental health concerns. However, 36% report that they are less than capable of responding effectively to their own mental health issues.

Many (44%) ministers have not been trained to recognize mental health concerns or how to minister to those individuals and families who face them. For several (22%), training has been on the job or learn as you go. Less than half had enrolled in a training course either in seminary/college (18%) or as a part of continuing education (16%).

For those who have sought training, 61% say that the training has improved ability to respond.

When asked to rate their own mental health:



40% of ministers describe their mental health as very good

Another 25% say excellent while 27% report it as good. This leaves 9% reporting as fair (8%) and 1% poor.

This includes the non-working retired ministers.

Ministry capabilities

When considering several mental health ministry scenarios, ministers used a 5-point scale of ***1 not at all capable*** to ***5 very capable***, to describe their ministry capabilities.

Most ministers score themselves as a 4, that is, **capable of providing effective ministry** with a few ministers saying that they are ***very capable.***

However, this is not true for all scenarios.

N=3191

Percentage of ministers who view themselves as ***less than capable*** to respond effectively in the following situations:

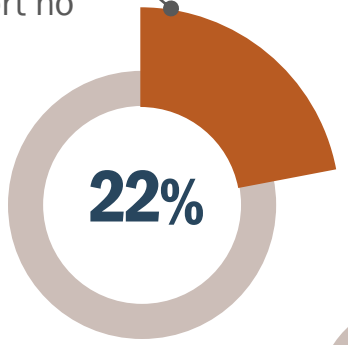
55%	A person with visible signs of mental illness or substance misuse attends an event that is part of my ministry
54%	A colleague shows signs of a mental health problem or substance misuse
46%	Pastoral care in the aftermath of a traumatic event such as the suicide of someone involved in my ministry or a hate crime, mass shooting, or natural disaster in my local community
45%	A leader of a youth ministry in which I am involved comes to me with concerns about the mental health of a young person involved in the ministry
43%	A person confides in me that they feel suicidal
42%	A person asks for help with drug or alcohol addiction
41%	A family member comes to me with concerns about a loved one with signs of mental illness, suicidal feelings, or addiction
32%	A person comes to me asking where to get help with a mental health problem
36%	A mental health challenge that I face

Training & resources

Given their interactions with individuals, families, and colleagues who are facing mental health challenges, ministers report the need for additional preparation, continuing education, and peer support groups. Ministers were given nine items from which to select then rank in the order of most importance from their perspective.

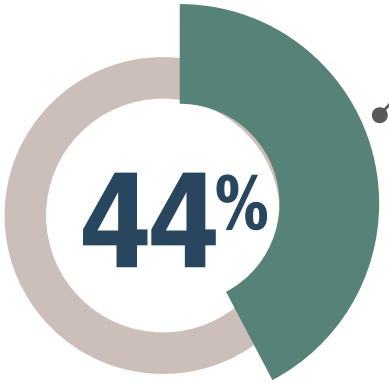
70%	Training in recognizing and responding to mental health issues that arise in a pastoral situations
53%	Mental Health module in seminary as part of preparation for ministry
51%	Information about Mental Health First Aid courses available in my community
51%	Information about creating faith communities that feel safe and welcoming for everyone
47%	Information about models and examples of mental health ministry across the church
44%	Peer support groups for ministers
39%	Age-specific mental health curricula
37%	Mental health worship resources such as bulletin inserts, sermon ideas, readings, & stories
32%	Access to grant funding for initiating or expanding mental health aspects of my ministry

About training



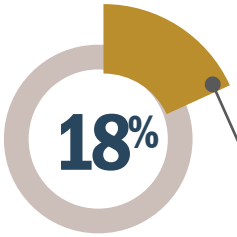
22% On the job

These ministers report no formal mental health training



44% no training

1,406 or nearly half of the 3,196 ministers who responded to this question reported that they have not had any training in the area of mental health awareness or how to minister to individuals, families, or peers who are facing mental health challenges.



18% seminary or college

Only 18% report any college or seminary courses in mental health

Other training

16% continuing Education
8% from a different denomination
8% secular employer

61%	of those trained, report improved skills & increased ability to respond effectively

Their stories

When considering mental health for congregants, their communities, and themselves, ministers shared the challenges and concerns.

