Hispanic, African American, and White ministers: The Intersection Between Spiritual and Mental Health Counseling.

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A thesis submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Master of Science

Auburn, Alabama
August 8, 2020

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Table of Contents

Acknowledgments 3

Introduction 4

Literature Review 6

Clergy as Mental Health and Relational Counselors..............................………………6

Ethnicity in Clerical Counseling... 9

Collaboration between Secular and Clerical Counselors………………………………..11

The Current Study 14

Methods 15

Findings 19

Discussion 43

References 51

Appendix A 61

Acknowledgments

I would first like to thank Dr. Scott Ketring for his willingness to work with me on this study and offer his experience as a clerical and secular counselor, though his differing research interests, quantitative leanings, and already formidable work load indicated otherwise. I thank Dr. Adrienne Duke for her key insights into issues of race in my study, as well as assistance in writing qualitatively, and Dr. Silvia Vilches for her essential help in guiding me through the project conceptualization and review stages. I want to thank all of the participating ministers, who have become friends and resources for AU MFT as a result of our association, and for all my friends who referred me to them.

Lastly, I want to thank the religious leaders I've observed in my years of ministry, who have averted crises, saved marriages, and lifted heavy hearts. I would like to recognize them as frontline workers in mental and relational health--therapists of the masses. It is their work that has inspired me to investigate the collaboration between religious and secular helpers and help build bridges where possible.

Introduction

If talk therapy is to "shape the way people think and behave" (Minuchin & Fishman, 1981, pg. 2), then the vast majority of relational and mental health therapy is done outside of therapy clinics. It is conducted by friends, family members, teachers, coaches, or anyone that may be approached for help. A common source of therapeutic help is clergy, as religious people are more likely to seek personal counseling from religious leaders than any other source (Shim, 2007; Wang et al., 2003). However, there is a dearth of literature on what happens in these therapeutic relationships (Hook & Worthington, 2009). There is little knowledge of how clergy address problems, how effective they are, or their level of collaboration with mental healthcare professionals (referred to hereafter as "MHPs", including all professionals licensed to treat mental health or relational issues, including medical personnel). These are important questions to address as the public gains greater awareness of mental health issues and collaborative relationships are created to best serve those who are mentally or emotionally struggling.

In recent decades, there have been numerous calls for greater collaboration between secular and religious counselors (Carbajal, 2015; Coyle, 2017; Hedman, 2014; King, 1978; Kramer et al., 2007; Stanford and Philpott, 2011; Sytner, 2018; Weaver et al., 1997), but little evidence of improvement (Breuninger et al., 2014; Edwards et al.,1999). Collaboration is necessary as various presenting issues require different forms of treatment; many people approach clergy with problems that would be more effectively addressed by a relational or mental health specialist, and many approach MHPs with problems that could potentially be addressed by an empathetic minister or other helpful acquaintance. Weaver et al. (1997) argue that clergy are "frontline mental health workers," and should be educated and supported in this

role. Research on the Common Factors--or basic components of effective therapy--would suggest that clergy, even without extensive training, could potentially be effective in relational and mental health treatment (Duncan et al., 2010).

In this thesis, I review the recent literature on the role of ministers as counselors, how this role differs across racial groups, and what is known about collaboration between religious and secular counselors. This study adds to this knowledge, especially regarding specific methods of clerical counseling, ministers' self-perceived efficacy, ways to improve collaboration, and how race/ethnicity contributes to differences in clerical counseling.

Keywords: Race/ethnicity, religion, clergy, collaboration, therapy, counseling

Hispanic, African American, and White ministers: The Intersection Between Spiritual and Mental Health Counseling.

Literature Review

Clergy as Mental Health and Relational Counselors

Demand. Religious leaders have been approached for help regarding personal and relational issues throughout history and across cultures. Studies suggest that religious individuals will approach religious leaders for help with mental or relational issues before secular professional counselors (Shim, 2007; Wang et al., 2003), and that the majority prefer a counselor who shares their beliefs (Ripley et al., 2001), or a religious and spiritual perspective (Bart, 1998). Some research indicates that people approach clergy not only because scientific mental health services are unavailable, but because clergy are often close acquaintances, require little or no charge, and are approachable without fear of stigma (Milstein, 2003). Given this demand, up to 90 percent of religious leaders in some Christian denominations provide a form of counseling services to congregants (Stanford and Philpott, 2011; Hedman, 2014), spending 10-20 percent or more of their time providing these services (Weaver, 1995).

Training. The literature shows that religiously active people approach clergy for help with all types of problems, especially for help resolving relational issues and mental health problems like depression and anxiety (Privette et al., 1994). However, less than 50 percent of seminary curricula offer a course on counseling (Ross and Stanford, 2011), and even fewer ministers are thoroughly trained in evidence-based methods of mental health counseling (Firmin and Tedford, 2007). Many do not have any formal training (Toh and Tan, 1997; UTSNYC, 2019). Though, this may depend on the denomination and specific position of a minister; those

employed full-time are often expected to complete formal training, while volunteer clergy often have little or none. Currently, there are no studies examining the methods clergy use in counseling according to their level of training.

Clerical counseling methods. Literature on specific methods of ministers in therapeutic interactions with congregants is especially sparse. The most recent peer-reviewed study on clerical counseling methods included interviews with 11 Catholic priests in Northern Ireland (O'Kane and Millar, 2002). This study found that these priests tended to have singular sessions with those seeking help, and tended to assume responsibility for solving problems quickly through suggestions. However, this is only one study with a small sample. Though the literature is sparse on the effects of ministers' faith-based interventions (such as prayer or scripture use), the use of them in mental health and relational therapy is well documented (Tan, 2007), as well as their positive effects generally (Boelens et al., 2009). Research should address how ministers use these methods in their counseling. If efforts are made to support clergy in helping congregants, it would be necessary to acquire current knowledge of what occurs in clerical counseling.

Efficacy. Though not studied extensively, preliminary outcomes research shows the intervention of religious lay counselors to be effective in reducing mental health symptoms (Toh and Tan, 1997; Hurst et al., 2008). These findings are consistent with a large body of research on the "Common Factors" of therapy, which shows that the educational degree obtained, the kinds of methods used, and number of years of experience do not significantly affect the outcomes of counseling or therapy (Duncan et al., 2010). According to this research, the most significant predictors of successful outcomes in therapy, or "the Common Factors" are a strong alliance with

clients--commonly defined as a “confident collaborative relationship” (Hatcher & Barends, 1996; Horvath et al. 2011)--and an organized rationale for treatment that the client understands and agrees to (Hatcher and Barends, 2006; Imel and Wampold, 2008). Untrained ministers may be able to achieve the same levels of efficacy as licensed professionals, as extensive training is not necessary to employ the Common Factors. Given their position as close acquaintances of parishioners and religious authorities, ministers may have an advantage in building trust and rapport, allowing for a strong alliance and cooperation on a given rationale of treatment.

A few studies have been conducted regarding counseling self-efficacy (CSE) in clergy, CSE defined as “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (Larson & Daniels, 1998, p. 180). However these often have small homogeneous samples or poorly defined measures, and none have concentrated on dealing with specific mental or relational problems. Watson (1992) found that seminary and graduate counseling students had approximately equal CSE levels, though the counseling students were observed to use more evidence-based skills in session. Mannon and Crawford (1996) used a 7-point Likert scale to measure CSE in a large sample of African American and White clergy, and found high CSE regarding spiritual and relational issues, but low CSE when facing mental illness. There was no difference in CSE in relation to years of education or type of theology, but African American clergy were found to have significantly higher CSE scores overall. The most recent study, which focused on changes in CSE in Christian lay-counselors after a short period of professional training, found significantly increased CSE, and that initial levels of CSE were substantially higher in lay-counselors than graduate level counseling students (Mikkelson, 2015).

Though these studies show ministers’ confidence in counseling, there is also evidence

that many clergy feel inadequate to the counseling tasks presented to them. Orthner's study of trained Methodist pastors found that only 39 percent felt competent to perform marriage and family counseling (1986). A study of clergy in New York found that most felt insufficiently trained to address common issues such as domestic abuse, chronic illness, substance abuse, and suicidality (Moran et al., 2005).

Ethnicity in Clerical Counseling

There is extensive research showing that minority groups in the US, especially African American and Hispanic populations, are significantly less likely to utilize mental health services than the general population (Alegria et al., 2002; Snowden, 2001). There are various suggested reasons for this underutilization, including cultural stigmas regarding mental illness (Menke and Flynn, 2009), low trust in MHPs (Anglin et al., 2008), and lack of familiarity with mental healthcare (Hines-Martin et al., 2003). Because members of these groups report higher religiosity than other racial groups (Pew Research Center, 2019), they are more likely to approach clergy for help, even when other professional services are available (Blank, Mahmood, and Guterbock, 2002).

