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Exploring the Mental Health Information Needs of Clergy

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EXPLORING THE MENTAL HEALTH INFORMATION NEEDS OF CLERGY

Abstract

Background: Findings from the National Comorbidity Survey indicated that clergy were often the first treatment contact for individuals seeking mental health care. However, recent research indicates that 71% of clergy felt inadequately trained to recognize mental illness symptoms. There is a gap in the literature regarding the mental health information needs of clergy. This study investigated the information gap(s), resources commonly utilized, barriers to finding information, the clergy's use of technology, and the format of information and education that would be most useful. *Methods:* A survey consisting of qualitative and quantitative questions was sent out to clergy. Forty clergy at 144 houses of worship in Portage County, Ohio were randomly selected to receive the survey, and 19 surveys (48% return rate) were returned. Frequencies were calculated for multiple choice questions and mean scores and standard deviations were computed for Likert scale questions. Thematic analysis was utilized to examine open ended questions. *Results:* Participants indicated that they are interested in learning about mental health information, specifically general mental health information and treatment options. Their biggest challenges are identifying mental health professionals in general and identifying mental health professionals who share the same religious beliefs. Participants have access to computers and feel comfortable using technology. Finally, participants prefer handouts and lecture to learn about mental health information. *Conclusions:* Results indicate that providing education to assist clergy in identifying treatment options and treatment information may facilitate referrals to appropriate resources. Providing general information about mental health may also be helpful in increasing clergy knowledge of mental health symptoms and increase comfort level with, and readiness to, facilitate referrals to appropriate resources.

Keywords: clergy, information seeking behavior, mental health, needs assessments

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Introduction

Research indicates that clergy are often the frontline community mental health gatekeepers for individuals with mental illness symptoms (Weaver, 1995) and are at times the first and only professional that an individual encounters (Taylor et al., 2000). In 1961, the Joint Commission on Mental Illness and Health issued an initiative that recognized the need to link the spiritual and mental health communities to provide comprehensive services to individuals struggling with problems related to mental health (Larson et al., 1988). According to Larson (1988), the needed linkage had not come to fruition. Findings from the National Comorbidity Survey indicated that clergy were often the first treatment contact for individuals seeking mental health care (Wang, Berglund & Kessler, 2003). The number of individuals seeking mental health care from clergy has varied over the years and has also varied among studies. According to Wang et al. (2003), the percentage of individuals seeking care from clergy was highest prior to 1960 (31.3 %), declined during the 1960s and 1970s and then stabilized during the 1980s and early 1990s at 25%. Within the same study, findings indicated that treatment contact with psychiatry declined over the same time period (40.4 to 16.7%). Another study indicated that an estimated 4 out of 10 Americans seeking help for emotional problems turn to clergy (Weaver, 1995). According to Dell (2004), more recent estimates are higher.

Americans seek help from clergy for problems that include serious mental health problems, substance abuse, alcohol addiction, martial and family problems, depression, unemployment, legal problems and teenage pregnancy (Taylor et al., 2000). Research suggests that some Americans may seek mental health counseling from clergy because they do not require insurance or copayments, services are provided free of charge, completion of forms is not required (Taylor et al., 2000) and clergy are easily accessible (Bissonette, 1979). In addition,

because clergy assist individuals with a multitude of problems, a visit to clergy does not automatically imply that the individual is mentally ill, thus reducing the fear of stigmatization (Bissonette, 1979).

According to Weaver (1995), clergy most often work in isolation from mental health specialists and are poorly prepared to recognize and counsel individuals with mental illness symptoms, more specifically, symptoms of severe mental illnesses (e.g., depression, bipolar disorder, schizophrenia). In their study, Farrel and Goebert (2008) examined the ability of clergy to recognize major mental illness symptoms and counsel individuals diagnosed with a major mental illness. Surprisingly, 71% of clergy surveyed felt that they were inadequately trained to recognize mental illness symptoms, yet "there was a strong tendency to counsel regardless of level of training or feelings of adequacy…" (Farrel and Goebert, p. 439). In a review of the literature, Weaver (1995) found that 50 to 80% of clergy felt they had not been sufficiently trained during seminary to address severe mental health problems. Dell (2004) wrote, "One must remember that the primary professional degree of pastoral counselors is in theology, not medicine" (p. 100). As a result, clergy are typically neither exposed to, nor trained in, diagnosing and working with individuals who present with severe mental illness symptoms.

