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Do Clergy in Hidalgo County, Texas Serve as a Bridge or Barrier to Mental Health Services?

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Do Clergy in Hidalgo County, Texas Serve as a
Bridge or Barrier to Mental Health Services?

by

John C. Park

A Thesis submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Clinical Psychology

September 2015

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABBREVIATIONS

FBO	Faith Based Organizations
HCT	Hidalgo County, Texas
IRB	Institutional Review Board
LLU	Loma Linda University
MH	Mental Health
MHP	Mental Health Professionals
NFCMH	New Freedom Commission on Mental Health
NRA	Non-Regionally Accredited
RA	Regionally Accredited
R/S	Religion/Spirituality
US	United States
USDHHS	US Department of Health and Human Services
UTPA	University of Texas Pan American
WHO	World Health Organization

ABSTRACT OF DISSERTATION

Do Clergy in Hidalgo County, Texas Serve as a Bridge or Barrier
To Mental Health Services?

by

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Doctor of Philosophy, Graduate Program of Clinical Psychology
Loma Linda University, September 2015
Dr. Johnny Ramirez-Johnson, Chairperson
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Clergy play the role of frontline mental health (MH) workers for many Americans (Ellison et al., 2006; Wang et al., 2005; Winet, Majors, & Stewart, 1979). There is insufficient information in regards to what the clergy believe about MH and how they respond to MH related concerns. What we know indicates that clergy are not sufficiently equipped or trained to respond adequately to people suffering from issues of MH. Using face to face interview process, 301 clergy members of the faith based organizations (FBO) in Hidalgo County, Texas (HCT) were interviewed. Key findings suggest that the clergy engage in significant MH intervention practices and referrals based on their ministerial duties with FBO members. The clergy reported that they were not properly trained in MH and that additional training and education would be beneficial to assist people with MH problems. The results of this study highlight the importance of providing MH training and education to the clergy and increasing collaboration among the clergy and MH professionals to strengthen the referral process. Suggestions are made for future research.

CHAPTER ONE

INTRODUCTION

Mental Health

Mental health (MH) is a fundamental aspect of a person's overall health, which encompasses factors such as social, psychological, and biological aspects of the individual. The World Health Organization (WHO) defines MH as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." Problems associated with MH are listed, but not limited, to the following: poor lifestyle habits, stress, violence, social disruption, physical health problems, poor socio-economic status, genetic and neurological disturbances, and environmental factors (WHO, 2012).

MH problems affect more than one out of three people worldwide (WHO, 2012). It has been shown that the US, when compared to other industrialized nations, has the highest rates of MH disorders (WHO, 2012). Combined, MH problems (i.e., MH disorders, substance abuse, and addictions) are the most widespread health problems in the US today and are more common than cancer, lung disease, and heart disease combined (National Council for Community Behavioral Healthcare, 2006; DeKraai et al., 2011).

Over 60 million Americans suffer from a diagnosable mood or anxiety disorder such as major depression, dysthymia, bipolar depression, or generalized anxiety disorder (Kessler et al., 2005). The US Department of Health and Human Services (USDHHS) documents that untreated MH issues have been associated with loss of productivity,

unemployment, homelessness, increase in school drop-out rate, higher suicidality, crime, violence, substance abuse, HIV/AIDS infection, sexually transmitted disease, and delinquent behaviors in adolescents (USDHHS, 2001). Moreover, it has been documented that almost 2 out of 3 individuals in the US do not seek professional MH services (WHO, 2012; Substance Abuse and Mental Health Services Administration, 2009; USDHHS, 2001; Neighbors et al., 1998). Established by President George W. Bush in 2003, the New Freedom Commission on Mental Health (NFCMH), a comprehensive study of the US mental health service delivery system, documents the disparities in treatment. This occurs because significant gaps and barriers exist which include, but are not limited to, lack of services in underserved areas, absence of information, unavailability of time, cultural and language barriers, financial cost, stigma, denial, lack of education and ignorance (NFCMH, 2003; USDHHS, 2001; DeKraai et al., 2011). It has been documented that rural communities, minority groups, individuals with MH problems and substance abuse, elderly, and at-risk youth are especially underserved in the US (NFCMH, 2003). Furthermore, the current healthcare system has disparities in benefits, accessibility, and lacks intervention services for a significant portion of the US population (NFCMH, 2003). Moreover, the annual financial burden for MH disorders which exceed 100 billion dollars over the past 20 years (USDHHS, 2001). Providing accessible MH services to those in need is vital to maintaining the health of society. Faith based organizations play a vital role in the provision of MH services.

Faith Based Organizations

Clinebell (1970): "Churches and temples collectively represent a sleeping giant, a huge potential of barely tapped resources for fostering positive mental health."

Faith based organizations (FBO) are establishments based on a particular religious belief or tradition. FBO have been widely accepted as playing a significant role in providing the space in major social events such as weddings, funerals, crises interventions, politics, social services, and providing help for the disadvantaged (Pargament, 2005; Aten et al., 2011; Djupe & Gilbert, 2009; DeKraai et al., 2011). Moreover, FBO are involved in providing the forum in the provision of services to those in need (Chaves, 2004; Wuthnow, 2004). These services encompass caring for the disadvantaged, advocacy for marginalized groups of people, and playing a role in humanitarian efforts. Guided by a distinct theology or belief system, FBO play an important role in virtually every aspect of society by advocating for people who have various needs which may be related to health, shelter, education, social support, and other basic necessities (Openshaw & Harr, 2009; DeKraai et al., 2011). Despite government agencies and other organizations taking a more prominent role in providing health and human services, FBO have continued to play a significant role in delivering valuable services to the community (Chaves, 2004; DeKraai et al., 2011).

Sternthal et al. (2012) notes that seeking MH services from FBO appears to be consistent across the major religious traditions and cultures. This is confirmed by the presence of over a million churches, temples, mosques, synagogues, and other religiously-oriented institutions which reside in virtually every neighborhood in America (Wuthnow, 2004). Based on self-reports of the importance of religion in daily life, the

Gallup Poll (2012) study, which interviewed over 320,000 Americans, documents that about 7 out of 10 Americans are “very or moderately religious.” This study further elaborates that the US is a predominant Christian nation, and the trends in religious beliefs suggest that religion is an increasingly important topic for years to come (Newport, 2012). Moreover, research has shown that about 40% of Americans attend a FBO on a regular weekly basis, and almost 90% of American adults report to praying occasionally (Gallup & Lindsay, 1999). It is evident that FBO play a major role in people’s lives as Dudley and Rozen (2001) state FBO create a “national, personal network of human services extending to virtually every community” (p. 201).

In the US, religious beliefs are the dominant coping behavior used by people who are suffering or experiencing major life events (Polson & Rogers, 2007; Koenig et al., 1998). Thus, FBO are one of the most attractive places for people to go for help and support (Pargament, 2005; Aten et al., 2011). Particularly, FBO have a long history of playing a major role in providing community MH services (Kress & Elias, 2000; Maton & Pargament, 1987; Spriggs & Slotter, 2003; Haugk, 1976; Clebsch & Jaekle, 1964; Frank, 1973; McNeill, 1951). FBO and their respective clergy provide spiritual guidance and support, social and health services, and other types of community involvement which is conducive for people who are experiencing problems (Mannon & Crawford, 1996; Pargament, et al., 2001). It has been shown that religious beliefs and active religious engagement help many people cope with their illnesses through the unique religious practices and rituals, as well as improve MH and health outcomes (Ellison et al., 2001; Mueller, Plevak, & Rummans, 2001). Thus, the involvement of FBO plays an important role in positive MH outcomes related to depression and anxiety (Koenig et al., 2001;

McCann, 1962; Clinebell, 1970); overall psychological well-being (Levin, 2001; Levin et al., 2005); improved positive coping skills when dealing with anxiety or stress (Kaplan et al., 1997; Ringdal, 1996); overall MH well-being and life satisfaction (Levin & Taylor, 1999); and the decrease of at risk behaviors and improved cognitive functioning (Bartkowski & Xu, 2007; Kendler et al., 2003).

Clergy

Clergy is a term used to describe the leadership of the FBO. The clergy have historically played a major role in the US and have been involved in social policy, political movements, and philanthropic efforts. The clergy are composed of religious leaders such as the priest, pastor, preacher, chaplain, or other religious professionals who play various roles in many religious traditions. They are involved in leading the FBO congregation in worship service, in leading the practice of the rituals and spiritual disciplines, and in being the active voice for the beliefs and standards of the respective FBO. As religious leaders, the clergy function primarily by guiding FBO members in the respective religious tradition, educating, providing information to their respective congregation, and supporting the FBO members to practice religious exercises and rituals (Koenig, 2007; Djupe & Gilbert, 2009). Moreover, they also provide their services at events such as weddings, baby dedications, crises intervention including tragedies, death, grief, bereavement, and loss, thus playing a major role in people's lives. Thus, they are respected members of their community (Spilka et al., 2003).

Clergy as MH Providers

Viewed as MH professionals, clergy play a pivotal role in the provision of MH services (i.e., individual counseling, crisis intervention, family therapy, MH referrals, and spiritual counseling) for the community (Kudlac, 1991; Levin, 1986; Bonura et al., 2001; Greenberg & Shefler, 2002; Ellison et al., 2006; Stransbury et al., 2012). Furthermore, Openshaw, and Harr (2009) report that clergy provide a variety of MH services to the community such as substance abuse counseling, counseling for prisoners, military personnel, health issues, crisis intervention, sexual identity, anger and stress management, intimate partner violence, and other MH issues. They also function as family counselors, diagnostic interviewers, assessors, therapists, and referral agents (Levin, 1986). On a weekly basis, clergy spend over 15% of their professional responsibilities on counseling and therapy, which is equivalent to approximately 138 million hours each year (Wang et al., 2006; Oppenheimer, Flannelly, & Weaver, 2004). According to Moran et al. (2005), clergy less frequently encountered MH issues related to depression, alcohol use, domestic violence, severe mental illness, HIV/AIDS, and suicide.

Being on the front line of MH services to millions of Americans, clergy are often the first to respond to crises which is more than psychiatrists, general practitioners, and medical doctors collectively encounter (Ellison et al., 2006; Wang et al., 2005; Winet, Majors, & Stewart, 1979). Approximately 40% of Americans prefer to see a clergy when dealing with a serious MH problem rather than seeing a trained or licensed MH professional due to the stigma associated with MH (Stansbury et al., 2012; Polson & Rogers, 2007; Kane & Williams, 2000; Payne, 2009; Gurin et al., 1960). Moreover,

clergy do not differ from MH professionals in regards to the types of MH encounters and severity of MH disorders and problems (Neighbors et al., 1998).

It appears that clergy involvement in MH is related to the several key factors: a trusting relationship with the clergy, accessibility, lack of financial burden, no MH stigma, and the desire to integrate religious and spiritual beliefs with MH, (Ellison et al., 2006; Wang et al., 2005; Pargament, 2005; Aten et al., 2011; Oppenheimer, Flannelly, & Weaver, 2004; Stansbury et al., 2012; O'Connor, 2003). Individuals often have a long standing relationship with clergy, which allows clergy to be able to observe any signs of MH distress and express concern. Moreover, clergy are readily available to provide help or support to the needs of the individual. When compared to MH professionals, studies document that clergy were perceived to possess higher levels of interpersonal skills such as warmth, empathy, caring, stability, listening skills and professionalism (Milstein et al., 2003). All these factors indicate that clergy act as a bridge to MH services.

What Factors Impact Clergy MH Interventions?

Previous studies document four factors which play an important role in the clergy intervention practices of MH: resources, belief system, education, and relationship with MH professionals. The next section will examine each factor specifically.

Resources

The resources that the FBO possess have been shown to play a significant role in the MH intervention practices of the clergy. According to Pipes and Ebaugh (2002), it has been documented that the majority of the financial resources of the FBO appear to

come from private donations and form the membership of the FBO, and not government funding. According to this researcher, there are few studies documenting the available resources that the FBO possess. However, the few studies have shown that available resources affect how FBO can provide services to the community. Studies show that the more available resources that the FBO possesses, the clergy will be more likely to engage in MH services such as referrals (Carson, 1990; Williams et al., 1999). In a study conducted in New Haven, Connecticut, Williams et al. (1999) showed that FBO, when they fall into the following categories, are less likely to engage in MH referrals: have FBO membership of less than 50, have annual budget of less than \$60,000, have clergy who spent less than 35 hours per week in ministry, have no paid pastoral staff and have clergy with no other paid employment. Clergy who serve in FBO state that they feel a “sense of frustration over the limited resources and the increasing number of people in need (Belcher & DeForge, 2007).”

Belief System

Clergy provide MH services to their community based on their belief system. Regardless of denominational affiliation and theological orientation, FBO in the US are involved in the provision of services to the community (Caldwell et al., 1995; Williams et al., 1999). Religious beliefs can both positively and negatively impact the referral behaviors, interventions, and practices of the clergy. Moreover, the interpretation of mental illness by the clergy may play a major role in how they may intervene for MH concerns. How the clergy conceptualizes mental illness within their spiritual and religious framework may also pose a problem in the collaboration between professional

MH services and the clergy (Leavey, 2010). According to McGuire (1988), in suburban America, beliefs of supernatural involvement in human suffering and illness are prevalent with reference to spirits, demonic possession, and other supernatural activity being common to clergy which are viewed as controversial within the medical and psychiatric communities (McGuire, 1988).

Thus, with increasing involvement of clergy in providing MH services, it is essential to understand different beliefs of the FBO in regards to MH in order to understand the FBO's capacity to provide such services (Friedli, 2000). In regards to the provision of MH services, there appears to be a wide range of views and attitudes among the clergy. Openshaw and Harr (2009) report that most clergy believe that MH services are needed and important in their line of work. Other views expressed by the clergy are people do not need MH services, people can solve their own problems, and there is only the need for love. Clergy also expressed that MH intervention is needed when the problem prevents the person from being able to function in their life (Openshaw & Harr, 2009).

Sexual Identity

In current society, people who identify themselves as homosexuals experience discrimination in society as they experience federal limitations in their rights, non-acceptance for their orientation, and cultural insensitivity (Crawford, Olson, & Deckman, 2001; Herek, 1991). The topic of homosexuality is one of the more controversial issues in religious circles (Campbell & Monson, 2008; Lewis, 2005; Boswell, 1980; Kloehn, 1999; Sanchez, 1999; Olson & Cadge, 2002; Ammerman, 2000; Cadge et al., 2012).

Recent data suggests that mainstream Christian denominations are growing more tolerant and accepting of homosexuality (Peterson & Donnenwerth, 1998).

Clergy have a major influence on the public opinion about homosexuality through their involvement in the FBO and public (Djupe & Gilbert, 2009). Clergy, in particular, remain mostly opposed to homosexuality as they remain to preserve traditional values and standards for the family (i.e., heterosexual) (Anderson 1997; Cadge 2002; Cadge and Wildeman 2008; Djupe & Gilbert 2009; Moon 2004). It has been reported that many clergy are uncertain about what they think about the issue and how they ought to approach it in their professional role (e.g., Anderson 1997; Ammerman, 2005; Dillon 1999; Moon 2004; Wood, 2000; Maloney, 2001; McNeill, 1976).

In their study, Cadge & Wildeman (2008) document that seven of ten clergy interviewed expressed uncertainty about homosexuality, either in terms of their personal beliefs, actions, or both. Furthermore, studies show that clergy experience significant professional constraints and limitations when dealing with homosexuality as they must act according to their religious traditions and beliefs and also the general attitude of their FBO congregation (Djupe et al. 2006; Moon, 2004; Olson et al. 2006; Olson & Cadge 2002). Moreover, clergy intervention practices vary by religious tradition, geographic location, and ministerial involvement, as well as their social and professional relationships, and most likely not their own personal views (Ellingson et al., 2001; Hartman, 1996).