The "Black Church" is a unique and extensively studied entity, "recognized as the most independent, stable, and dominant institution in Black communities," and seen as a "cultural womb" for African Americans (Lincoln & Mamiya, 1990, pg. 8). In Levin's 1984 commentary, he noted that, due to historical marginalization from community resources, the Black Church "has had to attend to the total needs of its members," particularly healthcare (pg. 478). In Blank, Mahmood, and Guterbock's 2002 study it was shown that predominantly African American churches take a much more prevalent role in their congregants' lives, offering many more

services than predominantly White churches, which may contribute to the low utilization of outside resources by African American church-goers. In a series of focus groups of African American clergy, Payne (2009) found that many were hesitant to refer parishioners to MHPs because of the amount of "red tape" involved in getting care, the potential for discrimination, and a perceived mutual distrust of both fields.

The English language literature of clerical counseling among Hispanic populations in the US is especially sparse. Kane and Williams (2003) conducted a study to compare the help-seeking habits of Hispanic and White Catholic parishioners and priests in Florida. They found that, when compared to Whites, Hispanic respondents were significantly more likely to recommend help from a priest, less likely to recommend help from an MHP, and more likely to suggest not seeking help for each of twelve hypothetical presenting problems, including marital problems, mental illness, and substance abuse.

A possible explanation for this trend is the Hispanic concept of *familismo,* which posits the family as a self-sustaining system on which members can depend to fulfill most needs (Sabogal, et al., 1987). The idea that members should depend on other members of the family for help may carry over into the rationale for help-seeking with clergy. Clergy are highly connected socially and spiritually with family members, and thus a culturally acceptable resource under familismo (Villatoro,et al., 2011). Another possible explanation is the lack of language resources in mental health, as shorter residency in the US and Spanish-speaking status are highly related to reduced mental healthcare usage (Keyes et al., 2012).

Collaboration between MHPs and Clerical Counselors

Weaver (1995) argues that, because those with relational and personal issues will continue to approach religious leaders for counseling, academic and secular counseling fields should acknowledge their utility and seek to increase collaboration between themselves and religious leaders. Research by Coyle (2017), Sytner (2018), and Carbajal (2015) suggests that collaboration would be highly beneficial in the treatment of mental disorders for religious clients. Clergy often feel ill-equipped to address certain issues (Moran et al., 2005), and MHPs often lack the training to adequately incorporate a client's religion into effective treatment (Saunders et al., 2014). Many of the calls for further collaboration indicate a need for clergy to refer parishioners to professional counselors and vice versa. They also call for means by which clergy can become more competent in empirical counseling methods, and for secular counselors to become more competent incorporating spirituality into therapy. Likewise, there needs to be more collaboration and respect in serving parishioners. The following sections review some of the literature about the current knowledge of referral practices between the fields, what impediments exist for collaboration, and potential directions for improvement.

Referral practices. There is very little research on the degree to which clergy refer parishioners to non-religious professionals, but what has been observed suggests that most cases of mental illness are not referred. One meta-analysis found that as few as 10% of cases presented to clergy are referred to psychological professionals (Meylink and Gorsuch, 1987). This finding is supported by Blank and colleagues'(2002) finding that 85 percent of both African American and White churches reported an average of 10 referrals per year, with a modal response of zero referrals.

One reason for low referral rates could be that many clergy consider some problems to be spiritually-based. One study of 204 Protestant pastors found a significant proportion that considered parishioner depression to be due to “a lack of faith” (Payne, 2009). In another study involving focus groups of clergy discussing depression, some impediments to referrals included the amount of work it takes to get someone medical care, the pastor’s distrust of secular care, and the parishioners’ distrust of secular care (Kramer et al., 2007).

Distrust of secular care. There are various reasons for parishioners’ and pastors’ distrust of secular care. One is that some religious groups stigmatize the use of secular services due to the belief that mental health or relational issues are the result of spiritual problems (Payne, 2009), or because faith healing is often preferred over non-religious methods (Kelly, 2016). Also, MHPs are often viewed as antagonistic to religion (Jenkins, 2010). There is some basis for this view, as MHPs are significantly more likely to report being non-religious than the general population (Bergin, 1991; Curlin et al., 2007b, Oxhandler et al., 2017), and have historically expressed opposition to religion (Ellis, 1965; Freud 1927/1964; Haque, 2001). More recent studies and academic dialogue on the relationship between psychology and religion indicate this is still often the case (Hodge, 2002; Moffatt, 2018).

This pattern is reflected in the curriculum of most psychological graduate programs, which have recently emphasized training in cultural competence, but often fail to address religion (Crook-Lyon et al., 2012; Elkonin et al., 2013). There is concern that mental health trainees, who are less religious, will fail to competently and respectfully discuss clients’ religion during treatment (Saunders et al., 2014).

Potential for Collaboration. However, there is also evidence that many MHPs find religion to be a significant factor in treatment, regardless of their own beliefs. Curlin and colleagues found that up to 80% of psychiatrists are encouraging of clients' beliefs (2007a). A more recent survey of clinical members of the American Psychological Association showed that 82% considered religion to be beneficial to clients (Delaney et al., 2013). Certain kinds of MHPs, such as marriage and family therapists and social workers, tend to be even more supportive of religion than the general field of mental health (Bergin, 1991).

Another potential ingress to collaboration could be in forms of counseling that deliberately market and use religious ideas. McMinn et al., (2010) have explained various forms of Christian counseling methods and advised on potential for collaboration between academically-based counselors and those professing religious integration or foundation in counseling. Those addressed are: Biblical Counseling, based wholly on scriptural passages; Pastoral Counseling, typically involving one with formal training in both theology and social science; Christian Psychology, typically involving one trained in social science but marketing as using religion in practice; and Ministry Approaches, often using spiritual methods of healing with or without accredited training (prayer groups, faith healing, etc.). These are examples of potential integrations of scientific and religious approaches within a Christian context. However, it must be considered that "religion" comprises an exceedingly vast spectrum of beliefs, and each broad category includes divisions (e.g., Christianity's main branches of Catholic, Orthodox, and Protestant contain doctrines contradictory to each other). Thus, any form of collaboration must involve mutual respect and regard, regardless of identified beliefs or models.

The Current Study

This study seeks to address several limitations in the literature on religious counseling. First, there is little documentation of what clergy actually do when counseling with parishioners; they do not track the progress of clients or use evidence-based methods. What evidence exists shows that clerical counseling can be effective, thus it invites further study on which methods are used to bring about change in parishioners. Second, there is scant research examining the self-perceived success of counseling ministers (O'Kane and Millar, 2002; Mikkelson, 2015). The degree of self-efficacy in handling parishioners' emotional and mental health needs may help us understand the burden clergy experience as frontline caregivers. It may also help us determine the degree to which clergy are willing to collaborate with other counseling personnel. Third, some research exists on perceived impediments to collaboration (Jenkins, 2010; Kelly, 2016; Payne, 2009), but very little on ways these challenges could be overcome (Edwardset al., 1999). To address these limitations in the current literature, my study seeks to answer the following research questions: 1) What methods do clergy use to conduct counseling? 2) How effective do they perceive themselves to be? And 3) how might collaboration be improved between religious counselors and MHPs? And, I will report any differences according to race/ethnicity. Further knowledge of the field of clerical counseling will help researchers know how to best provide support to these frontline mental health workers and how to use them as a resource for those seeking mental or relational help, all with the ultimate goal of providing effective service to those in need.

Method

Qualitative Research Design

Because this research is among the first to explore racial differences in clerical counseling, I employed an exploratory premise. I was unsure what kinds of responses would emerge, so open-ended questions were merited. I attempted to capture the experience of clergy, allowing them to express all aspects of counseling and collaboration they deemed important, which would be difficult using quantitative methods.

Participants. To participate in this study, contacts had to meet the following criteria: 1) Hold a position in a congregation that identifies as Christian, wherein they are approached for help with mental or relational issues, 2) are not a licensed pastoral counselor or other mental health professional, 3) are 21 years old or older, 4) live or minister within 20 miles or a 30 minute drive of Auburn, Alabama, and 5) the total of participants includes ministers of at least three predominantly African American, three Hispanic, and three White congregations.

The final sample consisted of 9 male ministers between the ages of 31 and 84 years old, who ministered to three Hispanic, three African American, and three non-Hispanic White congregations. The congregations varied in size from less than 50 members (n = 2), less than 150 (n = 4), to over 200 (n = 3). Eight ministered full-time, one part-time.

While attending church meetings and speaking with ministers, I observed that the congregations were generally racially homogeneous, with some meetings having a few members of other racial groups in attendance. The modal ethnic group amongst Hispanic congregations was Guatemalan, but congregations included parishioners from various Spanish-speaking countries, including Mexico, Cuba, the Dominican Republic, Honduras, and Venezuela. I

encountered one cross-racial clerical counseling relationship in an Hispanic congregation ministered by a White pastor. Though this minister had some unique experiences from this dynamic, thorough examination of cross-racial counseling relationships is beyond the scope of this study.

