Mental Health Services in Faith Communities: The Role of Clergy in Black Churches

Robert Joseph Taylor, Christopher G. Ellison, Linda M. Chatters, Jeffrey S. Levin, and Karen D. Lincoln

A small but growing literature recognizes the varied roles that clergy play in identifying and addressing mental health needs in their congregations. Although the role of the clergy in mental health services delivery has not been studied extensively, a few investigations have attempted a systematic examination of this area. This article examines the research, highlighting available information with regard to the process by which mental health needs are identified and addressed by faith communities. Areas and issues where additional information is needed also are discussed. Other topics addressed include client characteristics and factors associated with the use of ministers for personal problems, the role of ministers in mental health services delivery, factors related to the development of church-based programs and service delivery systems, and models that link churches and formal services agencies. A concluding section describes barriers to and constraints against effective partnerships between churches, formal services agencies, and the broader practice of social work.

Key words: *African American; help seeking; ministers; pastoral care; referral; religion*

Sociology and social work have a long tradition of documenting the centrality of religious concerns and institutions in black communities for some time (Frazier, 1974; Lincoln & Mamiya, 1990; Mays & Nicholson, 1933). Collectively, this documentation suggests that faith communities have occupied a primary role in black communities, encompassing a broad range of issues, including civic and political concerns, educational pursuits, and economic and community development. Empirical findings indicate that religion has a special prominence in the lives of African Americans, with churches assuming a particularly influential role. Survey evidence demonstrates that nearly nine of 10 black Americans view black churches as fulfilling multifaceted roles in black communities and as having a positive influence on their lives (Taylor, Thornton, & Chatters, 1987). Black adults display high levels

CCC Code: 0037-8046/00 $3.00 © 2000 National Association of Social Workers, Inc.

of religiosity across a variety of religious indicators, including church membership rates and frequency of public behaviors such as church attendance, as well as private devotional practices (for example, prayer and reading religious materials) (Ellison & Sherkat, 1995; Taylor, 1988a, 1988b; Taylor & Chatters, 1991).

An equally long tradition of faith-based initiatives and work in black communities has been concerned with the health and well-being of individuals and families (Gilkes, 1980; Levin, 1984; Olson, Reis, Murphy, & Gem, 1988). The past few years have seen a general resurgence of interest in the connections between religious involvement and a range of human behaviors among African Americans and the general population. Social sciences research documents associations between religious involvement and a variety of attitudinal and behavioral outcomes, including marital quality and duration (Call & Heaton, 1997; Heaton & Pratt, 1990; Lehrer & Chiswick, 1993), receipt of social support (Taylor & Chatters, 1988), contraceptive use (Goldscheider & Mosher, 1991), and fertility (Mosher, Williams, & Johnson, 1992). A growing literature shows that religious factors are linked with specific behaviors affecting health, such as drug, alcohol, and tobacco use (Brown & Gary, 1994; Cochran, Beeghley, & Bock, 1988; Gottlieb & Green, 1984), as well as the use of health care services (Levin, Chatters, Ellison, & Taylor, 1996; Levin & Vanderpool, 1992). In addition, studies indicate that religious involvement is associated positively with life satisfaction, self-esteem, and other aspects of well-being (Ellison, 1993; Thomas & Holmes, 1992) and self-rated health (Musick, 1996) and is related inversely to depression and distress (Brown, Ndubuisi, & Gary, 1990), long-term physical disability (Idler & Kasl, 1997), and mortality risk (Bryant & Rakowski, 1992; Strawbridge, Cohen, Shema, & Kaplan, 1997). Collectively, these works suggest that the study of religious involvement may provide unique insights into health status, health-related behaviors, and health attitudes of defined groups within the population.

Practitioners and researchers especially have been interested in religious involvement as it pertains to the health and human services professions. Building on the legacy of faith-based health initiatives in black communities, a number of investigations have identified several factors that characterize these efforts. First, the head minister or pastor is recognized as a pivotal figure in the church, whose leadership and direction are critical for understanding the types of programs organized in the church and the church's relationship with formal service agencies in the broader community. Second, ministers assume a variety of roles in relation to church-based programs and interventions, particularly as agents of health-related behavioral change and agents of health-related social change (Levin, 1986). Third, ministers often function as gatekeepers to formal mental health services (Veroff, Douvan, & Kulka, 1981). Fourth, ministers are sometimes the first and only professional that individuals encounter. As a consequence, pastors' positions as personal counselors and advisors are important ones with respect to the mental and physical health of their congregants. However, specific and systematic information about the role of clergy in mental health services delivery is particularly scarce. Information of this sort is critical for a more comprehensive understanding of the role of ministers in the delivery of mental health services (Larson et al., 1988; Maton & Pargament, 1987; Mollica, Streets, Boscarino, & Redlich, 1986; Report to the President's Commission on Mental Health, 1978) and is potentially useful for developing models of service delivery in the health and human services professions.

This article addresses these issues by providing a critical review of studies examining the role that ministers fulfill in mental health services delivery. This review also examines specific client characteristics and factors associated with the use of ministers. Factors related to the development of church-based programs and service delivery systems are explored, and models that link churches and formal service agencies are discussed; the article also addresses barriers to and constraints against effective partnerships among churches, formal service agencies, and the broader arena of social work practice.

Use of Ministers for Personal Problems

For many Americans, clergy play a critical role in their efforts to handle personal problems.

Thirty-nine percent of Americans who have a serious personal problem solicit help from a member of the clergy (Veroff et al., 1981), surpassing rates for help from psychiatrists, psychologists, doctors, marriage counselors, or social workers. Clergy are consulted for a variety of psychological issues, many of which are consistent with their ministerial and religious training (for example, comforting the bereaved and advising those with physical illness). However, clergy also are asked to address interpersonal crises and serious mental health problems. Veroff et al.'s (1981) study, based on the data from a national sample, found that almost half of all consultations with clergy concerned marital issues, whereas findings from a survey in two heavily Hispanic communities (Chalfant et al., 1990) revealed that clergy often provided help to people who were experiencing a serious personal problem.

