4-2016

A Grounded Theory Exploration of Clergy's Counseling Referral Practices in Black Churches

Morgan R.C. McCain
University of Nebraska-Lincoln, morgan8806@hotmail.com

Follow this and additional works at: http://digitalcommons.unl.edu/cehsdiss

Part of the Counseling Psychology Commons, and the Educational Psychology Commons

http://digitalcommons.unl.edu/cehsdiss/264

This Article is brought to you for free and open access by the Education and Human Sciences, College of (CEHS) at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Public Access Theses and Dissertations from the College of Education and Human Sciences by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.
A GROUNDED THEORY EXPLORATION OF CLERGY’S COUNSELING REFERRAL PRACTICES IN BLACK CHURCHES

by

Morgan R.C. McCain

A DISSERTATION

Presented to the Faculty of
The Graduate College at the University of Nebraska
In Partial Fulfillment of Requirements
For the Degree of Doctor of Philosophy

Major: Psychological Studies in Education
(Counseling Psychology)

Under the Supervision of Professor Michael J. Scheel

Lincoln, Nebraska

April, 2016
According to the National Institute of Mental Health (2008) nearly one-third of American adults experience a diagnosable mental disorder in any given year. Of those who experience mental illness only one in three will actually seek professional help (Obasi & Leong, 2009). This number becomes even smaller for people of African descent. African Americans are less likely to seek professional help for their personal problems (Cramer, 1999) because of barriers like inadequate health insurance and stigma. However, there are fewer challenges associated with African Americans seeking help from religious leaders (Chiang, Hunter, & Yeh, 2004). By their involvement in different communities, religious leaders are reasonably respected and trusted by many African Americans (Taylor, Chatters, & Levin, 2004). Therefore, many of their congregants may turn to them for help dealing with their personal issues. Religious leaders are presented with mental health concerns similar to that of counselors (Larson, 1988), but unlike counselors they may not recognize symptoms of serious mental illness (Farrel & Goebert, 2008). Consequently, in addition to other factors, religious leaders may fail to make counseling referrals when appropriate. The purpose of this study was to explore the referral process religious leaders engage in at Black churches. The Clergy Referral Process Model was developed using the information the participants of this study provided. The themes that make up the Clergy Referral Process Model include: understanding self, discussing mental health, relationship with parishioners, including staff, arranging a meeting, assessing need, spirituality, referring, barriers,
and follow-up. The model developed from this study provides a framework for understanding the referral process clergy in Black churches engage and it can be used to encourage clergy to begin making counseling referrals or increase the number of referrals being made.
Dedication

For my mother and grandmother, Phyllis and Rose. I thought about you both every step of the way and I hope I’ve made you proud. I wish I could celebrate with you; you are both missed.
Acknowledgements

I am extremely grateful for the love, support, and encouragement from my family and friends. To Sherman, thank you for your patience, especially during moments when I was stressed and overwhelmed with tasks. To my siblings, thank you for reminding me that I am human and mistakes are both normal and recoverable. To my nieces and nephews, thank you for the laughs, y’all make me smile constantly. And to Luna, you are such an awesome dog!

To my Sorors in the Lincoln Alumnae and Omicron chapters of Delta Sigma Theta Sorority, Incorporated, thank you for keeping me grounded. Thank you for helping me to remember that the work I do is important and necessary. You all model excellence in your own unique ways and inspire me to be and do better.

To my close friends in the program, Belinda, Lindsey, Nicole, Jess, and Janice, thank you for your empathy, listening ears, and words of encouragement. You comforted me when I needed it and challenged me when I didn’t want to be. To my advisor, Michael J. Scheel, Ph.D., ABPP, thank you for your guidance. To my committee members, Drs. Neeta Kantamneni, Wayne Babchuk, and Helen Moore, thank you for your advice and support in helping me to become the professional I am. To my mentors in Counseling and Psychological Services, Ms. Charlie Foster, Sonya Gray Belcher, Ph.D., and Tricia Besett-Alesch, Ph.D., thank you for always being there for me when I needed you.

Finally, to my participants, thank you for taking the time to share your experiences with me. It was truly humbling to hear your stories and to capture the genuine love you all have for the work you do and people you serve.
Table of Contents

Chapter 1: Introduction .......................................................................................................................... 1
  Purpose Statement and Research Questions ......................................................................................... 5
  Definition of Terms ................................................................................................................................. 6
  Researcher Positioning ............................................................................................................................ 7

Chapter 2: Literature Review .................................................................................................................. 10
  Help Seeking Behaviors of African Americans ....................................................................................... 10
  The Socio-Historical Role of the Black Church ....................................................................................... 15
  Church Therapy .................................................................................................................................... 19
  Collaborative Care ................................................................................................................................. 26

Chapter 3: Methodology .......................................................................................................................... 30
  Qualitative ............................................................................................................................................... 30
  Grounded Theory ................................................................................................................................... 30
  Participants ........................................................................................................................................... 32
  Procedures ............................................................................................................................................ 36
  Ethical Concerns ..................................................................................................................................... 40

Chapter 4: Findings ................................................................................................................................. 42
  The Model: Clergy Referral Process ......................................................................................................... 42
    Phase I: Before We Meet ....................................................................................................................... 45
    Phase II: Let’s Meet ............................................................................................................................. 68
    Phase III: Now That We’ve Met ........................................................................................................... 97
  Recommendations to Enhance the Model ............................................................................................... 107

Chapter 5: Discussion ............................................................................................................................... 111
Chapter 1: Introduction

A large number of people in the United States experience mental illness. According to the National Institute of Mental Health (2008) nearly one-third of American adults experience a diagnosable mental disorder in any given year. That means of the 313.9 million people currently living in the United States, nearly 104.6 million of them experience a mental, behavioral, or emotional disorder that significantly affects their functioning and is diagnosable by the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (National Institute of Mental Health, 2008). Of those who experience mental illness, only one in three will actually seek professional help (Obasi & Leong, 2009). This number becomes even smaller for people of African descent.

Research investigating the help-seeking attitudes and behaviors of African Americans is plentiful, but results mixed (Cramer, 1999; Vogel & Wei, 2005). Some scholars have suggested that African Americans are more likely to seek professional help than any other ethnic group when the illness they are experiencing is intense and frequent (Vogel & Wei, 2005). However, more have found just the opposite to be true. Even when gravely distressed, African Americans are less likely to seek professional help for their personal problems (Bender et al., 2007; Cramer, 1999; Masuda et al., 2009). Multiple barriers such as transportation, inadequate health insurance, and stigma have been identified to help explain the latter pattern. Fortunately, studies have also been conducted to further our understanding of how these barriers can be minimized in order to increase individuals’ help seeking behaviors (Snowden, 1999). Counseling provided by religious leaders is an alternative source of support many African Americans may seek because there are less of the aforementioned barriers (Chiang, Hunter, & Yeh, 2004).
Approximately forty percent of Americans wanting help for emotional problems seek counsel from religious leaders (Weaver, 1995; Dell, 2004). Reasons for this large and growing figure are numerous. For starters, the services provided by religious leaders are free. Congregants neither have to pay religious leaders for pastoral counseling nor do they need insurance to cover the expense. There are also no stigmatizing diagnoses made or documented to insurance companies. Furthermore, since people visit religious leaders for a variety of reasons, a mental health visit does not necessarily standout, which further reduces stigma (Bissonette, 1979). African Americans may also prefer to speak with religious leaders about their mental health concerns because of the relationships they have built with their religious leaders through their church and community involvement (McRae, Thompson, & Cooper, 1999). Besides the spiritual services they provide, religious leaders and the institutions they serve in have had a profound influence on African American communities for a long time. Black churches were and continue to be safe places for Black people to congregate and organize particularly during harsh social periods. In the 1960s, pastors (e.g., Rev. Dr. Martin Luther King Jr.) and other church leaders were truly community leaders; they planned and facilitated many of the civil rights demonstrations that have become famous in American history. Their commitment to their communities garners them trust from the people who witness their involvement. The varying roles of religious leaders have granted them access, legitimate access according to Bissonette (1979), to individuals’ private worlds. This may also be because religious leaders are seen as intermediaries between God and the people (Belgrave & Allison, 2010). People seem to trust their pastor to help them in culturally appropriate ways. This really allows religious leaders to operate as indigenous healers, “Using strategies that originate within the culture to treat the members of that cultural group,” (Belgrave & Allison, 2010, p. 111). With many people in
general and African Americans in particular turning to religious leaders for help, one might question if religious leaders are actually able to help. To this, Wampold (2007) would answer yes. Wampold (2007) argued that religious counseling is an alternative to psychological healing practices, but pastors and mental health professionals are trained differently. He reported that religious leaders are trained in the supernatural whereas psychologists are trained in psychological, empirically based, healing practices. This is not to suggest that one type of healing practice is better than the other, but rather they offer different forms of healing based on different epistemologies. As counseling psychologists, we work with clients to identify and hopefully remediate primary concerns with which they present in counseling. We intentionally select interventions that have proven to satisfactorily help with a specific change process and we evaluate outcomes. When we are unable to responsibly help a client, we refer our clients to other professionals who may be better able to assist them. We even have professional guidelines to support this process (APA, 2002). Since many African Americans are turning to religious leaders for their mental health needs, understanding what these leaders do to help their congregants is valuable.

Researchers suggest that religious leaders tend to use faith-based strategies to support their congregants (Neighbors, Musick, & Williams, 1998). They may encourage a person struggling with bereavement to pray about their circumstance and discuss their feelings with other churchgoers who may have experienced something similar and are able to offer support. Most African American congregants find solutions like these helpful (Neighbors et al., 1998), but does everyone? If religious leaders feel unequipped to help the people that come to them with mental health problems, do they refer these people to other religious helpers, or might they also
consider psychologically oriented helpers? The referral habits of clergy have only been superficially explored.

Two major findings emerge from the limited and dated research examining the referral practices of clergy. The first finding focuses on qualities of clergy making referrals. From the work of Mollica and colleagues (1986) we know Black clergy make more referrals than White clergy and clergy with more years of education are more willing to make referrals than those with less education. The second, and perhaps more important finding, is that the majority of religious leaders do not make counseling referrals. In fact, clergy refer less than ten percent of the individuals who see them to a mental health specialist (Meylink & Gorsuch, 1988). One reason for this is that religious leaders have difficulty recognizing serious symptoms of mental illness (Lee, 1976). Thus, they may continue to use pastoral counseling to assist with the care of their congregants when alternative services may be more beneficial. Even if they recognize the mental health needs of their congregants, religious leaders are often unaware of the services provided by different counseling agencies and how to get their congregants connected (Mobley, Katz, & Elkins, 1985). Since religious leaders are typically the first treatment contact for individuals seeking mental health care (Wang, Berglund, & Kessler, 2003), but they feel inadequately trained to recognize mental illness symptoms (Farrel & Goebert, 2008), there seems to be an opportunity to educate them about mental health resources. Such training might increase the number of counseling referrals they make. However, exploring the referral process some religious leaders already implement may inform a future teaching model that fits appropriately within their context that can be used to educate clergy about how that process looks.
Purpose Statement and Research Questions

The purpose of this study is to develop a theory and model of the process religious leaders enact to make counseling referrals for their primarily African American congregants demonstrating or professing mental health concerns. This study also explores factors that influence religious leaders decision to refer to mental health professionals. A grounded theory approach is taken to gain an understanding of the referral process religious leaders use to support their African American church members and the conditions necessary to initiate this process. The primary question driving this study is: What are the processes and experiences that influence religious leaders’ referral practices with their primarily African American congregants who have mental health concerns? To get a better understanding of this central question, I pose the following sub-questions:

1. What intrapersonal and interpersonal experiences may influence religious leaders decisions to make counseling referrals?
2. What client experiences and conditions may influence religious leaders decisions to make counseling referrals?
3. What explicit and implicit criteria do religious leaders use to determine who should be referred for counseling services?
4. How is a counseling referral made?
5. What barriers are perceived by religious leaders to exist in making referrals?
6. What improvements do religious leaders suggest to make the process more effective and useful?

These questions are believed to cover the entire referral process. Responses from participants would provide insight about how religious leaders go about making counseling
referrals and recommendations to improve the referral process. From this, a model can develop and be used to empower religious leaders who want to make counseling referrals.

**Definition of Terms**

Throughout this paper the words “Black,” “African American,” and “people of African descent” will be used interchangeably. These terms describe people who reside in the United States and have African ancestry. The mix of racial and ethnic terms represents the mixed, albeit sometimes incorrect, use of racial and ethnic constructs in research to describe a singular, heterogeneous group of people.

In addition, the terms religious leaders and clergy will be used interchangeably. In the United States Religious Landscape Survey conducted by the Pew Research Center’s Forum on Religion and Public Life (2009), 87% of African Americans identified themselves as belonging to a religious group. Of this percentage, 75% of African Americans reported belonging to historically Black Protestant denominations; the favored denomination was Baptist (40%). Within this tradition two positions are ordained, pastors and deacons. Although participants in this study are not required to espouse a Protestant belief system, this study will be referring to pastors and deacons when the terms religious leaders or clergy are used unless otherwise specified.

Also important to discuss is what is meant by a mental health concern. The National Institute of Mental Health (2008) defines a mental health concern as a mental, behavioral, or emotional disorder that significantly affects a person’s functioning and is diagnosable by criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders IV-TR*. This is the meaning that is implied when mental health concern is mentioned throughout this paper.
Finally, what is meant by referral process is explained here. The phrase referral process will be used to describe the process that clergy engage in to decide whether or not to provide a mental health care referral to congregants with identified mental health concerns. Although there are many referrals clergy can make (e.g., referrals to other clergy), this study is only interested in referrals to a psychologist or other mental health care professionals providing therapeutic services.

**Researcher Positioning**

Researcher positioning or reflectivity refers to the reflective process researchers engage in to make clear their stance in the research they are conducting (Creswell, 2013). The process requires that the researcher critically reflect on and state his or her biases, dispositions, and assumptions regarding the research being done (Merriam, 2009). This helps to protect the integrity of the research and provides readers with a lens to understand the study. Furthermore, readers can discern for themselves the validity of conclusions drawn from the data once a researcher has made his or her stance explicit. Thus, researcher positioning is a critical element to a well-constructed qualitative study.

I, Morgan McCain, am a sixth-year doctoral candidate in the Counseling Psychology Program of the Educational Psychology Department at the University of Nebraska-Lincoln. The need and desire to help remediate mental illness in Black communities is what drew me to the counseling field and continues to impassion me. However, as I learned and experienced many African Americans reluctance to seek psychotherapy, I was disheartened. I knew and observed many African Americans experiencing emotional distress and saw that many of them would turn to family, friends, and the people in their church for support. This piqued my curiosity about the kind of support religious leaders in particular, were offering. I wondered how they were helping
the people they encountered and further, I wondered if there were opportunities to collaborate and serve as a referral source when they felt that some issues were beyond their scope of expertise. I value the role and work of religious leaders, but I see their ability to help people as different from the help trained psychologists can provide. Unlike religious leaders, I believe psychologists are trained to view issues from a variety of perspectives, using structures of thought like the bio-psycho-social-spiritual model, and develop a variety of treatment solutions based on the diverse needs of their clients. I believe religious leaders can be effective with clients, but that their strategies may be limited to spiritual ones. Nonetheless, I hope they make use of trained mental health practitioners when they feel they are not being helpful and this hope may influence my interpretation of the data.

I believe it is also important to express my relationship to religion. My grandmother raised me as a Jehovah’s Witness, but for as long as I can remember I never subscribed to any of the teachings. As a child, I was upset that I could not participate in the holidays my friends celebrated (e.g., birthdays, Christmas, Easter). As I grew older, I did not believe in the submissive or uneducated role the religion promoted women to fulfill. Now, I consider myself spiritual and I believe there is a higher power, but I am not sure what to call him, her, or it. Nevertheless, I see how important religion is to other people and I think it is important to honor that even if it differs from my belief. My goal is to be of service in the Black community and if the church is where many Black people go for support, I will go there and anywhere else that seems to have an important function in this community.

I am also a Black woman. I hold great pride in my ethnicity and gender, but find my ethnicity to be more salient to my identity than gender. As a Black woman, I feel obligated to give back to the Black community when ever possible. I believe this comes from a deep love and
appreciation for my ancestors, both distant and immediate. When I think about the work that 
clergy do in their Black churches and communities, paid and unpaid, I get excited thinking about 
the connection to service we share. This positive affection may bias me throughout the study, 
including the interview, data collection, data analysis, and interpretation of the results.
Chapter 2: Literature Review

Help Seeking Behaviors of African Americans

Although people of color in the United States experience mental illness at the same rate as the general population (Leong et al., 1995), African Americans carry a disproportionate burden with respect to unmet mental health needs (Lindsey et al., 2006). Even when experiencing severe mental illness such as a personality disorder, African Americans are less likely to use formal counseling services compared to their White counterparts (Bender et al., 2007; Masuda et al., 2009). Multiple studies have been conducted to explore and attempt to explain why many African Americans are reluctant to seek traditional mental health services (Crosby & Bossley, 2012; Whaley, 2001) and several factors are involved. A major finding is that African Americans tend to perceive psychological help-seeking negatively (Crosby & Bossley, 2012; Whaley, 2001), which may lead to discomfort in talking to mental health professionals (Gonzalez, Algeria, Prihoda, Copeland, & Zeber, 2011). Other barriers are also prominent and discussed below.

Cost and transportation barriers. Even for people who want to receive professional mental health services, they must figure out how they are going to pay for treatment and arrive at a therapist’s location. When it comes to the economic barriers many African Americans face, the high cost of receiving services is no secret, but the financial resources available oftentimes are (Dobalian & Rivers, 2008). For those who have insurance, navigating the coverage for mental health issues can be confusing even for the most eager consumer. For many African Americans who do not have insurance, mental health services are usually a luxury they cannot afford. Transportation is another concern. Dobalian and Rivers (2008) found that people who seek help typically live within twenty minutes of their therapist’s office. This becomes an issue for African
Americans in highly populated metropolitan areas who may ride the bus or live considerably far from the nearest mental health clinic. Unfortunately, the cost of services and transportation issues are only two barriers researchers regularly discuss, but there are others.

**Cultural mistrust barrier.** Another barrier frequently discussed in the literature is cultural mistrust. Cultural mistrust is the belief that another person will not understand or may misinterpret experiences of an individual because they do not share similar backgrounds (Nickerson, Helms, & Terrell, 1994). Cultural mistrust has been found to significantly predict help seeking attitudes. Many African Americans believe that if and when they enter therapy, their therapist will be White (Sanders Thompson, Bazile, & Akbar, 2004). Though studies have not indicated therapist race or ethnic preferences among African Americans, people in this group may reserve some cultural mistrust toward White therapists because of a history of mistreatment. Nickerson and colleagues (1994) found that Black college students often avoided therapy because they were certain White therapists would misinterpret their issues and pathologize their experiences. There may have also been a fear that their therapist would not fully understand the oppression they face on an ongoing basis. The stigmas associated with being labeled mentally ill often deters African Americans from seeking therapy and this also represents the final barrier consistently mentioned in the literature.

**Stigma barrier.** Stigma is the most cited reason African Americans do not seek help (Bathje & Pryor, 2011; Vogel, Wade, & Haake, 2006; Vogel, Wade, & Hackler, 2007). Blaine (2000) describes stigma as, “The perception of being flawed because of a personal or physical characteristic that is regarded as socially unacceptable” (as cited in Vogel et al., 2006, p. 325). Differentiating between public and self-stigma helps to further define stigma. Public stigma involves peoples’ unacceptable beliefs and negative reactions to a person dealing with a mental
illness (Bathje & Pryor, 2011). For instance, people may believe that persons with a mental illness are inherently dangerous or somehow responsible for their illness. This belief may cause them to inappropriately respond to individuals they meet with a mental illness. Other reactions may be affective such as being fearful around a person with a mental illness or having a lack of sympathy. Self-stigma is the internalized experience of a person possessing a stigmatizing characteristic (Bathje & Pryor, 2011). For a person to stigmatize him or herself, he or she must be aware of and endorse public stigmas. Because individuals with self-stigma label themselves as unacceptable, their self-esteem and self-worth reduces as a result of self-labeling. These individuals more than likely experience emotions of shame, fear, alienation, and embarrassment, which are all central to self-stigma.

Having a diagnosed psychological disorder and the act of seeking treatment can both be stigmatizing (Bathje & Pryor, 2011). People may bypass mental health professionals to avoid any label of mental illness. They may also choose not to seek help because the act alone could be interpreted as a sign of weakness or acknowledgement of failure. Unfortunately, having the need to see someone could essentially be worse than the suffering for African Americans who endorse and internalize public stigmas.

Discussing barriers is necessary to understand why a large number of African Americans are reluctant to seek help from professional mental health practitioners. The cost of services, issues related to transportation, the perception of cultural mistrust, and stigmas associated with counseling services are some the major barriers discussed in the literature. However, there are other important topics requiring discussion in order to fully understand the help seeking issues for this population. To further this discussion, the incongruence between African American culture and westernized counseling follows.
**Cultural incongruence.** In a number of ways, African American culture is at odds with western forms of counseling. Components of African American culture include interdependence in relationships, reliance on nonverbal cues, keeping family problems private, and cultivating a relationship with God (Taylor, Chatters, & Levin, 2004). African American culture is communal/collectivistic and people rely on others heavily. Traditional roles may be expanded to include more responsibilities. Extended family members, for example, may function as a primary caretaker for young children in the absence of a parent or guardian. Heavy reliance on nonverbal communication cues is also characteristic of Black culture. Out of historical necessity, gauging their safety based on peoples’ body language, African Americans are more likely than any other ethnic group to rely on nonverbal cues than other forms of communication (Sue & Sue, 2007). Also important in this culture is keeping family problems private. For one family member to share a problem, particularly a mental health problem, brings a fear that the entire family will be negatively judged and reputation unsalvageable. With the many stereotypes already working against African Americans, keeping family problems private is a protective measure. Finally, cultivating a relationship with God is perceived as necessary. Going to church is a vehicle for enhancing this relationship, which is why many African Americans attend church on a regular basis. Values like these make western conceptualizations of counseling incongruent for many African Americans.

Western forms of counseling encourage independence, individuality, direct verbal communication styles, and there tends to be a clear distinction between mind and body (Constantine, Meyers, Kindaichi, & Moore, 2004). Therefore, people from different cultural groups that value collectivism instead of independence, nonverbal communication styles over verbal ones, and see a connection between mind, body, and spirit, may find western forms of
counseling unfit for their worldview (Ibrahim, 1991). Counseling in the United States has been criticized as being ethnocentric, monocultural, and inherently biased against ethnic and racial minorities as well as other culturally diverse groups (Ojelade et al., 2011; Sue & Sue, 2007). Grills and Rowe (1998) express this sentiment specifically with regard to African Americans as they claim, “Professional psychology is ill-equipped to serve as the theoretical foundation for examining the mental health needs of African Americans due to ideas of universality, tendency towards reductionism, overemphasis on pathology, and overreliance on the Western European scientific method,” (p. 72-73). In this vein, psychotherapy may be a “culturally inappropriate mode of service delivery” in some aspects and may explain ethnic and racial minorities underutilization of traditional counseling services (Kim & Omizo, 2003, p. 344). This conflict may also promote African Americans to seek help from religious leaders who are a form of indigenous healers.

**Indigenous healing/healers.** Constantine and colleagues (2004) define indigenous healing as “the helping beliefs and strategies that originate within a culture or society and that are designed for treating the members of a given cultural group,” (p. 111). Simply put, Ojelade and colleagues (2011) describe indigenous healing as interventions developed and used by people of a particular society. Indigenous healing is a culturally constructed care system that is influenced by historical, social, and cultural variables. Furthermore, indigenous practices encompass collectively held knowledge and beliefs regarding the cause, manifestation, and mitigation of mental health concerns among members of a specific group. Oftentimes, fewer stigmas are associated with seeing indigenous healers for mental health services and it is less expensive than formalized psychotherapy. Indigenous healing also tends to be less culturally biased than traditional forms of therapy for people of color (Constantine et al., 2004). All things considered,
this helps illustrate why African Americans are turning to professional mental health practitioners less and religious leaders more.

