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AN EXPLORATION OF FACTORS INFLUENCING THE REFERRAL PRACTICES OF BLACK CLERGY AND MENTAL HEALTH PROFESSIONALS: TESTING A CO-PROFESSIONAL MODEL FOR INTERACTING

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ABSTRACT

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The major purpose of this study was to examine the referral practices of Black clergy and mental health professionals from a bidirectional, co-professional perspective. The study concerned whether professional or co-professional variables most influenced four referral options of the bidirectional model.

The population comprised Black clergy and mental health professionals. The 51 Black clergy were from Lansing, Detroit, New York, Tennessee, and Mississippi. The clergy represented a cross-section of denominations, including Baptist, Seventh-Day Adventist, Church of God in Christ, Lutheran, and Methodist. The 62 mental health professionals included psychologists, social workers, and substance-abuse counselors from Lansing, East Lansing, Detroit, and Memphis.

Two instruments were used to collect data. The Mental Health Referral Questionnaire was used to collect data from the mental health professional sample. The Pastoral Counseling and Mental Health Questionnaire was used for the clergy sample. The instruments were mailed or administered in a group setting.

The data were analyzed using hierarchical regression, Pearson's product-moment correlation coefficient, and the Mann-Whitney test for two independent samples. Two-tailed tests were used in all cases. Major findings were: (a) Clergy who had a strong Theological-Psychological orientation were more open to concurrent referral with mental health professionals; (b) Clergy who had a strong C-T (conservative theology) orientation spent fewer hours in scheduled counseling appointments and pastored smaller churches; (c) Clergy who were more acquainted with mental health resources had served longer at their present churches, pastored larger congregations, had closer personal relationships with mental health professionals, and had spent more hours in scheduled counseling appointments; (d) Clergy who had more scheduled counseling appointments were more acquainted with mental health resources, pastored larger churches, had received more hours of supervised pastoral counseling, and had completed more undergraduate psychology courses; (e) Most clergy believed there should be close cooperation between clergy and mental health professionals; (f) Mental health professionals who had close personal relationships with clergy were less open to having a conjoint relationship with them; and (g) Mental health professionals who had taken more courses in multicultural and urban counseling made more referrals to clergy.

To my mom, Elaine Mars, for her love, sacrifices, and prayers. She was my inspiration throughout this project.

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To the late Dr. Pasteur, who started me on this journey. He made me believe that this final goal was possible with hard work.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION TO THE STUDY

Introduction and Statement of the Problem

The Black clergy and the Black church historically have played an important role in the lives of Black Americans. Today, they continue to have a profound effect on the lives of Blacks. The literature on Blacks and religion has indicated that religion is an integral part of their lives. For example, in comparison to Whites, Blacks attend religious services more frequently (Nelsen, Yokely, & Nelsen, 1971; Sasaki, 1979), pray at higher rates (Greely, 1979), and feel more strongly about their beliefs (Alston, 1973).

In a comprehensive study that used the 1972 National Election Study, the 1976 Gallup Poll, and the 1972-1977 General Social Survey, Saaski (1979) found that Blacks, as compared with Whites, were likely to (a) pray more frequently, (b) attend church more frequently, (c) endorse the Bible as the word of God, (d) indicate that they were "born again," (e) think that their religious beliefs were important, and (f) believe that God sends misfortunes as punishment for sins. Saaski also found that Blacks used hospital emergency rooms, private physicians, and ministers more frequently than did Whites. The results of this study, as well as the ones above, underscore the importance of the church in the contemporary Black community.

The close relationship that continues to exist between the Black clergy and the Black community has important implications for mental health service delivery. Less stigma is attached to seeking psychological help from the clergy than from a mental health professional, and the clergy are more accessible for giving help to people under stress (Neighbors, 1983). In view of the important role that the Black clergy plays in the Black community, it is critical that their psychological referral practices be examined. Moreover, it is crucial that community mental health agencies that serve Black communities consult with pastors in order to provide more culturally relevant and therapeutically efficacious interventions.

These alliances become even more important in light of several reports that have noted that when many people have emotional problems they first turn to the clergy for counsel. The final report by the Joint Commission on Mental Illness and Health (1961) posited that 42% of Christians first consulted the clergy when confronted with a psychological problem. Gurin, Veroff, and Field (1960) also reported that 42% of the Christians in their study said that the clergy was the most frequently consulted source of help when they were faced with an emotional problem. Woodward (1951) reported that 26% of the subjects in his study stated that they would seek advice from clergy concerning their condition.

The National Institute of Mental Health has suggested the inclusion of qualified members of the clergy on community mental health staffs, not in the role of traditional chaplains, but as resource persons (Winett, Majors, & Steward, 1979). Ultimately, the clergy have been placed in the position of "gatekeepers" in the mental

health system. It is their decision that determines whom they are to treat or who is to be referred to mental health professionals. The decision to treat or refer is determined not only by the nature of the presenting problem, but also by the clergy's attitudes and knowledge of mental health services, and their own mental health training (Winett et al., 1979).

Although the clergy make only about 3% of the referrals to psychiatrists, 42% of Americans have said that they would contact their clergy if they had an emotional problem. These statistics indicate that a large number of emotionally disturbed people are being served by the clergy and consequently are not coming into contact with psychiatrists/psychologists. Several factors could be responsible for this practice. First, clergy may be referring only those who are judged to be in serious need of psychiatric assistance. Second, many clergy, trained in pastoral counseling, may perceive that they are equipped to handle many of the presenting problems with or without consulting a psychiatrist/psychologist, and consequently no referral is made. Finally, the clergy may not be knowledgeable about the symptoms that indicate mental illness in order to make the required referral, when the psychiatrist/psychologist would recommend referrals of a similar nature were he or she fully cognizant of the circumstances. The attitudes and opinions of the clergy about mental illness and psychiatry are therefore very important as these individuals counsel the emotionally disturbed. Their definition of abnormal behavior and their image of psychiatry will determine how many emotionally ill church members are

ultimately referred to professionally trained mental health professionals (Larson, 1965).

Rabkin (1974) posited that the knowledge of mental health attitudes is not only essential to those professionals involved in the etiology and treatment of mental illness, but is essential to workers involved in the prevention, early intervention, and community treatment of mentally ill patients. Rabkin captured the importance of mental health workers' being cognizant of the environment in which their clients live when he wrote:

> In short, it is becoming generally recognized that mental health patients, and those who deal with them, exist in the lay framework of society and that it is imperative, in both planning and carrying out treatment programs, to be aware of the attitudes toward mental illness and treatment that prevail in this larger framework. (p. 9)

This unidirectional interaction between the clergy and psychologists tacitly assumes that the clergy will refer clients to mental health professionals. However, the statistics indicating low referral rates suggest that this model is not very effective (Meylink & Gorsuch, 1986). Using the concepts of reciprocity and equality in social relationships, Piedmont (1968) found that there was a significant relationship between referral activity and the amount of feedback received from the professional receiving the referral. In answer to this problem, Gorsuch and Meylink (1986) proposed a bidirectional and co-professional model, whereby psychologists and clergy work together in a more equitable relationship. In this relationship, referrals are made in both directions as these professionals interact with each other to

provide conjoint and concurrent treatment approaches to clients, in addition to the traditional two options--treat or refer.

Several researchers have examined the referral practices of the clergy from the gatekeeper's perspective (Cumming & Harrington, 1963; Kevin, 1976; Winett et al., 1979). However, the only known investigators who "tested" the bidirectional model used only a qualitative approach, with very small samples of clergy and psychologists (Gorsuch & Meylink, 1988). The variables that may influence the decision of the clergy and mental health professionals to use any one of the referral options have not yet been explored. Moreover, no study was found in which the researcher exclusively examined the referral practices of the Black clergy using either the unidirectional or the bidirectional model. Because the Black church and the Black clergy play such an important role in the Black community, and the consequent greater likelihood that the Black clergy will have a large percentage of their congregation turning to them for help with emotional/psychological problems, it is important that their referral practices and their relationship to mental health professionals be examined.

Purpose of the Study

The researcher's purpose in this study, therefore, was to examine the psychological referral practices of Black clergy and mental health professionals using a bidirectional, co-professional model. More specifically, the writer examined whether professional traits or co-professional interaction variables of the Black clergy and mental health professionals most influence four referral options of the

bidirectional model. Also examined was the relationship between these referral options and specific professional and co-professional variables.

Hypotheses

Several hypotheses were tested in this study. They are stated below.

Hypothesis 1a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict concurrent referral for the clergy.

Hypothesis 1b: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with the clergy) will predict concurrent referral for mental health professionals.

Hypothesis 2a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict conjoint referral for the clergy.

Hypothesis 2b: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with the clergy) will predict conjoint referral for mental health professionals.

Hypothesis 3a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict the treat-alone option for the clergy.

Hypothesis 3b: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with mental health professionals) will predict the treat-alone option for mental health professionals.

Hypothesis 4a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (acquaintance with mental health resources and personal relationships with mental health professionals) will predict the refer option for the clergy.

Hypothesis 4b: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal and professional relationships with the clergy) will predict the refer option for mental health professionals.

Hypothesis 5: Black clergy who have had more counseling-related education (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.
b. be more likely to use conjoint referral on the vignettes.
c. be less likely to use the counsel-alone option on the vignettes.
d. make more referrals to mental health professionals
e. receive more referrals from mental health professionals.

Hypothesis 6: Black clergy who have had more professional contact with mental health professionals (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.
b. be more likely to use conjoint referral on the vignettes.
c. be less likely to use the counsel-alone option on the vignettes.
d. make more referrals to mental health professionals
e. receive more referrals from mental health professionals.

Hypothesis 7: Black clergy who have had close personal relationships with mental health professionals (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.
b. be more likely to use conjoint referral on the vignettes.
c. be less likely to use the counsel-alone option on the vignettes.
d. make more referrals to mental health professionals
e. receive more referrals from mental health professionals.

Hypothesis 8: Black clergy who are more oriented to the Conservative Theology (C-T) model of pastoral counseling (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be less likely to use concurrent referral on the vignettes.
b. be less likely to use conjoint referral on the vignettes.
c. make fewer referrals to mental health professionals.
d. receive fewer referrals from mental health professionals.

Hypothesis 9: Black clergy who are more oriented to the Theology parallels Psychology (T-P) model of pastoral counseling (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.
b. be more likely to use conjoint referral on the vignettes.
c. make more referrals to mental health professionals.
d. receive more referrals from mental health professionals.

Hypothesis 10: Mental health professionals who are more religiously active (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive more referrals from the clergy.

Hypothesis 11: Mental health professionals who report that religion is more important in their lives (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive more referrals from the clergy.

Hypothesis 12: Mental health professionals who have had more professional contacts with the clergy (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive more referrals from the clergy.

Hypothesis 13: Mental health professionals who have had close personal relationships with the clergy (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive more referrals from the clergy.

Hypothesis 14: Mental health professionals who have had more training in multicultural or urban counseling (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive fewer referrals from the clergy.

Hypothesis 15: Mental health professionals with more positive perceptions of the importance to therapy of understanding a client's religious beliefs (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.
b. be more likely to agree that the clergy should use conjoint referral on the vignettes.
c. make more referrals to the clergy.
d. receive more referrals from the clergy.

Overview

Chapter II contains a review of pertinent literature related to the following areas: the importance of the Black church and the Black clergy in the Black community; the relationship between the clergy and psychologists/psychiatrists; the mental illness/health attitudes of the clergy, models of pastoral counseling, and variables that affect the referral practices of the clergy under the unidirectional model; and an outline of the bidirectional model. The methodology that was used in this study is described in Chapter III. The following subsections are included in this chapter: subjects, design, independent variables, measures (dependent variables), and procedure. The results of the data analyses are presented in Chapter IV. In Chapter V, the results and their implications are discussed. The limitations of the study and suggestions for future research in the area also are outlined.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

A limited number of researchers have assessed the referral practices of the clergy in general, but there are no known studies in which the referral practices of Black clergy have been addressed. This researcher attempted to fill that void. This chapter includes a review of literature on (a) the importance of the Black church and the Black clergy in the Black community, (b) historical and theoretical perspectives on the attitudes of clergy toward mental illness/health, (c) some models of pastoral counseling that could affect the referral practices of the clergy, (d) the mental illness/health attitudes of ministers, (e) factors that affect clergy referrals under the unidirectional model, and (f) the bidirectional model.

The Black Church and the Black Clergy

Hamilton (1972) examined the historical and current roles of the Black clergy in various areas of Black life, with a special emphasis on their role in the Black church and the Black community. He demonstrated the importance of religion in the lives of Blacks beginning with slavery. The church provided an outlet for the expression of their feelings of humiliation, pain, and anger. The church also played

a very important role in the escape of Blacks from slavery. Signals as to the time and place of an escape were given during the religious service. Hidden messages contained in the Negro spirituals were often the vehicle through which these signals were sent.

After slavery, the Black church continued to play a pivotal role in the lives of Blacks. In the absence of labor unions and very few social, political, or economic agencies for Blacks, the Black church became the major institution for Blacks. Out of this environment the natural leadership of the Black preacher evolved. The preacher was the most respected person in the Black community and was often sought by Whites who wanted to reach the Black community, either to give or receive information. Black preachers, in essence, became the natural and most convenient funnel. Consequently, Blacks used them as "intercessors" for them with the White community. For example, the preacher was generally the most sought after person for members who needed a character witness in court.

The importance of the Black church, and the concomitant prominence of the Black preacher, became even more pronounced in the light of a rigidly separated Black community. Blacks were systematically excluded from participation in the mainstream community and were denied the opportunity to develop their potential as total persons. Blacks, consequently, turned to the church to take care of their political, social, educational, and recreational needs. The church was also responsible for meeting the medical and mental health needs of its members. It was

the Black church that had to take care of Blacks who were sick and mentally ill because of the segregated hospitals and mental institutions (Wimberly, 1989).

Hamilton (1972) examined the Black preacher's role in the light of three dynamic and often traumatic experiences, involving abrupt cultural transformations in the lives of Blacks. Each of these experiences was viewed as having serious implications for the disruption of the Black community's social institutions and for the ways in which this group has attempted to adapt to these changes in their lives.

The first traumatic experience to which Blacks had to adapt was their capture and sale into slavery with all the inhumane conditions of the middle passage. The second significant experience was the change from slavery to freedom. Blacks were given their freedom after approximately 250 years of bondage. After being freed, the former slaves were not given enough support in the art of survival in their new environment. They were free officially, but politically, economically, and educationally they became the "slaves" of society. The third cultural transformation occurred with the mass movement of Blacks from the South to the North. Blacks were leaving an agrarian, personal, informal, slower-paced environment and came into an industrial, impersonal, formal, faster-paced society.

In all three of the above-mentioned experiences, Blacks had their social institutions disrupted. The one institution and individual on which they depended to bridge these transitional periods were the church and the Black preacher. In essence, the preacher became the linkage figure, helping to bridge the old and the new, the familiar with the unfamiliar.

Attitudes of Clergy Toward Mental Illness/Health: Historical and Theoretical Perspectives

Few researchers have examined the attitudes of the clergy toward mental illness. In this review, historical perspectives will be discussed along with the relationship between the clergy and mental health professionals.

Clark (1973) posited that it is very important that mental health professionals understand the history of Judaeo-Christian attitudes toward mental illness. They saw the Bible as the most important source of this history because of its historical value, in addition to the universal belief of Jews and Christians that the Bible is divinely inspired. According to Clark, this belief is held not only by Christians, but also by people who have been brought up by this tradition and have been influenced by these ideas.

A perusal of the Bible strongly indicates one conception of mental illness that is a consequence of sin and demonic possession. This conception is evidenced in several examples in the Old Testament where the exorcism of demons was used to "cure" the sick and insane. The following is a classic example of this frame of reference:

> And Jesus and his disciples came over unto the side of the sea of Galilee, into the country of the Gadarenes. . . . And when Jesus was come out of the ship immediately there came out of the tombs a man with an unclean spirit, who had his dwelling among tombs; and no man could bind him, no, not with chains: Because that he had been often bound with fetters broken in pieces: neither could any man tame him. . . . And always, night and day, he was in the mountains, and in the tombs, crying, and cutting himself with stones. . . . But when he saw Jesus afar off, he ran and worshipped him. . . . And he cried with a loud voice, and said, What have I to do with thee, Jesus, thou Son of the most high God. I adjure thee by God, that thou torment me not. . . . For Jesus said unto him, come out of the man, thou unclean spirit. . . .

> And he asked him, What is thy name? And he answered, saying, My name is Legion; for we are many. . . . Now there was nigh unto the mountains a great herd of swine feeding. . . . And the devils besought him, saying, send us into the swine . . . and forthwith Jesus gave them leave. And the unclean spirits entered into the swine: and the herd ran violently down a steep place into the sea and were choked in the sea. . . . Him that was possessed with the devil and had the Legion was sitting and clothed, and in his right mind. . . . And when Jesus was come into the ship, he that had been possessed with the devil prayed him that he might be with him. . . . Howbeit Jesus saith unto him, Go home to thy friends, and tell them how great things the Lord had done for thee and had compassion on thee. (Mark 5: 1-19) (King James Version)

An examination of this biblical frame of reference is important because the clergy's own conceptions about the causes of mental illness are directly affected by what the inspired word of God says is the cause. More important, having this theological world view of mental illness could directly affect the clergy's attitudes toward treatment if mental illness is perceived as resulting from sin or demonic possession.

Roberts (1953) posited that there is an important difference between the New Testament conceptions of mental illness and contemporary conceptions of it. No distinctions were made in New Testament times among physical, mental, moral, and religious health. When people received forgiveness of sin, they were concurrently healed of physical sicknesses and diseases. "There was no question of splitting human beatitude into a multiplicity of functions, and there was no question of trying to promote the welfare of the individual in abstraction from the salvation of the community" (Roberts, 1953, p. 19). Today, the concept of health is generally not perceived from a holistic perspective, with distinctions being made for physical, mental, moral, and religious health. This compartmentalizing of health into distinct

disciplines can result in one discipline attempting to monopolize or discount the other. The relationship between the psychologist and the clergy is an example of this:

> The psychologist tends to regard his own principles as furnishing the criteria whereby he can differentiate between illusion and valid world views, between religious [or unreligious] attitudes which enhance human welfare and those which tend to undermine it. On the other hand, the Christian believer tends to regard his conceptions of God, history, and human nature as enabling him to separate the wheat from the chaff in various and conflicting teachings of contemporary psychology. (Roberts, 1953, p. 20)

Roberts (1953) asserted that this conflict occurs generally at a theoretical level, and it tends to be reduced in actual clinical situations. He advanced that the psychologist and the minister usually are faced with situations in which they both recognize the need for and the benefits of the other's discipline. "The Protestant pastorate is just waking up to the fact that contemporary psychotherapy, along with perennial Christian resources, may revitalize the healing function of the church and throw fresh light upon traditional doctrines" (p. 21).