There are several advantages to using clergy for help with personal problems. For people who are poor, the clergy hold a distinct advantage over other professional counselors. Treatment expense is recognized as a significant barrier in seeking aid from traditional mental health workers such as psychiatrists and psychologists (Veroff et al., 1981). Distinct from other sources of professional assistance, clergy do not charge fees for their services or require insurance, copayments, or completion of required forms. Specific to black Americans, estimates of unmet needs for mental health services are particularly high (Neighbors, 1985). Given a situation of significant unmet needs, ministers may be an available and attractive alternative to the traditional mental health services delivery system. Furthermore, traditional mental health specialists usually are approached after an initial consultation with a referral source. Clergy, on the other hand, typically are approached directly by clients, and rarely is contact mediated by formal or informal referrals (Veroff et al.). Part of the professional role expectations and obligations incumbent on clergy is that they make personal visits to those in need (for example, visits to the sick in the home or in the hospital), thereby facilitating access to services. Finally, consultations with clergy typically occur within the context of a longstanding personal relationship that may have beneficial consequences with respect to establishing rapport and empathy.

With respect to sociodemographic factors, only a few appear to be related to the use of clergy. Religious denomination and church attendance exhibit relatively strong and consistent associations with use of clergy, as well as with use of psychiatrists and psychologists (Veroff et al., 1981). People identified with fundamentalist denominations use clergy extensively but tend not to use psychologists or psychiatrists. Jews, on the other hand, are more likely to seek help from psychiatrists and psychologists, but are less likely to use clergy (Veroff et al.). With respect to church attendance, those who frequently attend are more likely to seek assistance from clergy, whereas those who infrequently attend are more likely to seek assistance from psychologists or psychiatrists (Veroff et al.). Neighbors, Jackson, Bowman, & Gurin's (1983) work on the help-seeking process among black Americans, specifically the use of clergy, found that ministers were frequent sources of help for people facing serious personal problems. Ministers were significantly more likely to be contacted when the personal problem involved bereavement and grieving (Neighbors, 1991; Neighbors et al.). Finally, a recent analysis (Neighbors, Musick, & Williams, 1998) of black Americans found that women were more likely than men to seek assistance from a minister. People who saw clergy first were less likely to contact other professionals, especially if the problem concerned death, illness, or emotional adjustment issues. For those who used only one source of aid, people seeking help from clergy (compared with those who sought assistance from other sources) were more satisfied with the help they received and were more likely to refer others to clergy. The most common forms of assistance from a minister involved socioemotional support and engagement in religious activities.

The Role of Clergy in Mental Health Services Delivery

Despite the apparent importance of clergy, there is little systematic information concerning the interface among religious organizations and

the mental health services delivery system, including black ministers' roles with regard to the formal mental health system (Williams, 1994). Clergy frequently function as gatekeepers to the mental health services system and traditionally have played a role in the delivery of mental health services (Veroff et al., 1981). However, little is known about the types of services provided, the specific circumstances surrounding referrals to clinicians, and the relevant factors associated with those referrals (Williams). We do know, however, that ministers counsel on a wide range of personal problems, including alcohol and other forms of substance abuse, depression, marital and family conflict, teenage pregnancy, unemployment, and legal problems. A comparison of the types of clients encountered by clergy and mental health practitioners (based on data from five epidemiological catchment area sites) indicates that clergy and mental health practitioners encounter clients who are similar with respect to both type and severity of psychiatric problems they present (Larson et al., 1988). However, because clergy are a heterogenous group with respect to education and training, their counseling and services referral practices are not uniform (Gottlieb & Olfson, 1987). Specialized training in counseling regarding basic life issues and concerns (for example, marital relationship problems) is minimal even among ministers who have pursued postgraduate education (Friesen, 1988; Weaver, 1995).

The quality of mental health services provided by clergy is determined, in part, by their ability to identify serious mental health problems and their willingness to refer people to professional mental health practitioners. Apparent differences in background and training among clergy members may have important consequences for detecting mental illness and emotional distress and in making appropriate client referrals. Ministers frequently are called on to address these issues in their work, although they may be unfamiliar with various forms of psychopathology and the symptoms of severe mental illnesses (Bentz, 1970; Gottlieb & Olfson, 1987; Virkler, 1979). Not surprisingly, clergy, compared with other mental health services practitioners (for example, physicians, psychologists, social workers, psychiatric nurses), tend to underestimate the severity of psychotic symptoms (Larson, 1968) and are least likely to recognize suicide lethality (Domino & Sevain, 1985–86). Given their religious and ministerial training, clergy may interpret mental or emotional problems and symptoms in purely religious terms (Hong & Wiehe, 1974). For example, Larson found that ministers interpreted hallucinatory behaviors as evidence of religious conflict. The Larson and Hong and Wiehe studies shed light on an important area of investigation. These studies, however, were based on small, nonprobability samples conducted over 20 years ago. The absence of more recent research along these lines illustrates how little is known about clergy and mental health practices and the needs for future research.

With respect to referral practices, only a small number of clergy (an estimated 10 percent) refer their clients to mental health professionals for more specialized services (Mollica et al., 1986; Veroff et al., 1981; Virkler, 1979). Generally, clergy are unfamiliar with standard referral procedures and the availability of services offered at community health centers (Winett et al., 1979) and university clinics (Mobley, Katz, & Elkins, 1985). Members of the clergy with advanced education and liberal theologies are more likely to make referrals to mental health agencies. In contrast, those with less education and who endorse conservative theologies are more likely to attempt to treat people with symptoms of psychiatric disorders (Gottlieb & Olfson, 1987). However, the recent proliferation of graduate training programs in pastoral counseling suggests a growing recognition of the importance of addressing the mental health needs of church members.

