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PROMOTING EMOTIONAL WELL-BEING AMONG SOUTHERN CALIFORNIA PARISHIONERS THROUGH CLERGY/MENTAL HEALTH PRACTIONER COLLABORATION

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Promoting Emotional Well-Being among Southern California Parishioners through Clergy/Mental Health Practitioner Collaboration

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Abstract

Developing partnerships between clergy members and mental health practitioners can be an effective way to promote the well-being of parishioners. This article presents findings from a survey that was distributed to a sample of clergy members in the Southern California area. The participants were asked to rate the level of sufficiency of services provided; their current referral practices; and general attitudes toward collaborating with outside mental health practitioners. Findings suggest that clergy are largely unprepared to meet the mental health needs of parishioners, which can lead to high levels of clergy stress due to this unmet need. Furthermore, the respondents revealed positive attitudes toward referring to mental health professionals, and largely preferred referring to counseling centers over other community resources. Clinical implications include the need for increased clergy education and training on pastoral care, counseling, and mental health. Opportunities to implement clergy care interventions are also noted.

Key Words

mental health, counseling, congregants, parishioners, collaboration, clergy, faith leaders, pastors, clergy stressors

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Clergy are often called on to assist parishioners who may be experiencing emotional or relational distress. Though many faith leaders are not properly trained to treat these issues, parishioners are more likely to seek help from their pastors than consult mental health professionals (Weaver, 1995; Clemens, Corradi, & Wasman, 1978; Chalfant, 1990; Polson & Rogers, 2007). Because congregants look for emotional healing within the church, it is important that clergy become educated about mental health problems, and also become skilled facilitators at connecting parishioners to the professionals who can best meet their needs. This study explores (a) the demands on clergy in Southern California to provide mental health services to their parishioners, (b) the level of stress created by specific needs, (c) congregational resources available to meet these needs, and (d) referral preferences in clergy collaboration with mental health and social work professionals.

Parishioners and Mental Health

To many, the church represents a place to cultivate spiritual fulfillment and to build relationships with others based on common faith. Studies have shown positive correlations between church attendance and improved mental and physical health (Larson & Larson, 2003) and reduced risk for substance abuse and suicide (Koenig & Larson, 2001). Yet congregants who suffer from emotional problems may pose a dilemma for many faith communities. White, Jackson, and Martin (2003), propose that open discussion about some disorders within churches may be "covered up due to the fear that it implies spiritual failure," and sufferers of depression and other disorders are told to "just pray harder" when the subject of mental illness is brought up.

It is estimated that 20 percent of adults fall victim to depression at some time in their lives (Pettit & Joiner, 2001), which means many church members also are prone to this affliction (Payne, 2009). Additional prevalence rates of disorders in the general population, such as anxiety (16.6 percent), substance abuse (8 percent), schizophrenia and psychosis (1 percent) and suicide, considered the third leading cause of deaths for individuals between the ages of 10 and 24 (American Psychiatric Association, 2000), indicate the extent of emotional disturbances from which church members may suffer. With such a wide range of disorders and clinical situations, Holinger (1980) notes the importance of proper assessment in order for victims to receive the care they need. One step in achieving this goal may be for pastoral staff and other churchgoers to develop a deeper understanding of mental disorders that befall congregants.

Clergy as a Mental Health Resource

Clergy often play a crucial role in the emotional well-being of congregants, and studies have shown that over 40 percent of Americans seek help from clergy when suffering emotional distress (Weaver, 1995; Clemens, Corradi, & Wasman, 1978; Chalfant, 1990; Polson & Rogers, 2007). The U.S. Surgeon General found that annually one in six adults obtains mental health services from a health care worker, social service agency, school, or clergy (Satcher, 2000). Consequently, pastors are the primary mental health counselors for tens of millions of Americans (Weaver, Koenig, &Larson, 1997). The National Institute of Mental Health found that clergy are just as likely as mental health specialists to have a person with a DSM diagnosis come to them for help, including severe mental illness such as bipolar or schizophrenia (Hohmmann & Larson, 1993). Other studies have indicated that millions of Americans with personal problems seek the help of clergy first before any other helping professional (Abramczyk, 1981; Benner, 1992; Chalfant et al., 1990; Lowe, 1986; Weaver, 1995). In one study, young adults ranked clergy

higher in interpersonal skills (warmth, caring, stability, and professionalism) than psychologists (Schindler, Berren, Hannah, Biegel, & Santiago, 1987). Though congregants look to pastors for emotional support and comfort, most clergy are not adequately trained to meet the mental health demands of their congregations (Weaver, 1995).