Clergy are uniquely positioned to provide referrals to mental health providers; however, referral rates are quite low (Lee, 1976; Weaver, 1995). Weaver (1995) defines clergy as skilled facilitators within the mental health network. He proposes teaching clergy how to find referral resources within a network which would allow them to provide referrals to providers who can more appropriately treat individuals with mental illness symptoms. In a literature review of research spanning 20 years (1963-1983), Meylink and Gorsuch (1988) found that of the individuals seeking help from them, clergy referred less than 10% of these individuals to mental

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health specialists. Various reasons for low referral rates have been proposed. Lowe (1986) writes that part of the clergy's reluctance is attributed to their lack of awareness of competent referral sources. Another potential reason is an inability to recognize the seriousness of the situation (Lee, 1976). Farrel and Goebert (2008) examined referral patterns related to belief. According to participants in their study, when referrals were made, shared religious beliefs between provider and parishioner were important (41%) or essential (15%).

Pargament (1997) presents a compelling argument about the need for collaboration between the mental health and religious disciplines. Traditionally, the exchange has been one-sided. Whereas clergy have been willing to learn about psychotherapy and are willing to provide referrals, mental health professionals typically have not sought out the wisdom or resources of the religious communities (Pargament, 1997). In an effort to facilitate equal interaction between the disciplines, Pargament (1997) proposes a resource collaborator role that focuses on sharing resources that are distinct. For example, there is a need to assist clergy in identification of mental illness symptoms. According to Weaver (1995), over one-half of seminaries had no course requirement in pastoral care or counseling. Taylor (2000) proposed in-service training programs for both clergy and mental health agencies to allow for information exchange. Mental health agencies could provide training programs to educate clergy about referral sources and referrals for specific problems (e.g., emergency referral for crisis situations). Conversely, clergy could provide training to mental health agencies about religious beliefs and practices and how they influence both individuals and family members. Finally, Larson et al. (1988) write, "it is incumbent on mental health professionals to make a concerted and diplomatic effort to reach out to (clergy)" (p. 1968).

The purpose of the current study was to assess the needs of clergy in Portage County by examining the following questions: How frequently do clergy look for mental health information; Do clergy feel prepared when they provide information; What type of resources do clergy utilize when looking for mental health information; What are the barriers for clergy to find and assess information; and What is the optimal way to provide information and instruction to clergy?

Methods

Procedure

The current study was reviewed and approved by the Institutional Review Board for Studies Involving Human Subjects of Northeast Ohio Medical University. Lists of houses of worship from governmental agencies were requested and not received. The researcher identified houses of worship in Portage County, Ohio by using the Rand McNally atlas to identify county boundaries and townships/villages/cities in the county, then used yellow pages and local city, village, township and Chamber of Commerce web sites to identify houses of worship and contact information. The denomination was determined from church web sites and identifying information in the church name; e.g. Church of Christ is a Christian denomination. The Association of Religion Data Archive was also used to identify the ancestry of the denomination. Appendix A shows the denomination and number of houses of worship.

A total of 144 houses of worship were identified (largely Christian, Protestant, Evangelical, Methodist and non-denominational). A representative sample of clergy within the denominations was selected to participate in the study. A researcher made initial contact by phone with clergy to explain the survey and the rationale for conducting the study and ask for permission to send the survey. In the original recruitment plan, calls would be made until the

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clergy was contacted and agreed to receive a survey. However, only 14 clergy responded after two weeks of telephone calls. Because of the substantial time involved with this procedure, an Institutional Review Board amendment was requested and approved. The modified procedure allowed for the researcher to leave one message which asked for a callback by clergy. When the first call was not returned, a second message was left with a project description and the survey was then mailed. In both procedures, if the first house of worship contacted was not sent the survey, substitution was made within the denomination, if possible. The two page survey and a letter that described the purpose of the study were mailed to 40 clergy; 19 surveys (48%) were completed and returned.