Sampling. I began collecting contacts for this study in September, 2018. I asked previous acquaintances for contacts, and attended Bible study groups and church services to become acquainted with other potential participants, and asked them for other potential contacts, indicative of a snowball sampling method (Coleman, 1958). I chose this method to facilitate the collection of contacts in “natural interactional units” (Biernacki and Waldorf, 1981); I assumed that counseling clergy would have close contact with other counseling clergy, especially within their own racial group.

Procedure

Interviews. University Institutional Review Board approval was obtained to protect the rights of participants. Interviews began in September 2019 and concluded in February 2020. The location of interviews was determined by participant convenience, and all participants elected to be interviewed at their respective religious meeting sites. Interview lengths varied from 45 to 80 minutes. I provided participants with a document of consent, which they signed before being interviewed, and reminded them that I would be recording audio and taking notes. I reviewed the key points of the consent form, which were that the aim of the interview is to learn about the participant's work, not critique it, and that no identifying information would be solicited.

Interviews were conducted using a semi-structured protocol that allowed for probing and follow-up questions (see Appendix A).The interview protocol was pilot-tested with a member of

the research team that met study criteria (besides being an MHP himself). He provided feedback on the questions and interview protocol, which was then incorporated into the final protocol for this study. Questions in the interview were broad with probes to allow for elaboration. The interview begins with background questions about the participant's training and duties as a minister. The remainder of the questionnaire was divided into two sections: 1) Experience in Counseling Parishioners, and 2) Collaboration with Other Counselors (religious or secular). Following completion of the interview, participants were allowed to ask questions of the interviewer and were offered referrals for local therapy and counseling services if they desired.

Data Analysis

I used Temi transcription software to produce transcripts of each interview (Torrence, Baylor, & Yorkston, 2020), then listened to each recording while reviewing and correcting errors in the transcripts to ensure accuracy. As a fluent Spanish speaker, I conducted two of the interviews in Spanish according to participant preference, and I translated the transcriptions into English. I analyzed the transcripts using an inductive thematic framework (Patton, 1990). Though previous research provides clues as to the categories of potential responses, this study is exploratory and did not assume categories a priori. I performed this inductive analysis by memoing, coding, and tabling data.

Memoing served the purpose of making analytic connections between the raw data and identified themes and categories (Birks, Chapman, & Francis, 2008). I memoed interview transcripts concurrently with the data collection process to help me identify patterns and potential probes to improve the quality of the interviews. This process included reading through

the interview transcript, identifying key quotes according to the research questions, and annotating them with my initial interpretations.

I began thematic coding after an initial memoing of individual interviews. This process involved identifying responses that appear to follow a theme or relate to some characteristic of the interviewee. The major themes to develop were: Training and Education, Counseling Roles, Theories of Change, Interventions, Counseling Self-Efficacy, Collaboration and Referral Patterns, and Differences by Race/Ethnicity. Each theme was then divided into minor themes, as will be seen in the Findings section. Memoing, coding, and tabling were completed using Microsoft Word.

Trustworthiness (Lincoln and Guba, 1985). When reading these findings and analyses, it should be considered that I am a lay minister, have witnessed ministers effectively counsel congregants through their personal issues, and have substantial experience counseling without academic training. I believe in the legitimacy of the Common Factors in bringing about change, regardless of the amount of training or experience. Thus, I may more readily identify indicators of efficacy in clerical counseling than a researcher without similar experience. I have also witnessed ineffective and even detrimental clerical counseling, but believe this to be similar in frequency and nature to ineffective secular counseling; both fields have their strengths and weaknesses. Generally, I believe my perspective is well-suited to the aim of this study, which is not to highlight deficiencies in the work of clerical lay counselors, but to highlight strengths and discover needs in order to provide support and increase collaboration. I have sought to include all data relevant to the research questions in the findings, be they descriptive of weaknesses or strengths, in order to fairly represent the experiences and perspectives of participants.

Findings

Counseling Training

Participants took many different paths to the ministry. Five held graduate degrees in theology, two of whom completed undergraduate degrees in social science before their graduate degrees. Two held graduate degrees in other subjects, and two held undergraduate degrees in religion only. Some had known since childhood that they would minister, some did not enter seminary until years after beginning another career (A law-enforcer, an agricultural extension worker, and a highschool teacher were in the sample). However, all had some degree of counseling experience as ministers. The themes to develop during conversations of their training and education involved their Calling, Formal Training, Independent Study, and opinions on receiving Further Education.

The calling. For many ministers, the work they do is not simply a career choice, but a mission. All of the participants mentioned some form of a "calling", or a "task set by God with a sense of obligation to work for purposes other than one's own" (Christopherson, 1994, pg. 220). An African American pastor expressed what several others described:

> *I felt like God was calling me in the ministry, you know, as the scripture says, 'For many are called but few thereby be chosen* (Matthew 22:14).'

Some pastors cited this spiritual feeling as reasoning for working as ministers or to enter seminary. Some went through a process of "discernment" wherein they presented their feeling of being "called" to religious leaders, who then sought to know God's will through prayer and observation of the candidate. One minister did not have the same experience as the others in having a sensation of being called, but still felt divine guidance:

> *I didn't have a magical calling in some sense. I definitely feel called to where I am, it just wasn't necessarily prospective.*

Though the concept of a calling was not explored at length in this study, it is important to understand that many ministers feel divinely appointed to their positions, a perspective that guides their work. Believing that the work they do is divinely given may influence their course of action with congregants seeking counsel.

Formal training. Five ministers had completed a graduate seminary program, all of whom said they had at least one class on pastoral counseling. However, all indicated that their limited training was marginally applicable to current counseling duties. Most indicated that it did not prepare them for the counseling tasks they face, saying the counseling portion of their work was mainly "on-the-job" training:

> *-I had a year of clinical pastoral education. That's pretty much the extent of the training. We had one counseling class but it was really very introductory. I think in a lot of respects it's on-the job-training and continuing to do reading, depending on needs.*
>
> *-We had maybe one semester of pastoral counseling. It's not like we're trained therapists or anything. We have enough to let us know that we probably don't know what we're doing.*
>
> *-But they never specifically spoke about like, 'Refer this if you see it. Don't try and fix this.'*

Though the sample was small, the amount of social science or counseling education received seemed unrelated to the amount of time a minister spent in counseling activities. One minister who taught pastoral counseling classes at a tertiary institution had the smallest counseling load, while one with no counseling training was among those with the largest. The lack of relationship between training and practice is demonstrated by these quotes, by ministers with similarly large counseling loads:

> *-[In my seminary program] I worked with families doing field work, talking, planning activities, family relations. But then also I began to develop resources. We had to write a curriculum for a family course that would be offered at a particular church... We spent a*

> *lot of time role playing counseling, and reading Jay Adams and Carl Pennington and people like that to understand their principles for family and research...*
>
> *-I've not had any professional training. I think it shows.*

Independent Study. When asked about other training specific to counseling, five ministers indicated that they continue to study materials related to counseling, such as books, seminars, and research articles. They recognize the limitations of their training and research ways to better serve their members according to specific needs. The following quotes demonstrate this pursuit of knowledge:

> *-I don't remember the title, but it is one on scrupulosity I've been reading. There was The Gift of Imperfection by Brenee Brown* (2010). *With persons facing illness... I think it was Kitchen Table Wisdom* (Remen, 2010) *In some respects that training I got in the seminary was somewhat limited. It's to remain somewhat contemporary and prepared... reading on my own.*
>
> *-I'm always in leadership classes and different seminars. I'm trying to better myself because things always change.*
>
> *-"You go through college, and it gives you the basics of psychology, and you go from there, but the majority has been books and work experience."*

Further Education. These are some of the responses to demonstrate the range of opinions on whether further training in counseling would be useful to the participants, with some expressing no need for further formal education, and some expressing a sincere plea for support.

> *-I think I got enough [for] the counseling I do...That's why I need to send them to someone who has the ability to prescribe medication for them to try to help get them whole again.*
>
> *-If it's something that I'm dealing with, I'll google it or I go in and pull up papers on it. And read about that and see if I can pick up a nugget or two out of those things and apply them in a certain situation. So yeah, I don't know if more counseling [education] would help me.*
>
> *-Now there are a lot of things they didn't teach us in seminary that they should have...Your first marriage counseling, you do your first marriage, you do your first funeral. Those things you're never prepared for. And so I wish probably we had more in*

identifying mental illnesses. Maybe they didn't do that because they didn't want us to be fixers of things.

- (When asked if further counseling education would be useful) *Yes, it's necessary for us to be educated about what happens in our churches.*

Some of the ministers believed that, given the basic kind of counseling they provide, further education would serve little purpose. One expressed how he could seek whatever help they needed through the extensive materials available online. Others that felt less prepared to face counseling challenges, but still an obligation to help, expressed open willingness to receive education if provided. It should be noted that after the interviews, three ministers invited me to give presentations to their congregations on relevant counseling topics, indicative of a desire to learn from and collaborate with MHPs.