In their positions as church leaders, pastors are held in high esteem by parishioners who look to them for solace when suffering emotional distress. But clergy do not always feel competent to treat parishioners who suffer from depression and other mental health disorders (Moran, et al, 2005; Weaver, 1995), and without proper training, those who administer mental health interventions may not be able to help those who need it. Furthermore, cultural beliefs can impact the way that pastors perceive mental health treatment and the etiology of certain emotional problems such as depression, which may be a factor in congregants' receiving proper treatment. Payne (2009) states that while Caucasian American church leaders believe that depression is based on biological and genetic factors, African American pastors agree that it stems from a "moment of weakness when dealing with trials and tribulations" (p. 356).

In a study involving 293 self-identified Christians suffering from various mental disorders who sought counsel from church leaders (Stanford, 2007) approximately 30 percent of those interviewed had interactions that appeared to be "counterproductive to successful treatment." Considering the unique relationship between pastors and parishioners, along with cultural beliefs and levels of expertise in administering emotional care, avenues are needed in which sufferers of mental health disorders can receive the treatment they need.

Clergy Stressors

Clergy often report that they have a deep sense of fulfillment in their work. Rowatt (2001) found that satisfaction with ministry included counseling and crisis intervention, although

these are only two of the many duties clergy are required to perform in a multi-faceted role. Furthermore, while clergy report inherent satisfaction in the ministry, stressors are reported more often, and over the last 20 years, these stressors have changed – as has the nature and shape of pastoral ministry itself. As such, meeting the mental health needs of parishioners may be a major source of stress for clergy. Conflicting demands (real or perceived) from congregation and family have always created stress for ministers and spouses. Interpersonal stressors, including unrealistic, ambiguous demands and boundary intrusion from congregants, appear to be a major source of relational stress for clergy (Hall, 1997; Lee & Iverson-Gilbert, 2003; Morris & Blanton, 1994; Rowatt, 2001; Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). Additional stressors include emotional exhaustion, burnout, low personal satisfaction, and even a sense of personal failure as clergy attempt to navigate the overwhelming interpersonal demands of their unique role (Hall, 1997; Rowatt, 2001; Weaver et al, 2002). When caring for congregants suffering from trauma, clergy and healthcare workers often experience compassion fatigue and vicarious or secondary traumatic stress (Stamm, 2002; Cerney, 1995). It would seem that the cumulative stress of meeting the mental health needs of parishioners can result in emotional problems in clergy themselves, thus reducing their capacity to effectively provide care for parishioners. Collaboration between clergy and mental health practitioners may both directly and indirectly enhance the care of parishioners with mental health needs.

Collaboration among Clergy and Mental Health Practitioners

Historically, the relationship between traditional religious leaders and mental health practitioners has included elements of mistrust (Bland, 2005). In a study conducted by Polson and Rogers (2007) that involved 213 churches of five denominations, it was found that clergy rarely made referrals to mental health professionals and preferred to provide their own

counseling to congregants with emotional problems. This sense of skepticism may also affect lay persons' views of therapy. In their study, Weaver, Koenig, and Ochberg (1996) note the impact of a tornado that caused significant damage to the town of Greenville, South Carolina. Although 69 of the 116 respondents qualified for a diagnosis of acute posttraumatic stress disorder, not one person visited the area mental health center for help, all choosing instead to seek counseling from their clergy.

Many church leaders may view counselors' focus on scientific research and secular psychodynamic approaches as contrary to Christian values. As a result, when clergy refer parishioners with emotional problems to mental health professionals, they tend to recommend those with faith-based backgrounds. Openshaw and Harr (2009) interviewed 24 pastors from both rural and suburban areas of the Dallas/Fort Worth metroplex about their attitudes toward referring congregants to counselors for professional help. Although the overriding opinion was that emotional problems should not endure without intervention and support, the majority voiced a preference for counselors with "excellent skills and spiritual sensitivity."

Yet Weaver (1995) argues that the two fields of ministry and mental health share many common values. Emphasizing the need for collaboration, he states that pastors and counselors should "work together more effectively for the best interest of those they are called to serve." Weaver et al. (1996) note the importance of partnerships between parishioners and mental health experts when addressing serious mental health issues such as traumatic stress.