Instrument

The 18 item survey, designed by librarians and researchers, used both qualitative and quantitative questions. The survey goal was to gather information about frequency of need for mental health information, perceived preparedness to provide information, awareness of available resources, information need, resources commonly utilized and challenges in finding information. Questions 9-17 were designed to obtain information that would inform development of education or information for clergy (e.g., preferred method of learning, access to a computer, and comfort level with computer utilization). See Appendix B for the survey tool.

Data Analytic Strategy

For questions based on 5 point Likert responses, the researchers calculated mean and standard deviation values. Researchers calculated frequencies for multiple choice questions.

For open ended questions, researchers utilized thematic analysis. According to Braun and Clarke (2006), “Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data” (p. 6). Clergy were asked about their most recent need for mental

health information and how prepared they felt to address the need. Also, clergy were asked, "What makes finding mental health information challenging for you?" At the end of the survey, clergy were asked to provide additional information that was not asked in the survey.

The first analytic step of thematic analysis was to identify patterns or meaning within the data. Patterns that emerged during this first step were preparation to practice, referral to providers, and presenting problems. Initial codes were generated and attached to respondent answers to any of the clergy's exact words and phrases that referenced 1) information gaps; 2) resources for mental health information; and 3) challenges to finding mental health information. Data was then sorted into potential themes. Themes were analyzed to determine integrity (e.g., available data to support the theme) and the need to collapse them. The responses were then sorted into themes as follows: 1) Preparation; 2) Referral; and 3) Presenting Problems.

Results

Sample Description

Nineteen surveys were returned. The mean age of clergy was slightly less than 52 years (M=51.8), 79% were male (N=15), all were white/Caucasian, with an average of more than 23 years in the ministry (M=23.5). Table 1 shows the sample demographic makeup.

Frequency and Need for Mental Health Information

Clergy reported that the need for mental health information ranged from weekly to rarely. The majority reported a need occasionally; every few months or three to four times a year. See Table 2 for details.

Information Most Often Needed

When asked to specify the kind of information most often needed, clergy indicated that their most frequent need was for treatment options information, general information about

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mental health, treatment information and legal information. One respondent noted a need for counselor contacts. Table 3 has further details.

Resources for Mental Health Information

Surprisingly, health care providers and the Internet were used by the same number of respondents and by the majority (79%) of the respondents. People (people you work with and friends) and books were also used commonly. Table 4 shows the breakdown.

Continuing Education

The findings reveal a wide distribution of time spent earning continuing education credit yearly. Some clergy reported spending as few as five hours (N=2), while one clergy spent two semesters per year. In most cases, clergy reported spending between a few days (N=5) to one week (N=2) on continuing education. Of the 13 respondents to the question: "Where do you typically obtain continuing education credit," 7 (54%) responded through denominational educational events. Other responses included workshops, college, conferences, or not required (N=2, 15%). Most clergy reported spending minimal time learning about mental health, specifically less than two hours per month (N=12).

Interest in Learning about Mental Health and Preferred Format

Eighty four percent of clergy (N=16) indicated that they would be interested in learning about mental health information. Of those respondents, 11 noted that they would use handouts, 9 lecture and 6 tutorials. Responses to the "other" option included video or DVD's (N=2), seminars (N=2), and tables or summaries of diagnosis - treatment outcomes (N=1).

Computer Access & Use

All clergy have access to a computer and internet at home, with 18 of the 19 (95%) reporting office access. Most clergy 68% (N=13) report that they are very comfortable with

computers with the remainder noting that they are somewhat comfortable. Eighty four percent (N=16) use computers daily, the rest use computers a couple days a week.