Many African Americans turn to family members, close friends, and their church leaders to have their mental health needs met (Carter, 2000; McMiller & Weisz, 1996). Religious help-seeking in particular has been positively associated with religiosity, religious involvement, and inversely related to positive attitudes toward psychological help seeking (Crosby & Bossley, 2012). Next to doctors, clergy are the most sought out source of assistance for serious personal problems in the Black community according to the National Survey of Black Americans (data collected from 1987-1992; as cited in Taylor, Chatters, & Levin, 2004). Veroff and colleagues (1981) argued that clergy are the first and sometimes only option African Americans seek for their mental health needs despite the availability of psychologists, psychiatrists, professional counselors, marriage and family therapists, social workers and others. Given the various roles church leaders have played in African American history, this should come as no surprise.

**The Socio-Historical Role of the Black Church**

How did religion become a central part of African American culture? How did clergy come to have much influence in the African American community? To fully grasp the answers to these questions one must start with an examination of slavery in the United States. Cook and Wiley (2014) provide exceptional coverage of this history.

In their chapter in the second edition of the *Handbook of Psychotherapy and Religious Diversity*, Cook and Wiley (2014) state that African slaves took comfort in the Presence of God in order to cope with the atrocities of slavery. They shared that when African slaves were able to, they congregated in secret meetings to draw strength from one another. They used music and dance to both praise God, despite the suffering they were experiencing, and to communicate with
each other covertly (Phelps, 1990 as cited by Cook & Wiley, 2014). When European
slaveholders attempted to Christianize their slaves, Phelps (1990) reported African slaves
“adapted Christian forms of worship to their native spirituality, particularly adopting aspects that
provided solace in their enslavement,” (as cited by Cook & Wiley, 2014, p. 375). Though
slaveholders tended to use Christianity as a way to justify slavery, Jesus became a liberating
figure for enslaved persons. Many identified with his persecution, were strengthened by his
perseverance, and found hope in his resurrection (Lincoln & Mamiya, 1990 as cited by Cook &
Wiley, 2014). As African slaves began to form distinct ideas about religion and Christianity in
particular, the Black church was set to develop.

The catalysts for Black churches to develop were forced segregation and racism in White
congregations. Emerging in the late 1700s, these churches either operated independently as
African American controlled denominations or were predominantly African American churches
Per Holt, Lewellyn, and Rathweg (2005; as cited by Cook and Wiley, 2014), six core beliefs
unite Black churches:

1. God is in charge and has a plan for each of us.
2. God is fair and just.
3. God is omnipotent.
4. God is all-knowing and will not burden a person with more than they can bare.
5. God and creation are basically good.
6. God is forgiving and merciful.

In the Black church, African Americans were empowered by these core beliefs. They found
purpose in their suffering and were emotionally protected by their faith; they became equipped
with tools to cope with being treated as animalistic property. Furthermore, African slaves learned of their “freedom to be all that God intended,” and this became a mantra for people of African descent to fight for equality in America. From this, social justice movements erupted on the behalf of African Americans across the country.

Black churches were used as headquarters for organizing fights against slavery, planning for civil rights demonstrations, and other grassroots operations. Floyd-Thomas and others (2007) called Black churches “powerbrokers” in the fight for African American freedom and justice in the United States. Black churches were and continue to be a social, political, familial, psychological, and healing institution (McRae, Carey, Anderson-Scott, 1998). Especially during harsh social conditions, Black churches remained an oasis for Black people to feel safe, validated, and advocated for and a majority of African Americans recognize the significance of this space and the people who used it.

Using the National Survey of Black Americans, Taylor and his colleagues (1987) discovered that 82.2% of respondents stated that the church has had a beneficial influence on the circumstances of Blacks in America. (4.9% said it hurt Blacks and 12.1% reported no difference). Churches and clergy have provided spiritual assistance, personal support and aid, set guidelines for moral behavior, an organizational infrastructure by serving as a community gathering place, a source of ideological unity, a sustaining and strengthening influence for communities and individuals, and has actively encouraged social progress from Black Americans (McRae et al., 1998). Additionally, these churches have sponsored outreach programs intended to address the social ills of the membership and community it was nestled in. Billingsley (1999) also reported outreach services that included family counseling, teen parenting seminars, youth prevention programs, support programs for ex-offenders, as well as collaborations with social agencies.
There have also been antipoverty and material aid programs (Chaves & Higgins, 1992),
programs for the elderly and their caregivers (Caldwell et al., 1995), and programs promoting
general health (Eng & Hatch, 1991). Though a majority of African Americans identify with the
Protestant tradition of Christianity, most Black people, regardless of church affiliation, recognize
the role of the church in responding to the psychological, social, cultural, economic, educational,
and political needs of the community (Cook, 1993; Taylor et al., 2004; Wiley, 1991).

Today, African Americans endorse religion as a very important part of their lives more
than any other ethnic group in the United States (Pew Research Center, Pew Forum on Religion
& Public Life, 2009). With the primary role the church played in the liberation of African
Americans, this finding is easy to imagine and makes sense. Over 80% of African Americans
living in the United States consider religion “somewhat” important in their lives and over half
attend religious services at least a few times each month (Pew Research Center, Pew Forum on
Religion & Public Life, 2009). For those who do not attend church on a regular basis, they still
claim to pray on a daily basis and make financial contributions to a church. While talking about
the evolution of the Black church, one cannot minimize the role and presence of clergy. They
were either in the shadows completing tasks to support their membership or at the forefront
leading charges for change. In fact, clergy have had changing positions within different church
organizations. Their roles have involved community leadership, development, and empowerment.
They have also facilitated relations between Black communities, social institutions, and
organizations within a broader society (Taylor, Chatters, & Levin, 2004). Beyond some of these
critical roles clergy have played in their communities, clergy have also occupied the role of
counselor to assist with the personal problems of their congregants (Taylor, Ellison, Chatters,
Levin, & Lincoln, 2000).
Church Therapy

Black churches have multiple systems of support that can be offered to individuals. There are therapeutic aspects of church services, formal and informal community service programs, and formal and informal counseling services (Billingsley, 1999; Cook, 1993; Floyd-Thomas et al., 2007; Wiley, 1991). Cook and Wiley (2014) turn to Floyd-Thomas and colleagues (2007) to help showcase the therapeutic aspects of church services. They explain that music, preaching, and praying contribute to the healing through “bodily, emotional, relational, and spiritual restoration…evoking in people recognition and acceptance of a present and acting God in their unfolding life story and their imagining a way forward with God,” (p. 189). Additionally, scripture reading, pastoral prayers, and sermons guide congregants through reflections on the ways that their life stories are woven into God’s story to “reframe or fashion their stories in hopeful ways,” (p. 189). Furthermore, singing, clapping, dancing, shouting, and praying sustain worshipers through open “expression of feelings, tending to these feelings, and invoking in them the resources from God and community that can see them through difficulty,” (p.189). By the end of a worship service, attendants have been armed with hope, healing, care, and empowerment to help manage their daily lives; going to service has changed them. Cook and Wiley (2014) suggest “the therapeutic value of worship experiences may lead some congregants to believe that if they worship, pray, and live their faith, then they do not need traditional counseling,” (p. 381-382). However, if churchgoers do feel they need extra support, they can receive it from formal and informal community service programs or counseling services.

It is not unusual for clergy and other church administrators to develop formal and informal community service programs based on the needs of their membership. According to Cook and Wiley (2014) most African American churches have developed resources for the basic
needs of the community, including food, shelter, financial sustenance, education, child care, health care, communications, political action, safety and security, cultural expression, transportation, emotional support, and recreation. These resources are available to congregants and are often extended to the local community. When individuals have utilized the church services, participated in community programs, and yet still feel they need more support, they also have the option of seeking individualized support from clergy.

There are a variety of reasons African Americans may turn to clergy for help dealing with their mental health issues. Because of the work they do in their communities, clergy tend to have established rapport in many Black communities. This helps them to be regarded as trustworthy, respectful, and understanding. Another reason is that talking to ministers is free. When pastors or deacons talk individually with the members of their churches, they do not charge them or have to bill insurance. Accessing these individuals is easier and there are fewer stigmas associated with asking for help in this context. People seeking help from ministers may also share a belief about the nature of a problem and how to cope with that problem. For example, if a congregant is grieving a deceased relative, he or she may believe prayer is the best healing solution and that belief would more than likely be supported by his or her minister. Beck (2004, 2006) stated that because religious leaders view problems as spiritual ones, this is the primary reason African Americans had a preference for religious counseling. They also trusted their pastors to help with their problems because they viewed them as an intermediary between God and themselves and believed they could help with any issue they presented to them (Belgrave & Allison, 2010).

Indeed, clergy counsel on a wide range of issues. In a study conducted by Larson and colleagues (1988), they found that clergy counseled on topics such as alcoholism, differing forms of substance abuse, depression, marital and family conflict, teenage pregnancy, unemployment,
and legal problems. Mattis and colleagues (2007) similarly discovered that these same topics were covered in their investigation of the presenting problems pastors encountered. They also suggested that many African Americans went to clergy for counseling on religious and spiritual development, general advice and guidance on life decisions, romantic relationships, grief and bereavement, hospitalizations, unplanned pregnancies, and financial and work-related concerns. Additionally, they put forward that congregants call upon pastors to influence family members during conflicts and to assist with job disputes, believing a pastor’s influence extends into the larger society. These topics are not so different from ones psychologists and other mental health practitioners are presented with, but what is dissimilar is perhaps the help provided. Clergy may help with problems using religious coping (e.g., prayer, reading the Bible) and/or prescribing specific action to help the individual (Neighbors et al., 1998). Neighbors and colleagues (1998) found that people who used clergy are more likely to report satisfaction with their encounter and say they would refer others for this type of assistance. Although pastors are regularly solicited for mental health help and spend a significant amount of time engaged in individual counseling, it is only a recent development that pastors have become more open to the benefits of mental health counseling (i.e., non-faith based) for their congregation. Cook and Wiley (2014) attribute this to an increase in seminary-trained pastors as well as the inundation pastors receive and/or experience about counseling concerns beyond their professional expertise.

**Pastoral counseling training.** Pastoral counseling began as religious counseling prior to the 1900s (“Brief History,” n.d.). Before the 20th century, church leaders would listen to the troubles of individuals who approached them and offer religion-based solutions. It was Reverend Anton Boisen as well as other founders of the Clinical Pastoral Education movement who first acted on the long held knowledge that there is a link between spiritual and emotional well-being.
They were the first to place theological students in supervised contact with clients in hospitals and other settings. Religious and psychological integration emerged in the 1930s as collaboration between clergy and psychiatrists worked together more often for psychotherapeutic purposes. Once theology, spirituality, resources of faith communities, behavioral sciences, and systemic theory became integrated, pastoral counseling emerged as a professional role. When world-renowned psychologists (e.g., William James, Carl Jung, & Abraham Maslow) began to endorse the importance of one’s religious or spiritual health to one’s general health, pastoral counseling was cemented as a worthy endeavor for clergy. Caliandro expressed, “It only makes sense that religion and psychology - each of which is concerned with the fullness of the human experience - should be recognized as partners, because they function as partners within the human psyche,” (“Brief History,” n.d.). Today, pastoral counseling accounts for three million hours of treatment annually in institutional and community based agencies.

According to the American Association of Pastoral Counselors (American Association of Pastoral Counselors [AAPC], 2014), one in four individuals seek help from a faith leader. As others have reported, the AAPC has also found that this proportion is greater than that of psychiatrists and general medical doctors. The AAPC also recognizes that clergy oftentimes feel ill equipped to serve their congregants struggling with mental illness. For example, 90% of faith leaders report substance use as a significant problem in their congregations, but only 12.5% have had training on how to handle this kind of issue. Thus, the organization takes the training of pastoral counselors very seriously.

To gain membership as a certified pastoral counselor in the AAPC, an organization held in high esteem, one must meet several requirements. The first requirement involves the type of degree earned. One must either have a Bachelors and Masters degree of Divinity, a Masters or
Doctoral degree in theological/spiritual/biblical studies, or a Masters or Doctoral degree in pastoral counseling. All of these degrees must be obtained from schools that have been accredited by the U.S. Department of Education. The second requirement is that a religious body must make an endorsement to ministry on behalf of the applicant. An endorsement is a legal document that states an ordained minister is spiritually, doctrinally, educationally, and professionally qualified to represent his or her church or faith community in a specialized setting ministering to all in a religiously diverse context (Plummer, 2010). One must also be actively engaged in their local religious community. Additionally, candidates for membership must have worked for at least three years in ministry and completed a supervised self-reflective pastoral experience. A total of 375 hours of pastoral counseling must be completed as well as 125 hours of supervision; a third of the supervision must be provided by an AAPC Diplomat, Fellow, or approved training program in pastoral counseling. Nebraska offers one training program in Omaha.

The Adlerian Center in Omaha, Nebraska offers therapy, consultation, and education to meet peoples’ diverse needs. The pastoral care training provided there allows participants to learn from mental health professionals as well as receive consultation on any active cases. Participants are also provided with supplemental reading they can use to further their learning if they so choose. Some of the topics covered include a model of pastoral care and spiritual formation, understanding the dark side of leadership, developing a plan for self-care, and caring for the terminally ill and the grieving just to name a few. The training takes place over a three-month period and consists of 20 sessions lasting three hours each. Once individuals have completed this training and met all other requirements for AAPC membership they can become
certified pastoral counselors, which requires adherence to the AAPC Code of Ethics (AAPC, 2012).

The AAPC Code of Ethics (AAPC, 2012) consists of nine principles to guide behavior within pastoral counseling. The first principle is the prologue, which describes the purpose of the ethical codes. The second principle describes what professional practice looks like while the third principle discusses client relationships. Under the third principle one will read about the importance of members maintaining professional relationships with clients and avoiding harm to clients. The fourth principle involves confidentiality. Here, confidentiality seems to mimic the ethics of psychologists; it must be maintained, but can be broken in specific circumstances (e.g., client gives permission or appears to be a threat to self or others). Supervisee, student, and employee relationships represent the fifth principle. This principle explicitly details how professionals should interact with individuals in these positions without exploiting them. The sixth principle is about interprofessional relationships and how members should conduct themselves around colleagues or other professionals. The seventh principle relates to advertising. According to this principle, all advertising by and for a member of AAPC can only be done for the purpose of helping the public make informed decisions. The eighth principle is specific to research and concerns the protection of clients who may choose to participate in research. The ninth and final principle is about procedures for dealing with complaints of ethical misconduct. To be credentialed as a pastoral counselor, members must ascribe and strive to maintain these principles in all their professional work.

By this point, it has hopefully been made evident that clergy, particularly those credentialed through the AAPC, are trained to provide counseling services and they hold similar professional identities to psychologists and other mental health practitioners. There are certainly
nuances that distinguish pastoral counseling from other forms of counseling, but there is definitely some overlap. Some of this overlap was made clear in a study conducted by Giblin and Barz (1993). These researchers compared Masters level pastors and counselors’ responses to survey questions asking about their competencies in several areas. Both parties felt they had the ability to do primary prevention work and facilitate social emotional counseling. Both also reported receiving training in administrative skills and use of vocational tests. There are only a few areas that both parties seemed to significantly differ in their perceived competence. Of the 19 items listed on the survey, only 6 were significantly different suggesting either pastoral counselors or counselors felt better equipped in a particular area. Results revealed pastoral counselors felt less prepared to use personality tests, understand test construction, and use aptitude tests compared to their counselor counterparts. However, pastoral counselors felt more equipped to handle crisis interventions, do marital and family counseling, and supervise others compared to the counselors.

Though no connection has been demonstrated in research, the limitations in pastoral counselor competency may be why some individuals do not turn to clergy for mental health services. Certainly, there are topics people reported feeling uncomfortable sharing with clergy (Boyd-Franklin, 2006). Understanding the reasons why people would choose not to turn to clergy for mental health services is worth discussing.

In a focus group facilitated by Taylor and his colleagues (2004), participants shared reasons why they would not find clergy helpful. One reason provided was the need to keep family problems in the family. Some group members felt they were responsible for handling the issues in their families and to bring those problems to someone else would violate a family code. Another reason group members mentioned was that they wanted to speak directly to God and not
a “middleman.” Some also stated they did not want to give their minister a negative impression of themselves. Perhaps the most interesting reason the group gave for not talking to their ministers was a lack of trust. They expressed a fear that the information they disclosed would not be kept confidential since that was not their minister’s primary function. Boyd-Franklin (2006) discovered similar reasons why people did not go to clergy for mental health support. Issues not taken to ministers included day-to-day personal problems, family and marital conflicts, sexual concerns, reproductive and gender specific medical concerns, and some medical problems and sickness. Similar to Taylor and others, he found the reason for this is primarily because clergy do not have the same boundaries as clinicians. Though not made explicit in these studies, these remarks may also represent congregants who went to clergy and felt they were unable to help. A referral to a clinician might have been beneficial and congregants may have been more willing to discuss these topics with clinicians especially with clergy endorsement of a clinician.

**Collaborative Care**

Both psychologists and clergy seem to recognize the benefit and need to collaborate. Clergy dedicate nearly 15% of their work time to pastoral counseling and 70-90% profess a need and desire to have additional training in mental health issues (Weaver, 1995). Psychologists too have their strengths and deficits that clergy may be able to fill. Few psychologists report receiving training in any aspect of religion or spirituality while in graduate school and few seek out postgraduate opportunities in this area (Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). Not only can clergy help psychologists gain access to certain communities like the African American community, they can also help with service delivery (Weaver et al., 1997).

There are several ways clergy and psychologists can collaborate. McMinn, Chaddock, and Edwards (1998) list some in their study. Some collaborative activities they describe are
psychologists providing consultation, both parties working together on a community project, co-therapy, clergy providing consultation, clergy referral to a psychologist, and psychologists presenting seminars. The authors suggest the most common types of collaboration between these two entities are working together on a community service project, clergy making a referral to a psychologist, and psychologists presenting a seminar. Though many forms of collaboration are possible, clergy and psychologists may feel the benefits of collaboration can sometimes be unbalanced.

McMinn, Chaddock, and Edwards (1998) define collaboration as, “both parties working together and offering important expertise to solve a problem or help others,” (p. 565). However, collaboration becomes difficult when there is a lack of trust in the expertise of the other party. Clergy tend to view collaboration less favorably because they experience fewer benefits than psychologists. Oftentimes, psychologists are perceived as the experts who offer counseling services more consistently and clergy are simply the people who put in requests. Referral patterns also seem to be unidirectional with clergy providing more referrals to psychologists than vice versa. Even when psychologists do make referrals, they tend advocate for collaborative care, but when clergy make referrals they are encouraged by psychologists to “turn over” their clients. Fortunately, McMinn and colleagues also suggest ways to enhance collaboration. Having a previously established relationship, knowing of others’ professional reputation, as well as sharing beliefs and values are just some of the ways to enhance collaboration. Cultivating trust is also important. Weikart, Peggs, and Davies (1982), showed that clergy and family practice physicians who spent time together over breakfast and attended a training course together enhanced familiarity and referrals. Referrals in particular represent one of the most collaborative
activities possible for clergy and psychologists per results of the McMinn, Chaddock, and Edwards’ study (1998).

**Referrals.** The crux of the proposed study is to explore the referral practices of religious leaders. Previous work has explored why people turn to religious leaders for mental health help and the kind of help they receive from clergy, but fewer studies have been conducted to understand the referral procedures of clergy. Studies focusing on referrals have examined topics related to whether or not clergy where making referrals and the demographics of clergy making referrals. None have examined the entire referral process. Though this work has yet to be done, previous studies have laid the foundation and are discussed here.

The referral practices of clergy vary considerably, but most do not engage in this process (Gottlieb & Olfson, 1987). Only one in ten cases are referred to mental health professionals for more specialized services (Mollica, Streets, Boscarino, & Redlich, 1986; Veroff, Douvan, & Kulka, 1981; Virkler, 1979) and research has only revealed a few reasons for why this ratio is minimal. Part of the reason clergy do not make counseling referrals is because they struggle to recognize a mental health issue when it is presented. Most ministers are unfamiliar with psychopathology and symptoms of severe mental illness (Bentz, 1970; Farrel & Goebert, 2008; Gottlieb & Olfson, 1987; Virkler, 1979). They may mistake a person with depression as simply having a bad day or a person with anxiety as being circumstantially worried or flustered. Clergy also tend to underestimate the severity of psychotic symptoms compared to other mental health practitioners (Larson, 1968). As a result, they may continue meeting with someone who might benefit from professional counseling support. Additionally, symptoms are often interpreted in religious terms. Depressive symptoms may be interpreted as a test of one’s faith rather than a bio-psycho-social problem. For clergy who are able to recognize symptoms of severe mental
illness and recognize a professional limitation to help a client, they may be unable to make a referral because they are unaware of services available and offered at community health centers, university clinics, or other settings (Mobley, Katz, & Elkins, 1985). They may also be unfamiliar with referral procedures (Winett, Major, & Stewart, 1979). Though the majority of clergy are not making referrals, either because they are unable to or choose not to, those who are seem to share certain qualities.

Mollica and colleagues (1986) found that Black clergy were more likely than White clergy to make counseling referrals although both groups’ referral rates were low. Gottlieb and Olfson (1987) suggested that ministers’ education level also influences their likelihood of making a referral. They proposed that the more educated a minister is, the more likely he or she will make a clinical referral. Allen and colleagues (2010) also found this relationship with one addition. They further found that younger pastors were also more likely to make referrals to outside mental health providers than older pastors. This can bring into question when ministers choose to make referrals and how they go about that process.

Though we know the characteristics of clergy who tend to make referrals, the process by which they go about making a referral is unclear. Learning about the referral process a small percentage of clergy use will help us better understand this procedure and perhaps enhance it. Furthermore, we may be able to use what we have learned to educate other clergy and encourage them to make referrals. This study will explore specifically how religious leaders refer their congregants, whom are primarily African American, with mental health concerns.
Chapter 3: Methodology

Qualitative

Most qualitative research rests on the ontological assumption that reality is socially constructed (Merriam, 2009). Epistemologically, knowledge is gained through the individual experiences people have with phenomena and the subjective meaning they create from their experiences. This situates the purpose of qualitative research, which is to understand the uniqueness of situations in a particular context in more depth from the participants’ perspectives. When a researcher wants to explore a problem rather than use predetermined information, a qualitative study is fitting (Creswell, 2013). Creswell (2013) further suggests,

“Qualitative inquiry is appropriate when a researcher wants to empower participants, hear their stories, and minimize the power in relationships that sometimes exists between a researcher and a participant…we conduct qualitative research because we want to understand the contexts or settings in which participants in a study address a problem or issue” (p. 48).

In this study, I was interested in the process religious leaders use to refer their African American congregants with mental health issues. A qualitative approach was appropriate because it provided participants an opportunity to tell their stories. I also hoped to build rapport with participants by minimizing the perceived power between us so I could be viewed as a resource and collaborator in the future.

Grounded Theory

People often confuse grounded theory with a generic inductive qualitative model (Hood, 2007). Studies using a generic model vary from grounded theory studies in several ways including the research questions, sample, research process, data analysis, memoing procedure,
criteria for ending data collection, generalizability, range of theory, and design. A generic model would include questions that are descriptive and interpretive rather than address a process. Additionally, samples may be based upon a priori criteria that are non-theoretical and the research process is *usually* cyclical. In the data analysis phase, the focus may be on themes opposed to the development of theoretical categories. Plus, saturation may be perceived as met once added data yield no new information. Generalizability in a generic model is based upon cross population generalizability to similar cases and the goal of the design is to interpret rich data. Grounded theory is different from a generic model in several key ways.