What kinds of relationships between mental health professionals and clergy could most benefit parishioners suffering from emotional problems? Lish, McMinn, Fitzsimmons, and Root (2005) proposed six innovative working relationships involving clergy and Christian psychologists. One relationship involved the psychologist facilitating small group meetings to

achieve conflict resolution when a division among congregation members occurred. Another involved utilizing the therapist to establish a program of caregiving to enhance the congregational ministry. When 200 randomly identified clergy were surveyed, however, the opinions of these innovations were less than enthusiastic, with clergy only responding favorably to consulting with Christian psychologists about counseling strategies as needed (76 percent interested). Beyond noting a shared Christian commitment, an additional study suggests that idiographic relational factors between specific clergy and psychologists determine the effectiveness of collaboration, rather than categorical characteristics of clergy or psychologists. (McMinn, Ammons, McLaughlin, Williamson, Griffin, Fitzsimmons, & Spires, 2005). In other words, there are no clear factors that appear to determine effective collaboration other than clergy and Christian mental health professionals building a relationship of mutual trust and referral.

Programs such as Clergy Outreach and Professional Engagement (C.O.P.E.) advocate cooperation among clergy and mental health professionals for the purpose of pooling valuable expert knowledge and "reducing the caregiving burdens of clergy and clinicians through consultation and collaboration (Milstein et al., p. 220). Bland (2005) states that in order for psychologists and clergy to work together, there must be an intentional goal to do so built on mutual participation. His model proposes that psychologists teach and train pastoral staff and lead classes in order to recognize mental health problems to develop a "dynamic healing community" that includes empowering congregation members with lay-caring skills (p. 36).

Organizations That Promote Collaboration

Since 2004, California has witnessed a transformation of the public mental health system beginning with the implementation of the Mental Health Service Act (MHSA). The vision of

MHSA, to promote mental health recovery and resiliency through consumer-driven services and community collaboration, incorporates spirituality and faith, a historically neglected area in an individual's recovery. According to Lukoff, Mahler, and Manccuso (2009), the addition of spirituality provides a holistic approach to the treatment of serious mental health problems. This reinforces the significance of clergy members' collaboration with counseling professionals as a vital component of addressing parishioners' diverse needs.

Several faith-based initiatives have been implemented to support mental health recovery. On a federal level, the Substance Abuse and Mental Health Service Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services (HHS), established the Faith-Based and Community Initiative in 2000. It has served as a model of effective partnerships between federal programs and faith-based and community organizations in addressing the needs of those at risk for mental health and substance abuse problems (HHS, SAMHSA).

In 2008 the Center for Multicultural Development at the California Institute for Mental Health (CIMH) established the Mental Health and Spirituality Initiative. The goal of the initiative includes collaboration with faith-based organizations, mental health services providers, consumers, family members, and communities to reduce the stigma of mental illness and increase access to services by underserved individuals. In the Southern California area, the Los Angeles County Department of Mental Health has established a clergy advisory committee as part of efforts to advocate for the rights of consumers, fight stigma, and increase much needed services. Such efforts offer faith leaders opportunities to collaborate with mental health professionals when addressing the diverse emotional needs of parishioners.

Building Stronger Clergy/Counselor Relationships for the Future

Despite the proposed need for collaboration among clergy and mental health practitioners, it may be unreasonable to assume that new and dynamic relationships between the two would evolve overnight. As stated, a mutual mistrust often has impacted their relationship (Bland, 2005) and genuine progress would likely take time. Weaver (1995) suggests a practical approach to integrating the spiritual and mental health domains within the church, which would involve incorporating a brief model of parish-based pastoral counseling, training in faith expression and counseling integration, including self-care coping skills. This would aid clergy in becoming "skilled facilitators in the mental health network, not treating psychotherapists." Additionally, continuing education would be needed for clergy to remain abreast of new trends in mental health care (Polson & Rogers, 2007). With a dynamic referral process to supplement practical mental health components within the church, the emotional needs of parishioners could be more adequately addressed.