Thematic Analysis

Three main themes emerged from the existing data: preparation, referrals, and presenting problems. These main themes are confirmed in the existing literature.

Preparation.

Inadequately prepared.

The theme of inadequate preparation to counsel individuals presenting with mental health concerns demonstrates consistency with the literature (Farrell & Goebert, 2008). Several clergy felt unprepared to provide mental health information because they lacked training and knowledge:

> I never feel prepared. The emotion from the person I am speaking with usually takes me by surprise. As a pastor, once I realize I'm dealing with a mental health issue, then I direct that person to someone expert in that field.

Due to lack of preparation, two clergy in the study readily seek referral to resources that can better assist parishioners. One clergy wrote, "Not real prepared or qualified, haven't had any real training. I usually seek referrals or people I can send to. I can try to stand beside and help during the process as support." The second wrote, "Not as prepared as I would like to be. My training is limited. I do not feel that I know the available services in the area well enough to really recommend where someone should go."

Prepared.

Whereas the majority of clergy wrote that they felt unprepared, a few of the clergy wrote that they felt prepared to provide information. Of the clergy who wrote that they did feel

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prepared to provide information, their level of confidence in feeling prepared to address mental health problems ranged from fairly, relatively, to fully prepared.

Referrals

Identifying mental health professionals.

The second theme that emerged from the data focused on the need to know available resources in the community. This theme demonstrates how lack of awareness of referral sources impacts clergy ability to assist with referrals (Lowe, 1986). Not only was the lack of knowledge about referral sources noted as a challenge, but also finding resources that clergy deemed competent was perceived as a challenge: "Who do I trust for good referrals and information?" One clergy wrote "The need that is prominent is for referrals. Depending on the situation, I don't cross the line between being their pastor first – thus referring them to someone competent."

A few clergy utilized existing resources, "Had a decent list from the county." Two clergy utilized resources gathered from parishioners: "All I did was refer them to a list of counselors I gathered from in-congregation counselor and pastor friends."

Shared beliefs.

Several of the clergy identified shared beliefs as a barrier to finding and accessing mental health information (Farrell & Goebert, 2008). Clergy serve a dual role as gatekeepers because they monitor the path of treatment for their parishioners. The sharing of religious values and practices between clergy and mental health professionals impacted the clergy willingness to refer to mental health professionals: "It is important to send a person to someone who is Christian based and treats from a Christian ethic." Consequently, those mental health professionals that lacked shared beliefs were less likely to be utilized by clergy: "Not sure if it is compatible or will be so with convictions of faith."

Presenting Problems

The third theme that emerged from the data focused on the various reasons that parishioners sought out the help of clergy. This theme demonstrates consistency with the literature as parishioners seek out guidance from clergy for numerous problems (Taylor et al., 2000). Interestingly, 21% focused on depression. For example, one clergy wrote, "Typically, I work and try to help with issues of people struggling with depression."

Discussion

Although the generalizability of findings is limited, the results provide preliminary information. Our typical respondent was over 40 years of age, Caucasian, and male with an average of more than 23 years in their profession. The majority of clergy in this study were interested in learning about mental health information. The most pertinent information gaps were information on treatment options, general information about mental health and treatment information. Clergy were less interested in medication information and payment information.

Most clergy surveyed recognized a need for mental health information, however, on a somewhat inconsistent basis. Consistent with the existing literature (Taylor et al., 2000), they often encounter parishioners with a wide range of personal problems, varying from alcohol or substance abuse to depression or marital problems. Clergy often use health care providers, co-workers, doctors, friends, as well as the Internet and books for mental health information. Indeed, clergy indicated that they are aware of resources; however, they need guidance with finding resources that are both reliable and credible.

Many clergy responded that they struggle with locating mental health information, particularly with identifying mental health professionals (Lowe, 1986) and finding mental health professionals with similar religious beliefs (Farrell & Goebert, 2008). Collaborating with mental

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health specialists and agencies can simplify the process for clergy to find reliable information. Ideally, agencies and clergy need to understand the importance of partnering in order to fulfill the information needs of parishioners (Taylor et al., 2000).

