The Intersection of Chaplain Ministry and Mental Health Care

NOTES
Learning Objective: Participants will be familiar with the major concerns of providing pastoral care to the Mental Health Community

Participants will:
1. Understand the need and opportunity of providing pastoral care to the Mental Health Community
2. Compare and Contrast Chaplain Ministry and Mental Health Care
3. Address the Biblical Perspective on Mental Health Care
4. Assess Christian Approaches to Mental Health Care
5. Examine 5 Mental Health Care Concerns for Chaplains
6. Be familiar with Mental Health Assessments for Chaplain Ministry

1.1 The Intersection of Chaplain Ministry and Mental Health Care: The Need and The Opportunity
Learning Objective: Participants will understand the need and opportunity of providing pastoral care to those in need of mental health care.
Participants will be able to:

- Identify indicators of Mental Health Care need in America
- Identify indicators of Mental Health Care need in the American Church
- Identify Mental Health Care ministry opportunities for Chaplains
- Identify of Mental Health Care needs of Chaplains

Your Perspective:

- Are people in your ministry dealing with mental health concerns?
- How often do you minister to people who may have a mental health concern?
- How does the rate of Mental Health issues in churches and your ministry compare to general society?
- Do you know someone IN MINISTRY who has struggled with a Mental Health issue?
- How do you interact with Mental Health providers? Or, Do you interact with Mental Health providers?

Indicators of Mental Health Care need in America

- Only 17% of US adults are in a state of optimal mental health (CDC, 2013)
- Between 20% and 27% of American Adults will experience some form of Mental Health Disorder Annually (44 Million)
- 4% Experience Serious Mental Illness, “impedes day-to-day activities, such as going to work.”
- 47.4% Experience some Mental Health Disorder during Lifetime*
- 63% of those with Mental Illness received Mental Health Treatment in the year they reported the illness
- Estimated cost of Mental Health Problems $317.6 B (2002)
- By 2020, Mental Health Disorders “will surpass all physical diseases as a major cause of disability worldwide.”

Indicators of Mental Health Care need in the American Church

- The Church and Your Ministry Population is a subset of American Society
- Variable Influence of Church and Faith on Individuals
• Many in Church do not encourage Mental Health Care: 48% Evangelical, Fundamentalist, or Born-Again Christians believe that Prayer and Scripture Alone can Overcome Mental Illness (Stetzer, 2013)

• 65% of Church Members with Mental Health needs want their churches to talk openly about Mental Illness (Stetzer, 2014)

Mental Health Care Ministry Opportunities for Chaplains
• Pastors and Police are often the First Responders in Mental Health Crises
• 60% of Pastors have Counseled Someone Who received Mental Health Disorder Diagnosis (No comparison statistic for chaplain ministries) (Stetzer, 2014)
• People Seek Mental Health Care from Chaplains at a higher rate than Mental Health Providers (VA/DoD Chaplain MH Report and MHAT 9 Report)
• VA & DoD Chaplains: “Most common problems” are psychosocial (anxiety, depression, stress) vs overtly spiritual”
• Majority reported rarely making referrals to MHPs or receiving referrals from MHPs
• Majority reported Chaplain IS MH provider and would take person with MH need to Chaplain (MHAT 4 OEF, 74)
• Only 32% with MH needs received help (MHAT 3)
• MHP: Chaplain approach religious/spiritual, MHP approach is scientific/clinical, “Science takes the cake when it comes to helping someone. Religion can’t do everything.” (MHAT 4, OEF, 67)

Individual and Organization Preference for Chaplain Care
• Soldiers’ preference for Mental Health providers: Peer Soldiers (19%); Chaplains (21%), and Behavioral Health Professionals (14%)
• Benefits of Chaplain as MH Providers
  - Organization Presence
  - Confidentiality
  - Training
Serving Those with Mental Illness, by Ed Stetzer, Jared Pingleton, and Donald Garber, Focus on the Family

Mental Health Care and Mental Health Ministry for Chaplains

• 23% of Pastors report struggling with some form of Mental Illness
• 47.4% of General Population Experience some Mental Health Disorder during Lifetime (sl 4)
• 12% of Pastors report receiving a Mental Health Condition Diagnosis (Smietana, 2014)
• Are Chaplains free to seek MH Care?

“But all of these—sin, spiritual struggle, weakness and mental illness—are places for grace to shine.” (Stetzer, 2014)

CHECK ON LEARNING

Do (A) less than 20%, (B) between 20% and 60%, or (C) more than 60% enjoy “optimal mental health?”

DISCUSSION: Better mental health is a distinguishing factor of the church’s life and witness. TRUE or FALSE: Mental Health providers are considered first responders for mental health problems.

1.2 Chaplain Ministry and Mental Health Care: Compare and Contrast

Learning Objective: Participants will compare and contrast Chaplain Ministry and Mental Health Care

• Participants will be familiar with:
  • The SIMILAR HISTORIES of Chaplain Ministry and Mental Health Care
  • The SHARED GOALS of Chaplain Ministry and Mental Health Care
  • The SHARED ROLES of Chaplain Ministry and Mental Health Care
  • The SHARED RECIPIENTS of Chaplain Ministry and Mental Health Care
  • The DIFFERENT CHALLENGES of Chaplain Ministry and Mental Health Care
  • The DISTINCT CONCERNS of Chaplain Ministry and Mental Health Care
  • CONCLUSIONS about the similarities and differences in Chaplain Ministry and Mental Health Care
The **SIMILAR Histories** of Chaplain Ministry and Mental Health Care

1. The church was the seat of health care, both physical and mental
   - Mid 3C, Church in Rome cared for poor and ill, including mentally ill (Koenig)
   - 316-397, Martin of Tours, Roman soldier, vision of Christ, first Chaplain
   - 369, St. Basil of Caesarea, built 300 bed hospital (Beal-Preston))
   - 490, Jerusalem hospital devoted to treating the mentally ill (Koenig)
   - 700s, Monasteries cared for mentally ill (Koenig)
   - St. Mary’s of Bethlehem Hospital 1247, cared for the needy; became a hospital in 1330. 1346: passed to civil control; 1357: admitted first mental patient (“distracted people”). Bedlam. Continues to operate today
   - 1538, John of God, former infantry soldier, vision, founded psychiatric hospital: “May Jesus Christ give me the grace to run a hospital where the abandoned poor and those suffering mental illness may have refuge.” (Koenig)