Grounded theory is a qualitative procedure used to generate a theory about a process, action, or interaction (Creswell, 2012). A process is a sequence with identifiable markers and consists of a beginning, middle, and end (Charmaz, 2014). The benefit of this approach is that it allows researchers to “learn about the worlds they study and provides a method for developing theories to understand them,” (Charmaz, 2014, p. 10). According the Creswell (2012), this approach is most appropriate when existing theories do not address the problem a researcher is interested in or the participants a researcher wants to study. Unlike other approaches where researchers use theory to guide their study, this approach helps researchers to build a theory based on the data they collect. Theories developed using this method are often better for special populations because they fit the situation, work in practice, and are sensitive to the individuals in that setting. Grounded theory was the selected design for this study because no complete model existed to explain the referral process clergy use to manage the mental health issues they are presented with. Furthermore, I expected that by understanding this process, professional mental health practitioners could identify where they may be able to assist and possibly strengthen the
process. Of the various approaches to grounded theory, I felt Charmaz’s (2014) version was the most appropriate for my study.

Unlike traditional grounded theory methods that use data to gather facts and describe acts, Charmaz’s (2014) model focuses on the meaning ascribed to events and experiences by participants. Charmaz’s approach also advocates for a social constructivist perspective that emphasizes multiple realities and the complexity of particular worldviews and actions. Not only was I interested in the potentially diverse referral process clergy enact, but also how they felt about making referrals. I wondered, as research suggested, if qualities of a pastor (e.g., their ethnic background and educational level) influenced their willingness to make a counseling referral and how this influenced the process. Charmaz’s model also acknowledges the subjectivity of the researcher and the influence he or she can have on the study he or she is conducting. Even if I wanted to remain objective throughout my study, my position likely influenced the questions I had, how I asked my questions, and the information I took away from what participants shared. This is not necessarily a consequence of this approach, but a recognized reality of it.

Participants

Sampling. Participants in a grounded theory study do not have to be restricted to a single site (Creswell, 2013). The only requirement is that they have participated in the process the researcher is studying. For this reason, a purposeful sampling method was used for this study. Patton (2002) explained that purposeful sampling assumes that the researcher wants to know something about a specific topic and must therefore select a sample that offers the most information on that topic (as cited in Merriam, 2009). In order to get participants who could shed light on the referral process clergy use, the participants for this study met three requirements:
1. A leader at their church
2. The majority of church members are African American
3. Experience referring congregants for counseling services

To recruit participants, I emailed individuals that I suspected met the criteria for the study and invited them to participate (i.e., convenience sampling). In the email (see Appendix A), I shared an overview of the study, the purpose and goals for the study, what their participation would look like, and attached a copy of the informed consent document approved by the University of Nebraska-Lincoln’s (UNL) Institutional Review Board (IRB). Of the nine individuals I contacted using a convenience sampling method, two did not respond, one did not have experience making counseling referrals (he was a licensed mental health professional), and six agreed to participate. I phoned the individuals who agreed to participate and arranged an audio-recorded, hour long, in-person interview. Prior to the interview, I emailed the participants a copy of the interview protocol (see Appendix B) and informed them that I may not ask all the questions listed and we may discuss topics not included in the interview protocol. When I met with participants to begin the interview, I reviewed the informed consent document with them, had them sign a copy of the informed consent document, and I provided them with a copy of the informed consent document. At the end of the interview, I asked the participants to recommend and provide contact information for anyone they knew that met the criteria and might be interested in participating in the study (i.e., snowball sampling). Seven individuals were recommended using this method. I contacted the individuals (i.e., phone or email depending on the contact information provided) that were recommended for the study, explained the study, and asked if they would be willing to participate. Of the seven people I contacted, one did not respond, three did not meet the criteria for the study, and three agreed to participate. Because
additional participants were still needed after convenience and snowball sampling, I identified other clergy who met criteria using the Google search engine; I typed “Black churches in [state],” which produced several hits. I phoned six eligible religious leaders to invite them to participate, but only one responded; he agreed to participate. All participants engaged in a semi-structured interview and were informed of the possibility for a follow-up interview based on data analysis (i.e., theoretical sampling).

Sampling discontinued once saturation was reached. Saturation is reached when the researcher feels the theory is sufficiently developed and polished (Charmaz, 2014). I used discriminant sampling to determine saturation (Creswell, 2013). Discriminant sampling is a strategy where researchers obtain information from participants other than those initially interviewed to determine if the developed theory holds true for the additional participants. After collecting and analyzing data from four interviews, I developed a draft of a model for the clergy referral process in my memos. I used the information from an additional five interviews to refine the model and explore the possibility of missing elements of the model I developed. When I felt that the model was sufficiently developed, I created a final version of the model and used discriminant sampling with one participant to see if the model held true for that participant. When that occurred, saturation was reached and sampling ceased.

**Participant Characteristics.** As mentioned previously, the only requirement for individuals to participate in grounded theory qualitative research is that they have engaged in the process the researcher is studying (Creswell, 2013). Screening criteria were developed with this overarching goal in mind. As a result of using the three aforementioned screening criteria, the participants in this study composed a group with a range of experiences as clergy in Black churches operating in the Midwest. The information they shared on the demographic
questionnaire (see Appendix C) and in their semi-structured interviews allowed for understanding the phenomenon of interest, the *Clergy Referral Process*.

Table 1 displays the participants included in this study and the demographic information obtained from the demographic questionnaire. The ten clergy successfully recruited for this study represented a homogenous sample across the following characteristics. All had pastoral care or pastoral counseling training and everyone had at least one college degree; one participant had a bachelor’s degree, four had master’s degrees, and five had doctorates (two were currently working on their doctorate). Additionally, all participants currently served in the Midwest.

A range of diversity was also captured. With regard to gender, six participants identified themselves as male, three identified as female, and one did not disclose a gender. Ethnically, eight participants identified as either Black or African American, one participant identified as African/African American, and one participant did not disclose an ethnicity. The age of participants ranged from forty-six to seventy; one participant did not share his exact age, but provided a range instead (i.e., between the age of fifty-five and seventy).

All clergy were pastors at their church although their specific titles varied from Lead Pastor, Senior Pastor, and Executive Pastor; one pastor was also a chaplain at a Midwestern college. Participants held their current pastoral position from a range of six months to twenty-nine years. Their years of experience ranged from seven years to thirty-two years. Seven participants attended seminary school whereas three did not.
Procedures

Data Collection. Two forms of data were collected for this study. The first was a demographic questionnaire. The demographic questionnaire solicited information from the participants about their age, gender, ethnicity, position at the church, time in their current church position, years of experience, experience with pastoral counseling/care, the demographics of the church they are leading, highest level of education, and degree area. The participants’ responses to these questions are listed in Table 1. This information was used to provide a context for what the participants described to be their experience with the phenomenon. Charmaz (2014) recommends drafting an intensive interview guide to facilitate the interviews when needed, but also recommended the interviewer allow flexibility for interview participants to guide the conversation. Thus, a semi-structured interviewing style was selected. The interview protocol was developed using Charmaz’s (2014) recommendation of open-ended stage questions that fit
the literature examining parts of this process. As for where the interview took place, participants had the option to have their interview conducted in their church office or in an office selected by me at UNL. Nine participants chose to have the interview at their church and one decided to have the interview in an office on UNL’s campus. I conducted all the interviews, which lasted approximately one hour each. All interviews were audio-recorded with the participants’ consent and transcribed for analysis.

Once initial interviews were completed, the first stage of data analysis ensued using the constant comparative method recommended by Glaser (1998) as integral to the grounded theory method (Charmaz, 2014; Glaser, 1978; Glaser & Strauss, 1967). This process required taking information from data collection and comparing it to emerging categories. Based on the information learned from the first-round of analyses, I had the option to request a follow-up interview with participants to ask additional questions or get clarification on the first interview, but this did not occur. Other participants were interviewed and asked additional questions to contribute new information to the theorized model. After every interview, I engaged in memo writing. I wrote down my thoughts and ideas about the evolving theory throughout the interviewing and coding process. This helped me to formulate ideas about the process I was exploring and to create a sketch of the model. This cyclical process continued until the emerging theory was saturated and a substantive-level model developed.

Methodological rigor was attained through the application of credibility (Eisner, 1991), dependability and confirmability (Lincoln & Guba, 1985), and transferability (Creswell, 2013). To establish credibility, I used member checking (Eisner, 1991). After I reached saturation, I emailed the participants asking for their feedback on the theorized model as well as the analysis of the themes in the model (see Appendix D). Attached to the email were a depiction of the
theorized model and a brief description of each theme, which included quotes from the interviews conducted (see Appendix E). When I requested the participants’ feedback about the model and my conceptualization of the process, no one responded within the two weeks given. Creswell (2013) supports this “writ large” approach rather than taking actual transcripts and raw data to participants to get their views on written analyses and address what is missing (p. 252). Dependability and confirmability were established through an auditing of the research process (Lincoln & Guba, 1985). I asked Dr. Wayne Babchuk, a member of my dissertation committee and grounded theorist, to be an auditor. He reviewed the transcripts and assessed for the accuracy of the codes I developed at multiple stages of analysis. With him as my auditor and with the member checking described above, I was better able to triangulate my data. Transferability involves peoples’ ability to use the information they have learned from a study and apply that to other situations because of shared characteristics (Creswell, 2013). In this study, transferability was attained using the demographic questionnaire that participants completed. It helped to gather descriptions about the participants.

**Data Analysis.** As mentioned earlier, Charmaz’s (2006) constructivist grounded theory approach was used to analyze the data and generate a model. This process involved initial and focused coding, memoing, theoretical sampling to produce saturation, developing categories and themes, and constructing a model of the referral practices of religious leaders from the data (see Appendix F). All interviews were transcribed within a week of the interview and coded within two weeks of the interview. After the first interview was conducted and transcribed, coding began.

During the initial coding process, I carefully explored the data. While reviewing each transcript, I examined the responses participants gave to each question, using gerunds (i.e.,
transforming a verb into a noun by adding “-ing”) to note specific actions that were occurring. Following Charmaz’s (2014) recommendation, the codes I used were simple, short, open, and close to the data. In accordance to her other suggestions, I worked quickly and regularly reflected on how statements might fit a theoretical category. When creating different codes, I tried to capture what a participant had expressed, showcase an action, and detail a context. I was mindful of the labels I used because I knew this would eventually signify how a category was summarized and accounted for, which would impact my analytic interpretations. The variety of codes helped me to develop a frame for a theory to emerge. During this initial phase, I remained open to what the data presented although this may have been biased by my predispositions that I reflected on earlier. However, questioning what the data portrayed helped me to select a theoretical sample of participants that assisted me with filling the gaps of information in my initial coding. Using a grounded theory approach, I had the advantage of continuing with interviews after data analysis begun so I interviewed additional participants to gather new information. Who I chose to interview was based on the information I was trying to obtain and the theoretical sample of participants who could provide me with that information. This back-and-forth process between analysis and interviewing continued until the theorized model was saturated.

Throughout this process, I also used memoing. My memos consisted of me writing down my thoughts and ideas about the evolving theory throughout the coding process. This helped me to formulate ideas about the process I was exploring and to create a sketch of an evolving model.

Focused coding occurred after initial coding. During this phase of coding, I took the most significant or frequent codes that appeared across the participants during the initial coding phase to categorize larger amounts of data. I developed focused codes by comparing data to data and
data to codes. Although Charmaz (2014) does not prescribe axial coding to link categories and sub-categories, she suggests that it can be a useful strategy to make sense of and apply a frame to the data. While examining the data I asked myself how does a participant share something, what do they share, what their stated intentions for sharing were, and in what context did they share. Answers to these questions helped me chart the conditions for which my phenomenon of interest occurred. Next, I used focused codes to form categories. The categories added coherence to the focused codes and helped build a story. From the categories I developed themes to capture the essence of the categories. Then, I used the themes that emerged from the data to describe the Clergy Referral Process Model.

**Ethical Concerns**

The research participants’ rights were the primary ethical concerns. In this study as well as other studies, research participants have a right to know what they are volunteering for, have their identities kept confidential, withdraw their participation without consequence, and review the results. Although there were no known risks that compromised the participants’ safety and well-being, I took all necessary precautions to honor the participants’ rights. Before conducting the study, I received permission from UNL’s IRB. I also provided the participants with an informed consent document approved by the IRB that detailed the purpose of the study, what was being asked of the participants, their rights, and how the information they disclosed will be used. Participants were asked to sign a copy of the informed consent document and they were provided with a copy to keep for their records. Signed copies of the informed consent document are kept in a locked file cabinet that only I have access to. Audio-recordings of the interviews are kept on a password protected computer and field notes are locked in a file cabinet. To keep the participants’ participation confidential, I assigned pseudonyms to every participant. These
pseudonyms are the ascribed labels to identify the participants’ transcribed interviews. Once the study is complete, participants will be notified and informed how to access the paper if they wish to read it.
Chapter 4: Findings

From the rich data collected from participant interviews, a model emerged to describe the process religious leaders use to make counseling referrals for their primarily African American congregants. This model has been named the Clergy Referral Process Model. Qualitative data analysis also revealed the context in which this process occurs as well as the conditions or factors that facilitate and hinder this process. Also presented at the end of this chapter are participants’ suggestions to make the Clergy Referral Process Model better.

This chapter will outline and give a depiction of the Clergy Referral Process Model, which is based on the themes that emerged through data collection and analysis. This model has been interpreted and described in three phases. Information collected from participant interviews was utilized to showcase the richness of the model and how it was conceptualized.

The Model: Clergy Referral Process Model

The model, Clergy Referral Process Model, represents the counseling referral experience that religious leaders of predominantly Black churches in the Midwest engage in. The process is discussed from the time clergy begin to understand themselves, including, but not limited to how they define their roles in the Clergy Referral Process Model, to when a counseling referral is followed-up upon, if and when, one is provided to a parishioner. The model dissects the main process religious leaders use during the Clergy Referral Process Model into three phases, Phase I: Before We Meet, Phase II: Let’s Meet, and Phase III: Now that We’ve Met. Phase I begins with religious leaders learning about and coming to understand themselves. From this two possibilities emerge that involve clergy discussing mental health with their church members or developing relationships with church members. By hearing their pastor openly discuss mental health or developing a close relationship with their pastors, parishioners begin to trust their
pastor, which leads to a meeting being arranged. At times, parishioners may reach out to a staff member at the church instead of the pastor for a mental health concern, but ultimately the staff member relinquishes that responsibility over to the pastor, which is when he or she will arrange a meeting. All of this occurs before a meeting is held and Phase II begins. During Phase II, aptly titled Let’s Meet, the pastor privately meets with the church member to hear what is going on and the pastor assesses what he or she needs. Based on that assessment, the pastor may determine that the issue the member is presenting with is a spiritual issue, and thus an issue the pastor feels comfortable managing. Otherwise, a referral needs to be made. Sometimes, as the pastor continues to meet with a church member over a spiritual matter, the pastor may determine that what started out as a spiritual issue is actually a mental health issue and a referral needs to be made. Once clergy have decided to make a referral, multiple considerations are contemplated and Phase II is complete. Phase III consists of possible barriers to clergy connecting parishioners with mental health practitioners as well as follow-up.

The model presented incorporates all of the information gathered during data collection, including interview data and responses to the demographic questionnaire. Each element of the model is described in detail using quotations from the participants’ interviews to support how this model was conceptualized. The Clergy Referral Process Model is presented in Figure 4.1.
Figure 4.1 Clergy Referral Process Model
**Phase I: Before we meet.** Phase I deals with the conditions that are necessary to encourage parishioners to open up about their mental health concern(s) with clergy. It is the process that occurs prior to parishioners meeting with clergy for support. How clergy understand themselves, discuss mental health in their church, develop relationships with their church members, involve staff in the referral process, and arrange meetings all make up Phase I. Each of these components is discussed in greater detail below.

**Understanding self.** Once in pastoral care/counseling training or soon after receiving “the call” to minister, participants consistently discussed ways they began to understand themselves. Understanding themselves included their general feelings about mental health, how they felt when they learned about counseling referrals, when they began to accept their professional limitations, how they defined their roles, and when they started trusting counselors. These categories within the theme of understanding self are the catalysts that set the Clergy Referral Process in motion. Each category is discussed here using quotations from the participants’ interviews.

Participants were asked about their general feelings regarding mental health as a way to understand how their views of mental health may or may not contribute to their willingness to make counseling referrals. Most participants responded to this question by sharing that mental health is important to a person’s overall health. For example, Matt said:

People ought to be healthy in every area of life. We ought to strive for being healthy and that includes mental health. You know for many years as a people we did not go to counselors in part because we didn’t trust them and in part because for many years they didn’t look like us, those who were mental health professionals. We’ve probably always had people in the Black community who were engaged in mental health and engaged in
counseling, but they may not have had the specifications, the degrees and so on. And so it is something I think that is relatively new for us and then so, historically the church provided us with our mental health counseling and the church gave us what we needed to buttress ourselves in terms of mental health.

Matt was able to describe how Black people met their mental health needs in non-traditional ways that were beneficial. He stated that peoples’ mental health was critical to their overall health. Mark shared a different perspective suggesting most African Americans, particularly preachers, are harming themselves because they are not getting mental health help. However, he also showed his value for mental health when he suggested all pastors needed to get mental health help.

Come on, that’s why these preachers are killing themselves because we are not mighty. We are not God. We can’t shoulder all of this stuff. Even pastors have to refer ourselves out. In the United Methodist system, you get one month of counseling every year. Twelve sessions a year and they are documented. You got to go because that’s the only way you can stay sane. And sometimes folks can get it through just dumping, sometimes they got to dump plus getting a little something something else on the side you know, to help you to cope with some of this stuff that you deal with, but that’s what I call responsible pasturing.

Mesa confirmed Mark’s claim that United Methodist pastors are encouraged to get counseling. She said:

In the United Methodist system you have to go to a psychiatrist before you come to this system even saying that you’ve been called to be a pastor. Then you have to go again when you come to the board is about fifty some odd people and then you have to be, then
you have to go again right before you are ordained an elder to make sure in the mist of those matriculations are going through being a pastor or a student pastor or local pastor that you have recognized that there are some things that you can’t, there’s a residue that can be upon you that if you have not kind of decomposed or let those things go then you will bring them to the pulpit or bring them in your ministry so they want to make sure that you are seeing someone on a regular basis and it’s also in our package, our medical plan we have twelve free visits a year so, I take advantage of them….So they really push that you kind of have that mental health issue, holistic health, exercising and just taking care of yourself. Taking your days off. Taking your vacations. Things like that so, yeah.

Mesa also added that she perceived counseling as normal for a long time. She said her family talked about mental health problems regularly and many of them went to counseling as well.

Well, I guess counseling has been in my life, all my life because I’ve watched my mother push my father in counseling when I was around the age of fourteen or thirteen years old so it became something that was not taboo in [outside state]. We were in the south, where I was from, and with my culture in my family. So talking out issues and dealing with counselors and having different tools in your life other than the Bible, and prayer, and tarrying and understanding that God will make a way somehow. Uh, that you might need some additional help or assistance in dealing with some of the issues or circumstances within your life so that started a long time ago.

From what has been illustrated by these participants’ stories, mental health is necessary for one’s overall wellbeing. They valued their own counseling experiences or were able to see the value of counseling in other peoples’ lives. This may also be a reason why most of the participants had a positive reaction when they learned about counseling referrals.
Rick was able to recall the exact year he first learned about counseling referrals. He portrayed his initial reaction as shock, but later explained how he understood the need for counselors. He shared:

I was introduced to counseling referrals in 1996. My mentor, who was um, at the time I was the Associate Pastor and the Senior Pastor [names senior pastor] we’d do what he called pre-education classes and so even before I had my M. Div. we talked a lot about how we do pastoral care and one of those discussions was don’t be afraid to admit what you don’t know. Jesus cannot heal everyone and in the sense of if you sit in front of me and I pray for you, you’re going to be healed, that that’s not how it really works…There is a need for professional counselors and he was really big on the phrase that’s why people go to school. So that was my first introduction in pastoral care.

As can be observed from Rick’s experience, many clergy learn about counseling referrals and the necessity of them via a conversation about their limitations. Though accepting limitations is another distinct category within the theme of understanding self, conversations about knowing limitations appeared to be the typical mechanism by which participants learned about counseling referrals. For example, Mark shared:

In pastoral care and counseling we were taught very specifically that there are boundaries. We know, those who take pastoral care and counseling know what the margins are and how far we can go before we refer. And then, I spent a number of my years of ministry in the United Methodist Church and they have a well-defined process for counseling and pastors. So between those three areas of work and education I’ve become acutely aware of what it means to counsel and what it means to refer and why I counsel and why I refer.
Jeff similarly expressed:

We were told, first of all you need to know your own limitations as a pastor. You are not a professional counselor unless you have a degree in counseling. You are a spiritual counselor and we need to be able to identify how far we can go, our limitations, and know what our limitations are and in the process of knowing that, know that it is okay to make referrals when our expertise cannot help that person to make the kind of adjustment that they need to make to become a better person…I was okay with that to be honest with you. I was okay with that. Traditionally, especially within the African American community, the pastor is viewed as everything so people will not normally go beyond asking their local pastor, I mean asking somebody else other than their local pastor for any psychological help.

Once he learned about referrals, Jeff seemed to experience some relief. He accepted that he could not help everyone all the time and thus accepted the need to make referrals. Tara shared something similar. When asked if she felt okay with making counseling referrals after she learned about them, she responded by saying:

Yes, cause I mean we can’t do everything even though sometimes pastors want to. We want to fix it, but we know that we can’t always fix situations and that people have to work on those and sometimes it can be a process to get them the help and get them to the place that they want to be at.

She later added:

If you don’t feel that you can handle the problem that is at hand than it’s best to refer it out to someone. I mean not just to the counselor but if I need to send them to a doctor or even to a [hospital], I have no problem telling people that that’s where they need or
should go to seek further help. I realize it’s one thing to come and talk to the pastor because you’re looking for support or whatever, but then a counselor, a therapist is really going to help you and going to press it to where it needs to go. And so as a pastor, I can help you because you’re coming at me from possibly a spiritual sense and you trust me, but then when I realize that I’m not going to be able to move you to where you need to go, I need to help you get to where you need to go.

Now, learning about one’s limitations and the consequential need for referrals is one thing, but accepting one’s limitations is another. Though some of the participants struggled to accept that they could not manage all the problems their parishioners presented with, they all eventually came to accept their limitations. For Mark, this meant losing his messianic complex. He shared:

It was in school, in pastoral care and counseling. Through the course Pastor as Diagnostician meaning there’s a diagnosis and we can only prescribe certain medications once we understand what the issues are. And, that class was really, it was almost like a case study approach, page after page after page of situational analysis. And then you had to take the role of the pastor, take the role of the third party, so we, in that course, we had to see ministry and pastoral care and counseling from the various people that were in the equation. That allowed me to not have tunnel vision. That allowed me to understand that I don’t have to have this messianic complex where I think I can be all things to all people. That was a hard class. Because most pastors really believe, early in our ministry, we think that when we are called, [laughter] when I passed the exam right, when I can hang my shingle, I can do this! I got this! No. It’s still a collaborative approach. The quality of life is a collaborative approach. Never about me, it’s about us. And who is us? The team of
people that make sure that any one person that is under our care is served at the highest level possible…the synergy in the room was that once you became a pastor, you thought you could serve the world’s problem with prayer. You thought that you had all the answers. And that’s where we had a hard time. They chipped away at our misunderstanding of our role. That was hard.

Lisa also discussed her struggle to realize that she could not be all things to all people. She said:

At first I was trying to fix everybody’s problems and it became very frustrating for me because I didn’t, I wouldn’t accept that it was out of my fear. It was out of my fear. I needed to send it where it belonged so it would get the proper help.

Beyond what he shared about accepting his own limitations, Nate provided an added perspective about accepting the Bible’s limitations. He shared:

Well, what makes it different for me is that I think the Bible has a lot of answers and I think there are certain situations where the answers are right there, right and clear. But I think there are other situations, particularly ones I’ve been involved in regarding domestic violence with a person, where my skill set quite simply isn’t enough. And so there has to be an admission on your part that you may not have the full capability of addressing the total of all the issues.

