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THE CLERGY AS A RESOURCE FOR THOSE ENCOUNTERING PSYCHOLOGICAL DISTRESS[1]

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The counseling role of clergy has been seen as threatened by the profession-alization of mental health care. There are two reasons to reject this view. First, a theologically and psychologically sound program for training pastors in counseling has been growing for more than 50 years. Second, research find-ings, spanning a period of more than 20 years, consistently show that the clergy is the most frequently sought source of help for psychological distress.

Findings reported in this study are based on a sample of 806 respondents selected from El Paso, Texas. As in past research, the clergy continue to be by far the most popular source of help for a personal problem. Popularity of the clergy as a help resource is not significantly affected by religious affiliation, but is affected by ethnicity, church attendance, and socioeconomic status.

Among other conclusions, it is suggested that an intensive community mental health care orientation be promoted among clergy, practitioners of family medicine, psychiatrists/psychologists, and psychiatric social workers.

Since Blizzard's pioneering work on the Protestant parish minister (1956a; 1956b; 1985) a plethora of research activity has been conducted on the changing role of Catholic, Protestant and Jewish clergy in the United States. Two excellent reviews of this literature (Mills, 1985; Nelsen, 1985) have uncovered the existence of two underlying themes. Secularization and accompanying professionalization are widely perceived to be contributing factors in declining prestige and scope of the clergy role.

As in other contemporary professions, the clergy are becoming more special-ized. Historical functions performed by clergypersons have been absorbed by other professionals. An example of this loss of function is the alleged divestiture of counseling from the clergyperson's role. According to Roof (1982) and Mills (1985), professionalization in the mental health field has presented a special prob-lem for the clergy as counselor.

Without doubt, secularization and professionalization have impacted the clergy along with other professionals. Nevertheless, we reject the view that the clergy are experiencing lower prestige or losing out to mental health professionals within the general area of counseling.

There are, in fact, two reasons to reject this view. First, a viable and psychologi-

cally oriented pastoral counseling movement has been active for more than 50 years. Since 1963 a highly professionalized organization, the American Association of Pastoral Counselors has provided pastoral counseling training based on theology and psychology/psychotherapy (for a history of this movement see VanWagner, 1983; Strunk, 1984). While some disagreement exists about amount and type of training needed (see Hiltner, 1964; Clinebell, 1964) it is widely recognized that counseling is a vital part of the parish minister's role (Switzer, 1983; Hiltner, 1949).

A second reason for rejection is grounded in empirical data. Research conducted over a period of more than twenty years indicates that the clergyperson is the most frequently sought source of help for problems of psychological distress. In general, these studies show that about 40 percent of those seeking help for psychological distress prefer going to a member of the clergy over other possible sources of care (see, e.g., Gurin, Veroff and Feld, 1960; Srole et al., 1962; Bell et al. 1976; Kulka, Veroff and Douvan, 1979; and Veroff, Kulka and Douvan, 1981).

Presented here are research results again demonstrating that the clergy are mentioned most frequently as a source of help for general psychological distress. Unlike other research, we were able to assess joint effects of religious affiliation, frequency of church attendance, ethnicity (defined as degree of Mexican acculturation) and socioeconomic status on propensity to seek the clergy for mental health counseling.

METHODS

A stratified random sample of 806 respondents residing in the El Paso Standard Metropolitan Statistical Area was selected and interviewed in 1985 and 1986. Six census tracts were selected representing upper-middle, middle- and lower-class areas for Anglos and Hispanics. The underrepresentation of upper-middle-class Hispanics and lower-class Anglos in the city's census tracts necessitated some deviation from randomness. A combination of random and quota sampling was devised for these groups.

Every attempt was made to ensure representative sampling of Hispanic and Anglo respondents. In all, 783 of the 806 respondents could be classified without ambiguity as belonging to one of our three ethnic categories: Mexican (N = 141), Mexican-American (N = 305), or Anglo-American (N = 337). The 23 non-classifiable respondents have been excluded from all statistical analysis.