2. Reform and Promotion of Competent Care
   - Psychiatric Hospitals:
     Phillipe Pinel, devout religious man, releases mentally ill from restraints, treats with compassion
     Mid-19C, Dorothy Dix, religious woman, led reform in US mental institutions
   - Clinical Chaplaincy: Anton Boisen, became the first chaplain at Boston Psychopathic Hospital and founded Clinical Pastoral Education following psychiatric admission 1920-1921

3. Departure from Biblical Position

Mental Health
   - Atheism among Psychologists and Psychiatrists (approx. 50%, general population 4%)
   - Freud, Religion: an “obsessional neurosis”
   - Ellis, Religion correlated with “emotional disturbance.”
Clinical Chaplaincy

- Education and Certification Bodies Promote Religious Diversity
- Education and Certification Bodies Promote Moral and Sexual Diversity
- Many conservative Christians report a lack of respect for their theology and practice among these organizations. There is no well-accepted alternative organization to the existing training and certifying agencies.

The **SHARED GOALS** of Chaplain Ministry and Mental Health Care

Promotion of Personal, Relational, and Community Well-Being

**Mental Health Care:** Mental health is described by WHO as:

*... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001a, p.1).*

In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community.

**Chaplain Ministry:**

A Mature Christian is able to self-manage and contribute to the life and work of the Church, Relationships, and Personal Concerns

- **Luke 2** The boy grew up and became strong, filled with wisdom, and God’s grace was on Him.
- **52** Jesus increased in wisdom and stature, and in favor with God and with people.
- **Matthew 5** Be perfect, therefore, as your heavenly Father is **perfect**.
- **Ephesians 4** until we all reach unity in the faith and in the knowledge of God’s Son, growing into a **mature** man with a stature measured by Christ’s fullness.

What measures or standards do these verses provide for assessing maturity?

**Autonomy** is the ability to conduct oneself without immediate or significant guidance, direction, or control by others.

**Adaptability** is being able to respond to changing and dynamic circumstances

**Appropriateness** refers to how the mature person responds to demands in a way that resolves the situation (effective) without violating values (acceptable)
Maturity Assessment
• Assessing Adaptability:
  Rigid ------------------------Flexible------------------------Chaotic
• Assessing Autonomy:
  Needy Dependence------Balanced Interdependence -----Haughty Independence
• Assessing Appropriateness:
  Acceptable---------Unacceptable
  Effective----------Ineffective

The **SHARED RECEPIENTS** of Chaplain Ministry and Mental Health Care
Chaplains, Physicians, Social Work, Psychiatry, Legal, and Administrative Personnel often
discover they are seeing the same individuals.
• Co-morbidity and therefore see other providers.
• Malingering: Avoiding duty
• Hypochondriac: Enlisting multiple care givers for support, therapy roulette
• Necessity of Multi-Disciplinary Treatment

The **SHARED ROLES** of Chaplain Ministry and Mental Health Care
Carl Jung
“That is why the priest not only hears the confession, but also asks questions—indeed, it is
incumbent on him to ask them.  
(Jung, vol11, 350)
“My method, like Freud’s, is built upon the practice of confession. (Jung, vol 11, 536)
• Familiarization
• Assessment
• Intervention
• Support
• Cooperation
• Training/Professional Development

**Assessment**: Evaluate Those in Need
• Mental Status Assessment
• Crisis Assessment
• Depression Assessment
• Substance Abuse Assessment
• Suicide Assessment
• Violence Assessment
• Comorbidity Assessment: Co-Existing Conditions

Cooperation working with Mental Health Care
• Inter-Disciplinary Treatment Team Meetings
• Consultation with Mental Health Provider (Shared Population)
• Emergency Response
• Employee Assistance Program (EAP)
• Referral

Training/Professional Development
Opportunities for Training and Professional Development
• Organization Provided Continuing Education Classes
• Local Mental Health Organization Continuing Education Classes
• Online Mental Health Organization Continuing Education Classes
• Academic Courses: Online, Classroom, Credit, Audit

The Benefits of Participating in Training and Professional Development:
• Increases your competence and confidence
• Promotes participation and acceptance in Inter-Disciplinary Team Meetings
• Encourages reciprocal relationships between You and the Mental Health Community

The DIFFERENT CHALLENGES of Chaplain Ministry and Mental Health Care
Therapist and Chaplain Boundary Comparison
• Contact with Client outside therapy
• Hug or other physical contact
• Visiting Client in hospital or other crisis setting
• Participation in Client’s life events (Freeman, 1999, www.psychologytoday.com)
• Opportunity to initiate Therapeutic Relationship

(Clinebell, Basic Types of Pastoral Care & Counseling, 2011)
• Prayer

The **DISTINCT CONCERNS** of Chaplain Ministry and Mental Health Care
Mental Health Care must address the mental health concern from a mental health perspective.
• Trained and credentialed to address mental health issues
• Standard of Care interventions
• Maintenance of Objectivity and Distance
• Worldview and Meaning are not within the Domain of Mental Health Care
Chaplains must address mental health care concerns from the **perspective** of the pastoral and biblical perspectives
• Typically lack formal training and credentialing to provide Mental Health Care
• Standard of Care Interventions

The **DISTINCT CONTRIBUTIONS** of Chaplain Ministry and Mental Health Care
Chaplains must address mental health care concerns from the perspective of the pastoral and biblical perspectives
• Provide Care from a biblical perspective
• Address ultimate values and absolute truth
• Engage in genuine and meaningful relationships (biblical love vs. unconditional positive regard (Rogers))
• Address needs with pastoral authority
• Centrality and expectancy of God’s presence, participation, and response
• Affirmation of redemption and healing through the gospel beyond mental and emotional well being

**Conclusions:** Chaplain Ministry and Mental Health Care
• Chaplains and Mental Health Care Providers share significant histories, goals, and practices
• Mental Health Care is scientific, Pastoral Care is miraculous
• Chaplains offer support and have challenges that are different than Mental Health Care Providers
Chaplains must expand the association and cooperation with Mental Health Providers

CHECK ON LEARNING
1. How did mental health hospital admissions contribute to the development of chaplaincy and mental health care?
2. Both Chaplain Ministry and Mental Health Care are concerned with the ability of the person to ____________ to the community.
3. Participating in Mental Health Continuing Education may encourage ____________ relationships.
4. True or False Chaplains and Mental Health providers should deal with their clients in exactly the same ways.