Lucy also discussed the importance of accepting limitations by sharing the story of a colleague she once knew. Her colleague did not accept his limitations and unfortunately, it cost him and others their lives. She shared:

There was an incident in an African American Episcopal Church in [State] where a person who had been going to her pastor for pastoral counseling…The parishioner needed more than pastoral care, needed more than pastoral counseling because she had
been going to see this clergy person and his default was just pray to God and ask God for deliverance etcetera etcetera. Well a couple of days later she goes into the worship service, early morning service, during Sunday school and brings a gun. She kills the pastor, kills a couple of other people who were there and then commits suicide. So it’s like, that was such a big wake up call cause had that pastor seen the signs; what are the signs, you know? No one really ever believes that someone is in that great dire straights because it could be just a general bad day, but there’s got to be a better way for clergy, especially African American clergy to figure out what are those signs. We can’t default when people have chronic clinical issues with chemical imbalances that prayer just won’t help. You know, you really need to go and see the psychiatrist or psychologist to get the help that is necessary.

Clearly, accepting limitations can help keep people safe by getting them the help they need, especially for individuals with severe problems. However, clergy still have a role to play in the lives of parishioners and they are charged with defining that role to better understand themselves. Most defined their role as spiritual leader. For example, Jeff stated:

It was comforting to me to know that I do have limitations. I’m not an expert in every area. My area is in spirituality, it’s in God and so forth so I need to be able to say I can collaborate with others so that I can give better care to my parishioners.

Matt also defined his role as spiritually related and he was able to illustrate exactly what he sees his responsibilities are within that role. He explained:

I see myself as a Sheppard and as a friend more so than an authoritarian to the membership. I usually sum up the work of the pastor saying that my work is to lead, feed, and to oversee.
When asked to elaborate on what he meant by leading, feeding, and overseeing he said:

Lead, to the lead the people toward a mission, toward a vision, and to fulfill the purpose of the church and our purpose is to make disciples by proclaiming the gospel, obeying the gospel, and living the gospel. And so I lead them in an organized church program. I work with them in organizing a church program to achieve those ends so that’s the lead part. To feed means to teach, to preach, to feed them with the word of God and then to oversee means to be there to guide and to offer guidance and we can only guide people that want to be guided so a lot of it becomes being ready when people seek you out for guidance and to be a good steward to oversee them, but financial resources in the church and to manage and to administer the churches resources.

Nate describe his role in a different way, he considered himself a resource with his primary task as moving people from where they are to a better place, even if that means having them connect with someone else. He stated:

Well those kinds of things I think for me, coming from an educational background and knowing that oftentimes I had, I was a resource for students who needed help one way or another, whether mentally, psychologically, socially, whatever, financially. I always considered myself a resource to move people from where they are to a better place.

Trusting counselors represents that last category within the theme of understanding self. This category can almost be viewed as the outcome of what valuing mental health help, learning about referrals, accepting limitations, and defining one’s role produces, although these do not necessarily have to occur sequentially. If clergy value mental health, know their role(s), accept their limits, and are aware of and open to the possibility of needing to refer, then trusting counselors seals the potential of the Clergy Referral Process progressing to the next steps. Rick
provided an example of how he began to trust counselors after having a conversation with his mentor.

He said Jesus can’t handle everything. Oh? But we also talked [about] how Christ caring for you can look very different and just because it doesn’t come from you, you the source of, as he put it, the source of the word, just because it doesn’t come from you doesn’t mean it’s not Christ. So after that, I was like yeah you’re right.

Trusting counselors became easier for Rick when he realized that Christ works through them too. Mark also began trusting counselors when he realized counselors were not so different from clergy in what they were trying to achieve. He shared:

After about five years of ministry, what I figured out was that it really is a team approach and what I call ministry, social workers call social services. What I call ministry, you as a professional counselor will call treatment and well care. And what that allowed me to do was to understand that we have to pass the ball off at various places to effectively move that person along the continuum until they get what they really need. So you got family counselors, you have therapists, clinicians, those that prescribe, those that don’t, but that’s not my role to determine. My role is to understand.

How participants understand themselves is the first step of Phase I in the Clergy Referral Process. During this part of the process, clergy are reflecting on their values surrounding mental health, learning about referrals, understanding and accepting their limitations, defining their roles, and beginning to trust counselors. Once these things occur, the process evolves to discussing different aspects of mental health in the church and clergy building relationships with parishioners.
**Discussing mental health.** Most of the participants expressed feeling that many African American people, including the ones in their church, are leery about receiving mental health services. However, many participants further expressed an appreciation for counseling that they wanted to impress upon their congregation. Thus, they preached about mental health in their sermons as a way to lessen mental health stigmas and encourage help-seeking. For example, Rick described a series of sermons where he preached about mental health:

Mental health for me is something I preach from the pulpit. I preach mental health from the sense of, um, oh, let’s do Elijah. So Elijah runs through this mountain part and he’s clearly depressed. He sits down under the tree and he won’t get up for days. He goes into the cave and he hides and he comes to the edge of the cave and he says I wish I could die. Alright, he sits under the tree and he says enough is enough. He literally says enough is enough. I’m just going to sit here and I’m just going to die. And that to me is depression and he in the midst of his depression, he has all these awful things that are going through his head and he seeks the quiet still voice of God and so many of us can’t hear that voice amongst the chaos of life and then when people can’t hear the voice of God like Elijah did in that brief moment when he was going to jump, when they don’t hear it they jump. And that’s sad because the voice was there, it’s just they never stopped and life never stopped and nothing saved them from that moment and so when people are saying to you I’m tired, enough is enough, listen to them and at the very least don’t be the chaos around them that prevents them from hearing the voice of God. So yeah I preach mental health from the pulpit. In fact, I do a lot of series preaching. I did a five week series on depression and why it’s important that we trust people other than our pastors and even in the midst of our counseling that we get from other people that we hear God
and that we understand that God speaks in all of those moments…I preach it from the pulpit because I think it’s important

Tara shared Rick’s commitment to preaching about mental health in the pulpit. From her perspective, this was a natural conversation for her to have in order to promote a holistic ministry. She shared:

I deal with a lot. I’m very health conscious. I seek to have a holistic ministry so we have a health moment every third Sunday.

Mesa also explained that mental health is something she preaches about regularly, both from the pulpit and in church meetings. She energetically expressed:

I preach about it. I preach about therapy. I preach about counseling. I preach about getting help on my pulpit, I mean it’s probably in a sermon a month. I talk about it at meetings. I’m like, I know I’m going to call my therapist after this meeting because you all, you know. So they know I am avid, I’m an advocate pusher of talking to somebody because y’all have taken me all the way to the left, a glass of wine ain’t going to help, I’m going to need to talk to somebody. So I can go in there and say it’s okay, you know. You’re human, I know you wanted to kill him but it’s okay, you didn’t act on it [laughter]. So they know that I push.

Besides the pulpit, mental health may also be discussed in Bible study. In fact, Mesa said she preferred to talk about mental health during Bible study. She explained that in Bible study she could really go into depth about the stories in the Bible that display different concepts involving mental illness. She stated:

In the Bible study when your congregants know you and you got forty, fifty people here and they’re like yeah pastor I want to talk, let’s talk about this tonight I’m like yeah let
me find that in the Bible, it’s in there you know. What we talked about a couple of weeks ago, Jonah and the whale. I said Jonah was depressed. Depression is all in the Bible. I said don’t nobody go, here God comes and tell you to go and minister to the people that are raped, killed, and destroyed your whole community, your whole race. Then God says [to Jonah] go to them, preach to them, and they will repent and I will forgive them. He’s like, I ain’t going there. I’m going to Tosha. So he gets on up goes to the arc, gets on the boat and the boat start going crazy then the people on the boat said man what you doing, who are you. Well I’m running from the Lord. Well you got to get the hell off this boat and then they throw him off the boat. Then he end up in the whale. Then he can’t deal with the whale and the whale throw him up and he ends up in the same place where he started. So he goes and do what God tells him to do and he tells the people they need to repent and God will forgive them. He’s depressed cause he don’t want them to be forgiven because he wants them to be punished. He goes to sit down in the heat of the sun and says I want to die. And God sends compassion and grows a tree and puts shade over his head so that the sun don’t kill him, but he’s depressed and he wants to die. That ain’t nothing new and he was used by God. So can I be depressed please. They be like alright pastor we understand we got it in the book. It was old’ Jo who was depressed. So it’s things like that I think that have my parishioners that come to me and go I need to talk to you and I’m like shut the door and we going to work it out. We going to pray about it, we going to talk it out, and then we going to see somebody.

As alluded to by Mesa, discussing mental health amongst the entire congregation either during service or Bible study helps parishioners feel more comfortable learning about, accepting, and sharing their own mental health issues. By using Biblical tools, mental health is normalized
and parishioners are empowered to reach out to their pastors to discuss mental health issues. However, some pastors stated they do not preach about mental health at all. For example, Zack shared:

Sermons that focus primarily on mental health are not very interesting. People are not going to listen to a twenty-five, thirty minute sermon about mental health. Just mental health…And then let me say it another way too. Most times the relationship that exists between faith and what you call mental health um, person’s of faith use their faith in God to deal with a host of problems. And probably your research would share, suggest that Christians are less likely to seek outside counseling. They’re more likely to go within their church and then they work their way outside of the church rather than sitting down and saying well you know, I just need to go get help. Most Christians don’t do that and I don’t know what your research shows about Blacks, but most African Americans are very leery of one, particularly men, of dealing with mental health and even doctors…And African Americans sometimes can have a very negative perception of mental health issues. That if you have mental health you need to talk to someone that means you’re weak and I try to encourage people, it doesn’t mean that. It just means that you need somebody to talk to. Not that you weak, you know…And that’s a struggle. Now that’s something that I’ll say in a sermon or talking to people, observations that if you need help come and ask…And don’t feel embarrassed because you need help.

Although Zack said he has never preached about mental health, he has preached about help-seeking stigmas that may prevent people from soliciting services. Matt shared he has never discussed counseling in his sermons, but addressed concepts related to mental health in some
ways. He also added that he would be open to talking about mental health more directly in Bible study. He explicitly stated:

I have not intentionally, purposefully dealt with the subject of mental health, or counseling in sermons. I have not. I guess I’ve talked about issues we confront in our mental health, but I have never talked about counseling per say and the power of counseling, the importance of counseling, the value of it. Never have I, I don’t think I’ve done that. If I were to do it, I would be much more likely to do it in bible study where I can engage the membership.

Lisa also revealed that she never preached about mental health, but was considering doing so in the future. She took the fact that she was asked a question about this as a sign that preaching about mental health was something she needed to do. She stated:

We were trying to put something in place in order to be able to reach out…cause we’ve been talking about it and sometimes God will…it takes someone outside to confirm what He’s saying to you. Wow, that’s something, wow.

For the pastors that did discuss mental health with their congregation, the parishioners were encouraged to reach out to their pastors for support. For the pastors who did not discuss mental health, their church members still approached them with mental health concerns. Instead, the relationship these clergy had with parishioners was the condition that facilitated a meeting being arranged.

**Relationship with parishioners.** Many of the participants highlighted the importance of developing relationships with church members in the *Clergy Referral Process*. At the core of building relationships was developing trust. Many participants shared they cultivated trust by
reaching out to church members when they were doing well so that when they were not doing well, they felt comfortable reaching out to their pastor. For example, Zack stated:

Generally I have very strong relationships with people [and] their children. I try to respect people. I try to be concerned about their needs. If a person is feeling down in church, I’ll go up and talk to them and I try every Sunday to shake hands with everybody in some form. I try to talk to them when they don’t need help because I have experienced that if you don’t have a good relationship with people when they don’t need help, they’re less likely to come to you when they need help.

Tara agreed with Zack’s claim that getting to know members when they were okay helped her to be seen as a resource when they were in times of need. Tara also discussed cultivating trust with members by capitalizing on moments they invited her into their lives. This has made her incredibly close to her church members. She said:

I’m very hands on, personable, will get in with you when you invite me in. For some parents, I have access to their child’s school records. They sign the forms that if something happens, that the parent can’t get off from work, but they can call me and I can come up…I’m known to go to four families on a holiday. I be wore out, but I will get to four different families and share with them as a time to not only get to know the family that I pastor but their extended family members. I’m from the old school where the pastor became a part of the family you know, not that I go eat Sunday dinner with them every Sunday, but that we’re there and it’s not just in crisis times. That I’ve already built a relationship so that in the midst of crisis we can deal and talk and oftentimes I’m called in on those family discussions if its end of life issues because I’ve already built those relationships.
Mesa shared that she tries to be open about her struggles with her members so that they know she can relate to their difficulties. By being vulnerable with them, she cultivated trust.

Well I’m real first of all. I’m probably the most realest person you going to meet in a long time. I talk about my issues in the pulpit…Even today is a bad day. A lot of stuff is going on with my children and my grandchildren and I let them know I’m not preaching at them. God has delivered me from whatever pain or whatever dysfunction that I am talking about within this scripture, I’ve been through it so I’m not talking at you. We are going though this deliverance together.

Mesa believed her honesty and openness with her congregation helped to build relationships with church members. She felt that her realness helped church members feel more comfortable talking to her about their mental health concerns. Rick also believed that how he carried himself around his church members influenced their willingness to trust and build a relationship with him. He explained:

Who you are, well in my opinion, who you are influences peoples’ level of comfort for you. I’ve always believed I love you and I don’t care what you do, I’m going to continue to love you because I believe that’s what God’s called me to do. So in terms of that, always being open, always being willing to listen, being willing to take phone calls in the middle of the night, I think those things endear your for lack of a better word…They endear you to people and when people believe that you are genuinely out for them, that you’re supportive for them, that your fighting for them, then they’ll do that.

Lisa contributed an additional perspective to this category of cultivating trust, by introducing boundaries in her relationships with parishioners. She said she is still very personable, but wants
her church members to be able to differentiate what is her opinion versus the word of God. She revealed:

I’m very personable yet there is a boundary because not only am I [name], I’m also your pastor and so then we have to stay within those boundaries. My congregation knows very well, and I’ll tell them this is [name] talking now. Or I’ll say this is pastor talking now because some things come by my opinion and other things come strictly by the word of God. Well when it’s God speaking then that’s pastor cause that’s the gift right, but when it’s my own, you ask me for my personal opinion, okay this is [name] speaking now. And I say that because I don’t want them to say that’s not what the Bible says you know and that’s exactly what they would say so I make sure they know who they’re talking to. So I have a very personable relationship with them. Very personable.

Although all participants said they had or wanted close relationships with their parishioners, not all of them were successful. Nate suggested that building a relationship with his parishioners has been difficult for him despite wanting to have close relationships with his church members.

You know I think it’s just like a marriage, most husbands think they’re doing better than the wives do. You know, what’s your relationship? Husband says oh we’re a ten, she goes no we’re a five. I think it’s challenging because in a small church like this you should have very intimate relationships with just about everybody. But you realize, and as a peoples’ centered pastor for me, I’m really all about relationships. I want to be close to people. I want people to be close to me, but that’s not the relationship everybody wants…Some people are okay with a working relationship. Some people are okay with just a casual relationship, you know, a hi and bye kind of thing. And there are those certain members who want an intimate relationship.
Participants like Nate might have been more successful preaching about mental health than developing close relationships with parishioners, but both encourage parishioners to talk with clergy about their mental health concerns. If pastors have the luxury of having a staff, the staff may also develop relationships with parishioners that lead to a meeting.

**Including staff.** When asked how other staff members are involved with making counseling referrals, the participants explained they either do not have a staff and function independently or that their staff reports to them what is happening and they, as lead pastors, take over. Some participants further reported that even though they do not have a staff, they would prefer to function independently and handle congregants’ personal issues themselves because they feel that it is their responsibility. For example, Mesa explained:

I’m the only one that’s ordained, so if somebody else does something and it slips out, there’s no repercussions for them. They’re a lay minister or they’re a Director of Education, or my administrative assistant and I tell them my butt is on the line for this church, nobody else. So whatever you do or whatever you say and if it’s inappropriate and it slips out, you shouldn’t have said it. Guess what? You can go to another church. I lose my ordination, I lose my pension.

Rick also shared that he functioned independently when it came to pastoral care and would not have it any other way:

I’m anal in terms of counseling and pastoral care. I don’t care how large the church is. If I can’t manage all the care, if I can’t see all of the care myself then I’m not going to want to be there. Um, cause I just, and this goes back to the Bible itself, I just believe that I am ultimately responsible for those people and if something screwy happens, um, yeah that’s not going to be good. I think that I would see that as my fault.
Zack acknowledged that his parishioners may have turned to other religious leaders in his church, but he managed all crises. He shared:

They come to me. Well, we have Deacons, but generally when people have problems they going to be very leery of coming to a Deacon…People can go to others, but when the crisis is really bad, I’m like the president, you bring it to me. Now I’m quite sure there are people who have issues and concerns and they talk to someone else and I may not be aware of that, that’s more informal.

Other participants, like Jeff, shared that they too functioned independently, but want to include staff more in the future. Jeff stated:

For now, I’m the only one doing it, but we’re doing training and we have leaders. I have several kinds of ministries and one of them has to do with what we are taking about but we are going to have some trainings set aside to do that and I have talked with my wife to do a, to put together a training for us on how to go more into depth with that and what needs to be done so we haven’t done the training yet and we haven’t had anybody outside of myself to do that but once we do that and I ask my wife to do that then they will start getting involved in it.

Tara shared Jeff’s sentiments. She said that she has always functioned independently, but wanted a staff to help support her vision for a holistic ministry. She shared:

It’s just me and I find time to do it all. I hope one day I will [have a staff], but right now, cause if I can have the holistic physical, psychological, emotional, financial, economical, as well as spiritual I’m really helping the people along the way is my philosophy and that’s what my heart and passion is.
Participants with staff at their churches tended to be bigger churches. Mark is actually second in command as the Executive Pastor at his church and working under a Senior Pastor. Though he is not the Senior Pastor, he receives all reports involving mental health concerns. Mark described how staff function at his church:

In many large churches, they pastor works with a pastoral team and because of the size of our church, one person can’t do all of the work. And so we have a pastoral staff of, I have five pastors under me…My role is to manage the pastors and then I have thirteen other ministers on staff who are coming up the ranks…so I take care of all of that. The director of operations takes care of the day-to-day stuff and what we do is free [Senior Pastor] up to preach and teach and that’s all he does. He preaches and he teaches, he casts vision and if there’s a problem that I can’t solve then he and I will collaborate.

Then, Mark provided an example of a time he received a report:

One of the Deacons received a phone call from a woman who had decided that end of life was a viable alternative. She then said can I speak to minister X. Minister X just received a license to train and then he turned and called the Discipleship Pastor to let him know what was going down because he didn’t feel comfortable. He called me.

Lucy discussed other unique ways she included staff in the Clergy Referral Process. She disclosed that sometimes she asks her staff, the stewards in particular, to help connect parishioners she has spoken with to counseling services. She said, “The stewards in particular pretty much are there when I ask…when I say hey it’s time to make the phone call, they follow my leadership.” She also shared that if she notices a parishioner is mentally ill and distracting others while in church, she will signal her staff to help minimize the distraction. She explained:
I have had sort of a signal for the officers of the church when I’ve picked up on something that is out of the ordinary that may need special attention and I immediately let my officers know that when you see me do this then you need to call the authorities or the hotline etcetera because this person has greater needs than what I am able to handle. Case and point we’ve had a people who were schizophrenic, frequently come into the church and other major mental health issues and I have driven people to [hospital] or [center] and physically taken as best I can to say we love you we care for you but this place will do even greater care for you at this particular time so...I might rub my ear, I might do some kind of gesture, it just depends but they know. Like I have a couple of officers who are close to me when I’m up preaching and I may pass a note or turn around and say hey make the phone call or do this. It’s time to get this person some help

By hearing clergy discuss mental health at church, developing a relationship with clergy, or developing a relationship with a staff member who typically directs parishioners to clergy, parishioners grow comfortable confiding in their religious leader. The religious leader is someone they have grown to trust to help them. Then, they progress to the final component of Phase I, which is arranging a meeting.

*Arranging a meeting.* When participants were asked how meetings were arranged that lead to a referral being made, a variety of responses were provided. At times, parishioners approached clergy directly. Other times, clergy grew concerned about a church member and asked to speak with that member. Church members also shared their concern(s) about other church members with the pastor and the pastor would ask to meet with the struggling individual. For example, Rick explained his experience with church members approaching him:
Pastoral care normally starts with someone grabbing your arm after church and saying I need to talk to you. It doesn’t happen for the most part with a planned phone call where they say I’d like to come and see you, I’d like you to block some time out for me.

Normally it’s, when they see you, they’ve had this thing, they’ve built up the courage and they have this one split moment where they go I need to trust you, I’ve got enough strength to tell you, I’ve got to tell you this now. And if you don’t capture that most of the time you miss it so it’s all just very quick.

Tara’s also described members approaching her:

Most of the time members will come to me. I mean they might say something on Sunday and if it stays in my crawl then I might say you know we need to talk. Most of the time people will say pastor can I make an appointment to talk to you and then that’s when they’ll share.

Matt gave his perspective of experiencing other members sharing a concern about another church member:

The mother called me that morning and said, ‘I have just gotten a phone call and the person that called me was one of my son’s neighbors and she said the police are at the house and there’s people everywhere and my son maybe dead.” So, you know, in the church as a pastor quite often we are the first persons that our members call when they’re struggling.

He further added:

In the Bible it talks about discernment and um, where I can see a change in behavior. Sometimes it can be something as simple as church attendance. Somebody who has been coming regularly will suddenly stop coming. Or sometimes it’s someone who continues
to come, but I can see a difference in their countenance and their physical appearance and their whole approach and I’ll talk to them.

Lisa explained that when she noticed an issue, she does not always share her concern with the individual. She would rather have them approach her or ease into the conversation casually.

Just because you see it that doesn’t mean you jump on it. That doesn’t mean you say something. You wait for an opportunity because you don’t ever want to offend anybody or you never want to hurt any bodies feelings cause everything that Jesus did he did in love. And so you never want to do that. You wait for an opportunity cause He’ll let you know when it’s time to approach it. And then even if it doesn’t come to you, when you approach it, it will be received because he has already prepared the heart to receive it…I’ll say I need to talk to you about something. Can we meet after church for a few minutes? And then, we’ll go in the office or whatever and we’re sitting around talking and we might start out with just an idle chit chat and before you know it they’re talking about to me what I wanted to talk to them about.

Understanding how parishioners get to the point of having a meeting with their pastor is important. The purpose of arranging a meeting is so the pastor and parishioner can discuss the concern(s). Once the meeting is scheduled, Phase I is complete and Phase II begins.

**Phase II: Let’s meet.** Once a meeting has been arranged, Phase II begins. Phase II starts with clergy assessing the need of the church member they are meeting with. Through the assessment, the religious leader determines if the concern is spiritual and thus something they are able to help with. Otherwise the church member needs outside help and the pastor chooses to make a referral. Phase II is further depicted below.
Assessing need. When clergy meet with a church member, they are managing two primary tasks. First, they are attempting to define the problem. By defining the problem, they are able to determine if they can help or not. If they are unable to help, they begin the second task of deciding what needs to be referred.

To define the problem, the participants revealed several approaches. Some have developed a checklist, others ask specific questions, and others relied on their listening skills to understand what the parishioner is going through. Lisa shared that she uses a checklist that she developed to determine what is within her scope of practice. She said:

I have a checklist that I use to meet the criteria because you got to know your boundary and so to be inside my boundary, there’s certain criteria. If they don’t meet that than that means they’re outside my boundary and so then I look at referral…One of the questions that I ask is what are your hobbies? What are some of the things that you like to do? How do you feel about your dad? How do you feel about your mom? Tell me five things about yourself that you like and five things you don’t like. You’d be amazed about what you can find out about people by just asking those simply questions.