It is documented that homosexuals are more likely to suffer from MH problems, violence, and oppression than those who are not homosexual (Wright, 2008). Some related issues are increased levels of depression, anger, anxiety, PTSD, and crime related

fears (Garnets, Herek, & Levy, 1990). Despite the changes in attitude, a significant number of FBO still have intolerant views of homosexuality and are unaccepting of their involvement in the FBO. Thus, their involvement in providing MH services to the homosexual community may not be conducive or beneficial to society at large. Moreover, there appears to be few studies about the religion and homosexuality (Anderson, 1997; Beuttler, 1999; Burgess, 1999; Cadge, 2002), but even fewer studies examine the clergy attitudes towards homosexuality (Wellman, 1999). Olson and Cadge (2012) note that more research is needed into clergy attitudes towards homosexuality and how it may impact clergy intervention practices. The authors note in their study how clergy express indecision as the common theme when it comes to issues dealing with homosexuality.

Education

Education plays an important role in clergy MH intervention practices. Clergy encounter MH problems that range in complexity and variety that warrant specialized training and education in order to provide appropriate MH services. Despite their significant involvement in MH, clergy receive very limited to no education and/or training in regards to counseling, referrals, and intervention practices (Worthington, 1986). Their education and training may be limited in that they receive specific denominationally affiliated schools and colleges, which may not be nationally accredited or recognized. Clergy were the least competent in their knowledge of psychopathology when compared to licensed psychologists, psychology graduate students, and other MH professionals (Moran et al., 2005). Some clergy have received professional training

which serves to benefit them when dealing with MH issues. Studies document that clergy feel most confident in their abilities to provide appropriate MH services when dealing with issues of grief, death and dying, anxiety, and marital problems, but they feel less competent when dealing with issues such as depression, alcohol/drugs, domestic violence, severe mental illness, HIV/AIDS, and suicide (Moran et al., 2005). The authors also note that clergy were concerned about legality issues, inadequate training, and licensure issues in regards to providing counseling. Thus clergy have reported their concern and apprehension in providing services related to MH concerns.

Pena et al. (2005) document the role of graduate education in the Hispanic community. Graduate education (i.e., seminary training, theological education, or formal training) has been shown to have a positive relationship with ministerial status, job ranking, and employment status in the Hispanic community (Pena et al., 2005). Pena et al. also note that such education is particularly valuable to address issues of “racism, poverty, and inequality (p. 17).” The authors further document how clergy note that training in MH which incorporates “listening skills, comprehensive engagement, family systems theory, family therapy, and case management process” has been shown useful for ministerial training (p. 20). Thus, graduate education appears to play an important role in the training of clergy.

Mental Health Professionals

MH professionals are defined as “health care practitioners who offers services for the purpose of improving an individual's mental health or to treat mental illness” (WHO, 2012). This broad category includes psychiatrists (D.O. or M.D.), clinical

psychologists (Psy.D or Ph.D.), clinical social workers (MSW), psychiatric nurses, mental health counselors, therapists, pharmacists, as well as many other professionals (WHO, 2012; Kramer, 1962). Furthermore, MH professionals are responsible for treating individuals specifically in regards to their MH with the purpose of relieving pain, alleviating symptoms and distress, and to help the person to function to the highest level possible (Adair et al., 2003; Bachrach, 1981). MH professionals engage in counseling that is considered “secular” which is defined as “pluralistic, and characteristic of contemporary society” (Worthington, 1986).

On the other hand, clergy and the FBO provide the person with a sense of religious community, support, and guidance in their life affairs while providing spiritual counsels in accordance to the respective faith or religion, and thus, they more frequently engage in religious counseling. It has been shown that MH professionals have the general negative, indifferent, or antagonistic view towards religion (Ellis, 1980; Walls, 1980; Shafranske & Maloney, 1990). Explicit religious therapy was viewed negatively even though over 70% of psychologists believed that spiritual issues were pertinent to therapy (Shafranske & Maloney, 1990). Many people in the field of psychology and religion have advocated for the open and collaborative relationship between the field of psychology and religion (Meylink & Gorsuch, 1986; Hubbell, 1989). However, it has been noted that only a small number of MH professionals endorse such union as they express skepticism due to the potential conflict and issues that may arise from such an alliance (Stafford, 1993). More and more, social science scholars have acknowledged integrative and collaborative MH care as an essential component of the provision of MH services. Individuals suffering from MH problems have various challenges and

difficulties. It is only through collaborative efforts and partnerships with various organizations, agencies, and professionals that the needs of these people can be met. Notably, FBO are in a unique position to attend to some of the current challenges in the MH system (DeKraai et al., 2011; Ali, Milstein, & Marzuk, 2005; Clemens, 2005).

Mental Health Referrals

Interactions and collaborative efforts of the various professionals are needed to provide appropriate MH care (Kramer, 1962). Despite the common occurrence of MH encounters, clergy appear to make few MH referrals when they feel that the MH concern is outside the scope of their competency (Mannon & Crawford, 1996; Openshaw & Harr, 2009). Studies document that only 10% of clergy make MH referrals (Taylor et al., 2000; Perlmutter, 1974; Bell et al., 1976). Moreover, there is insufficient information or research examining the specific role that clergy play in the MH referral process (Neighbors, Musick, & Williams, 1998; Ellison et al, 2006). Issues that warrant a MH referral may be related to addictions, suicidal and homicidal ideation and intent, severe depression, serious mental illness including psychosis, issues of abuse and neglect, and intimate partner violence (Openshaw & Harr, 2009). Studies have also shown that clergy have difficulty in being able to identify emotional or psychological distress, when an individual poses a danger to others, and suicidality (Domino, 1990; Weaver, 1992; 1995). When clergy refer, they most often refer to social workers and psychologists for MH concerns, and when dealing with severe issues of psychiatric or medical issues, clergy would most often refer to a psychiatrist (Lish et al., 2003).

Many factors contribute to the clergy's lack of MH referrals. First, it has been documented that clergy with advanced levels of education and liberal ideologies are more likely than those who are less educated and hold conservative ideologies to make MH referrals (Gottlieb & Olefson, 1987). Second, clergy simply lack the education and training to make appropriate MH interventions and referrals. In a nationwide survey of 2000 Protestant clergy, nearly all indicated that they would benefit from additional training in pastoral counseling with regards to MH issues (Weaver et al., 1996). Third, clergy do not feel comfortable in the MH referral process. It was reported that clergy feel most comfortable referring to MH professionals whom they have a long standing relationship with the MH professional, they respect the spiritual aspect of the individual, and identify with a similar faith tradition (Openshaw & Harr, 2009). The clergy are willing to make MH referrals, but they may lack the education, the resources, and the contact information to make such referrals (Neighbors, Musick, & Williams, 1998). Openshaw and Harr (2009) note that research examining the specific nature (i.e., time spent in referral process, knowledge of MH professionals) of the referral process is lacking in the current literature.

Collaborative efforts between the clergy and MH professionals can provide the person with beneficial MH services. Current literature documents that the majority of clergy are aware of their limitations in MH, and they express the need for collaboration (Aten et al., 2011; Belcher & DeForge, 2007; Bland, 2003; Gee et al., 2005; Kirchner et al., 2011; Kramer et al., 2006; Weaver et al., 1996). The effort in coordinating efforts in collaboration among FBO and MH agencies and professionals are limited and lacking (Gee et al., 2005). Furthermore, Openshaw, and Harr (2009) documented that clergy

desire to engage in a mutual relationship with MH professionals in which both parties would engage in the referral process and intervention practices. However, the barriers of collaboration are noted as the following: religious/doctrinal differences, inter-congregational tensions, and unwillingness to unite with secular agencies, lack of interest, financial limitations, small FBO size, instability of FBO members and clergy, and lack of support (Gee et al., 2005).

Background for Current Study

The Hidalgo County, Texas (HCT) borders Mexico and is part of the Rio Grande Valley. It is located at the southern-most tip of South Texas which lies along the northern bank of the Rio Grande which separates Mexico from the US. According to the Texas State Data Center (US Census Bureau, 2010), it estimates that the population of Rio Grande Valley is approximately 1.1 million. Approximately 99% of the population identifies with Hispanic or Latino background (US Census Bureau, 2010), and 83.1% of its population has been raised speaking a language other than English (US Census Bureau, 2010). Hidalgo County has one of the fastest growing counties in the US, and is the 8th most populated county in Texas (US Census Bureau, 2010). In 2010, the population was 774,769, which is a 35% increase from the year 2000. It is known for its involvement in agricultural production and livestock cultivation. Hidalgo County is known to have one of the highest unemployment rates in the state of Texas, as well as an underfunded county government which is not able to provide adequate healthcare programs to the people of the county. The Texas Data Center (2010) documents the median income for a household in the county as below \$25,000. The per capita income

for the country was \$9,900. Over 30% of families lived below the poverty line which includes over 45% who are under the age of 18 years. These statistics indicate that HCT is one of the poorest counties in the US. Moreover, it has been documented that there is a strong connection between religion and identity. Cultural identity, moral beliefs and religious traditions are intertwined in the fabric of the HCT population (Leon, 1982; Castañeda, 1976; Harrison, 1952).

Purpose of Study

This dissertation analyzes survey data that broadens the perspective on the role of clergy in the MH intervention practices in HCT. The study design and research questions were based on the awareness of the importance of the religious faith in HCT. The focus of this study examines the perceptions and views of the senior clergy of the FBO in this region. An analysis of the MH services and referral practices of the FBO in HCT is particularly unique in regards to this study. It is noted that HCT is a predominant Hispanic population; however, previous research documents that FBO involvement in MH care is generalizable to the broad US population (Haugk, 1976; Chaves, 2004; Aten et al., 2011). For the purposes of this investigation, the researcher attempts to understand the specific role of clergy in MH in HCT.

Hypotheses of the Study

There were four main hypotheses examined in this study as listed below. We were particularly interested in two specific areas: (1) the demographic characteristics of the FBO and clergy and its relation to the MH interventions and referral practices; and (2)

common attitudes and beliefs that the clergy and its impact on the MH intervention and referral practices.

Table 1 displays the hypotheses with the corresponding items of the survey used for the statistical analyses.

- (1) Clergy with more personal resources (years served in FBO, relationship with other MH professionals, social class of FBO, less years in age, and involved in other paid employment) are more likely to engage in MH services (counseling and referral).
- (2) Clergy who view psychiatric illness as a biological as opposed to a spiritual disorder are more likely to make MH referrals.
- (3) Clergy adherence to the belief that homosexuality is associated with a psychological disturbance contributes to less MH referrals.
- (4) Clergy with more years of formal education are more likely to engage in increased hours of MH services (counseling and referral).

Table 1

Hypotheses of the Study and the Corresponding Survey Items (Numbered in Parentheses)

Hypothesis 1

Clergy with more years of education (230), less years in age (226), not involved in other paid employment (222), and increased years in service in the particular FBO (213) are likely to engage in MH services (counseling and referrals).

Survey Items

- (213) How long have you served in this congregation? _____years
- (222) In addition to your work for this religious organization, are you engaged in other paid employment? (Y/N)
- (226) What is your date of birth? Month___ Day___ Year_____
- (230) What is the highest grade or year of school that you have completed? _____
- (2) How likely are you to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker? (6 pt Likert Scale 1=very likely to 6=not likely)
-

Hypothesis 2

Clergy who view mental illness as a biological disorder (35) are more likely to make MH referrals (2).

Survey Items

- (35) How often is mental illness caused by biological disorder? ____
- (2) How likely are you to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker? (6 pt Likert Scale 1=very likely to 6=not likely)
-

Hypothesis 3

Clergy adherence to the belief that homosexuality (45) is associated with a psychological disturbance (45) contributes to increased MH referrals (2).

Survey Items

- (45) Homosexuals are more psychologically disturbed than heterosexuals. ____
- (52) Approximately how many hours per week does this require? _____hours (hours of intervention per week)
- (2) How likely are you to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker? (6 pt Likert Scale 1=very likely to 6=not likely)
-

Hypothesis 4

Clergy with more years of formal education (230-232) are more likely to engage in increased hours (52) of MH services (counseling and referrals).

Survey Items

- (230) What is the highest grade or year of school that you have completed? _____
- (231) Where did you receive your training for ministry? _____
- (232) Degree(s) obtained, if any. _____
1. Bible School/Bible College Certificate
2. Bachelor of Science/Bachelor of Arts
3. Master of Science/Master of Arts
4. Doctorate of Philosophy
5. Honorary Doctorate
- (52) Approximately how many hours per week does this require? _____hours (hours of intervention per week)
-

CHAPTER TWO

METHOD

Participants

To gain a comprehensive picture of the clergy involvement in the MH services of HCT, the clergy were actively recruited to participate in this study which was approved by the Institutional Review Board (IRB) of Loma Linda University (LLU) and University of Texas-Pan American (UTPA). The research team was comprised of graduate and undergraduate students from the College of Health and Human Services, Department of Social Work, UTPA. Because the clergy often serve as MH alternative providers, the target population for this study was the senior clergy from all faith traditions in HCT. By combining available resources, a master list of approximately 301 properties owned FBO was compiled from the Hidalgo County, Texas Assessor's Office. All clergy were identified and invited to participate in this project through personal contacts and/or telephone calls. After the initial contact, face to face interviews were conducted. Graduate and undergraduate students from the UTPA received IRB training to perform face-to-face interviews with clergy members. Out of the 301 identified FBO, there were 245 complete interviews with the senior clergy. After data cleaning and screening, 231 total participants remained in the dataset for final analyses.

Procedure

The clergy represented many denominations of the Christians faith as shown in Table 4. Once the clergy were contacted, the research assistant would explain the purpose and procedure of the study. The participant was given a consent form that states

the confidential nature of the information. The process of maintaining confidentiality, keeping strict safety protocol and maintaining the privacy of information was thoroughly explained. Approximately 60-120 minutes were spent to complete the survey with an average of 90 minutes. The interviews were conducted primarily at the FBO of the clergy member. To account for the language diversity in the Rio Grande Valley, the interviewee was given the option to take the survey in English or Spanish. Data was collected from the senior clergy members of the originally listed 301 FBO between January and May 2009. There were 245 completed interviews for a participation rate of 81% which is notably high compared to the 60% participation rate in previous studies (Caldwell et al., 1995; Lincoln & Mamiya, 1990).

Design and Measure

Archival data originally collected in 2008 was used for this study. This study sought to replicate the interview questionnaire used by Williams et al. (1999) in his study of FBO in New Haven, Connecticut. Additional culturally contextualized questions for HCT were added to the original survey (See Appendix). The interview protocol focused on the following information: (a) types of services provided by the FBO; (b) demographic information of clergy and FBO; (c) beliefs and interventions of MH; (d) four case vignettes related to MH; (e) aspects of pastoral care; (f) contact and collaboration with other organizations; and (g) MH training and education. For the purposes of this dissertation, only the items that were related to this project were examined (See Table 1). The survey instrument also contained open ended items which were appropriately labeled and coded for statistical analyses. It was determined that

conducting personal one on one interviews using structured survey questions were the best method for data collection. It is noted that the term “clergy” denotes the recognized faith leader of the FBO, even though not all FBO may recognize this title as the appropriate classification.

Variables of Interest

Clergy were interviewed and were asked various demographic information about their respective FBO and their personal information. The following demographic information is used as the independent variables of the study. A brief one sentence description of the survey item is explained next to the variable of interest.