Clergy in this study have the necessary technology to access web information. All can access the Internet at home, and almost all have office access. This capability could make education and collaboration easier, particularly if clergy do not have the available time or resources to attend seminars and/or training.

Most clergy surveyed indicated that the optimal ways to provide information and instruction is by handout, lecture and tutorial. However, while the clergy surveyed here report accessing the Internet for mental health information, they do not identify web-based training as a preferred training method. These results suggest that clergy may feel more comfortable with face to face interaction to learn about mental health information. Ultimately, these findings indicate that members of the clergy may be amenable to outreach efforts to provide them with the mental health information that they need.

The current study has several limitations. For example, the study sample size limited the ability to make firm conclusions. Additionally, participants were only located in Portage County, which resulted in a homogenous sample. The clergy sample in this study was all Caucasian. To learn if the findings are generalizable, participants should be recruited from a more diverse setting. Having a more diverse sample will be important because some races, particularly African Americans, place even greater value on clergy to assist them with personal problems (Taylor et al., 2000). Comparing racial and ethnically diverse clergy could determine whether their needs are different. The initial recruitment design impacted the sample size because of the time needed to talk with clergy about the study. A larger sample will allow

researchers to make inferences, validate findings and recognize patterns or outliers. Because the study had qualitative components, many of the findings could not be generalized. Two of the participants were unclear about how mental health was defined in the survey. In future studies, a definition of the phrase "mental health" should be noted in the survey. Finally, voluntary response bias may have impacted the study.

Despite these limitations, implementing an information intervention based on the data gathered may prove successful.

Conclusions

The current study was undertaken to develop a mental health information outreach plan in Portage County that would be informed by clergy need. Findings indicate that the majority of clergy in the current study are interested in learning about mental health information and treatment options. As a result, the researchers will provide outreach to clergy that utilizes technology and focuses on mental health information, treatment information and treatment options. Finally, future studies that focus on larger, culturally diverse sample sizes may produce findings that are more representative of clergy in the region.

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Table 1:
Sample Demographics (N=19)

Demographics	N (%)	M (SD)
Age		51.8 (10.4)
30-36	2 (11%)	
37-43	1 (5%)	
44-50	4 (21%)	
51-57	5 (26%)	
58-64	5 (26%)	
65 and older	2 (11%)	
Gender		
Male	15 (79%)	
Female	4 (21%)	
Race/Ethnicity		
White/Caucasian	19 (100%)	
Length of time as a clergy (years)		23.5 (11.9)
0-10	3 (16%)	
11-20	5 (26%)	
21-30	4 (21%)	
31-40	7 (37%)	

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Table 2

Clergy Frequency of Need for Mental Health Information (N=17[a])

Range of Time	Number of Respondents	Percent
Weekly	1	6%
Monthly	5	29%
Occasionally/every few months/3-4x/yr	7	41%
Twice/year & yearly	2	12%
Longer (rarely, every 2 years)	2	12%
Total	17	

[a] Two responses were invalid and removed from analysis for this question only.

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Table 3

Topics Most Often Needed (N=19)

Description of item	**Mean**	**SD**
Treatment options	3.4	1.2
General information about mental health	3.2	0.9
Treatment information	3.1	0.9
Legal information	2.9	1.0
Prescription medication information	2.4	1.1
Payment information	1.7	1.2

Table 4:

Resources Utilized for Mental Health Information (N=19)

Resources	**Total**	**%**
Doctors, nurses or other health care providers	15	79%
Internet	15	79%
People you work with	13	68%
Friends	12	63%
Books	11	58%
Magazines/journals	7	37%
Other resources	7	37%
In-house library collections	4	21%
Health departments	3	16%
Other people	3	16%
Audiovisual materials	2	11%
Databases	1	5%
Libraries	1	5%