Mesa also gives her church members, new members in particular, a questionnaire when they first come to her church. The questionnaire helps her to have meaningful conversations with parishioners, which helps her to define problems. She explained:

So when our new members come and they do new members class, there’s a little maybe about eight questionnaire mixed in with spiritual awareness…How do you react when you can’t solve a problem and some of the things that people say when they can’t solve a problem kind of throws off red flags. What do you do when your back is against the wall? Some people say pray other people say that’s when the bull comes out. I had one
person say that’s when the bull come out. I’m like a bull in a china shop and I’m like you know and then on they give them to me then I say on answers four six and twelve could you tell me more. Could you kind of elaborate a bit more and then you kind of find out some stuff.

Some participants have not created a document to help define problems, but they do ask questions about why a parishioner has come to see them. For example, Mark shared:

First of all, you come to see me, hypothetically, you set up a meeting to meet with the pastor. Alright, we pray. After prayer I normally say, ‘Why are you here?’ I always ask that direct question. ‘Why are you here?’ And not as an offensive question, but I want to be real clear that before I waste our time if I can help you. And if I can’t help you, I’ll stop you. In other words I don’t have to hear the story if at the end of the story I can’t do anything for you. I’ve already prayed for discernment, Lord whatever this meeting is going to be about, be present God and allow you to speak through me that this person needs be met. So when I find a person I start with scripture and I ask the question, “Is this a spiritual matter,” and most of them say it can be. Okay, then they go a little further and we go into the scriptures and we find a scripture that meets or resembles their concern. Once we determine that it can be solved or there are scriptures that can help them deal with their issues we work down that road.

As Mark discussed, asking questions to define the problem quickly helps him to determine if he is able to help. Zack also said he prefers to ask probing questions in order to define a problem. He shared:

Once I hear the cues I ask them questions. Probing questions like what you feel like, what’s going on, what’s happening, why did you call me at this time? You know, what’s
happening in your life, how is your wife, how are your children doing, how are things going on at your job. And that gives people an opportunity to say things. If I just held the phone they would never say, but if I ask how your children are doing, how’s your wife doing, how’s your husband is doing, and so forth, uh, how you feel. Don’t tell me that you feel good, I’ll say that jokingly. How are you really feeling?

While some participants were comfortable asking parishioners’ about their problems, others preferred to take a passive approach, at least initially. Some participants shared that they try to listen for what is going on with the participant before asking questions in order to define the problem. For example, Jeff shared:

> Usually, you have to sit and listen to the person for a long period of time because usually, when people come in sometimes they camouflage what is happening to them at a deeper level with spiritual clichés. So the first thing I do, I sit down and I listen attentively to what the person is saying and I try to bypass the initial conversation and ask questions.

Due to the complexity of the issues parishioners present with, Nate said that while he is listening to church members, he is trying to define the problem by separating parts he can handle and parts he cannot. He reported:

> So as you are examining the process, examining all of that…you’re first thinking through all of these different dimensions of what has, why the problem is a problem in the first place. And that’s the first challenge is trying to ascertain okay why is this person where they are. Why is what’s going on and then what do you do about it…So let’s sit down and talk. Let’s sit down and try to get a sense of why we are where we are. I know in domestic violent situations it’s so convoluted, there’s so many pieces, there’s so many
dynamics associated with all that goes on and I have to admit that I’m not fully capable of handling all of those issues and now I have to find someone.

Nate further commented on how defining a problem can be difficult. He explained that defining any problem as something other than spiritual can be challenging.

I have enough sensibility to kind of diagnosis okay why is what’s happening and is it possible that I can help address the issues without any other issues, without anybody else being involved. And that also takes into consideration how involved the person wants other people to be because they think the same thing in many instances. They think that by coming to me that they’re going to get, they’re going to get a diagnosis and a resolution whereby they don’t need anybody else involved…Some pastors will never classify any issue as a mental health issue, they are all spiritual issues. You don’t need counselors, you don’t need other, you know, all you need is God. That’s it and by giving the issue to a human, you’re giving it to somebody who can’t, you know, God should be able to solve it. God is greater than every human so if we give it to God then we have, He has the capacity to bring the healing that no human can bring…No human being is going to be able to handle this. By taking it out of his hands you are summarily saying that He’s not capable of bringing the kind of healing that a person needs. I’ve heard that conversation before and that’s challenging cause on the one hand going, you know, that makes sense to me cause I trust in God that much. I know the transformation that He’s made in my life and you talk about mental health, I was a mental health mess. I didn’t get any counseling. I didn’t get anything, but you know what alcohol is no longer an issue. You know, smoking is no longer an issue. Staying true to one woman is no longer an issue. That didn’t happen because of counseling. It happened because of God. It
happened because of a true transformation and relationship with Jesus Christ. And so you’re in that place of saying all I need, all this person needs to do is surrender their life to Christ because that’s what happened for me…I think so many, particularly African American clergy, because I think you also have to remember if you don’t go to a seminary and you receive the call quote unquote to pastor, then in seminaries you may get a formal counseling class as a part of your ministry training but if you don’t go to seminary as many African American pastors don’t in small churches like this you usually are part of a in-house ministry training program as I was back in ’93.

As previously illustrated, defining the problem can be a strenuous task, but there are many options to complete the task. Once clergy have a firm idea about what the problem is, they must do another kind of assessment. This assessment involves deciding what to refer. Mark provided a general idea of what he feels capable of managing and how that, in turn, helps him decide what to refer.

We counsel for marriage. Pre-marital counseling, which results into post-marital counseling and even some of those end up being referred to family counseling…We counsel that way and after they are married we have couples that run into conflict. We try to do conflict resolution as part of the counseling process…We do Baptismal counseling…There is a counseling process with becoming a member of our church because we have new member orientation, new member counseling, because we have to teach and tell people what they’re getting in to. We do counseling for death and bereavement. So see what I’m saying? They’re all related to church functions. Then we do what we call crisis counseling when people call or people are frantic and we’re trying
to help ground them and make some sense out of where they are. Then we refer because usually the crisis stuff we can’t handle and at that point we send them out.

Mark stated he felt comfortable managing problems related to church functions and anything outside of that he refers. Matt described something similar. He shared:

Self, where the person identifies some deep seeded issues. Once I had a young lady who came and said that she felt that she was, that she had multiple personalities and so we talked about it and made a referral. In other words, when a person believes that they are having some mental issues or they come to me and they ask for me, me to give them a referral. I talked about the situation where the issue has many different levels and layers, that maybe if we had the time together we could unpack them but somebody who’s trained in that area would be able to take them through that process much more efficiently and effectively than I would. But um, where there has been great trauma, where there has been a sudden change of circumstances, even in some instances where there’s been something as common as grief, sometimes there’s been persons that, and of course I deal with grief all the time. We have a service, we have a funeral service on Saturday. I deal with grieving persons all the time but sometimes when a person seems to be stuck in their grief process I’ll make a referral So, situations were persons are stuck when there are many multiple levels, or where they have, they have admitted or that they believe that they have some serious mental issues and everything from suicide, consideration of suicide to feeling that they are bipolar or multiple personality because when they are familiar with the mental health nomenclature like that then that tells me that they are not, that they are open to seeing someone who works in the mental health field.
Rick also shared what he felt comfortable managing and how knowing what is in his wheelhouse helped him decide what to refer. He said it took him some time to figure out what was in his wheelhouse, but now that he knows what his abilities are, he can decide what to refer more quickly.

What you’re also doing as a pastor is you’re assessing your own abilities. You are assessing your own, what do they call it, your own wheelhouse. For me, I’m determining is this something I have counseled people in before. Let’s say it’s marriage, okay done. Did that, and she’s saying oh my husband ignores me or my husband doesn’t go to church and I need to talk about that. Great, cool, my wheelhouse, cool, got that. She comes in and she says, um, I’m having some gender identity issues I really think I’m a man or I just got some issues with gender or I got some issues with sex, something like, not in my wheelhouse.

Lisa was also able to clearly define what was in her wheelhouse, which served as a helpful guide for her to determine what she needs to refer.

So when a person first comes to you for counseling the first thing you got to do is find out what type of counseling they need and then you’ll know if it’s in your area…[my area is] Christian counseling, marriage counseling, individual counseling, but basic. When it gets to be in depth like with abuses and sexual abuses and stuff like that, that’s out of my area. But your basic counseling, female counseling, marriage counseling, some youth counseling, minor, but some youth counseling, but definitely Christian counseling. If it’s not Christian counseling I don’t know how to do it and so I send that.

Clergy’s goal when meeting with parishioners and assessing their need(s) is to determine if they can help or need to solicit outside support to meet that parishioners need(s). As mentioned
earlier by Mark, if the problem is within “church functions” or what Rick called his “wheelhouse,” the problem is likely a spiritual issue that clergy can manage. Clergy providing spiritual counseling to their church members may be an end of itself, but it may also lead to a referral based on what emerges from subsequent conversations.

**Spiritual issue.** Once clergy have assessed the need(s) of the church member they met with, it may be determined that the church member’s issue is a spiritual one. In the event that the issue is a spiritual matter exclusively, the pastor provides the necessary help to deal with that problem. However, there are times when clergy begin helping with what seems like a spiritual matter, but turns out to be or evolves into a mental health concern. Separating spirituality from mental health can be a tricky task, but necessary if the pastor wants to help the individual get their needs adequately met.

One of the ways the participants described being able to separate spirituality from a mental health concern was by recognizing unresolved, deep rooted issues. In many instances parishioners revealed a deep pain that continued to fester. For example, Jeff shared:

> Over the years I have learned my limitations. So for example, if I’m talking with somebody and this person starts to talk to me about things that happened to them in their childhood and it seems like some of those things are still playing out now I know that it’s beyond a spiritual issue. That person needs to talk to somebody to get some professional help…So if I hear that in a conversation with a person then I’ll tell the person I’ll say look as your pastor my expertise is in helping you to get adjusted spiritually but it seems to me that this is happening and I think that you’ll be better served if you get, if you seek professional help because it seems to me like some of these things that are happening in the past are playing out now in your life and I think you might need somebody who can
help you professionally to get deeper than I can get because I don’t have that expertise to do that. So he said okay if we try to find somebody who can help you professionally. Like Jeff, Matt was able to separate spirituality from other types of concerns by recognizing the depth of certain issues. He described sensing the layers of complexity in a person and feeling that a mental health professional could make a difference.

When I get to a point where I’ve said all I can say and we haven’t made any progress and I’ve given all that I can give and share all that I know how to share or when I know that the problem is something that’s bigger than my skill set and what does that mean. That means that there are layers, I sense that there are layers of complexity in that person or in the situation and to separate all those layers would take somebody who is really very skillful at that and has taken time to develop a competency in knowing that specific area of going deep. I can sit and talk to someone and I don’t even know if I’m using the term correctly, but talk therapy and Biblical study, Bible study can certainly help and make a difference, but when I sense that there are layers to it I think that’s when a health care professional, I mean a mental health professional can step in and make a difference.

Tara also acknowledged that experiencing the depth of an issue helped her to separate spiritual concerns. Like Jeff and Matt, she felt a counselor could push that person in a way that would be beneficial. She said:

When I feel that I cannot help that person. That I’m not getting them to work on areas that they need to and someone who is more equipped, schooled in how to set those action plans or those things that people need to do. I realize it’s one thing to come and talk to the pastor because you’re looking for support, but then a counselor, a therapist is really going to help you and going to press it to where it needs to go. And so as a pastor, I can help
you because you’re coming at me from possibly a spiritual sense and you trust me, but then when I realize that I’m not going to be able to move you to where you need to go, I need to help you get to where you need to go.

Lucy added to these sentiments.

If there are these constant conversations, the same conversations nothing has changed. We’re still talking about things that happened in childhood and this person is now thirty, forty years old and they’re still rehashing some of the things that took place and during the course of the conversation, say some child abuse issues may have come out, then I know immediately even though intuitively I know there is something deeper then what they are saying. Typically the way that it happens to me is that the relationship is built first before anyone feels comfortable enough to disclose a lot of especially traumatic issues and in the course of it might be weekly or monthly conversations that take place or an appointment after they feel comfortable enough with me as a pastor when those issues rise or come to the forefront than I know that this is, when it comes to child abuse or some other sort of emotional issue that I know has a deep, deep scars, that’s when I know you really need to go and work through that at a deeper level than with me to process all of this.

When the participants recognized a mental health professional could help parishioners process their pain, the participants made a counseling referral. However, participants were also likely to refer if no progress was made on a spiritual concern after prayer, encouragement, and participating in church services. Mark even suggested that getting mental health help is necessary for one’s spirituality and thus will prioritize a person’s mental health over his or her spiritual development:
We know that if we can’t deal with your mental health issues, you’ll never get to Jesus. You are never going to get to him. And we know because you go to the alter, you pray, you listen to a sermon, you hear the songs, and you go home and nothing has changed and you just keep rubbing that genie in a bottle and your problem is still there because it’s not spiritual and nobody has enough integrity to say you need a different kind of help…People can’t get spiritually developed until their mental health issues are resolved. And if you look in the Bible, in the gospels, Jesus always met need before he gave them the kingdom. He never went to you and said, “Let me tell you about God.” He went to you and said, “I see you have an issue. Let me fix your problem. Then, let me tell you about the kingdom.”

Lucy affirmed that if the spiritual tools she gives to parishioners do not work, she is also compelled to believe the issue they are dealing with is not spiritual. She also introduced a timeline many other participants agreed with for determining if an issue is spiritual or not. She shared:

Prayer is great. Meditations are good. I’m here to listen, but I am not qualified to give you what you need to get…I know it’s beyond my capacity to deal with it. And I say if I have met with a person a couple of times, three times, and we are at the same place when we made the initial contact, that’s when I say, third times a charm, go get the help that you need. I’m so confident in me that I don’t have time to keep hearing the same stuff. You know? I got a lot of people to deal with and you still stuck here so it’s probably better that you get other help.

Three times. If after three meetings with her parishioners nothing has gotten better, Lucy is confident that she cannot help and the issue is not spiritual. Mesa said something similar.
I think when I’ve spoken to them maybe three times or four times and they are still quoting scriptures to me and I’ve given them some tool, some psychological tools that they could use or I’ve given them a book that they could read that is not scripturally oriented, and they have not done any of those things and they are still just this is my cross to bear. Then I’m going no. God did not put you here to be abused or, you know. God put you here to be liberated to have life abundant and if you’re not feeling that then it’s time to let me walk you through a new process.

Zack does not indicate a number, but he does reference a lack of progress as a way to determine if a problem is outside his spiritual expertise. He stated:

No matter how much I talked to them, they had not gotten any further. It was like a repeat performance and I recognize that whatever I was doing, whether it was beyond my skills or it was beyond the level of intimacy they wanted to share with me, I recognize that uh, myself, who I was, my relationship with them and that we were not working out. We needed someone else. And then there are some people who want resolutions and I wait and see am I able through talking to them giving them some satisfactory resolutions and sometimes reading the Bible ain’t enough. They need to go to someone who has expertise in deciphering issues and concerns that most pastors are not aware of.

It would seem that separating spirituality is easy if one stuck to the aforementioned guidelines of referring deep-seeded issues or an issue that remains unresolved after multiple meetings. However, separating spirituality is not that easy. People may present with more than one issue that they need help with: one being spiritual and the other something else. Plus, it is sometimes hard not to see everything as spiritual. Jeff spoke about how he deals with separating spirituality and other concerns. To the parishioner, he says:
Based on what is happening I can say look, I think there are two components to what is happening here. One is spiritual the other one is not. I can help you with the spiritual aspect of this one, but the other one I cannot help you. So for now, let’s look at the spiritual component first and then I try to help the person spiritually and then I say look this area I cannot help you. You need to seek professional help in this regard.

Rick takes a similar approach, but included in his description how his role evolves based on the demand to manage the spiritual issue and refer the non-spiritual issue. He explained:

When people come to me and say I don’t know how to forgive this person for hurting me, that’s where it starts getting into two separate wheelhouses. Let’s say it was a female and…let’s say her father abused her. Alright, so she comes in with the initial stuff, the forgiveness, the working through it, the does God love me, all that stuff I still, I got that. Um, you know mandatory self-report I ask hey, you know, if she’s a minor is this continuing to go, I need to tell you this, that type of stuff is cared for, but I don’t really know, I don’t know how to put her back together. And so there are people who have gone for years in training to do that and so that’s when I go part of what you need is in my wheelhouse, but part of what you need is somewhere else and we have to get you there and I, and part of my job is to make you feel comfortable enough to share that with someone else who is not your spiritual leader, who’s not your pastor who you might not trust and the other part of my job is to hold your hand while you walk through it so that the stuff that is in my wheelhouse, love, care, concern providing any resource that I can, that I still have an opportunity to give that to you.

Nate shared his perspective that most pastors couch everything as a spiritual matter. For him, the line is drawn when he feels Biblical advice will not help. He shared:
I don’t think African American pastors are thinking about outsourcing anything to anybody. Okay, I think they believe they have the where with all to handle most situations that come to them regardless of what it is. You know, social, mental, because I think the challenge of it may all be couched in the fact that it’s a spiritual problem. I think that’s the thought is that most problems are spiritual problems. And if you think of them as spiritual problems then we have the spiritual textbook to handle it. Okay, and so we’ll address it that way…Sometimes they don’t want anybody else involved. You know, I’ve come to you, tell me what to do, give me some Biblical advice, some spiritual advice, pray for me, and you know, send me on my way. Okay, and then you have to ask yourself, I mean, does that solve the problem? When they come back to you with another black eye you’re like uh oh, you know what do I do now.

Obviously, if parishioners present with spiritual issues, clergy are best equipped to handle these issues and provide guidance. The Clergy Referral Process ends before a referral is ever made and that is okay if the issue is exclusively spiritual. However, if an issue becomes something other than a spiritual concern, the Clergy Referral Process continues.

**Referring.** Clergy experience this theme of Phase II if they determined a referral was needed after their initial assessment or they began spiritual counseling with a person and realized that part of the concern required outside support. At this point, clergy shared what issues they typically refer, how they go about making refers with or without guidance from a governing entity, the difference between making counseling referrals and other kinds of referrals, as well as how they go about selecting a counselor to refer to. Most participants were able to identify one or more concerns that they typically refer. Mark most typically referred for abuse.
Like anything that we would deem mental health or where there may be abuse. She got broke arm, she got a black eye, oh I’ll tell them real clear this is abuse, we ain’t dealing with this. If it’s a child, right away, defect, I’m a tell you right now I’m calling. Don’t bring them in here and I see it or I suspect the child is being abused I’m calling. But the church knows that. That’s real clear that this is not the Catholic church, this ain’t no confession booth, no no no. You beat up on a child or a child look like they being neglected or abused we’re calling. Why? Because that’s the law. We don’t play with that.

Lisa also reported that she typically refers abuse, but she added to that list neglect, sexual concerns, and identity issues.

Like I told you those that have those deep down hurts. You know, the abuse, neglect, sexual. I had um, homosexual. You know there are, those are things that are out of my sphere. I don’t know how to deal with them and so I refer those on. But I don’t have a lot that come that I don’t try to handle myself.

Rick mentioned identity concerns too. He said:

I tend to refer more if they have issues with who they are identity wise so if they’re having cultural ethnicity identity issues or if they’re having gender identity issues or anytime they say they’re suicidal, you’re out of here. You know, yeah, it's time for me to get the big guns in. The big guns for me include, hey let’s talk about how God deals with depression but at the same time let’s get you to someone who sees this all the time and they can help you walk through…I consider the mental health community in terms of the treatment people, a resource of mine. So I use all the resources I have and anytime the Bible becomes my only resource, I’ll quit.
The issues that Zack reported typically referring were different from what Mark, Lisa, and Rick shared. He said he usually refers for:

Marriage, suicide, parent/children relations, those are the general ones that I get. Some people have anger issues, well men more so than women.

Mesa referenced parenting too.

I think depression is a very high issue right now as well as inappropriate, how do you say it, at the, in the last five to ten years there are single parents that don’t know how to parent so inappropriate parenting…Grief has been one too.

Each participant was able to identify issues that they typically referred for and overall, the breath of issues they referred was diverse. For as many issues the clergy referred, the participants reported mixed results as to whether or not a governing entity outlined if and/or how they should implement referrals. For those who went to seminary school, they reported learning what to refer and when to do it, but little about how. This was reflected in the experiences of Jeff, Tara, and Mesa. Jeff explained he mostly learned about his boundaries and when to refer, but expressed there is no governing body that guides his practice of making referrals.

It was more of in the practice of ministry when you encounter this kind of situation you need to understand that you are not an expert and you need to make a referral and this is how you make a referral. You need to be able to identify resources within the community once you get to a new place and find out what the resources are and the people who you can collaborate with to make referrals. And if you are going to make a referral call the person introduce yourself to the person, you are pastor so-in-so I have this person who I would like for you to work with. Is it okay if you can work with that person if I can make that, refer to that person and that person can call you to set up an appointment if you can
work with that person and I can follow-up to make sure the person is going through the process. Not to know that is happening but to make sure that person is following through. So there is nothing standardized, one. Two we don’t have a, the way it is set up we don’t have a governing body that do that. Now maybe other denominations do but that’s not the way we are set up in that regard.

Mesa explained that when she was in seminary school, she too learned about her boundaries and when to refer, but not necessarily how to refer. She said she automatically refers issues involving children, but her actions are not dictated by anyone.

During seminary we had so many classes on certain questions to ask, what to look for or if it’s not spiritual it’s something else. I mean that’s just the bottom line for me…When it comes to children, that’s automatically something you need to send to a professional, but the Methodist denomination does not have a standard of how we deal with that type of issue.

Tara reported the same thing essentially, but added that how she responds to problems involving children is governed by her church policies.

We have what we call, we have to go through boundary training and so in there it talks about if you feel that a situation is over your ability to help that you ought to be able to make referrals because boundary uh deals with that aspect it also deals with how members treat us or how we feel and interact with members and I’m due for my boundaries training is coming up and we also do safe gathering which is similar to safe sanctuary to make sure that everyone knows how to interact with children, youth, and uh developmentally disabled adults. So our church does have those policies.
Lucy, who also attended seminary school, revealed that she too does not follow any mandated referral policy. Instead, she relies on her gut.

There hasn’t been a particular protocol in terms of referring parishioners to those areas, but its just basically my gut, my intuition, and having good friends who are mental health profession and just letting them know that hey this person is coming to see you is that okay? What are your hours of operation? How can we make this work?

Lisa and Nate did not attend seminary school, but they successfully make counseling referrals. They have relied on their intuition to make referrals while also “learning on the fly.” For example, when Lucy was asked if she had any training on how to make counseling referrals she said:

I go more with my instinct…Everybody gives you a card, everybody. I mean you can go to any grocery store and see a whole jar full of cards, everybody puts a business card in there. But when I look at referrals I want my referralees to have the best possible experience they can have. I don’t want them, its like I’m a daycare provider and so I’m full and somebody calls me and they say I’m looking for daycare and I’m like I’m full and then I just look in the phone book and say but here one that’s right down the street from me. I’m referring them and I don’t even know who you are. I don’t know anything about you. You could be a child abuser or molester…So, I take referrals very, I don’t take it lightly because I want them to have the best possible experience because your hope is that they’ll come back to you. That’s your hope.

Nate said he is learning as he goes despite his lack of seminary training.

So a seminary trained pastor may have more opportunity to get a counseling class quote unquote as opposed to a non seminary trained person who’s received the call, maybe
done an in-house program that in no way involved any kind of counseling or counseling training. You can count on it. It did not happen. It didn’t happen for me. So you’re learning on the fly. I’m fortunate to have done something before I came into this role whereby I served as an advocate for various and sundry situations, older and younger, knowing that and if you really want to help people get whole there are people who are trained to ask the kind of questions to help a person over time with the support to address some of the issues.

Every participant admitted that their church members come to them for help on various issues. Besides wanting help with mental health problems, they sometimes want other help like finding a job or a place to live. When asked if counseling referrals were different from other types of referrals clergy make, the participants suggested that counseling referrals are more personal and thus, handled more delicately. Zack specifically expressed:

I’m more delicate. I talk to them in the office whereas if someone just asks me, you know, with someone having problems, legal problems, I talk to them in the office as well, but some people just come up and say well Reverend do you know of a real estate agent?