2.1 Chaplain Ministry and Mental Health Care: A Biblical Review
Learning Objective: Participants will be familiar with the Mental Health Care Issues in the Bible
Participants will be familiar with:
- A brief overview of Mental Health and the Bible
- The biblical vocabulary addressing Mental Health
- The biblical accounts addressing Mental Health
- Special Considerations: The Miraculous and the Demonic
- Conclusions about Mental Health in the Bible

Initial Considerations
- Are Bible Verses Appropriate and Adequate?
- Does the Bible Provide Sufficient Data for Mental Health Analysis or Diagnosis?
- What is the Primary Message of the Bible?
- Does the Bible Provide Sufficient Information to Promote Mental Health?

Biblical Vocabulary
Mad and Madness
- SAGA, SAGAN

Deuteronomy 28 The Lord will afflict you with madness, blindness, and mental confusion,
You will be driven mad by what you see.

1 Samuel 21:14 “Look! You can see the man is crazy,” Achish said to his servants. “Why did you bring him to me?

2 Kings 9:20 Again the watchman reported, “He reached them but hasn’t started back. Also, the driving is like that of Jehu son of Nimshi—he drives like a madman.”

Zechariah 12:4 On that day—this is the Lord’s declaration—“I will strike every horse with panic and its rider with madness

- HALAL

1 Samuel 21:13 so he pretended to be insane in their presence. He acted like a madman around them, scribbling on the doors of the gate and letting saliva run down his beard.

15 Do I have such a shortage of crazy people that you brought this one to act crazy around me? Is this one going to come into my house?”

Psalm 34 Title
Concerning David, when he pretended to be insane in the presence of Abimelech, . . .

Confusion

- TIMMAHON

Deuteronomy 28:28 The Lord will afflict you with madness, blindness, and mental confusion

Zechariah 12:4 On that day—this is the Lord’s declaration—“I will strike every horse with panic and its rider with madness I will keep a watchful eye on the house of Judah but strike all the horses of the nations with blindness.

- MEHUMAH

Deuteronomy 7:23 The Lord your God will give them over to you and throw them into great confusion until they are destroyed.

Deuteronomy 28:20 The Lord will send against you curses, confusion, and rebuke in everything you do until you are destroyed and quickly perish, because of the wickedness of your actions in abandoning Me.

1 Samuel 14:20 Saul and all the troops with him assembled and marched to the battle, and there, the Philistines were fighting against each other in great confusion!

Out of One’s Mind

- EXHISTEMI and EKSTASIS (Ecstasy)

Mark 3:21 When His family heard this, they set out to restrain Him, because they said, “He’s out of His mind.”

2 Corinthians 5:13 For if we are out of our mind, it is for God; if we have a sound mind, it is for you.

- MAINOMAI, MANIA (Maniac)

Acts 12:15 “You’re crazy!” they told her.
Acts 26:24 As he was making his defense this way, Festus exclaimed in a loud voice, “You’re out of your mind, Paul! Too much study is driving you mad!”
1 Corinthians 14:23 Therefore, if the whole church assembles together and all are speaking in other languages and people who are uninformed or unbelievers come in, will they not say that you are out of your minds?

Fear (Anxiety)
- YAH-RAY

GEN 32:11 Please rescue me from the hand of my brother Esau, for I am afraid of him; otherwise, he may come and attack me, the mothers, and their children.
JUD 7:3 Now announce in the presence of the people: ‘Whoever is fearful and trembling may turn back and leave Mount Gilead.’ ” So 22,000 of the people turned back, but 10,000 remained.
- PHOBEO, PHOBOS

MATT 14:26 When the disciples saw Him walking on the sea, they were terrified. “It’s a ghost!” they said, and cried out in fear.
LUKE 21:26 People will faint from fear and expectation of the things that are coming on the world, because the celestial powers will be shaken.

Worry (Anxiety)
- METEORIZOMAI

LUKE 21:29 Don’t keep striving for what you should eat and what you should drink, and don’t be anxious.

Anxious, Concerned, Fear
- DA’AG

1 SAM 5: When they came to the land of Zuph, Saul said to the attendant who was with him, “Come on, let’s go back, or my father will stop worrying about the donkeys and start worrying about us.”

- KERA

DAN 7:15 “As for me, Daniel, my spirit was deeply distressed (anxious ESV) within me, and the visions in my mind terrified me.

Carry, Worry, Anxiety
- MERIMNAO

LUKE 21:34 “Be on your guard, so that your minds are not dulled from carousing, drunkenness, and worries of life, or that day will come on you unexpectedly”
Sanity/Mind/Reason

- **MANDA**

**Daniel 4**

34 But at the end of those days, I, Nebuchadnezzar, looked up to heaven, and my sanity returned to me.

36 At that time my sanity returned to me, and my majesty and splendor returned to me for the glory of my kingdom. My advisers and my nobles sought me out, I was reestablished over my kingdom, and even more greatness came to me.

Right Mind

- **SOPHRONEO**

**Mark 5**

15 They came to Jesus and saw the man who had been demon-possessed by the legion, sitting there, dressed and in his right mind; and they were afraid.

**Luke 8**

35 Then people went out to see what had happened. They came to Jesus and found the man the demons had departed from, sitting at Jesus’ feet, dressed and in his right mind. And they were afraid.

**2 Corinthians 5**

13 For if we are out of our mind, it is for God; if we have a sound mind, it is for you.

**2 Timothy 1**

7 For God has not given us a spirit of fearfulness, but one of power, love, and sound judgment.

Counsel/Advice

- **ESAH, MO’ESAH**

**2 Samuel 16**

23 Now the advice Ahithophel gave in those days was like someone asking about a word from God—such was the regard that both David and Absalom had for Ahithophel’s advice.

**1 Kings 12**

13 Then the king answered the people harshly. He rejected the advice the elders had given him.

**Jeremiah 7**

24 Yet they didn’t listen or pay attention but followed their own advice and according to their own stubborn, evil heart. They went backward and not forward.

**Hosea 1**

6 A sword will whirl through his cities; it will destroy and devour the bars of his gates, because of their schemes.

- **YA’AS**

**1 Kings 12**

6 Then King Rehoboam consulted with the elders who had served his father Solomon when he was alive, asking, “How do you advise me to respond to these people?”