Stigma

Ministers share that they feel a heavy presence of stigma as it relates to mental health. This stigma makes people reluctant to ask for help. The idea of an “affluent” church also causes similar struggles. Many operate on “don’t ask, don’t tell.” Even when the issues of mental health are in people’s faces, they are still reluctant to discuss the topic or issue.

Ministers also express the stigma they feel when needing or wanting to discuss their own mental health with those within the church. They are reluctant to do so out of fear of losing their job or being ostracized after doing so. They are also reluctant to share about mental health struggles within their families.

Verbatim Comments from Ministers

This congregation has had more people in and close to the church with mental health issues than others I have served, and I have been working at destigmatizing and helping people know they are not alone. Congregation seems puzzled but not actively resistant.

This is an affluent and status-driven setting, so people are less open and vulnerable about mental health issues.

When I told my session about my depression and that I was seeking help, it was the beginning of the end of my ministry with them. Mental health issues are still a stigma to 'perfect pastor' congregation expectations. I personally know colleagues/friends who have experienced the same context. Ugly & sad.

Truthfully, we're 'high church.' I don't know of many people in our sizeable congregation that have severe mental health issues. By no means does that mean we don't have folks that do. Of course, we do. However, we struggle at our church by trying to look the part in this affluent congregation. So, anyone that has a mental health issue rarely discusses it or makes it known. I recognize that's not healthy.

Most people do not want to talk about mental health issues due to the traditional shame culture of our community. We need to develop a biblical basis for mental health ministry.

I have two daughters with mental health issues. I would characterize the church response as mixed. There remains so much stigma surrounding mental illness, and I have tried to model transparency and a willingness to address it.

Rural & Remote Areas

Many ministers in rural and remote settings express how there are limited to no resources available. Some express that their settings are ones of isolation. They share that these are ongoing challenges. Some point out that there are resources available to those who are able to drive to the nearest “big city.” For some, transportation and confidentially then poses as problematic. Having to travel to the city also poses a problem, as some feel that their problems may not be understood by “city folk.”

Living in an area such as these also thickens the stigma and the “don’t ask, don’t tell” factor. Living in areas where everyone knows everyone can create reluctance or fear of asking for help.

Verbatim Comments from Ministers

Rural community - fear and shame rule, since everyone talks about everyone's problems (gossip). There are no resources nearby, and no information within the community.

We are a rural community and the nearest access to suicide prevention teams is 1/2 hr to 45 minutes away. Rural settings need help in figuring out how to address emergency situations.

Many parishioners are reluctant to address this issue due to being in a rural and/small town setting. Mental health issues carry a lot of stigma, especially in an environment where everybody knows everybody.

We are in rural America, and these challenges are ongoing. Couple that with the conviction of most of us living and serving out here that our situation is not understood by 'city folk,' and you begin to see the challenges!

Mental health services are not as readily available in the rural parts of our Presbytery, although we have brought in resources (e.g. Training from state Council of Churches to teach opioid addiction training. How to identify overdoses, how to use Narcan)

This is a rural area with limited resources. There are agencies around, however there are limited funds for helping the community. Education is one of the best ways to help with mental health, however the stigma holds so many back from seeking help.

What We Provide & Need

There are some churches offering what they can to the congregation and the community. These include but are not limited to pastoral counselors on staff, mental health support groups, AA and AIANON. Many ministers also express being very open to referring people in need to professionals that they feel can provide them with adequate help. Some do this when a situation is more than they can handle, while others state that they make referrals because they do not do counseling.

Needs expressed include resources for children & youth, persons with anxiety, resources for LGBTQIA, theologically sound marriage retreats, mental health first aid training, grief training, mental health training for the aging population, resources for those experiencing trauma, and early signs of dementia or mental illnesses.

Verbatim Comments from Ministers

Our church joined with the Methodist and Episcopal downtown churches to start a pastoral counseling center

We have a weekly coffeehouse that is a safe social space for a wide variety of people. It is designed especially for those with disabilities and their families but also attracts a wide variety of people with mental health issues. We don't specifically offer resources, but we do offer friendship and a safe place to hang out. We are doing Mental Health First Aid training for our congregation.

I will not do any counseling, but I will listen and tell them that here are referral sources. Ask them to make the contact and help them in any way possible to make that contact, even if it means making a call myself.

We need to talk more about the impact of trauma and mental health. We need to talk more with pastors and congregations about how they might prepare and how they can respond.

We need more support and education about sexual predators and signs of abuse. And how to best support victims.