Reisman (1951) and Preston (1955) expressed a similar view of the relationship between the clergy and the mental health professional. They saw a new reconciliation between these two disciplines that has been forged as a result of the reciprocal contributions made to both fields. In essence, there is no essential conflict between psychiatry and religion (Fletcher, 1952). The themes of mutual contributions and no essential conflict suggest that the clergy are becoming more sympathetic and understanding of the problems that confront the field of psychiatry. The clergy, however, seem to have accepted the position that there is no conflict

between psychiatry and religion only on a theoretical level. At a behavioral level, there still seem to be many unanswered questions (Larson, 1965).

Richardson's (1989) research showed that African American clergy have positive attitudes toward mental health professionals. This research contradicted the prevailing belief that the absence of working relationships between these professionals is due to the Black clergy's fear that their parishioners will seek out professional psychological help for their problems. Richardson concluded that this research may indicate that the African American clergy and mental health professionals are ready to establish a working relationship that will enhance the spiritual, social, and psychological well-being of African Americans.

Richardson (1991) further proposed some guidelines that counseling professionals should follow when working with African American churches. The counseling professionals need to reach acceptance within the church by being perceived as sincere, trustworthy, and humble. These professionals also need to develop a relationship with the Black clergy through ministerial alliances. Richardson suggested that counseling professionals should use this forum to present workshops on problems that confront African Americans rather than simply talking about their skills. After establishing a relationship with the clergy, the counseling professional should then be introduced to the local congregation, where he or she should once more present those skills through workshops. Suggested workshop topics were parenting, peer pressure, racism, and male/female relationships.

Edwards-Patterson (1993) explored the help-seeking attitudes of African American clergy toward psychotherapy and pastoral counseling. The African American clergy were seen as being confronted with some of the same stressors that other African Americans face in society. The clergy's role as leader, however, predisposes them to experience even more stress and hence greater need for support in the form of counseling. The clergy were asked to respond to four vignettes describing a person with a problem. The vignettes varied on the following two dimensions: identification of person and level of stigma associated with the described problem. Results indicated that there was a significant difference in the help-seeking attitudes of pastors who had low stigma tolerance as compared to those with high stigma tolerance.

Models of Pastoral Counseling and Their Influence on Clergy's Referral Practices

Kevin (1976) discussed three models of pastoral counseling with which to examine the functional relationship that exists between psychology and religion. The three models advanced were the Conservative-Theological (C-T), the Theological-Psychological (T-P), and the Religious-Community (R-C) model.

The Conservative-Theological (C-T) model holds that the theory and practice of psychology are of no benefit in helping emotionally disturbed individuals. The essence of this school of thought was described by Shaw (1970) as the belief that a person's behavior is a function of free will working harmoniously with a God who has the power to, and does, intervene in the life of human beings. This model

therefore sees mental illness as stemming from "wrong acts or wrong choices," which result in disharmony with the will of God. Even though this model does not deny the working of the psychological, it overwhelmingly emphasizes that emotional problems have a religious base and therefore need religious remedies. The C-T model sees only a very limited need for professional mental health intervention in mental problems. Referrals to mental health professionals would not be expected because mental illness is seen as stemming from improper choices and disharmony with God's will. Clergy would be expected to refer only the most pathological cases that are disruptive to the church community.

The Theological-Psychological (T-P) model holds that psychology and theology both provide valid and complementary answers to human problems. Dittes (1970) expressed the premise of this model:

> Religion–and hence church and ministry–is largely called into being by man's recognition of the gap between what he is and what he is intended to be. And the religious apprehension of this gap is congruent with the psychologist's apprehension of psychic malfunctioning. Sometimes the religious apprehension is made sharper and richer by the help of the psychologist. (p. 69)

Within the T-P orientation, a wide gamut of counseling activities is appropriate. Burch (1969) posited the following three levels of pastoral counseling: depth counseling, which cannot be distinguished from psychotherapy; social counseling, which involves helping parishioners deal with daily problems and situational crises; and support-referral counseling, which does not require formal training because its focus is to help troubled parishioners find professional mental health resources.

Clergy who operate under the T-P model use a psychotherapeutic approach to counseling. Jaekle (1973) posited that clergy who have received training in psychotherapy should have equal status with psychologists and other mental health workers.

According to the Limited Counseling (LC) model, the clergy's counseling role should be guided by their comfort level and counseling skills. However, the clergy are not encouraged to engage in psychotherapy or "depth" counseling. This model has two paradoxical components. First, there is the ability to appreciate psychological concepts and be aware when psychological approaches are necessary to deal with parishioners' problems. The second component of this model is the belief that the clergy should not counsel but should refer to mental health professionals, in addition to having the disturbed parishioner use the support of the church community.

In summary, several predictions have been made regarding the attitudes and behavior of the clergy who operate under the three models. Clergy from the C-T school of thought are expected to be neutral, at best, toward using psychological interventions to treat emotional problems. Conversely, clergy operating under the T-P and R-C models would be more predisposed to using psychological approaches. Consequently, clergy from the C-T model, perceiving themselves as the interpreters of religious symbols and morality, are seen as being more likely to emphasize pastoral interventions. Conversely, clergy from the T-P and R-C orientations are expected to place more emphasis on using mental health resources.

Empirical Research on Ministers' Attitudes Toward Mental Illness/Health

There is a paucity of empirical research on the attitudes of ministers toward mental illness/health, their treatment and referral practices, their knowledge of mental health services, and their training in handling psychological/emotional problems. The following studies, however, do contain pertinent information in these areas.

Larson (1964) examined the attitudes and opinions concerning mental illness and psychiatry of 422 clergy members from a New England state. The following socioeconomic variables that were hypothesized to be related to their attitudes toward mental illness were examined: the clergy's social class position, educational background, age, religious affiliation, ethnicity, and father's education and occupation.

The results indicated that the United Church of Christ had the most favorable attitudes about mental health, whereas Advent Christian Apostolic, Christian and Missionary Alliance, Church of Christ, Jehovah's Witnesses, Latter-Day Saints, Nazarene, Orthodox, Pentecostal, Plymouth Brethren, Primitive Methodist, Salvation Army, Seventh-Day Adventist, and United Brethren had the most unfavorable attitudes. Catholic priests generally had unfavorable attitudes; however, they did not differ significantly from the fundamentalists and the "other" category. Clergy reporting the most favorable mental health attitudes were under 45 years of age, had parents who were born in the United States, had majored in the social sciences, and had completed five or more hours in pastoral counseling.

The results also indicated that Presbyterian and Unitarian-Universalist clergy had the most "scientific" opinions about the causes of mental illness. These ministers viewed the following hypothetical causal factors as having no causal relationship to mental illness: drinking too much, not enough will power, lack of self-control, masturbation, and so on. Roman Catholic priests had the most "unscientific" opinions about the causes of mental illness. It is significant to note that, in contrast to the attitudes about mental health, father's occupation, amount of training in pastoral psychology, major in college, rural-urban background, and birthplace of parents were not related to the ministers' opinions about the causes about mental illness. These findings also indicate that religion was still a significant factor when the above-mentioned variables were controlled.

In another study, Larson (1965) examined denominational variations in clergy's attitudes concerning the causes of mental illness and their attitudes about mental illness in a West South Central state--part of the "Bible Belt." The differences between 274 Catholic and 5,268 Protestant clergy's attitudes about mental health were still significant when age, rural-urban background, father's occupation, father's education, type of school attended by subject, college major, and parents' socioeconomic status were controlled. The rank order of denominations by percentage of favorable responses was as follows: Episcopal (87%), Disciples of Christ (74%), Presbyterian (73%), Lutheran (71%), Methodist (61%), Roman Catholic (57%), Southern Baptist (49%), Church of Christ (42%), Church of the Nazarene (29%), Churches of God (27%), Free Will Baptist (23%), Baptist (other)

(21%), Assembly of God (12%), and Pentecostal (6%). An examination of the relationships revealed some important findings. Clergy from urban environments had more favorable attitudes toward mental health than did their rural counterparts. Clergy who had large congregations, had fathers with college training or white-collar jobs, had a professional or college degree, had been social science majors, had been exposed to seven or more hours of pastoral training, had seen at least 10 emotionally disturbed people during the year, and had referred four or more persons to a psychiatrist reported the most favorable attitudes toward mental health.

The rank order of denominations with respect to their opinions about the causes of mental illness was similar to the mental health rank order. Episcopal ministers had the most "realistic" opinions, whereas Pentecostal ministers had the most "unrealistic" ones.

Types of Unidirectional Referrals

Kogan (1957) posited two ways in which a client can be sent from one professional to another under what he called a gatekeeper or unidirectional model. The first type (steering) involves a one-time act of giving a client the name and telephone number of a referral resource. Kogan differentiated this approach from the term "referral," which was seen as occurring when the professional is more actively involved in the transfer process (that is, actually making the telephone call and following up with additional information about the referral source).

Factors Determining the Referral Practices of Clergy Under the Unidirectional Model

Larson (1964) empirically examined some of the conflicts that occur between clergy and psychiatrists at the behavioral level. He sought to determine whether a consensus existed between the clergy and psychiatrists regarding how clergy should handle the emotionally disturbed in their congregations. Consensus was determined by comparing the responses of 420 clergy to those of 30 psychiatrists concerning four hypothetical case histories. The variables age, religion, ethnicity, and amount of training in pastoral counseling were used to examine the responses.

The results of this study underscored the gulf that exists between the clergy and psychiatrists regarding the expected role that the clergy should play when dealing with emotionally disturbed parish members. In general, psychiatrists perceived the role of the clergy as one of referral only or as providing some assistance. Conversely, the clergy perceived their role as one of major assistance or some assistance. Psychiatrists and clergy also differed significantly regarding to whom referrals should be made (the referral response categories were no referral, family physician, psychiatrist, family physician and psychiatrist, and other). Psychiatrists believed that all the cases should be referred to a psychiatrist only, whereas most clergy thought that the four cases should be referred to a psychiatrist and a family physician. Some clergy said they would refrain from referring if the case contained any problems that were perceived as "immoral." The variables age, ethnicity, and training in pastoral counseling were related to the role conceptions and referral practices of the clergy.

The results of this study also highlighted the failure of the clergy's counseling and referral policies to meet psychiatric standards. In addition, these results indicated that formal course work in pastoral counseling does result in fostering congruence between the views of psychiatrists and clergy regarding the role of clergy in the therapeutic setting.

In a qualitative study, Sandler (1966) examined the attitudes of the clergy toward psychiatry, their handling of psychological problems, and their training in pastoral counseling. The researcher used a wide cross-section of religions, including Catholic priests, Protestant pastors, and Jewish rabbis. A questionnaire was used that addressed six areas. In the first question, respondents were asked to label a presenting problem as religious, psychological, social, or legal. The second question concerned the level of mental health training these religious leaders had received. The third question asked the respondents to prioritize the severity of a series of problems. The fourth elicited the types of problems the respondents thought they were able to handle. The final question asked the respondents to discuss what they thought was the "desirable relationship between psychiatry and the ministry."

Sandler (1966) found that the problems most frequently encountered by ministers, in order, were marital, alcohol consumption, religious questions, and sexual problems. Conversely, the clergy referred, in order, "obvious mental disease," sexual problems, and drinking problems. Even though a large percentage (67.3%) of the clergy labeled the presenting problem as psychological, most (73.6%)

said they would attempt to do counseling themselves. It is interesting that even those who said they would attempt to do counseling themselves commented that they would refer to a psychiatrist if they did not see any progress after a couple of sessions. "Self-study" was the answer given most frequently (57.4%) in response to the question on training in counseling. The fact that the pre-1945 group were less formally trained than the post-1945 group could lead one to conclude that they were cognizant of their deficient counseling ability and therefore were more inclined to refer. The fact that the older clergy were less inclined to refer "obvious mental disease" than were younger clergy suggests that the less trained clergy were also less able to make valid judgments with respect to who should be referred to mental health professionals.

Ordination date also was found to affect referral judgment. Clergy who were ordained before 1945 seemed to be more likely than clergy ordained after 1945 to perceive a problem as requiring referral. However, clergy who were ordained after 1945 were twice as likely to refer when the case was "obvious mental disease."

Responses on the perceived desirable relationship between psychiatry and the ministry were mixed. Some of the comments were: "One compliments the other" (Baptist), "Psychiatry is as confusing to a minister as religion is to a psychiatrist" (Catholic), "Religion must mature with psychiatry. Mental illness must be left to the psychiatrist" (Jewish), "Psychiatrists should inform the ministers of their progress" (Presbyterian), and "Let the minister quit practicing psychiatry and concern himself with religious matters" (Unitarian).

The findings of this study are weakened due to the open-ended format of the questionnaire used. For example, 33% of the respondents indicated that they would handle marital problems themselves, whereas 11% indicated that they would refer them to a psychiatrist. The remaining 66% of the sample was unaccounted for. It was not clear whether this 66% were undecided about how to handle marital problems or if the questionnaire failed to elicit their position.

Cumming and Harrington (1963) conducted a study in Syracuse, New York. Interviews were conducted with 59 clergy pertaining to the nature of problems they counseled, the kinds of problems that were referred, and the extent to which the clergy had a relationship with social service and mental health resources in the community. Clergy who had a college education were perceived to be more likely to have attitudes similar to college-educated professionals like psychologists, social workers, and physicians. These clergy were also seen as being more likely to sit on committees with these professionals and consequently to know them personally. This personal acquaintance, in the opinion of the researchers, makes psychologists and other mental health professionals exempt these clergy from the stigma of "judgmental clergy" and to perceive them as "professionalized" or "sophisticated." These perceptions ultimately result in greater cooperation between them and mental health professionals. The clergy in this study reported making 5.4 referrals to agencies while receiving only 0.63 referrals from these agencies. The clergy were very dissatisfied with this imbalance, thinking that their role in the referral network was unappreciated.

Cumming and Harrington (1963) also found that clergy were more frequently involved in marital and premarital counseling. The respondents listed "vague mental disorders" as the second more frequently seen problem. Fifty percent of the sample indicated that they had encountered alcoholism and parent-child conflict. Only 15% to 35% of the sample indicated that they had seen clients with depression, psychosis, and sexual problems. The clergy reported referring the following problems most frequently to secular sources, in order of occurrence: psychosis, "vague mental disorders," and alcoholism.

Several predictor variables were related to the clergy's referral activity in the referral network. It was found that the socioeconomic level of the congregation was related to referral activity. Ministers who pastored in middle-class churches were more active in referring than those in lower-class churches. In addition, within the lower-class churches, clergy from larger congregations (more than 1,000 members) tended to be more active in making referrals than those from smaller congregations. The clergy in this study tended to make referrals to community agencies that provided a concrete, well-defined service. Alcoholics Anonymous, Planned Parenthood, and the welfare department were examples of those agencies.

Stayton (1967) examined the influence of theological liberalism, amount of training, attitude toward counseling, and amount of experience in counseling on the referral behavior of pastoral counselors. Data were collected from 63 clergy in the Boston, Massachusetts, area. The following variables were found to relate positively to the number of referrals to mental health services: the amount of experience in

pastoral care, the degree to which the clergy exhibited a supportive as opposed to an authoritarian counselor style, and the number of counseling courses that the clergy had taken. Theological liberalism was found to be unrelated to the number of referrals to mental health services.

Winett et al. (1979) examined the mental health, mental-health-related attitudes, and practices of physicians and clergy in a Lexington, Kentucky, community. The 288 physicians and 144 clergy participating in this study were asked to respond to questions pertaining to their knowledge about available mental health services and practices, the effectiveness of these services, their method of treating or referring different psychosocial problems, the demographic characteristics of their patients or congregations, the extent of their training in mental-health-related areas, and their opinions about the causes of the problems they treated.

The results of this study indicated that the clergy and physicians were actively engaged in the counseling and referring process, but they were lacking in knowledge about mental health services. These gatekeepers, although endorsing a psychosocial base for many mental health problems, still perceived counseling from a traditional individual perspective. Clergy and physicians who had previous mental health training were more involved in counseling and referrals to mental health centers. However, even these "trained" gatekeepers had limited knowledge of traditional and innovative services. The finding that clergy and physicians who had received mental health training were more predisposed to referring clients to mental health centers suggests that mental health training for clergy could result in more

efficacious treatment for church members whose presenting problems really need professional psychological interventions. It is also an endorsement for more mental health training for the clergy. The results highlighted the importance of examining the mental illness conceptualizations of the clergy. They suggest that individuals who contact different clergy with similar mental health problems could receive different responses, depending on each minister's knowledge and conceptualization of mental illness.

Kevin (1976) sought to determine how certain variables such as a minister's age, education, size of congregation, income of congregation, acquaintance with mental health resources, counseling-related education, and model of pastoral counseling affect his or her referral practices. He also investigated the influence of variables such as age, religiosity, clinical training, and acquaintance with the clergy on the referral practices of psychologists. Finally, the researcher compared the judgments of psychologists and clergy regarding their conceptualization of the need for the clergy to refer. Hypothetical cases were used for this purpose. The results indicated that modal income was not related to referral activity. This finding contradicts those of Cumming and Harrington (1963), who found that referral activity was significantly related to socioeconomic class. It should be noted that a valid comparison of this variable is difficult because Cumming and Harrington did not specify the boundaries of the class categories that they used in their study. There was an observed relationship between congregation size and referral activity. Clergy from smaller congregations tended to refer a disproportionately low number

of parishioners who came for help. Clergy with more academic training in psychology and counseling made more referrals than those who were less highly trained. However, clergy with more counseling-related education made lower ratings on the vignettes concerning the need to refer. Psychologists, when compared to clergy, made more positive ratings on the vignettes regarding the need for referral to a mental health professional. Overall, the psychologists in this study were not involved in exchanging referrals with the clergy. Kevin concluded that the absence of any difference in referral activity between religiously active and nonreligious psychologists presupposes that the lack of referrals by psychologists cannot be attributed to their having a negative attitude, in general, toward psychology.

Good (1977) investigated the relationship between certain variables such as age, education, training in psychology, referral source used, theological orientation, size of congregation, and referral practices of the clergy. This study also involved the use of a workshop designed to increase the number of referrals. Education was found to be related to the types of resources to which parishioners were referred. The results indicated that clergy who were low on referral to mental health resources tended to be conservative theologians, had on the average fewer psychology courses, had less clinical training, and had less formal education.