Although several studies have focused on the counseling and referral practices of clergy (see Meylink & Gorsuch, 1988, for a review), only a few have examined the practices of black ministers. The study by Mollica et al. (1986) of the mental health counseling practices of 214 black and white ministers found that black ministers were more heavily involved in counseling, with nearly seven of 10 spending more than 10 percent of their time in counseling activities. Black

ministers, to a greater extent than white ministers, were involved in crisis intervention and in counseling individuals with diagnosed mental illnesses. Compared with their white peers, black clergy placed greater emphasis on using religious practices (for example, church attendance) as a method for treating emotional problems. Although general rates of referrals made and received were low for all clergy, there were important differences by race in referral patterns. Overall, black ministers were much more likely than white ministers to make referrals to community mental health centers. Chang, Williams, Griffith, & Young (1994) examined the relationship among organizational and clergy factors and referral exchanges among black clergy and community health agencies. In their sample, 47 percent of black clergy had referred parishoners to community mental health professionals. Furthermore, they found that the number of organizational ties that a church had to community agencies was associated positively with the number of referrals clergy made to mental health professionals.

Mental Health Services Delivery in Faith Communities

African American communities have a long tradition of human services delivery in the context of religious institutions. Historically, black churches have provided a wide range of resources and opportunities that were inaccessible to African Americans from mainstream institutions (Frazier, 1974; Lincoln & Mamiya, 1990; Nelsen & Nelsen, 1975). Mays and Nicholson's (1933) classic study of black congregations found that churches sponsored a diverse array of community outreach programs, including programs to feed unemployed people, free health clinics, recreational activities, and child care programs. These activities reflect a longstanding tradition of providing for those in need in their communities.

In the wake of recent reductions in funding of state and federal assistance programs serving individuals and families, there has been a resurgence of interest in the tradition of church-based services provision (for example, Palmer & Sawhill, 1984; Burt & Pittman, 1985). Some observers have concerns about whether black churches have sufficient prestige and an adequate resources and administrative base to address the social problems presently plaguing urban black people (for example, Wilkes, 1990; Winston, 1992). However, recent research indicates that a strong ethos of community service is still evident among African American congregations (Billingsley & Caldwell, 1991; Caldwell, Chatters, Billingsley, & Taylor, 1995; Lincoln & Mamiya, 1990), suggesting at least a compatible ideological perspective.

Overall, black churches tend to participate in community programs to a greater extent than do white churches (Lincoln & Mamiya, 1990), particularly antipoverty and material aid programs (Chaves & Higgins, 1992). Isolated ethnographic accounts and small-scale studies have documented a range of church-sponsored programs and initiatives, youth programs (McAdoo & Crawford, 1990), programs for elderly people and their caregivers (Haber, 1984), and community economic development initiatives (Williams & Williams, 1984). Churches provide health care screening and health programs to poor black people (Levin, 1984, 1986), such as programs to help ameliorate hypertension (Perry, 1981) and to control weight (Kumanyika & Charleston, 1992). Eng and Hatch (1991) developed one of the most notable programs in this area, using churches as a focus for health promotion activities in several rural counties in North Carolina. These and other variations of community-based partnerships recognize that religious institutions occupy a position of trust and respect in black communities. In collaboration with black churches and their resources, these efforts have effectively tapped into longstanding traditions of mutual assistance and self-reliance to improve the health of community members (for example, Eng & Hatch; Eng, Hatch, & Callan, 1985; Hatch & Jackson, 1981; Olson et al., 1988).

Faith Communities and Mental Health Services Delivery: Survey Findings

A recent survey of 635 African American congregations in the northeastern United States provides a current profile of contemporary church-based programs. Studies (Billingsley & Caldwell, 1991; Caldwell et al., 1995; Caldwell,

Greene, & Billingsley, 1994; Thomas, Quinn, Billingsley, & Caldwell, 1994) have identified more than 1,700 outreach programs. About 40 percent of church-based programs provide basic needs assistance (food and clothing distribution, home care, and child care), and an additional 6 percent offer income maintenance programs, such as financial services and low-income housing. Approximately 18 percent of the programs identified involve some form of counseling and intervention for community members, such as family counseling, parenting and sexuality seminars, youths-at-risk programs, and aid to incarcerated individuals and their families. Other initiatives include various educational and awareness programs (for example, life skills and academic tutoring), health services-related activities (for example, HIV/AIDS care, substance abuse counseling), and recreation and fellowship for families and individuals. In addition to sponsoring a diverse array of programs, many congregations also cooperate with a range of community institutions and government agencies through referrals and other means.

Previous studies, although largely descriptive in nature, provide information on the numbers and types of church-based programs (for example, Caldwell, Greene, & Billingsley, 1992; Caldwell et al., 1994; Lincoln & Mamiya, 1990; McAdoo & Crawford, 1990). However, more detailed information about the distribution and operation of church-based community outreach programs is useful for human services practitioners wishing to establish partnerships with faith communities. Caldwell et al. (1994) examined the types of formal programs that churches offer to support families. They used a conceptual model in which the church functions as a mediator between African American families and the formal network of services delivery. The model assumes that when family and church are geographically proximal and share close affective bonds, churches can function in an optimal manner for providing direct assistance to families and facilitating referrals to formal health and social services institutions.

Results from this study also indicated that two-thirds of black churches operated at least one outreach program designed to meet family, health, and social services needs. The majority of church-sponsored programs targeted the family as a unit, whereas about 33 percent were specifically geared toward children and adolescents, 8 percent were for the elderly, and 10 percent were community development programs (Caldwell et al., 1994). Thomas et al. (1994) found that many black churches were actively involved in the delivery of specific types of health care services. The most common health programs involved drug abuse prevention activities and health education workshops. However, considerably fewer church programs were specifically designed to meet the health-related needs of adolescents. The Caldwell et al. (1995) analysis of the types of services that black churches offered elderly people indicated that this group was the least likely to receive formal services through church programs. When available, however, social services accounted for the largest portion of church programs for elderly people.

Billingsley and Caldwell's (1991) study of the relationships among churches, families, and schools in African American communities identified different patterns of collaboration between black churches and local community agencies. Fifty percent of churches surveyed indicated that they had collaborated with a mental health services agency to provide community outreach programs. The study also examined case studies of churches that had collaborated with one another to provide programs geared toward strengthening families. Twenty-eight percent of the family support programs offered by black churches provided emotional support services through family counseling and support groups for women and men (Caldwell et al., 1994).