**Psalm 32**

8 I will instruct you and show you the way to go; with My eye on you, I will give counsel.

- **SUMBOULIAN, SUMBOULEUO**
Matthew 27
When daybreak came, all the chief priests and the elders of the people plotted against Jesus to put Him to death.

Matthew 27
So they conferred together and bought the potter’s field with it as a burial place for foreigners.

Revelation 3
I advise you to buy from Me gold refined in the fire

Biblical Accounts of Mental Health Disorders

• Drunkenness / Substance Abuse: Noah GEN 9:21; Lot GEN 19: 33 and 35; Amnon 2 SAM 13:28; Nabal 1 SAM 25:36; Warning PRO 23:31

• Anxiety (Paranoia): Saul, 1 SAM 13:9 and 12; 18:8; 20:30-33

• Suicide: Samson* JUDG 16:25-30; Saul’s Armor Bearer 1 SAM 31:5; Ahithophel 1 SAM 17:23; Zimri 1 KNGS 16:15-20; Judas MATT 27:3-5; Assisted Suicide/Euthanasia: Abimelech JUDG 9:52-54; Saul 1 SAM 31:4 & 2 SAM 1:10

• Hypersexuality: Solomon 1 KINGS 11:3 700 wives, 300 concubines

Biblical Accounts of Individuals

Saul

Samuel 16
Now the Spirit of the Lord had left Saul, and an evil spirit sent from the Lord began to torment him, so Saul’s servants said to him, “You see that an evil spirit from God is tormenting you. Let our lord command your servants here in your presence to look for someone who knows how to play the lyre. Whenever the evil spirit from God troubles you, that person can play the lyre, and you will feel better.”

Samuel 19
Then Saul himself went to Ramah. He came to the large cistern at Secu, looked around, and asked, “Where are Samuel and David?” “At Naioth in Ramah,” someone said. So he went to Naioth in Ramah. The Spirit of God also came on him, and as he walked along, he prophesied until he entered Naioth in Ramah. Saul then removed his clothes and also prophesied before Samuel; he collapsed and lay naked all that day and all that night. That is why they say, “Is Saul also among the prophets?”

Nebuchadnezzar

Daniel 4
At that moment the sentence against Nebuchadnezzar was executed. He was driven away from people. He ate grass like cattle, and his body was drenched with dew from the sky, until his hair grew like eagles’ feathers and his nails like birds’ claws. But at the end of those days, I, Nebuchadnezzar, looked up to heaven, and my sanity returned to me. Then I praised the Most High and honored and glorified Him who lives forever: For His dominion is an everlasting dominion, and His kingdom is from generation to generation.

Jesus
Mark 3 Then He went home, and the crowd gathered again so that they were not even able to eat. When His family heard this, they set out to restrain Him, because they said, “He’s out of His mind.”

The scribes who had come down from Jerusalem said, “He has Beelzebul in Him!” and, “He drives out demons by the ruler of the demons!”

Gerasenes Demoniac

Mark 5 Then they came to the other side of the sea, to the region of the Gerasenes. As soon as He got out of the boat, a man with an unclean spirit came out of the tombs and met Him. He lived in the tombs. No one was able to restrain him anymore—even with chains—because he often had been bound with shackles and chains, but had snapped off the chains and smashed the shackles. No one was strong enough to subdue him. And always, night and day, he was crying out among the tombs and in the mountains and cutting himself with stones.

And He gave them permission. Then the unclean spirits came out and entered the pigs, . . . They came to Jesus and saw the man who had been demon-possessed by the legion, sitting there, dressed and in his right mind; and they were afraid.

Special Consideration: The Miraculous in Mental Health Care

- Natural mental health without intentionality
- Enhanced mental health care using evidence based scientifically validated interventions
- Miraculous healing

A miracle is the suspension of natural laws and predictability due to divine intervention.

When miracles become predictable they are considered natural and normal

This true for all miracles, including physical health and mental health

Special Consideration: The Demonic in Mental Health Care

Matthew Stanford, PhD

CEO: Hope and Healing a Center and Institute

Co-Founder: Grace Alliance

Member: SBC, Mental Health Advisory Group

Former Professor, Psychology and Neuroscience, and

Biomedical Studies, Baylor University

Author, A Clinical and Biblical Perspective on Mental Illness, IVP, 2008

1. Demons never existed, the biblical presentation is dependent on a pre-scientific worldview

“While the layers of that narrative (Mark 5:1-20) are likely too thick to make a medical diagnosis, the evidence extant in the story might suggest that this man suffered from a mental illness that featured psychotic episodes, all attributed to being possessed by demonic powers.
Exorcism was the singular ‘treatment of choice,’ simply because knowledge of mental illnesses as we know them today had not yet been discovered.”
(Albers, Meller, Thurber, Ministry with Persons with Mental Illness and Their Families, 2012, 4)

2. Demons existed in biblical times but do not exist in post-biblical times
Explains the absence of demons as a significant factor in the modern world
Mirrors the experience of miracles in the Bible and modern experience
Does not have any biblical indictors
3. Demons existed in biblical times and exist today although they are not as significant as some report
Specific Healings by Jesus or Apostles
Refer to Demonic Influence (Synoptics)
Possibly refers to Mental Health Issue (Gadarene/Gerasenes), noted in the conclusion (Lk 9:35 “in his right mind” and 9:36 “healed”)
“In comparison to ‘natural’ illnesses, demonic infirmity and possession are rare in the biblical text and are not even mentioned in a majority of the Scriptures” (p 33-35).

Conclusions about Mental Health in the Bible
1. Mental Health Issues are present in the Bible
   • Mental Health issues appear as part of the human condition
   • The passages that address poor Mental Health do not describe it in detail
   • Several passages address false accusations
   • The passages that address good Mental Health do not describe it in detail
   • Mental Health Issues are distinct from demonic possession (although, there is some association with the 2 conditions)
   • The vast majority of biblical characters do not appear to have Mental Health concerns
2. Therapeutic interventions are not present in the Bible
   • (Although the Saul/David account records use of music as a therapeutic intervention)
   • Psychological Counseling, in the modern sense, is not present in the Bible
3. Pastoral Care Providers should promote good Mental Health
CHECK ON LEARNING

1. TRUE / FALSE The Bible provides specific and detailed descriptions of mental health disorders.
2. The Bible’s vocabulary for mental disorders includes __________, __________, and __________.
3. According to Deut. 7:23 and 28:28, those afflicted with madness or mental confusion:
   a. are individually responsible due to personal sin
   b. are subject to God’s judgement on the rebellious nation
   c. should be punished by those who are not suffering
   d. will be immediately relieved if the person publicly repents
4. Some may cite David as an early __________ therapist.
5. The Bible presents mental health concerns as:
   a. exclusively mental health issues
   b. exclusively demon possession
   c. On occasion, with an association of mental health concerns and demon possession.
6. TRUE or FALSE The purpose of the Bible is to provide definitive treatment of mental health concerns

2.2 Chaplain Ministry and Mental Health Care: Christian Approaches

Learning Objective: Participants will assess Christian approaches to mental health care.