Gilbert (1981) examined the referral practices of 74 Assemblies of God pastors in the West Texas district. Specifically, the researcher sought to predict the extent of clergy's involvement in counseling and referral, using the following two

dependent variables: the percentage of total pastoral time spent in counseling and the percentage of people counseled or talked to about mental health concerns who were referred to mental health professionals. These variables were correlated with age: the number of semester hours of counseling- and psychology-related courses, theological orientation, acquaintance with mental health professionals, and size of congregation. Consistent with results from previous studies, almost 50% of the counseling caseload involved some kind of family-oriented counseling. These pastors were also involved in treating other problems like drug and alcohol abuse, sexual maladjustment, suicidal situations, and mental retardation. Only the number of hours of counseling courses and the perceived importance of counseling were significantly correlated with the total pastoral time spent in counseling. There was also a positive relationship between attendance at a counseling workshop and the percentage of people referred.

Summary of Empirical Studies on Clergy Referrals

The above-mentioned studies focused on how the clergy variables of age, education, counseling-related education, theological orientation, and size of congregation affect the referral activity of the clergy. Most of these researchers also investigated the presenting problems that clergy encountered. Finally, research on the interactions between the clergy and psychologists was examined. Meylink and Gorsuch's (1986) comprehensive summary and critique of the studies that have been discussed will be used in this summary.

The researchers who examined the relationship between age and referral behavior generally did not find a significant relationship. Only Larson (1964) detected a relationship, finding that younger clergy were more likely to counsel than refer. Cumming and Harrington (1963), Binkley (1976), Good (1978), Gilbert (1981), and Elkins (1983) failed to detect a significant relationship between age and referral behavior, perhaps because they used very small samples (Meylink & Gorsuch, 1986).

There were more studies in which a significant relationship consistently was found between referral behavior and counseling-related education. These studies also tended to include small samples from limited geographic areas. Most of these researchers found that clergy who had more counseling-related education tended to have higher referral rates. Only Binkley (1976) found contradictory results. However, he used hours of clinical training instead of counseling- and psychology-related education. Meylink and Gorsuch (1986) concluded that clergy receiving pastoral clinical education should feel more competent to counsel themselves and hence refer less. They concluded that "some education in psychology and counseling in general leads to a greater appreciation of the fellow professionals and therefore to more referrals," but the training of clergy in counseling techniques themselves may produce more of an "equal professional" feeling, so the total number of referrals is actually lower. The results on theological orientation were mixed, with some researchers finding that more conservative pastors were less likely to refer. The results on size of congregation were also mixed, with more researchers

finding that clergy coming from larger congregations had higher referral rates. Commenting on this tendency, Meylink and Gorsuch (1986) concluded that this may be the result of other variables that have a more direct relationship to clergy but show up indirectly in size of congregation. These other variables they suggested were "sophistication" of the clergy, the differential role of the clergy in larger as compared to smaller churches, and the location of larger churches. They hypothesized that the larger churches tend to attract more "sophisticated" ministers, who would be more likely to have been exposed to counseling-related education and consequently to be more predisposed to refer than ministers from smaller churches. It was also advanced that larger churches, in contrast to smaller churches, would be more likely to be located in metropolitan areas, close to more mental health facilities, to which people could be referred. Another submission was that clergy from larger congregations simply did not have enough time to devote to counseling and consequently referred more. Research on the relationship between congregational income and referral activity generally indicated that clergy from higher-income congregations tended to have more referrals.

Studies on the nature of the presenting problems that clergy encounter indicated that they faced a wide spectrum of emotional problems. Family-related issues accounted for about 50% of the clergy's caseload. Clergy were also very involved in dealing with substance-abuse problems, sexual maladjustment, and suicide cases. However, apart from identifying the most frequently presented problems, it was difficult to integrate the results because different diagnostic labels

for emotional distress were used. This multi-labeling system results in some confusion in sorting out which problems clergy see as compared to those referred.

It becomes even more difficult to summarize the data pertaining to presenting problems when the research also included referral. The researchers generally used vignettes and retrospective data gathering to collect data. When the retrospective data-gathering approach was used, obvious mental disease, including psychotic and severe neurotic ideation, was found to be the most frequently referred. However, with these studies, it was difficult to ascertain the referral rate as compared to the base rate of occurrence in the congregation.

Researchers who examined clergy-psychologist interactions used the vignette approach to ascertain referral rate. Psychologists and clergy were asked to rate the degree to which the hypothetical cases presented should be referred. Summarizing these studies was difficult due to the different types of vignettes that were used. For example, Larson (1964) found that 29% of the clergy would suggest referring a person described as a violent male paranoid, whereas only 6% said that they would refer a woman who was having marital and sexual problems. Kevin (1976), on the other hand, found that the vignettes that involved values and grief required less need for professional mental health intervention. The results of these studies suggest that the clergy perceived their role as providing at least some major assistance in addition to referring. Conversely, psychologists recommended referral, with little or no ongoing help from the clergy.

The second approach to studying clergy-psychologist interaction was to investigate the acquaintance between mental health professionals and the clergy. Notwithstanding varying operational definitions of "acquaintance," Kevin (1976) and Good (1978) found a significant relationship between the clergy's high referral rates and acquaintance with mental health professionals.

The third approach was to look at the clergy's awareness of mental health resources. Bentz (1979), Gilbert (1981), and Winett et al. (1979) all found that most clergy were aware of basic mental health resources.

The final method researchers used to study clergy-psychologist interaction was to examine the level of reciprocity. In almost all of the studies previously discussed, a unidirectional approach was reported between these two disciplines, with the clergy making most of the referrals to the psychologists. The few researchers who examined bidirectional referrals found that clergy referred more clients than were referred to them (Beals, 1982; Cumming & Harrington, 1963; Good, 1978). The clergy in these studies generally expressed a lack of satisfaction with both the level of reciprocity and the lack of feedback.

Comparison of the Unidirectional Model With the Bidirectional Model

The bidirectional model for clergy-psychologist referrals was first proposed by Gorsuch and Meylink (1986) in response to the perceived ineffectiveness of the unidirectional or "gatekeeper" model. The failure of the gatekeeper model, which is based on the assumption that the clergy will refer clients to the psychologist, was

attributed to the absence of reciprocity and equality in social relationships. Piedmont (1968) found that there was a significant relationship between clergy's referral practices and the amount of feedback received from the professional receiving the referral. Several researchers who examined bidirectional referrals advanced the notion that clergy refer more clients to mental health professionals than are referred to them (Beals, 1982; Binkley, 1976; Good, 1978). Social exchange theory posits that an unequal relationship will not endure if one of the participants perceives that the other is benefiting more from the relationship. Consequently, the gatekeeper model, which results in referrals primarily from the clergy to the psychologist, will ultimately break down.

The unidirectional model also fails to acknowledge that clients will sometimes seek out a minister specifically for religious problems (Hart & Osborne, 1985). In addition, this model does not allow psychologists to make use of the expertise of ministers who have been trained in religious issues (Wright, 1984). Gorsuch and Meylink (1986) also advanced that psychologists operating from a gatekeeper model failed to make use of the support systems that are found in the church.

The bidirectional model proposes two types of relationships that can operate between psychologist and clergy. The first type of relationship, concurrent treatment, occurs when a client sees both professionals at the same time, while the professionals continuously consult with each other about treatment issues and progress. Conjoint treatment, on the other hand, occurs when the psychologist and the clergy do therapy together with a client in a session.

Proposed Model for Co-professional Referral Relationships

Gorsuch and Meylink (1986) proposed a co-professional model that incorporates those clergy variables from the gatekeeper model that have empirically been shown to influence a clergy's decision to treat or refer to mental health professionals. This model places these variables, in addition to those proposed for helpseekers and co-professionals, in a flow chart. When a helpseeker initially contacts a professional, a set of variables, called situation variables, is already operating and influences the client's decision to seek a psychologist or clergy. These situation variables include the nature of the presenting problem, awareness of resources, conscious or unconscious values, religion, and their view of clergy and psychologists.

The second and third sets of variables, defined as professional and co-professional traits, respectively, will influence the professionals' decision as to whether they can be helpful to a particular client or whether a referral should be made. These traits include role definition, education, felt autonomy, orientation toward psychology, and size of practice or congregation. In summary, a client with a problem will approach either a psychologist or clergy. The psychologist or clergy will use his or her own frame of reference, professional traits, and personal skills in relation to the presenting problem, in addition to information that was gained from interacting with the clergy or mental health resources. After this cognitive and affective appraisal, the professional will decide whether to treat or refer.

The next category of variables, the helpseeker-professional interactions, describes the manner in which the professional and helpseeker interact. The salient aspects of this interaction involve the way in which the presenting problem is conceptualized by the professional. More specifically, this includes having diagnostic criteria and becoming aware of spiritual and/or psychological problems. It also includes the level of the professional's training in the art of referral.

Another set of variables in this model that is hypothesized to influence the decision to refer or treat is the professional-co-professional interaction variables. These variables include acquaintance with a co-professional, the awareness of resources available within the other profession, and the level of reciprocity experienced in the relationship.

Referral options, the last category, includes variables that go beyond the limited options of the unidirectional model–counsel or refer. This co-professional model incorporates the additional options of conjoint and concurrent treatment. In conjoint treatment, the helpseeker sees both clergy and psychologist in the same session. Concurrent treatment occurs with the client sees both clergy and psychologist separately during the same period of time. These professionals maintain appropriate communication throughout the time that the client is seen. Another form of concurrent treatment occurs when another professional resource is used instead of a specific co-professional. For example, the clergy may see a member individually, and that person may at the same time attend an Alcoholics Anonymous or ACOA group. Another example is a client in therapy with a

psychologist while at the same time participating in religious resources such as worship services and/or church groups for singles.

New Proposed Adapted Co-professional Model for Black Clergy and Psychologists

This researcher will use an adapted, more culturally and spiritually relevant version of Gorsuch and Meylink's (1986) model to examine variables that influence the co-professional relationship between Black clergy and psychologists. This "new model" will examine only the influence of professional and co-professional variables on the proposed four outcome referral options. This model will examine the following professional traits for clergy: counseling-related education, training in pastoral counseling, and pastoral role. The psychologist professional traits that are to be examined are religious involvement, importance of religion in the psychologist's life, perception of the importance of clients' religious beliefs to therapy, and training in multicultural/urban issues. The co-professional interaction variables that will be examined are the professional and personal relationships that psychologists and Black clergy have had with each other.

Research on the Bidirectional Model

Meylink and Gorsuch (1986) conducted an exploratory study on the bidirectional model. Five psychologists and five clergy who were already involved in this type of relationship participated in the study. The methodology in this study involved a 45-minute interview that involved gathering information on some variables that were hypothesized to influence the referral process. The interview also involved

inquiring about actual cases that highlighted the following treatment options: treat alone, refer, conjoint treatment, and concurrent treatment.

The psychologists in this study proposed two primary situations in which they would make use of religious resources. The first situation was where a client lacked a support system and was open to using church resources. The other case was where a client's presenting problem had a spiritual component such as anger toward God, being punished by God, or inappropriate guilt for religious reasons. On the other hand, the clergy reported that they would refer when it was apparent that the parishioner's problem was obviously psychological. This would occur if, after the first few sessions, the clergy deduced that the client had a history of psychological problems and that this situation was just a recurrence. The intensity of the problem was another criterion that would be used. A depressed, suicidal person, for example, is a case that might warrant making a referral. Finally, all members of the clergy indicated that they would use a general rule whereby a parishioner would be seen for two to six sessions, and if the problem was not resolved in that period of time, a referral would be made.

The psychologists and ministers participating in this study cited the following examples that illustrated their use of concurrent and conjoint treatment. One psychologist talked about a female client who had reached an impasse in therapy because of irrational guilt and fear of hell. The psychologist suggested that the client talk over these spiritual issues with a priest in the area. After talking over her

spiritual issues with the priest, the client continued her therapy sessions with the psychologist with great progress.

Another example of concurrent treatment involved a young female church member who had a family history of incest and physical abuse. After many months of unsuccessful treatment for her depression and suicidal ideation, the minister decided to prepare her for referral by encouraging her to accept God's forgiveness and love. The minister decided to prepare her for referral this way instead of making an immediate referral because he recognized that her problems with trust, stemming from her dysfunctional background, may have jeopardized the referral. A concurrent relationship evolved between the minister and the psychologist to whom the client was eventually referred. This concurrent relationship provided the safety for the client to explore her issues with the psychologist while at the same time maintaining the support of the minister. The professionals continued to see and update each other on progress the client was making. The pastor, for example, kept the psychologist informed on the quality of relationships that the client was establishing within the church family. The client was eventually diagnosed with borderline personality disorder.

A minister initially steered a male church member who had pathological anxiety that blocked normal urinary function to a psychologist who specialized in that dysfunction. When treatment was unsuccessful, the pastor recommended that the member join a male church group in which he could be encouraged and supported. The client was subsequently steered once more to a clinical hypnotherapist, and this

time he was open to clinical help. His urinary problems were alleviated after a few sessions.

The final case involved a suicidal lesbian client who was making little progress. Her impasse in therapy and suicidal ideations were due, in part, to her feelings of rejection from her church. After unsuccessful attempts by her therapist to convince her that God loved her, it was recommended that she speak with a local minister. The pastor invited her into his home for a session where, with his personal acceptance and forgiveness, and her participation in the Lord's Supper, which symbolized communion with God, he was able to reach this woman and convince her that God loved her. This new acceptance gave her the required self-worth that made her want to live. The pastor and the psychologist continued to communicate about this client, and the psychologist reported that her own conceptualization of this client's dynamics was enhanced.

Two examples of conjoint therapy were cited by the participants in this study. The first case involved a young male client who thought that his impasse in therapy was occurring because of demonic possession. The psychologist recommended that they meet with the client's pastor to explore the issue. During this conjoint session, the pastor reported that he did not discern any presence of demonic possession. With this submission, and the encouragement of the psychologist, the client recommitted himself to therapy.

The second example of conjoint therapy involved a female client who was seeing a therapist while concurrently stopping by to see her pastor. She reported

that her talks with the pastor were fulfilling some needs that were not being met with her therapist. The client subsequently recommended that they all meet together in a conjoint session. During this session, the interaction among the minister, the therapist, and the client provided the ideal situation for a role play of early family issues. During this role play, the client had a primal experience in which she saw the three of them formed into a new family system. This unique experience resulted in some ongoing conjoint therapy sessions where the focus now became reparenting.

Meylink (1988) sought to implement this recommendation in a study on the effect of referral training on the referral behavior intentions of doctoral psychology students to clergy. Meylink used Ajzen and Fishbein's (1980) theory of reasoned outcome, which posits that in order to change behavior intention, one needs to change the salient beliefs that are responsible for the attitudes toward the behavior. Thus, Meylink hypothesized that the behavior intention of psychologists and clergy would be increased if their salient beliefs about the consequences of referring were examined through an educational seminar. The participants were asked to respond to 12 vignettes that were grouped into the following categories: need for psychological help alone, need for clergy help alone, and need for both psychological and clergy help.

The results indicated that the referral-intention behavior of the psychologists regarding conjoint and concurrent treatment was increased. However, there were several instances in which the psychologists elected not to refer to clergy vignettes that specifically had spiritual dilemmas. Meylink concluded that his predisposition,

coupled with the fact that referrals to clergy did not increase, suggested that psychologists still perceived themselves as the primary professional in treating clients.

CHAPTER III

METHOD

Introduction

This chapter includes the research procedure, design, characteristics of the sample, independent variables, and dependent variables. The measures used in this study are also discussed.

Procedure

The names of Black Protestant clergy were obtained from the Black Pastors' Council, the Council of Churches Directory, and, informally, in the cities of Lansing, Flint, Detroit, and New York. The pastors were then contacted by telephone and informed of the nature of the study, as well as the time and effort that would be required.

The sample from the southern states of Tennessee, Mississippi, and Alabama was obtained from Black Seventh-Day Adventist pastors who were participating in a ministerial retreat in Alabama. These pastors were informed of the purpose of the study, and voluntary participation was solicited.

The sample of mental health professionals was obtained from a list of mental health professionals in the yellow pages in the cities of Lansing and East Lansing,

Michigan. After randomly selecting the names, the researcher called the mental health professionals and informed them about the nature of the study. Their voluntary participation was solicited. Mental health professionals from Detroit and Memphis were obtained informally. All participants were informed about the nature of the study, issues of confidentiality, and the time and effort that would be required.

The Black clergy and mental health professionals who agreed to participate were mailed or given the following materials:

1. A cover letter.
2. A copy of the questionnaires.
3. A self-addressed, postage-paid envelope in which to return the completed questionnaire.

Research Design

A correlational design was used to explore how certain variables are related. No attempt was made to establish causation. Rather, an attempt was made to show associations among variables hypothesized to have influenced the types of referrals. As a result of this study, it will be possible to indicate what variables occur together but not to conclude that one caused the other.

The research design is also descriptive, employing two surveys to answer the question, "What have we here?" in an inductive fashion (Goldman, 1978). No attempt was made to manipulate the subjects, but rather to describe what was already the current situation. The study was designed to investigate the validity of hypotheses on data collected on preexisting conditions.

Subjects

Professional Characteristics of Black Clergy

Fifty-one clergy questionnaires were returned from the original 200 that were distributed, resulting in a return rate of 26%. The mean age of the responding clergy was 44 years; all of them were males. They had been pastoring at their present churches for an average of 7 years and had been a member of the clergy for 14 years. Seventh-Day Adventists and Baptists comprised 86% of the sample (Seventh-Day Adventists, 61%; Baptists, 25%). Church of God in Christ, Lutheran, Methodist, and Nondenominational clergy made up the remaining 14%. These churches were located in the following cities and states: New York (26%), Detroit (22%), Lansing (15%), Alabama (15%), Tennessee (15%), and Mississippi (4%).

Most of the clergy had completed high school (76.5%) and college (72.5%). Theological school had been completed by 58.8% of the clergy. Doctor of Divinity degrees had been obtained by 34.8%, 4.3% had a Ph.D., 13% had an M.A. in religion, 8.7% had an M.A. in counseling, 8.7% had a social work degree, and another 8.7% had completed training in pastoral clinical education. Correspondence courses in theology had been completed by 4.3% of the sample. Most clergy had also taken at least one graduate-level psychology course (34% had taken one to three courses, and 36.4% had taken four or more).

The mean number of hours in supervised pastoral counseling was 197.2. This number, however, was skewed by seven clergy who had between 999 and 3,000 hours. The median of 10 hours was, therefore, a better measure of central

tendency for this variable. It is also important to note that 25.5% of the clergy had no hours of supervised pastoral counseling.

The mean number of hours spent in scheduled counseling appointments was 4.3; the mean number of cases that were coming in for counseling was 3.84. The mean congregation size was 436.1; however, this number was skewed by six congregations that had more than 1,000 members. The median of 200 is, therefore, a more accurate number.