Factors Associated with Services Delivery

The scope and range of outreach programs, including mental health services initiatives such as counseling and intervention programs, are shaped by congregational, ministerial, and other factors (for example, Caldwell et al., 1995). Congregation size is identified in studies of white and black churches as a key predictor of the number of community outreach programs offered (National Council of Churches,

1992; Olson, 1988). Lincoln and Mamiya (1990) reported that larger churches have more programs and are more actively involved in their surrounding communities. Similarly, larger churches tend to offer a wider range of family support services and health-related programs, as well as more specialized services than do their smaller counterparts (Caldwell et al., 1992; Thomas et al., 1994).

There are several reasons why congregation size may be related positively to the level of community outreach. Funding issues are obviously critical to the success of such programs. Larger and more stable churches tend to have more financial resources (for example, a larger base of donations and pledges) and facilities (for example, church buildings and buses) to support outreach programs (Carson, 1990; Lincoln & Mamiya, 1990). The fiscal advantages of size may be offset somewhat by access to alternative sources of funding for these programs, such as denominational or ecumenical support, government monies, or private foundation grants.

In addition to greater physical and financial resources, larger churches also may have larger available pools of volunteers for outreach programs, as well as the ability to attract trained professionals to staff and coordinate outreach efforts (Eng & Hatch, 1991). In at least one study of African American congregations in the northern United States, churches without paid clergy and other paid staff were least likely to sustain programs to assist elderly people (Caldwell et al., 1994). Other research suggests that the per capita income of church members is also an important factor influencing service delivery. Specifically, congregations that are characterized as middle-class often have more financial resources than churches with primarily poor or working-class members (National Council of Churches, 1992).

Characteristics of the minister are important for determining the types of programs and activities of churches. The extent of the minister's formal education is an important predictor of a church's level of community activism and outreach. Clergy with high levels of education are more aware of community social problems, have a stronger interest in politics, and are more likely to cooperate with other community organizations than their less-educated counterparts (Lincoln & Mamiya, 1990). Furthermore, ministers' educational level is associated positively with the presence of community outreach programs (Caldwell et al., 1994; Thomas et al., 1994). Research on the mental health services referral practices of clergy also shows that well-educated clergy are better informed regarding mental health issues and services available from professionals and public agencies, are more confident in their understanding of these issues, and deal more frequently with the mental health community than their less-educated peers (Gottlieb & Olfson, 1987).

Although educational attainment of clergy is clearly important, other aspects of clergy background also influence program development at the congregational level. First, although there is less research on age or age cohort differences in clergy activism, younger clergy may have greater exposure to mental health issues as part of their ministerial training and interest in church-based counseling and intervention programs. On the other hand, senior clergy members with longer tenures at a church may have had more opportunities to establish broader networks in the community, including contacts with mental health services agencies, clinics, and professionals. Second, because of the scarcity of financial resources and other considerations, many black churches lack full-time paid clergy (Lincoln & Mamiya, 1990) and other paid staff members (for example, assistant ministers or secretaries). Ministers who have other work obligations (full-time or even substantial part-time jobs) may lack the time to be actively involved in the delivery of community services. As a consequence, the scope and diversity of church-based services could be limited because of the constraints of time on clergy. Congregations with multiple full-time, paid clergy may have the personnel resources to offer a wide range of programs and services.

The theological and political views of a minister and his and her interest in racial and community issues also may influence patterns of services delivery. Clergy in more theologically conservative churches may emphasize individual evangelism (personal salvation) as opposed to

ministries based on ideals of racial justice and community development. To date, there is little evidence that the theological orientation of clergy influences services delivery (Adams & Stark, 1988). Among African American members of the clergy, there is general agreement across theological and denominational lines that churches should be involved in community affairs and politics (Lincoln & Mamiya, 1990). On the other hand, an individual minister's definition of the proper social mission of religious institutions and his or her racial ideology and overall level of involvement in community and political affairs are likely related to the scope and range of church-based services delivery. Among white members of the clergy, a minister's perception of the seriousness of community problems had an effect on levels of services delivery (National Council of Churches, 1992). Furthermore, socially conservative pastors sponsored fewer services to elderly people than their more liberal counterparts (Adams & Stark). Consistent with this line of reasoning, Lincoln and Mamiya found that among black clergy members, racial consciousness was related positively to involvement in community outreach programs.

Directions for Future Research

Although there is a historical importance of black churches in meeting the mental health needs of its members, this review shows that there is limited information on this topic. Current investigations provide useful information regarding the types of problems addressed by clergy, the numbers and types of community outreach programs sponsored by churches, and the correlates of service delivery. However, additional research examining the interface between faith communities and formal service delivery is needed. Of particular importance is research that identifies the type and quality of services provided, assesses clergy's knowledge of available professional mental health services within the community, and examines the counseling and referral practices of black clergy.

The majority of current investigations in this area use small, nonprobability samples and are largely descriptive or anecdotal in nature. As a consequence, it is difficult to generalize about these findings with regard to the black population. Future research efforts that examine the connection between faith-based organizations and mental health services delivery among African Americans should use large probability samples to investigate systematically the role of ministers in addressing the mental health needs of their congregants; how and why congregants use ministers (versus other help sources) for assistance with their personal problems; the extent of current collaboration among faith-based organizations and mental health agencies; and congregational, ministerial, and other factors that influence the extent of outreach programs, including mental health services delivery programs. Such efforts promise to increase and improve the quality of the literature in this area.

Practice Implications

The research findings from this literature review suggest a number of implications for social work practitioners. First, it is important that social workers conduct a systematic assessment of churches and other religious institutions found in their service delivery area. At the most fundamental level, this would involve an overall census of churches in the community that would include both larger churches that have an established history in the community, as well as smaller storefront churches. On a more detailed level, this assessment would examine various characteristics of churches, such as congregation age and socioeconomic status, educational background and religious training of clergy, and clergy orientation, with respect to community activism. Similarly, it is important to understand the current programs and services that operate within an individual black church, the history of their development, and their existing (or potential) connections to similar programs organized by city, state, and federal agencies. These and other factors provide some indication of the resources and capacities inherent in churches and their possible orientation toward partnerships with social work practitioners.