Counseling Duties

The counseling experiences of these nine ministers varied greatly in terms of volume of counseling work, kind of service provided, issues presented, and sense of competence in providing it. In terms of congregants approaching the minister for counseling, their work ranged from only a handful of cases every year to three or more per day. These quotes demonstrate the range of personal counseling loads, as answers to the question, “How often do congregants approach you for help with relational or personal issues?”:

-*Our obligation during the week here is very minor, unless there is a need for visitation, some sickness in the community or some unexpected occurrence that may be given attention.*

-*I mean, the needs vary. But once, maybe twice a week, perhaps more.*

-*Multiple times a week… And so it's not uncommon for those [hours] be filled up and then even more people want to meet with me. So I would guess as far as a pure type of counseling situation, three to five a week would not be uncommon.*

-*Normally I plan for three or four families a day, three days a week.*

-Just today I've already had three sessions of counseling with people, and a lot of these are not members of my church.

-Somebody coming in saying, 'I'd like to talk,' maybe once a month. My job, especially now, is pastoral care, so I'm visiting every day, usually out seeing somebody. Usually in hospitals or at home... you know, just checking up on people.

Interestingly, the sample included three different degrees of counseling roles in each racial category; the ministers of African American, Hispanic, and White churches each had one respondent with a small load (one or fewer counseling sessions monthly), one with a medium load (less than three sessions weekly), and one with a high load (more than three weekly).

Role of the counseling minister. The perceived roles in bringing about change varied among participants, though none indicated that they are either fully responsible for a person, or have no responsibility for creating change. The general consensus was that ministers should do their best to help according to their capacity. Some indicated that they feel obligated to give imperative directives as religious authorities, but others steered away from directives in favor of fostering insight to help members make decisions. Others considered themselves mediums by which members could be connected to resources. These quotes demonstrate the range of perceived responsibility:

-I try to make sure that I don't tell them what to do. I try to lead them in the direction where they can see themselves in their situation. And if I'm able to do that, then they can determine what to do themselves in order to solve the problem.

-Every once in a while, if it's bad enough, I will come and say, 'Let me tell you what you need to do,' especially if they are one of my members...I don't foresee them being able to determine what to do on their own.

-I don't really say I'm a counselor. I'm a pastor. So I give biblical advice and direction. I don't think a lot of times the two titles are that different, but our job is to help people recognize where they are in their situation and then give them next steps to move forward in that situation. And we feel like the local church is a huge component. Serving the local church, using your gifts, getting a Small Group (See Helping Systems)*, getting around*

people. We feel like that's an avenue for people to get counseled.

Some of the ministers take a very active role in parishioners' lives, feeling a strong sense of responsibility for their well-being when presented with problems, as seen in the following quotes:

> *-As a pastor I feel I have a responsibility to help people keep balance in their life.*
>
> *-I think they would see me in some sense as a 'wise mentor.' That sounds grandiose… but I think that's why they're coming to me.*
>
> *-You cannot pastor now just from the pulpit...You now have to be able to talk about finance in the church. You have to talk about medical issues in the church. It's going to take more than a scripture now to help God's people.*
>
> *-It's a lot of work on me, but yet at the same time I want families to be together and be strengthened.*
>
> *-Especially the couples that I counsel… or those I marry, I tell them I'm the first line of contact. If there's a frustration, a problem, don't go to parents, call me and we'll try to work through it.*
>
> *-I love what I do. And I probably spend more time here than I need to at times.*

These ministers appear highly integrated in members' lives. One minister reserves several hours every day to counsel individuals and couples in his office. Another reserves three evenings every week to visit families at home to discuss their issues. The sense of responsibility they feel is more than just addressing mental health or relationships, it involves helping people in all aspects of their lives.

"Counseling" took various forms among the respondents, such as infrequent and informal conversations with parishioners, counseling over the pulpit, home and hospital visitation, and regular hourly visits in an office. Several ministers eschewed the term "counseling" in favor of "pastoral care," saying they would not consider their work "counseling" in a clinical sense.

Regardless of the form of help given, they reported a wide range of member problems they had faced, including generalized anxiety, depression, OCD, bipolar disorder, infidelity, pornography addiction, grief, immigration stress, financial stress, racial stress, schizophrenia, separation anxiety, substance abuse, suicidal ideation, complex trauma, child misbehavior, and couple communication difficulties.

Theories of Change

"Theory of Change" is a popular concept in counseling research that refers to the belief system that guides the course of counseling (Nelson & Prior, 2003). It is suggested that counselors are more effective at facilitating change if they have a defined theory of the source of problems and their resolution (Taibbi, 2015). Though ministers' theories of change were not an object of direct inquiry, many participants gave indications of their beliefs surrounding problem formation and resolution through their case narratives and responses to the question, "What effects do theology and faith have in the change process?" and follow up questions. The following are responses illustrating ministers' beliefs about various systems and concepts:

Couples. Two ministers who regularly meet with couples volunteered these ideas of addressing couple relationships:

> *-The man has one major responsibility and that is to make his wife happy. And I tell him, 'If you make your wife happy, then she in turn is going to do the things that are going to make you happy.'*
>
> *-One has to have a sufficient mind to remember all that is said, so you can identify where the problem began. I always say, 'The problem is not the problem.' If you are a car mechanic, what do you need to do? You study the car, the manufacture, the assembly process, and then you will know how to fix it. But if you don't know how this car was made, you won't be able to repair it. It is the same with couples.*

Spirituality. Many of these quotes were answers to the question about faith's

relationship to change, but also came during participants' final remarks in the interview, when asked "Is there anything else you have to add about your experience?". These quotes demonstrate a strong belief in many of the respondents that spirituality plays a significant role in the root of problems and their resolution.

> *-If I can determine through scripture where they are, then I have a basis to begin to work and bring about a resolution to the problem. And so spirituality plays a very important part of my counseling.*
>
> *-I've led many people to the Lord through my counseling because, once I begin talking with them and they see where they are, I make sure they understand that it's not a secular problem, it's a spiritual problem.*
>
> *-But if there's no spirit, if Christ is not their Lord and there's no spirituality, that person is not going to make any long lasting changes.*
>
> *-It's all spiritual. We're spiritual beings. We all have this gravitational pull to selfishness to do the things we want to do. We're triune beings: a body, soul, and spirit. When you live and make decisions out of what your flesh wants to do, that never ends up well. But when you live by the spirit of God, that's where the fruit of the spirit comes. Whichever [being] you feed the most wins.*
>
> *-A man established in the word of God will not be moved.*
>
> *-I believe that we're drawn to God's life now whether or not people acknowledge that. But it's saying in essence, spirituality asks us to transcend ourselves and to be able to see that where I happen to be in my life at this point in time isn't the sum of what my life could be.*

Views of mental illness. Participants gave varying responses about the nature of mental illness and how they should be addressed, often presented as follow up questions to "What types of problems are presented?". This first quote demonstrates an extraordinary observation of one pastor that depression can be completely prevented or eradicated with various behavioral interventions, indicating the belief in an environmental source of this mental illness:

> *-I have been a pastor for five years, and have never seen a case of depression or anything like that, because we always have ways to keep people involved in church activities. One of the best therapies I give to families, besides the Family Devotional* (see Interventions)

and books I give them to read, is to be involved in the activities of the church.

The condition most likely to be viewed as non-biological was anxiety, thus more likely treatable with behavioral or spiritual intervention:

> *-They might think, 'You know, this is just a high anxiety time.' But it's not. It doesn't seem to be a medical problem.*
>
> *-When your soul is at peace, most of the time it's because your spirit man is leading your life. When you have anxiety, the flesh man is leading your life.*

However, respondents generally acknowledged utility in medical intervention for other kinds of mental illness, as exemplified in these quotes:

> *-Some mental illness is hereditary, just like some sickness. Blood pressure is a hereditary thing, and heart conditions and diabetes...It doesn't have anything to do with the Holy Spirit."*
>
> *-If it's a true medical depression you need to get help for that. Talking in prayer is not necessarily going to resolve that.*
>
> *-And then we'll go, 'There might be some clinical solutions, like are you taking medication?' And there are great medicines and great doctors for people. We're never wanting to say you need to do that, but we'll ask them if that's part of their remedy.*

Interventions

For this study, I define "interventions" as any sort of action one takes to address a problem. Most respondents described specific interventions they used in counseling meetings when giving accounts of cases they had seen. I categorized these interventions into forms of Listening, Faith-Based, In-Session, Behavioral Directives, Helping Systems, Non-Counseling Referrals, and use of Published Materials.

Listening. The majority of respondents said that some form of empathic listening was essential to the help they give, and some said that many people simply needed a listening ear to feel better:

-After service, a lot of time people will come telling me their concerns, and just being able to give them words of encouragement or listening to them. A lot of times, that's all people want-- someone to have a listening ear.