Co-professional Characteristics of Black Clergy

Of the 51 responding clergy, 58% had occasional or ongoing contacts with mental health resources. Only 7.8% had no personal knowledge of mental health resources. On the other hand, 56.8% had had occasional or ongoing contacts with mental health resources. The mean number of referrals made to mental health professionals was 4.5. The mean for Black mental health professionals was 2.8, and the mean for White mental health professionals was 1.8. The mean number of referrals received from mental health professionals was 3.2.

Personal Characteristics of the Mental Health Professionals

Sixty-two mental health professional questionnaires were returned from the original 250 that were distributed, a return rate of 24.8%. These respondents came from the following cities: Lansing (52.8%), East Lansing (28.3%), Detroit (7.5%), and Memphis (9.4%). Eight professionals (14.5%) did not indicate their city. Thirty-eight (61.3%) of the respondents were in institutional practice, 16 (25.8%) were in

private practice, and 16 (25.8%) were in both private and institutional practice. The mean number of years for mental health professionals in private practice was 7.2 years. For those in institutional practice, the mean was 6.5 years. Males constituted 48.4% of the sample, and females made up 51.6% of the sample. The sample included 23% African Americans, 65.6% Caucasians, 1.6% Asian Americans, 4.9% Hispanic Americans, and 4.9% Native Americans.

Doctoral-level clinical psychologists made up 16.7% of the sample, doctoral-level counseling psychologists 21.7%, master's-level counselors 5%, master's-level social workers 28.3%, B.A.-level social workers 1.7%, master's-level rehabilitation counselors 1.7%, school psychologists 1.7%, substance-abuse counselors 3.3%, and B.A. in psychology 1.7%.

The mental health professionals varied in their predominant theoretical orientation. In this sample 35% identified themselves as cognitive behavioral, 1.7% as behavioral, 22.6% as psychodynamic, 8.3% as systemic, 1.7% as gestalt, 1.7% as feminist, and 28.3% as other.

Thirty-six (58.1%) of the mental health professionals were affiliated with a religious denomination. Of those who were religiously affiliated, 37.5% were Catholics, 12.5% were Baptists, 12.5% were Methodists, 9.4% were Lutherans, 6.3% were Episcopalians, 6.5% were Baptists, 3.2% were Reach Out Christians, 1.6% were Seventh-Day Adventists, 3.1% were Bahai, and 3.2% were other.

The mean number of years that the mental health professionals had been practicing in the community was 6.5 years. A large percentage (80.4%) of them had

completed college courses in either multicultural or urban issues (39.3% had completed one to three courses; 41.1% had completed four or more), whereas 80.3% had attended workshops or seminars (60.7% had attended one to three; 19.6% had attended four or more). All of the mental health professionals in this sample were currently seeing clients for psychotherapy or counseling.

Most mental health professionals valued religion, church attendance, and the religious beliefs of the client. In this sample, 79.3% of the mental health professionals said that religion was important or very important in their lives; 45.1% attended church frequently or were actively involved in church activities. An overwhelming 84.2% thought it was important to know the religious beliefs of the clients they were treating.

Co-professional Characteristics of the Mental Health Professionals

Twenty-eight (45.2%) of the mental health professionals had a close personal friendship with a clergy, whereas 24 (38.7%) had a casual friendship with a clergy. Twenty-seven (44.3%) had made referrals to the clergy, and 20 (32.8%) had consulted with the clergy. Fourteen (23%) had had no professional contact with the clergy. In this sample, it was interesting that during the last year, 36.7% of the mental health professionals had referred one to four clients, 11.7% had referred five to nine clients, and 5% had referred 10 or more clients to the clergy. Conversely, only 24.2% of the mental health professionals had received one to four referrals,

8.1% had received five to nine referrals, and 3.2% had received 10 or more referrals from the clergy.

Instrumentation

The researcher adapted two questionnaires used by Kevin (1976) for the purposes of this study. They were the Pastoral Counseling and Mental Health Questionnaire and the Mental Health Referral Questionnaire. The following changes were made to the Pastoral Counseling and Mental Health Questionnaire: (a) two questions that elicited the clergy's professional and personal relationship with mental health professionals were added, (b) some of the vignettes were changed, and (c) four referral options were added for each vignette.

The following additions were made to the Mental Health Referral Questionnaire: (a) information on mental health professionals' perceptions of the importance of knowing the client's religious belief, (b) their predominant theoretical orientation, (c) the importance of religion in their lives, (d) the number of courses and workshops in multicultural and urban issues, and (e) their professional and personal contact with the clergy. Some of the vignettes were also changed.

The Pastoral Counseling and Mental Health Questionnaire

The Pastoral Counseling and Mental Health Questionnaire, which was given to the Black clergy, comprises the following sections. (A copy of the questionnaire is contained in Appendix A.)

The **Personal Information** section includes questions concerning the pastor's age, denomination, date of ordination, number of years served at the present church, total number of years served as a pastor, and size of congregation.

The **Schooling** section includes questions pertaining to the academic, theological, and psychological/counseling education received by clergy. Information on supervised practical experience is also sought.

The **Counseling and Referral Activity** section contains questions on the number of cases seen for counseling, hours spent in counseling in a given week, the number of referrals made to and received from mental health professionals during the last year, and the number of referrals that were specifically made to and received from Black mental health professionals. This section also taps into the clergy's professional and personal acquaintance with mental health resources and personnel.

The **Pastoral Role** section is made up of statements that pertain to the relationship between psychology and theology (see page 18). After conducting a factor analysis on the original pool of 21 items, Kevin (1976) came up with three scales that included 14 items. These scales reflected the points of view of the three models of pastoral counseling (C-T, T-P, LC), which were discussed in the review of literature. Two items from the T-P scale and one item from the C-T scale were adapted from the Relation Between Religion and Psychiatry scale (Webb & Kobler, 1961), whereas the others were developed by paraphrasing items from the pastoral counseling literature that reflected the tenets of the three scales.

To establish validity for the three empirically derived factors, Kevin (1976) constructed three scales for the 21 items. An item was assigned to a particular scale if it had a primary factor loading of .38 or higher on that scale and if it did not have a secondary factor loading greater than .30 on any other factor. Factor loadings for items in the LC, C-T, and T-P scales are shown in Table 3-1.

The LC scale comprised five items that loaded on the LC factor. The factor loadings ranged from .710 for item 12 to .547 for item 9. Item 2, which had a loading of .399 on this factor, was excluded from this scale because it also loaded .359 on the T-P scale. Cronbach's alpha coefficient for the LC scale was .66.

The C-T scale had five items that loaded on the C-T factor. The factor loadings ranged from .779 to .381. One item, which had a loading of .438, was not included in this scale because it also loaded .435 on the LC factor. Cronbach's alpha for this scale was .61.

The T-P scale was made up of four items. These items loaded between .699 and .551 on this factor. One item, which had a loading of .568, was eliminated from the scale because it also had a loading of .341 on the C-T scale. This scale was reversed before scoring because of the negative loading of item 13 (-.570). Cronbach's alpha for this scale was also .61.

These three scales had very low intercorrelations. There was a correlation of -.01 between the C-T and T-P scales. The correlation between the C-T and LC scales was .14.

Table 3-1: Factor loadings for items in the Limited Counseling, Conservative-Theological, and Theological-Psychological subscales.

Loading	Item
Limited Counseling Scale	
.71	The amount of counseling that a clergy does should depend solely upon his/her comfort with and skill in the practice of pastoral counseling.
.62	Individuals who appear to need depth counseling are best referred to mental health professionals.
.59	The severity of the emotional problems with which a clergy deals should depend solely upon his/her comfort and skill in pastoral counseling.
.57	Clergy can profit from the study of psychology, but they should leave psychotherapy to the professional psychotherapists.
Conservative-Theological Scale	
.78	Prayer, repentance, and an active effort to lead a moral life are what is needed by most emotionally troubled individuals.
.71	In most cases a parishioner who thinks he/she needs psychiatric help would do best to improve his religious life.
.66	Faith in God is the most sustaining force in the life of an individual undergoing an emotional crisis.
.52	The most significant help which the church offers to an individual undergoing an emotional crisis is the opportunity to seek the counsel of an understanding clergy.
.38	Most emotional problems are rooted in man's sinfulness.

Table 3-1: Continued.

Loading	Item
Theological-Psychological Scale	
.70	Theology and psychology are both valid perspectives upon human issues.
.61	Close cooperation between clergy and mental health workers is necessary to provide the best possible help for emotionally troubled individuals.
-.57	There is little need for psychological knowledge in pastoral counseling.
.55	A clergy can and should use knowledge of both psychology and practical theology in his/her counseling activities.

The 14 items in the Pastoral Role section of the instrument are arranged in random order; no more than two items occur consecutively from any one subscale. Respondents were asked to rate their agreement or disagreement with each statement, using a 6-point scale ranging from -3 (Disagree Strongly) to +3 (Agree Strongly).

The **Views on Mental Health Problems** section consists of seven vignettes that were used in Kevin's (1976) and Larson's (1964) studies. These vignettes were selected because they were identified in the literature as representing the kinds of problems that clergy frequently encounter in their ministry. The hypothetical situations used in the vignettes cover a wide gamut of problem severity. Two of the vignettes were adapted from published case studies (Oglesby, 1968; Rodgers,

1972). Another three were composed by Kevin (1976) based on theoretical information and clinical experience. The remaining two were used by Larson (1964) in a similar study comparing the responses of psychiatrists and members of the clergy. The following are summaries of the vignettes that were used in this study.

Vignette I (Depression) is a description of a 29-year-old married woman who is experiencing depression, a lack of energy, and a loss of self-confidence. The intention of this vignette is to portray a vague complaint that does not contain any indicators of serious psychopathology. However, one or more underlying etiological factors, ranging from marital discord to glycemia, could be hypothesized to be responsible for the problem.

Vignette II (Paranoid) is a description of a young adult man who is very delusional. He does not trust anyone and has been violent with strangers. He also believes that his wife, whom he has threatened to kill, is after him like everyone else. This vignette was used in Larson's (1976) study.

Vignette III (Values) portrays a successful businessman with the dilemma of having his family suffer because of the pressure from his career. According to Kevin (1976), this case was intended to represent a class of problems that does not denote serious psychopathology, even though they may be painful and disturbing to the individual who is experiencing them. Values clarification and choosing a direction in life, rather than some labeled neurotic or behavioral problem, was seen as being the main issue here.

Vignette IV (Grief) involves a 54-year-old woman who was perceived to be experiencing a pathological grief reaction to the death of her son. She is also angry with her husband, whom she thinks is not validating her feelings. This vignette was an adaptation of an actual case presented by Oglesby (1968).

Vignette V (Homosexual) involves an unmarried young Christian who has been bothered with homosexual thoughts and wants advice on how to become "normal."

Vignette VI (Sexual) describes a 45-year-old man who is experiencing considerable anxiety due to recurring thoughts about exposing himself. He is also feeling guilty for having these thoughts. This vignette was taken from Larson's (1976) study.

Vignette VII (Spiritual) describes a middle-aged devout Christian woman who has had a celestial vision and also hears a strange voice that constantly speaks to her. She is confused about how she should respond to this voice. This case was used in Larson's (1964) study.

The respondents were told that the vignettes described a hypothetical situation in the lives of one or more persons. In each case, the people involved are members of a Black Protestant church. They are aware that they need help, but they are unsure whether a Black clergy or mental health professional is the most appropriate source of help. The respondents were instructed to read each vignette carefully and indicate on a 7-point Likert scale ranging from Not Likely (1) to Very Likely (7) how likely they were to use one of the following four referral options:

1. I would counsel this client and not refer him/her to a mental health professional.

2. I would counsel this client in addition to referring him/her to a mental health professional who would be willing to maintain a co-professional relationship with me, where information about the client will be shared.

3. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's beliefs become an issue in therapy.

4. I would not attempt to counsel this client and would refer him/her to a mental health professional.

A cover letter (see Appendix A) was sent along with this questionnaire. It contained the following information: a brief explanation of the purpose of the study, instructions on how to complete the questionnaire, and a statement that the results would be kept confidential and anonymous. The respondents also were told that they could receive feedback on the results of the study.

The Mental Health Referral Questionnaire

The Mental Health Referral Questionnaire was sent to mental health professionals and consisted of items that elicited information on the respondents' education, clinical practice, religious activity, and referrals. (A copy of the questionnaire is contained in Appendix B.)

The **Basic Information** section sought information on the mental health professionals' age, gender, and race.

The **Education and Theoretical Orientation** section contained items concerning respondents' field of specialization, type of practice, theoretical orientation, length of time in practice, the importance to therapy of knowing the

religious beliefs of the client in treatment, and training in multicultural or urban issues.

The **Private Practice** and **Institutional Practice** sections each contain questions pertaining to hours worked per week, active cases in the last year, and the length of time in practice.

The **Religious Activity** section contains question relating to the respondents' denomination, the frequency of church attendance, the importance of religion in their lives, and their religious beliefs.

The **Referrals** section contains questions pertaining to the number of referrals respondents had made to clergy in the past year and the number of referrals they had received from clergy during that time. Finally, respondents were asked to categorize their personal relationship with clergy.

The **Views on Mental Health Problems** section is identical to that section of the clergy instrument with two exceptions. First, the mental health professionals were asked to specify how they thought, from a mental health professional's standpoint, members from the clergy should respond when confronted with these cases. Second, the beginning of each referral option began with "The clergy should" instead of "I would."

A cover letter was included with each Mental Health Referral Questionnaire (see Appendix B). This letter was similar to the one that was sent to the clergy. It contained a brief explanation of the study, instructions on how to complete the

questionnaire, an offer of feedback, and an assurance that the results would be confidential.

Predictor (Independent) Variables

Predictor Variables for Black Clergy Model

Co-professional variables:

1. **Acquaintance with mental health resources** was defined as the clergy's description of their knowledge and use of mental health resources. This variable was measured by the clergy's response to one of four categories ranging from having no knowledge of mental health resources to having ongoing contact with mental health resources.

2. **Personal relationships with mental health professionals** was defined as the clergy's description of their personal friendships with mental health professionals. This variable was measured by the clergy's response to one of three categories ranging from having no personal friendship with a mental health professional to having a friendship with a mental health professional who was Christian.

Professional trait variables:

3. **Counseling-related education** was defined as the number of undergraduate and graduate courses in psychology.

4. **Pastoral counseling training** was defined as the number of hours of supervised pastoral counseling practicum experiences as a student.

5. **Pastoral role** was defined as the model of pastoral counseling from which the clergy operate (C-T, P-T, or LC model), as measured by their responses in the Pastoral Role section of the Pastoral Counseling and Mental Health Questionnaire.

Predictor Variables for the Mental Health Professional Model

Co-professional variables:

1. **Personal relationships with clergy** was defined as the mental health professionals' description of their personal relationships with clergy. This variable was measured by their responses to one of three categories ranging from having no personal friend who is a clergy to having a close personal relationship with a clergy.

2. **Professional relationships with clergy** was defined as the mental health professionals' description of their professional relationships with clergy. This variable was measured by the psychologists' responses to one of three categories ranging from having no professional contact with clergy to having ongoing contact with clergy for the purpose of consulting or making and receiving referrals.

Professional trait variables:

3. **Training in multicultural and urban issues** was defined as the number of workshops or college courses in multicultural or urban counseling that the mental health professionals reported having taken during their training and since graduating.

4. **Religious involvement** was defined as the mental health professionals' description of their involvement in church activities. This variable was measured by their response to one of four categories ranging from not being a member of a church to frequent church attendance and involvement in church activities.

5. **Importance of religion in mental health professionals' lives** was defined as the mental health professionals' description of the part that religion plays in their lives. This variable was measured by their responses to one of four categories ranging from not being important at all to being very important.

6. **Importance of clients' religious beliefs to the therapy process** was defined as the mental health professionals' perceptions of the importance of understanding the religious beliefs of their clients. This variable was measured by their responses to one of four categories ranging from not important to very important.

Data-Analysis Procedures

The data were analyzed using hierarchical multiple regression and correlation techniques. The multiple regression technique enabled the researcher to use a linear relationship between a set of predictor variables and an outcome variable while taking into account the relationships among the predictor variables. Nie (1975) proposed that the main goal of multiple regression is to produce a linear combination of independent variables (predictor variables) which will correlate as highly as possible with the dependent (criterion) variable. This linear combination can then

be used to "predict" values of the outcome variable. The importance of each independent variable can also be assessed.

Hierarchical multiple regression procedures were used to test the first four hypotheses. The goal of hierarchical regression is to explain--make statements about theory on the basis of the interpretation of the importance of various independent variables. On the other hand, the goal of stepwise regression is to explain or produce the best explanatory model by maximizing R^2 (Wampold & Freund, 1987). In hierarchical regression, the researcher chooses in advance the order in which single variables or sets of variables are entered, based on theoretical or methodological grounds. This method of entry was selected for this study because the researcher wanted to first control for certain demographic and professional variables entered in sets, from both the clergy's and mental health professionals' models, before entering the co-professional variables as a set to see whether they significantly predicted the outcome variables and whether they accounted for more variance above that which was accounted for by the professional variables.

The first step in the analysis process was to construct a correlation matrix of all variables. Only those predictor variables that were not significantly correlated with each other were to be included in the model (i.e., those with an r of .6 or greater). None of the demographic variables was significantly related to the outcome variables, and they were therefore not used. Four separate regression models were used to test the four outcome referral options for both the clergy and

the mental health professional samples. The following are the four outcome variables against which the clergy and mental health professional variables were regressed: counsel alone, refer, conjoint counseling, and concurrent counseling. The following were the professional-traits variables that were entered into the regression models as a set: For the clergy model, these variables included counseling-related education, number of graduate and undergraduate courses in psychology, supervised clinical experience, and model of pastoral counseling (scores on the C-T, T-P, and LC scales). For the mental health professional model, these variables included religious activity, importance of religion in their lives, training in multicultural and urban counseling, and perception of the importance of the client's religion to therapy.

The co-professional interaction variables were next entered into the model as a set to see whether they added more variance above and beyond the variance accounted for by the professional trait variables. The co-professional interaction variables for the clergy model included acquaintance with mental health professionals and personal relationship with mental health professionals. For the mental health professional model these variables included personal and professional relationships with the clergy. After the co-professional and professional variables were entered as a set, the individual variables from each set (beta weights) were examined to determine how much of the variance they accounted for in the dependent variables. Correlations were used to analyze Hypotheses 6 through 15.