The role of the minister or pastor is pivotal in the development and operation of church-based services and programs and in the delivery

of mental health services. For many, a member of the clergy is the first professional contacted for personal problems. Although there is little systematic information on the nature and quality of mental health counseling and referral practices of clergy, there is some indication that ministers with advanced education are more likely to make referrals to mental health agencies. Among clergy more generally, however, there is little preparation in recognizing mental illness and an apparent lack of knowledge of standard referral practices and services offered by mental health agencies (Mobley et al., 1985; Winett et al., 1979). Accordingly, this is an area in which clergy and mental health agencies might collaborate with one another in addressing the mental health needs and emotional well-being of church members and community residents. Given the pivotal role of clergy in the development and implementation of various church-based health and social welfare programs, information about and contact with relevant members of the clergy is extremely important for establishing collaborative relationships with faith communities.

Second, social workers should be involved in outreach activities with the various religious institutions found in their service delivery area. In particular, they should familiarize clergy, lay officials, and church members about the type of services offered by their agencies. This could be done in several different ways, including individual meetings with clergy and lay officials, meetings with groups of church members (for example, choir or women's groups), providing pamphlets and other written materials, and making brief presentations concerning the agency as part of religious services. In addition to material about the agency and its services, social workers should provide information about appropriate procedures for referrals for services. Accurate knowledge about available services is critical for both self-referrals and referring others for needed services. Research using the National Survey of Black Americans found that among those who used a social services agency, a large percentage indicated that a friend or relative referred them and also was instrumental in facilitating the use of the agency (Taylor et al., 1987). Given clergy's pivotal role as gatekeepers to formal services, it would be particularly important to provide them with information about community agencies and their specific referral procedures.

As the preceding comments suggest, social workers should anticipate investing considerable time and energy in developing close relationships with the churches in their service delivery areas. A further suggestion for an outreach activity is that agencies designate one or more individuals to function as full- or part-time liaisons to area churches. The church liaison would be responsible for establishing a point of contact and a channel of communication between churches and the agency. This person also could incorporate a number of the recognized benefits of seeking help from ministers. Close partnerships with churches' ministers would provide access to the congregation and confer legitimacy to the church liaison and the social services agency. The church liaison could capitalize on the role of the minister as the gatekeeper to services and the specialized knowledge that ministers have regarding their congregations (for example, financial circumstances) that affect use of formal services. In addition, because the church liaison requires familiarity and ongoing relationships with the church, the liaison would develop an appreciation for the workings of the congregation that would serve to establish rapport and empathy with members of the church.

Along these lines, it might be useful for social services agencies to employ both men and women in the position of church liaison. Gender-matched pairings of congregants and a church liaison may further reduce the barriers to seeking formal care. Earlier research clearly demonstrates that ministers represent an important link to formal services. However, women in the church may be reluctant to approach a male minister about their problems (similarly, men may be hesitant to discuss their problems with female clergy) and miss an opportunity to use this resource. In these situations, a female church liaison can serve as a link to women who need formal assistance and services for physical and mental health problems.

Third, social services agencies should use a partnership model in the development of

programs with religious institutions. These types of endeavors have proven to be very successful in black churches. With the assistance and sponsorship of community health care agencies, a variety of health programs (for example, blood pressure screening, nutrition, stress reduction, smoking cessation, dental health screenings, exercise and health promotion, and general health awareness fairs) have been conducted in black churches. Along similar lines, social services agencies and churches might collaborate to develop grant proposals for church-based programs. This potentially could be an ideal partnership, given their unique and complementary resources. Churches have access to large groups of individuals (and typically physical space), whereas social services agencies have expertise in delivering services. Working alliances of this sort may be particularly important in the current political atmosphere, in which both federal and state governments are increasingly channeling funds for social services programs directly to churches.

Fourth, because clergy and lay leaders may feel unprepared to deal with some of the more serious problems confronting church members, social work agencies might consider conducting in-service training programs for clergy and lay leaders. In-service programs for clergy may be particularly helpful for determining whether a church member should be referred for formal services and what type of referral is required (for example, emergency referral for suicidal behavior or for violent tendencies toward others). Conversely, clergy could provide in-service training to social workers on how religious beliefs and practices influence the experience of personal and family problems. Collaborations of this sort might be particularly useful for clients who are facing life problems that involve issues of ultimate concern (for example, illness, disability, and death) that call into question one's basic beliefs about life (for example, spiritual meaning, suffering). For example, clergy could address issues of individual bereavement in relation to religious beliefs, as well as the grieving process within the family (for example, grief reactions or unresolved family conflicts). Clergy face issues of this sort on a regular basis, and their experience may be useful to social workers who often have difficulty counseling clients about spiritual concerns.

Fifth, social work agencies can provide administrative and technical assistance to churches. For smaller churches, in particular, assistance with accounting and spreadsheet computer programs may be quite helpful. Churches may need some level of consultation and training on how to provide volunteer-supported church-based programs. Finally, programs of social work education and training could facilitate linkages to ministerial and religious training programs (for example, seminaries and schools of divinity). For example, several schools of social work at universities that have divinity schools have either formal joint degree programs or offer elective courses that provide social work training to divinity students (for example, Boston College and the University of Chicago). Similarly, a few seminaries have social work programs (for example, Carver School of Church Social Work, Southern Baptist Theological Seminary). MSW and BSW programs also might consider developing courses that explore the link between social work and religious institutions and place students in church-based field placements. Currently at the University of Michigan, several MSW students are placed in church-based social services programs or agencies that began as church-based volunteer programs.

There are many exciting possibilities for linking the practice of social work with the work of the clergy. However, it is important to recognize that there are obstacles that may prohibit the development of effective partnerships between social workers and clergy. A fundamental hindrance to these partnerships is the potential for conflicts in perspectives and values held by professional social work and religious institutions. Social work and religious institutions share many common goals and orientations regarding the provision of support and services to individuals, families, and communities. However, there are potential differences in how they define behaviors—as illness or as moral limitations—and given that definition, the appropriate measures to be pursued to ameliorate the condition. Furthermore, social work

values emphasizing client self-determination and autonomy may be at odds with religious institutions and teachings that endorse more authoritarian relationships and patterns of interaction.