Participants will:

- Identify three approaches to Mental Care
- Evaluate the three approaches from a Biblical and Theological Perspective
- Determine the approach to Mental Health Care that is most common in their ministry settings.
- Develop confidence in dealing with other treatment team members

Preliminary Observations

- The Sources of Knowledge
  1. General Revelation (Psalm 19)
  2. Special Revelation (John 1; 11; 16, and 2 Peter 1)
3. **Human Inspiration, Illumination, and Insight**

- **Competing Ideas:**
  1. Truth is a statement that corresponds to reality; Ultimate truth corresponds to ultimate reality
  2. All Truth is God’s truth
  3. Not all *truth* is true

**Secular Perspective Only**
1. Began as medical specialty in 1800s
2. Contributors
   a. Sigmund Freud, neurologist  
      Psychosexual Development  
      Formulated a construct of human psychology including the Id, Ego, and Superego;  
      Developed Psychoanalysis (not Psychotherapy) or Talk Therapy  
      Atheist, Hostile to Religion  
      Had some valuable ideas: Identification, Transference, and Counter-Transference
   b. Jung: Psyche; The Conscious, Personal Conscious, and Collective Unconscious; opposed Freud’s emphasis on sex; valued Religion
   c. Erikson: Psychosocial Development
   d. Rogers, Client Centered Therapy and Unconditional Positive Regard
   e. Bowen, Family Systems Theory
   f. Ellis, Rational Emotive Behavioral Therapy
   g. Take your pick: Brief Therapy, Emotional Focused Therapy, Eye Movement Desensitization and Reprocessing (EMDR)
3. Psychopharmacology: 1950s and following
4. Clinical Pastoral Education: Emphasis on Pluralism and Secular Psychology
5. Concern is rejection of biblical values and worldview

**Biblical Perspective Only**
1. Psychotherapy and Counseling is based solely on the Bible
2. Rejection of secular psychology
   a. The Bible is sufficient to provide psychological counsel
   b. Counsel is primarily guidance not exploration
   c. Sin is the starting point of psychological stress
   d. Faith, repentance, and obedience to the gospel are the keys to mental health
   e. Rejection of psychopharmacology

4. Progressive Biblical Counseling
   a. Cautious of modern psychology but more open to its findings
   b. Promotes centrality of Scripture
   c. Defines everyone’s primary need as sin and the gospel as the solution

5. Concern is working in a secular organization and mental health care providers

Unified Perspective
1. Acknowledges authority of Scripture
2. Accepts secular psychological findings that do not contradict scripture
3. Values scientific method
4. Presentations
   a. Integration Model: Integrates psychology and theology with evidence based approach in the secular setting, Everett Worthington
   b. Christian Psychology Model: Integrates psychology and theology with evidence based approach in the Christian setting (Exempt from work in pluralistic setting)
   c. Concern is maintaining balance with biblical values and worldview with the best of secular psychology

CONCLUSION:
While most of us are not and will not be trained psychologists or mental health care professionals:
  • We must be confident in our understanding and practice of mental health care
  • We must recognize the importance of the Bible and theology as we engage in the mental health community
  • We must be conversant with mental health care providers in our ministry settings
• Remember: Your ministry is to the clients of the organization and the providers in the organization

CHECK ON LEARNING

1. One approach to mental health care is ______________.

2. Freud’s description of human psychology was based primarily on
   A. Social Development; B. Sexual Development; C. Religious Development; D. The impact of the gospel on the individual

3. Matching
   A. Freud ___ Unified Approach
   B. Adams ___ Biblical Counseling Approach
   C. Worthington ___ Secular Approach

2.3 Chaplain Ministry and Mental Health Care:
   Five Mental Health Concerns for Chaplains

Learning Objective: Participants will examine 5 mental health concerns for chaplains.

Participants will:
• Be familiar with 5 significant mental health concerns for chaplains
• Be able to identify significant signs and symptoms of 5 mental health care concerns for chaplains
• Review pastoral encounters from their ministries that addressed the five mental health concerns

Items of Consideration
• If the person could manage the situation with existing coping skills, he would not ask for help
• A miraculous outcome is desired but is not typical
• When the miraculous becomes routine it is no longer considered miraculous

Depression (Mood Disorders)
Diagnostic Description

• A Mood Disorder (Major Depression, Persistent Depressive Disorder (Dysthymia), and Bi-Polar)
• Depressed mood or loss of interest in significant and numerous activities
• Interferes with work, sleep, eating, daily activities, or spiritual activities.
• Family History!

Diagnostic Features (Major Depressive Disorder)

• Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
• Mood represents a change from the person's baseline.
• Impaired function: social, occupational, educational.

Specific symptoms, at least 5 of these 9, present nearly every day:
1. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. Decreased interest or pleasure in most activities, most of each day
3. Significant weight change (5%) or change in appetite
4. Change in sleep: Insomnia or hypersomnia
5. Change in activity: Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt
8. Concentration: Diminished ability to think or concentrate or more indecisiveness
9. Suicidality: Thoughts of death or suicide, or has suicide plan

Impact

• 10 % (18M) of population will experience depression annually
• Depression work absences > 1 day per month; Reduced productivity = 1 day per week
• 15% of suicides had depression disorder
• 25% will seek assistance from clergy, more than psychiatrists or medical doctors
• Depression, like all Mental Health issues, affects the church at a similar rate to the rest of society
• Clergy are 1.5 times more likely to be depressed than the general population
Treatment: BioPsychoSocial and Spiritual

**Individual:** Pastoral Screening, Refer (!)
Discover origin and onset,
Promote healthy behaviors
Therapy (understanding, hope, realistic expectations, problem solving, and cognitive behavioral therapy)
Spiritual practices
Explore familial depression

**Family:** Encouragement, understanding, support

**NOTE:** Family members can become depressed, too!

**Congregation:** Present depression in a supportive manner, arrange group support activities, provide relief for care givers

**Psalm 30** For His anger lasts only a moment, but His favor, a lifetime. Weeping may spend the night, but there is joy in the morning.