CHAPTER IV

RESULTS

In this study, an attempt was made to determine to what extent certain predictor variables from two separate samples (clergy and mental health professionals) had on the following four outcome variables: counsel alone, refer, concurrent referral, and conjoint referral. In addition, a number of correlations between several variables were computed. Examination of correlations between several of these variables provided important information on the referral practices of and bidirectional relationship between mental health professionals and members of the clergy.

Results of Hypothesis Testing

Tables 4-1 through 4-4 contain a summary of the multiple regression results for Hypotheses 1 through 4: the beta weights for the professional and co-professional traits variables, the R square for the professional traits variables, and the R square change when the co-professional variables are added to the model.

> **Hypothesis 1a**: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict concurrent referral for the clergy.

As shown in Table 4-1, Hypothesis 1a was not confirmed. The professional variables explained 23% of the variance in the outcome variable, concurrent referral. The only professional variable that was significant was the T-P (Theology parallels Psychology) variable (r = .31, p = .05). Thus, clergy who had a stronger T-P orientation were more likely to be open to concurrent referral. When the professional variables were controlled for, the co-professional variables were not significant and accounted for only an additional 2% of the explained variance.

> **Hypothesis 1b**: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with the clergy) will predict concurrent referral for mental health professionals.

An inspection of Table 4-1 shows that Hypothesis 1b was not confirmed. The professional variables in this model accounted for 10% of the explained variance. When the co-professional variables were added to the model, they were not significant and accounted for only an additional 8% of the explained variance.

> **Hypothesis 2a**: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict conjoint referral for the clergy.

As shown in Table 4-2, Hypothesis 2a was not confirmed. The professional variables accounted for 9% of the variance. When the co-professional variables were added to the model, they were not significant and accounted for only an additional 5% of the explained variance.

Table 4-1: Regression results for Hypotheses 1a and 1b--Concurrent referral.

Hypotheses & Variables	Beta	R^2 (as a %)	R^2 Change (as a %)
1a: Clergy Regression Model		23%	
Professional Variables			
Undergrad psy. courses	-.365		
Graduate psy. courses	.281		
Supervised counseling	-.050		
LC model	-.025		
C-T model	.089		
T-P model	.305		
Co-professional Variables			25%
Personal rel. with MHP	-.065		
Professional rel. with MHP	.089		
1b: MHP Regression Model			
Professional Variables		10%	
Church involvement	-.18		
Clients' religious beliefs	.16		
Multicultural courses	.08		
Multicultural workshops	-.26		
Importance of religion	-.00		
Co-professional Variables			18%
Personal rel. with clergy	-.292		
Professional rel. with clergy	.099		

Note: MHP = mental health professional.

Table 4-2: Regression results for Hypotheses 2a and 2b--Conjoint referral.

Hypotheses & Variables	Beta	R^2 (as a %)	R^2 Change (as a %)
2a: Clergy Regression Model		9%	
Professional Variables			
Hours of supervised couns.	-.106		
Undergraduate psychology	.022		
Graduate Psychology	.118		
T-P model	.073		
LC model	.148		
C-T model	.124		
Co-professional Variables			14%
Professional rel. with MHP	.343		
Professional rel. with MHP	-.185		
2b: MHP Regression Model		2%	
Professional Variables			
Church involvement	-.158		
Clients' religious beliefs	.034		
Multicultural courses	.032		
Multicultural workshops	.067		
Importance of religion	.101		
Co-professional Variables			16%
Personal rel. with clergy	-.415		
Professional rel. with clergy	-.007		

Note: MHP = mental health professional.

Hypothesis 2b: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with the clergy) will predict conjoint referral for mental health professionals.

As shown in Table 4-2, Hypothesis 2b was confirmed. The professional variables accounted for 2% of the explained variance. None of the professional variables was significant. When the co-professional variables were added to the model, the professional variable, personal relationship with the clergy, was significant (r = -.41, p = .02) and accounted for an additional 14% of the variance.

Hypothesis 3a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal relationship with mental health professionals and acquaintance with mental health resources) will predict the treat-alone option for the clergy.

Hypothesis 3a was not confirmed (see Table 4-3). The professional variables accounted for 11% of the variance. None of the professional variables was significant. When the co-professional variables were added to the model, they were not significant and accounted for only an additional 4% of the explained variance.

Hypothesis 3b: Controlling for the professional variables (religious activity, importance of religion, training in multicultural and urban issues, and perception of the importance of clients' religious beliefs), the co-professional variables (personal and professional relationships with mental health professionals) will predict the treat-alone option for mental health professionals.

As shown in Table 4-3, this hypothesis was not confirmed. The professional variables accounted for 19% of the explained variance. The only professional variable that was significant was importance of clients' religious beliefs (r = .40, p = .02). When the co-professional variables were added to the model, they were not significant and accounted for only an additional 1% of the explained variance.

Table 4-3: Regression results for Hypotheses 3a and 3b--Counsel alone.

Hypotheses & Variables	Beta	R^2 (as a %)	R^2 Change (as a %)
3a: Clergy Regression Model		11%	
Professional Variables			
Undergrad psy. courses	.257		
Graduate psy. courses	-.001		
Supervised counseling	.075		
LC model	-.168		
C-T model	-.051		
T-P model	.103		
Co-professional Variables			15%
Personal rel. with MHP	-.159		
Professional rel. with MHP	.133		
3b: MHP Regression Model			
Professional Variables		19%	
Importance of religion	.050		
Clients' religious beliefs	-.405		
Church involvement	.076		
Multicultural workshops	-.044		
Multicultural courses	-.201		
Co-professional Variables			20%
Personal rel. with clergy	-.278		
Professional rel. with clergy	.291		

Note: MHP = mental health professional.

Hypothesis 4a: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (acquaintance with mental health resources and personal relationships with mental health professionals) will predict the refer option for the clergy.

As shown in Table 4-4, this hypothesis was not confirmed. The professional variables accounted for 5% of the explained variance. None of the professional variables was significant. When the co-professional variables were added to the model, they were not significant and accounted for only an additional 2% of the explained variance.

Hypothesis 4b: Controlling for the professional variables (counseling-related education, supervised pastoral counseling, and model of pastoral counseling), the co-professional variables (personal and professional relationships with the clergy) will predict the refer option for mental health professionals.

This hypothesis was not confirmed (see Table 4-4). The professional variables accounted for 15% of the explained variance. Of the professional variables entered, only the variable, number of workshops in multicultural counseling, was significant ($r = .36$, $p = .02$). Thus, mental health professionals who had attended more workshops in multicultural counseling were more likely to agree that the clergy should not counsel but should refer to a mental health professional. When the co-professional variables were added to the model, they were significant and accounted for only an additional 1% of the explained variance.

Table 4-4: Regression results for Hypotheses 4a and 4b--Refer without counseling.

Hypotheses & Variables	Beta	R^2 (as a %)	R^2 Change (as a %)
4a: Clergy Regression Model		5%	
Professional Variables			
Undergrad psy. courses	.168		
Graduate psy. courses	-.156		
C-T model	.107		
LC model	.089		
T-P model	-.050		
Supervised counseling	-.084		
Co-professional Variables			7%
Personal rel. with MHP	-.044		
Professional rel. with MHP	.184		
4b: MHP Regression Model			
Professional Variables		15%	
Importance of religion	.198		
Clients' religious beliefs	.024		
Church involvement	.197		
Multicultural workshops	.358		
Multicultural courses	-.124		
Co-professional Variables			16%
Personal rel. with clergy	-.056		
Professional rel. with clergy	.112		

Note: MHP = mental health professional.

Hypothesis 5: Black clergy who have more counseling-related education (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.

As shown in Table 4-5, this hypothesis was not supported. None of the counseling-related-education variables was significantly related to concurrent referral (number of graduate psychology courses $r = .22$, $p = .12$; number of undergraduate psychology courses $r = -.247$, $p = .08$; hours of supervised pastoral counseling $r = -.082$, $p = .71$).

b. be more likely to use conjoint referral on the vignettes.

As shown in Table 4-5, this hypothesis was not confirmed. The counseling-related-education variables were not significantly related to the outcome variable, conjoint referral (number of graduate psychology courses $r = .161$, $p = .56$; number of undergraduate psychology courses $r = .001$, $p = .95$; hours of supervised pastoral counseling $r = -.144$, $p = .63$).

c. be less likely to use the counsel-alone option.

This hypothesis was not confirmed (see Table 4-5). The counseling-related variable number of undergraduate psychology courses was significantly related to the outcome variable, counsel alone ($r = .281$, $p = .05$). However, this relationship was the opposite to that hypothesized. Clergy who had taken more undergraduate courses in psychology were more inclined to counsel and not refer parishioners to a mental health professional.

Table 4-5: Correlational results for Hypotheses 5a through 5e: Counseling education.

Hyp.	Criterion Variable	Other Variable	r	Signif.
5a	Counseling Educ.			
	Graduate psy.	Concurrent referral	.223	N.S.
	Undergrad. psy.	Concurrent referral	-.247	N.S.
	Supervised couns.	Concurrent referral	-.082	N.S.
5b	Counseling Educ.			
	Graduate psy.	Conjoint referral	.161	N.S.
	Undergrad psy.	Conjoint referral	.001	N.S.
	Supervised couns.	Conjoint referral	-.144	N.S.
5c	Counseling Educ.			
	Graduate psy.	Counsel alone	.044	N.S.
	Undergrad psy.	Counsel alone	.281	*
	Supervised couns.	Counsel alone	.205	N.S.
5d	Counseling Educ.			
	Graduate psy.	Referral to MHP	-.092	N.S.
	Undergrad. psy.	Referral to MHP	.283	N.S.
	Supervised couns.	Referral to MHP	-.078	N.S.
5e	Counseling Educ.			
	Graduate psy.	Referral from MHP	.087	N.S.
	Undergrad. psy.	Referral from MHP	.053	N.S.
	Supervised couns.	Referral from MHP	.159	N.S.

Note: Referred means number of referrals to mental health professionals.

*Significant at the .05 level.

d. Make more referrals to mental health professionals.

This hypothesis was not confirmed (see Table 4-5). Number of referrals to mental health professionals was not significantly related to any of the counseling-related variables (number of graduate psychology courses $r = -.092$, $p = .71$; number of undergraduate psychology courses $r = .283$, $p = .26$; hours of supervised pastoral counseling $r = .078$, $p = .76$).

e. Receive more referrals from mental health professionals.

This hypothesis was not confirmed (see Table 4-5). Number of referrals from mental health professionals was not significantly related to any of the counseling-related variables (number of graduate psychology courses $r = .087$, $p = .96$; number of undergraduate psychology courses $r = .053$, $p = .84$; hours of supervised pastoral counseling $r = .159$, $p = .69$).

Hypothesis 6: Black clergy who have had more professional contact with mental health professionals (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:
a. be more likely to use concurrent referral on the vignettes.

As shown in Table 4-6, this hypothesis was not confirmed. The variable, professional contact with mental health professionals, was not significantly related to concurrent referral ($r = -.09$, $p = .53$).

Table 4-6: Correlational results for Hypotheses 6a through 6e: Professional contact with mental health professionals.

Hyp.	Criterion Variable	Other Variable	r	Signif.
6a	Professional contact	Concurrent referral	-.090	N.S.
6b	Professional contact	Conjoint referral	.139	N.S.
6c	Professional contact	Counsel alone	.140	N.S.
6d	Professional contact	Referrals to MHP	.232	N.S.
6e	Professional contact	Referrals from MHP	-.415	*

*Significant at the .05 level.

b. be more likely to use conjoint referral on the vignettes.

There was no significant correlation between the variables, professional contact with mental health professionals and conjoint referral ($r = .139$, $p = .33$) (see Table 4-6). Thus, this hypothesis was not confirmed.

c. be less likely to use the counsel-alone option on the vignettes.

As shown in Table 4-6, this hypothesis was not confirmed. No significant correlation was found between the variables, professional contact with mental health professionals and counsel-alone ($r = .140$, $p = .33$).

d. make more referrals to mental health professionals.

This hypothesis was not confirmed (see Table 4-6). The variables, professional contact with mental health professionals and number of referrals to mental health professionals, were not significant related ($r = .232$, $p = .36$).

e. receive more referrals from mental health professionals.

As shown in Table 4-6, this hypothesis was not confirmed. The variables, professional contact with mental health professionals and number of referrals received from mental health professionals, were negatively correlated ($r = -.415$, $p = .00$). Thus, clergy who had more professional contact with the clergy received fewer referrals from them.

Hypothesis 7: Black clergy who have had close personal relationships with mental health professionals (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.

As shown in Table 4-7, this hypothesis was not confirmed. The variables, personal relationships with mental health professionals and concurrent counseling, were not significantly related (r = -.132, p = .36).

Table 4-7: Correlational results for Hypotheses 7a through 7e: Personal relationships with mental health professionals.

Hyp.	Criterion Variable	Other Variable	r	Signif.
7a	Personal relationships	Concurrent referral	-.132	N.S.
7b	Personal relationships	Conjoint referral	-.018	N.S.
7c	Personal relationships	Counsel alone	.007	N.S.
7d	Personal relationships	Referrals to MHP	.081	N.S.
7e	Personal relationships	Referrals from MHP	-.262	N.S.

b. be more likely to use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-7). No significant relationship was found between the variables, personal relationships with mental health professionals and conjoint referral (r = -.018, p = .90).

c. be less likely to use the counsel-alone option on the vignettes.

This hypothesis was not confirmed (see Table 4-7). No significant relationship was found between the variables, personal relationships with mental health professionals and counsel without referring (r = .007, p = .96).

d. make more referrals to mental health professionals.

As shown in Table 4-7, this hypothesis was not confirmed. The variables, personal relationships with mental health professionals and number of referrals to mental health professionals, were not significantly related (r = .081, p = .75)

e. receive more referrals from mental health professionals.

This hypothesis was not confirmed (see Table 4-7). The variables, personal relationships with mental health professionals and number of referrals received from mental health professionals, were not significantly related (r = -.262, p = .07).

Hypothesis 8: Black clergy who are more oriented to the Conservative Theology (C-T) model of pastoral counseling (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be less likely to use concurrent referral on the vignettes.

As shown in Table 4-8, this hypothesis was not confirmed. The variables, score on the C-T scale and concurrent referral, were not significantly related (r = .125, p = .46).

Table 4-8: Correlational results for Hypotheses 8a through 8d: Scores on the C-T scale.

Hyp.	Criterion Variable	Other Variable	r	Signif.
8a	C-T scores	Concurrent referral	.125	N.S.
8b	C-T scores	Conjoint referral	.178	N.S.
8c	C-T scores	Referrals to MHP	-.170	N.S.
8d	C-T scores	Referrals from MHP	-.034	N.S.

b. be less likely to use conjoint referral on the vignettes.

This hypothesis was not supported (see Table 4-8). The variables, scores on the C-T scale and conjoint referral, were not significantly related (r = .178, p = .38).

c. make fewer referrals to mental health professionals.

This hypothesis was not confirmed (see Table 4-8). No significant relationship was found between the variables, scores on the C-T scale and number of referrals to mental health professionals (r = -.170, p = .50).

d. receive fewer referrals from mental health professionals.

As shown in Table 4-8, this hypothesis was not confirmed. The C-T variable and the variable, number of referrals received from mental health professionals, were not significantly related (r = -.034, p = .82).

Hypothesis 9: Black clergy who are more oriented to the Theology parallels Psychology (T-P) model of pastoral counseling (as measured by the Pastoral Counseling and Mental Health Questionnaire) will:

a. be more likely to use concurrent referral on the vignettes.

As shown in Table 4-9, this hypothesis was not confirmed. The variables, scores on the T-P scale and concurrent referral, were not significantly related (r = .225, p = .12).

b. be more likely to use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-9). The variables, T-P scale scores and conjoint referral, were not significantly related (r = .073, p = .61).

Table 4-9: Correlational results for Hypotheses 9a through 9d: Scores on the T-P scale.

Hyp.	Criterion Variable	Other Variable	r	Signif.
9a	T-P scores	Concurrent referral	.225	N.S.
9b	T-P scores	Conjoint referral	.073	N.S.
9c	T-P scores	Referrals to MHP	-.173	N.S.
9d	T-P scores	Referrals from MHP	-.060	N.S.

c. make more referrals to mental health professionals.

As shown in Table 4-9, this hypothesis was not confirmed. The variables, T-P scale scores and number of referrals made to mental health professionals, were not significantly related (r = -.173, p = .49).

d. receive more referrals from mental health professionals.

This hypothesis was not confirmed (see Table 4-9). The T-P scale scores variable and the variable, number of referrals received from mental health professionals, were not significantly related (r = -.06, p = .68).

Hypothesis 10: Mental health professionals who are more religiously active (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

As shown in Table 4-10, this hypothesis was not confirmed. The variables, religious activity and concurrent referral, were not significantly related (r = -.047, p = .73).

Table 4-10: Correlational results for Hypotheses 10a through 10d: Religious activity.

Hyp.	Criterion Variable	Other Variable	r	Signif.
10a	Religious activity	Concurrent referral	-.047	N.S.
10b	Religious activity	Conjoint referral	-.056	N.S.
10c	Religious activity	Referrals to clergy	.106	N.S.
10d	Religious activity	Referrals from clergy	.201	N.S.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-10). The variables, religious activity and conjoint referral, were not significantly related (r = -.056, p = .68).

c. make more referrals to the clergy.

This hypothesis was not confirmed (see Table 4-10). The variables, number of referrals to the clergy and religious activity, were not significantly related (r = .106, p = .42).

d. receive more referrals from the clergy.

As shown in Table 4-10, this hypothesis was not confirmed. The variables, number of referrals received from the clergy and religious activity, were not significantly related (r = .201, p = .12).

Hypothesis 11: Mental health professionals who report that religion is more important in their lives (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

As shown in Table 4-11, this hypothesis was not confirmed. The variables, importance of religion and concurrent referral, were not significantly related (r = .105, p = .54).

Table 4-11: Correlational results for Hypotheses 11a through 11d: Importance of religion.

Hyp.	Criterion Variable	Other Variable	r	Signif.
11a	Importance of religion	Concurrent referral	.105	N.S.
11b	Importance of religion	Conjoint referral	-.056	N.S.
11c	Importance of religion	Referrals to clergy	.235	N.S.
11d	Importance of religion	Referrals from clergy	.113	N.S.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-11). The variables, importance of religion and conjoint referral, were not significantly related (r = -.056, p = .68).

c. make more referrals to the clergy.

As shown in Table 4-11, this hypothesis was not confirmed. The variables, religious activity and number of referrals made to the clergy, were not significantly correlated (r = .235, p = .42).

d. receive more referrals from the clergy.

As shown in Table 4-11, this hypothesis was not confirmed. The variables, religious activity and number of referrals received from the clergy, were not significantly correlated (r = .113, p = .12).