Data were collected through face-to-face interviews with a structured interview schedule. The questionnaire was originally written in English and subsequently translated into Spanish by means of a cross-translation procedure. The interview schedule was administered in Spanish or English depending upon the respondent's preference.

Variable Measures

Two dependent variables were operationalized for this research. Readiness for self-referral to a particular mental health care source was measured, with slight modification, by a series of questions included in the research of Kulka, Veroff and

Douvan (1979:3-4). These questions pertained to actual and potential utilization of existing mental health care resources for broadly defined personal problems.

Respondents were asked:

Sometimes people are very unhappy, or nervous and irritable, all of the time. Sometimes in a marriage, husband and wife just can't get along with each other. Or sometimes it's a personal problem with a child or a job.

Sometimes when people have problems like this they go someplace for help. Sometimes they go to a doctor, minister, or priest. Sometimes they go to a special place for handling personal problems—like a psychiatrist, marriage counselor or social agency. How about you—have you ever gone anywhere like that for advice and help with a personal problem?

Respondents answering in the affirmative were asked, "Where did you go for help?" Respondents were not prodded on their answers. Answers were either noted on a list provided on the interview schedule or noted verbatim under the category "other."

Respondents answering "no" to the above question were asked, "Can you think of anything that's happened to you— any problem you've had in the past— where going to someone like this might have helped you in any way?"

If an affirmative answer was obtained, respondents were asked:

If you had gone somewhere for help, where do you think you would have gone?

Informants responding negatively to both questions were asked a third:

Do you think you could ever have a personal problem that got so bad that you might want to go someplace for help— or do you think you could always handle things like that yourself?

Those responding, "I might need to go someplace for help" were asked: "Where do you think you would go for help if this type of problem happened to you?" Those answering "I could always handle things myself" were considered to be strongly self-help oriented.

Answers to this series of questions categorized respondents into one of four ordinal categories with regard to "readiness for self referral": (1) "strong self-help"; (2) "might need help"; (3) "could have used help"; and (4) "has used help." Sources of help were obtained for informants whose answers fell into categories 2-4. Sources of help included: (1) clergy: (2) medical doctors; (3) psychiatrist-psychologist; (4) social service agency; (5) attorney; (6) marriage counselor, and (7) other mental health sources.

A second dependent variable (tendency to select clergy as a source of help) was also defined. This dummy variable, clergy, was constructed for informants whose responses fell into self-referral response categories 2-4. Respondents citing a clergyperson as a help source were assigned the numerical value, 1, while respondents citing another type of mental health service were coded as zero.

Ethnicity and religious affiliation comprise the study's most important independent variables. Ethnicity, defined as group membership, is based on respondent's self-identification and country in which he or she was reared. Mexicans are respondents who define themselves as either Mexican or Mexican-American but have experienced most or all of their childhood rearing in Mexico. The Mexican-American category consists of respondents defining themselves as Mexican or Mexican-American but who have experienced most or all of their childhood rearing in the United States. A third ethnic group is comprised of respondents defining themselves as Anglo.

A second measure of ethnicity, used in the multiple regression analyses reported below, is defined in accordance with the suggestion made by a number of authors (e.g., Oimeda, Martinez and Martinez, 1978; Yancy, Eriksen and Juliani, 1978; Mirowsky and Ross, 1984) that ethnicity is a continuous rather than discrete variable. Ethnicity here is defined as degree of Mexican acculturation.

A Mexican acculturation scale was derived from factor analysis of several items developed by Cuellar, Harris and Jasso (1980). Scale items measure the degree to which the following activities and events are important to each respondent: Mexican songs, fiestas, culture, television shows, radio stations, movies, authors, jokes, music and sports. Cronbach's alpha for this scale is .962.

Religious affiliation is defined in terms of respondent's religious preference. Religious categories include: Roman Catholic, liberal Protestant (including Disciples of Christ, Episcopalians, Methodists and Presbyterians), and conservative Protestant (e.g. Southern Baptist, Church of Christ, other Baptists and sectarians). In multiple regression analysis, religious affiliation is treated in dummy form with Roman Catholics serving as the comparison category.