The need for de-stigmatizing persons with mental health issues and the sharing and communicating of accurate information - i.e. - most mental health issues are manageable and do not keep most from leading a normal and healthy life.

Working Experience

Of the responding ministers, many share that their experience with aiding in mental health comes from outside of the church. These ministers are licensed therapist, counselors, and psychologists. Some have had training and experience in crisis and suicide prevention. This experience is being used within the church, hospitals, academic settings, as chaplains, and serving first responders, in hospice and retirement communities.

Verbatim Comments from Ministers

I have served on the Board of Directors of NAMI in our city, taught classes locally to churches and at Synod School. People know that I am a resource.

I currently serve as a Lead Outpatient Therapist at a mental health hospital.

I also work a part-time consulting role to pay my bills. It is grant-funded by a Mental Health Services Act grant through Health and Human Services. I volunteer and work for the effort toward suicide prevention and mental health for all.

I am also a Licensed Mental Health Counselor (LMHC) in the state of New York.

I've had a lot of training and experience in crisis intervention, suicide prevention, as a fire chaplain, working with first responders at disaster sites.

With an MA in psychology, and Ph.D. studies in Clinical Psychology I was the mental health provider in some of the small towns where I was pastor. I am retired now but still help out at the church I attend, just as a member.

Seminaries

Some ministers mention that seminaries need to give more training in regards to mental health. Ministers are requesting training on substance abuse, critical incident training, aging population, and pastoral care.

It was also shared that at least one minister has considered seeking an additional degree to supplement the information they did not receive in seminary.

Other ministers do acknowledge the training that they received while in seminary. Some mention that there was not enough time spent on dealing with mental health, while others express that at the time, they had no idea how important that information would end up being.

Verbatim Comments from Ministers

Seminaries do not spend enough time on this subject, covering the basic pastoral care activities of pastors. on the more difficult issues I refer to an outside source.

I had no idea in seminary that mental health knowledge would be as important as it is. I also don't think I could have learned what I needed to know in a seminary setting. (My personal philosophy that seminary should make us into theologians; ministry makes us into pastors.) It should be like 'healthy boundaries' in our presbytery - a 'required tune-up class' every so often in the course of ministry.

There is ZERO training for dealing with mental health issues in seminary, and ZERO in the 3 presbyteries I have served as an intentional Interim. The Church is FAILING to prepare ministers in this area.

I have had extensive training/education in Pastoral Care/Counseling, Spiritual Direction, and Coaching. I believe all ministers would benefit from Critical Incident Training and this be part of seminary education and/or Presbytery ongoing specialized training.

By far, the most applicable education I received in seminary was pastoral care with a family systems perspective.

Glad to see you focusing on this aspect of things. Neither seminary nor church gave me any awareness of dealing with mental illness--which affects 20-25 % of our (church) population. I had to learn everything on the fly.

Addressing Homelessness and Substance Abuse

Many ministers share that homelessness is a large problem in their communities and that their congregations serve many who are homeless. They express that many of those they serve have mental health issues and aiding them can be difficult. They also share how the opioid epidemic is also affecting their communities.

Safety is also a concern shared by some ministers. They express feeling unsafe at times depending on the seriousness of the person's mental health status. They also express concern for their congregation in those situations and that they need resources to protect themselves and members of the congregations.

Verbatim Comments from Ministers

We serve a lot of homeless folks who wander into our service in order to get food from our pantry. I believe that we are welcoming, but we are grappling with the tension between being open and welcoming and staying safe.

I serve in a congregation made up predominantly by people who are experiencing chronic street homelessness. It is not uncommon to have person(s) present, who are experiencing mental health issues. Everyone is welcome, and it really does work out.

We serve a lot of low income and homeless folks, and we have a lot of elderly in our congregation. There are different types of mental health issues with each group, but the challenges are consistently present with both groups.

Again, our agency works directly with chronically homeless people who are struggling with mental health issues. The challenge that I am finding is interpreting that work to congregational communities who do not have much experience in this area.

This congregation is situated in a declining small city with many hooked on opioids. I hope settlements with the companies who produced this stuff will enable further programs/help for them; our church cannot possibly cope with the needs we are seeing.

In a downtown setting most people who are on the street are there because of some mental health related reason, including use and abuse of substances.