I say she’s just right over there, you know. That’s not so personal.

Rick echoed Zack’s sentiments and added that counseling referrals sometimes weigh more heavily on him than other types of referrals.

They’re just more intimate, more difficult, and they weigh more heavily on me than any other referral. I know I can feed people. I don’t know if I can keep people from being suicidal or if I can help people walk through sexual abuse or if I can help people find people to walk them through their gender identity issues.
Lisa and Matt alluded to counseling referrals being more delicate also. They also stated that they are more conscious about whom they refer to. Lisa shared:

There is because sometimes people come to the church for a referral for housing, or for a referral for food, you know and it doesn’t have to be a necessarily a business relationship to send them to [homeless shelter] or to send them to [social service], you know, but then when people come for counseling then you take that a little bit, not that both aren’t serious probably not the right word, but you take that to a higher degree than you would just sending someone for food or sending someone for housing…As far as because you’re talking about an experience, this person is going to have an experience. When you send some body for food, what’s the experience? You go in, you get a box, and you go home, right. You probably don’t even know the person’s name that’s helping you get the food right. But when you go into counseling you’re asking someone to open up their personal life to a stranger. So that when I say a higher degree so because of that things are shared that are pains, hurts, embarrassments, you know. And so you want it to be someone that’s trustworthy, not someone that’s going to have a drink at the bar and talk about this session they just got out of.

Matt said:

I think with counseling referrals, because the heart and the mind are so fragile, I really have to have a lot of confidence in the people to who I refer, to whom I make referrals. And of course in anything I want to have confidence in their skills, their abilities, but particularly when it comes to counseling. So there maybe greater concern and a little bit more, I may give a little more attention to what the need is. That may be the biggest
difference. You can’t trust everybody with your heart. The Bible talks about guarding your heart.

A critical element of making a counseling referral is selecting a mental health professional to refer to. Participants were asked how they choose the person or agency they connect parishioners with and what, if any, factors contribute to their selection. Some shared a list of providers for their parishioners to choose from. Some refer to the one agency or person they know about, regardless of the issue. Some try to match parishioners and mental health providers based on their shared attributes and personalities. Some did a mixture of all these things when making counseling referrals. When asked how she selected counselors to refer to, Lisa said:

I pray. Just like I did with the phone book in picking the lawyer. You know, sometimes people don’t understand, but God will lead you. He’ll lead you in the direction to go if you’ll just, if you’ll yield to him and listen to him. You know, I don’t deal with a whole lot of people. I have probably five colleagues that I deal with on a regular basis.

Lisa also added that she considers the race and gender of the professional she refers to.

One of the big things I look for in referral is ethnicity. That is very important…Yeah, the ethnic background of the counselor. If it’s an African American couple, a lot of times an African American couple doesn’t counsel well with a Caucasian counselor because there again counseling it’s not just the book because how can the counselor tell an African American young man, because you don’t feel what he feels. The life he’s lived you have no clue about, right. And so you can’t relate so everything from that counselor would just be book. It couldn’t come from personal experience and sometimes that’s the best counseling. It couldn’t come from that thought cause he couldn’t relate. So gender has a
lot to do with it as well because when you send a woman, and I just endured this, a young lady was in counseling with a male and she came to me and I’m now counseling her. But she came to me and when she came to me she was so frustrated and I’m like, cause it’s like a female going to a doctor for her pap smear. A male has no clue about you. He doesn’t know how rough he is, he doesn’t know that it’s uncomfortable whereas if you go to a woman she can relate cause she goes through it too right so she knows to be gentle even though it’s something that she has to do.

Just as Lisa preferred to match parishioner characteristics with the characteristics of the mental health professionals she referred to, Jeff preferred to refer his church members to Christian counselors. He stated:

Everybody has a worldview and our worldview informs our various things in life and our worldview is informed, I believe as a Christian, your worldview is informed by your Christian life. I think and I believe, and I might be wrong, that your approach based your worldview can be different from person to person and so a Christian worldview on counseling might be a little different. The person might be freer to talk about certain things that they might not be free to talk about if they were not a Christian. And so because of that, that would be my preference…because the person is a Christian, [pause] I believe that they will be, it is foundational to the person’s complete, total development to know that the person to whom the counselor understands that person and can not think about that person or think of that person in a different light. I believe there is a difference when someone understands you religiously is working along with you as oppose to somebody who does not understand you religiously…I don’t have to have relationship with that person. I just have to be satisfied within myself that number one, the person is
Christian and if the person is not Christian at least I have a sense of what their worldview is what the counseling, for lack of word, style is, for lack of word, but I need to be confident because again the referral I’m making, I’m making a referral and that person is following through based on the person’s understanding that I’m their Sheppard. It’s as if it’s an extension of me in a way that I’m not the person but yet I’m still the person because I’m the person who has spiritual over care over them and because of that I just want to make sure that by extension whoever is following through kind of have that same value, understanding.

Like Lisa, Jeff believed if a counselor could not identify with the worldview of his or her client, the client would not have a positive experience. He wanted to make sure his parishioners worldviews were understood and taken seriously in counseling. He later added:

The fact that when my people come to me they are coming to me as their spiritual leader and they are coming to me as somebody who has a care who provides care for them and they are coming me because a lot of them have a negative view of counseling. Some people just believe that I can talk to my pastor and that’s it. I don’t need to talk to anybody else and so if I’m going to make referral it’s as if I’m the one doing the counseling, but I’m not the one doing the counseling, its an extension of me and I just want to make sure that certain things are understood and the person that is providing it has and worldview that impacts who I am and who the person is.

Nate took a similar position. He claimed that he would not refer his church members to a secular clinician if they did not believe in God.

The question isn’t am I going to outsource this person, the question is to whom am I going to outsource this person and so if as a Christian pastor I’m going to send this
person to a secular counselor, I’m not going to do that because that person, we’re not on
the same wave length in terms of what this person is going to give the person I have
referred. But if I know that the person I’m going to send them to is a faith based
counselor or has a foundation of faith than at least the person will be getting a similar line
of impact, influence as opposed to somebody who’s at best an atheist, at best an agnostic
and someone who will not integrate at least to some degree of even value the faith
dynamic at all and so I think that’s the other thing. I would rather hold on to this person
and prod away at trying to figure out what’s going on than to give this person to some
ungodly counselor who is going to take him or her in a direction that’s totally off base.
I’m not even going to hand this person over to that person. There’s no way I’m going to
do that. And so it, the referral part I don’t have a problem with, but I’m going to seek out
that person who I think is more in line with my belief system and yeah you can help them
but if you’re not, if your one of these out there counselors with all sorts of incense and
kooky stuff, no you’re not getting this person and I wouldn’t, it would be a disservice for
me as a pastor to give this person to that person because you know particularly if they
done have that faith framework as a foundation of their counseling.

Rick felt the same as Nate. He said:

I don’t want to send my people to atheists. I don’t want to send my people to counselors
who won’t allow them or afford them the opportunity to speak on or talk about their
Christian life, their God life, while they’re working through their counseling. And do that
free of ridicule and free of shaming and those types of things…if they just said hey I
really have to pray about this and you go no you don’t need to pray, you have to work,
you have to do this, this, and this. God can’t help you, I’m the one who. If I knew that
that wasn’t going to happen then I would be more willing to send my people to you. And trust me when I find those people, when I discover those people, even through casual conversations or whatever, they immediately come off the list. Immediately because I don’t need you to create more issues while you are trying to quote unquote help them.

Zack also said he preferred to refer to Christian counselors, but his reasoning was because he considers most problems spiritual. He said:

I think many of our problems are spiritual problems and um, and not all, but many of our problems are spiritual problems and if I was making a suggestion or a referral, I try to refer persons to people who are Christians.

To find people to refer to, he asks people around him.

I talk to people outside of my church. Who do you go to; I ask somebody this. Do you know any counselors that are good? That’s what I do. I do those kinds of things.

Then, when he meets with a parishioner who he thinks would benefit from a counseling referral, he may recommend someone for them to see, but he allows them to choose. He highlighted this in one instance where he said:

I did not have a person in mind. I allowed them [to choose]. I recommended a counselor… but I thought it was their business. I’m not in the business; I didn’t feel that it was my job to enhance her business. I recommended her and I told them why I was recommending her.

Like Zack, several other participants also said they allowed the parishioner to choose which provider to see. However, they may provide guidance by showing them a list of options or making a recommendation based on the individual’s need. For example, Lucy said:
I give them a list and I usually base it, the contacts that I make, that I give, the referrals that I give is based on what I think the person’s specialty is in dealing with this certain issue so.

Mark was also a fan of giving his church members options for providers, so he shares a list he has created. He suggested this takes the pressure off of him and his church should something go wrong.

We don’t do single source referrals. In fact, that’s detrimental. We don’t want to be the reason you went to that person, we’re going to give you a list of people and you get to choose from the list anybody you like. We vetted, everyone on, they are credible by you know the Chamber of Commerce, we done a few little background checks to make sure they are credible companies to refer out to. And you pick and choose whatever you want. But I just can’t use you because if you mess up than that’s going to come back on the church because we told you to go there.

He also said that he will ask the opinion of church members who work in the mental health field. They help to continually add to the referral list.

There are several counselors in our church. We have one that works at [hospital] and different agencies around the city. The lead supervisor for [hospital] is a Deacon at our church. He helps a great deal with, while he does a mix at the hospital and church he doesn’t do anything in here that is remotely related to counseling, but he helps us with referrals.

Tara also provided an example of this. She explained:

Say that I think that they would need to see someone else and I would call that counselor if I’m making a personal referral and I’m concerned that I think that this person might be
able to help them or even I’ll tell the person and give them some options because if they want a counselor that’s by them or in their area or if it has to be where they need to go through a doctor’s part where their insurance will cover it so I will first mention it to the person and then try to make it happen.

Tara also indicated a preference for certain counselors in certain situations. In the example she provided below, she thought an African American counselor would be a good match for this particular family.

The reason why I chose the African American female therapist was because if the mothers are passive and their daughters are controlling, this situation a mother doesn’t know what to do, I feel that they almost need an African American therapist to help. Not only for that child to realize that that therapist is there and can continue to pull out as oppose to a European woman or the Asian American woman that I have, I figure who are somewhat passive themselves that I don’t need to send this mother daughter situation, relationship, into that type of situation. I need someone strong to be before them so that they can know when the teenager is playing and trying to dominate the conversation whereas the parent is just being passive and not saying anything and the child is still controlling. An African American woman will push both sides to make them really deal with the issues that are there because they are culturally sensitive to that relationship, I guess I would want to say because not everyone is culturally, we are known to talk to as well as discipline our children. Others might not be.

Mesa explained that she considers the personalities of her church members when she refers them to a counselor. She said:
I don’t give an option because I know the person’s personality. It’s like this one particular
guy who’s like sixty-seven years old, old school, very protective very secretive very,
although, very southern and he was from [outside state], but you know very traditional.
He’s not going to see a white therapist. He’s not going to see a woman therapist. I was
the first woman pastor he ever had and he was still trying to deal with that …he needs a
brotha that’s around his age or maybe a little younger to say that understands his culture
before he can even deal with his head and so that’s how I pick the therapists that I refer
them to. I don’t just give them a list cause I do know for a fact if my father had went to
another therapist that I knew he probably would have shot, he probably would have killed
himself. He needed the respect he needed the out the barn, you couldn’t come in there
and say well [First Name] come on in there and have a seat my dad would be like [First
Name], you don’t even know me. You know, I’m Mr. [Last Name], you see what I’m
saying so he would have been closed automatically so I try to get to know the nuances
and the culture and the personality of the therapist before I refer them.

Some participants are married to mental health professionals so they rely on them to help with
referrals. Matt said he typically refers to his wife’s agency because he believes in the vision of
the director.

I chose my wife’s counseling center. That was because I know the people there, we have
a couple of our church members who work there, who are therapists there and I had great
confidence in the director, the center, the founder, the director of the center and her
mission in terms of what’s she’s trying to do, a community based counseling facility I
think is just a tremendous vision. There are not many African Americans who have that
kind of vision and they don’t just do counseling. They also do other kinds of community
programming with, mostly with youth. So it was for me kind of a no brainer.
Rick’s wife is a mental health professional too and he sometimes directs his parishioners to her
in order to get connected with counseling services in their community.
   At the very least, I’ve always been able to say hey, my wife ‘s a counselor and what I
want you to do is call her and she’s going to recommend someone or she’s going to start
that journey for you. I trust her, I know she’s not going to divulge anything you say and
so that’s probably happened I don’t know, maybe fifty percent of it has been just I don’t
know anyone but let me give you her. And then the other half has been hey I know
someone who does something like this.
   Although the participants had minimal, if any, guidance on how to make counseling
referrals, they found a way that works for them that is different from the way they make other
kinds of referrals. Whether they refer to people they know or people they believe would be most
qualified to help their parishioners, they are successfully connecting their members to mental
health professionals. Unfortunately, after a counseling referral has been made, barriers may
prevent parishioners from engaging in counseling with a mental health provider. This is
illustrated in Phase III: Now that we’ve met.

   Phase III: Now that we’ve met. Phase III of the Clergy Referral Process represents
what happens after clergy have met with a parishioner and made a counseling referral. Barriers
that prevent a parishioner from committing to counseling services are part of this phase as well
as follow-up, which includes clergy’s involvement with parishioners once they have started
receiving services. Both of these components are discussed further in the following sections.
**Barriers.** Barriers represent anything that hinders an individual from receiving services. When participants were asked about barriers, three categories emerged about the parishioners: affording services, not wanting help, and not trusting counselors. Lucy was one of the participants who pointed out a financial barrier that interferes with parishioner’s ability to follow through on a referral.

A lot of it has to do with the fact that it might be a little expensive and for the most part there has been out of pocket expense of going to see a therapist is pretty incredible. Matt acknowledged the financial barrier as well. He explained:

Financial sometimes and the case of, for example, my wife’s agency, they do not offer a sliding scale, which sometimes presents some challenges. If a person is in that middle area where they may not be so well off, they can pay or they feel they can afford to pay for counseling session, but they don’t have Medicare…Don’t have the insurance that takes care of it and they have had, I haven’t actually had to make a referral where they need a sliding scale and they could not, and it’s a result of them not offering sliding scale, they couldn’t take advantage of their services, but that’s something that I’ve had conversations with them about before.

Tara also recognized the financial barrier that parishioners sometimes face and she has taken it upon herself to try to remove that barrier. She shared:

If it gets to the point that the free therapy is not helping then we’ll work out how you can get to the right therapist that you need and financially how we can handle that because I had to work on, a lot of people did not have health insurance and now with affordable health care we had the enrollment time here at the church to make sure people got signed up.
While financial barriers may prevent parishioners from getting the help their pastors recommend, some parishioners simply do not want the help recommended. The participants cited frequent occasions when they made a referral for a parishioner and the parishioner declined. Lucy suggested this is because people in the Black community are leery of mental health providers. She said one of two things usually happen when a parishioner declines a referral she has made.

I just keep asking and then finally either they quit coming or [laughter], pastor I finally called and, you know, I went a couple of times and I am okay, so yeah. But it’s thin line especially in the Black community because people are, it’s still a taboo subject, you know, its like psychiatrist, therapist, what is that? You know. I can pray. If I can’t pray it away, if I can’t talk to my friends and work it out, I’ll just sleep on it and it will be alright, but that’s just so not true.

Other participants agreed that they try to respect the person’s decision to not move forward with counseling, but they still encourage them nonetheless. Tara stated:

We’ll talk to them because they’re going to still come back. I mean, you know, whatever brought them to me that means that they’re going through something for them to open up to say to me and I say well you might need help. Okay they might refuse the first time, there’s not much I can do, but then if they come back the second time or a situation then I’ll say you know I think you need to uh, you know, it would help or say, you know, I want to introduce you to someone or just check it out and see what they can do for you.

Jeff said something similar to Tara. He stated:

There were occasions where I made suggestions for people to seek professional assistance and they refused. In those situations I cannot compel the person to do it, it has
to be voluntary...Life is about choices. My goal is to influence choice, not to make a choice for a person because I don’t make choices for people I try to influence choices. And when it comes time to make that choice I just have to go along with what choice they make and hopefully, through a period of time that choice can be reversed. It can be changed and that person can make a better choice to better themselves.

Jeff tries to respect the parishioner’s choice to not receive services. Matt also discussed that he respects their choice not only because it is their decision, but because he believes they will not benefit from counseling if they do not want to be there. He said:

I had a situation where the person did not follow through so they did not say no to me, but they just didn’t take, didn’t continue with it, didn’t follow through and most of the time when I do this by the way, ninety percent of the time, ninety eight percent of the time it’s for members of my church and so I will see them and interact with them and I will ask them are you following up on it and if they say no, I might have the opportunity to ask them why and most of the time it’s not because they didn’t want to, but it’s, they have so much going on in their life that they don’t, they haven’t been able to find the time to do it. And so I don’t push them or press them. I think counseling is something you really need to do because you want to do it. I think, because if you’re there not, we have had some people who have been forced to go into a mental health facilities, a residential mental health facilities, but that’s a, that’s a different level of mental health care. But I don’t think counseling does much good.

Lisa also talked about not taking their declination personally.

You learn to not look at rejection as a personal thing. You take nothing personal cause it’s not me that he rejected, it was the service I was offering. It wasn’t me, he still loves
me, he still hugs me, he’s still able to do service and you know that goes back to every body, um, there’s a season for everything. You know, this just wasn’t his season. I’m not going to hold it against him.

Presumably, if the problem does not go away for the parishioner, the pastor is going to continue to promote outside support. However, if the pastor feels there is no professional mental health provider he or she can trust, another barrier arises. Nate and Matt both spoke to this. Nate said:

How do I trust this person, how do I know this person really has my best interest, what are they trying to do to me. I know in my experience even with education you know counseling has turned in to a little bit of advice and some medication and I think that’s a lot of what people fear as well.

Matt also said that if he noticed a parishioner’s health is worsening after he or she has started treatment with the counselor he has referred them to, he would discontinue referring to that professional because he no longer trusts him or her.

If there were counselors, if there was no one that I trusted. Now, as I’ve said that’s not the case here in [names city], then I might not make a counseling referral. If I see people going to a counselor and I’ve referred them and they seem to be doing worse and not better I might discontinue my practice of referring them to that counselor or to that agency. Um, but um, I think that would be about it.

Identifying barriers in the Clergy Referral Process appeared somewhat easy for most participants. The information they shared about barriers also converged. When asked about supports, Lucy was the only participant able to give a response. She said:
I think that with my name recognition I think it helps the parishioners get in quicker. I think that’s the beauty of having relationships with people that you know that are certified counselors. You know that they drop a name than they can typically get in immediately rather than having to wait, so.

Whether or not the participants experienced the same kind of support as Lucy, if they were able to avoid or overcome the aforementioned barriers then their parishioners were able to successfully connect to a mental health provider for services. Perhaps surprisingly, most clergy’s work is still not done. Once the individual begins counseling, clergy follow-up with their church member.

**Follow-up.** If parishioners choose to follow through with a counseling referral, the pastor typically follows up with them. When clergy follow-up with a parishioner, they usually want to ensure that the parishioner is engaged in counseling. To get a sense of this, the pastor may ask if an appointment has been arranged, offer to attend a session, and/or ask how a session went after the parishioner has gone. The participants also shared that they maintain confidentiality about their meetings with parishioners as well as the parishioner’s involvement with therapy. Lucy and Jeff both explained that they gage if their church members are engaged in counseling services by monitoring set appointments. Lucy said:

I follow up to make sure they have called. I usually give between maybe three to seven days before I start asking the question of if they’ve made that contact and its obvious if a person doesn’t come to church than I know there’s something deeper going on and I know that they haven’t made that contact with the therapist and I call and try to figure out what is going on.

Jeff said:
The only thing was I wanted to make sure and I told the person, I want to make sure that you are following through the sessions. I want to make sure that you are consistently going to your sessions so every time a payment was made, I knew about it and that way I would know whether or not the person was being consistently going through with the counseling.

Mesa takes another approach to see if her church members are engaged in counseling. When parishioners allow her to, she goes to their sessions with them. She shared:

I’ve went with members and walked them into the door and sat with them and even, I would say maybe ten to twenty, stayed in the room with them maybe one or two sessions until they understood it was okay and then they did it on their own.

Several participants said they ask about their church members experiences in counseling as a way to see if they are engaged in services. For example, Rick shared:

For me that looks like, um, constant contact. That looks like, hey so you have your session today, and most of the time they do choose to share with me if they’re going outside when their sessions are. Um, so I call and say hey you’re having your session today, you want me to come and sit outside and wait for you. Sometimes yes, sometimes no. So doing that. Always a call afterwards. Say hey how did it go? You feel comfortable? Everything alright? Do you like them? So it’s more of a how do you feel about the counselor.

Zack explained that he also asks how sessions are going, but he tries to limit his involvement in order to avoid smothering his members.

I’ll ask them sometimes or how is it going. I’ll call them in the office and ask how is it going and some people who are not members I’ll ask them, uh I’ll call them, how is it
going. And some people say well much better now, I’m doing well. And some people will say well I tried it and it’s really working and so, and you have, I’ve learned that you give people space. You, most people don’t want you hovering. What you call them? The helicopter pastor? I don’t like to be that way because people will once they get out of the situation they will tell other people well he hovers he’s always interfering and I don’t want to be, uh create the reputation of interfering.

Lucy echoed Zack in that she too wanted to give her church members space after they started counseling so they can stay focused on what they are doing in counseling. However, she still follows-up at least a few times.

Typically they will send me a note saying thanks. And I typically check in maybe once or twice at the beginning and I just back up because I want them to fully encounter what their therapist is offering so if they’re paying for it, I don’t want to cross the line. I don’t want them saying well my pastor said so in so, no.

Mark detailed a more structured follow-up procedure. Since he has an active staff that interacts with his parishioners, he asks his staff to follow-up with parishioners. His staff reports to him how any given parishioner is doing and unless his senior pastor needs to know, the communication ends with him.

The first step is for me to do the follow, even though I’m at the top of the ladder we follow the protocol. My first call is to the Discipleship Pastor, what’s the condition of that referral. If he hadn’t heard he’ll call the Deacon and the Deacon will know. Every week we have a report that identifies all the people that are sick, shut-in, homebound, and all of the Deacons are assigned so many different, so many members, as a class so they are responsible 100, 200, 300 people. They make sure that if they’re on that list they get
updates and we announce that on Sunday morning. We pass out a list either to people still
needing prayer etcetera etcetera. And then that Deacon, if they have not done so then they
will reach out to their person get info and then it comes back up the chain. So that
Deacon called to the hospital found out about the status and it just came back up and it
got to me. Ultimately, he [Senior Pastor] doesn’t get it. [Senior Pastor] will not get the
information unless, in my experience he needs to know. If we solved it, he doesn’t need
to know. Not that he can’t know, he can know anything he wants to know, but that’s one
less burden that we put on him.

The participants followed-up with the church members they referred for counseling
services because they want to make sure that the church members are actually receiving services
that are beneficial. The participants also revealed that they are mindful of confidentiality in all of
their private interactions with parishioners, but particularly when a parishioner begins to receive
counseling. This was believed to maintain an atmosphere of openness between the parishioner
and pastor and presumably the counselor and parishioner. In one simple statement, Lisa shared
that she maintains confidentiality with her church members and understands the confidential
relationship other professionals maintain.

What I talk to them about is confidential. What any other doctor talks to them about or
psychologist, is confidential.

Zack likened himself to a lawyer, claiming he is not obligated to share anything to anyone, even
in court. He said his discussions with parishioners are:

Very confidential. I don’t, if someone comes to me with a problem and if I ask them do
you want me to share it with someone else, most people say no. They have um, there’s a
very confidential relationship that exists between the pastor and the members. Actually
it’s the same thing as a lawyer, if someone tells me something under certain conditions, I’m not even in court, I’m free, I’m obligated not to tell.