There is the potential for conflict over issues of territory encroachment and what the appropriate roles of clergy versus social work professionals should be. The human services professions often have viewed religious institutions as adversaries, despite their history of providing for the physical and mental health of individuals and communities. Social work practice that involves faith communities must acknowledge that religious institutions possess a long tradition of providing for the spiritual and social welfare needs of African Americans; have a special relationship with individuals, families, and other institutions in black communities; and are distinctive from one another with respect to organizational structure and leadership characteristics. Failure to appreciate these factors seriously would underestimate the complexities of these institutions, overlook key individuals and important resources available in black churches, and hinder efforts to create effective collaborative partnerships.

For their part, religious institutions may be reluctant to form church–social work partnerships because of longstanding mistrust of formal institutions based on past patterns of discrimination and prejudice by the helping professions in dealing with black communities. Social work professionals must reflect on whether their own personal biases with respect to religion and religious institutions influence their willingness to work in collaboration with faith communities. Commitment to examining and confronting these personal and professional biases will facilitate efforts to affiliate with religious institutions and draw on their resources to improve personal and community health.

Church–social work partnerships involve a number of difficult ethical issues. Potential conflicts over basic beliefs, values, and the goals of programs present a serious challenge to church–social work partnerships. Ministers may be reluctant to develop sexual education and AIDS prevention programs because they are inconsistent with doctrinal beliefs. Despite the prevalence of breast and prostate cancer in black communities, some ministers may be reluctant to sponsor cancer screening programs in the church because of their perception that these issues are too sensitive in nature. Finally, church–social work partnerships present complicated issues of confidentiality and privileged communication among church members, ministers, and social workers. Faced with these important issues, social workers and clergy will have to find ways to resolve these differences, at the same time preserving and strengthening their partnership.

Conclusion

Contemporary portrayals of African American life tend to focus on the social and economic problems and challenges facing this group. This perspective often overlooks the resources and strengths that have assisted black communities in overcoming formidable obstacles and barriers. This article has provided a critical review of the literature on mental health services delivery in black churches, with a particular focus on the roles that clergy assume in this process. It is important to recognize that black churches have a long tradition of assisting those in need and possess a natural community-based infrastructure for providing services to groups that are difficult to reach. The available literature certainly is limited in addressing these questions in a systematic manner. However, current evidence documents that black churches are important sources of information and services for church members and community residents.

Descriptive studies indicate that black churches provide services in the areas of assistance with basic needs of living (for example, clothing and food programs), family services, and health programs. The literature also identifies a number of organizational and resource characteristics that describe churches that offer formal programs and services. Among the important factors associated with the operation of formal programs are the resources available within the church (for example, congregation size or financial resources) and factors that characterize the ministerial staff (for example, educational background of clergy and theological and political orientation). Studies of this

sort demonstrate the differences that exist across black churches and their distinctiveness as separate entities with unique organizational structures and profiles.

Renewed interest in the role of faith communities in the delivery of health and social welfare services and programs has stimulated discussion and research in these areas and reflects an explicit attempt to identify various cultural resources and strengths existing in African American communities. The current literature, although primarily composed of descriptive studies and anecdotal evidence, is useful for providing a broad overview of church-based programs and services. However, this information is not sufficient for addressing questions concerning the correlates of programs or the linkages between churches and broader community agencies. Future research that is well-conceptualized, uses large probability samples, and undertakes rigorous examination of these issues holds promise for providing a more thorough understanding of this valuable community resource and its position in the broader context of mental health services delivery for African Americans. ■

References

Adams, R. G., & Stark, B. J. (1988). Church conservatism and services for the elderly. *Journal of Religion and Aging, 4,* 69–85.

Bentz, W. K. (1970). The clergyman's role in community mental health. *Journal of Religion and Health, 9,* 7–15.

Billingsley, A., & Caldwell, C. H. (1991). The church, the family, and the school in the African American community. *Journal of Negro Education, 60,* 427–440.

Brown, D. R., & Gary, L. E. (1994). Religious involvement and health status among African American males. *Journal of the National Medical Association, 86,* 825–831.

Brown, D. R., Ndubuisi, S. C., & Gary, L. E. (1990). Religiosity and psychological distress among blacks. *Journal of Religion and Health, 29,* 55–68.

Bryant, S., & Rakowski, W. (1992). Predictors of mortality among elderly African Americans. *Research on Aging, 14,* 50–67.

Burt, M. R., & Pittman, K. J. (1985). *Testing the safety net: The impact of changes in support programs during the Reagan administration.* Washington, DC: Urban Institute Press.

Caldwell, C. H., Chatters, L. M., Billingsley, A., & Taylor, R. J. (1995). Church-based support programs for elderly black adults: Congregational and clergy characteristics. In M. A. Kimble, S. H. McFadden, J. W. Ellor, & J. Seeber (Eds.), *Handbook on religion, spirituality, and aging.* Minneapolis: Augsburg Fortress.

Caldwell, C. H., Greene, A. D., & Billingsley, A. (1992). The black church as a family support system: Instrumental and expressive functions. *National Journal of Sociology, 6,* 21–40.

Caldwell, C. H., Greene, A. D., & Billingsley, A. (1994). Family support programs in black churches: A new look at old functions. In L. S. Kagan & B. Weisbourd (Eds.), *Putting families first* (pp. 137–160). New York: Jossey–Bass.

Call, V. R., & Heaton, T. B. (1997). Religious influences on marital stability. *Journal for the Scientific Study of Religion, 36,* 382–392.

Carson, E. D. (1990). *Black volunteers as givers and fundraisers* (Working Papers for the Center for the Study of Philanthropy), University of New York, New York.

Chalfant, H., Roberts, P. A., Heller, P. L., Briones, D., Aguirre-Hochbaum, S., & Farr, W. (1990). The clergy as a resource for those encountering psychological distress. *Review of Religious Research, 31,* 305–313.

Chang, P. M., Williams, D. R., Griffith, E., & Young, J., (1994). Church–agency relationships in the black community. *Nonprofit and Voluntary Sector Quarterly, 23,* 91–105.

Chaves, M., & Higgins, L. H. (1992). Comparing the community involvement of black and white congregations. *Journal for the Scientific Study of Religion, 31,* 425–440.