Clergy

1. *Years of education.* “How many years of education have you had prior to starting your ministerial position?”
 - a. Highest grade or year of school _____
2. *Type of education.* “Where did you receive your training for ministry?”
 - a. Bible School/Bible College Certificate
 - b. Bachelor of Science/Bachelor of Arts
 - c. Master of Science/Master of Arts
 - d. Doctorate of Philosophy
 - e. Honorary Doctorate
3. *Age of clergy.* “When is your date of birth?”
 - a. Month___ Day___ Year_____
4. *Years in ministry.* “How long have you served in the FBO?”
 - a. _____years

5. *Weekly hours spent in ministry.* “How many hours do you spend in ministry per week?”
- a. _____ hours
6. *Other paid employment.* “Are you involved in other paid employment?”
- a. Yes/No
7. *Mental illness as biological disorder.* “How often is mental illness caused by biological disorder?”
- a. Very Often
 b. Fairly Often
 c. Not Too Often
 d. Never
8. *Homosexuality as psychological disturbance.* “Homosexuals are more psychologically disturbed than heterosexuals.”
- a. Strongly Agree
 b. Agree
 c. Disagree
 d. Strongly Disagree
9. *Relationship with professionals.* “How familiar are you with the professionals?”
- (1-very well, 2-well, 3-little, 4-not at all)
1. ___Medical nurse
 2. ___Medical or surgical physician
 3. ___Psychiatrist
 4. ___Psychologist
 5. ___Social worker who does counseling
 6. ___Psychiatric nurse
 7. ___Another minister
 8. ___Institutional chaplain
 9. ___Pastoral counselor
 10. ___Hospital emergency room
 11. ___Other hospitals
 12. ___Other mental health agency
 13. ___Other mental health professional
 14. ___Congregation-related professional

- 15. ___Folk medicine practitioner
- 16. ___Herbal Medicine
- 17. ___Alternative medicine

Faith Based Organizations

- 1. *Years FBO in community.* “How long has the FBO served in the community?”
 - a. _____years
- 2. *FBO membership.* “How many people are members of the FBO?”
 - a. _____people
- 3. *Social class of FBO members.* “What socioeconomic class do the majority of the FBO members identify with?”
 - a. Poor
 - b. Working class
 - c. Middle class
- 4. *Annual budget.* “What is the annual budget of the FBO?”
 - a. _____ approximate dollars
- 5. *Paid pastoral staff.* “What is the number of the staff who have a paid position in the FBO?”
 - a. _____people

Clergy were asked about the intervention and referral practices they engaged in when dealing with MH issues. The following demographic variables were used as the dependent variables of the study. Clergy were interviewed and asked questions regarding MH problems, including marital distress, family disturbance, severe psychiatric

problems, and depression. Clergy responded in regards to intervention (spiritual, psychological, or both) and likelihood of making MH referrals.

Intervention and Referral Practices

1. *Intervention practices.* “What are the MH intervention practices that the clergy engage in?” (spiritual, psychological, or both)
2. *Hours of intervention.* “What are the numbers of hour per week that the clergy engages in MH interventions?” (_____ hours)
3. *MH referral.* “Are the clergy likely to make a MH referral?” (Yes/No)

CHAPTER THREE

RESULTS

Statistical Analyses

A power analysis using G*Power 3.1.4 (Erdfelder, Faul, & Buchner, 1996) revealed an achieved power of .91, $ES = 0.5$, $\alpha = .05$. One way ANOVA, t tests, and simple linear regression were used on composite scores for hypothesis testing. For statistical analyses, composite scores and subscales were used for hypothesis testing. Data were analyzed using SPSS version 20.0.

Participants

By combining available resources, a master list of approximately 301 properties owned by FBOs in the Hidalgo County, Texas Assessor's Office was created. All clergy were identified and invited to participate in this project through personal contacts and/or telephone calls. After the initial contact, face to face interviews were conducted. Out of the 301 identified FBO, there were 245 complete interviews with the senior clergy. After data cleaning and screening, 231 total participants remained in the dataset for final analyses.

Descriptive Analyses

A series of descriptive analyses were conducted to gain a comprehensive picture of the demographic characteristics of the clergy and the MH intervention practices of the clergy in HCT. Tables 2 and 3 display the demographic characteristics of the clergy and FBO. Frequency tables and descriptive statistics were examined looking at the type of

MH encounters, perception of the etiology of mental illness, the clergy counseling and referral making practices, attitudes toward MH, and how education impacted these factors.

Clergy were asked about the various MH issues that they encountered on a regular basis. According to the data analysis, the three most frequently encountered MH concerns by clergy are adolescent problems, marriage and family disturbance, and religious/spiritual issues (see Table 5). More than 65% of clergy (138/211) interviewed report to have personally counseled suicidal individuals. More than 56% of clergy (118/208) interviewed report to have personally counseled dangerous individuals. Clergy reported that the most common problem that they encountered were marriage/family problems which are similar to results of previous research conducted by Leavey (2010).

The descriptive information of the clergy and their MH encounters provides a picture in the role they play in MH. Analysis shows that 99% of MH encounters appear to be voluntary and initiated by the individual and not clergy. Less than 1% of clergy charge a fee, and 3.6% of clergy ask for a donation. About 81% report to being involved in counseling people from other religious traditions. Furthermore, a comparative analysis was conducted examining the demographic differences between Catholic and Christian clergy. Although statistical significance was not found ($p > .05$), notable differences were seen in the following areas: likelihood of making MH referral, annual budget of FBO, education level, and paid pastoral staff. Catholic clergy were more likely to make MH referrals, had higher FBO annual budget (\$408,471 compared to \$189,801 for Christian FBO), had higher level of graduate education (62.5%) compared to Christian clergy (23.6%), and had more paid pastoral staff (6.5) compared to Christian clergy (3.1).

Table 2

Demographic characteristic of Clergy of FBO in HCT (N = 231)

Characteristics	N	%	M	SD	R
Age	174	75.6	53.61	6.7	24-90
24-29 years	5	2.1			
30-45 years	43	19			
46-64 years	92	39.8			
65 + years	34	14.7			
Gender	80	34.6			
Male	46	19.9			
Female	34	14.7			
Race/Ethnicity					
White/Caucasian	62	26.8			
Latino/Hispanic	132	57.1			
American/Indian	6	2.4			
Other	3	1.2			
Missing	29	12.5			
Years served in FBO	197	85.3	10.4	9.7	0-60
Other paid employment					
Yes	46	19.9			
No	144	62.2			
Education					
High School	24	11.7			
Certificate (NRA)	86	37.2			
College (RA)	29	12.6			
Graduate (RA)	51	22.1			
Missing	38	16.4			

Note. Other = racial/ethnic background not represented by given choices. All participants of study were senior clergy member of their respective FBO. NRA denotes non-regionally accredited post secondary education. RA denotes regionally accredited post secondary education.

Table 3

Demographic Information for Faith Based Organizations

	<i>N</i>	<i>%</i>	<i>M</i>	<i>SD</i>	<i>Range</i>
Membership	199	86.1	375.90	1422	2-15,000
Annual Budget	111	48.1	203,598	325,730	0-2,500,000
Social Class					
Poor	27	11.6			
Working	88	37.8			
Middle	80	34.3			
Religious Affiliation					
Protestant	161	69.1			
Catholic	16	6.4			
Muslim	1	0.4			

Note. All participants of the study were senior clergy member of their respective FBO.

In HCT, the majority of the population (33.5%) are members of the Roman Apostolic Catholic Church, though only 16 clergy (6.5%) oversaw this population (see Table 4). Table 4 is the self-assigned religious affiliation of the senior clergy.

Table 4

Senior Clergy Assigned Religious Affiliation of FBO in HCT

Denomination	<i>N</i>	%	Membership Size (<i>N</i>)	Total %
Christian	72	29.4	14,907	20.6
Non-denominational	30	12.2	4,025	5.6
Pentecostal	35	14.3	4,284	5.9
Baptist	25	10.2	7,075	9.8
Catholic	16	6.5	38,660	33.5
Muslim	1	0.4	NR	NR
Not Reported	66	26.9	3,300	4.6

Note. NR=Not Reported. According to *The Catholic Directory (2013)*, there are 51 listed Catholic churches in Hidalgo County.

Clergy were asked the types of MH problems they most often encountered on a regular basis in their counseling practices. Table 5 represents what was most commonly reported by clergy. The most common MH problems that clergy reported were in regards to adolescent problems and marriage/family problems.

Table 5

Frequency of MH Encounters Clergy Report

MH Concerns	Very Often	Fairly Often	Not Too Often	Never
Adolescent Problems	31.3	40.4	26.9	1.4
Suicide	1.6	9.7	67.6	20.8
Mid-life Problems	12.6	38.8	37.4	11.2
Elderly Problems	9.8	36.1	39.0	15.1
Death/Dying	8.3	35.4	48.1	8.3
Grief	22.3	41.7	30.6	5.3
Physical Illness/AIDS	12.7	32.2	38.5	16.6
Domestic Violence	5.3	24.8	59.2	10.7
Sexual Problems/Abuse	3.9	13.0	59.9	23.2
Marital/Family Problems	38.6	42.0	15.0	4.3
Unemployment/Work Related	12.7	29.3	49.3	8.8
Mental Illness	3.6	11.2	63.5	21.8
Alcohol/Drug Addiction	13.1	31.1	46.6	9.2
Religious/Spiritual Problems	53.7	37.1	6.8	2.4
Life Crises	12.9	38.3	40.3	8.5
Teenage Pregnancy/Motherhood	4.4	19.9	56.8	18.9
Gangs/Violence/Criminal Activity	4.9	15.1	51.7	28.3
Premarital Counseling	17.1	39.0	35.6	8.3
Financial/Economic/Poverty	20.0	39.0	30.7	10.2
Child Abuse/Sexual Abuse	3.9	9.2	52.9	34.0
Hunger/Homelessness	12.2	26.3	49.8	11.7
Religious Organization/Funding	23.1	25.1	35.4	16.4
Legal/Immigration Status	8.6	13.1	32.7	28.2
Traditions and Cultural Values	5.3	19.2	37.1	21.2
Racism/Discrimination	3.0	6.9	53.2	36.9
Access to Health Care	7.5	18.6	46.2	27.6

Note: Scores are based on a 4 point scale (1 = very often, 2 = fairly often, 3 = not too often, 4 = never).

It has been documented that clergy have many views in regards to their belief in the etiology of mental illness. Table 6 displays the clergy perception for the cause of mental illness. The response choices are the following: biological disorder, unconfessed sin, unhealthy early family relationship, not being in a right relationship with God, widespread social forces, stunted spiritual growth, and stress in living. The clergy in HCT appear to recognize the different perspectives of MH. Clergy report that the two most significant causes of mental illness are related to *stress in living* and *unhealthy early family relationships*. Biological causes were ranked as fourth whereas *not being in a right relationship with God* was ranked third.

Table 6

Clergy Perception for the Cause of Mental Illness

Causes	<i>N</i>	<i>M</i>	<i>SD</i>
Biological disorder	212	2.18	.75
Unconfessed sin	211	2.26	.95
Unhealthy early family relationships	210	1.89	.86
Not being in a right relationship with God	215	2.09	1.04
Widespread social forces	212	2.47	.86
Stunted spiritual growth	211	2.23	.96
Stress in living	218	1.83	.75

Note. Scores are based on a 4 point scale (1=very often, 2=fairly often, 3=not too often, 4=never).

Clergy who received higher education were more likely to have tolerant and mainstream views of MH and engage in more MH intervention practices (refer to Table 7). Those with masters or doctorate level degrees recognized the biological nature of MH conditions more than all the other education levels (i.e., high school, college, or certificate).

Table 7

Percent of Clergy Beliefs for the Etiology of Mental Illness Based on Education Level

Causes	HS	Cert	College	Grad
Biological disorder	.17	.20	.07	.28
Unconfessed sin	.17	.32	.31	.09
Unhealthy family relationships	.44	.43	.30	.38
Not right relationship with God	.52	.39	.41	.25
Widespread social forces	.17	.13	.12	.16
Stunted spiritual growth	.17	.34	.20	.21
Stress in living	.38	.42	.31	.35

Note. Based on clergy who answered "Very Often" to these survey items. (HS = High School, Cert = Certificate, and Grad = Graduate).

The clergy intervention practices were examined to understand how many contacts the clergy were making, how much time they spent, and the type of interaction they had with the individuals. On average clergy made three contacts per week, and spent over seven hours of counseling/therapy per week. Sixty percent of clergy reported

they had encountered substance abuse problems. Table 8 displays the demographic characteristics of the MH intervention practices of the clergy.

Table 8

Demographic Characteristics of MH Intervention Practices of the Clergy

Intervention	Range	<i>M</i>	<i>SD</i>
Contacts made in week	0-15	3.00	1.02
Hours spent per week	0-40	7.48	7.18
How often met with counselee (in a month)	1-5	3.27	1.30
Duration of counseling sessions (in hours)	.25-2	1.50	.51
Length of time (in months) spent with clergy	0-24	6.00	5.01

Clergy appear to engage in various spiritual practices in their encounters with MH problems. Out of the many spiritual practices, prayer appears to be the most dominant spiritual intervention practice (i.e., attend FBO, scripture reading, prayer, meditation, exorcism, confession, faith healing, other rituals, oil anointing, laying on hands, and fasting) in which 89.5% of clergy report to engaging in with MH concerns. In regards to severe MH problems, clergy engage in spiritual practices at least 50% of the time.

Clergy were also asked in regards to their comfort level and likelihood of making MH referrals. They were asked how comfortable they would be in making a MH referral to a professional. Clergy were also asked about their likelihood of making an actual referral. The referral process was examined in regards to the types of MH problems and

the clergy characteristics. Over 51% reported being comfortable with the MH referral process, while 42.9% reported being uncomfortable. Clergy reported that they were most comfortable with the following MH professionals: psychologists, another ministers, and pastoral counselors. Clergy were least comfortable with the following: herbal medicine doctors, alternative medicine doctors, psychiatric nurses, psychiatrists, and surgeons.

Attitude and Beliefs of Mental Health

Clergy were asked about their perception and beliefs of mental illness and religion. A majority of clergy believed that they could recognize an individual with a serious MH problem. Only 10% of the clergy interviewed chose the following response: *Psychological problems can be dealt with in the same way as spiritual problems, and no additional training is required.* Overall, most clergy favor a biomedical understanding of mental illness. About 79% of clergy either disagree or strongly disagree that most people suffering from anxiety or depression can cure themselves. The survey items #43, 44, and 45 specifically addressed issues related to inpatient psychiatric hospitalization, self-cure of depression, anxiety, and homosexuality. Table 9 displays the mean and standard deviations of these survey items. The results suggest that among issues related to psychiatric hospitalization, mood disorders, and homosexuality, clergy viewed homosexuals as having more disturbance when compared to the other issues.

Table 9

Attitudes of Mental Health: Survey Items 43, 44, and 45

Survey Items	<i>N</i>	<i>M</i>	<i>SD</i>
43. People who have been in a psychiatric hospital are more dangerous to society than the general population.	216	2.51	.80
44. If they put their minds to it, most people suffering from severe anxiety or depression can cure themselves.	220	2.94	.81
45. Homosexuals are more psychologically disturbed than heterosexuals.	211	2.45	.90

Note. Scores are based on a 4 point scale (1 = very often, 2 = fairly often, 3 = not too often, 4 = never).

Hypothesis Testing

Statistical analyses were conducted for each mental health service outcome with clergy factors (personal resources, attitudes and beliefs, and education). Results are displayed in Tables 10 through 14. According to the results, significance was found only in the education level of the clergy and mental health services provided. Personal resources, attitudes and beliefs did not show significance with MH practices.

Hypothesis One

Clergy with more personal resources (years served in FBO, social class of FBO, less years in age, and not involved in other paid employment) will be more likely to engage in MH services (counseling and referral).

Results showed that there were no significant differences for the number of years served in FBO ($p > .05$), social class of FBO ($p > .05$), less years in age ($p > .05$), or not being involved in other paid employment ($p > .05$). However, significance was found for clergy who reported having more relationships with other MH professionals and engaging in MH services. Results revealed that those who knew mental health professional were significantly more likely to refer their members to MH professionals for MH services than those who did not ($U = 2221.0$, $p = .001$).