Control variables to be used in a multiple regression analysis include frequency of church attendance, socioeconomic status, age and sex. Attendance is measured in ordinal form from "never attend" to "attend at least once a week."

Education and income are combined into one summated socioeconomic status scale with each SES variable multiplied by its relative z-score. Age is defined as respondent's age at last birthday. Sex is defined as a dummy variable with females and males assigned numerical values of one and zero respectively.

FINDINGS

As in the national findings of studies cited above, it is clear (see Table 1) that for El Paso residents the clergy are by far the most popular source of help for a personal problem. In decreasing order of popularity (after clergy) are doctors (other than psychiatrists), psychiatrists, psychologists, and social service agencies

Table 1

SOURCE OF HELP SELECTED BY EL PASO RESPONDENTS WHO HAVE "USED HELP", "COULD HAVE USED HELP", OR "MIGHT HAVE USED HELP." (N=530)[a]

Source of Help	N	%[b]
Clergy	215	41
Medical doctor	156	29
Psychiatrist - Psychologist[c]	114	21
Social service agency	96	18
Attorney	68	13
Marriage counselor	63	12
Other mental health source	16	03

[a]Responses were not ascertained for four of the 534 respondents possessing some readiness for self-referral.
[b]Column totals more than 100% because some respondents mentioned more than one source.
[c]Seventy-two respondents mentioned a psychiatrist; 42 preferred a psychologist.

(including social workers). Attorneys, marriage counselors and "other" sources of mental health care are mentioned by no more than 13 percent of the sample.

Religious Affiliation and Ethnicity

The popularity of the clergy as a help resource among El Paso respondents is not significantly affected by religious affiliation. Among the sample's 127 Roman Catholics, 28 percent selected a clergyperson as an actual or potential mental health care source. Among liberal (N = 25) and conservative (N = 48) Protestants, these percentages were 29 and 31 percent respectively.

Ethnicity does influence selection of the clergy for help with a personal problem. From the viewpoint that Mexico constitutes a more traditional society than that of the United States, one would predict that of the study's three ethnic groupings, Mexicans would be most likely to choose a clergyperson as a help resource.

Our results support this hypothesis. Anglo- and Mexican-American respondents tend to be quite similar in tendency to see the clergy as a general mental health resource (26 and 27 percent respectively). However, 32 percent of the Mexican respondents view the clergy in this way.

Further evidence for this finding is presented in Table 2 a-c. This table summarizes step-wise multiple regression analysis predicting propensity to select the clergy as a general source for mental health care. Included in analysis are religious affiliation and ethnicity (defined as degree of Mexican acculturation). Subtable 2a shows relative effects of these variables on clergy choice without inclusion of control variables. At this point in the analysis, liberal Protestants are significantly more likely than Roman Catholics to select a member of the clergy. Degree of Mexican acculturation is also positively and significantly associated with clergy selection.

Inclusion of control variables in subtables b and c of Table 2 shows that the most important contributor to clergy selection is frequency of church attendance. Inclusion of this variable improves the amount of explained variance in clergy selection by about five percent. Socioeconomic status also positively associates with clergy selection. It should be noted that even with the inclusion of all independent and control variables, degree of Mexican acculturation remains significantly and positively associated with selection of clergy as a general mental health resource.

CONCLUSIONS

In terms of sources of referral sought, the most clinically trained mental health professionals (i.e. psychiatrists, psychologists and psychiatric social workers) are less popular than either the clergy or medical doctors and the clergy were by far the most frequently mentioned source of self-referral.