Cochran, J. K., Beeghley, L., & Bock, E. W. (1988). Religiosity and alcohol behavior: An exploration of reference group theory. *Sociological Forum, 3,* 256–276.

Domino, G., & Sevain, B. J. (1985–86). Recognition of suicide lethality and attitudes toward suicide in mental health professionals. *Omega Journal of Death and Dying, 16,* 3010–3018.

Ellison, C. G. (1993). Religious involvement and self-perception among black Americans. *Social Forces, 71,* 1027–1055.

Ellison, C. G., & Sherkat, D. E. (1995). The "semi-involuntary" institution revisited: Regional variations in church participation among black Americans. *Social Forces, 73,* 1415–1437.

Eng, E., & Hatch, J. (1991). Networking between agencies and black churches. *Prevention in Human Services, 10,* 123–146.

Eng, E., Hatch, J., & Callan, A. (1985). Institutionalizing social support through the church and the community. *Health Education Quarterly, 12,* 81–92.

Friesen, D. H. (1988). *Sex education in the seminary setting: Its effects on attitudes, knowledge, and counseling responses.* Unpublished doctoral dissertation, University of Iowa, Ames.

Frazier, E. F. (1974). *The Negro church in America.* New York: Schocken.

Gilkes, C. T. (1980). The black church as a therapeutic community: Suggested areas for research into the black religious experience. *Journal of the Interdenominational Theological Center, 8,* 29–44.

Goldscheider, C., & Mosher, W. D. (1991). Patterns of contraceptive use in the United States: The importance of religious factors. *Family Planning, 22,* 102–115.

Gottlieb, N. H., & Green, L. W. (1984). Life events, social network, life-style, and health: An analysis of the 1979 national survey of personal health practices and consequences. *Health Education Quarterly, 11, 91–105.*

Gottlieb, J. F., & Olfson, M. (1987). Current referral practices of mental health care providers. *Hospital and Community Psychiatry, 38,* 1171–1181.

Haber, D. J. (1984). Church-based programs for black caregivers of non-institutionalized elders. *Journal of Gerontological Social Work, 7,* 43–56.

Hatch, J. W., & Jackson, C. (1981, May). The North Carolina Baptist church program. *Urban Health,* 70–71.

Heaton, T. B., & Pratt, E., (1990). The effects of religious homogamy on marital satisfaction and stability. *Journal of Family Issues, 11,* 191–207.

Hong, B. A., & Wiehe, V. R. (1974). Referral patterns of the clergy. *Journal of Psychology and Theology, 2,* 291–297.

Idler, E. L., & Kasl, S. V. (1997). Religion among disabled and nondisabled persons: II. Attendance at religious services as a predictor of the course of disability. *Journal of Gerontology: Social Sciences, 52B,* S306–S316.

Kumanyika, S. K., & Charleston, J. B. (1992). Lose weight and win: A church-based weight loss program for blood pressure control among black women. *Patient Education and Counseling, 19,* 19–32.

Larson, D. B., Hohmann, A., Kessler, L., Meador, K., Boyd, J., & McSherry, E. (1988). The couch and the cloth: The need for linkage. *Hospital and Community Psychiatry, 39,* 1064–1069.

Larson, R. F. (1968). The clergyman's role in the therapeutic process: Disagreement between clergymen and psychiatrists. *Psychiatry, 31,* 250–260.

Lehrer, E. L., & Chiswick, C. *(1993).* Religion as a determinant of marital stability. *Demography, 30,* 385–404.

Levin, J. S. (1984). The role of the black church in community medicine. *Journal of the National Medical Association, 76,* 477–483.

Levin, J. S. (1986). Roles for the black pastor in preventive medicine. *Pastoral Psychology, 35,* 94–103.

Levin, J. S., Chatters, L. M., Ellison, C. G., & Taylor, R. J. (1996). Religious involvement, health outcomes, and public health practice. *Current Issues in Public Health, 2,* 220–225.

Levin, J. S., & Vanderpool, H. Y. (1992). Religious factors in physical health and the prevention of illness. *Religion and Prevention in Mental Health, 9,* 41–64.

Lincoln, C. E., & Mamiya, L. H. (1990). The black church in the African American experience. Durham, NC: Duke University Press.

Maton, K. I., & Pargament, K. I. (1987). The roles of religion in prevention and promotion. *Prevention in Human Services, 6,* 161–205.

Mays, B. E., & Nicholson, J. W. (1933). *The Negro's church.* New York: Russell & Russell.

McAdoo, H., & Crawford, V. (1990). The black church and family support programs. *Prevention and Human Services, 9,* 193–203.

Meylink, W. D., & Gorsuch, R. L. (1988). Relationship between clergy and psychologists: The empirical data. *Journal of Psychology and Christianity, 7,* 56–72.

Mobley, M. F., Katz, E. K., & Elkins, R. L. (1985). Academic psychiatry and the clergy: An analysis of ministerial referrals. *Hospital and Community Psychiatry, 36,* 79–81.

Mollica, R. R., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal

pastoral counseling activities of the clergy. *American Journal of Psychiatry, 14*, 323–328.

Mosher, W. D., Williams, J. B., & Johnson, D. P. (1992). Religion and fertility in the United States: New patterns. *Demography, 29*, 199–214.

Musick, M. A., (1996). Religion and subjective health among black and white elders. *Journal of Health and Social Behavior, 37*, 221–237.

National Council of Churches of Christ in the U.S. (1992). *Church involvement in health: Findings from a national survey.* New York: Columbia University, School of Public Health.

Neighbors, H. W. (1985). Seeking professional help for personal problems: Black Americans' use of health and mental health services. *Community Mental Health Journal, 21*, 156–166.

Neighbors, H. W. (1991). Mental health. In J. S. Jackson (Ed.), *Life in black America* (pp. 221–237). Newbury Park, CA: Sage Publications.

Neighbors, H. W., Jackson, J. S., Bowman, P. J., & Gurin, G. (1983). Stress, coping, and black mental health: Preliminary findings from a national study. *Prevention in Human Services, 2*, 5–29.

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education and Behavior, 25*, 759–777.