Hypothesis Two

Clergy who view psychiatric illness as a biological as opposed to a spiritual disorder are more likely to make MH referrals.

Clergy attitudes towards MH issues were analyzed using Mann Whitney U tests for the second hypothesis. Results revealed that there were no significant differences between how clergy perceived the etiology of psychiatric illnesses and their referral practices ($p > .05$). We also examined clergy attitudes toward various mental health issues and found no significance between clergy attitudes and referral practices.

Hypothesis Three

Clergy adherence to the belief that homosexuality is associated with a psychological disturbance contributes to fewer MH referrals.

The third hypothesis was in regards to clergy beliefs in regards to homosexuality. Analysis revealed no significant differences in beliefs regarding the etiology or treatment of homosexuality. Clergy adherence to the belief that homosexuality is associated with

psychological disturbance was not found ($p > .05$); further, clergy unwillingness to make MH referrals due to biases toward homosexuality was not found ($p > .05$).

Further examination of the education level of clergy and how it impacted attitudes toward homosexuality revealed significant findings. Significant differences were found between the certificate and graduate education level groups and their beliefs regarding homosexuality ($p < .02$). Analysis revealed that the graduate level group believed that homosexuality was less associated with psychological disturbance when compared to the certificate level group as displayed in Table 10 below.

Table 10

ANOVA for Clergy Education Level and Beliefs of Homosexuality

	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>Sig.</i>
Between Groups	7.501	3	2.500	3.323	.021
Within Groups	130.909	174	.752		
Total	138.410	177			

Post hoc analyses using Bonferroni Pairwise comparisons showed significant differences between graduate and certificate level of education in beliefs toward homosexuality being due to psychological disturbance (see Table 11).

Table 11

Multiple Comparisons for Clergy Education Level and Beliefs of Homosexuality

Education	Level	MD	SE	Sig.	95% CI	
					Lower	Upper
High School	Certificate	-.056	.196	1.000	-.58	.47
	College	.015	.243	1.000	-.63	.66
	Graduate	.428	.211	.266	-.14	.99
Certificate	High School	.056	.196	1.000	-.47	.58
	College	.071	.199	1.000	-.46	.60
	Graduate	.483*	.159	.016	.06	.91
College	High School	-.015	.243	1.000	-.66	.63
	Certificate	-.071	.199	1.000	-.60	.46
	Graduate	.413	.214	.333	-.16	.98
Graduate	High School	-.428	.211	.266	-.99	.14
	Certificate	-.483*	.159	.016	-.91	-.06
	College	-.413	.214	.333	-.98	.16

Note. *The mean difference is significant at the 0.05 level. Certificate denotes non-regionally accredited post secondary education. College and Graduate denotes regionally accredited post secondary education.

Hypothesis Four

Clergy with more years of formal education are more likely to engage in increased hours of MH services (i.e., counseling and MH referrals).

The fourth hypothesis was in regards to clergy education level and likelihood of engaging in MH services. First, a correlation matrix was created to test for relationships between variables of interest (education level) might impact MH services (counseling and referral) (see Table 12).

Education level was distinguished into four groups: high school, certificate, college, and graduate. Each denotes the highest level of education received by the clergy. As previously mentioned, the certificate group entails clergy who attained education or training specifically geared towards their ministerial position at a non-accredited or independent Christian Bible schools.

Table 12

Correlation Matrix of the Variables of Interest: Education Level, Likelihood of MH Referral, How Often You Refer, and Referred Elsewhere

	Education	Likelihood of MH Referral	How Often You Refer	Referred Elsewhere
Education	--			
Likelihood of MH Referral	-.234**	--		
How Often You Refer	-.294**	-.304**	--	
Referred Elsewhere	-.155*	-.252**	-.355**	--

**Significant at 0.05 level (2-tailed). **Correlation is significant at the 0.01 level*

All correlations were highly significant. One way ANOVAs were then conducted. Analyses revealed that clergy with more years of formal education were more likely to engage in increased hours of MH services ($p = .009$) (see Table 13). There were four main levels of education: high school, certificate, college, and graduate. A post hoc analysis using Bonferroni Pairwise comparisons revealed that significance was found between clergy who possessed a certificate degree when compared to those who had

graduate degrees (see Table 14). Post hoc analysis also revealed that clergy who possessed a certificate were the least comfortable with MH referrals when compared to clergy with other educational backgrounds. Figure 1 also displays this relationship. However, clergy with certificates were engaged in counseling practices at similar levels as those with graduate degrees.

Table 13

ANOVA for How Good of an Idea is it to Refer Members of FBO to MH Professionals?

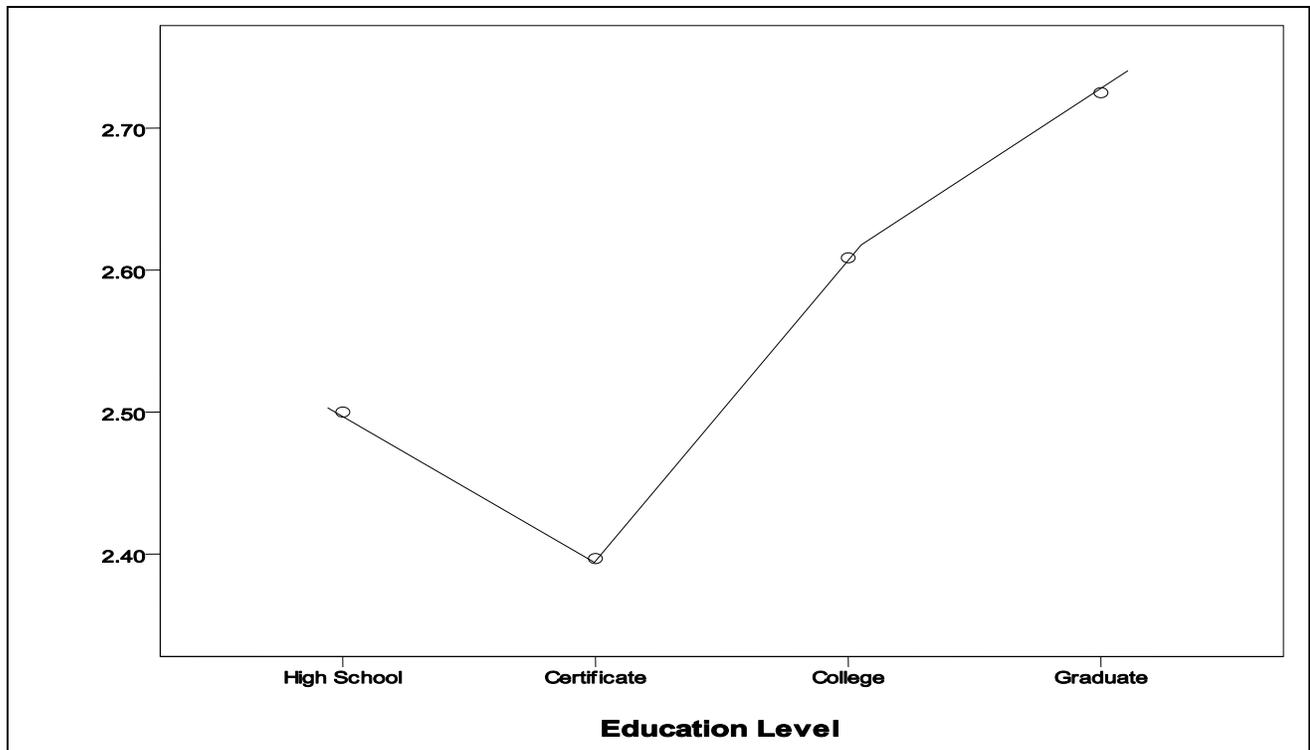
	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>Sig.</i>
Between Groups	12.552	3	4.184	3.975	.009
Within Groups	186.310	177	1.053		
Total	198.862	180			

Table 14

Post Hoc Comparison Scores of the Types of Education and MH Referral Practices of the Clergy

Education	Level	MD	SE	Sig.	95% CI	
					Lower	Upper
High School	Certificate	-.032	.239	1.00	-.67	.61
	College	.208	.288	1.00	-.56	.98
	Graduate	.581	.254	.14	-.10	1.26
Certificate	High School	.032	.239	1.00	-.61	.67
	College	.241	.229	1.00	-.37	.85
	Graduate	.613*	.184	.006	.12	1.10
College	High School	-.208	.288	1.00	-.98	.56
	Certificate	-.241	.229	1.00	-.85	.37
	Graduate	.373	.244	.773	-.28	1.02
Graduate	High School	-.581	.254	.140	-1.26	.10
	Certificate	-.613*	.184	.006	-1.10	.12
	College	-.373	.244	.773	-1.02	.28

**The mean difference is significant at the 0.05 level. Certificate denotes non-regionally accredited post secondary education. College and Graduate denotes regionally accredited post secondary education.*



Further analyses were conducted with the case vignettes. The four case vignettes from the survey addressed the following topics of MH: marital disturbance, adolescent behavioral problems, schizophrenic presentation, and postpartum depression. Descriptive analyses and one-way ANOVAs were performed to examine the education groups and their MH practices. There were no significant differences found between education level and the variables tested in any of the four case vignettes in regards to clergy intervention practices ($p > .05$).

CHAPTER FOUR

DISCUSSION

This dissertation is the first empirical study performed in the Hidalgo County, Texas (HCT) to capture the role of the faith based organizations (FBO) and the respective clergy in examining their attitudes, beliefs, and intervention practices of mental health (MH). The results of this research confirm that FBO provide services to their communities in the US to meet their spiritual, cultural, social, and MH needs (Ammerman, 1997; Warner & Wittner, 1998; Ebaugh & Chavetz, 2000; Nesbitt, 2001; Cnaan, 2002; Mata, 1999; Slessarev-Jamir, 2003). Furthermore, this investigation confirms that education plays a significant role in clergy MH interventions as it increases clergy understanding and competency in understanding MH. The following thesis statement (as shown in Table 15) is substantiated from this research: *Education makes a difference in the understanding of MH conditions and referrals, and views of homosexuality for clergy in HCT.*

Education

Education was the single factor in the study that showed a significant positive relationship with clergy practices and attitudes toward mental health. Clergy with graduate education (regionally accredited masters or doctorate level) recognized the biological nature of MH more than all the other education levels (i.e., high school, college, or certificate). Furthermore, clergy with graduate level education were more likely to engage in MH referrals than those who received less education. These results were similar to the Williams et al. (1999) study in which African American clergy in

New Haven, Connecticut with less education were less likely to engage in the MH referral process. Furthermore, Thomas (2011), in his study, documented how academic education was the strongest positive indicator of collaborative practice with MH professionals. This investigation confirms that education plays a significant role in collaborative MH practice as documented in other studies (Mathews, 2011; Pena, Hernandez, & Mauldin, 2005) (see Table 15).

Table 15

Thesis Statement: Education (231, 232) makes a difference in the understanding of MH conditions and referrals (2) and views of homosexuality (45) for clergy in HCT.

(231) Where did you receive your training for ministry? _____

(232) Degree(s) obtained, if any. _____

- a. High School
- b. Bible School/Bible College Certificate (NRA)
- c. Bachelor of Science/Bachelor of Arts (RA)
- d. Master of Science/Master of Arts/Doctorate of Philosophy (RA)

(45) Homosexuals are more psychologically disturbed than heterosexuals.

(4 pt Likert Scale: 1 = Very Often to 4 = Never)

(2) How likely are you to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker?

(4 pt Likert Scale: 1 = Very Likely to 4 = Not Likely)

Note. NRA denotes non-regionally accredited post secondary education. RA denotes regionally accredited post secondary education.

Clergy with non-regionally accredited (NRA) certificate education ($n = 86$) were the least comfortable with MH referrals, made the least MH referrals, and engaged in the fewest MH services when compared to other education level and/or types of education.

The certificate education does not meet regional accreditation standards and entails specific training from the local church or denomination which may adhere to strict biblical training in accordance to the religious tradition. Thus, they hold views of MH that are inconsistent with current attitudes and beliefs of MH or may not address MH issues. These schools may generally avoid literature or sources that are secular or scientific in nature. The specific nature of this education is unknown, but our study reveals that the certificate education group held to less tolerant views of MH compared to other education levels. This study suggests the importance of clergy receiving a regionally accredited (RA) graduate education and/or ministerial training as opposed to independent schools which are not regionally accredited.

Homosexuality

RA graduate education plays a significant role in the development of the belief system of the clergy in regards to the topic of homosexuality. Clergy with this type of graduate education had the lowest level of belief that homosexuality was associated with psychological disturbance, whereas clergy with NRA education had the highest level. This may be due to the fact that RA graduate education seeks to provide a scholarly, scientific based approach to knowledge and instruction. Moreover, such education increases clergy's interaction and development of relationships with many different professionals, as well as providing resources which may be valuable to their ministerial encounters. NRA education, as stated previously, focuses on a single framework that excludes other belief system that are considered "unbiblical." Thus, it may be plausible that clergy with NRA education may accept homosexuals into their congregation with the

purpose of modifying their lifestyle. RA graduate education may play a role in clergy possessing more diverse views of homosexuality. Thus, RA graduate education promotes clergy to function as more inclusive religious/spiritual leaders in their community.

Mental Health Referrals

RA graduate education increases clergy's ability to identify someone with MH problems and be able to provide the appropriate MH interventions. Clergy with RA graduate education were more comfortable and more likely to engage in MH referrals compared to the NRA education groups. As stated previously, clergy who receive RA graduate education receive a more comprehensive training of ministry which more likely than not, includes a minimum of one class in pastoral counseling which introduces MH theories and lexicon. Moreover, they may have more exposure and experience in the field of ministry than those who do not receive such education. Yet in spite of their significant involvement in the MH process, overall, clergy engaged in minimal MH referral practices (less than 10%). When they did engage in the MH referral process, the referrals were mostly to other religious professionals and not MH professionals. Of the licensed MH professionals, the most referrals were made to the licensed social workers.

However, when confronted with MH concerns such as severe mental illness or schizophrenia, almost all clergy, regardless of education, stated that they would make a referral to a MH professional. In this study, about 50% of clergy reported making an actual MH referral when it was deemed necessary, while 41.3% of clergy reported never making a MH referral (survey item #59). This may be due to the fact that, as Neighbors et al. (1998) note, clergy may not be able to identify the symptoms and consequences of

the MH conditions (i.e., depression, schizophrenia, anxiety, or mood disorders), or that their inclination to treatment is directed to a religious/spiritual interpretation.

Barriers

Barriers exist that hinder FBO and clergy from engaging in effective MH interventions. First, there exist differences between the disciplines of religion and MH. Studies document widespread skepticism and prejudice against religion and FBO involvement in MH services, and minimal support in integration and collaboration among religious and MH professionals (Koenig, 1988; 2007). Clergy are generally not perceived by MH professionals as partners in healing but rather with distrust despite their widespread historical involvement in healing and healthcare (Koenig, 1988; Leavy, Loewenthal, & King, 2007). Second, it was reported that financial limitations restrict the FBO to provide services to the community, as well as the education for clergy. This may be a major factor into why the majority of clergy in HCT do not receive RA graduate education but rather NRA education. Thus, RA graduate education may be viewed as more of a privilege than a necessity for their ministerial training.

In light of these barriers, this study highlights the importance of collaboration between clergy and MH professionals as have other studies confirming positive associations between religion, FBO involvement, and an individual's MH (Koenig et al., 2001). Studies have documented empirical evidence supporting the positive relationship between religiosity on mental health (Hill & Pargament, 2003; Koenig & Larson, 1998; Koenig et al., 2001). Religious beliefs and practices have been shown to provide individuals with resources for coping and dealing with MH issues (Koenig, 2008).