In summary, research indicates that many congregations have a significant number of parishioners who are suffering from mental health difficulties. Parishioners are likely to first seek help from clergy, who may or may not have the education, training, and/or experience to meet these needs, and may experience these demands as stressful. Clergy appear to vary in their preferences of collaborating with and referring to other helping professionals. Facilitating collaboration could result in the increased care of the mental health of parishioners, as well as improved mental health of clergy themselves. The current study seeks to explore these issues among clergy in Southern California by asking the following:

- What mental health needs do clergy perceive in their congregations?
- What mental health needs do clergy currently meet?

- What mental health needs are met by congregational resources other than clergy?
- What mental health needs are currently unmet?
- What demands for mental health assistance are the most stressful for clergy?
- How prepared are clergy to meet these needs? Where did they receive their preparation?
- What are the referral and collaboration patterns and preferences of clergy?

Method

Research Tool

The researchers utilized a modified version of an established survey instrument with permission from authors Openshaw & Harr (2009). The original instrument was created to collect open-ended questions through an interview format. Based on the survey instrument, the researchers constructed a questionnaire to collect written data through closed and open-ended questions (Appendix). A written survey instrument was selected because of its ease of use for participants, and for the opportunity to collect a large sample size for quantitative and qualitative data analysis. The researchers obtained permission from their university's Institutional Review Board to survey participants. Each participant signed an informed consent form and confidentiality statement before completing the survey.

The survey contained 15 major questions, with one question (#11) subdivided into 17 parts. The initial seven items gathered demographic information through a multiple choice format. The remaining questions assessed (a) participants' previous attendance at workshops on mental health (provided by the researchers), (b) their perceived knowledge about mental health, (c) types of mental health and/or social service interventions provided by a clergy member or other church member, (d) whether services were perceived as needed if determined as unmet,

and (e) levels of perceived stress as a result of providing these services. Additionally, participants were asked:

- to rate the level sufficiency of the services provided.
- to indicate where they referred congregants for outside mental health serviced.
- to indicate with whom they wished to collaborate for outside mental health services.
- to comment on their general attitude toward referring their congregants to outside mental health professionals.

The survey was distributed on three separate occasions through a convenience sampling method. In November 2011, the researchers attended two area ministerial association meetings during which clergy were invited to complete the survey. A total of 16 completed surveys were received at the end of each meeting. In June 2011, to increase the sample size, the researchers expanded the demographic survey area by sending survey packets to 260 clergy in Southern California. These individuals were identified from a list provided by the university's theology department and campus pastors' office. The researchers selected individuals on the list who were active church leaders serving in a pastoral role. The individuals surveyed by mail were offered a $5 gift card as incentive for completing the survey.

Participants

Of the 276 surveys distributed, a total of 87 were completed and returned. In order to focus the research, four surveys were eliminated from the sample because the participants were not working in the Southern California area; nine other surveys were eliminated because the participants did not indicate that they were currently acting as members of the clergy for their parish. This elimination process resulted in a final sample size of 74 participants. The age of the

participants ranged from 28 to 79 years with the average age being 53.6 years. The sample included both male (70.3 percent) and female (29.7 percent) participants with 7 percent identifying as Asian, 1 percent as African American, 11 percent as Latino, and 81 percent as Caucasian. Eighty-seven percent of the subjects identified themselves as Protestants; with the denomination most represented being United Methodist (24 percent), Baptist (4 percent) and Brethren in Christ (4 percent). When asked about their knowledge of mental health, 19 percent indicated that they were very knowledgeable, 77 percent endorsed having some knowledge, while the remaining 4 percent indicated that they were "not at all" knowledgeable of mental health issues.

Data Analysis

Response frequencies, means, and percentages were calculated with a commonly used statistics software program (PASW Statistics 18.0). The results of these calculations can be found in the tables provided. Additionally, grounded theory, a systematic methodology for analyzing qualitative information, was used to ascertain the themes and patterns present in the answers to the open-response items of the questionnaire (e.g., "How did you obtain your knowledge of mental health?"). This entailed the researchers collaboratively consulting with one another in order to determine the prominently common themes and categorize responses accordingly.

Results

The results of the analysis are presented in terms of the statistical analysis of survey data obtained from 74 clergy members from the Southern California area. As part of the survey, participants were given a list of services and asked to identify those that were provided by clergy and/or non-clergy at their place of worship (See Table 1). Of the services listed, participants

indicated that those most often provided by clergy were premarital and marital counseling (87 percent), grief and bereavement (55 percent), issues related to depression (53 percent), and parenting issues (51 percent). Services mostly provided by non-clergy included homeless assistance (19 percent), financial help (16 percent), assistance with substance abuse (12 percent), and help with finding employment (12 percent).