Nelsen, H. M., & Nelsen, A. K. (1975). *Black church in the sixties.* Lexington: University Press of Kentucky.

Olson, L. M. (1988). The religious community as a partner in health care. *Journal of Community Health, 13*, 249–257.

Olson, L. M., Reis, J., Murphy, L., & Gem, J. H. (1988). The religious community as a partner in health care. *Journal of Community Health, 13*, 249–257.

Palmer, J. L., & Sawhill, I. V. (Eds.). (1984). *The Reagan record: An assessment of America's changing domestic priorities.* Cambridge, MA: Ballinger.

Perry, E. J. (1981, May). The Memphis church-based high blood pressure program. *Urban Health*, pp. 69–70.

Report to the President from the President's Commission on Mental Health (Vol. 1). (1978). Washington, DC: U.S. Government Printing Office.

Strawbridge, W., Cohen, R., Shema, S., & Kaplan, G. (1997). Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health, 87*, 957–961.

Taylor, R. J. (1988a). Correlates of religious non-involvement among black Americans. *Review of Religious Research, 30*, 126–139.

Taylor, R. J. (1988b). Structural determinants of religious participation among black Americans. *Review of Religious Research, 30*, 114–125.

Taylor, R. J., & Chatters, L. M. (1988). Church members as a source of informal social support. *Review of Religious Research, 30*, 193–202.

Taylor, R. J., & Chatters, L. M. (1991). Religious life of black Americans. In J. S. Jackson (Ed.), *Life in black America* (pp. 105–123). Newbury Park, CA: Sage Publications.

Taylor, R. J., Thornton, M. C., & Chatters, L. M. (1987). Black Americans' perceptions of the socio- historical role of the church. *Journal of Black Studies, 18*, 123–138.

Thomas, M. E., & Holmes, B. (1992). Determinants of satisfaction for blacks and whites. *Sociological Quarterly, 33*, 459–472.

Thomas, S. B., Quinn, S. C., Billingsley, A., & Caldwell, C. H. (1994). The characteristics of northern black churches with community health outreach programs. *American Journal of Public Health, 84*, 575–579.

Veroff, J., Douvan, E., & Kulka, R. (1981). *The inner American: A self portrait from 1957 to 1976.* New York: Basic Books.

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology, 7*, 271–280.

Weaver, A. (1995). Has there been a failure to prepare and support parish-based clergy in the role as front-line community mental health workers? A review. *Journal of Pastoral Care, 49*, 129–147.

Wilkes, P. (1990, December). The hands that would shape our souls. *Atlantic Monthly*, pp. 59–88.

Williams, C., Jr., & Williams, H. B. (1984). Contemporary voluntary associations in the urban black church: The development and growth of mutual aid societies. *Journal of Voluntary Action Research, 13*, 19–30.

Williams, D. R. (1994). The measurement of religion in epidemiologic studies: Problems and prospects. In J. S. Levin (Ed.), *Religion in aging and health: Theoretical foundations and methodological*

frontiers (pp. 125–148). Thousand Oaks, CA: Sage Publications.

Winett, R. A., Major, J. S., & Stewart, G. (1979). Mental health treatment and referral practices of clergy and physician caregivers. *Journal of Community Psychology, 7*, 318–323.

Winston, D. (1992). Churches endure as havens of hope. *Progressions: The Black Church in America, 4*, 1–4.

***Robert Joseph Taylor**, MSW, PhD, is professor, School of Social Work, University of Michigan, Ann Arbor, MI 48109. **Christopher G. Ellison**, PhD, is associate professor, Department of Sociology, University of Texas at Austin. **Linda M. Chatters**, PhD, is associate professor, School of Public Health, University of Michigan, Ann Arbor. **Jeffrey S. Levin**, PhD, MPH, is senior research fellow, National Institute for Healthcare Research, Rockville, MD. **Karen D. Lincoln**, MSW, MA, is graduate research assistant, School of Social Work, University of Michigan, Ann Arbor. Address correspondence to Robert Joseph Taylor, School of Social Work, University of Michigan, Ann Arbor, MI 48109; e-mail: rjtaylor@umich.edu.*

Original manuscript received December 22, 1997
Final revision received July 31, 1998
Accepted September 7, 1998

COLUMBIA UNIVERSITY
IN THE CITY OF NEW YORK
SCHOOL OF SOCIAL WORK

The Columbia University School of Social Work invites nominations and applications for four

ENDOWED PROFESSORSHIPS

The Maurice V. Russell Professorship in Social *Policy and Social Work Practice.*
The appointee to the Russell Professorship must have a distinguished record of teaching, research and practice in social policy or in clinical or advanced generalist practice. Preference will be accorded to candidates with a master's and/or a doctoral degree in social work.

The John Smart Centennial Professorship.
The first appointee to the Smart Centennial Professorship must have a distinguished record of teaching, research and practice about programs that promote independent and autonomous functioning. Preference will be accorded to candidates with a master's and/or a doctoral degree in social work.

The Sylvia D. and Mose J. Firestone Centennial *Professorship in Clinical Social Work.*
The appointee to the Firestone Professorship must have a distinguished record of teaching, research and practice in clinical social work. Candidates must have a master's and/or a doctoral degree in social work.

The Marion Kenworthy Professorship of Psychiatry in Social Work. The appointee to the Kenworthy Professorship must have a distinguished record of teaching, research and practice in psychiatry and must be able to relate this expertise to social work education, particularly regarding human behavior and the social environment. Candidates must have an M.D. degree and advanced training in psychiatry.

Successful candidates must have nationally or internationally recognized research and publications in the above areas as well as a continuing record of exceptional teaching and innovation in the classroom. The candidate should be able to mentor students and junior faculty in ways that enhance the profession. Endowed Professors will exercise a leadership role in the School, particularly in procurement of major grants, collaborative research, and curriculum development in the cited areas.

Nominations and applications should be forwarded to:

Ronald A. Feldman, Dean

**COLUMBIA UNIVERSITY
SCHOOL OF SOCIAL WORK**
622 West 113th Street, New York, NY 10025

Columbia University is an affirmative action/equal opportunity employer. Minority and women candidates are especially urged to apply.