The United States-Mexico Border Health Commission (2009), a national government health initiative study, examines the public health assessment of the United States-Mexico border region. The health commission outlines the border healthcare issues as the following: access to care, cancer, diabetes mellitus, environmental health, HIV/AIDS, immunization and infectious diseases, injury prevention, maternal, infant and child health, MH, oral health, and respiratory diseases (The United States-Mexico Border Health Commission, 2009). This study documents that the MH and health needs of HCT are not sufficiently met due to the reduction in the federal government's role in supporting the provision of social and human service programs, as well as the lack of integration and involvement of FBO in the provision of these services (The United States-Mexico Border Health Commission, 2009). Thus, there exists the need for non-governmental organizations, such as FBO, to play a greater role in the provision of these needed services to meet the unmet MH needs of society (Warner & Jahnke, 2003; Ebaugh, Chafetz, & Pipes, 2003; Chaves, 2004; Adams & Stark, 1988; Netting, Thibault, & Ellor, 1988).

Collaboration

Collaboration between MH professionals and clergy continue to be minimal. Studies have found that clergy in FBO report very little interaction with MH professionals (Blank et al., 2002; Thomas, 2011). McMinn et al. (2005) also document a lack of willingness of MH professionals to interact with clergy. However, because of the significant contribution of clergy in MH services, MH professionals could benefit from collaborative relationships with clergy. The following obstacles have been documented

in collaboration between MH professionals and clergy: lack of trust, communication, educational awareness, lack of teamwork, and power struggles (Abramson & Mizrahi, 1996; Badger et al., 1997; McMinn et al., 2003). Moreover, McMinn et al. (2005) demonstrated that the most important factor in the clergy-MH professional referral pattern is shared values between the individuals. A model for collaboration between clergy and MH professionals is encouraged in the following section.

Model for Collaboration

A collaborative response from the various MH professionals and agencies may prove to be most effective in serving the MH needs of the community of HCT. The assets and resources of FBO (i.e., availability, space, support, social services, programs, and activities) may prove to be a bridge to MH services for a portion of the US population. FBO have the capacity to engage individuals and groups to form partnerships as they have the physical presence in the community for holding meetings and programs.

To facilitate collaboration, a model is provided for clergy to become active partners in MH as it may provide guidance in understanding the resources of the FBO and how clergy can utilize these resources. The framework for this proposal is based on the established models of Bronfenbrenner's (1979) and DeKraai et al. (2011). Figure 2 describes the aspects of this model.

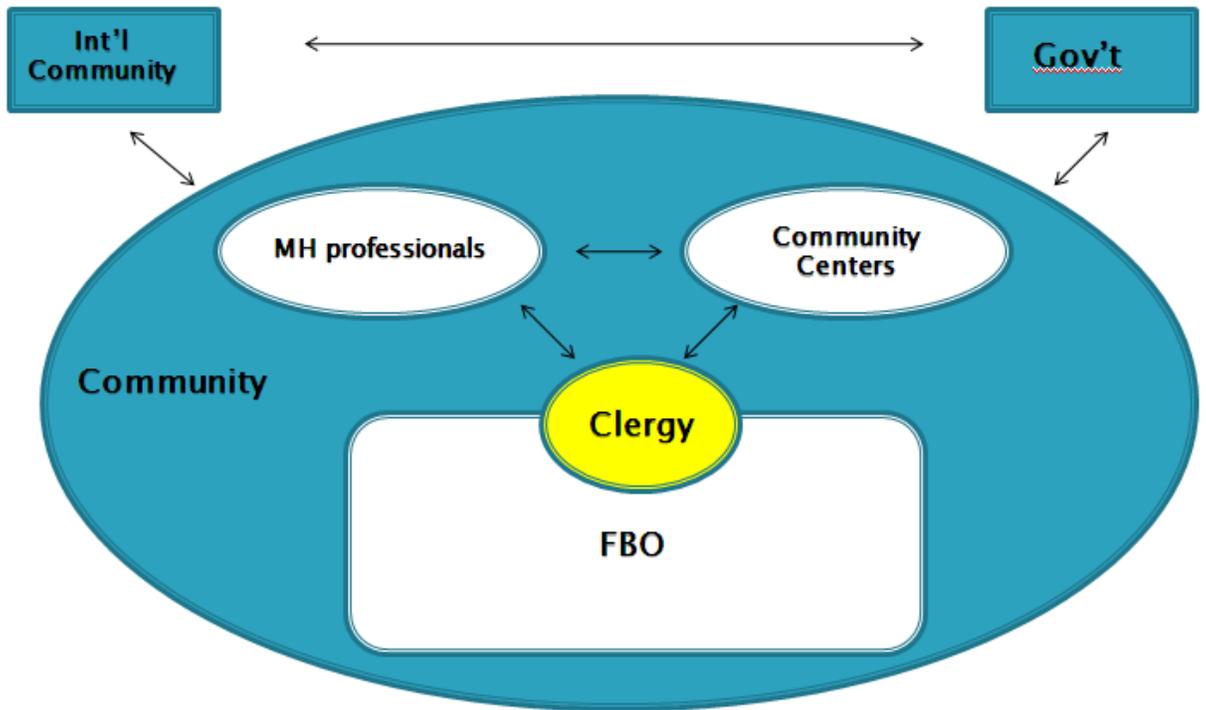


Figure 2. *Model for Sharing Resources and Collaboration Between Clergy and MH Professionals*

First, the contribution of FBO in MH services is essential for the health of the community. This recognizes the importance of FBO and their active participation in the community. FBO are not only religious and spiritual agencies, but they touch the biopsychosocial aspects of human lives.

The second component focuses on resources that FBO possess. FBO provide services, activities, and resources such as shelters, pantries, social support, and programs. The following suggestions are made: incorporating a ministry specifically geared towards MH concerns (i.e., small groups, mentoring relationships, marital counseling, divorce relationships, and recovery groups), providing education seminars led by MH

professionals, and making available resources and brochures to the communities that they are a part of. FBO may also benefit greatly by implementing a counseling service within the FBO or hiring a case manager to make appropriate referrals. Clergy may also benefit from understanding the role that medications play in MH especially in regards to proper medical care and compliance to pharmacotropic regimen. This may require concentrated leadership on the part of the clergy to develop such a culture and awareness of MH needs (Bland, 2003).

Third, facilitating communication, dialogue, and collaboration between FBO and MH professionals is vital in the provision of MH services. It is encouraged that clergy and MH professionals interact in conferences, interfaith meetings, and initiate seminars with the purpose of building professional partnerships. FBO can also provide opportunities for MH professionals to be involved in seminars to address MH issues, advising the FBO leadership in important policies and procedures related to MH, and providing professional insight into MH issues, interventions, and crises (McMinn at al., 2001; McMinn & Phillips, 2001; Bland, 2003).

It is also encouraged that clergy engage with MH professionals in developing an inclusive language and conceptualization of MH in their interactions with MH concerns. By integrating religious and spiritual concepts with physical and MH concepts, this may help to facilitate a beneficial MH treatment approach to assist individuals with MH concerns as well as MH collaborative efforts by both clergy and MH professionals (Hill & Pargament, 2008). It is encouraged, as shown in Tables 16 and 17, that a shared language be developed in regards to MH concerns and coping skills.

Table 16

Examples of Developing Shared Language for MH Concerns.

MH Problem	Religious View	Shared Language
MH opposed to R/S	“Only God can help”	“God can work with MHP also”
MH problems	“Separation from God”	“Also contributes to biological problems”
MH referrals	“God is enough”	“God has used and still can use MHP”
Medication compliance	“Pills are of the devil”	“Blessing from God”

Note. R/S denotes religion/spirituality. MHP denotes MH Professionals.

Table 17

Examples of Integrative Language for R/S Exercises and MH Terminology.

Religious/Spiritual	MH Terminology
Prayer	Meditation, imagery
Confession, forgiveness acceptance	Emotional expression, self-
Scripture reading	Narrative therapy
Worship	Experiential therapy
Small groups	Social support
Love others as you love yourself interactions	Practice of healthy interpersonal
Practices to strengthen walk with God	Utilization of positive coping skills

In my clinical experience as a MH provider who also received RA ministerial training, I have seen the importance of addressing R/S in psychological services. To provide comprehensive care, it is encouraged that MH professionals assess for R/S when working with their clients. As suggested by Moreira et al. (2006), MH professionals are also encouraged to assess for the patients' religious and spiritual background as shown in Table 18. This may serve to encourage collaborative efforts among clergy and MH professionals. Table 18 displays questions that may be useful in the assessment process for MH professionals in regards to religion and spirituality.

Table 18

Questions for R/S Assessment by MH Professionals

1. Does patient engage in R/S coping skills? Is it positive or negative?
2. Is patient an active member of a supportive R/S community?
3. Does patient have questions or concerns regarding their R/S?
4. Does the R/S beliefs impact the MH treatment? If so, how?

Note. R/S denotes religion/spirituality.

FBO can help individuals connect with the appropriate professionals or agencies such as: community hospitals, outpatient clinics, counseling centers, social service agencies, emergency medical hospitals, community MH clinics, community centers, crisis intervention centers and hotlines, community colleges, universities, schools, department of human services, other local FBO, housing agencies, transitional housing agency, juvenile justice system, correctional facilities, homeless shelter, nursing homes,

advocacy centers, educational centers, local businesses, transportation services, recreational centers, and support groups. Useful information may include the MH agency name, type of service, and contact information (DeKraai et al., 2011). Additional information about eligibility of services, accessibility, hours of operation, licensure, and cultural competency may also be helpful in such MH encounters. It is also encouraged that this resource information be in a quick and accessible manner such as providing business cards, or easy to understand pamphlets that are simple in nature (DeKraai et al., 2011). Posting flyers, making announcements, and advertising may increase attention to MH issues. This collaborative model encourages FBO in building a professional relationship with MH leaders in the provision of MH services, as well as improving the MH outcomes of the community.

Limitations

Limitations are identified in this study. This study was represented by the Christian Protestant and Catholic faith traditions with one representation of the Muslim faith. The results of this research may not be consistent across other religions and traditions as the findings are relevant to HCT. Second, the broad terminology and scales used in the survey questionnaire allowed variability in the answer responses, which may have affected the statistical analyses of the dataset. It is noted that certain items and scales were collapsed and reverse coded for ease of interpretation. Despite these limitations, this study provided a comprehensive picture of the MH aspect of the clergy of HCT, and important information was obtained in regards to the clergy intervention practices.

Conclusion

There has been limited research dedicated to the FBO communities and their clergy in HCT. It is the researcher's hope that this research will be used to increase the knowledge and bring to awareness of the concerns that exist with clergy and their involvement in MH issues. Education was the single significant bridge to MH services for clergy in HCT. On the other hand, lack of education was the single significant barrier to MH services for clergy in HCT. The results of this study showed that RA graduate education increases clergy understanding and intervention practices in MH as it improved clergy understanding and competency of MH issues. Increasing educational opportunities are needed for the clergy of HCT since a lack of such education may negatively affect the ministerial involvement of the clergy as well as their MH intervention practices. It is encouraged that FBO take initiative in providing educational opportunities for their respective clergy as studies document a vast majority of clergy indicate a desire to increase their education in MH (Lowe, 1986; Polson & Rogers, 2007; Bland, 2003; Pena et al., 2005). It is also encouraged that the educational curriculum be examined to increase awareness to the following topics of MH: diagnoses, assessment, therapy, treatment, collaborative practice, referrals, medication management, and emergency MH situations. Providing educational opportunities and improving educational outcomes may prove to make a positive impact in the health outcomes of the community. Through education, FBO have the potential to be a dynamic healing community addressing the biopsychosocial and spiritual needs of the individual bridging the barrier between religion and mental health.

REFERENCES

- Abramson, J., & Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work, 41*, 270-281.
- Adams, R. G., Stark, B. J. (1988). Church conservatism and services for the elderly. *Journal of Religion and Aging, 4*, 69-85.
- Adair, C., McDougall, G., Beckie, A., Joyce, A., Mitton, C., & Wild, C. (2003). History and measurement of continuity of care in mental health services and evidence of its role in outcomes. *Psychiatric Services, 54*, 1351-1356.
- Ali, O., Milstein, G., & Marzuk, P. (2005). The imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatric Services, 56*, 202-205.
- Ammerman, N. T. (2000). *A quick question*. <http://hrr.hartsem.edu/research>
- Ammerman, N.T. (1997). *Congregation and community*. New Brunswick: Rutgers University Press.
- Anderson, J. (1997). The lesbian and gay liberation movement in the Presbyterian church (USA), 1974-1996. *Journal of Homosexuality, 34*, 37-65.
- Aten, J., Topping, S., Denney, R., & Hosey, J. (2011). Helping African American clergy and churches address minority disaster mental health disparities: Training needs, model, and example. *Psychology of Religion and Spirituality, 3*(1), 15-23.
- Bachrach, L. L. (1981). Continuity of care for chronic mental patients: A conceptual analysis. *American Journal of Psychiatry, 138*, 1449-1456.
- Badger, L. W., Ackerson, B., Buttell, F., & Rand, E. H. (1997). The case for integration of social work psychosocial services into rural primary care practice. *Health and Social Work, 22*, 20-29.
- Bartkowski, J. & Xu, X. (2007). Religiosity and teen drug use reconsidered: A social capital perspective. *American Journal of Preventive Medicine, 32*(6), 182-194.
- Belcher, J., & DeForge, B. (2007). Faith-based social services: The challenges of providing assistance. *Journal of Religion & Spirituality, 26*(4), 1-19.
- Bell, R., Morris, R., Holzer, C., & Warheit, G. (1976). The clergy as a mental health resource: Part I and II. *Journal of Pastoral Care, 30*, 103-115.

- Beuttler, F. (1999). Making theology matter: Power, polity, and the theological debate over homosexual ordination in the Presbyterian Church (USA). *Review of Religious Research, 41*, 239-261.
- Bland, E. (2003). Psychology - church collaboration: Finding a new level of mutual participation. *Journal of Psychology and Christianity, 22*, 299-303.
- Blank, M. B., Mahmond, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health, 92*, 1668 -1672
- Boswell, J. (1980). *Christianity, social tolerance, and homosexuality*. Chicago, IL: University of Chicago Press.
- Burgess, J. (1999). Framing the homosexuality debate theologically: Lessons from the Presbyterian Church (USA). *Review of Religious Research, 41*, 262-274.
- Bonura, D., Fender, M., Roesler, M., & Pacquiao, D. (2001). Cultural congruent end-of-life care for Jewish patients and their families. *Journal of Transcultural Nursing, 12*(3), 211-220.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
- Cadge, W. (2002). *Vital conflicts: The mainline denominations debate homosexuality*. In *The quiet hand of God: Faith based activism and the public role of mainline Protestantism*, edited by R. Wuthnow and J. H. Evans. CA: University of California Press.
- Cadge, W., Girouard, J., Olson, L., & Lylerohr, M. (2012). Uncertainty in clergy's perspectives on homosexuality: A researcher's note. *Review of Religious Research, 54*, 371-387.
- Cadge, W., & Wildeman, C. 2008. Facilitators and advocates: How mainline Protestant clergy respond to homosexuality. *Sociological Perspectives, 51*, 587–603.
- Caldwell, C. H., Chatters, L., Billingsley, A., & Taylor, R. (1995). *Church-based support programs for elderly black adults: Congregational and clergy characteristics*. In Kimble, M., McFadden, S., Ellow, J., & Seeber, J. (Eds.). *Handbook on religion, spirituality, and aging* (p. 306-324). MN: Augsburg Fortress.
- Campbell, D., & Monson, J. (2008). The religion card: Gay marriage and the 2004 presidential election. *Public Opinion Quarterly, 72*, 399–419.