-I learned not to stand over somebody, but sit at their bedside so that I'm eye to eye with them. And before I pray, I usually ask, are there things you'd like us to pray about? Because a lot of times you might assume that it's 'that I get well,' but it might be 'I'm worried about my grandchildren' or something like that. And so you talk about those things. But again, that's that's just sharing. I'm not fixing anything. But I think listening is a big part of the pastoral care that I do.

-I do hear confessions and I think that's a form of therapy as well.

Faith-based intervention. All the ministers mentioned some form of religious intervention in their counseling in the form of prayer, scriptural counsel, or religious education. Their uses of prayer include direct divine supplication for help with issues, building connection between the pastor and congregant, increasing acceptance of circumstances, and increasing connection within families:

-But rather than say, 'you need to let go of that,' maybe prayer is a way of saying, 'Listen, let's pray and try to put that into God's hands or leave that at the altar.'

-We would go back for a prayer chain...[my wife] and I would be in prayer for them, not with them, but just praying for them.

-The first remedy we give to all couples is the Family Devotional, a proven technique (wherein the family meets daily to pray and study the Bible).

The ministers often use biblical passages when providing comfort or counsel to those in distress. These are the specific passages mentioned:

-If they have a lot of self doubt, low self esteem, I might point them to Psalm 1:39. Or they're wondering about meaning in their life... it would be like Psalm 63.

-The 23rd Psalm, which has a kind of a healing element.

-Matthew 18:15, 'If your brother sins against you, go and tell him his fault between you and him alone.' Probably a third of the people end up actually going and confronting the person. They're so avoidant.

One minister, who confided about a personal challenge during the interview, mentioned how he often used scriptures when counseling, but had unsuccessfully tried to use scripture to bring personal relief:

> -*Whatever scriptures and stuff I feel was working over the years has little to do with bringing me comfort...*

Two ministers directly mentioned the need to guide families in the interpretation of scripture to bring about adaptive systems, particularly in the writings of Paul in the Bible regarding marital relationships.

> -*Then I had to break down that and bring to his understanding as to really what Paul is saying. And in that particular passage of scripture is not obey and be dominant, but to submit.*

> -*I give historical context like, here's what this Greek word means, range of meanings for this. But I'm really trying to get them to think through, 'what does it mean?' What is it gonna mean for them? How are you going to interpret this? Are you going to be egalitarian? Are you going to be complementarian, hierarchical, or traditional?*

Some ministers explained that stress resolution requires assistance in understanding doctrine, such as moral guidance to right and wrong, or the role of God in one's life:

> *It's not me explaining to him it's wrong, but us talking through--what is moral formation like as a Christian, you know?*

One minister explained how he helps members understand God's influence by recounting stories of divine intervention. He explained, *"When they are down, hanging by a thread. I help them know that God is with them."* For example:

> *We had a woman whose mother was sentenced to death by the mafia in her country. She was broken. She didn't have the ransom. All she could do was trust in God. Thanks to God, the mafia boss decided to let her go, not knowing why.*

In-Session Intervention. Many of the ministers articulated the work they do in non-religious terms. They described general techniques they use, or told stories to describe what

they have done. A common intervention was the facilitation of communication between couples, often involving observation and feedback from the minister to the couple:

-I'm going to talk for [a defined amount of time] and you have to listen. And then you talk.

-I mean, talking about communication skills and the dynamics that take place in those communications in offering feedback to them about what I perceive. I think to be in touch with some of their own feelings, but to be respectful of the other, and communicating a willingness to listen to the other perspective and to try to find where there's common ground.

-To look at alternatives when they're angry and maybe saying 'this isn't the time to talk,' but to understand when would be a more optimal time to do that.

-[Referring to a male partner] He just kept saying, 'You're not going to have a problem. I know you're going to pass this. I know you're going to pass it.' And he kept saying it..., I asked him, 'Why are you telling her this?' And he said, 'I just wanted her to not be stressed, to feel confident…' I said [to her], 'What do you feel every time he says that?' And she said, 'I feel it's even worse.' And I told him, 'What you're doing is raising the stakes on the situation she's nervous about.'

Some ministers emphasized the importance of helping members find a new perspective on their problem, often through a religious lens, but also through what MHP's might consider *cognitive reframes*--statements that phrase the problem behavior in benign or neutral terms:

-(In addressing a complaint of nagging) *I just tried to [help] him understand the fact that she wants to make sure the kids are taken care of. 'What can you do in order to get the information she's going to give to you without she having to give it to you?'*

-Alcoholism is a disease and he needs help for it.

Two mentioned their use of identifying positive exceptions to problems to increase members' recognition of their strengths:

-I always tell a couple just to remember what brought you all together. Whatever brought you together, if you keep doing that, chances are it will keep you together.

-And so I begin to question her judgment, ...and her ability to discern what is wrong and what might be construed as a sin. I've been trying to help her to make those distinctions but also to help her to recognize her capacity to make good judgements.

Two mentioned their use of what might be considered *exposure techniques*, often used in Cognitive Behavioral Therapy to decrease anxiety regarding a certain stimulus:

> -*I try to discourage the constant confession* (In the case of scrupulous OCD).
>
> -*When they come in, [I help them] get okay with the worst case scenario that's [making them anxious].*

Helping Systems. One minister from each racial group outlined a system to either screen for members' challenges, or a process of treatment when someone presents an issue to the church. An African-American minister described a system of following up with couples he had worked with in premarital counseling, setting appointments with them one year, three years, and seven years after their marriage to workshop marital issues. An Hispanic minister with a large counseling load outlined in great detail how he comes to meet with families:

> *Each elder* (*member of church leadership*) *has a group of families they are assigned to visit and pray with regularly, because I can't see them all. I meet with the elders and ask them how things are going and who I need to visit; who needs help or counsel? I take notes and set appointments to visit them.*

This minister continued to explain a 3-visit method of rapport building, problem assessment, and treatment planning, which may involve a series of counseling sessions with him, homework assignments, or referrals to other sources of help.

A White minister described a system of help-seeking centered around "small groups," a recent movement among churches in the US, wherein members with similar interests or issues gather regularly outside of church meetings (Wuthnow, 1994). Unlike the previous two ministers whose work was based on a personal individual interaction, this system works to connect members to each other:

> *Everything we do is small groups. It's very rare someone comes to me… The goal is not to meet with people two, three, four, five, six times in a row. It's to get them a small*

group, around other believers who could encourage them and walk that out with them. [If someone does come to me], I'm listening to them, thinking, 'Your next step is to go to this small group. Your next step is to meet with this ministry team. Your next step is to go home and repent. Your next step is to go and ask her forgiveness,' and will give them a next step to take. We'll pray together, but most of the time the next step is not 'come back and let's meet again.'

Behavioral directives. Many of the ministers reported giving behavioral assignments or directives that they had found helpful in producing positive changes. Here is a list of behaviors they suggested:

-Walking or journaling or things like that (to help with anxiety).

-The skill of practicing touch. It is important for couples to touch each other, to have physical contact... I think someone studied this one time--that men who kiss their wives daily live longer.

-I may tell them, you need to lay aside your pornography. You need to focus more on your spouse. And then I'll tell the wife... you need to make yourself more attractive. You need to do things to cause your husband to want to be with you.

-Instead of sitting down and watching television, if she's cooking, go in the kitchen and help her cook. Spend time with her, wash the dishes.

-A simple suggestion of, 'Get your parents to come keep the kids for the weekend so you can get away.'

-I say you need to learn this word: 'No'. That's your homework. (In the case of workload anxiety)

-Give one phrase (to your spouse) every day to express love, to show connection, to break walls.

-Put a verse of scripture in [your partner's] pocket, leave it where they'll find it.

-When you feel the desire to drink, buy some juice, go see your family, go to the mall. Call me and talk to me about it.

Referrals to non-counseling resources. A common intervention mentioned was the referral to a specific kind of organization, activity, or non-counseling person. Organizations were

subdivisions within the church that help congregants address specific issues such as financial difficulty or addiction:

> *-We have a [financial aid program]... we don't give people money, but if they have a bill that needs to be paid, they can bring it to the church and we will pay that bill up to a certain amount.*

> *-We hold a weekly [AA] meeting here once you start out.*

Three ministers talked about how they address relevant counseling topics in regular church meetings, or they host special events with guest speakers to discuss relevant topics to improve members' lives, demonstrating the pastoral advantage of creating interventions in large groups:

> *-I may bring a doctor here to talk about issues, to do a 'life changing' class.*

> *-Most of our sermons are designed with some counseling elements, it has a gospel or theological twist to it, but we do have counseling injected into most of our messages.*

Three ministers mentioned the pattern of referring help-seekers to other non-counseling congregants. This minister, who avidly advocated for the use of small groups, fleshed out the reasoning for this kind of referral:

> *I'll meet with them once and then I'll connect them to people that I know that have walked through that situation. And I think that's key to hear it from someone who's walked through it. They have skin in the game, they have equity, they've walked through it, they'd been on the other side of it… they can help be a good resource for people.*

One minister mentioned his more intensive personal involvement in counseling through 1) inclusion of his own wife: *"A lot of time I bring my wife in and she assists in some counseling..."* and 2) direct confrontation of financial difficulties, using his position as a minister as leverage:

> *I've had one or two creditors that I've called on behalf of others and they just say, 'Well, we'll write it off and we'll just let them get a new start.*

Published programs. Four ministers mentioned their use of published resources to aid in their counseling. The following are the specific titles mentioned:

> *-I use what's called* FOCCUS (Williams & Jurich, 1995). *I have found it very helpful in premarital counseling. I've also mentioned the* Five Languages of Love (Chapman, 2005).