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Appendix A

Number of Churches in Portage County Ohio by Denomination

Denomination	Number	Per Cent
American Evangelical Christian	7	4.90%
Bible [Christian]	2	1.40%
Catholic [Christian]	10	6.90%
Christian	8	5.60%
Christian Science	1	0.70%
Church of Christ [Christian]	11	7.60%
Church of the Brethren [Christian]	1	0.70%
Disciples of Christ [Christian]	1	0.70%
Episcopal [Christian]	2	1.40%
Evangelical Christian-Nazarene	2	1.40%
Evangelical of North America [Christian]	2	1.40%
Islam	1	0.70%
Jehovah's Witness [Christian]	5	3.50%
Judaism	1	0.70%
Lutheran [Christian]	8	5.60%
Mennonite [Christian]	1	0.70%
Methodist [Christian]	17	11.80%
Methodist-African Methodist Episcopal [Christian]	2	1.40%
Mormon [Christian]	2	1.40%
Nondenominational	11	7.60%
Orthodox Christian	1	0.70%
Pentecostal [Christian]	3	2.10%
Pentecostal-Apostolic [Christian]	1	0.70%
Pentecostal-Assembly of God [Christian]	4	2.80%
Pentecostal-Church of God [Christian]	8	5.60%
Presbyterian [Christian]	1	0.70%
Protestant [Christian]	3	2.10%
Protestant-Baptist [Christian]	25	17.40%
Quakers [Christian]	1	0.70%
Seventh Day Adventist [Christian]	1	0.70%
Unitarian [Christian]	1	0.70%
Total	144	

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Appendix B

Assessing Mental Health Information Needs of the Clergy

Please circle one answer unless otherwise directed.

1. Demographic information.

Age_____ Gender_____

Race/Ethnicity_____

2. How long have you worked as a clergy? _____

3. How often do you need information on a mental health topic?

Daily Weekly Monthly Other _____

4. Describe your most recent need for mental health information

_____

_____

_____

5. How prepared did you feel when you provided information during your most recent mental health information need?

_____

_____

_____

6. What kind of information do you most often need? On a scale of 1-5, please answer the following questions, with 1=no need, 2=little need, 3=some need; 4-frequent need; 5=a great deal of need

General information about mental health	1	2	3	4	5
Prescription medication information	1	2	3	4	5

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Treatment information	1	2	3	4	5
Billing, insurance, payment information	1	2	3	4	5
Legal information	1	2	3	4	5
Information on treatment options	1	2	3	4	5
Other (explain) _____	1	2	3	4	5

7. What resources do you use when looking for mental health information? Please circle all that apply.

Audiovisual materials
Books
Databases
Internet
Magazines or journals
Other (please specify)
_____

Do you use any of the following when looking for mental health information? Please circle all that apply.

People you work with
Libraries
Doctors, nurses or other health care providers
In-house library collections
Health departments
Friends
Other (please specify)
_____

Please circle one answer unless otherwise directed.

8. What makes finding mental health information challenging for you?

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_____

_____

_____

9. How much time do you currently spend yearly on continuing education?

_____

10. Where do you typically obtain continuing education credit?

_____

11. How much time do you currently spend *monthly* on *learning* about mental health?

_____

12. Would you be interested in learning about mental health information? Yes No

13. How would you prefer to learn about mental health information? Please circle all that apply.

Handout Lecture Tutorial Other, please specify_____

The following questions are about your access to computers and your comfort level in using computers.

14. Do you have access to a computer and Internet connection (so that you can find information later on your own)? _____ Yes _____ No (if no, skip to question 18)

15. Where do you use a computer? Circle all that apply

Home Work office Library Friend's or relative's Other (specify) _____

16. How comfortable are you using computers?

Not comfortable Somewhat comfortable Very comfortable

17. How often do you use a computer?

Every day A couple of days a week Once a week Bi-weekly Monthly

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18. Is there anything relevant, and not in the survey, that you would like to add?

_____

_____

_____

_____