Hypothesis 12: Mental health professionals who have had more professional contacts with the clergy (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

This hypothesis was not confirmed (see Table 4-12). The variables, professional relationship with the clergy and concurrent referral, were not significantly related (r = .073, p = .58).

Table 4-12: Correlational results for Hypotheses 12a through 12d: Professional contact with clergy.

Hyp.	Criterion Variable	Other Variable	r	Signif.
12a	Profess. contact with clergy	Concurrent referral	.073	N.S.
12b	Profess. contact with clergy	Conjoint referral	.009	N.S.
12c	Profess. contact with clergy	Referrals to clergy	.302	**
12d	Profess. contact with clergy	Referrals from clergy	.564	*

*Significant at the .05 level. **Significant at the .01 level.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

As shown in Table 4-12, this hypothesis was not confirmed. The variables, professional contact with the clergy and conjoint referral, were not significantly related (r = .009, p = .95).

c. make more referrals to the clergy.

This hypothesis was confirmed (see Table 4-12). The variables, professional contact with the clergy and number of referrals made to the clergy, were significantly related (r = .302, p = .01).

d. receive more referrals from the clergy.

As shown in Table 4-12, this hypothesis was confirmed. The variables, professional contact with the clergy and number of referrals received from the clergy, were significantly related (r = .564, p = .05).

Hypothesis 13: Mental health professionals who have had close personal relationships with the clergy (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

As shown in Table 4-13, this hypothesis was not confirmed. A significant negative correlation (r = -.29, p = .03) was found between the variables, personal relationship with the clergy and concurrent referral. Thus, mental health professionals who had more personal relationships with the clergy made less positive judgments regarding the need for concurrent referral with the clergy.

Table 4-13: Correlational results for Hypotheses 13a through 13d: Personal relationship with the clergy.

Hyp.	Criterion Variable	Other Variable	r	Signif.
13a	Personal rel. with clergy	Concurrent referral	-.286	*
13b	Personal rel. with clergy	Conjoint referral	-.220	N.S.
13c	Personal rel. with clergy	Referrals to clergy	-.108	N.S.
13d	Personal rel. with clergy	Referrals from clergy	.086	N.S.

*Significant at the .05 level.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-13). The variables, personal relationship with the clergy and conjoint referral, were not significantly related (r = -.220, p = .09).

c. make more referrals to the clergy.

This hypothesis was not confirmed (see Table 4-13). The variables, number of referrals to the clergy and personal relationship with the clergy, were not significantly related (r = -.108, p = .41).

d. receive more referrals from the clergy.

As shown in Table 4-13, this hypothesis was not confirmed. The variables, number of referrals received from the clergy and personal relationship with the clergy, were not significantly related (r = .086, p = .51).

Hypothesis 14: Mental health professionals who have had more training in multicultural or urban counseling (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

As shown in Table 4-14, this hypothesis was not confirmed. The variables, number of courses and workshops in multicultural or urban issues, were not significantly related to concurrent counseling (multicultural workshops $r = -.199$, $p = .15$; multicultural courses $r = .117$, $p = .40$).

Table 4-14: Correlational results for Hypotheses 14a through 14d: Multicultural workshops and courses.

Hyp.	Criterion Variable	Other Variable	r	Signif.
14a	Multicultural workshops	Concurrent referral	-.199	N.S.
	Multicultural courses	Concurrent referral	.117	N.S.
14b	Multicultural workshops	Conjoint referral	-.063	N.S.
	Multicultural courses	Conjoint referral	.031	N.S.
14c	Multicultural workshops	Referrals to clergy	.320	*
	Multicultural courses	Referrals to clergy	.250	N.S.
14d	Multicultural workshops	Referrals from clergy	-.093	N.S.
	Multicultural courses	Referrals from clergy	.089	N.S.

*Significant at the .05 level.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

This hypothesis was not confirmed (see Table 4-14). The variables, conjoint referral and number of courses and workshops in multicultural or urban issues, were

not significantly related (multicultural courses r = .031, p = .82; multicultural workshops r = -.063, p = .65).

c. make more referrals to the clergy.

As shown in Table 4-14, this hypothesis was confirmed. A significant positive relationship was found between number of referrals to the clergy and the number of multicultural workshops taken (r = .320, p = .02). Thus, mental health professionals who had attended more workshops in multicultural issues had also made more referrals to the clergy.

d. receive fewer referrals from the clergy.

This hypothesis was not confirmed (see Table 4-14). The variables, number of workshops or courses in multicultural or urban issues, were not correlated with the number of referrals that were received from the clergy (multicultural courses r = -.089, p = .51; multicultural workshops r = -.093, p = .50).

Hypothesis 15: Mental health professionals with more positive perceptions of the importance to therapy of understanding a client's religious beliefs (as measured by the Mental Health Referral Questionnaire) will:

a. be more likely to agree that the clergy should use concurrent referral on the vignettes.

This hypothesis was not confirmed (see Table 4-15). The variables, importance of a client's religious beliefs and concurrent referral, were not significantly related (r = .129, p = .33).

Table 4-15: Correlational results for Hypotheses 15a through 15d: Importance of a client's religious beliefs.

Hyp.	Criterion Variable	Other Variable	r	Signif.
15a	Client's religious beliefs	Concurrent referral	.129	N.S.
15b	Client's religious beliefs	Conjoint referral	.018	N.S.
15c	Client's religious beliefs	Referrals to clergy	.035	N.S.
15d	Client's religious beliefs	Referrals from clergy	-.085	N.S.

b. be more likely to agree that the clergy should use conjoint referral on the vignettes.

As shown in Table 4-15, this hypothesis was not confirmed. The variables, importance of a client's religious beliefs and conjoint referral, were not significantly related (r = .018, p = .89).

c. make more referrals to the clergy.

As shown in Table 4-15, this hypothesis was not confirmed. The variables, number of referrals made to the clergy and importance of a client's religious beliefs, were not significantly related (r = .035, p = .79).

d. receive more referrals from the clergy.

This hypothesis was not confirmed (see Table 4-15). The variables, number of referrals received from the clergy and importance of a client's religious beliefs, were not significantly related (r = -.085, p = .51).

Other Correlations

Although only four of the hypotheses were confirmed, the data yielded other interesting correlations and statistics. Pearson's product-moment correlation was used to compare the variables. All significant sets of variables are listed in Tables 4-16 (mental health professionals) and 4-17 (Black clergy). The results of the significant bivariate correlations are discussed in this section.

Correlations for Mental Health Professionals

Importance of religion. The variable, importance of religion, correlated positively with perceptions of importance of a client's religious beliefs to therapy (r = .252, p = .04), personal relationships with the clergy (r = .317, p = .01), professional relationships with the clergy (r = .40, p = .00), and number of referrals to Black clergy (r = .352, p = .01). (See Table 4-16.)

Table 4-16: Significant correlations of criterion variables with related predictor variables for mental health professionals.

Criterion Variable	Related Predictor Variable	r
Importance of religion	Imp. of a client's religious beliefs Personal relationship with clergy Profess. relationship with clergy Referrals to clergy	.252* .317* .400** .352**
Professional contact	Referrals to clergy Referrals from clergy	.564** .301*
Personal contact	Inv. in church activities	.490**

*Significant at the .05 level. **Significant at the .01 level.

Professional contact with clergy. The variable, personal contact with clergy, correlated positively with the number of referrals made to the clergy (r = .564, p = .00) and the number of referrals received from the clergy (r = .301, p = .02). (See Table 4-16.)

Personal relationships with clergy. The variable, personal relationships with the clergy, was positively correlated with involvement in church activities (r = .490, p = .000). (See Table 4-16.)

Other Correlations for Clergy

Acquaintance with mental health resources. The variable, acquaintance with mental health resources, was positively correlated with number of years that the clergy had served in the present church (r = .28, p = .05), personal relationships with mental health professionals (r = .660, p = .000), number of hours spent in scheduled counseling appointments (r = .382, p = .000), and size of congregation (r = .284, p = .05). Conversely, the variable, acquaintance with mental health professionals, was negatively correlated with number of referrals received from mental health professionals (r = -.414, p = .003). (See Table 4-17.)

Conservative-Theology scale. The C-T variable was negatively correlated with size of congregation (r = -.454, p = .001) and number of hours spent in scheduled counseling appointments (r = -.277, p = .05). Conversely, the C-T variable was positively correlated with theological school–whether clergy had completed or partially completed theological school (r = .30, p = .05) and city (r = .288, p = .05). (See Table 4-17.)

Limited Counseling scale. The LC variable was negatively correlated with number of hours spent in scheduled counseling appointments (r = .326, p = .03). The LC variable was also positively related to the variable, theological school–whether clergy had completed or partially completed theological school (r = -.306, p = .03).

Table 4-17: Significant correlations of predictor variables for Black clergy.

Predictor Variable	Related Predictor Variables	r
Acquaintance with mental health resources	Years at present church Personal relationship with MHP Hours in scheduled counseling Size of congregation	.280* .660** .382** .284**
Conservative-Theology scale	Size of congregation Hours in scheduled counseling Theological school City	-.454** -.277* .300* .288*
Limited Counseling scale	Hours in scheduled counseling Theological school	-.306* .326*
Hours in scheduled counseling	Acquaintance with MHP Size of congregation Hours of supervised pastoral counseling Undergrad. psychology courses Referral to MHP Conservative-Theology scale Limited Counseling scale	.382** .284* .383** .410 .788** -.277* -.307*

Note: MHP = mental health professional.

*Significant at the .05 level. **Significant at the .01 level.

Hours spent in scheduled counseling. The variable, hours spent in scheduled counseling appointments during the last week, was positively correlated with the variables, acquaintance with mental health professionals (r = .382, p = .000), size of congregation (r = .284, p = .05), number of hours in supervised pastoral counseling (r = .383, p = .006), and number of undergraduate psychology courses (r = .410, p = .003). Conversely, the variable, hours spent in scheduled counseling during the last week, was negatively correlated with the C-T scale variable (r = -.277, p = .05) and the L-C scale variable (r = -.307, p = .03).

Pastoral Role Analysis

Most of the clergy responding to the pastoral role statements (80.4%) either strongly or moderately agreed with statements that were consistent with the Theology parallels Psychology (T-P) model. This model is based on the premise that theology and psychology offer valid and complementary perspectives on human problems. Conversely, only 32.6% either strongly or moderately agreed with statements that were consistent with the Conservative-Theology (C-T) model. This model postulates that psychological principles are of little help with emotionally troubled individuals. According to this model, human problems stem from spiritual rather than psychological causes. The Limited Counseling (LC) model statements were strongly or moderately agreed to by 67.2% of the respondents.

The responses to the following statements were especially noteworthy: The statement, "The clergy can and should use knowledge of both psychology and practical theology in his/her counseling activities," was strongly or moderately

endorsed by an overwhelming 96.3% of the clergy. Moreover, 90.2% strongly or moderately agreed that "Close cooperation between the clergy and mental health workers is necessary to provide the best possible help for emotionally troubled individuals." The statement, "Theology and psychology are both valid perspectives upon human issues," was strongly or moderately agreed to by 84.3% of the respondents. However, 70.6% also strongly or moderately agreed that "Individuals who appear to need depth counseling are best referred to mental health professionals."

It is interesting that only 16% of the clergy strongly or moderately agreed that "In most cases a parishioner who thinks he/she needs psychiatric help would do best to improve his/her religious life," and only 25.5% of the clergy strongly or moderately agreed that "Prayer, repentance, and an active effort to lead a moral life are what is needed by most emotionally troubled individuals." However, 74% of the clergy also strongly or moderately agreed that "Faith in God is the most sustaining force in the life of an individual undergoing an emotional crisis."

Comparison of Clergy's and Mental Health Professionals' Responses to Vignettes

Results of the Wilcoxon signed-rank test for related samples computed for the clergy versus mental health professionals on each rating are presented in this section. In Table 4-18 it can be seen that both clergy and mental health professionals gave negative ratings (less than 4.0) to the need for the clergy to counsel alone, and more positive ratings (more than 4.00) to the need for concurrent

and conjoint referral, except on the Values and Grief vignettes. On these vignettes, the clergy gave more positive ratings to the need for the clergy to counsel alone, whereas mental health professionals gave more negative ratings to the need for the clergy to counsel alone.

Table 4-18: Means and standard deviations for clergy and mental health professionals on four referral judgment scales for the vignettes.

Vignette	Clergy		Mental Health Prof.		Z	p
	Mean	SD	Mean	SD		
Depression						
Counsel alone	3.55	1.76	2.20	1.37	-3.47	.00**
Concurrent	5.04	1.58	4.54	2.05	-1.04	.30
Conjoint	4.74	1.98	4.68	1.94	-1.38	.89
Refer	2.43	1.25	3.32	1.77	-2.47	.01**
Paranoid						
Counsel alone	2.80	1.87	1.30	0.77	-4.38	.00**
Concurrent	4.51	1.91	3.72	2.18	-1.91	.05*
Conjoint	5.11	1.83	4.37	1.95	-1.71	.09
Refer	3.59	2.02	4.78	1.99	-2.69	.01**
Values						
Counsel alone	5.39	1.60	3.77	1.82	-3.57	.00**
Concurrent	3.50	1.80	3.87	3.87	-1.14	.26
Conjoint	3.72	1.99	4.03	1.88	-0.44	.66
Refer	2.32	1.44	2.34	1.53	-0.13	.89
Grief						
Counsel alone	4.39	1.97	2.80	1.88	-3.72	.00**
Concurrent	4.20	1.70	4.19	1.78	-0.27	.79
Conjoint	4.30	1.89	4.17	1.70	-0.05	.96
Refer	2.40	1.44	2.41	1.59	-0.16	.88

Table 4-18: Continued.

Vignette	Clergy		Mental Health Prof.		Z	p
	Mean	SD	Mean	SD		
Homosexual						
Counsel alone	2.92	1.78	2.35	1.63	-1.01	.31
Concurrent	4.55	1.71	4.45	2.20	-2.11	.03*
Conjoint	5.08	1.81	4.43	1.79	-1.57	.12
Refer	3.74	2.02	3.91	2.01	-0.42	.67
Sexual						
Counsel alone	2.88	1.61	1.95	1.49	-2.43	.01**
Concurrent	4.56	1.63	3.65	2.06	-2.27	.02*
Conjoint	5.03	1.75	4.50	1.98	-1.42	.16
Refer	3.86	1.93	3.89	2.09	-0.29	.77
Spiritual						
Counsel alone	3.20	1.91	1.71	1.29	-3.44	.00**
Concurrent	4.41	1.87	4.45	2.20	-0.61	.54
Conjoint	4.92	1.74	4.74	2.05	-0.60	.55
Refer	3.62	2.09	3.93	2.03	-0.66	.51

*Significant at the .05 level. **Significant at the .01 level.

CHAPTER V

SUMMARY AND DISCUSSION OF RESULTS

In this study, the psychological referral practices of Black clergy and mental health professionals were examined using a bidirectional, co-professional model. More specifically, the researcher examined whether the professional traits or co-professional variables of the Black clergy and mental health professionals most influenced four referral options. Also investigated were the relationships between certain predictor variables and the four outcome variables. In addition, several interesting correlations were found that were not originally hypothesized.

This chapter contains a summary and interpretation of the findings regarding the hypotheses, as well as the additional findings. These results are then discussed in the light of findings from previous research. How the findings converge with or diverge from relevant findings of others is also discussed. Moreover, the implications of the findings and the limitations of the study are discussed. Finally, future directions for this area of research are suggested.

Discussion of Results for Clergy

The first four hypotheses concerned whether, after controlling for the professional variables (number of undergraduate and graduate psychology courses;

hours of supervised pastoral counseling; and the LC, C-T, and T-P models), the two co-professional variables (personal and professional relationships with mental health professionals) will most influence four referral options. The four referral options were counsel alone, concurrent referral, conjoint referral, and refer without counseling. None of these four hypotheses was confirmed. When the professional variables were controlled, the co-professional variables did not significantly predict any of the referral options. Moreover, they did not account for any significant amount of variance above and beyond that which was accounted for by the professional variables.

The only professional variable that was significant for concurrent referral was the T-P (Theology parallels Psychology) variable in the clergy model. That is, clergy who had a stronger T-P orientation were more likely to be open to concurrent referral than the C-T or LC clergy. The T-P model is based on the premise that psychology and theology have equally valuable contributions to make to understanding human problems. Consequently, it seems natural that clergy operating from this frame of reference would be more open to developing a co-professional relationship with mental health professionals. Moreover, having this schema of how to deal with human problems was more important than their personal or professional relationships with mental health professionals in influencing their decision about whether to have an ongoing co-professional relationship with them.

Hypotheses 6 through 9 were not confirmed. Closer professional and personal relationships with mental health professionals and counseling-related

education were not associated with more positive judgments regarding concurrent, conjoint, and counsel-alone options, or more referrals to and from mental health professionals.

A stronger clergy C-T orientation was not related to more positive judgments regarding counseling without referring, more negative judgments regarding concurrent referral and conjoint referral, or fewer referrals to and from mental health professionals. In addition, a stronger T-P orientation was not related to more positive judgments regarding concurrent and conjoint referrals, or more referrals to and from mental health professionals.

The finding that clergy with a stronger T-P orientation were not more open to concurrent referral seems to contradict the previous results from the regression model, where the T-P variable was positively related to concurrent referral. The T-P variable significantly predicted concurrent referral in the regression model when the counseling-related variables, hours of supervised pastoral counseling and number of graduate and undergraduate psychology courses, were also in the regression model. Thus, it seems that having strong beliefs about the efficacy of psychology and theology working together to solve human problems is not sufficient to motivate Black clergy to engage in a co-professional relationship with mental health professionals. Education in human behavior and formal training in counseling needs to accompany this orientation before the clergy will be motivated to work with mental health professionals in a co-professional relationship to help clients. It may be that Black clergy need to feel competent in counseling and to feel like an equal co-

professional before being motivated to enter into a co-professional relationship with mental health professionals.

Discussion of Other Correlation Results

Although only a small amount of variance was accounted for with the multiple regression models that were used, the data produced other interesting correlations. Tables 4-16 and 4-17 contained a list of all the significant sets of correlating variables. As is the case in multiple regression, simple correlations between variables are not an indication of causation. Rather, they are indicative of a level of predictable association, wherein when one is present, the other is likely to be present to the degree indicated by the strength of the correlation coefficient expressed as a percentage. These significant correlations are discussed in the following paragraphs.

The variable, acquaintance with mental health resources, was positively correlated with the variables, number of years that clergy had served at the present church, size of congregation, relationships with mental health professionals, and number of hours spent in scheduled counseling appointments. Thus, clergy who were more acquainted with mental health resources had served longer at their present church, were pastoring larger congregations, had closer personal relationships with mental health professionals, and had spent more hours in scheduled counseling appointments. These correlations provide an interesting, multifaceted picture of the clergy who is more acquainted with mental health resources.