**Anxiety**

Diagnostic Description
A serious mental illness characterized by overwhelming and constant worry and fear, which may interfere with normal relationships and activities

(Angie is future oriented; Fear is present oriented)

Types of Anxiety Disorders
- Panic Disorder
- Obsessive-Compulsive Disorder (OCD)
- Generalized Anxiety Disorder
- (PTSD: No longer DSM 5 Anxiety Disorder, now Trauma and Stress Related Disorders)

Diagnostic Features
Fear or anxiety is:
Out of proportion to situation or age inappropriate
Persistent, lasts longer than 6 months
Interferes with ability to function normally

“People who struggle with various kinds of troubling anxiety tend to make meaning along a story line that predicts more trouble, a loss of control, or grave risk.”

Diagnostic Features

**Physiological:** Pounding Heart, Dizziness, Sweating, Trembling, Shortness of Breath, Chest Pain, Nausea

**Cognitive:** Fear of Losing Control, Fear of Dying, Feelings of Unreality, Feelings of Depersonalization

**Behavioral:** Exaggerated Startle Response, Irritability, Avoidance Behavior, Difficulty Sleeping

Impact

- 40M American Adults, 18% of population
- Annual cost: $42B (1999)
- Medical Costs: $22.8B
- People with Anxiety Disorders are 3 to 5 times more likely to seek medical care and have psychiatric hospitalizations 6 times more than general population
- Only 33% receive treatment

Treatment: BioPsychoSocial and Spiritual

**Individual:** Pastoral Screening, Refer (!), cognitive behavioral therapy, narrative therapy, encourage proper spiritual perspective

**Family:** Encouragement, understanding, coping strategies, support

**Congregation:** Present anxiety in a supportive manner, prevent inappropriate religious behavior (personal and church behaviors), arrange group support activities, provide relief for care givers

**Chaplains:** Little research available; multiple demands and little control increase risk; expectations of others may promote anxious self-narrative
Phil 4: Don’t worry about anything, but in everything, through prayer and petition with thanksgiving, let your requests be made known to God.

Addiction

Diagnostic Description: Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.

It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

A Definition by attributes
- Primary
- Chronic
- Progressive
- Fatal

A Definition by Behavior
- Heavy Drinking: 3 or more drinks 3 or more times a week; May not be addictive drinking
- Threshold is inebriation or Under the Influence, Impaired
- Other substances, cannabis, or behaviors (Acceptable or Casual Use)

A Practical Definition by Behavior
Continuing to engage in a behavior that creates life-problems without the ability to stop the behavior

Note to Addicted: If you have a behavior that causes problems and you continue the behavior, you have a problem, you are an ADDICT!

Note to Chaplain: If a person has a behavior that causes problems and continues the behavior, the person is an ADDICT! Don’t just tell them to STOP!

Types of Addiction
Arousal
• Sensations of intense, raw, unchecked power
• Amphetamine, cocaine, ecstasy, first drinks, gambling, spending, stealing, sex

Satiation
Sensation of being full, complete, beyond pain
• Opiates, barbiturates, marijuana, alcohol, overeating, love

(Nakken, *The Addictive Personality*, 3)

Types of Addiction

Substance

Behavioral (Process or Hidden)

Impact on Society:
• Alcohol Healthcare: $25B Overall: $224B
• Illicit Drugs Healthcare: $11B Overall: $193B
• Total Healthcare: $36B Overall: $417B (DoD $577B)
• Alcohol-Attributed Deaths: 88K, 3rd leading CoPD
• Annual Drug/Alcohol-Related ED Visits: 2.1M (2009)
• Alcohol Related Hospitalization Cost: $5.1B
• Crime: Violent Crime, 50%; Spouse Abuse 57%; Sex Offense 60%; Convicted Murders 86%

Impact on Clergy (Pastors and Chaplains):
• Little research of clergy-specific addiction
• Rick Warren, 54% of pastors viewed pornography in the past year
• Glenn Prescott, IMB no longer asks “If” applicants have used pornography. Now, asks
  “when” did you use pornography
• Anecdotal: Current seminarians question “no-alcohol” practice and policy
• Chaplains experience personal, family, and career problems due to addictive behavior
• Self-Medication and other compensatory behaviors are concerns for those who suffer
  depression, anxiety, PTSD, or Compassion Fatigue

The Baptist Approach
“... to abstain from the sale of, and use of, destructive drugs or intoxicating drinks as a beverage; to shun pornography; ...” (Baptist Church Covenant)

Is this plan informed?
Is this plan effective?
Is this a plan?

Treatment: BioPsychoSocial and Spiritual

**Individual:** Pastoral Screening, Refer (!), Support

**Family:** Pastoral Screening for Addiction and Codependency
  Provide support for family members
  Refer to support program

**Congregation:** Integrate recovery language into preaching
  Establish relationships with 12-Step programs
  Establish relationship with Celebrate Recovery
  Protect congregation from Codependency behaviors

**Chaplain:** Self-Refer (before disciplinary problems), Spouse-Refer, Peer Inquiry,
Contact CH Jim Hartz, NAMB for intervention

**Eph 5** And don’t get drunk with wine, which leads to reckless actions, but be filled by the Spirit

**Psalm 19** Keep your servant also from willful sins; may they not rule over me. (NIV)

**Compassion Fatigue**
Definitions
1. Compassion Fatigue (CF): The caregiver’s reduced capacity or interest in being empathic or “bearing the suffering of clients” and is “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by (another person). . .”
2. Secondary Trauma: Exposure to a traumatic event of another through the retelling of the traumatic event of the victim. Subjects of secondary trauma include mental health workers, clergy, first responders, case workers, spouses, associates, and others.
3. Secondary Traumatic Stress: “(T)he emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD).” (Edit from Conference Presentation) (NCTSN, Fact Sheet)

4. Burnout: Fatigue, frustration, or apathy resulting from prolonged stress, overwork, or intense activity
   A state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations (vs. specific exposure to the trauma and suffering of a particular client)
   *A state associated with stress and hassles involved in one’s vocation.*

5. Vicarious Trauma: When a single member is affected out of contact with the other members (war, mining accidents, hostage situations, etc.)