Notes from Retired Ministers

A few ministers state how since they are now retired, their need for mental healthcare is not as great. Some express how the stress of the job pushed them toward retirement, some early. Others express how they feel once you are retired, you are then on your own, forgotten.

Although some express not having a great need for mental healthcare, there are those who express that as they age, it is helpful. Some of them are able to get this care in their retirement communities.

Verbatim Comments from Ministers

I have skills in this area that I miss putting to use. I also miss being around people who are willing to acknowledge problems instead of saying that everything would be fine if (I could only roll back the clock a few decades).

The stress of being often the only woman and frequently the only person of color finally burned me out. Took early retirement.

Once you are retired, you are on your own. I never hear from my presbytery, except for a couple of friends occasionally. And members of two churches where I served as interim.

Since I am retired, the need is not as great. But I believe it should be offered to every pastor without incrimination... just to keep ministry in perspective along with family and self preservation.

I live in a Continuing Care Retirement Community where we observe mental and physical losses every day. I try to be a friend and support people with those losses and have shared my perceptions with appropriate staff.

Living in a retirement community with social and chaplain resources available if needed or desired

Personal Experiences

Some ministers took this opportunity to share their own experiences with mental health. They share how their experiences with depression, being bipolar, struggles with anxiety, grief, loneliness, and the stresses of the job. Some share that they seek counseling, sometimes regularly and sometimes just as a routine check-in. Others explain how they are a part sharing groups that allows them to share with other individuals in similar situations.

Ministers also share the struggles of their family and those that are close to them. They have spouses, children, and close friends who struggle with mental health and this affects those ministers.

Verbatim Comments from Ministers

In my last two calls, I established relationships with ministry colleagues and other professionals who had comparable secular positions with whom I could meet and reflect on some the stresses faced in our positions. I met periodically with a professional counselor to do a 'self-check' on my personal mental/emotional health.

I was forced to leave the pastoral ministry that I dearly loved (and where I had been loved) because of my own mental health challenges 8 years ago. It is absolutely crucial that we find ways to address the stigma surrounding mental health challenges in the church.

I have depression for which I am medicated and a great number of others in the congregation are depressed and aware of such issues. We work with persons who are bipolar also.

Since I have experience with mental health with my nuclear family (bi-polar), I feel I have lots of offer. I also have a son who used counseling in college for mental health reason, so feel I know signs of some mental illness.

As a suicide survivor, I do suicide prevention and loss training for myself and education for others.

I lived with bi-polar disorder without knowing it for years, went through a crisis, and with more than a decade of effective treatment now enjoy my life and ministry.

Suicide

Suicide is a concern that some ministers shared. Some ministers are in communities where suicide rates are high, or it is considered an epidemic. They share how suicide affects the families, congregations, and communities. The ministers express the need for training on how to aid those impacted.

Verbatim Comments from Ministers

Suicide is an epidemic in this community. There has been some training and support for clergy and congregational leaders.

Suicide is real and the church has failed to be ready to minister to those families who are involved.

Public Stigma 한국인의 자살이 타인종에 비해 매우 심각한 수준이다. 유교와 체면문화가 심각한 가정폭력을 가져오고, 소리없는 자살에 이르고 있다. 회중 안에 우울증이 심각하다. 자살은 죄 라는 신학적 입장이 회중과 목회자들이 심각한 우울증으로 치료 받기를 꺼려 한다. 대중에게 가족이 노출되어서는 안된다는 체면문화가 가족을 패쇄적 환경을 고수하게 하고 정신병자, 미친 자 라는 stigma 낙인을 찍어 정신건강 치료를 방해한다. 특히 미국장로교 내 한인교회의 자살에 대한 인식을 환기시켜 주지 않는다면 한인교회 내 회중 안에 소리 없는 울부짖음은 계속 될 것이다. (Translation: The suicide of Koreans is very serious compared to other races. Confucianism and face-to-face culture have brought serious domestic violence, leading to silent suicide. Depression is severe in the congregation. The theological position that suicide is a sin makes congregations and pastors reluctant to be treated for severe depression. The face culture that the family should not be exposed to the public keeps the family in a closed environment and interferes with mental health treatment by labeling the stigma as a psychopath or a madman. In particular, if the Korean church in the Presbyterian Church in the United States does not raise awareness of suicide, the silent cry will continue in the congregation of the Korean church.)