One conclusion that could be drawn from our findings is that seminaries should include more courses on pastoral counseling and clinical experience in their curricula, a process that has been underway since the 1940s (Strunk, 1984) and continues to be improved today (Duncombe, 1988). This view has merit if the pastor is seen as another version of psychologist or, more likely, a "gatekeeper" (see Gorsuch and Meylink, 1986; Meylink and Gorsuch, 1986; Bentz, 1970, 1972; Rumberger

Table 2$_{a-c}$

UNSTANDARDIZED AND (STANDARDIZED) REGRESSION COEFFICIENTS FOR PREDICTING
SELECTION OF CLERGY FOR A PERSONAL PROBLEM

Subtable 2 a. Effects of Religious Affiliation and Degree of Mexican Acculturation

Independent Variables	Dependent Variable: Tendency to Select Clergy	
Religious Affiliation[a]		
Liberal Protestant	.075	(.067)*
Conservative Protestant	.054	(.038)
Degree of Mexican Acculturation	.006	(.101)**
R^2 = .01		

Subtable 2 b. Entering Frequency of Church Attendance

Liberal Protestant	.093	(.082)*
Conservative Protestant	.040	(.028)
Degree of Mexican Acculturation	.003	(.048)
Church Attendance	.076	(.082)***
R^2 = .06		

Subtable 2 c. Entering Socioeconomic Status, Age and Sex

Liberal Protestant	.070	(.062)
Conservative Protestant	.052	(.022)
Degree of Mexican Acculturation	.005	(.082)*
Church Attendance	.075	(.224)***
Socioeconomic Status	.022	(.086)*
Age	1.775	(.007)
Sex	.021	(.024)
R^2 = .06		

[a]Dummy variables with Roman Catholic serving as comparison category.

*p = .05
**p = .01
***p = .001

and Rogers, 1982) for entry into care by psychologists and psychiatrists. We reject the notion of the clergy as either gatekeeper or simply a substitute psychiatrist.

The popularity of the pastor as a source of help may be due to the fact that he or she has something different to offer in terms of spiritual resources undergirding this type of counseling. As Hiltner and Colston (1961) suggest, the context of pastoral counseling, especially its setting and the expectation of the counselee, are vital factors in the choice of clergy as a source of help.

A second conclusion could be drawn that the clergy do, in fact, act as gatekeepers. Studies concerned with the relationship between pastors and mental health professionals suggest that psychologists and psychiatrists view the clergy in this "gatekeeping" role (Meylink and Gorsuch, 1986). Pastors are seen as the help seeker's first contact, but it is expected that they will quickly refer clients to "more appropriate" resources (Bentz, 1970, 1972; Rumberger and Rogers, 1982). Research shows, however, that clergy seldom refer help seekers to psychiatrists and

psychologists. Meylink and Gorsuch (1986) report that less than 10 percent (sometimes less than 5 percent) of those coming to the clergy for help are ever referred to other mental health professionals. Researchers in this area suggest that attempts be made to work out a bi-directional referral system between psychologists/ psychiatrists and the clergy (Gorsuch and Meylink, 1986; Meylink and Gorsuch, 1986).

We would agree with this latter alternative and reject the gatekeeper model by suggesting the need for an intensive community mental health care orientation among the clergy, and/or practitioners of family medicine, psychiatrist/psychologists and psychiatric social workers. People would continue to do what they already do—go to different sources depending upon perception of need and obtain guidance from those sources most suited to their specific problem by way of a referral system between clergy and mental health professionals. In other words, clergy/mental-health professional referral should be a two-way street.

We conclude that individuals seek the clergy for help in times of psychological distress because they are seeking something other than general psychological help. In part this choice may be due to a wish not to internalize problems but find external reasons for them. It is also probable that, at least for church-goers, those seeking help are looking for it within what is a familiar environment.

Another reason for clergy popularity may have to do with labeling and stigma. The mental health clinic, and even private care, may represent a foreign environment for the potential client and carry with it connotations of craziness. In general, we conclude that those coming to the clergy for help in times of psychological distress are seeking religious rather than psychological counseling. Spiritual help appears to be what they want. Research seems to indicate that more attention should be given to the unique contribution the clergy offer as clergy rather than "apprentice" psychologists (see Hiltner, 1960, Browning, 1984; Switzer, 1983).

As usual, we must suggest that more research is needed. The study from which these data were drawn was not primarily concerned with why a particular resource was utilized. Rather our research focused on help seeking behavior. Research is thus question of why clergypersons are most frequently sought in cases of psychological distress.

NOTES

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