6. Compassion Satisfaction (CS): The perceived joys derived from experiencing the suffering of others and succeeding in helping relieve their suffering in some way.

   *Compassion Fatigue Among Chaplains, Clergy, and Other Respondents After 9/11,* Figley, et al
   “No significant differences were found between clergy respondents and non-clergy respondents” (p. 757).

   *Is this good news or not? Why?*

   Elements of Self-Care:
   1. Self-monitoring
   2. Social Support monitoring
   3. Self-Care Plan

   Elements of Self-Care: With Clients:
   1. Breathing
   2. Self-Talk
   3. Movement

   Elements of Self-Care: Between Clients:
   1. Breathing Meditation
2. Prayer and Meditation
3. Visualization
4. Writing, Music, Art

Gal 6\textsuperscript{9} So we must not get tired of doing good, for we will reap at the proper time if we don’t give up.

**Forgiveness:** Mental Health and Pastoral Concern
- Not officially a mental health concern (DSM 5)
- Forgiveness is presented as a topic in secular psychology and business
- The Mayo Clinic promotes forgiveness as a form of therapy
- Almost >50\% of the counseling load of a Christian Counseling service involve forgiveness issues \textit{(Christianity Today)}
- Unresolved offenses may contribute to a variety of mental health issues such as depression and anxiety
- Clergy experience unique ministry and calling related offenses affecting mental health and need forgiveness, including preaching forgiveness when struggling with forgiving!

Approaches to Forgiveness
**Smedes,** 1984, seminary professor, introduced forgiveness to the populace and the therapeutic and research communities

\textit{Forgive and Forget: Healing the Hurts We Don’t Deserve}

Four Stage Forgiveness
- **Hurt:** A hurt you cannot forget creates the crisis of forgiving
- **Hate:** You remember the hurt and sometimes you want the person who hurt you to suffer like you do
- **Healing:** “Magic Eyes” to see the person in a new light
- **Coming Together:** Invite the person back into your life

**Enright,** 2001, “the Father of forgiveness research”
Forgiveness is a Choice: A Step-by-Step Process for Resolving Anger and Restoring Hope

Four Phase, Twenty Step Model
- **Uncovering** Your Anger
- **Deciding** to Forgive
- **Working** on Forgiveness
- **Discover and Release** from Emotional Prison

**Worthington**, 2001, Christian psychologist and researcher
Profound personal experience
*Forgiving and Reconciling: Bridges to Wholeness and Hope*

Five Stage Pyramid Model to REACH Forgiveness
- Recall the hurt
- Empathize
- Altruistic gift of forgiveness
- Commit Publicly to forgive
- Hold on to forgiveness

**Conner**, Luke 6:37, Account of abuse victim
Non-Judgmental Forgiveness
- Stop being the **Jury**: Reviewing the Evidence
- Stop being the **Judge**: Pronouncing Guilt
- Stop being the **Jail**: Enforcing the Verdict

Approaches to Forgiveness
A Comparison of Smedes, Enright, and Worthington
- Enright and Worthington have significant research validation
- Enright and Worthington have about the same rate of success (Dodo Effect)
- None identify the **active ingredient** (But, empathy is central in Smedes, Enright, and Worthington)
- Emphasis on psychological benefit to the person forgiving (The person you free is yourself)
• Requirement of empathy
• Acceptable to secular and religious communities

Conner
Non-Judgmental Forgiveness
• Theoretical only, no research to validate model (Incidental affirmation)
• Focus is biblical obedience, honor God through obedience vs. psychological well-being of forgiver (The active ingredient)
• Develops the biblical command (Luke 6 “Do not judge, and you will not be judged. Do not condemn, and you will not be condemned. Forgive, and you will be forgiven.)
• Does not require empathy (From a theological and personal perspective)
• Recognition of miraculous nature of forgiveness

Luke 6\textsuperscript{37} “Do not judge, and you will not be judged. Do not condemn, and you will not be condemned. Forgive, and you will be forgiven.”

Check On Learning
1. Depression, anxiety, __________, compassion fatigue, and forgiveness are 5 important mental health issues for chaplains.
2. True or False Depression is a way of describing significant but routine sadness.
3. Anxiety disorders affect A. Less than 10%; B. Not more than 20%; C. More than 25% of the population
4. Types of addiction are arousal and __________.
5. Compassion Fatigue occurs when chaplains are exposed to _________ trauma.

3.1 The Intersection of Chaplain Ministry and Mental Health Care: The Ministry of Assessment and Referral
Learning Objective: Participants will be familiar with the use of a variety Mental Health Assessment resources
Participants will be familiar with:
• The goal and practice of mental health assessment
• Mental Health Orientation (Status) Assessment
• Crisis Assessment
• Depression Assessment
• Substance Abuse Assessment
• Suicide Assessment
• Violence Assessment
• Comorbidity Assessment

**The goal and practice of mental health assessment**

Goal: Ensure appropriate care for constituents

Practice

• Screening, Assessment and Diagnosis
• Assessment and Referral
• Various Assessment Tools

Criteria for Pastoral Screening, Assessment, and Diagnosis

• **Pastoral** Screening: An effort of pastoral care providers to identify individuals with mental health concerns. If positive, it should lead to referral for assessment by mental health or medical professional.

• **Assessment:** An effort of medical or mental health care professionals to identify individuals with mental health concerns. If positive, it should lead to referral for diagnosis and treatment.

• **Diagnosis:** A professional determination by a qualified provider that an individual has a mental health disorder, it should lead to treatment order.

Pastoral Screening, Assessment, and Diagnosis

• **SIGNS:** Indicators the chaplain observes

• **SYMPTOMS:** Indicators the individual reports

• **FEATURES:** Indicators of a diagnosis present in the individual
• **DIAGNOSIS:** Formal and official determination of the presence of a mental health condition by a licensed care provider

• **KEY:** Direction of Signs and Symptoms plus Dysfunction

• **An Analogy:** A-B-C; Temperature

Settings for Assessment Administration

• Pre-Counseling Questionnaire

• Formal Administration: Written or Oral

• Informal Administration: Conversational Administration

• Administration to Associate of Individual (Spouse, Family Member, Fiancé, Friend (Formal or Informal))

Assessment and Referral Protocol: **EASIER/R**

• **E:** Explore why the person is seeking assistance

• **A:** Assess for mental health concern

• **S:** Suggest possible mental health need

• **I:** Identify resources to promote wellness

• **E:** Enlist commitment to participate in the therapeutic process

• **R:** Remind of relapse and the importance of following the process

• **R:** Refer for appropriate care

© Conner, 2015

ALERT: A: Acknowledge; L: Listen; E: Engage; R: Refer; T: Talk with MHP

https://www.uoguelph.ca/counselling/awareness/alert-0

*Explore* Questions

• What changed?