Nate shared his value of maintaining confidentiality as a way to gain trust. He shared that his church members were sometimes hesitant to open up to him because of their past experiences with another pastor who was not so private.

Well you know, trust is critical so you want to make sure, at least I want to make sure that whatever is said in that space is something that no one else is going to hear and of course you have to, you have to make sure the person at least is willing to trust you enough to say what needs to be said and knowing that you’re not going to, you know unless it’s something that has to be shared, you know, unless there’s danger or someone wanting to hurt themselves or whatever, but uh yeah, you have to make sure that you are that trustworthy person. And I think that the idea is that clergy are people, they’re like lawyers, you can tell them something you won’t hear it anywhere else. I can say that there are people who’ve come to me who’ve felt very apprehensive because in previous situations that confidentiality has been breached and so there is some hesitancy, there is some reluctance to be able to say certain things or people say very candidly, I’m not, I don’t know if really I can trust you. And I say well why would you say that. Well because of previous situations. Well the only way this can work is if I assure you I mean only way to do is to have the experience. I mean you tell me whatever you want to tell me and you know I’ll just have to gain that trust from you and so I make that investment over time.

Following-up represents the final component of Phase III and end of the Clergy Referral Process model. By this point, pastors who have engaged in this process have taken the time to understand themselves, discussed mental health in the church, built relationships with
parishioners, relied on their staff (if they have one), arranged a meeting with church members, assessed for need, dealt with spiritual matters, made a referral decision, overcome barriers, and followed-through to make sure a church member was engaged in services. This is the complete model that clergy engage in to successful make a counseling referral.

**Recommendations to Enhance the Model**

Near the end of each participant interview, clergy were asked if they had any recommendations to make the counseling referral process better either on the side of clergy or mental health providers. Their responses included gaining awareness of mental health providers in their area and their specialties, building relationships with mental health providers, and discussing mental health more in their church community. Tara was one of the participants who suggested that pastors could make the referral process better by making sure they know what services are available, especially culturally competent services. She specifically stated:

I think its more of making sure that a we know what is out there and what is offered because we might be the first person that people will approach because they might feel comfortable approaching us so I just need to be made aware of what services are available in the community that are culturally competent to help because for so long I believed that African Americans are a little leery of opening up and sharing so you know we’ve got to make sure that they realize there is someone out here, but oftentimes we don’t want the community to know our business so we don’t want to go to somebody that we might know or that the family might know or know our family. But if you go somewhere and then their not aware of your culture that can also hurt you too. That’s my feel.
Zack made the same plea. He suggested a leaflet with names of providers, their background, and their specialties would be helpful for making counseling referrals.

A compilation of names, I think that would be very helpful. And what counselors specialize in, uh the people do marriage, but are there persons who specialize in various forms, that would be very helpful…Some type of little leaflet that should have and you can go through, that would make it much easier and if there were African American counselors here, if we had some type of little publication of persons who understand African Americans because from my perspective uh, a lot of White counselors don’t, from my perspective, don’t understand the challenges that are presented to African Americans and everybody who has a marriage problem is not the same. There are dynamics that I believe African Americans bring to the situation that Whites, if you’re not, um, I don’t want to use the word competent, but if you’re not familiar, Whites may not be able to help. That’s my thinking.

Rick also mentioned a resource list like a leaflet. He further added that knowing church friendly providers would be helpful.

If there was a quick resource where even on my desk I started forming just a list, a sheet of if it’s this issue, this person or these are just the people and these are the church friendly people, counselors…If people had that list and I knew that I could send my person to you in the midst of all their stuff.

Besides a referral resource list, some participants supposed that building relationships with mental health providers would help with making counseling referrals. Matt and Mesa said this explicitly and Lisa gave her perspective on why she thought it was important to build relationships with Christian counselors especially. In short, Mesa said:
I think establishing relationships prior to makes the referral easier…with pastors and therapists, counselors. I think that makes it easier.

Matt said:

Build relationships…I feel I have a good relationship with the agency that my wife works with and three of the therapists, well two of them are currently members of our church. One was a member of our church and she passed away, but I’d say building relationships, staying in touch.

Lisa explained that the reason she wanted to build relationships with Christian mental health providers was because she wanted to help ease the transition from counseling back to the church for parishioners. She shared:

On the side of the mental health, I think that if there were more counselors that dealt with that on a regular basis that it could make the transition from the professional counselor to the clergy counselor smoother. Um, a lot of times your professional counselor is not a Christian and so you have a conflict of information that’s being shared to the person that’s being counseled. That’s why I was telling you about the young lady that went over there for counseling, but came back to me for marriage counseling, but it was a Christian that she went to, okay. But had she went to a non-Christian, we wouldn’t be speaking the same language and what does that do. It causes confusion so I believe that as a clergy, that’s why it’s good to have relationships with, business relationships, networking so that you can, like I said I want the person to have a top of the line experience. I don’t want them to come back to me in worse shape than they were when they left, right. So the clergy and the professional should have somewhat of a relationship and a respect for what each other stands for. I think that would help as far as mental health.
Lucy was the only participant to highlight more mental health discussions as a possible way to enhance the referral process. She also added that a brochure summarizing different mental health symptoms might help people to recognize when they are struggling. She shared:

I think it would be nice to do a maybe a Sunday or a month of mental health awareness month in churches. Sort of like we do health fares and job fairs etcetera. Why not do a mental health awareness month in churches and demystify some of the taboo about having mental health services. I think that would be just a wonderful thing. I think it also would be nice if we had brochures on what are the signs for certain red flag instance where a person might need to see a therapist if you are feeling this way etcetera. And make it appropriate in the context of folks who go to church and I don’t even know what that looks like but it would be nice. Even if it was a little book mark that says you know after you have prayed and you have done this or done that than maybe as you are waiting for whatever answer you are waiting for that these can also aid in your wholeness.

The Clergy Referral Process model outlined in this chapter is comprehensive. It was derived from what the participants shared as their experience providing counseling referrals. In the next chapter, I will discuss the significance of this study as well is the impact of the findings.
Chapter 5: Discussion

The implications of the findings of this research will be the focus of this chapter. First, a review for how the Clergy Referral Process Model was developed will be outlined and used to understand responses to the research questions. The findings will be integrated with the existing literature. Next, research and practice implications will be discussed. Then limitations of the study will be presented. The chapter will end with a brief summary.

Findings

The Clergy Referral Process Model was developed using Charmaz’s (2014) constructivist grounded theory approach. Transcripts were initially coded using gerunds, which captured actions occurring in the referral process as described by the participants. After each interview, I engaged in memoing. In my memos, I wrote my reflections after each interview. I also wrote questions that seemed important to ask in proceeding interviews. For example, the question involving participants’ values about mental health was developed from my memoing process. Following the fourth interview, I developed a sketch of the Clergy Referral Process Model. This initial model was broken into three parts, later labeled Phases I, II, and III, to align with Charmaz’s (2014) specification that a process is a sequence that consists of a beginning, middle, and end. Although the initial sketch of the Clergy Referral Process Model did not have some of the same labels as the themes included in the final model, the actions captured were similar. One potential theme in the model was omitted from the final model because data did not support the inclusion of that component. Specifically, I wrote questions about support(s) in the referral process in my memos, but when participants were asked about this, their collective responses did not suggest any clear supports. My auditor reviewed my initially coding and provided guidance for using gerunds appropriately. He later reviewed the entire analysis and approved my
interpretation of the data. Focused coding was used to analyze the data across participants. Categories were then developed that captured the essence of the focused codes. The categories were then elevated into themes, which make up the components of the Clergy Referral Process Model. Once the model that was develop from the participants responses and the participants ceased to contribute any additional information to the model, I recruited one more participant to determine if saturation was met (i.e., theoretical sampling).

The overarching goal for this study was to understand the counseling referral process that clergy at Black churches engage in and to build a model that depicts this process. What are the processes and experiences that influence religious leaders’ referral practices with their primarily African American congregants who have mental health concerns was the primary question that drove this study. The following sub-questions were developed to break down this larger question:

1. What intrapersonal and interpersonal experiences may influence religious leaders decisions to make counseling referrals?
2. What client experiences and conditions may influence religious leaders decisions to make counseling referrals?
3. What explicit and implicit criteria do religious leaders use to determine who should be referred for counseling services?
4. How is a counseling referral made?
5. What barriers are perceived by religious leaders to exist in making referrals?
6. What improvements do religious leaders suggest to make the process more effective and useful?
To answer the question of what intrapersonal and interpersonal experiences may influence religious leaders decisions to make counseling referrals, parts of Phase I of the Clergy Referral Process Model are interpreted. Several factors influence congregants’ decision to inform their church leader(s) about their personal struggles. Additionally, the extent to which clergy feel they can help a parishioner fluctuates. Both of these components influence clergy’s decision to make counseling referrals. Considering intrapersonal experiences only, in the understanding self theme of Phase I, participants were charged with developing an understanding about their general feelings of mental health, learning about counseling referrals, accepting their professional limitations, defining their roles, and trusting counselors. If the participants did not have these experiences, then their parishioners may have struggled to turn to them, ask for guidance, and receive a counseling referral. Every participant, both as a result of their seminary training or professional experience in their role as pastor, viewed counseling referrals as appropriate and necessary in certain situations. Although Gottlieb and Olfson (1987) would consider these participants part of the minority of clergy who make counseling referrals, the fact that they make counseling referrals should come as no surprise.

The majority of participants in this study fit the descriptions provided in previous research related to clergy counseling referrals. According to Mollica and colleagues (1986), Black clergy are more likely to make counseling referrals compared to their White counterparts. Unfortunately, no explanation for this difference was provided, but nevertheless nine of the ten participants in this study identified themselves as Black or African American. For this study, this may be a consequence of the selection criteria, which included being a leader at the church, experience making a counseling referral, and serving at a predominantly Black church. Although the participants did not have to identify as Black, the majority of participants solicited for this
study were Black including those that chose not to participate or did not meet all three selection criteria. It may be that the majority of clergy in Black churches are Black and thus, more Black clergy are making counseling referrals than White clergy. However, this would need to be further examined. All of the participants in this study were also highly educated and trained. Five of the participants had doctoral degrees and the lowest education level of any participant was a bachelor’s degree. All of the participants also engaged in some form of pastoral care training and seven of the ten participants went to seminary school. This fits with Gottlieb and Oflson’s (1987) as well as Cook and Wiley’s (2014) finding that ministers’ educational levels and experience in seminary school influence their likelihood of making referrals. Some of the participants were even able to speak to this through their observations of their non-seminary trained colleagues. For example, Lucy said:

   We are experiencing a lot of folks who have been diagnosed with chronic mental health issues and most of us are not equipped to offer anything other than a smile or a hug, which seems to do a disservice.

It seems the more educated clergy are, the more likely they are to be exposed and educated about different resources they can consider using when a parishioner turns to them for help. Most of the participants shared they really got the chance to learn about themselves while in pastoral care training or during their time in seminary school. Pastors without those experiences may miss out on these opportunities to learn about themselves and other resources.

   In terms of interpersonal factors that may influence religious leaders decisions to make a counseling referral, the themes of discussing mental health and relationship with parishioners in Phase I of the Clergy Referral Process model are helpful to consider. Although the relationships clergy have with church members does not directly influence their decision to make a counseling
referral, it does seem to influence church members willingness to meet with clergy and open up about their struggles, which in turn, leads to clergy making decisions about referring. By discussing mental health in the church and cultivating trust with church members, clergy appear to encourage help-seeking and increase the potential for church members to follow through on a counseling referral. When pastors preach about the reality of mental illness and say it is okay to ask for help, church members are essentially given permission to share their pain that they may otherwise conceal or attempt to deal with in isolation. Furthermore, when pastors are intentional about getting to know their church members on a personal level, parishioners are encouraged to use them as a resource for a variety of things, including mental health help.

From the work of Cook and Wiley (2014), we know that clergy serving in African American churches in particular strive to create a network of resources for their congregants. These efforts are made in an attempt to meet the basic needs of a congregation and can include a variety of resources (e.g., childcare, financial planning, mental health awareness). When clergy provide these resources and discuss the need for these resources, parishioners who are listening and trust the wisdom of their religious leader(s) are likely inclined to explore that topic further, perhaps on a personal level. Since the Black church is commonly perceived as a healing institution (McRae, Carey, Anderson-Scott, 1998), it would make sense that parishioners would turn to clergy for help, especially after hearing their pastor comment on a particular problem. The expectation that clergy are suppose to help (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000) only increases the chance that a parishioner will reach out if mental health was discussed at the church and he or she has a relationship with the religious leader(s). This might explain why clergy are the second most sought out resource for serious personal problems in the Black community (Taylor, Chatters, & Levin, 2004) and sometimes the only option African Americans
seek for their mental health needs (Veroff et al., 1981). When there is trust and clergy are willing to engage people in taboo topics, it is no wonder they are viewed as helpers that can meet the unique needs of their communities in an authentic, perhaps indigenous way (Constantine et al., 2004; Ojelade et al., 2011)

The second sub-question posed was, “What client experiences and conditions may influence religious leaders decisions to make counseling referrals?” The purpose of this question was to explore if there was a shared experience or characteristic amongst parishioners that clergy referred. Though the analysis did not reveal a pattern among parishioner characteristics (e.g., female parishioners being referred more often than males), common issues for referral emerged, which was captured primarily in the assessing need theme. When the participants met with parishioners, they assessed what was needed based on the situations parishioners detailed. When parishioners shared struggles related to child abuse, domestic violence, identity concerns, and/or trauma, these were concerns most participants reported providing referrals for. Participants also shared that regardless of the issue, if a parishioner came to them with a “deep seeded problem” that was multi-layered and seemed to require advanced skill to safely dissect, a counseling referral was provided. Although each participant had his or her own unique way of understanding what a parishioner was going through and assessing what was needed to address a problem, they all seemed to have a sense for what was a mental health concern and appropriate for a counseling referral.

Similar to the results of Larson and colleagues (1988) research, the participants of this study were presented with a range of concerns by their parishioners. In addition to the issues mentioned in the previous paragraph, some participants further reported dealing with parishioners who struggled with marital conflicts, alcoholism, and severe mental illness;
concerns that mental health professionals are commonly presented with (Mattis et al., 2007). Whereas previous research has suggested that many religious leaders do not make counseling referrals (Mollica, Streets, Bocarino, & Redlich, 1986; Veroff, Douvan, & Kulka, 1981; Virkler, 1979) either because they do not recognize a problem as a mental health issue (Bentz, 1970; Gottlieb & Olfson, 1987; Virkler, 1979) or they underestimate the severity of psychotic symptoms (Larson, 1968), the participants of this study seemed to recognize and honor the severity of the issues parishioners presented with and they referred.

A number of factors may contribute to the participants’ ability to recognize mental health issues and the severity of psychotic symptoms. For starters, as mentioned previously, all of the participants had some form of pastoral care or pastoral counseling training. As part of their training, participants consistently shared that they engaged in discussions about when to consider making a referral. They were encouraged to build relationships with people in their communities because it was expected that, at some point, they would need to call for help or support. Beyond these classroom discussions, some participants also shared they quickly learned that making referrals alleviates stress that may come from not making a referral. For example Mark reflected on a time he did not make a referral and was later “burned” by it. He said, “I’ve learned, I’ve been burned, you make the referrals. It’s better to make a referral and be safe for both church, parishioner, and pastor than to not make the referral and then something happens.” Although he did not go into detail about how he was burned, Mark captured his value around making referrals as a result of this experience. Perhaps it’s through their training and/or professional experiences that these participants have come to recognize mental health problems and the severity of symptoms parishioners present with.
The third sub-question asked, “What explicit and implicit criteria do religious leaders use to determine who should be referred for counseling services?” While the participants of this study have been encouraged to make counseling referrals as a result of their pastoral care training or seminary experience, they reported no governing body that outlines expectations for making counseling referrals nor any training focused on mental health care management. Instead, each participant has developed his or her own set of questions that when answered help to determine who should be referred for counseling services. One question participants ask themselves before deciding to make a counseling referral is whether or not the issue(s) the parishioner is sharing is spiritual. A second question is whether or not they can help. In Phase II of the Clergy Referral Process model, we see that after clergy assess the need of a parishioner, they have to decide if the need is spiritually based or something else that would require any kind referral (e.g., counseling, housing, food). If the issue is strictly spiritual (e.g., feeling like God has abandoned them), then the answer to the second question is typically yes because the issue, as Rick said, “Is in my wheelhouse.” However, if the issue is not spiritual and they do not feel they can help, then the participants said they are inclined to seek help from other professionals.

Sometimes, the line separating spirituality from other kinds of issues or needs is difficult. Some participants shared that at times it was hard not to see every problem through a spiritual lens. This may make it hard for clergy to recognize that a parishioner may benefit from a counseling referral. Nate’s story exemplified this struggle.

I don’t think African American pastors are thinking about outsourcing anything to anybody. Okay, I think they believe they have the where with all to handle most situations that come to them regardless of what it is. You know, social, mental, because I think the challenge of it may all be couched in the fact that it’s a spiritual problem. I think
that’s the thought is that most problems are spiritual problems. And if you think of them as spiritual problems then we have the spiritual textbook to handle it. Okay, and so we’ll address it that way…I think that there will be some pastors who will never classify any issue as a mental health issue, they are all spiritual issues. You don’t need counselors, you don’t need other, you know, all you need is God…I’ve heard that conversation before and uh, that’s challenging cause you’re on the one hand going you know what, that makes sense to me, cause I trust in God that much. I know what the transformation is that He’s made in my life and you talk about mental health, I was a mental health mess.

Nate’s struggle to separate spirituality may be why previous research has found that many clergy, who likely experience the same struggle, do not make counseling referrals (Beck, 2004, 2006; Mobley, Katz, & Elkins, 1985). If they see every problem as spiritual and do not recognize a limitation in their ability to help, why would they refer? Although Nate experienced this struggle, perhaps the reason he decides to make counseling referrals is because of his educational background and experience working as a community resource where he reportedly helped students who, “Needed help one way or another, whether mentally, psychologically, socially, whatever, financially.” Perhaps his attunement with community resources has helped him to appreciate what others are capable of providing for the people he works with. Clergy who do not share his background, but experience his struggle and furthermore, may be unfamiliar with referral procedures, it is likely they will not make counseling referrals (Winett, Major, & Stewart, 1979).

While deciding who should be referred for counseling services is the direct result of the initial meeting where an assessment of needs occurs, sometimes clergy determine what was originally a spiritual issues evolves or actually reveals itself to be a mental health concern. Many
of the participants shared a common assumption that if after approximately three meetings the parishioner’s problem is not solved using spiritual tools (e.g., reading scripture), the problem is not spiritual and thus other tools need to be introduced. Thus, a counseling referral may be provided if clergy originally thought a problem was spiritual and could help, but came to feel the problem was not spiritual and they could not help.

The fourth sub-question asked, “How is a counseling referral made?” That is, after it has been determined a counseling referral is needed, how is the referral actually made? The critical piece to answering this question lies in Phase II of the Clergy Referral Process model in the theme of referring where participants discussed how they select the mental health professionals they refer to. In this regard, participants primarily discussed whether or not they give parishioners options for selecting a professional to work with or identify a specific professional for the parishioner and whether or not they preferred referring to certain professionals. Mark, for example, gave his parishioners several professionals to consider before making a referral. He explained he does this because he wants his parishioners to be autonomous in their decision about who they want to care for their mental health. Mark might also be encouraged to give his parishioners options because of the resources he has as part of a large church that is able to solicit, vet, and accumulate a list of contenders. Most other participants made referrals to specific people for a variety of reasons.

Interestingly, some of the participants were married to mental health professionals who work in the community. Jeff, Rick, and Matt all discussed that they often refer to their spouse’s agency or they ask their spouse for recommendations on who to refer to. None of them suggested they ask their spouse to provide counseling as this may be a conflict of interest to the parishioner
who likely knows and has a relationship with the participants’ spouses as the first lady of their church.

Participants also described a desire to refer their parishioners to professionals they felt would understand them best. There was a common feeling that if, for example, the parishioner were Black then a Black mental health provider would be preferred. Participants discussed their desire to match parishioners with the person they referred to on the basis of race, gender, or even personality. The sentiment behind this was that a white counselor might not understand and thus be able to help a person of color. A male counselor may not comprehend and be able to help a female struggling with a sexual trauma. An older Black male that values respect may not listen to a younger counselor, as Mesa gave an example:

This one particular guy who’s like sixty-seven years old, old school, very protective, very secretive very, although, very southern and he was from [outside state], but you know very traditional. He’s not going to see a white therapist. He’s not going to see a woman therapist…he needs somebody, he needs a brotha that’s around his age or maybe a little younger to say that understands his culture before he can even deal with his head and so that’s how I pick the therapists that I refer them to.

Since no previous research has explored the referral practices of clergy, it is challenging to situate the aforementioned findings into a scholarly context. However, it may not be too much a stretch to assume the participants of this study, whom most identify as African American or Black, experience some of the same barriers to mental health that have been outlined in the help-seeking literature. Just as an African American who may not seek mental health services because of cultural mistrust (Nickerson, Helms, & Terrell, 1994), so may clergy not refer to White counselors to prevent cultural mistrust. To work around the assumption that the counselor is
going to be White (Sanders Thompson, Bazile, & Akbar, 2004), clergy may make referrals to therapists of color to encourage follow-through on a referral. These connections are only speculative, but worth mentioning.

The fifth sub-question asked, “What barriers are perceived by religious leaders to exist in making referrals?” While this question was originally developed to capture possible reasons clergy would choose not to make counseling referrals, the question evolved to also capture barriers the clergy saw parishioners experiencing when it came to their willingness and/or ability to follow-through on a counseling referral. In terms of the original question, clergy consistently reported that the main reason they would not make a counseling referral would be because they felt capable of handling the problem a parishioner is struggling with. In terms of the evolved question, barriers related to money and stigma came up in the barriers theme of Phase III of the Clergy Referral Process model.

Dobalian and Rivers (2008) brought attention to the high cost of receiving mental health services and the economic barriers many African Americans face. Several participants affirmed this when they discussed the financial hardship some of their parishioners face that prevents them from acting on a counseling referral. However, the participants also discussed several ways they have overcome this barrier. For example, Tara shared that she has help sessions with her congregation to help them get signed up for health insurance. Tara also shared that her church also assigned counselors to every church in its organization so if parishioners are willing to meet with that individual although they might not share the same background, it is a free service.

Besides an economic barrier, stigma was another barrier participants alluded to. Sometimes when the participants suggested professional counseling to parishioners, they would decline. When this happened, the participants would explain they were not offended, but
interpreted the declination in a variety of ways. One of those ways was simply that the parishioner was not ready for counseling. Perhaps they still felt their problem was spiritual and their pastor was responsible for healing them as Belgrave and Allison (2010) found. Although the participants never used the word “stigma” to describe a reason parishioners declined a referral, this may be part of the reason they did. They might have carried a public or self-stigma that led them to believe that persons with a mental illness are somehow responsible for their illness or internalized their experience of possessing a stigmatizing characteristic (Bathje & Pryor, 2011). Whether or not a parishioner had a stigma concerning mental health help, the participants remained patient and supportive of the parishioner, which sometimes led to a later referral.

Also worth highlighting in this section is how supportive the participants were when their parishioners experienced different barriers. These clergy would take the time to find free services for parishioners who could not afford services. If parishioners did not have a ride to get to a counseling office, these clergy would take them. If parishioners were afraid of what they might experience in counseling, these clergy would offer to attend a session with them. If parishioners wanted their pastor present in the office, but not to sit in on the session, these clergy would sit in a waiting area until the session was over. These clergy work hard to overcome barriers with and for their parishioners and this helps to get their parishioners connected to services.