- Carson, E. (1990). *Black volunteers as givers and fundraisers: Working papers series for the center for the study of philanthropy*. New York: Graduate School and University Center, City University of New York.
- Castañeda, C. (1976). *Our Catholic heritage in Texas*. New York: Arno Press.
- Chaves, M. (2004). *Congregations in America*. Massachusetts: Harvard University Press.
- Clebsch, W. A., & Jaekle, C. (1964). *Pastoral care in historical perspective*. Englewood Cliffs, New Jersey: Prentice Hall.
- Clemens, N. (2005). The faith community and mental health care. *Psychiatric Services*, 56, 133.
- Clinebell, H. (1970). *The local church's contribution to positive mental health*. In Clinebell (Ed.). *Community mental health: The role of church and temple*. TN: Abingdon.
- Cnaan, R. (2002). *The invisible caring hand: American congregations and the provision of welfare*. New York: New York University Press.
- Crawford, S., Olson, L., & Deckman, M. (2001). Understanding the mobilization of professionals. *Nonprofit and Voluntary Sector Quarterly*, 30, 321-350.
- DeKraai, M., Bulling, D., Shank, N., & Tomkins, A. (2011). Faith-based organizations in a system of behavioral health care. *Journal of Psychology and Theology*, 39(3), 255-267.
- Dillon, M. (1999). *Catholic identity: Balancing reason, faith, and power*. New York: Cambridge University Press.
- Djupe, P., & Gilbert, C. (2009). *The political influence of churches*. New York: Cambridge University Press.
- Domino, G. (1990). Clergy's knowledge of psychopathology. *Journal of Psychology and Theology*, 18, 32-39.
- Dudley, C., & Roozen, D. (2001). *Faith communities today: A report on the religiosity in the United States today*. CT: Hartford Seminary: Institute of Religion Research.
- Ebaugh, H. R. & Chafetz, J. (2000). *Religion and the new immigrants: Continuities and adaptations in immigrant congregations*. New York: Altamira Press.
- Ebaugh, H., Pipes, P. F., Chafetz, J. & Daniels, M. (2003). Where's the religion?

- Distinguishing faith-based from secular social service agencies. *Journal for the Scientific Study of Religion*, 42(3), 411-426.
- Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's psychotherapy and religious values. *Journal of Consulting and Clinical Psychology*, 48, 635-639.
- Ellingson, S., Tebbe, N., Haitzma, M., & Laumann, E. (2001). Religion and the politics of sexuality. *Journal of Contemporary Ethnography*, 30, 3-55.
- Ellison, C. G., Boardman, J., Williams, D., & Jackson, J. (2001). Religious involvement, stress, and mental health: Findings from the 1995 Detroit area study. *Social Forces*, 80(1), 215-249.
- Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 48(2), 190-211.
- Erdfelder, E., Faul, F., & Buchner, A. (1996). G*Power: A general power analysis program. *Behavior Research Methods, Instruments, & Computers*, 28, 1-11.
- Flannelly, K., Koenig, H., Ellison, C., Galek, K., & Krause, N. (2006). Belief in life after death and mental health: Findings from a national survey. *Journal of Nervous and Mental Disease*, 194(7), 524-529.
- Frank, J. D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (2nd ed.). Baltimore, MD: Johns Hopkins Press.
- Friedli, L. (2000). A matter of faith: Religion and mental health. *International Journal of Health Promotion*, 2(2), 7-13.
- Gallup, G. & Lindsay, M. (1999). *Surveying the religious landscape: Trends in US beliefs*. Philadelphia, PA: Morehouse Publishing.
- Garnets, L., Herek, G., & Levy, B. (1990). Violence and victimization of lesbians and gay men: Mental health consequences. *Journal of Interpersonal Violence*, 5(3), 366-383.
- Gee, L., Smucker, D., Chin, M., & Curlin, F. (2005). Partnering together? Relationships between faith-based community health centers and neighborhood congregations. *Southern Medical Journal*, 98(12), 1245- 1250.
- Gottlieb, J., & Olefson, M. (1987). Current referral practices of mental health care providers. *Hospital and Community Psychiatry*, 38, 1171-1181.

- Greenberg, D., & Shefler, G. (2002). Obsessive compulsive disorder in ultra-orthodox Jewish patients: A comparison of religious and non-religious symptoms. *Psychology and Psychotherapy: Theory, Research, and Practice*, 75(2), 123-130.
- Gurin, G., Veroff, J., & Fields, S. (1960). *Americans view their mental health: A nationwide interview survey*. New York: Wiley.
- Guth, J., Green, J., Smidt, C., Kellstedt, L., & Poloma, M. (1997). *The bully pulpit: The politics of protestant clergy*. Kansas: University Press of Kansas
- Harrison, D. (1952). *A survey of the educational and administrative policies of the Baptist, Methodist, and Presbyterian churches among Mexican-American people in Texas*. MA Thesis, University of Texas.
- Hartman, K. (1996). *Congregations in conflict: The battle over homosexuality*. New Brunswick, New Jersey: Rutgers University Press.
- Haugk, K. C. (1976). Unique contributions of churches and clergy to community mental health. *Community Mental Health Journal*, 12(1), 20-28.
- Herek, G. (1991). Stigma, prejudice, and violence against lesbians and gay men. In Gonsiorek & Weinrich (Eds.), *Homosexuality: Research implications for public policy*. Newbury Park, CA: Sage Publications.
- Hill, P., & Pargament, K. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *The American Psychologist*, 58, 64-74.
- Hubbell, J. F. (1989). An analysis of psychiatric admission patterns with implications towards pastoral ministry. *Dissertation Abstracts International*, 50, 1110B.
- Kane, M. N., & Williams, M. (2000). Perceptions of south Florida Hispanic and Anglo Catholics: From whom would they seek help? *Journal of Religion and Health*, 39(2), 107-121.
- Kaplan, M., Marks, G., & Mertens, S. (1997). Distress and coping among women with HIV infection: Preliminary findings from a multiethnic sample. *American Journal of Orthopsychiatry*, 67(1), 80-91.
- Kendler, K., Liu, X, Gardner, C., McCullough, M., Larson, D., & Prescott, C. (2003). Dimensions of religiosity and their relationship to lifetime psychiatric and substance use disorders. *American Journal of Psychiatry*, 160(3), 496-503.
- Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, K. & Waters, E. (2005). Lifetime prevalence and age of onset distributions of DSM-IV disorders in the

- National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-602.
- Kirchner, J., Farmer, M., Shue, V., Blevins, D., & Sullivan, G. (2011). Partnering with communities to address the mental health needs of rural veterans. *The Journal of Rural Health*, 27, 416-424.
- Kloehn, S. (1999). Protestants face schism on homosexuality, *Chicago Tribune*. May 3, Section 1.
- Koenig, H. (1988). *Handbook of Religion and Mental Health*. San Diego: Academic Press.
- Koenig, H. (2007). *Spirituality in patient care, second edition*. PA: Templeton Foundation Press.
- Koenig, H., George, L. K., & Peterson, B. L. (1998). Religiosity and remission of depression in medically ill older patients. *American Journal of Psychiatry*, 155(4), 536-542.
- Koenig, H., & Larson, D. B. (1998). Use of hospital services, religious attendance and religious affiliation. *Southern Medical Journal*, 91, 925-932.
- Koenig, H., McCullough, M. & Larson, D. (2001). *Handbook of religion and health*. Oxford: Oxford University Press.
- Kramer, B. M. (1962). *Day hospital: A study of partial hospitalization in psychiatry*. New York: Grune & Stratton.
- Kramer, T., Blevins, D., Miller, T., Phillips, M., Davis, V., & Burris, B. (2006). Ministers' perceptions of depression: A model to understand and improve care. *Journal of Religion and Mental Health*, 46(1), 123-139.
- Kress, J. S., & Elias, M. J. (2000). Infusing community psychology and religion: Themes from an action-research project in Jewish identity development. *Journal of Community Psychology*, 28, 187-198.
- Kudlac, K. (1991). Including God in the conversation: The influence of religious beliefs on the problem-organized system. *Family Therapy*, 18(3), 277-285.
- Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry*, 47, 571-590.
- Levin, J. (1986). Roles for the black pastor in preventive medicine. *Pastoral Psychology*, 35(2), 94-103.

- León, A. (1982). *The Tejano community, 1836-1900*. Albuquerque: University of New Mexico Press.
- Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for the mental health care in the community. *Social Science and Medicine*, 65, 548-559.
- Levin, J. (2001). God, love, and health: Findings from a clinical study. *Review of Religious Research*, 42(3), 277-293.
- Levin, J., Chatters, L., & Taylor, R. (2005). Religion, health, and medicine in African Americans: Implications for physicians. *Journal of the National Medical Association*, 97(2), 237-249.
- Levin, J., & Taylor, R. (1998). Panel analyses of religious involvement and well being in African Americans: Contemporaneous vs. longitudinal effects. *Journal for the Scientific Study of Religion*, 37(4), 695-709.
- Lewis, G. (2005). Same-sex marriage and the 2004 presidential election. *Political Science & Politics*, 38, 195-199.
- Lish, R., McMinn, M., Fitzsimmons, C., & Root, A. (2003). Clergy interest in innovative collaboration with psychologists. *Journal of Psychology and Christianity*, 22(4), 294-298.
- Lowe, D. (1986). Counseling activities and referral practices of ministers. *Journal of Psychology and Christianity*, 5(1), 22-29.
- Maloney, H. (2001). *Pastoral care and counseling in sexual diversity*. New York: The Haworth Pastoral Press.
- Mannon, C. & Crawford, R. (1996). Clergy confidence to counsel and their willingness to refer to mental health professionals. *Family Therapy*, 23(3), 213-231.
- Mata, M. (1999). *Protestant Hispanics serving the community: Summary of research findings*. The Pew Charitable Trusts.
- Maton, K., & Pargament, K. (1987). The roles of religion in prevention and promotion. *Prevention in Human Services*, 5, 161-205.
- McCann, R. (1962). *The churches and mental health*. New York: Basic Books, Inc.
- McGuire, M. (1988). *Ritual healing in suburban America*. New Jersey: Rutgers Press.
- McMinn, M. R., Aikins, D. C., & Lish, R. A. (2003). Basic and advanced competence in

- collaborating with clergy. *Professional Psychology: Research and Practice*, 34, 197–202.
- McMinn, M. R., Meek, K. R., Canning, S. S., & Pozzi, C. F. (2001). Training psychologists to work with religious organizations: The center for church-psychology collaboration. *Professional Psychology: Research and Practice*, 32, 324-328.
- McMinn, M. R., & Phillips, T. R. (2001). *Care for the soul: Exploring the intersection of psychology and theology*. Downers Grove, IL: InterVarsity Press.
- McNeill, J. J. (1976). *The church and the homosexual*. Kansas City: Sheed Andrews & McMeel, Inc.
- McNeill, J. T. (1951). *A history of the cure of souls*. New York: Harper & Row.
- Milstein, G., Bruce, M., Kennedy, G., & Flannelly, K. (2003). Clergy roles in psychiatric care: Elder patients' views. Presented at Integrating Research on Spirituality and Health and Well-Being into Service Delivery: A Research Conference. MD: Natcher Center, HIM Campus.
- Moran, M., Flannelly, K., Weaver, A. J., Overvold, J., Hess, W., & Wilson, J. (2005). A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area. *Pastoral Psychology*, 53(3), 255-266.
- Moreira-Almeida, A., Lotufo-Neto, F., & Koenig, H. (2006). Religiousness and mental health: A review. *Review of Brazilian Psychiatry*, 28(3), 242-250.
- Myelink, W. D., & Gorsuch, R. L. (1986). New perspectives for clergy-psychologist referrals. *Journals of Psychology and Christianity*, 5, 62-70.
- Moon, D. (2004). *God, sex, and politics: Homosexuality and everyday theologies*. Chicago: University of Chicago Press.
- Mueller, P., Plevak, D., & Rummans, T. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinical Proceedings*, 76(12), 1225-35.
- National Council for Community Behavioral Healthcare. (2006). *Building healthy communities*. Rockville, MD.
- Neighbors, H., Musick, M. A., & Williams, D. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education & Behavior*, 25(6), 759-777.
- Nesbitt, P. (2001). *Religion and social policy*. New York: Altamira Press.

- Netting, F. E., Thibault, J. M. & Ellor, J. W. (1988). Spiritual integration: Gerontological interface between the religious and social service communities. *Journal of Religion and Aging*, 5, 61-74.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. Rockville, MD: US Department of Health and Human Services.
- Newport, F. (2012). *God is alive and well: The future of religion in America*. New York: Gallup Books.
- O'Connor, T. S. (2003). Pastoral counseling and pastoral care: Is there a difference? *The Journal of Pastoral Care and Counseling*, 57, 3-14.
- Olson, L., & Cadge, W. (2002). Talking about homosexuality: The views of mainline Protestant clergy. *Journal for the Scientific Study of Religion*, 41(1), 153-167.
- Olson, L., Cadge, W., & Harrison, J. (2006). Religion and public opinion about same-sex marriage. *Social Science Quarterly*, 87, 340-360.
- Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, 36, 301-325.
- Pargament, K. (2005). The sacred search for significance: Religion as a unique process. *Journal of Social Issues*, 61, 665-687.
- Pargament, K., Koenig, H., Tarakeshwar, N., & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients. *Archives of Internal Medicine*, 161, 1881-1885.
- Payne, J. (2009). Variations in pastor's perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal*, 45, 355-365.
- Perlmutter, F., Yudin, L., & Heinemann, S. (1974). Awareness of a community mental health center among three gatekeeper groups. *American Journal of Community Psychology*, 2(1), 23-33.
- Pena, M., Hernandez, E., & Mauldin, M. (2005). "Hispanic clergy and the task of ministry in urban America." Research Reports, 3, Institute for Latino Studies, University of Notre Dame.
- Peterson, L., & Donnerwerth, G. (1998). Religion and declining support for traditional beliefs about gender roles and homosexual rights. *Sociology of Religion*, 59, 353-371.

- Pipes, P., & Ebaugh, H. (2002). Faith-based coalitions, social services, and government funding. *Sociology of Religion*, 63(1), 49-68.
- Polson, L., & Rogers, R. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, 34(1), 72-87.
- Ringdal, G. (1996). Religiosity, quality of life, and survival in cancer patients. *Journal Social Indicators Research*, 38(2), 193-211.
- Sanchez, R. (1999). At gay wedding, Methodists take a vow against church ban. *Washington Post*, January 17, Section A.
- Shafranske, E. P., & Maloney, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.
- Slessarav-Jamir, H. (2003). "Sustaining hope, creating opportunities: The challenge of ministry among Hispanic immigrants." Report for the Annie E. Casey Foundation.
- Spilka, B., Hood, Jr., R., Hunsberger, B., & Gorsuch, R. (2003). *The psychology of religion: Third edition*. New York: The Guiliford Press.
- Spriggs, J. D., & Sloter, E. (2003). Counselor-clergy collaboration in a church based counseling ministry. *Journal of Psychology and Christianity*, 22, 323-326.
- Stafford, T. (1993). *The Therapeutic Revolution*. Christianity Today, 24-32.
- Stansbury, K. L., Harley, D., King, L., Nelson, N., & Speight, G. (2012). African American clergy: What are their perceptions of pastoral care and pastoral counseling? *Journal of Religion and Health*, 51, 961-969.
- Sternthal, M., Williams, D., Musick, M., & Buck, A. (2012). Religious practices, beliefs, and mental health: Variations across ethnicity. *Ethnicity and Health*, 17(1), 171-185.
- Substance Abuse and Mental Health Services Administration. (2009). *National survey on drug use and health series*. Retrieved June 15, 2009 from <http://www.datafiles.samhsa.gov>
- Taylor, R., Ellison, C., Chatters, L., Levin, J., & Lincoln, K. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work*, 45, 73-87.
- The Catholic Directory. (2013). *List of Catholic churches in Hidalgo County, Texas*. Retrieved from <http://www.thecatholicdirectory.com/directory.cfm?fuseaction=>

search_directory&country=US&state=TX&county=HIDALGO

- The Texas State Data Center. (2010). *Total population estimates for Texas councils of governments*. Retrieved from http://txsdc.utsa.edu/Resources/TPEPP/Estimates/2012/2012_txpopest_cog.pdf
- The United States-Mexico Border Health Commission. (2009). *Healthy border 2010: An agenda for improving health on the United States-Mexico border*. El Paso, TX & Mexico City, Mexico: The United States-Mexico Border Health Commission, accessed on March 18 <www.borderhealth.org>.
- Thomas, M. (2012). The interprofessional collaborative practice: Clergypersons and mental health professionals. *Pastoral Psychology*, 61, 99-112.
- U.S. Census Bureau. (2010). *U.S. Census, 2010*. Washington, D.C.: Department of Labor and Statistics.
- U.S. Census Bureau. (2010). *Hidalgo County Texas: State and county quickfacts*. Washington, D.C.: Department of Labor and Statistics.
- U.S. Department of Health and Human Services. (2001). *Mental health: A report of the surgeon general*. MD. Retrieved from <http://mentalhealth.samhsa.gov/features/surgeongeneralreport/home.asp#topper>.
- Walls, G. (1980). Values and psychotherapy: A comment on "Psychology and religious values." *Journal of Consulting and Clinical Psychology*, 48, 640-641.
- Wang, P., Lane, M., Olsson, M., Pincus, H., Schwenk, T., Wells, K., & Kessler, R. (2006). Changing profiles of service sectors used for mental health care in the United States. *American Journal of Psychiatry*, 163(7), 1187-1198.
- Warner, D., & Jahnke, L. (2010). U.S./Mexico border health issues: The Texas Rio Grande Valley. San Antonio, TX: Regional center for health workforce studies at the university of Texas health science center at San Antonio reached from the web at <www.uthscsa.edu/RCHWS/Reports/NAFTA2.pdf>.
- Warner, S., & Wittner, J. (Eds.). (1998). *Gatherings in diaspora: Religious communities and the new immigration*. Philadelphia, PA: Temple University Press.
- Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as front-line community mental health workers? A review. *The Journal of Pastoral Care*, 49(2), 129-149.
- Weaver, A. J. (1992). Working with potentially dangerous persons: What the clergy needs to know. *Pastoral Psychology*, 40, 313-323.