The positive relationship between acquaintance with mental health resources and number of hours spent in scheduled counseling appointments is similar to results of Kevin's (1976) study. In that study, acquaintance with mental health professionals was positively related to counseling and referral activity. Kevin concluded that clergy who were involved in counseling did have more contact with mental health professionals. However, one cannot infer that acquaintance with mental health resources causes more counseling or referral because the argument could also be made that more acquaintance with mental health resources might be related to the need for professional consultation by the clergy.

The finding that clergy who pastored larger congregations were more acquainted with mental health resources may be due to other variables that are more related to clergy but manifest themselves indirectly in size of congregation (Meylink & Gorsuch, 1986). These indirect variables are sophistication of the clergy, the role of the clergy in larger churches as compared to smaller churches, and location of larger churches. Larger churches are more likely to be located in metropolitan areas where there are numerous mental health resources. Larger churches also tend to attract more educated clergy who have had counseling-related courses and are more open to referring parishioners to mental health professionals.

The variable, Conservative-Theology (C-T) scale, correlated negatively with size of congregation and number of hours spent in scheduled counseling appointments. Thus, clergy who had a theological frame of reference that sees little need for psychological intervention for emotionally troubled parishioners were

pastoring smaller congregations and were doing less counseling. The C-T variable was also positively related to the variable, theological school--whether clergy had completed or partially completed theological school. Thus, clergy who had more conservative theological views were more likely to have completed theological school.

These findings are interesting when compared with Kevin's (1976) results, which indicated that clergy from the C-T model were less educated. Kevin's finding that C-T clergy tended to be less educated may help explain why C-T clergy were more likely to pastor smaller congregations. Less educated clergy often are given smaller congregations with less "sophisticated" parishioners. It seems logical that C-T clergy will be involved in less pastoral counseling because of their views that spiritual remedies are needed for emotional problems. Similarly, the negative relationship between the Limited Counseling (LC) model and the number of hours spent in counseling appointments also reflects the underlying frame of reference of this model. Clergy operating from this model see their role as primarily that of fostering a supportive church community with some limited supportive counseling.

The variable, hours spent in scheduled counseling appointments, was significantly correlated with more variables than any other variable. Clergy who had more scheduled counseling appointments were more acquainted with mental health resources, pastored larger congregations, had more hours of supervised pastoral counseling, and had completed more undergraduate psychology courses. Thus, clergy who were doing more counseling were those who had received more training,

both theoretically and practically, in human behavior and counseling techniques. They also were pastoring larger congregations, which usually have more educated, "sophisticated," and psychologically minded parishioners.

Discussion of Results of the Pastoral Role Statements

The majority of the clergy, regardless of their pastoral model, believed that there should be "close cooperation between them and mental health professionals," that the clergy should "use knowledge of both psychology and practical theology in his/her counseling activities," and that "theology and psychology are both valid perspectives upon human issues." Conversely, only a very small number of clergy believed that "in most cases a parishioner who thinks he/she needs psychiatric help should best improve his/her religious life" and that "prayer, repentance, and an active effort to lead a moral life are what is needed by most emotionally troubled individuals." These beliefs suggest that the clergy in this study, intellectually, were open to a co-professional relationship with mental health professionals and were less inclined to use spiritual remedies for psychological problems. However, their low rate of referrals to mental health professionals raises questions about their willingness to act on these beliefs.

Discussion of Results for Mental Health Professionals

The first four hypotheses tested whether, after controlling for the professional variables (involvement in church activities, importance of the client's religious beliefs, importance of religion, and number of multicultural courses and workshops), the co-

professional variables (personal and professional relationships with the clergy) will most influence four referral options. The four referral options were counsel alone, concurrent referral, conjoint referral, and refer without counseling.

Only the hypothesis predicting conjoint referral was confirmed. It was hypothesized that after controlling for the professional variables, the co-professional variables should significantly predict concurrent referral. The results showed that when the professional variables, involvement in church activities, importance of clients' religious beliefs, importance of religion, and number of courses and workshops in multicultural issues, were controlled for, the co-professional variables, personal and professional relationships with the clergy by mental health professionals, did significantly predict the conjoint referral option. Of the two co-professional variables, only the variable, personal relationship with the clergy, was significant. However, this variable was negatively related to the conjoint referral option. Mental health professionals who had closer relationships with members of the clergy were less open to having a conjoint relationship with them. This finding was surprising because, logically, one would expect that mental health professionals who had closer personal relationships with the clergy should have a better opportunity to get to know and trust them. Such close relationships should also allow both professionals to get more acquainted with each other's discipline and what each has to offer. The contrary finding of this study may indicate that mental health professionals may develop a negative schema of the proficiency of the clergy, based on their close relationship with one or a few clergy. These results may also

suggest that mental health professionals perceive that counseling/psychotherapy is their domain exclusively and close personal relationships with the clergy have not changed that view.

None of the other mental health professional hypotheses, except 13a, were confirmed. It was predicted that mental health professionals who were more religiously active, who reported that religion was important in their lives, and who had more positive perceptions of the importance to therapy of understanding the clients' religious beliefs would be more open to being involved in concurrent or conjoint referral with the clergy. It was also predicted that they would make more referrals to the clergy. None of these hypotheses were confirmed. These findings are consistent with those of Kevin (1976), who also failed to find a positive relationship between religious activity and a willingness to refer clients to the clergy. Kevin concluded that the low level of cooperation between mental health professionals (psychologists) and the clergy could not be attributed to any hostility or negativism on the part of the mental health professionals. Rather, he attributed it to the fact that these psychologists had a well-defined area of competence and a clientele who sought them out. The psychologists, therefore, would have little motivation or time to actively seek out cooperation with the clergy.

Multicultural training was not found to be related to mental health professionals' willingness to be involved in concurrent or conjoint counseling. However, mental health professionals who had more multicultural training had made more referrals to Black clergy. This finding suggests that multicultural training may

sensitize mental health professionals to the contribution that Black clergy can make to helping emotionally ill people and result in their making more referrals to the clergy.

Discussion of Other Correlations for Mental Health Professionals

The variable, importance of religion, was positively correlated with (a) perceptions of importance of clients' religious beliefs to therapy, (b) personal and professional relationships with the clergy, and (c) number of referrals to Black clergy. The finding that mental health professionals who reported that religion was important in their lives also reported that it was important to therapy to know the religious beliefs of the client they were treating is not surprising. Mental health professionals whose world view is influenced by their religious beliefs will be more sensitive to the influence of their clients' religious beliefs on their perceptions of reality and presenting problems.

The positive relationship between importance of religion and the variable, personal relationship with the clergy, indicates that mental health professionals who reported that religion was more important in their lives also had closer personal relationships with the clergy. These results also were not surprising because mental health professionals who reported that religion was important in their lives would be more likely to attend church and, because of their professional status, be personal friends with the clergy. However, as discussed earlier, these relationships do not

seem to break down territorial barriers and produce working co-professional relationships.

The positive relationship between the variable, importance of religion, and the variables, professional relationships with the clergy and number of referrals made to the clergy, indicates that mental health professionals who reported that religion was more important in their lives had more professional contact with the clergy and made more referrals to the clergy. Mental health professionals who were more religious would be more likely to be aware of the counseling proficiency of the clergy and also to be acquainted with more members of the clergy.

Comparison of Clergy's and Mental Health Professionals' Responses to the Vignettes

The clergy and mental health professionals were in general agreement on the vignettes that merited higher and lower ratings on the four referral options, except for the Values and Grief vignettes. Both professionals agreed that the clergy should not counsel alone the Depression, Paranoid, Homosexual, Sexual, and Spiritual clients. However, they were in agreement that these problems warranted concurrent or conjoint referral. The Sexual and Paranoid vignettes had the lowest ratings. The low rating on the Sexual vignette is consistent with those of Cumming and Harrington (1963), Sandler (1966), and Kevin (1976), who found that clergy usually referred problems relating to sex. The Paranoid vignette portrayed a situation involving significant psychopathology, and the clergy seemed to be aware of their lack of competence to intervene alone.

The Depression vignette was left vague intentionally, and the low ratings by the clergy on the need to counsel alone are also consistent with Kevin's (1976) findings. Kevin concluded that because this hypothetical situation did not present a clear-cut problem, the clergy pursued the safest course of referring along with supportive counseling. The Spiritual vignette also was not a clear-cut case and had elements that are normal from a Black religious experience, while having some overtones of possible psychopathology. This vignette portrayed a woman who had a vision of God and Hell and continued to hear a strange voice telling her what to do. Both professionals made positive ratings on the need for concurrent and conjoint referral, seemingly recognizing the complexity of the problem and how both disciplines working together could help.

The low ratings by the mental health professionals on the need for the clergy to counsel alone the Values and Grief clients are surprising and inconsistent with Kevin's (1976) findings. These vignettes did not contain any psychopathology and seemed to be within the competence of the clergy. In Kevin's study, both mental health professionals and clergy had high ratings for the clergy to counsel. The low ratings by mental health professionals in this study may be reflective of a territorial battle that perceives counseling as still the exclusive domain of mental health professionals. It is interesting that, in most of the cases, both professionals gave higher ratings on the need for conjoint referral as compared to concurrent referral. This finding suggests that, whereas clergy and mental health professionals are open to a co-professional relationship, they are more comfortable with a relationship that

involves more consultation and occasional contact rather than an ongoing relationship.

Limitations of the Study

This study was an exploratory investigation testing a bidirectional model of clergy's and mental health professionals' referrals. In evaluating the results, several methodological issues relating to internal and external validity, sampling, statistical analysis, and instruments need to be considered. The relatively small sample sizes for both the clergy and the mental health professionals could have affected power. Threats to internal validity were present because the experimental controls of randomization and manipulation of variables were not carried out. Moreover, the validity of the questionnaires used in this study was questionable. Both questionnaires were adapted from other surveys. On the Pastoral Counseling and Mental Health Questionnaire, the Pastoral Role section had good Cronbach alpha, and the vignettes that were included had been used in several previous studies in the area. However, no test-retest reliability analysis was done for the questionnaire as a whole, even though it had high face validity.

Sections of the Mental Health Professional Questionnaire also were adapted from a questionnaire that had been previously used. However, as with the clergy questionnaire, several sections were new, and the instrument as a whole was untested with respect to test-retest reliability or construct validity. Another threat to internal validity was the Hawthorne effect. Accurate reporting of data by the subjects could have been affected by their knowledge that they were participating in a study.

In this study, the Hawthorne effect was probably evidenced through both demand characteristics and social desirability. Demand characteristics suggest that the subjects would alter responses to fit what they perceived the intention of the study to be. The social desirability factor could have been manifested because some ministers might have given responses in the direction of "the right thing to do."

Using multiple regression techniques, like all parametric statistics, has certain conditions that, if they are not met, can pose certain problems. First, the problem of multicollinearity, which occurs when two or more of the predictor variables are highly correlated with each other, can result in none of the independent variables demonstrating a substantial, unique contribution to the prediction of the dependent variable (Wampold & Freund, 1987). The independent variables need to have high correlations with the criterion variable but low correlations with each other. Tabachnick and Fidell's (1989) recommendation that bivariate correlations above .7 indicate a possible problem was used as a yardstick to determine whether multicollinearity existed. Tabachnick and Fidell, however, pointed out that the presence of a low bivariate correlation is not a guarantee that multicollinearity does not exist. They pointed out the possibility that two predictor variables could be only moderately correlated with a criterion variable when examined individually but might be highly correlated when examined together. In this study, the failure to confirm most of the hypotheses that involved the use of multiple regression analyses could be attributed to the aforementioned problems.

The use of multiple regression also results in two statistical limitations. First, as the value of the regression coefficient approaches 100%, one can place reasonable confidence in the validity of the predictor variables that accounted for the differences in the outcome variable. However, in reality, even high values of r are not going to reach 100%. There will always be a percentage of the variance that remains unaccounted for due to unexplained factors. Any conclusions that the predictor variables actually account for any observed changes in the outcome variable must be based on the assumption that the unexplained variance is not a significant factor. One can make this assumption with more confidence as the value of the regression coefficient gets closer to 1.0 (100% of the variance).

In addition, when multiple regression techniques are used, both predictor and criterion scores exist for the subject population. In this study, therefore, it would be hoped that the findings could be used to predict for another group of Black clergy and mental health professionals. However, this possibility is very unlikely. If the researcher were to use the same regression equation, having a high coefficient of multiple correlation, with another group of Black clergy, it is very likely that the regression equation would be less accurate with a smaller coefficient. This drop-off, called "shrinkage," will be evidenced because the new group of Black clergy and mental health professionals will not be identical to the group that was used in this study.

The external validity of this study is also limited because true random sampling techniques were not employed. The results of this study cannot be

generalized to the population of Black clergy and mental health professionals. However, the results are generalizable across specific populations that share similar characteristics with the population used in this study.

Finally, the low return rate was another limitation that could have affected the power. This low return rate is comparable with that of previous studies in which mailed questionnaires were used to collect data.

Implications of the Results

This study was motivated by the low level of cooperation and the unidirectional relationship that exists between the clergy and mental health professionals. In the unidirectional interaction, the clergy are the gatekeepers who refer parishioners to mental health professionals. In this investigation, several variables were tested that could affect a bidirectional, co-professional model, where mental health professionals work together in a more equitable relationship. In this relationship, referrals are made in both directions as these professionals interact with each other to provide conjoint and concurrent treatment approaches to clients, in addition to the traditional two options--counsel or refer.

Several of the findings have implications for possible cooperation between the clergy and mental health professionals. The results suggest that most of the clergy believe that there should be close cooperation between the clergy and mental health professionals and are open to exploring a co-professional relationship with mental health professionals. However, clergy with a strong T-P (Theology parallels

Psychology) orientation, with training in human behavior and counseling, will be more open to a co-professional relationship with mental health professionals.

The finding that mental health professionals who had more multicultural training made more referrals to the Black clergy has important implications for training mental health professionals who will be working in the Black community. Multicultural courses should include more content on the importance of working with the Black clergy in order to be effective in the Black community. As previously mentioned, the Black church is an integral part of the Black experience. In addition, institutions that train mental health professionals could invite members of the clergy to come in and provide first-hand information about Black spirituality as part of the multicultural course content. The Black clergy could also meet informally with these mental health professionals to share information about each other's discipline. The Black clergy could also invite mental health professionals in training to conduct workshops on referring and recognizing psychopathology. Ultimately, as Meylink and Gorsuch (1988) suggested, rather than training clergy and mental health professionals only on issues within their field, these professionals should be trained to look for specific signals suggestive of issues outside their field of expertise. Moreover, it was concluded that this dialogue could result in the creation of a diagnostic list of spiritual and psychological problems that are often encountered.

This co-professional relationship could also be fostered by Black mental health professionals who are actively involved in the Black church. These mental health professionals have a first-hand opportunity to educate the clergy on

psychological issues and to become actively involved in establishing a co-professional relationship with them.

Recommendations for Future Research

This study should be replicated using a larger sample of mental health professionals and Black clergy. In addition, more valid and reliable instruments should be used. Future studies could also use a sample of exclusively Black mental health professionals to compare with the Black clergy. Future researchers should use better operational definitions of the variables used in both the clergy and mental health professional samples. More qualitative studies are needed in which mental health professionals and Black clergy are asked specifically how they feel about working with each other and what barriers now exist that prevent such a relationship.

The finding in this study that both clergy and mental health professionals were more open to using conjoint referral than concurrent referral warrants future exploration. Possible variables that may be responsible for this choice should be examined. Future researchers should also examine how mental health professionals and Black clergy determine when a presenting problem is outside their area of expertise and need intervention by the other professional. Finally, future investigators could examine clients' and parishioners' feelings about the use of a co-professional relationship to help with their problems.

APPENDICES

APPENDIX A

PASTORAL COUNSELING AND MENTAL HEALTH QUESTIONNAIRE

AND COVER LETTER TO CLERGY

May 30, 1994

Dear Clergy,

Thank you for agreeing to spend your valuable time responding to this questionnaire. The information that you provide will be used to gain a clearer picture of how Black clergy deal with potential mental health problems. It is my belief that the results of this survey will contribute to better understanding and more fruitful cooperation between mental health professionals and Black clergy.

Trial runs have indicated that the questionnaire can be completed in less than 45 minutes. Please answer the questions in order and do not leave any blanks. All the information collected will be regarded as completely confidential. Names will never be associated with the results of the survey. To ensure confidentiality, please do not put your name on the questionnaire.

To make sure that your comments are included in the survey along with those made by the other Black clergy who have been contacted, please return the completed questionnaire within two weeks. A stamped, self-addressed envelope is enclosed for your convenience.

I will be happy to furnish a summary of the findings of this survey to you. If you desire to receive a copy of the summary, please send your name and mailing address to me at the address listed below. Feel free to contact me by telephone if you have any questions regarding the questionnaire.

Again, thank you for your help.

Appreciatively,

Raymond Mars
E135 Owen Hall
Michigan State University
East Lansing, MI 48825

Pastoral Counseling and Mental Health Questionnaire

Please answer as indicated in each question. The information you give will remain confidential.

Personal Information:

1. Your age _____

2. Denomination _____

3. Name of church or parish you serve _____

4. How many years have you served in your present church? ____

5. What is the total number of years you have been a pastor? ____

6. Do you give full time to the work of the pastorate? Yes____ No____

7. What is the total number of members in your congregation? _____

Schooling:

8. In the space below, check the appropriate blanks to indicate the level of education you have received:

   a. High school (check one) Completed___ Partially completed___
   b. College (check one) Completed___ Partially completed___
   c. Theological school (or other professional school) (check one) Completed___ Partially completed___
   d. Describe any additional education you have received:

   _____

9. Estimated number of undergraduate psychology or counseling courses: None_____ 1-3_____ 4 or more_____

10. Estimated number of graduate courses in psychology or counseling: None_____ 1-3_____ 4 or more_____

11. Estimated number of hours in supervised pastoral counseling: _____

Counseling and Referral Activity:

12. During the last week, how many hours would you estimate that you spent in scheduled counseling appointments? _____

13. At the present time, how many cases (individual, couples, and family groups) are coming to you for counseling? _____

14. During the last year, did you receive any referrals from mental health professionals? Yes_____ No_____ **If No, go to Question 16.**

15. How many would you estimate were from:
    a. Black mental health professionals? _____
    b. White mental health professionals? _____

16. During the last year, did you refer any member to a mental health professional? Yes_____ No_____ **If No, go to Question 18.**

17. Of the cases that you referred, how many were referred to:
    a. A Black mental health professional? _____
    b. A White mental health professional? _____
    c. Other (specify)? _____

18. Please check the statement that best describes your acquaintance with mental health resources such as psychologists, psychiatrists, and mental health centers:
    _____ I have no personal knowledge of mental health resources.
    _____ I know at least one mental health resource, but I have not used it.
    _____ I have made occasional contacts with mental health resources in order to refer a counselee or discuss a counseling problem.
    _____ I maintain ongoing contact with one or more mental health resources for the purpose of making or accepting referrals.