> *-I have used personality tests for couples to let them see what their personalities are. Now, a lot of people do Enneagram stuff* (Riso, & Hudson, 1996).

> *-I typically do eight, one hour sessions (with premarital couples), and that's based off of* Prepare and Enrich (Olson, & Olson, 1999).

> *-I recommend books for the couples to read. One is* Secretos de La Dicha Conyugal (Secrets of Marital Bliss) (van Pelt, 2001). *The idea is to repair their character. The other is called Me* Casaría de Nuevo Contigo (I Would Marry You Again) (Zabala, 2010).

Counseling Self-Efficacy

Interpretations of CSE were drawn from participants' responses to inquiries about successful cases, failures, and referrals. The following quotes demonstrate ministers' confidence or lack thereof in their counseling work. The first two come from ministers with high counseling loads. Both expressed high confidence in their ability to facilitate change, one especially with particular kinds of cases, but both acknowledged the inevitable choice people have to not change:

> *-I take on cases of communication, addictions, and spiritual cases… I don't refer these to a specialist because I can help resolve them.*

> *-When I first started in this work, I thought I could save [the marriage] if you came to me for counsel. I found out real, real early that was not the case. But I do all I can, and I think all therapists or counselors would do all they can, but then it comes to a point where people have their own decisions. They have their choice.*

However, the majority seemed to indicate that the level of help they could give was limited due to their lack of training in mental health or other counseling methods, or because

they felt like the last resort of those seeking help:

> *-Like [the member] in our ministry who has gender dysphoria, who's never told anybody about it basically. I don't know how to deal with that... I don't know how to help [them] understand why.*
>
> -(In a case of complex sexual trauma)*I'll pray with her, I'll tell her how much I hurt for her and how much I wish that hadn't happened and tell her I don't have the training to help her in the way she needs to be helped.*
>
> *-For the most part, by the time people will come talk to their clergy, you think, 'that's your first point of contact.' But usually their minds are already made up. We'll give it one last shot, but, you know, it's not gonna do any good...*

Patterns of Collaboration

"*Where no counsel is, the people fall: but in the multitude of counselors there is safety***"** (Proverbs 11:14). This scripture, cited by an African-American minister, demonstrates the belief indicated by all participants that counseling is not an isolated process. Each minister indicated that they had referred congregants to someone for help with personal issues, or wish they had someone to refer to. Though they varied in their confidence to address problems, not one believed they could conduct all stages of counseling for all kinds of issues alone. All of the ministers had people referred to them, mostly from other parishioners, but some from other ministers. None mentioned receiving referrals from MHPs.

Views of MHPs. All participants expressed generally positive or neutral opinions of MHPs, and none could recall any negative feelings they had about an MHP's treatment of a parishioner. However, one minister noted that *"Doctors will not refer them back for pastoral care,"* indicating a one-sided dynamic of collaboration. These quotes are examples of positive and neutral views:

> *-I've learned to refer to people that are trained in these areas. That doesn't necessarily mean that the individual was going to do that. I've seen situations where you refer them and... they'd rather believe the Lord and trust that God is going to help them. But the*

reality of it is that they really need some other help. You know, because Luke was a physician, the apostle Luke.

-I've never heard of a problem with non-religious professionals. I don't tell people NOT to go. I don't tell them TO go. I don't know who to send them to.

This last quote was an interesting remark from a minister about MHPs' role in addressing religious stress. It demonstrates the belief that some religious teachings, whether or not they are official doctrine of a belief system, may have detrimental effects on one's mental health, and so may need to be addressed by someone with an alternate perspective:

I think a lot of our problems are from religious pathology, bad teaching, things our grandmothers taught us, 'Maybe God's got a little black book and he's writing all this down' kind of thing… A lot of time the church is to blame for a lot of the stress that we put on ourselves. I don't remember a time being critical of a healthcare professional blaming us because, if they do, we probably are to blame.

Impediments to referral. The impediments the ministers reported were consistent with those found in the literature (Kramer et al., 2007), with a few additions. One White minister referred to a lack of supply to meet the mental health demands of his congregation:

There don't seem to be enough counselors [here]. And so, a situation where somebody will call and it'll take them two weeks to get through to the person, because they don't have the support staff because it's a small practice. When I've referred the [member] with gender dysphoria... I think it was six weeks before [they] got in.

This same minister expressed doubt as to the practicality of seeking professional help, being somewhat familiar with Common Factors research, and having had negative experiences with the delay and uncertainty of psychiatric treatment:

The world of psychology and psychiatry...it's kind of like a black hole to me.

An Hispanic minister had much to comment about MHPs' lack of public presence, emphasizing how ministers have a natural rapport with their congregants, making them a logical first contact when congregants need help:

Therapists are normally stuck in their offices. We don't listen because we don't know who they are. We listen more to pastors than therapists… but if the therapists would put themselves in the same plane as the pastor, they would have the same recognition.

Two African American ministers discussed the periodic difficulty they had in referring cases to MHPs due to congregant reluctance, though they themselves had no qualms about doing so. This quote exemplifies the feeling they conveyed of this situation:

If they don't want to be referred, I just tell them, 'I'm sorry, I've done all I can for you and the choice is up to you now.' And sometimes they still stay together, but then a lot of times, they decide to go their separate ways... I feel obligated to do all that I can in order to save a marriage and if they're not willing to be referred, I have to wash my hands of it.

The other African American minister reported having never made a referral to an MHP due to a lack of need:

We've had contacts where people would send notices that they were interested in receiving referrals. In any event, if we'd needed them, but we never needed them.

Cases for referral. All but two ministers reported having referred congregants to an MHP at some point in their ministry. The most common reason for referral was the time commitment predicted for a particular case (e.g., this would take more than three sessions). The other main reason for referring member was the ministers' low confidence in addressing the presenting issues, namely depression, suicidal ideation, severe trauma history, and high conflict relationships:

-Depression seems to be the most prevalent thing that you see. 'I just wish I could get over this kind of thing.' I was like, 'Well, you know… you probably should tell your doctor about this.'

-It's easy for me to do more damage in those situations by letting them talk to me because... that often enables them to not see a professional therapist. I don't want them to think that they're basically getting treatment from me.

Common referrals. The most striking pattern of referrals among the participants was the

tendency to refer to help within or connected to their churches. Four ministers said they regularly refer cases to other ministers. One Hispanic minister explained his reasoning for doing so:

> *Normally, we as pastors refer to other specialized pastors. Why? Because we understand that the pastor has a Christian philosophy and will follow our same philosophy, but go deeper.*

Three ministers mentioned their tendency to seek out "Christian counselors" when referring. According to the names and organizations they mentioned, this category included those with graduate degrees in theology that worked as counselors, those with pastoral counseling degrees, and or those with MHP degrees that market themselves as religious. Of the ministers who regularly referred to MHPs not marketed as religious, they were either members of the congregation, or colleagues of those in their congregation. The two ministers that mentioned funding members to see MHPs included only MHPs with close connections to the church.

When asked which non-religious MHPs or organizations they refer to, the ministers could not immediately recall specific names besides the local hospital or community mental health agency, and even then sought to utilize church connections where possible, as seen in these quotes:

> *I'll usually go to the mental health department here. Occasionally I've sent someone to [the local hospital]. Most of the time I have one or two members here who work for mental health. And so if I need to, I can call them and say, 'I need you to help me to get this person some help.'*

> *If I've got somebody that's in the medical field within my church, then that's different. I'm going to refer them within the church.*

Differences by Race/Ethnicity

There were no questions in the semi-structured interview protocol for detecting differences in counseling needs and practices by race, but themes of race naturally arose in the

interviews of ministers of African American and Hispanic congregations. However, there were surprisingly very few common themes among the three groups, as each minister had a significantly different experience to report. What follows are the commonalities I noticed from the interviews with those in each group.

African American. The three African American ministers had few similarities in their experiences, one performing counseling almost daily, one with several cases a month, and one with infrequent individual counseling duties. However, a notable commonality between all three is that they had referred counseling cases, especially couples, to other ministers. Their reported reasons for doing so were to reduce bias in cases of those they knew well, and because they viewed other ministers as experienced in counseling particular problems.