- Weaver, A. J., Koenig, H. G., & Ochberg, F. M. (1996). Post-traumatic stress, mental health professionals, and the clergy: A need for collaboration, training, research. *Journal of Traumatic Stress, 9*, 847-856.
- Wellman, J. (1999). The debate over homosexual orientation: Subcultural identity theory in American religious organizations. *Review of Religious Research, 41*, 184-206.
- Williams, D. Griffith, E. H., Young, J. L., Collins, C., & Dodson, J. (1999). Structure and provision of services in Black churches in New Haven, Connecticut. *Cultural Diversity And Mental Health, 5*(2), 118-133
- Winet, R., Majors, J., & Stewart, G. (1979). Mental health treatment and referral practices of clergy and physician caregivers. *Journal of Community Psychology, 7*(4), 318-323.
- Wood, J. (2000). *Where the spirit leads: The evolving views of United Methodists on homosexuality*. Nashville: Abington Press.
- World Health Organization. (2012). Mental health: Strengthening our response: Fact sheet. Retrieved February 3, 2013 from <http://www.who.int/mediacentre/factsheets/fs220/en/>
- Worthington, D. (1986). Religious counseling: A review of published empirical research. *Journal of Counseling and Development, 64*, 421-431.
- Wright, S. (2008). Bearing the cross: Churches' intolerance of homosexuals. *Reflections, 22*, 26-27.
- Wuthnow, R. (2004). *Saving America? Faith-based services and the future of civil society*. Princeton and Oxford: Princeton University Press.

APPENDIX A

INTERVIEW QUESTIONNAIRE

G1. Participant #: _____ Exact Time Started:

_____AM or _____PM

Faith-Based Organization Address:

_____ Hidalgo County, TX

Telephone: _____

Email: _____

Survey Administrator: _____

NOTE: In order to protect confidentiality, upon entering data this page will be separated from survey.
--

1. In your opinion, how good of an idea is it to refer members of your congregation to mental health care professionals such as psychiatrist, psychologist, or social workers?
 1. very good
 2. good
 3. somewhat good
 4. not so good
 5. bad
 6. very bad

2. How likely are you to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker?
 1. Very likely
 2. Likely
 3. Somewhat Likely
 4. Somewhat Unlikely
 5. Unlikely
 6. Not likely

3. I am interested and I feel responsible for the physical, emotional, and mental health of my parishioners.
 1. Strongly Agree
 2. Agree

3. Somewhat Agree
 4. Somewhat Disagree
 5. Disagree
 6. Strongly Disagree
4. I am interested and I feel responsible for the physical, emotional, and mental health of larger community.
1. Strongly Agree
 2. Agree
 3. Somewhat Agree
 4. Somewhat Disagree
 5. Disagree
 6. Strongly Disagree
5. In regards to your parishioner's health, please list the top 3 main interests of you and the leaders of the FBO.
1. _____
 2. _____
 3. _____
6. I would welcome a partnership with a faith-based healthcare system, even if from a different faith than mine.
1. Strongly Agree
 2. Agree
 3. Somewhat Agree
 4. Somewhat Disagree
 5. Disagree
 6. Strongly Disagree
7. Is your organization cooperating with other social agencies, groups or congregation in dealing with community problems? (Y/N)
8. If so, what type group(s) are you involved with?
1. Other Congregations/Religious Organizations
 2. Government Agencies (police, etc.)
 3. Community Organizations
 4. Civil Right Organizations
 5. Faith-Based Initiative
9. What activities do these groups perform?
1. Education
 2. Substance Abuse
 3. Child Abuse
 4. Parenting
 5. Domestic Violence

6. Job Training/Unemployment
7. Adoption/Foster Care
8. Homeless Shelter
9. Soup Kitchen
10. Adolescent/Youth
11. Elderly
12. Long-term Severe Illness (e.g. schizophrenia, severe depression)
13. AIDS
14. Prison/Jail Programs
15. Food and Clothing Distribution
16. Counseling/Teaching/Discussion
17. Spiritual Outreach
18. Daycare/Nursery
19. Recreation/Community Center
20. Social/Political Activism
21. Visits/Visitations (e. g. hospital, etc.)
22. Financial (Credit Union, etc.)
23. Administrative/Office Work
24. Miscellaneous Volunteer Work
25. Immigration Status
26. Language Issues
27. Prevention/Maintenance Health

10. Have you made health care referrals during the last years for any of the following?

1. Breast cancer prevention
2. Cardiovascular disease
3. Diabetes
4. Prostate cancer
5. Positive lifestyle promotion

11. Where did you refer them to?

1. Local clinic
2. Local hospital
3. Private physician
4. Other faith-based institutions
5. Governmental institutions
6. Other

12. Have you received referrals during the last year for any of the following?

1. Breast cancer prevention
2. Cardiovascular disease
3. Diabetes
4. Prostate cancer
5. Positive lifestyle promotion

13. Where did the referrals come from?

1. Local clinic
 2. Local hospital
 3. Private physician
 4. Other faith-based institutions
 5. Governmental institutions (social welfare, child support, etc.)
 6. Other
14. Do you or any member of your staff do any volunteer work, without pay, for another congregation, community organization, or anyone else? (Y/N)
15. If so, what type of groups?
1. Other Congregation/Religious Organizations
 2. Government Agencies (police, etc.
 3. Community Organizations
 4. Civil Rights Organizations
 5. Faith based organizations
16. What types of activities do these groups perform?
1. Education
 2. Substance Abuse
 3. Child Abuse
 4. Parenting
 5. Domestic Violence
 6. Job Training/Unemployment
 7. Adoption/Foster Care
 8. Homeless Shelter
 9. Soup Kitchen
 10. Adolescent/Youth
 11. Elderly
 12. Long-term Severe Illness (e.g., schizophrenia, severe depression)
 13. AIDS
 14. Jail/Prison Programs
 15. Food and Clothing Distribution
 16. Counseling/Teaching/Discussion
 17. Spiritual Outreach
 18. Daycare/Nursery
 19. Recreation/Community Center
 20. Social/Political Activism
 21. Visits/Visitations (e. g. hospital, etc.)
 22. Financial (credit union, etc.)
 23. Administrative/Office Work
 24. Miscellaneous Volunteer Work
 25. Immigration Status
 26. Language Issues
 27. Prevention/Maintenance Health

17. Do other, groups, or organizations use your facilities for meetings, programs, or other activities? (Y/N)
18. If so, what type of groups?
 1. Other Congregation/Religious Organizations
 2. Government Agencies (police, etc.)
 3. Community Organizations
 4. Civil Rights Organizations
 5. Faith based organizations
19. What activities is your facility used for?
 1. Religious Services and Programs
 2. Weddings
 3. Educational/Enrichment
 4. Recovery/Support (e.g., AA)
 5. Other Community (i.e., block meetings, lodge, political)
20. Do they pay a rental fee? (Y/N)
21. Does your facility provide financial or any other kind of assistance to any other groups or organizations? (Y/N)
22. If so, what type of groups?
 1. Other Congregation/Religious Organizations
 2. Government Agencies (police, etc.)
 3. Community Organizations
 4. Civil Rights Organizations
 5. Faith-based organizations
23. What type of assistance?
 1. Financial
 2. Other In-kind Support
24. Are you a member of any civil rights organizations? (Y/N)
25. How active are you in these organizations?
 1. Very Active
 2. Fairly Active
 3. Not Very Active
 4. Not At All Active
26. Do you serve on the board of directors of any local organizations? (Y/N)
27. If so, what type of organizations?
 1. Other Congregation/Religious Organizations
 2. Government Agencies (police, etc.)

3. Community Organizations
 4. Civil Rights Organizations
 5. Faith-based organizations
28. Do you hold any other office or post in other groups or organizations? (Y/N)
29. If so, what type of organization?
1. Other Congregation/Religious Organizations
 2. Government Agencies (police, etc.)
 3. Community Organizations
 4. Civil Rights Organizations
 5. Faith-based organizations
30. What office or post do you hold?
1. President/Chairman
 2. Vice President, Secretary, Treasurer
 3. Other Office
31. Is your facility involved in any programs or efforts to fight the problem of drugs in your county? (Y/N)
32. Is your facility involved in programs/efforts to support young minority men? (Y/N)
33. If money was not an issue, what additional services or programs would you like your facility to provide to the community?
1. Education
 2. Abuse
 3. Child Abuse
 4. Parenting
 5. Domestic Violence
 6. Job Training/Unemployment
 7. Adoption/Foster Care
 8. Homeless Shelter
 9. Soup Kitchen
 10. Adolescent/Youth
 11. Elderly
 12. Long-term Severe Illness (e.g., schizophrenia, severe depression)
 13. AIDS
 14. Prison/Jail Programs
 15. Food and Clothing Distribution
 16. Counseling/Teaching/Discussion
 17. Spiritual Outreach
 18. Daycare/Nursery
 19. Recreation/Community Center
 20. Social/Political Activism

21. Visits/Visitations (e.g., hospital, etc.)
22. Financial (credit union, etc.)
23. Administrative/Office Work
24. Miscellaneous Volunteer Work
25. Immigration Status
26. Language Issues
27. Preventive/Maintenance Health

Section B: Attitudes Regarding Psychological Problems and Their Treatment

34. Here are several possible causes of mental illness. How often do you think mental illness is caused by each? Please answer the following questions with these choices.
 1. Very Often
 2. Fairly Often
 3. Not Too Often
 4. Never
35. How often is mental illness caused by biological disorder? ____
36. How often is mental illness caused by unconfessed sin? ____
37. How often is mental illness caused by unhealthy early family relationships? ____
38. How often is mental illness caused by not being in a right relationship with God? ____
39. How often is mental illness caused by widespread disruptive social forces? ____
40. How often is mental illness caused by stunted spirited growth? ____
41. How often is mental illness caused by stress in living? ____
42. Which of the following statements most closely reflects your opinion?
 1. All clergy should be required to receive some formal instruction in psychological problems and their treatment.
 2. Formal instruction in psychological problems and their treatment should be available to all clergy but should be optional.
 3. Psychological problems can be dealt with in the same way as spiritual problems, and no additional training is required.

Do you strongly agree (1), agree (2), disagree (3), or strongly disagree (4) with the following statements?

43. People who have been in a psychiatric hospital are more dangerous to society than the general population. ____

44. If they put their minds to it, most people suffering from severe anxiety or depression can cure themselves. ____
45. Homosexuals are more psychologically disturbed than heterosexuals. ____

Here are five statements, each representing a different viewpoint. Although you may believe each to be true in some situations, please select the statement that best represents your own opinion and the one that least represents your own opinion.

(Label M = most; L = least)

46. Counseling is effective to the extent that it enables the counselee to experience, express, and verbalize his or her deepest feelings. ____
47. The effectiveness of counseling depends entirely on the relationship between the counselor and the counselee. ____
48. When counseling works, it does so because the counselee has been led into a deeper, truer, and more meaningful relationship with God. ____
49. Counseling is effective to the extent that it enables the counselee to replace maladaptive ways of thinking with a positive mental attitude toward the realities of living. ____
50. Counseling is effective to the extent that it concentrates on ways to change behavior. ____

Section C: Counseling Activities

We are interested in the nature of your own counseling ministry. A counseling session is defined as an individual or family contact lasting at least 15 minutes in which your primary aim is to provide care, counseling, compassion, or advice, mainly in relation to emotional, psychological, or moral problems.

51. Please estimate the number of such contacts you make in an average week.
1. None
 2. 1 – 5
 3. 6 - 10
 4. 11 – 15
 5. More than 15
52. Approximately how many hours per week does this require? _____ hours
53. Do you think the time you spend in counseling is just about right, too much, or too little?
1. Just about right
 2. Too much
 3. Too little

54. When someone comes to you for counseling, do you usually set up a schedule so that he/she can come to you on a regular basis? (Y/N)
55. How often do you meet with them?
1. Every day
 2. One or more times a week
 3. 2 – 3 times a month
 4. Once a month or less
 5. Whenever they come
56. On average, what is the usual duration of your counseling sessions?
1. Under half an hour
 2. Half an hour to one hour
 3. More than one hour
57. On average, how long does someone need to remain in counseling with you?
1. Less than a month
 2. 1 – 3 months
 3. 4 – 6 months
 4. 7 – 12 months
 5. More than a year but less than two years
 6. More than two years
58. Do any members of your congregation or their families have problems with long term severe mental illness like schizophrenia or depression?(Y/N)
59. What are the one or two most important things you do in dealing with this problem?
- _____
- _____
60. [Classify the response in field 1 & field 2]
1. Religious/Spiritual only
 2. Counseling/Support/Psychotherapy only
 3. Both
61. Field 2 – Is referral mentioned?(Y/N)
62. Do any members of your congregation or their families have problems with substance abuse?(Y/N)
63. What are the one or two most important things you do in dealing with this problem?
- _____
- _____
64. [Classify the response in field 1 & field 2]

Field 1

1. Religious/Spiritual only
2. Counseling/Support/Psychotherapy only
3. Both

65. Field 2 – Is referral mentioned?(Y/N)

66. What are the three problems you have dealt with most frequently during the past year? (Circle the three and rank them 1-3.)

- a. Adolescent Problems
- b. Suicide
- c. Middle Life Problems
- d. Elderly problems
- e. Problems of the Dying
- f. Grief
- g. Problems of Physical Illness/AIDS
- h. Domestic Violence
- i. Sexual Problems/Sexual Abuse (not child specific)
- j. Marital/Family Problems
- k. Unemployment/Work Related
- l. Mental Illness
- m. Alcohol/Drug Addiction
- n. Religious/Spiritual Problems
- o. Other Life Crises
- p. Teenage Pregnancy/Single Motherhood
- q. Gangs/Violence/Criminal Activity
- r. Premarital Counseling
- s. Financial/Economics/Poverty
- t. Child Abuse/Child Sexual Abuse
- u. Hunger/Homelessness
- v. Congregation Organization and Funding
- w. Stress Related to Legal/ImmigrationStatus
- x. Traditions and Cultural Values Clash at Home
- y. Racism/Discrimination/Bias

67. What percentage of your total counseling time do you spend in crisis intervention? (Dealing with situations that are considered by you or the individuals involved to be emergencies, of crisis proportions, or of special urgency).