19. Please check the statement that best describes your personal relationships with mental health professionals:
    _____ I do not have a personal friendship with a mental health professional.
    _____ I have a personal friendship with a mental health professional.

    If Yes, what is the race of that professional? (check one)
    a. Black_____ b. White_____ c. Other_____

    _____ I have a personal friendship with a mental health professional who is also an active Christian.

    If Yes, what is the race of that professional? (check one)
    a. Black_____ b. White_____ c. Other_____

Pastoral Role:

Listed below are various statements that investigate the relationship between religion and psychology and the role of the clergy as a pastoral counselor. Please read each statement once and indicate the strength of your agreement or disagreement with the item by circling the appropriate number using the following coding system:

-1 Disagree strongly
-2 Disagree moderately
-3 Disagree slightly
+1 Agree slightly
+2 Agree moderately
+3 Agree strongly

20. The amount of counseling that a clergy does should depend solely upon his/her comfort with and skill in the practice of pastoral counseling.

-3 -2 -1 +1 +2 +3

21. Individuals who appear to need depth counseling are best referred to mental health professionals.

-3 -2 -1 +1 +2 +3

22. The severity of the emotional problems with which a clergy deals should depend solely upon one's comfort and skill in pastoral counseling.

-3 -2 -1 +1 +2 +3

23. The clergy can profit from the study of psychology but should leave psychotherapy to the professional psychotherapists.

-3 -2 -1 +1 +2 +3

24. The most significant help that the church can offer to an individual undergoing an emotional crisis is support by members of the congregation and the various subgroups sponsored by the church.

-3 -2 -1 +1 +2 +3

25. Prayer, repentance, and an active effort to lead a moral life are what is needed by most emotionally troubled individuals.

-3 -2 -1 +1 +2 +3

26. In most cases, a parishioner who thinks he/she needs psychiatric help would do best to improve his/her religious life.

-3 -2 -1 +1 +2 +3

27. Faith in God is the most sustaining force in the life of an individual undergoing an emotional crisis.

-3 -2 -1 +1 +2 +3

28. Most emotional problems are rooted in human sinfulness.

-3 -2 -1 +1 +2 +3

29. Theology and psychology are both valid perspectives upon human issues.

-3 -2 -1 +1 +2 +3

30. Close cooperation between the clergy and mental health workers is necessary to provide the best possible help for emotionally troubled individuals.

-3 -2 -1 +1 +2 +3

31. There is little need for psychological knowledge in pastoral counseling.

-3 -2 -1 +1 +2 +3

32. The clergy can and should use knowledge of both psychology and practical theology in his/her counseling activities.

-3 -2 -1 +1 +2 +3

33. The amount of counseling that the clergy does should depend solely upon his/her comfort with and skill in the practice of pastoral counseling.

-3 -2 -1 +1 +2 +3

Views on Mental Health Problems:

Instructions: Each of the following vignettes describes a hypothetical problem situation in the lives of one or more persons. In each case, the people involved are members of a Black Protestant church. They are aware that they need help, but they are unsure whether the clergy or a mental health professional (psychologist, psychiatrist, or social worker) is the most appropriate source of help.

Please read each vignette carefully. Then indicate how likely you are to use each of the four methods of handling this case by circling the number on the rating scale that best describes your likelihood. Please make your judgment on the basis of your own personal intuition and experience.

Below is a statement that illustrates how this rating scale should be used.

I would recommend disfellowship for a church member who is an adulterer.

Not Likely Very Likely

1 2 3 4 5 6 7

If the probability that you would take this action is very strong, you would circle 6 or 7, according to how strongly you feel about the probability. If the probability is only moderately strong, you would circle 5. If you are uncertain or undecided, you would circle 4. If the probability is very weak, you would circle 1 or 2, according to how improbable you feel it is that you would take this action.

Please circle only one number for each statement.

I. *Mary J. is a 29-year-old housewife who states that she is generally unhappy about herself and the way that her life has been progressing. Mary describes herself as a sensitive and intelligent person who was once quite active with a large circle of friends. Although she states that she had held several responsible and rewarding jobs before her marriage, she complains that she now has barely enough energy to go through her daily routine of housework. Doctors, she says, have had no success in finding a medical reason for her lack of energy. She says that she is becoming absent-minded and that she has frequent and often inexplicable crying spells.*

34. I would counsel this client and not refer her to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

35. I would counsel this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

36. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

37. I would not attempt to counsel this client and would refer her to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

II. *Mr. Brown is a young man in his twenties. During the last two years, he has become very suspicious. He comes to you because his wife insists that he seek help. Mr. Brown does not trust anybody, and he is sure that everybody is against him. Sometimes he thinks that the people he sees on the street are talking about him or following him around. He has cursed and hit his wife because he feels that she is working against him just like everybody else.*

38. I would counsel this client and not refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

39. I would see this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship with me where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

40. I would refer this client to a mental health professional who would be open to inviting me to participate in some of the sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

41. I would not attempt to counsel this client and would refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

III. *Henry B. is a 40-year-old man with a wife and two sons. He states that he has become dissatisfied and uncertain about the path which his life has been taking for the last several years. Henry says that he is aware and proud of the fact that he has become a successful businessman and a good provider for his family. But he has become progressively more distressed by his total absorption with his work and the deterioration of his family life. Henry says that he is presently wondering if there is a way to improve his relationship with his wife and sons without sacrificing the materials gains which he has struggled so hard to achieve.*

42. I would counsel this client and not refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

43. I would see this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

44. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

45. I would not attempt to counsel this client and would refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

IV. *Helen A. is a 54-year-old woman whose husband has recently retired. She expresses exasperation and anger over the behavior of her husband and a few close friends. As Ms. A describes the situation, her husband and their friends are pressuring her and making light of her grief over the death of her teenage son, six months past. She complains that they do not honor her desire to be left alone with her grief.*

46. I would counsel this client and not refer her to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

47. I would see this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

48. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

V. *Mr. Jones is a young man in his thirties, a high school teacher, and unmarried. He has been a member of your church for several years. He comes to you for counsel. He complains of regular headaches and that he is working hard. Then, without any preliminaries, he starts talking about sexual problems. He is afraid that he is "perverted" and has been bothered with homosexual thoughts. He claims to have had no heterosexual sexual contact, but masturbates a great deal. He wants advice and help to make him "normal." He tends to go off into a long monologue about his sex life and is difficult to interrupt.*

50. I would counsel this client and not refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

51. I would see this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship with me where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

52. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

53. I would not attempt to counsel this client and would refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

VI. *William D, a 45-year-old married man, reports that he feels considerable anxiety because of thoughts that have been running through his head lately. He states that for several weeks he has been experiencing impulses to expose himself and to commit other indecent acts in a public place. Mr. D. says that he is afraid that he is losing control of himself and that he is not sure how much longer he can resist these impulses. He expresses feelings of guilt for what he is thinking and says that he is fearful of the same and disgrace that would follow his imagined activities. Mr. D. further states that he has been happily married for 10 years and has one child whom he loves dearly. He describes his relationship with his wife as very satisfying and states that sex has not been overly important to either his wife or himself. William is also adamant that none of the fantasies and impulses that he is experiencing have ever occurred in the past.*

54. I would counsel this client and not refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

55. I would counsel this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

56. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

57. I would not attempt to counsel this client and would refer him to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

VII. *Ms. Smith is an attractive married woman in her forties. She has been very active in church or synagogue affairs and is considered a good woman. She states that she conversed with God shortly after seeing a strange star on Christmas Day. Later, in a vision she saw and heard God talking with His angels. also got a glimpse of the Devil and the fires of Hell. She repeatedly h ears a strange voice telling her what to do and how to behave. Ms. Smith wants to know whether she should obey the voice.*

58. I would counsel this client and not refer her to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

59. I would see this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client would be shared.

Not Likely Very Likely

1 2 3 4 5 6 7

60. I would refer this client to a mental health professional who would be open to inviting me to participate in some sessions if the client's religious beliefs become an issue in therapy.

Not Likely Very Likely

1 2 3 4 5 6 7

61. I would not attempt to counsel this client and would refer her to a mental health professional.

Not Likely Very Likely

1 2 3 4 5 6 7

APPENDIX B

MENTAL HEALTH REFERRAL QUESTIONNAIRE AND COVER LETTER TO MENTAL HEALTH PROFESSIONALS

May 30, 1994

Dear Mental Health Professional:

Thank you for agreeing to spend your valuable time on this questionnaire. The information that you provide will be of great help in increasing the degree of understanding and cooperation between those of us working in the mental health field and Black clergy. As you may know, this cooperation is particularly important in the light of evidence that in the Black community the clergy are sought out by persons with emotional and psychological problems more often than members of any other professional group.

Pretests have indicated that this questionnaire can be completed in less than 30 minutes. Please answer the questions in order and do not leave any blanks. All responses will be regarded as confidential, and the data will be analyzed as a group only.

For your responses to be included along with those of the other mental health professionals who are participating in this study, please return the completed form within two weeks. A stamped, self-addressed envelope is enclosed for your convenience.

I will be happy to furnish a summary of the findings of this survey to you. If you desire to receive a copy of the summary, please send your name and mailing address to me at the address listed below. Feel free to contact me by telephone if you have any questions regarding the questionnaire.

Again, thank you for your help.

Appreciatively,

Raymond Mars
E135 Owen Hall
Michigan State University
East Lansing, MI 48825

Mental Health Referral Questionnaire

Basic Information:

1. Your age: _____

2. Sex: Male____ Female____

3. Race: Black____ White____ Other (describe)_____

Education and Theoretical Orientation:

4. Highest degree earned_____

5. Field of specialization_____

6. Predominant theoretical orientation (check one):
   ____ Rogerian ____Psychoanalytic
   ____ Cognitive ____ Systemic
   ____ Cognitive behavioral ____ Gestalt
   ____ Psychodynamic ____ Feminist
   ____ Other (please explain)_____

7. How important to therapy is knowing the religious beliefs of the client you are treating?
   ____ Not important ____ Important
   ____ Somewhat important ____ Very important

8. What has been your training in multicultural or urban issues (check only one per category)?

   Courses taken in college: None____ 1-3____ 4 or more____
   Workshops/seminars attended: None____ 1-3____ 4 or more____

Private Practice:

9. Hours per week: _____

10. Number of active cases in the last 30 days: ____

11. Time in years that your practice has been established in the community: ____

Institutional Practice:

12. Institutional affiliation: _____

13. Hours per week: _____

14. Number of active cases in the last 30 days: _____

15. Years in present setting: _____

Religious Activity:

16. What is your denominational affiliation, if any? _____

17. Please check the category that characterizes your personal religious beliefs:
    ____ Atheist ____ Christian ____ Islam
    ____ Agnostic ____ Jewish
    ____ Theist (one who believes in the reality of some divine power or a supernatural force but who does not accept the doctrine of any church as to the nature of the divinity or force)
    ____ Other (please explain) _____

18. How important is religion in your life?
    ____ Not at all important ____ Important
    ____ Somewhat important ____ Very important

19. Please check the category that best describes your involvement in church activity:
    ____ I'm not a member of an organized church
    ____ I attend church occasionally (once a month or less)
    ____ I attend frequently (almost weekly)
    ____ I attend church frequently and I'm actively involved in church activities

Referrals:

20. Estimated number of cases referred to you during the last year by the clergy: None____ 1-4____ 5-9____ 10 or more____

    If none, go to Question 20.

    Of those referred to you, how many were referred by Black clergy:
    None____ 1-4____ 5-9____ 10 or more____

21. a. Estimated number of cases that you referred to a clergy during the last year: None____ 1-4____ 5-9____ 10 or more____

b. Of those referred, how many were referred to a Black clergy: None____ 1-4____ 5-9____ 10 or more____

22. Please check the category that best describes your professional contact with clergy:

____ I have never had any professional contact with a member of the clergy (i.e., consultation, making or receiving referrals).
____ I have consulted with the clergy, but I have never referred a client to them.

Of the consults that you have had over the last year, how many were with: Black clergy____ White clergy____ Other clergy____

____ I have made referrals to the clergy.

Of the referrals that you have made over the last year, how many were made to: Black clergy___ White clergy___ Other clergy___

23. Please check the category that best describes your personal relationships with the clergy:

____ I have never had a personal friendship with a clergy.
____ I have a casual friendship with a clergy.
What is the race of that clergy? Black___ White___ Other___
____ I have a close personal relationship with a clergy.
What is the race of that clergy? Black___ White___ Other___

Views on Mental Health Problems:

Instructions: Each of the following vignettes describes a hypothetical problem situation in the lives of one or more persons. In each case, the people involved are members of a Black Protestant church. They are aware that they need help, but they are unsure whether the clergy or a mental health professional (psychologist, psychiatrist, or social worker) is the most appropriate source of help.

Please read each vignette carefully. From a psychologist's point of view, you are to indicate how you think members of the Black clergy should respond when confronted with these cases. Indicate your opinion by circling the number on the rating scale that follows each of the four referral options.

Below is a statement that illustrates how this rating scale should be used.

I would break confidentiality and inform an uninformed partner of an HIV positive client.

Disagree Agree

1 2 3 4 5 6 7

If you strongly agree, you would circle 6 or 7, depending on the strength of your agreement. If you agree slightly, you should circle 5. If you are neutral or undecided, you would circle 4. If you disagree slightly, you would circle 3. If you disagree, you would circle 1 or 2, depending on how strongly you disagree.

Please circle only one number for each statement.

I. *Mary J. is a 29-year-old housewife who states that she is generally unhappy about herself and the way that her life has been progressing. Mary describes herself as a sensitive and intelligent person who was once quite active with a large circle of friends. Although she states that she had held several responsible and rewarding jobs before her marriage, she complains that she now has barely enough energy to go through her daily routine of housework. Doctors, she says, have had no success in finding a medical reason for her lack of energy. She says that she is becoming absent-minded and that she has frequent and often inexplicable crying spells.*

24. The Black clergy should counsel this client and not refer her to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

25. The Black clergy should counsel this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

26. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

27. The Black clergy should not attempt to counsel this client and should refer her to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

II. *Mr. Brown is a young man in his twenties. During the last two years, he has become very suspicious. He comes to you because his wife insists that he seek help. Mr. Brown does not trust anybody, and he is sure that everybody is against him. Sometimes he thinks that the people he sees on the street are talking about him or following him around. He has cursed and hit his wife because he feels that she is working against him just like everybody else.*

28. The Black clergy should counsel this client and not refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

29. The Black clergy should counsel this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

30. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

31. The Black clergy should not attempt to counsel this client and should refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

III. *Henry B. is a 40-year-old man with a wife and two sons. He states that he has become dissatisfied and uncertain about the path which his life has been taking for the last several years. Henry says that he is aware and proud of the fact that he has become a successful businessman and a good provider for his family. But he has become progressively more distressed by his total absorption with his work and the deterioration of his family life. Henry says that he is presently wondering if there is a way to improve his relationship with his wife and sons without sacrificing the materials gains which he has struggled so hard to achieve.*

32. The Black clergy should counsel this client and not refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

33. The Black clergy should counsel this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

34. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

35. The Black clergy should not attempt to counsel this client and should refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

IV. *Helen A. is a 54-year-old woman whose husband has recently retired. She expresses exasperation and anger over the behavior of her husband and a few close friends. As Ms. A describes the situation, her husband and their friends are pressuring her and making light of her grief over the death of her teenage son, six months past. She complains that they do not honor her desire to be left alone with her grief.*

36. The Black clergy should counsel this client and not refer her to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

37. The Black clergy should counsel this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

38. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

39. The Black clergy should not attempt to counsel this client and should refer her to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

V. *Mr. Jones is a young man in his thirties, a high school teacher, and unmarried. He has been a member of your church for several years. He comes to you for counsel. He complains of regular headaches and that he is working hard. Then, without any preliminaries, he starts talking about sexual problems. He is afraid that he is "perverted" and has been bothered with homosexual thoughts. He claims to have had no heterosexual sexual contact, but masturbates a great deal. He wants advice and help to make him "normal." He tends to go off into a long monologue about his sex life and is difficult to interrupt.*

40. The Black clergy should counsel this client and not refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

41. The Black clergy should counsel this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

42. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

43. The Black clergy should not attempt to counsel this client and should refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

VI. *William D, a 45-year-old married man, reports that he feels considerable anxiety because of thoughts that have been running through his head lately. He states that for several weeks he has been experiencing impulses to expose himself and to commit other indecent acts in a public place. Mr. D. says that he is afraid that he is losing control of himself and that he is not sure how much longer he can resist these impulses. He expresses feelings of guilt for what he is thinking and says that he is fearful of the same and disgrace that would follow his imagined activities. Mr. D. further states that he has been happily married for 10 years and has one child whom he loves dearly. He describes his relationship with his wife as very satisfying and states that sex has not been overly important to either his wife or himself. William is also adamant that none of the fantasies and impulses that he is experiencing have ever occurred in the past.*

44. The Black clergy should counsel this client and not refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

45. The Black clergy should counsel this client in addition to referring him to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

46. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

47. The Black clergy should not attempt to counsel this client and should refer him to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

VII. *Ms. Smith is an attractive married woman in her forties. She has been very active in church or synagogue affairs and is considered a good woman. She states that she conversed with God shortly after seeing a strange star on Christmas Day. Later, in a vision she saw and heard God talking with His angels. also got a glimpse of the Devil and the fires of Hell. She repeatedly h ears a strange voice telling her what to do and how to behave. Ms. Smith wants to know whether she should obey the voice.*

48. The Black clergy should counsel this client and not refer her to a mental health professional.

Disagree Agree

1 2 3 4 5 6 7

49. The Black clergy should counsel this client in addition to referring her to a mental health professional who would be willing to maintain an open co-professional relationship where information about the client will be shared.

Disagree Agree

1 2 3 4 5 6 7

50. The Black clergy should refer this client to a mental health professional who would be open to inviting him to participate in some sessions if the client's religious beliefs become an issue in therapy.

Disagree Agree

1 2 3 4 5 6 7

51. The Black clergy should not attempt to counsel this client and should refer her to a mental health professional.

Disagree						Agree
1	2	3	4	5	6	7

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REFERENCES

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