Participants also were given a list of services and asked which were needed but unmet (See Table 1). Of the services listed, the greatest needs were employment (24 percent), gay and lesbian issues (22 percent), substance abuse (19 percent), stress and anger management (16 percent) and legal issues (16 percent). From the same list, participants were asked to rate each service in terms of the level of stress it caused: high, moderate and low. Those that most participants endorsed as highly stressful related to suicide (26 percent), abuse (spousal, child or elder) (19 percent), and crisis intervention (18 percent). Services identified as either highly or

Table 1

Services Provided (N= 74)

Services and those who provide them					Services needed but unmet	Level of stress providing these services			
	(C) Clergy; (NC) Non-Clergy; (C/NC) Both Clergy & Non-Clergy; (NP) Not Provided					(H) High; (M) Moderate (L) Low; (NP) Not Provided			
	(C)	(NC)	(C/ NC)	(NP)		(H)	(M)	(L)	(NP)
1. Hospital/Nursing Home	35.1%	1.4%	32.4%	31.1%	6.8%	1.4%	16.2%	54.0%	28.4%
2. Homeless Assistance	28.4%	18.9%	36.5%	16.2%	12.2%	2.7%	33.8%	36.5%	27.0%
3. Premarital/ Marital Counseling	86.5%	1.4%	6.8%	5.4%	2.7%	6.8%	18.9%	60.8%	13.5%
4. Financial	33.8%	16.2%	25.7%	24.3%	16.2%	4.1%	20.3%	45.9%	29.7%

5. Parenting Issues	51.4%	9.4%	21.6%	17.6%	5.4%	4.1%	27.0%	44.6%	24.3%
6. Grief/ Bereavement	55.4%	4.1%	35.1%	5.4%	5.4%	5.4%	25.7%	55.4%	13.5%
7. Substance Abuse/Addictions	25.7%	12.1%	41.9%	20.3%	18.9%	10.8%	16.2%	23.0%	50.0%
8. Employment/ Job Search	14.9%	12.1%	20.3%	52.7%	24.3%	8.1%	14.9%	18.9%	58.1%
9. Crisis Interventions	44.6%	5.4%	23.0%	27.0%	9.5%	17.6%	29.7%	12.2%	40.5%
10. Gay/Lesbian Issues	33.8%	2.7%	8.1%	55.4%	21.6%	6.8%	18.9%	21.6%	52.7%
11. Stress/Anger Management	44.6%	6.8%	13.5%	35.1%	16.2%	9.5%	28.4%	17.6%	44.6%
12. Depression	52.7%	5.4%	13.5%	28.4%	13.5%	5.4%	23.0%	32.4%	39.2%
13. Severe Mental Illness	23.0%	2.7%	5.4%	68.9%	17.6%	9.5%	12.2%	12.2%	66.2%
14. Suicide	41.9%	2.7%	9.5%	45.9%	10.8%	25.7%	13.5%	14.9%	45.9%
15. Legal Issues (e.g., jail, undocumented persons)	18.9%	9.5%	13.5%	58.1%	16.2%	6.8%	17.5%	14.9%	60.8%
16. Abuse (spousal, child, elder)	41.9%	5.4%	17.6%	35.1%	13.5%	18.9%	21.6%	16.3%	43.2%

moderately stressful (combined percentages) were crisis intervention (47 percent), homeless assistance (36 percent), suicide (39 percent), abuse (spousal, child or elder) (41 percent), and stress and anger management (38 percent).

Given the choice of (a) counseling center, (b) physician, (c) hospital, or (d) other, when asked to whom they would refer for outside mental health services, most participants provided multiple responses and the majority (84 percent) chose counseling centers. When given the same choices and asked with whom they wished to collaborate, counseling centers also represented the preferred choice over other options (84 percent).