All three ministers spontaneously spoke about needs pertinent to their congregations as part of the African American community. Two ministers commented on general characteristics of their congregations they considered unique, indicating difficulties in working with those feeling victimized by larger institutions:

> *-We've got some guys transitioning back out of the prison system. We have to make sure the guys take their medicine, make sure they get to their doctor's appointment. Some of them after staying in the prison system for 20 and 15 years.*
>
> *-We deal with people who can't find work, and who have worked or are underemployed, people who are disenchanted with the powers that be, conditions that exist. We are kind of pigeon-holed into... second class citizenry. Not all, but a number of our members. And you have to try to keep their spirits up.*

Two of the ministers had highly dissimilar counseling experiences. One had a large counseling load, which included referrals from White congregations. When asked if he noted general differences in counseling between African American and White congregants, he said:

> *I find that sometimes the White families will listen easier than an African American family… I don't want to draw a line and say that is the case. But sometimes I've seen that*

happen. I think it's the background that some have come through. But the issues are pretty much the same.

The other minister to a community congregation with an older constituency noted a distinct lack of individual help-seeking; if problems exist, members are likely to keep them to themselves:

Our people are not... pastoral dependent...where they come in with a lot of problems. They may be operating under the conviction that 'this, too, shall pass.

Two ministers commented on their perception of their congregants' views of mental illness, indicating a stigma against the label of "mentally ill." They expressed sympathy for this view, saying that they had felt the same at some point in life:

I would probably be a little reluctant myself to go to regular psychiatry or psychology for psychoactive treatment or something. They would be a little reluctant because it kind of brands them--have it on their record that they are mentally ill.

We ignore mental illness because we don't want to accept it.

Hispanic. The three participants in this category were a White minister to a large Central American congregation (over 200 members), a Central American minister to a medium sized Central American congregation (less than 150), and a Carribean minister to a highly mixed small Hispanic congregation (less than 50). One theme they all mentioned was *"a degree of pride the people have that makes them hesitant to seek that help."* They spoke of this pride in the form of *machismo*, or a sense of superiority often ascribed to Hispanic males (Mirandé, 2018). This theme coincides with the concept of *familismo* discussed earlier, which posits that people should be able to resolve problems with their own resources. The ministers said this often kept members from seeking out counseling, either from them or from MHPs.

Another commonality was discussion regarding obstacles to help-seeking due to immigrant status. Besides the conspicuous lack of Spanish-speaking counselors in the region,

mental health counseling is a foreign concept for many congregants, many of whom come from rural districts in Guatemala and Honduras. Counseling from MHPs is also costly (often more than $80/hour in the study area); many immigrants are compelled to perform entry-level manual labor, and their undocumented worker status makes their employment precarious:

> *Access to such services would be almost nonexistent in many of these countries where the people have lived. So it's a new experience for them."*

> *...the cost that's involved, the time away when a person may need to work, and jeopardizing your job…*

Another impediment is the severity of mental or emotional problems to be addressed. Ministers said many of the congregants left their countries to escape ongoing violence, corruption, and economic turbulence, often experiencing severe trauma in those countries and on the journey to the United States. The fear and pain of revisiting trauma, as well as the grief of separation, appears to significantly impede members from opening up to potential sources of help:

> *I have found the people have been very reticent to talk about their experiences in their respective countries… they have been through genuine pain and hardship and suffering. It's almost that they want to leave that behind and hope they can start anew.*

> *It's separation, where people haven't seen their families now for... 10 years or longer, or they have children that are still in their country...*

> *When someone dies in the home country, it tears them apart. They feel broken because they can do nothing after years being here. The loneliness is stronger with these ones.*

One minister with substantial experience working with parent-child relationships had several comments about the conditions of Hispanic youth with migrant parents:

Many of the youth suffer bullying. It is real for Latinos, some commit suicide. If there's rebellion, it's because the [parental] relationship is lacking, so the kids go outside looking for it. They look for affection. Someone to listen. They buy clothes. They have an image that gives them value, but they still feel the same. They look for freedom like they see in American culture. They fight the rules and order of the family.

The Latino father is very absent. American fathers play with their kids on the carpet. Horse playing. Latinos might play soccer. But to read books? None of that. Maybe the difference is the Macho, 'Men are strong,' this has affected them. We lose our kids…

Our children are a reflection of our own lives. Sometimes they suffer the lack of love we had. First, sit with the parents to heal their hearts. Men are still children on the inside, wounded on the inside. They know nothing about paternity. They were never children, but are now fathers. It's a responsibility they don't know about. They need to learn how to be fathers.

Parents need to understand cultural change. They need to know what is going on. You cannot bring Guatemala here. You need to learn to adapt, learn the language. We try to motivate the parents to learn and grow with the kids.

White. Traits common to counseling a predominantly White congregation did not arise spontaneously in the interviews, and thus were not discussed. Only one minister of a White congregation mentioned demographics, but on a regional level:

A lot of people don't want to see, there's still a stigma maybe in the Southeast... about seeing a therapist. It takes a lot for them to take that first step, and if they don't get a call back, they're done.

One specific reason he cited for this stigma was the admission that congregants had done something wrong, as seen in the case of a mother with resentment stemming from postpartum depression:

Well, she didn't want to go because it made her feel like she was a bad mom because it was taking the shape of hating her kid. So, to even admit that she was mad at him to somebody took a lot.

Only the White ministers mentioned dealing with congregant symptoms of scrupulosity (anxiety over moral failing, often considered a sub-type of OCD), possibly indicating a general pattern. However, White persons are only slightly more likely to experience OCD than other groups Williams et al. (2017), and the scrupulous subtype has not been studied enough to make any conclusions about demographic patterns.

Discussion

Counseling and therapy are not restricted to the domains of clinics and academics. They are prevalent in many aspects of life--essentially any relationship or activity that leads to growth and healing. Clergy are just one common source of counseling, albeit a poorly-understood source. This study has contributed to the small research base by providing information on what clergy might do in a counseling relationship, how effective they perceive their work to be, and how they view relationships with non-religious counseling professionals, while adding insights into differences by race/ethnicity.

What clerical counselors do. It must be understood that not all clergy have the same counseling role; some meet with members frequently on an individual basis; some have systems to reduce individual counseling in favor of small groups. Some have congregants that rarely approach them with personal issues, some meet an overwhelming demand for help, and some go into homes to draw out unspoken problems. And, when confronted with problems, ministers expressed concern for the members, but feel differing levels of responsibility in helping them find resolution.

Ministers view many problems through differing spiritual perspectives, in much the same way MHPs use various scientific models. However, ministers prescribe spiritual interventions such as prayer, scripture study, religious teaching, confession, forgiveness, and repentance, many of which have significant overlap with non-spiritual interventions, which they also use. The most prominent techniques discussed were empathetic listening and behavioral directives, but also included were cognitive exercises and in-session communication feedback, making the aggregate

secular technique setlist of these ministers similar that found in Cognitive Behavioral Therapy, one of the most common models used by MHPs in the US. Several ministers intervened by facilitating connections to other members or groups that provided support, essentially differing therapy to other non-professionals.

In seeking to address mental health and relational issues, MHPs should be aware of the kind of help available to their clients. If a client is involved in a church community, comprehensive systemic treatment should include its resources, whether that involves individual counsel with a minister, classes, support groups, or other connections. Within these resources, it is important to understand the kinds of interventions used (Are they spiritual? Are they behavioral? Do they build connections? Do they provide education?). Religious communities can often help members meet many of their basic needs, including mental health and relational, thus it behooves MHPs to become cognizant of clients' communities and the resources easily accessible within them. Such knowledge can help MHPs fill in gaps where they exist, or direct clients to immediate resources previously untapped.

How effective clergy feel in counseling. Ministers feel various levels of self-efficacy in addressing certain issues, and this confidence can be drawn from sources outside of counseling training. It can come from years of counseling experience, robust faith in religious tenets, from trust in one's calling, or others' belief in ministers' capacity to help. There are some issues counseling ministers feel highly competent and qualified to address, and so may not refer to an MHP (such as marital conflict, parenting difficulties, anxiety, substance abuse, grief, and religious stress) and there are issues they will immediately refer (such as depression, bipolar disorder, complex trauma, and gender dysphoria).

When collaborating with religious leaders, MHPs should be aware of the issues which clerical counselors feel competent to address independently or within their clerical networks, and be able to support them in areas they feel unqualified. MHPs must be aware that many ministers engage in continuous study and use published materials to support and stay current in their counseling; it cannot be assumed they are unaware of academic methods. And, MHPs must be personally familiar to clergy, as well as trustworthy, respectful, and mutually serving. To date, the only research on clerical counseling outcomes shows its efficacy, so MHPs must acknowledge a minister's confidence in facilitating change and the real possibility of success independently of accredited secular training.

How collaboration can improve. The findings of this study provide both direct quotes and indirect implications of how MHPs might better work with clergy to improve care for those struggling with mental or relational stress. An Hispanic minister spoke at length about the necessity of MHPs becoming more public to gain recognition and trust in the same way pastors do. Another spoke of the need to know that counselors share beliefs that align with theirs so the faith of members is not threatened. A White minister spoke about the need for closer connections to the church so congregations can feel comfortable providing funding for members to see specific MHPs, as well as the need for easier access to appointments. An African American minister spoke of his congregation's need for more education about mental health. These are all addressable needs.