1. 0%
2. 1 – 10%
3. 11 – 25%
4. 26 – 50%
5. 50% and above

68. Have you personally counseled any suicidal individuals?(Y/N)

69. Have you personally counseled any dangerous individuals? (Y/N)
70. Here is a list of problems that the clergy sometimes deal with. How often do you deal with each of them in counseling? Please answer the following questions with the answer choices.
1. Very often
 2. Fairly often
 3. Not too often
 4. Never
71. Adolescent Problems ____
72. Suicide ____
73. Mid- Life Problems ____
74. Elderly Problems ____
75. Dying ____
76. Grief ____
77. Problems of Physical Illness/AIDS ____
78. Domestic Violence ____
79. Sexual Problems/Sexual Abuse ____
80. Marital/Family Problems ____
81. Unemployment/Work Related ____
82. Mental Illness ____
83. Alcohol/Drug Addiction ____
84. Religious/Spiritual Problems ____
85. Other Life Crises ____
86. Teenage Pregnancy/Single Motherhood ____
87. Gangs/Violence/Criminal Activity ____
88. Premarital Counseling ____

- 89. Financial/Economics/Poverty ____
- 90. Child Abuse/Child Sexual Abuse ____
- 91. Hunger/Homelessness ____
- 92. Religious Organization and Funding ____
- 93. Stress Re: Legal/Immigration Status ____
- 94. Traditions/Cultural Values at Home ____
- 95. Racism/Discrimination/Bias ____
- 96. Access to Health Care ____
- 97. When people come to you for help with personal problems, what do you do that seems to work?

**[Classify the response in field 1 & field 2]

- 98. First mentioned – Field 1
 - 1. Religious/Spiritual only
 - 2. Counseling/Support/Psychotherapy only
 - 3. Both (1 & 2)
 - 4. Unique rituals
- 99. Second mentioned – Field 2
 - 1. Religious/Spiritual only
 - 2. Counseling/Support/Psychotherapy only
 - 3. Both (1 & 2)
 - 4. Unique rituals
- 100. Why do you think it works?
 - 1. Divine intervention only (religious/spiritual)
 - 2. Mostly divine intervention (religious/spiritual) and some human agency (counseling/psychotherapy)
 - 3. Mostly human agency (counseling/psychotherapy) and some divine intervention (religious/spiritual)
 - 4. Human agency only (counseling/psychotherapy)
 - 5. Both

Please answer the following questions with the answer choices.

- 1. Very often
- 2. Fairly often

3. Not too often
 4. Never
101. How often do you recommend increased attendance and participation in religious activities to troubled individuals? ____
 102. How often do you explicitly quote from Scripture during a typical formal counseling session? ____
 103. How often do you use the following religious practices in your counseling?
 104. Prayer____
 105. Meditation____
 106. Exorcism ____
 107. Confession____
 108. Faith Healing____
 109. Miscellaneous and Unspecified Rituals____
 110. Oil Anointing____
 111. Laying on of hands____
 112. Fasting____
 113. When troubled individuals come to you for counseling...
 114. Do they come on their own? ____
 115. How often are they referred elsewhere? ____
 116. How often are they actively sought out by you? ____
 117. Do you charge a fee for your counseling services? (Y/N)
 118. What is your average fee? \$_____
 119. Do you ask for a donation? (Y/N)
 120. Does this money go to your religious institution?
 1. Yes
 2. Only some of it (if voluntary)

3. No

121. How often do people you counsel bring something to pay you with, or give you, in appreciation for your time?

1. Very often
2. Fairly often
3. Not too often
4. Never

122. Do you counsel people from other religions or other religious denominations?
(Y/N)

Please answer the following questions with the answer choices.

1. Very often
2. Fairly often
3. Not too often
4. Never

123. In counseling very poor people, how often are you able to offer each of the following?

124. Employment counseling ____

125. Food ____

126. Financial Assistance ____

127. Temporary Housing ____

128. Transportation ____

129. A Job in the Congregation ____

130. Home Care ____

131. Legal Assistance ____

132. Immigration Status Assistance ____

133. Issues of Language Assistance ____

134. Health Care Assistance ____

Section D: Collaboration

135. What are the 3 most pressing needs in creating a healthier community?
1. _____
2. _____
3. _____
136. Are you familiar with medical professionals? (1-very well, 2-well, 3-little, 4-not at all)
- 18. ___ Medical nurse
 - 19. ___ Medical or surgical physician
 - 20. ___ Psychiatrist
 - 21. ___ Psychologist
 - 22. ___ Social worker who does counseling
 - 23. ___ Psychiatric nurse
 - 24. ___ Another minister
 - 25. ___ Institutional chaplain
 - 26. ___ Pastoral counselor
 - 27. ___ Hospital emergency room
 - 28. ___ Other hospitals
 - 29. ___ Other mental health agency
 - 30. ___ Other mental health professional
 - 31. ___ Congregation-related professional
 - 32. ___ Folk medicine practitioner
 - 33. ___ Herbal Medicine
 - 34. ___ Alternative medicine
137. Name the 3 main educational institutions in your community.
1. _____
2. _____
3. _____
138. Name the 3 main medical centers / hospitals that are members of your community.
1. _____
2. _____
3. _____
139. Name the 3 main resources that you think local hospitals or educational institutions have that would be most interesting to you and your FBO in working together to create a healthier community.
1. _____
2. _____
3. _____
140. Name the 3 main resources that you bring to a partnership for health promotion of your FBO.

1. _____
2. _____
3. _____

141. Would your FBO name a healthcare ambassador(s) who would partner with a healthcare system (hospital) to create a better continuum of care for the prevention of illness, to aid in healthcare access, and home care if needed? (Y/N)
142. If YES, How likely is this to happen?
1. Very likely
 2. Likely
 3. Somewhat Likely
 4. Somewhat Unlikely
 5. Unlikely
 6. Not likely

Section E: Referral Patterns

143. Is there a mental health agency or professional to whom you would feel comfortable making a referral? (Y/N)
144. If so, what type of mental health professional (s) or agency (s)?
1. Medical nurse
 2. Medical or surgical physician
 3. Psychiatrist
 4. Psychologist
 5. Social worker who does counseling
 6. Psychiatric nurse
 7. Another minister
 8. Institutional chaplain
 9. Pastoral counselor
 10. Hospital emergency room
 11. Other hospitals
 12. Other mental health agency
 13. Other mental health professional
 14. Congregation-related professional
 15. Folk medicine practitioner
 16. Herbal Medicine
 17. Alternative medicine
145. Do you personally know a psychiatrist, a clinical psychologist, or a social worker who does counseling? (Y/N)
146. Do you personally know a pastoral counselor? (Y/N)
147. Have you ever referred one of your clients elsewhere for help with problems related to mental health? (Y/N)

148. How often do you refer a member or client elsewhere for help with problems related to mental health?
1. More than once a week
 2. 3 – 4 times a month
 3. 1 – 2 times a month
 4. Once every 2 – 6 months
 5. Once every 7 – 12 months
 6. Never
149. How often do you refer parishioners or clients to any of the following health-care professionals or agencies? Please answer using answer choices.
1. Very often
 2. Fairly often
 3. Often
 4. Not too often
 5. Never
150. Medical Nurse ____
151. Medical/Surgical Physician ____
152. Psychiatrist ____
153. Psychologist ____
154. Social Worker ____
155. Psychiatric Nurse ____
156. Another Minister ____
157. Institutional Chaplain ____
158. Pastoral Counselor ____
159. Hospital ER ____
160. Other Hospitals ____
161. Other MH Agency ____
162. Other MH Professionals ____
163. Religious Professional ____

164. Folk Medicine Practitioner ____
165. Herbal Medicine ____
166. Alternative Medicine ____
167. Have any health professionals or agencies referred troubled individuals to you?
(Y/N)
168. How often have health professionals or agencies referred troubled individuals to you? Please answer using answer choices.
1. Very often
 2. Fairly often
 3. Often
 4. Not too often
 5. Never
169. Medical Nurse ____
170. Medical/Surgical Physician ____
171. Psychiatrist ____
172. Psychologist ____
173. Social Worker ____
174. Psychiatric Nurse ____
175. Another Minister ____
176. Institutional Chaplain ____
177. Pastoral Counselor ____
178. Hospital ER ____
179. Other Hospitals ____
180. Other MH Agency ____
181. Other MH Professional ____
182. Religious-Related Professional ____
183. Folk Medicine Practitioner ____

184. Herbal Medicine ____
185. Alternative Medicine ____
186. In making referrals, how important is it to you to know the religious orientation of the mental health worker or agency?
1. Very important
 2. Fairly important
 3. Not too important
 4. Not at all important
187. When you are engaged in counseling, who would you consult for advice if you needed it? (Check as many as apply).
1. No one
 2. A university or seminary affiliated minister
 3. A psychiatrist
 4. Another minister engaged in counseling
 5. A mental health professional at an agency
 6. A mental health professional other than a psychiatrist or minister
 7. God
188. Would you consult someone of a different race? (Y/N)
189. What is the racial composition of the majority of the people that you counsel?

190. What is the gender composition of the people you counsel? Are they mostly men, about evenly mixed, or mostly women?

Section F: Problem Situations

How would you handle the following situations?

Case I

A couple has been having increased marital difficulties. They are unable to work out their problems alone and have been thinking about divorce. They are in their early twenties, both working and have no children. They come to you for help.

191. What are the two or three most important things you would do in dealing with this problem?

**[Classify the response in field 1 & field 2]

- 192.
1. Religious/Spiritual only
 2. Counseling/Support/Psychotherapy only
 3. Both

193. Is prayer mentioned? (Y/N)
194. Is referral necessary? (Y/N)
195. If so, which two professional would you refer them to? (circle two and rank them accordingly)
1. Medical nurse
 2. Medical or surgical physician
 3. Psychiatrist
 4. Psychologist
 5. Social worker who does counseling
 6. Psychiatric nurse
 7. Another minister
 8. Institutional chaplain
 9. Pastoral counselor
 10. Hospital emergency room
 11. Other hospitals
 12. Other mental health agency
 13. Other mental health professional
 14. Congregation-related professional
 15. Folk medicine practitioner
 16. Herbal medicine
 17. Alternative medicine

Case II

A middle-age couple is having trouble with their eight-year-old son. The boy is getting into trouble at school. He is either inattentive or hitting other children. He has an above average intelligence. They come to you for help.

196. What are the two or three most important things you would do in dealing with this problem?
-
197. [Classify the response in field 1 & field 2]
1. Religious/Spiritual only
 2. Counseling/Support/Psychotherapy only
 3. Both
198. Is prayer mentioned? (Y/N)
199. Is referral necessary? (Y/N)
200. If referral is necessary, which two professional would you refer them to? (circle two and rank them accordingly)
1. Medical nurse
 2. Medical or surgical physician

3. Psychiatrist
4. Psychologist
5. Social worker who does counseling
6. Psychiatric nurse
7. Another minister
8. Institutional chaplain
9. Counselor
10. Hospital emergency room
11. Other hospitals
12. Other mental health agency
13. Other mental health professional
14. Congregation-related professional
15. Folk medicine practitioner
16. Herbal Medicine
17. Alternative medicine

Case III

A man complains that people are watching him. He feels his activities are being closely watched and is suspicious of even his family and friends. He thinks that he can destroy the city at will.

201. What are the two or three most important things you would do in dealing with this problem?
-
202. [Classify the response in field 1 & field 2]
1. Religious/Spiritual only
 2. Counseling/Support/Psychotherapy only
 3. Both
203. Is prayer mentioned? (Y/N)
204. Is referral necessary? (Y/N)
205. If referral is necessary, which two professional would you refer them to? (circle two and rank them accordingly)
1. Medical nurse
 2. Medical or surgical physician
 3. Psychiatrist
 4. Psychologist
 5. Social worker who does counseling
 6. Psychiatric nurse
 7. Another minister
 8. Institutional chaplain
 9. Counselor
 10. Hospital emergency room

11. Other hospitals
12. Other mental health agency
13. Other mental health professional
14. Congregation-related professional
15. Folk medicine practitioner
16. Herbal Medicine
17. Alternative medicine

Case IV

After the birth of her second child a young woman becomes very depressed. She stays in bed most of the time, seldom changing from bed clothes. She doesn't care for the baby or prepare food for her family. When asked about behavior, she cries.

206. What are the two or three most important things you would do in dealing with this problem?
-

207. [Classify the response in field 1 & field 2]

1. Religious/Spiritual only
2. Counseling/Support/Psychotherapy only
3. Both

208. Is prayer mentioned? (Y/N)

209. Is referral necessary? (Y/N)

210. If referral is necessary, which two professional would you refer them to? (circle two and rank them accordingly)

1. Medical nurse
2. Medical or surgical physician
3. Psychiatrist
4. Psychologist
5. Social worker who does counseling
6. Psychiatric nurse
7. Another minister
8. Institutional chaplain
9. Counselor
10. Hospital emergency room
11. Other hospitals
12. Other mental health agency
13. Other mental health professional
14. Congregation-related professional
15. Folk medicine practitioner
16. Herbal Medicine
17. Alternative medicine

Section G: Religious Background

211. How long has your congregation been in the county community?
_____years
212. How many years at the current address?
_____years
213. How long have you served in this congregation?
_____years
214. What is your religious affiliation?

215. What is the size of your present membership?
_____people
216. What is the total average attendance at the main worship service(s)?
_____people
217. What is the social class background of the majority of the members in your congregation?
1. Poor
 2. Working class
 3. Middle class
 4. Upper middle class
218. What is the total dollar amount of your annual budget?
\$ _____
219. What is the size of your paid ministerial staff (ministers/priests and assistants) including yourself?

220. How many are female?

221. How many hours per week do you spend in ministry?
_____hours
222. In addition to your work for this religious organization, are you engaged in other paid employment?
1. Yes
 2. No
223. About how many hours do you work on this job in an average week?
_____hours

224. What is your occupation (what sort of work do you do)?

Section H: Personal and Education Background

Now a few questions about yourself.

225. What is your marital status?

1. Married
2. Divorced
3. Separated
4. Widowed
5. Never married

226. What is your date of birth?

Month___ Day___ Year_____

227. What is your sex?

1. __Male
2. __Female

228. What is your race/ethnicity?

229. What is your nationality?

230. What is the highest grade or year of school that you have completed?

231. Where did you receive your training for ministry?

232. Degree(s) obtained, if any.

1. Bible School/Bible College Certificate
2. Bachelor of Science/Bachelor of Arts
3. Master of Science/Master of Arts
4. Doctorate of Philosophy
5. Honorary Doctorate

233. Do you have a degree in counseling? (Y/N)

234. After taking the survey, how good of an idea is it to refer members of your congregation to mental health care professionals such as psychiatrist, psychologist, or social workers?

1. Very good
2. Good
3. Somewhat good

4. Not so good
 5. Bad
 6. Very bad
235. After taking this survey how likely are you now to consider referring a member your congregation to a mental health care provider such as a psychiatrist, psychologist, or social worker?
1. Very likely
 2. Likely
 3. Somewhat likely
 4. Somewhat Unlikely
 5. Unlikely
 6. Not likely
236. After taking this survey, I would welcome a partnership with a faith based healthcare system.
1. Strongly Agree
 2. Agree
 3. Somewhat Agree
 4. Somewhat Disagree
 5. Disagree
 6. Strongly Disagree