Participants provided qualitative feedback by answering two questions pertaining to their views of mental health. For the first, they identified ways in which they obtained their knowledge of the subject (See Table 2). A variety of responses were given, including “books,” “college courses,” “education,” “research on the internet,” and “seminars and workshops”

attended. Some noted that they possessed expertise in the field (e.g., "Licensed MFT and Certified Pastoral Counselor," "M.Ed in Professional counseling," and "MA in the field of counseling"), while personal experiences played a key role in some participants' understanding of the field, as evidenced by responses such as the following: "My daughter has a bipolar condition," "Mother's schizophrenia . . ." and ". . . I was married to a psychiatric social worker for 40 years." Several responses embodied multiple skills that contributed to the subject's knowledge of mental health, such as the following participant response: "Seminary classes, ongoing reading, observation of people across 33 years of pastoring, and self-awareness."

For the final qualitative response, participants were asked to discuss their general attitude about referring congregants to outside mental health professionals (See Table 3). Many

Table 2

*How participants obtained their knowledge of mental health (N=74)**

Resources	Percent	*Frequency*
Coursework		
Undergraduate or General	13.2%	21
Pastoral/MDiv/Seminary	9.4%	15
Counseling Degree	5.0%	8
Seminars, Training, Workshops	17.6%	28
Experience		
Personal	11.3%	18
Occupational	12.6%	20
Not Specified	7.0%	11
Personal Study, Research, Reading	18.2%	29
Consultation with Mental Health Professionals or Colleagues	3.8%	6
Other Responses	1.9%	3

*159 total responses; most participants indicated that they obtained their knowledge of mental health from multiple sources

responses were favorable, including: “I’m completely comfortable referring my congregation to outside services,” “I have experienced the benefits of counseling and support our members to look for that kind of expert help,” and “I affirm this fully.” A number of responses indicated a favorable opinion of referring to spiritually-based counselors: “I wish to collaborate with MH professionals so that congregants receive the spiritual aid they need” and “Helpful! When I know they are Christ-centered, I consider it a great partnership.” A few responses indicated reticence to refer outside the church, as in the following: “Concern - I need to know the professional well and trust her/his approach” and “Each referral is a lesser or greater risk of trusting our congregants' emotional, relational needs to outside mental health professionals.” One response implied a

Table 3

Participant Attitudes about referring their congregants to mental health professionals (N= 74)

Attitudes	Percent	*Frequency*
Positive (no reservations about referring)	68.9 %	51
Positive, as long as counselor is Christian or part of a Christian Organization	14.9%	11
Cautious (must know the counselor and his/her faith background)	12.2%	9
Negative (would not refer)	.01%	1
Other	.03%	2

negative view toward mental health intervention: “We have not had this type of situation occur so far, but if it presents itself our first resource would be prayer and faith.”

Discussion

Major Findings

It should be noted that the sample size was relatively small. Furthermore, the sample consisted largely of older, male, Caucasian, Protestant clergy. The data also had some limitations due to survey construction issues.

Findings suggest that the most frequent mental health issues addressed by clergy are mild to moderate in terms of severity, which is appropriate scope of practice in many cases. Many of the needs met by non-clergy or unmet altogether are more severe and complex. These also tended to be the issues that create moderate or high stress levels for clergy. Clergy are largely unprepared to meet the mental health needs of parishioners. Consequently, clergy and congregations would benefit from collaboration with mental health professionals to address these issues. Interestingly, the current sample responded that their attitudes are quite positive toward referring to mental health professionals, preferring counseling centers to any other single resource. This result differs significantly from previous research (e.g., study by Openshaw & Harr, 2009, involving 24 clergy members from the Dallas/Fort Worth area), and may reflect a bias in Southern California subculture that is more amenable to accessing the services of therapists. The efforts of the state public mental health system to involve the clergy members, as leaders in the faith community, may also serve as a factor in these results.

Clinical Implications

Results suggest that clergy have varying degrees of education and training regarding pastoral care, counseling, and mental health issues. In the current sample, a minority of

participants had any coursework or continuing education in these topics. In order to address the gap in clergy education and training, the primary investigators are creating a series of seminars for Southern California clergy through the community counseling center at a local university to address the needs that emerged in the major findings. Clergy will be invited to continuing education seminars on (a) knowing when and how to refer to mental health professionals, (b) developing a congregational-specific resource list, (c) mental health issues such as depression, suicidality, family violence (child abuse and domestic violence), and anger management, and (d) working with social work professionals to provide financial and job assistance to parishioners. Professional development seminars may also be developed, focusing on the counseling services most often offered by clergy, such as premarital or bereavement counseling. Training in undergraduate and seminary institutions should include supplementary curriculum to prepare clergy for the practical realities of the pastoral role. Faculty at these institutions also should consider conducting ongoing seminars for the pastoral staff or parishioners of local congregations.