Not long ago, a member with multiple mental and physical illnesses took his own life. This reverberated loudly in our small community. It matters.

Cost

Many ministers mention that a hinderance of getting mental healthcare for themselves or others is the cost. Not having the funds stop many from seeking care, then the ministers have little to no options or resources to help. Ministers acknowledge that even with insurance, the copays or type of care they can receive is not helpful.

Verbatim Comments from Ministers

Many people cannot afford mental health providers. They are difficult to find and difficult to pay for.

I have struggled with depression for a long, long time. PCP care is not sufficient. 'Identified patient' counseling with copays - the only kind supported by insurance - is neither sufficient nor affordable. Psychiatry has been most helpful, but has not always been available in my various ministry settings.

If you have money, your access to help is FAR greater than the general population. FUNDING is the biggest limitation to quickly guiding people with mental health issues to the help they need.

My wife and I have said that a list of therapist or psychiatrist for clergy, spouses, and families that take Board of Pensions insurance would be such a great help. It is incredibly hard to find a good therapist that takes our insurance.

Our presbytery is geographically diverse so some areas have access to very good mental health services while other areas have virtually no mental health services available even though ministers all have the same insurance through BOP.

There seems to be no provision for pastoral counseling of pastors. Other mental health services are widely available in our area--largely depending on insurance or other financial means.

Mental Health in Our Congregations

Ministers are aware that there are members in their congregations that struggle mental health issues, illnesses and disabilities who need help. Ministers explain how this can and has created challenges for their churches. They also share how and when the church is aware of the circumstances. Some congregations come together to make these situations work.

Security is a concern for ministers and the congregations. Ministers express congregational concern about unknown person with mental health issues coming into churches and causing harm. Ministers are also concerned with those within the congregation whose mental health issues raise safety issues for members, female pastors, and security teams.

Verbatim Comments from Ministers

In our small congregation we respond with warm hospitality and reasonable effectiveness. We're relatively savvy and get help when we need it.

Every member of my congregation suffers from something from mild depression to homelessness and drug abuse. it is an unending merry go round here in my little urban church

there is much concern in the congregation about strangers acting out especially in relation to the mass shootings in churches. There is high anxiety about this.

We have strong support in our community for adults with mental health needs however I do not see this enabling our churches to be present to the mentally ill in worship or faith practices.

We have a very outspoken bipolar woman in our congregation that has disrupted worship in the past. We work to welcome her even though that means extra work for the pastors and the security team.

Our congregation speaks openly of mental health issues. Members share openly during prayer time and are given support and encouragement in the midst of the dark times and we rejoice with the victories!

What was not in the survey comments

To this point you have read what was selected or written in the survey responses. However, there were many who would not respond to the online survey because they feared their responses would be shared with their presbytery. Instead, they chose to call me and tell me why they could not provide a written response.

They wanted to tell their stories, share their experiences, and to be heard.

These ministers want the churches to know that they experience the same deep emotions, illnesses, joys, and sense of loss as do the members. For some, once they shared their illness with the session, they soon were dismissed, even when they were receiving professional care, were succeeding with care, and until this point had the support of the session and church. It was because of the success of the care that they shared.

Others were deeply hurt, “shocked” when the church did not show compassion after the death of a spouse, child, or significant other, especially when these deaths were sudden and unexpected. It seemed as if the minister was to return to the pulpit in a few days and to keep their grief private.

Several commented that they have found new ways to serve the church they love. Each one said thank you for asking the question.

Susan Barnett, PhD, MSSW

What's next?

These findings will be shared with PC(USA) leaders and those whose programs directly focus on mental health and ministry so that leaders and educators can consider two things. First, what can be done to support ministers as they face their own mental health concerns and illness? Second, what additional training resources should be offered to assist ministers as they minister to their congregations?

Some of the issues raised cannot be changed. An isolated church cannot be moved to a resource rich community. The challenge then becomes how can equitable services be brought to those communities.

Some can.

Research Services helps the Presbyterian Church (U.S.A.) make data-informed decisions using surveys, focus groups and interviews, demographic analysis, and program evaluations.

We are social scientists with backgrounds in sociology, public policy, and economics. We serve congregations, presbyteries and synods, PC(USA) national agencies, and other PC(USA)-related organizations. Research Services is a ministry of the Administrative Services Group.

If you have any questions or would like a copy of this report, contact us at 502-569-5077 or research@pcusa.org.