• When did it change?

• How did you know it changed?

• Why is it important to you?

• Why me?
Types of Referral
1. Personal Referral: Informal (on-site visit)
2. Personal Referral: Scheduled appointment
3. Appointment Referral to MHC Provider
4. Emergency Referral to MHC Provider
5. Secure for Emergency Responders

Mental Health Orientation Assessment
• Conscious?
• Alert?
1. Oriented to Identity, Who You Are?
2. Oriented to Place, Where You Are?
3. Oriented to Time, When You Are (Date and Time)?
4. Oriented to Activity, What You Are Doing? What Is Going On?

Crisis Assessment
• Nature: Chronic, Confusion, Chaos, Crisis
• Timing: Warning, Delayed, Immediate
• Participants: Individual, Couple, Family, Church, Organization, Community
• Diagnostic Questions:
  What has changed in the last 24 hours?
  What will change in the next 24 hours?
  What are you doing to improve the situation?

Depression Assessment
• Little interest or pleasure in doing things
• Feeling down, depressed, or hopeless
• Trouble falling or staying asleep, or sleeping too much
• Feeling tired or having little energy
• Poor appetite or overeating
• Feeling bad about yourself—or that you are a failure or have let yourself or your family down
• Trouble concentrating on things, such as reading the newspaper or watching television
• Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
• Thoughts that you would be better off dead or of hurting yourself in some way

Administration: Over last 2 weeks;
0: Not at all; 1: Several days; 2: More than half the day; 3: Nearly every day

How difficult have any of these problems made it for you to do your work, take care of things at home, or get along with others: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult

1-4: Minimal Depression; 5-14 Depression; 15-27: Severe Depression

http://www.phqscreeners.com/

**Anxiety Assessment** (Generalized Anxiety Disorder Screener (GAD-7))

Over the past 2 weeks have you been bothered by these problems?
1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritated
7. Feeling afraid as is something awful might happen.
8. If you checked any problems, how difficult have these problems made it for you to do your work, take care of your things at home, or get along with other people?

When did the symptoms begin?

Scoring 1-7: 0: Not at all; 1: Several days; 2: More days than that; 3: Nearly every day
Scoring 8: Not difficult at all; Somewhat difficult; Very difficult; Extremely difficult
0-7: None; 8+: Probable Anxiety Disorder

http://www.tbh.org/sites/default/files/Generalized_Anxiety_Disorder_Screener_GAD7.pdf

Substance Abuse and Addiction Assessment: CAGE
• Have you ever felt you should **CUT DOWN** on your drinking?
• Have people **ANNOYED** you by criticizing your drinking?
• Have you ever felt bad or **GUILTY** about your drinking (or what you do when you drinking)?
• Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**EYE-OPENER**)(or other inappropriate use)?

Scoring: 2: Clinical Significance; 1: Referral for clinical assessment

Rephrase for substance abuse or behavioral addictions


Suicide Assessment
Levels of Suicide Activity: Ideation; Behavior; Attempt

Suicidal Indicators:
• **No Hope**: No expected change in situation
• **No Help**: No one is willing, available, or capable of assisting with resolving the situation
• **No Heart**: No longer possess emotional strength to endure the situation

Suicidal Risk Factors: **S A D**
• Specific plan vs. general expression of thought
• Available
• Deadly

**Additional Concerns**: Depression, History of suicide ideation or attempt, Presence of suicide in family and associations

**ASK**: Do you plan to hurt yourself or someone else?

Are you concerned that you may hurt yourself or someone else?
Violence Assessment--Victim: HITS
How often does your partner

- Physically **Hurt** you
- **INSULT** or talk down to you
- **THREATEN** you with harm
- **SCREAM** or curse at you

*(Does your partner have access to a weapon)*

Scoring: 1: Never; 2: Rarely; 3: Sometimes; 4: Fairly Often; 5: Frequently
Score above 10 is clinically significant

http://www.orchd.com/violence/documents/HITS_eng.pdf  Kevin_sherin@doh.state.fl.us
http://www.ementalhealth.ca/index.php?m=survey&ID=18

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Violence Assessment--Offender: HITS (Modified)
How often have you:

- Physically **HURT** someone
- **INSULTED** or talk down to others
- **THREATENED** others with harm
- **SCREAMED** or curse at others
- Do you have access to a weapon

**Scoring:** 1: Never; 2: Rarely; 3: Sometimes; 4: Fairly Often; 5: Frequently

**Score above 10** is clinically significant

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Co-morbidity Assessment (The presence of more than 1 disorder or disease)

- Be aware that many suffer from a combination of physical, mental health, and spiritual problems
- Recognize that some signs and symptoms appear in different problems
- Recognize that some disorders frequently are concurrent with other disorders (substance abuse and violence, depression, or suicide)
- Conduct multiple assessments when appropriate
• Due to the complexity of comorbidity cases, assess for safety and refer promptly

Conclusion:
Every pastoral encounter may involve a Mental Health issue.
Chaplains must be able to:
• Make appropriate assessments
• Make appropriate interventions
• Make appropriate referrals
• Follow-up for pastoral care

CHECK ON LEARNING
1. A “sign” is observed by the ________ and a “symptom” is reported by the ________.
2. True or False It is unethical to conduct a mental health assessment in an informal manner.
3. A chaplain assessment and referral protocol should __________ the possibility of a mental health need.
4. Conscious and _________ are the initial elements of a mental status evaluation.
5. Symptoms of depression must last at least ___ weeks for diagnosis.
6. Assessment of suicide behavior must determine if the method is specific, __________, and deadly.

The Intersection of Chaplain Ministry and Mental Health Care:
Blessing
1 Thessalonians 5:23-24 May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ. The one who calls you is faithful and he will do it. (NIV)

Go and Serve the Lord!
Non-Judgmental Forgiveness