Results also indicate that clergy are regularly exposed to many forms of mental illness, including chronic and severe mental illness, as well as exposure to trauma. These results would suggest that clergy themselves are likely in need of support as they care for their congregations. The primary investigators will also address the mental health of the clergy themselves by providing a series of Clergy Care Days. These workshops will access multiple university departments to provide clergy with (a) personalized mental and physical health assessments, (b) a detailed self-care plan, and (c) resources for professional development, spiritual direction, emotional support through peer groups and psychotherapy, exercise and nutrition planning, and personal financial planning.

Future Research

Future analysis of the current data will explore group differences in parishioner mental health needs, congregational resources, clergy stress, and referral preferences by demographic variables (age, gender, denomination, and size of church). Future research should also utilize regression models to explore whether any demographic factors predict clergy responses to survey items. Additional research projects may consider utilizing established measures of clergy demands and stress in combination with congregational needs and resources assessments to further establish a nuanced perspective of the met and unmet needs that create the most stress in clergy. More research is needed in the area of the mental health of clergy themselves, and further assessing the degree to which counseling parishioners contributes to poor clergy mental health in combination with other factors.

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Appendix

Clergy Questionnaire

AZUSA PACIFIC UNIVERSITY

CLERGY QUESTIONNAIRE

Date _____

Name (optional) _____ Age _____

Job Title _____ Gender _____

1. Ethnic Identification:
    a. Asian
    b. Black
    c. Hispanic
    d. Native American
    e. White
    f. Other _____

2. Experience in this job (years):
    a. 0-3 yrs.
    b. 4-7 yrs.
    c. 8-11 yrs.
    d. 12+ yrs.

3. Select highest level of education completed:
    a. H.S. diploma
    b. AA
    c. BA/BS
    d. MA/MS
    e. Doctorate
    f. Other (specify): _____

4. Did you attend seminary?
    a. Yes If yes, name of seminary: _____
    b. No

5. Denomination of your church:
    a. Catholic
    b. Protestant Specify: _____
    c. Other (specify): _____
6. Location of church (city): _____

7. Select the approximate size of your church:
    a. under 50
    b. 50-150
    c. 151-300
    d. 301-500
    e. 500+

8. Did you attend an Azusa Ministerial Association "Mental Health and Congregations" Workshop in 2009?
    a. Yes If yes, circle which one(s) attended? March 2009 November 2009
    b. No

9. How knowledgeable are you about mental health?
    a. Not at all knowledgeable
    b. Somewhat knowledgeable
    c. Very knowledgeable

10. How did you obtain your knowledge of mental health?

    _____

    _____

11. Please use the following table and check all that apply:

	Check if provided by the following: Clergy (C) Non-Clergy (NC) Not Provided (NP)			**Check number of times <u>per month</u> that each service is provided:**			**Check if this service is NEEDED but currently UNMET**	**Rate your level of stress as a result of providing this service High (H) Moderate (M) Low (L)**
	C	**NC**	**NP**	**1-3**	**4-6**	**7 or more**		
1. Hospital/nursing home								
2. Homeless Assistance								
3. Premarital/Marital Counseling								
4. Financial								
5. Parenting Issues								
6. Grief/Bereavement								
7. Substance Abuse/Addictions								
8. Employment/Job Search								
9. Crisis Intervention								

10. Gay/Lesbian Issues								
11. Stress/Anger Management								
12. Depression								
13. Severe Mental Illness								
14. Suicide								
15. Legal Issues (e.g. jail, undocumented persons)								
16. Abuse (spousal, child, elder)								
17. Other (specify: _____)								

12. How sufficient are the above services provided by your church to meet the needs of your congregation?
    a. Not at all sufficient
    b. Somewhat sufficient
    c. Very sufficient

13. To whom do you refer for outside mental health services (circle all that apply)?
    a. Counseling Center
    b. Physician
    c. Hospital
    d. Other (please specify): _____

14. With whom do you wish to collaborate for outside mental health services (circle all that apply)?
    a. Counseling Center
    b. Physician
    c. Hospital
    d. Other (please specify): _____

15. What is your general attitude about referring your congregants to outside mental health professionals?

_____

_____

_____

_____

_____

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