Though some ministers denied the need for further education, others expressed humble pleas and invitations to increase their knowledge of scientific counseling. MHPs should be responsive to these openings to provide high quality relevant education, and also to reciprocate,

expressing desire to learn what clergy--those approached most for counseling--have to offer. This form of collaborative education could likewise carry over into clerical education programs and seminaries. Counseling academics have the opportunity to communicate with instructors of religious programs, acknowledging the role that clergy play in counseling individuals and offering what services they can, and likewise providing an invitation for religious instructors to educate academic counselors in religious competency.

Overall, collaboration must be a joint effort. I repeat one minister's poignant remark, "*Doctors will not refer them back for pastoral care.*" The impetus to communicate with clergy and congregations should not simply be to increase clientele, but to sincerely and altruistically help people. If MHPs expect to be trusted by religious communities, they must trust in communities' capacity to help. As seen in the interviews, clergy provide support in many ways beyond individual counseling, especially in linking people to helping systems in the religious community. They connect members to small groups, other members, and other supportive bodies such as financial aid and AA meetings. They provide spiritual education and experiences to create a sense of purpose. They are stable fixtures in the community, and often have many more social connections than MHPs, and can maintain these for much longer and in much more intimate ways than MHPs are ethically allowed (think of the minister who counsels in the homes of congregants). Their positions give them authority with unique influence in congregants' lives and decisions. And, of course, they can potentially provide counseling of equal effectiveness to that of an MHP. The kind of support clergy provide may be of equal or greater importance to a client's well-being than empirically-based therapeutic interventions, thus it would be advantageous for MHPs to work bilaterally with clergy to meet needs holistically.

Insights on race/ethnicity. The findings of this study are consistent with those in the literature while contributing unique insights into ways MHPs may connect with these three groups. A tendency was noted for African American ministers to refer congregants to other ministers for counseling. This is consistent with Blank, Mahmood, and Guterbock's finding that the Black church tends to provide many more services for congregants than other church communities (2002), an understandable pattern in the context of historical marginalization of community resources (Levins, 1984). The ministers of Hispanic congregations discussed the unfamiliarity of mental healthcare, the barrier that undocumented status creates to access, and the impediments to disclosure of problems, namely the pain of addressing traumatic memories and the aversion to seeking help outside the family. A White minister reiterated the continued existence of stigma in the White community, adding that a significant cause may be the scrupulous anxiety over moral failure tied to the admission of mental illness. When building relationships with community leaders, MHPs have the opportunity to communicate directly to those these leaders serve. Recall that, without prompting, four ministers invited me to present to their congregations. Congregational meetings are excellent opportunities to acquaint large groups in the community to mental health professionals, helping build preliminary trust and rapport. In these settings, MHPs can also provide education to help people recognize treatable conditions, validate emotions, normalize mental illness and relational stress, and to phrase them in terms that acknowledge and affirm religious beliefs. Collaboration begins with communication, and MHPs have the capacity to open dialogues and build bridges by initiating contact with congregations and clergy.

Limitations. This study's findings should be considered in the context of several limitations. Participants were identified according to my convenience and social contacts. This limited participation to those that had the availability to interview in a time and location conducive to my schedule. The topics of the interview may have limited who successfully completed an interview. There were four ministers I contacted who agreed to be interviewed, but with whom I was unable to meet for various reasons. Though participants had a wide range of involvement in counseling activities, a minister's lack of knowledge on the subject or unspoken lack of desire to speak with an MHP may have deterred some from participating.
And, limits on the ministers' time prevented me from exploring all interview questions at length, which may have inhibited the gathering of useful information.

All ministers had completed an undergraduate education, with 7 completing graduate degrees, which may be related to the study taking place in a semi-urban university city. Such high levels of education may have influenced the ministers' exposure to academic counseling topics and their theories of change. Future studies may find distinct differences between the interventions and change theories of ministers with differing formal education levels.

All participants were ministers of Christian congregations. These were chosen deliberately to increase the study's relevance to the local area, in a state where 86 percent of adults--and 99 percent of those who identify with a common religion--identify as Christian (Pew Research Center, 2015). However, future researchers should investigate the unique help-seeking patterns and counseling experiences of ministers in other faiths, such as Judaism (the second largest religious group in the US) and Islam, the fastest growing religious group in the world

(Pew Research Center, 2017). These groups merit individualized studies to explore how MHPs can best collaborate with their ministers and congregations.

All participants in the sample are male, so the results, while expected to generally be true of clerical counseling, should be explored further with female ministers to explore the unique experiences for this population, especially considering the increasing proportion of female clergy in common Christian denominations (Strachan, 2010). Though I contacted and scheduled interviews with two female ministers, difficulty in receiving responses from them after scheduling prevented the interviews from occurring.

Lastly, I explained the underlying assumption of the study to participants at the beginning of each interview: that ministers untrained in academic methods can provide effective counseling. This expression may have altered the account of experiences to frame them more positively than the ministers originally perceived, but may have also encouraged exploration of vulnerabilities if they felt assured of a positive and confidential environment. Oakley (1981), for example, opened up new topics by interviewing women about childbirth as a conversation from woman to woman, between women who had both given birth. In traditional studies this would be said to introduce bias, but in such exploratory studies as this, my positive assumption of participants' work may have prompted greater openness. On the same note, my knowledge of Christian theology and vocabulary may have created a stronger sense of commonality between myself and participants, allowing for more natural expression from them and for me to interpret from an emic advantage.

Implications and future directions. Firstly, implications should be drawn from the immediate fruits of this study--the relationships I built with participant ministers. I came to know

them on a personal level, shared information about secular mental and relational health treatment, and provided a personal contact and source of support. These relationships have already yielded referrals, invitations to present to congregations, and continued friendships. Similar interactions may prove useful to other clinicians in understanding the needs of local clientele and in increasing collaboration with local clergy. These may include studies such as this, MHP participation in local religious communities, or directed efforts to contact ministers to offer support in their work to help congregants.

In interacting with and studying religious communities, MHPs must consider several potential risks. One is the inevitable disagreement on theories of change and kinds of help people should receive. MHPs must be knowledgeable and respectful when providing scientific education to religious groups, careful to affirm beliefs while presenting new ideas in culturally sensitive ways. Another risk is the potential of

It is also anticipated that these findings will lead to further studies that develop academic knowledge of clerical counseling as a common and potentially effective practice in order to increase trust and understanding between fields. It is hoped that greater understanding will increase cooperation between MHPs and religious leaders, including opportunities for MHPs to gain greater competence in understanding religious community resources in client healing, clergy to understand mental health components of congregant distress, and for both to engage in dialogue to promote effective comprehensive treatment.

This exploratory study has demonstrated the benefits of researching the clerical counseling experience, such as creating contact between academic and religious fields through the act of gathering data, and it had contributed to the breadth of knowledge the mental health

field has about the potential interventions, perceptions, referral patterns, and addressable needs of counseling ministers. This largely unexplored field has numerous possibilities for future research questions to be studied quantitatively or on a deeper qualitative level: How effective do congregants perceive their counseling experience to be? How many ministers feel the need for further counseling training? How comfortable do they feel referring members to MHPs, pastoral counselors, or other ministers? What proportion of ministers use evidence-based, faith-based, or other techniques in counseling? What measurable effects do various forms of helping systems have on congregants? And, how do these findings differ according to demographics (gender, race, religion, denomination, geographical region, age, congregation composition, SES, etc.). Of course, clerical lay-counseling is but one field in a vast range of topics implicated by Common Factors Research. Again, if therapy is to "shape the way people think and behave" (Minuchin & Fishman, 1981, pg. 2), there are countless human interactions that could be studied as forms of therapy.

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Appendix A. -- Interview Protocol

Background
What was the process for becoming a minister?

What are your main duties as a minister?
-How does counseling fit in?

Is this position full-time, part-time or volunteer?

Experience in Counseling Parishioners
How often do congregants approach you for help with relational or personal issues?

What types of problems are presented?

What is your role in resolving these problems?

What examples can you give of times when you succeeded, did not succeed, or had parishioners seek help elsewhere? Why did you succeed or not succeed?

What effects do theology and faith have in the change process?

Have you had any training in mental health counseling or relational counseling, either religious or secular?
-Would training in religious or secular methods be useful for you or other ministers? How, or why not?

Collaboration with Other Counselors
How often do you refer to a secular professional? A non-professional or other clergy?

Are there types of problems that you refer more than others?
-Any circumstances that would keep you from referring?

When parishioners got help elsewhere, what interaction did you maintain?

How much did the marriage counselor or mental health professional who received the referral respect the faith of your parishioner?

Who else do you refer to?

What would increase your willingness to refer?

Is there anything else you have to add about your experience?