The sixth and final sub-question asked, “What improvements do religious leaders suggest to make the process more effective and useful?” Participants’ responses included gaining awareness of mental health providers in their area and their specialties, building relationships with mental health providers, and discussing mental health more in their church community. Although participants did not specify where in the referral process these improvements can be
made, they did explain how these improvements would help them to make counseling referrals overall. For those who said gaining awareness of mental health providers in their area and their specialties would be helpful, they explained that having this information would help them to make more informed decisions about who they should refer parishioners too. For example, if there is a licensed mental health professional that specializes in spirituality, participants might be more inclined to refer to that person if religion is central to parishioners’ identity. Participants who suggested that building relationships with mental health providers seemed to believe that having better relationships would bring about more collaboration between the two fields. For those who made this suggestion, there seemed to be a feeling or belief that clergy are devalued. In fact, Tara asked me rather directly how I would include clergy in efforts to better the African American community. She said:

How will you be engaging in the community and with some of the leaders in that community as well as religious leaders? Because we are leaders in the African American community and sometimes people forget about us and they will wait and we’re the last leg that they want to bring on because, you know, we don’t want to deal with religion or we don’t want to deal with spirituality, but that is a part of a person’s life that uh we have to make sure that we are all working together to better our community.

Tara was not the only participant that felt this way and this sentiment has been reflected in previous research. McMinn, Chaddock, and Edwards (1998) found that clergy view collaboration less favorably because they experience fewer benefits than psychologists; they are the ones putting in requests to psychologists and not receiving referrals. And when psychologists make referrals, they advocate for collaborative care, but expect clergy to “turn over” their clients if they make a referral. Tara and others suggestion for building relationship might indeed help
clergy and psychologists to collaborate more (Weikart, Peggs, & Davies, 1982) and should be strongly considered. While only one participant suggested that discussing mental health in the church more would be beneficial, this might also be connected to others' plea to build relationships and have more collaboration. One way that psychologists could collaborate is by leading these presentations in the church.

**Research Implications**

A model depicting the counseling referral process that clergy in Black churches engage in is absent from previous research. In fact, a model depicting the counseling referral process of clergy in any church could not be identified. With the Clergy Referral Process Model that was developed from this study, researchers now have a framework to further study the referral process. A study aiming to replicate the findings across a variety of factors is suggested. Replicating this study with clergy who preach in a variety of Christian denominations and other religions may yield differences for the process and inform an overarching model that can be applied to religious leaders in general. For example, different Christian denominations (e.g., Catholic) may provide varying kinds of support to clergy to make referrals. This might include mental health professionals within the religion that clergy can refer to, financial support for parishioners to utilize when they want to follow through with a referral, and/or guidance for making counseling referrals.

Future research is also necessary to determine if the conditions and factors that facilitate a referral being made, such as clergy understanding themselves, discussing mental health in the church, and developing relationships with parishioners, truly impact the model as anticipated. Furthermore, replicating the model with consideration of the improvements the participants suggested might alter the model. Clergy with close professional relationships with mental health
providers may inform the process in ways not showcased in the Clergy Referral Process Model. Also worth exploring through replication is if the model holds true when researched with mental health professionals as participants. There may be nuances revealed from the perspective of mental health providers that impact the model. A study that further examines how clergy separate spiritual and mental health concerns would also be useful. The participants in this study seemed to have a clear idea of what was a spiritual versus mental health issue, but more research is needed to explore how clergy separate these two areas. Understanding this dichotomy could have a direct impact on what, when, and how clergy choose to make counseling referrals. A final consideration for the replication of this study is to see if the model fits in non-Black communities. The Clergy Referral Process Model may change in predominantly White churches with White clergy. The culture across settings may impact the model develop in this study.

Pastoral care/counseling training on counseling referrals should be formalized, standardized, and evaluated. Several participants shared that they learned what referrals were while in pastoral care/counseling training, but they did not receive training on how to engage in this process. Such training could include ways to identify and connect with clinicians in the community who specialize in areas of interest to the clergy (e.g., counselors with an emphasis on spirituality). This could potential make the referral process easier since many of the participants discussed preferences for who they refer to.

**Practice Implications**

The current study has practice implications for clergy in Black churches. The primary implication is that clergy now have a template for making counseling referrals if they desired a guide to follow. One participant actually requested something like this. Rick said:
If there was a book that every pastor could have that says these are the steps for making a referral, oh my God, that would be great. It would be well received by many and some of them would throw it away, but the good ones would use it.

Clergy can also use the *Clergy Referral Process* model to increase parishioners’ likelihood of seeking them out for support, which, in turn, can lead to an opportunity to provide a counseling referral. They can do this by reflecting on their roles and limitations, striving to develop relationships with their parishioners, and initiating discussions in their church about mental health. Attending to all these elements is believed to encourage parishioners to seek the support of clergy per the *Clergy Referral Process* model. The *Clergy Referral Process* model may also inform clergy on how to separate spirituality from other issues that require different skills. Several participants shared that if after three meetings a parishioner’s issue has not dissolved, they assume the spiritual resources they provided are not sufficient because the issue is not spiritual. Clergy may utilize this three meeting rule-of-thumb if they are unsure how to separate spirituality from a mental health concern. Understanding the process that clergy go through to make a counseling referral has practice implications for mental health care providers too.

Mental health providers might be able to help with the progression of the *Clergy Referral Process* model in a variety of ways. First, clinicians can intervene while clergy are in pastoral care/counseling training and destigmatize mental health. Clinicians can address concerns related to cultural mistrust and resources clergy can suggest to parishioners who may experience economic barriers. This may help clergy to define their roles and trust counselors in what they can provide. Clinicians can also help train clergy on the referral process while they are in pastoral care/counseling training. This could allow clergy a space to process their reactions when learning about referrals and allow them to ask any questions they may have about referrals. If
desired by clergy, clinicians can also offer to host mental health workshops in the churches they receive referrals from. The participants in this study and others like them might appreciate this kind of collaboration, as they tend to plan these events without much support from people outside their church. As clergy attempt to do when discussing mental health in the church, clinicians can help to demystify and destigmatize mental illness by doing some psychoeducation that encourages people to seek help if they are struggling. Also suggested for clinicians is that they attempt to build relationships with clergy by collaborating with them while a parishioner/client is receiving care. Clinicians can also involve clergy in the transition the parishioner/client goes through after ending treatment. Several participants shared they remain concerned about their parishioners after they have made a referral so this kind of inclusion may be beneficial to all parties involved.

The Clergy Referral Process model also has implications for the field of Counseling Psychology. The purpose of this study was to develop an understanding of the referral process clergy use in Black churches so that ultimately parishioners could be served in clinical settings for their mental health concerns. Mental health professionals can support clergy in the Clergy Referral Process model to establish collaborative relationships, cultivate trust, and build up their practices simultaneously. Additionally, social justice and advocacy for African Americans calls for the genuine effort of psychologists to build relationships with clergy in Black churches. Doing so would benefit this community by potentially decreasing the disparity for African American mental health help seeking. By being visible in the church, the place many African American go to for support, psychologists would minimize many barriers that sometimes extends peoples’ mental illness.
Limitations

Limitations can be found in any study and this one is not exempt. A grounded theory research methodology was selected because the goal of this study was to understand the referral process clergy in Black churches use to make counseling referrals. Although attempts were made to limit that impact of biases throughout the research process, researcher bias is inherent with this approach. For example, I, the primary researcher, am driven to help and support clergy in their efforts to support their primarily Black congregations. This likely has shaped the questions I asked, my analysis of the data, and interpretation of the results. I believe this particular bias may have guided me to notice several areas that clinicians can intervene to strengthen the clergy referral process, which may have caused me to overlook opportunities to empower clergy. Researchers that attempt to replicate this study may discover different findings because of the potential impact of this and other researcher bias.

Another limitation is the possible impact of social desirability from the participants. The participants were aware before the interview that the primary investigator was a counseling psychology doctoral student. Although participants were encouraged to share their experiences without fear of judgment from the researcher, they may have felt pressure to showcase themselves in a favorable manner. There was an attempt to minimize this kind of response by explaining the intent of the study, which was to learn from them how they were making counseling referrals. The participants seemed to respond genuinely, but it is possible that some of their responses aimed for social desirability.

The sample selected for this study is another possible limitation. All of the participants were serving as pastors in the Midwest at the time their interviews were conducted. Conducting this study in regions where more Black people reside may present more diversity in participants
for a richer analysis. The majority of participants in this study qualified their church as a small church, which consequentially had fewer resources than larger churches. Interviewing clergy in different sized churches may inform the model in ways unseen through this study. Greater diversity in the religious denominations of clergy interviewed might also impact the model.

Conclusion

Making referrals is common practice for mental health professionals. When we are limited in our ability to help a client, we must refer our clients to another professional per our ethical guidelines. Referrals occur less often from religious leaders to counseling agencies (Mollica et al., 1986 as cited by Taylor, Chatters, & Levin, 2004). Clergy are encountering individuals with mental health concerns and they are counseling them (Larson et al., 1988). As indigenous healers, clergy have tools and resources that do indeed help ameliorate some of the mental health issues their congregants present with, but clergy are also reporting feelings of inadequacy for managing more serious mental health concerns (Farrel & Goebert, 2008; Neighbors et al., 1998). With the high number of African Americans turning to clergy for mental health help and clergy not always feeling capable of helping, this makes understanding the referral process of clergy vital.

The Clergy Referral Process Model creates future opportunities. In the event that clergy who already make referrals have gaps in their process, mental health professionals can offer feedback about how to strengthen their referral process. Additionally, collaborations can be developed that enhance the support of congregants and clients alike. Though clergy refer less than ten percent of their congregants to counselors, mental health professionals rarely refer to clergy. Needless to say, collaboration is good for all parties and ultimately better for the congregant/client. Finally, the Clergy Referral Process Model can be used to educate clergy
wanting to engage in the referral process, but are unsure how to do so. If clergy are informed about different resources and how to make appropriate referrals, they may make more. All of these opportunities arise by understanding the referral process clergy use and ultimately lead to greater support for African Americans.
References


Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as frontline community health workers: A review. *Journal of Pastoral Care, 49*(2), 129-147.


Hi, my name is Morgan Conley and I want to start off by saying thank you for letting me share with you a study I am conducting for my dissertation. I am exploring how clergy of predominantly African American churches go about making counseling referrals. I am interested in understanding the process clergy engage in when making referrals as well as what conditions facilitate or hinder that process. The goal of the study is to develop a model depicting the referral process clergy use with their predominantly African American congregants. I hope the model developed from this study can be used to empower clergy unfamiliar with how to make counseling referrals to begin making referrals and to strengthen professional relationship between clergy and other mental health providers.

As a participant in this study, you would take part in an approximately hour-long confidential interview with me during which I will collect different pieces of information. In addition to interviewing you about your experience making counseling referrals, I will also ask you for some demographic information including your educational background and the make-up of your church. Depending on how data-analysis goes, there is a potential for me to ask you to participate in a follow-up interview that is expected to last an hour or less. Throughout the entirety of the study, I will make protecting and maintaining confidentiality a priority.

If you are interested in learning more about the study, I have attached a small flyer with my contact information. Anyone can contact me to learn more about the study or to express interest in participation. By contacting me, you are not obligated to participate in this study. Instead, it is an opportunity to provide you with more information about the study and for you to ask questions.

Thank you again for your time and I hope to hear from you soon.

Morgan Conley, M.A. 
Primary Investigator 
Doctoral Candidate in Counseling Psychology 
Phone: 402-937-5827 
Morgan8806@hotmail.com

Michael J. Scheel, Ph.D. ABBP 
Faculty Advisor 
Associate Professor 
Phone: 402-472-0573 
Mscheel2@unl.edu
Appendix B

Semi-structured Interview Protocol

Time of Interview: ______________________________________________________________

Date: _________________________________________________________________________

Place: _____________________________________________________________________

Interviewee Pseudonym: _________________________________________________________

Interview Guide

1. What intrapersonal and interpersonal experiences may influence religious leaders decisions
to make counseling referrals?
   • Could you tell me about your thoughts and feelings when you learned about counseling
     referrals (e.g., referrals to professional counselors, psychologists, psychiatrists and/or
     social workers)?
   • When did you first experience making a counseling referral?
   • What was it like? If you recall, what were you thinking then? Who/what (if anyone or
     something) influenced your actions? Tell me how he/she/they/it influenced you.
   • Can you describe the events that led up to you making the counseling referral?
   • What contributed to you making your first counseling referral?

2. What client experiences and conditions may influence religious leaders decisions to make
counseling referrals?
   • What types of congregants receive referrals more frequently and less frequently than
     others? Are there gender or age differences in who receive a referral?

3. What explicit and implicit criteria do religious leaders use to determine who should be
referred for counseling services?
• How are counseling referrals similar or different to other types of referrals you make?
• Are there professional standards or practices that govern your referral decision?
• What training have you received on providing counseling referrals?
• What training have you received on mental health care management?
• Have you worked with a mental health professional before? If so, what was your relationship like with him/her/them?

4. How is a counseling referral made?
• What symptoms need to be present?
• Does the congregant have to agree with the referral?
• What steps do you take in the process?
• How is your staff involved?

5. What barriers are perceived by religious leaders to exist in making referrals?
• Are there some reasons you would chose to not make a counseling referral? If so, what are those reasons?

6. What improvements do religious leaders suggest to make the process more effective and useful?
• How could you make the process easier? How could anyone else make the process easier?

Ending Questions

1. Is there something that you might not have thought about before that occurred to you during this interview?
2. Is there something else you think I should know to understand counseling referrals better?
3. Is there anything you would like to ask me?
Appendix C

Demographic Questionnaire

Pseudonym: _____________________________________________________________

Ethnicity: ___ Asian American
           ___ Black/African American
           ___ Hawaiian or Pacific Islander
           ___ Hispanic/Latino
           ___ Native American
           ___ White/Caucasian (European American)
           ___ Other(s)________________________

Age: ________________________________________________________________

Gender: _______________________________________________________________________

Highest Degree Earned: _______________________ Degree Area: ______________________

Current Position at Church: _________________ Time in Current Position: ________________

Length of Professional Experience in this Position: ______________________________

Have you had pastoral counseling training? Please circle YES or NO

Please describe the demographic composition of your church below (e.g., ethnic populations represented, gender break-down, class, etc.)

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Appendix D

Member Checking Email

Greetings!

Thank you again for participating in my dissertation research study exploring the referral process of clergy who serve in predominantly Black churches. As we discussed, I want to share with you the tentative model I have developed based on the information shared by all participants in the study so far. Attached you’ll find a model I created for the counseling referral process clergy use. Beneath the model, you’ll see a short description for each part of the model as well as some quotes from the interviews to support why I included that part in the model.

If you are willing, I would like your feedback on the model in the attached document. At the end of the document, I ask questions to solicit some specific feedback, but you may respond however you wish. I want to ensure I am not missing anything nor misrepresenting what has been shared with me.

Please respond by Friday, July 31st with your feedback and if I do not hear from you by then, I will assume you are okay with the model as described.

Thanks and I look forward to hearing from you!

Sincerely,

Morgan Conley, M.A.
Counseling Psychology Doctoral Candidate
Educational Psychology
Appendix E

*Member Checking Email Attachment*

The Clergy Referral Process Model
Themes of the Clergy Referral Process Model

Understanding Self

Either while in pastoral care/counseling training or soon after receiving “the call” to minister, participants discussed ways they began to understand themselves. This seemed to include accepting limitations, defining their helping role, functioning within their expertise, embracing the referral process, and growing to trust counselors as healers too.

First of all you need to know your own limitations as a pastor. You are not a professional counselor unless you have a degree in counseling. You are not a professional counselor. You are a spiritual counselor and we need to be able to identify how far we can go, our limitations, and know what our limitations are and in the process of knowing that know that it is okay to make referrals when our expertise cannot help that person to make the kind of adjustment that they need to make to become a better person.

I think for me, coming from an educational background and knowing that oftentimes I was a resource for students who needed help one way or another, whether mentally, psychologically, socially, whatever, financially, I always considered myself a resource to move people from where they are to a better place.

Many participants discussed ways that understanding themselves ultimately affected their process for making referrals. It seems that once pastors understand themselves, particularly their power as a helper, they move to discuss different aspects of mental health and focus on building relationships with their parishioners.

Discussing Mental Health

Numerous participants expressed a prevailing feeling that many Black people, including the ones in their church, are leery about receiving mental health services. However, many participants expressed an appreciation for counseling that they want to share with their congregation. Thus, pastors may sometimes discuss mental health in their sermons.

I did a five week series on depression and why its important that we trust people other than our pastors and even in the midst of our counseling that we get from other people that we hear God and that we understand that God speaks in all of those moments. I preach it from the pulpit because I think it’s important.

I deal with a lot, I’m very health conscious. I seek to have a holistic ministry so we have a health moment every third Sunday.

Mental health may also be discussed during Bible study. In fact, some use the Bible to showcase examples of mental health.

In Bible study when your congregants know you and they’re like ‘Yeah pastor I want to talk, let’s talk about this tonight,’ I’m like yeah let me find that in the Bible, it’s in there
you know. What we talked about a couple of weeks ago, Jonah and the whale. I said Jonah was depressed, depression is all in the Bible.

Discussing mental health amongst the entire congregation may help parishioners feel more comfortable coming to their pastor for a mental health concern.

Relationship with Parishioners

Besides discussing mental health with parishioners, participants also expressed attentiveness to developing relationships with their church members. Many talked about cultivating trust by engaging members when they are doing well so that when members are not doing well, they know they can reach out to their pastor.

Generally I have very strong relationships with people [and] their children. I try to respect people. I try to be concerned about their needs. If a person is feeling down in church I’ll go up and talk to them and I try every Sunday to shake hands with everybody in some form. And I try to talk to them when they don’t need help because I have experienced that if you don’t have a good relationship with people when they don’t need help, they’re less likely to come to you when they need help.

It seems that when pastors are discussing mental health in their church and cultivating close relationships with their members, they empower parishioners to share their mental health concerns.

Including Staff

Sometimes, other church leaders get involved in the referral making process. Members may approach other church leaders instead of the pastor or a pastor may request the assistance of another church leader. However, most participants said they prefer to be the primary person handling mental health concerns because they either like it or because it is their responsibility.

One of the Deacons received a phone call from a woman who had decided that end of life was a viable alternative. She then said can I speak to minister X. Minister X just received a licensed to train and then he turned and then called the Discipleship Pastor to let him know what was going down because he didn’t feel comfortable. He called me.

So if somebody else does something and it slips out, there’s no repercussions for them. They’re a lay minister or they’re a Director of Education, ah my administrative assistant and I tell them I’m, my butt is on the line for this church nobody else so whatever you do or whatever you say and if it’s inappropriate and it slips out, you shouldn’t have said it, guess what you can go to another church. I lose my ordination, I lose my pension.

The stewards in particular pretty much are there when I ask them. When I say hey its time to make the phone call, they follow my leadership in other words. If I diffuse the situation enough to where I’m holding the person’s hand and we are literally walking then the
officers are right there with me walking beside me as well trying not to make things
glad.

Meeting

Participants explained that meetings are arranged in one of two ways. First, a pastor would share
his or her concern with a parishioner.

Just because you see it that doesn’t mean you jump on it. That doesn’t mean you say
something. You wait for an opportunity because what happens, you don’t ever want to
offend anybody or you never want to hurt any bodies feelings cause everything that Jesus
did he did in love. And so you never want to do that. So you wait for an opportunity
cause He’ll let you know when it’s time to approach it. And then even if it doesn’t come
to you, when you approach it, it will be received because He has already prepared the
heart to receive it.

More common is that a member will approach the pastor asking to meet with him or her.

Most of the time members will come to me. I mean they might say something on Sunday
and if it stays in my crawl then I might say you know we need to talk. Most of the time
people will say pastor can I make an appointment to talk to you and then that’s when
they’ll share.

Assessing Need

Once a meeting has been arranged, participants explained they assess the needs of the
parishioner. The first step is listening to what the parishioner is experiencing.

Usually you have to sit and listen to the person for a long period of time because usually
when people come in sometimes they camouflage what is deeper, what is happening to
them at a deeper level with spiritual clichés, okay. So the first thing I do, you know I sit
down and I listen attentively to what the person is saying and I try to go, I try to bypass
the initial conversation and ask questions.

Then, the pastor must determine if they can manage what the parishioner shares or if they must
consider making a referral.

For me I’m determining is this something I have counseled people in before. Let’s say
it’s marriage, okay done. Did that, and she’s saying oh my husband ignores me or my
husband doesn’t go to church and I need to talk about that. Great, cool, my wheelhouse,
cool, got that. She comes in and she says, um, I’m having some gender identity issues I
really think I’m a man or I just got some issues with gender or I got some issues with sex,
something like, not in my wheelhouse.

If there are these constant conversations, the same conversations [and] nothing has
changed. We’re still talking about things that happened in childhood and this person is
now thirty, forty years old and they’re still rehashing some of the things that took place and during the course of the conversation say some child abuse issues may have come out then I know immediately even though intuitively I know there is something deeper then what they are saying

Some issues are automatically referred.

When it comes to children, that’s automatically something you need to send to a professional.

There may be several meetings before deciding a referral is needed. One participant actually developed a checklist to determine what is within her expertise.

Usually when I have to make a referral it’s after several meetings. Sometimes you have to realize that it’s not your expertise and so of course you send it to where it belongs whether it’s a psychologist, whether it’s a uh, whatever, you know, if it’s not your expertise. So it’s based off a number of things. I have a checklist that I use to meet the criteria because you got to know your boundary and so to be inside, in my boundary, there’s certain criteria. Um, if they don’t meet that than that mean they’re outside my boundary and so then I look at referral.

Spiritual Issue

All participants agreed about feeling capable of managing spiritual issues that their parishioners present to them. However, sometimes what was deemed as a spiritual issue turns out to be something else. Participants discussed how they distinguish between a spiritual matter and something they might need to refer.

So for example if I’m talking with somebody and this person starts to talk to me about you know things that happened to them in their childhood and it seems like some of those things are still playing out now I know that it’s beyond a spiritual issue. That person needs to talk to somebody to get some professional help.

No matter how much I talked to them, they had not gotten any further. It was like a repeat performance and I recognize that whatever I was doing whether it was beyond my skills or it was beyond the level of intimacy they wanted to share with me, I recognize that uh, myself who I was, my relationship with them and that we were not working out. We needed someone else. And I referred them, suggested to them that they should go to a marriage counselor.

And then there are some people who want resolutions and I, I wait and see who I, am I able through talking to them giving them some satisfactory resolutions and sometimes they you know, reading the Bible ain’t enough. They need to go to someone who has expertise in deciphering issues and concerns that most pastors are not aware of.
Refer

When it comes to actually making the referral, many pastors lack formal training, but they have developed a process on their own.

There hasn’t been a particular protocol in terms of referring parishioners to those areas but it’s just basically my gut, my intuition and having good friends who are mental health profession and just letting them know that hey this person is coming to see you is that okay, what are your hours of operation, how can we make this work.

Who the pastor decides to refer to depends on a variety of factors. This includes the breadth of counselors that pastor knows about as well as the specialty area of the counselor. Many participants reflected a desire to refer their members to Black and/or counselors with a Christian belief.

Everybody has a worldview and our worldview informs our various things in life and our worldview is informed I believe as a Christian your worldview is informed by your Christian life I think and I believe and I might be wrong that your approach based your worldview can be different from person to person and so a Christian worldview on counseling might be a little different. The person might be freer to talk about certain things that they might not be freer to talk about if they were not a Christian. And so because of that I prefer that, that would be my preference.

The question isn’t am I going to outsource this person, the question is to whom am I going to outsource this person and so if as a Christian pastor I’m going to send this person to a secular counselor, I’m not going to do that because that person, we’re not on the same wave length in terms of what this person is going to give the person I have referred. But if I know that the person I’m going to send them to is a faith based counselor or has a foundation of faith than at least the person will be getting a similar line of impact influence as opposed to somebody who’s at best an atheist, at best an agnostic and someone who will not integrate at least to some degree of even value the faith dynamic at all and so I think that’s the other thing. I would rather hold on to this person and prod away at trying to figure out what’s going on than to give this person to some ungodly counselor who is going to take him or her in a direction that’s totally off base. I’m not even going to hand this person over to that person. There’s no way I’m going to do that.

One of the big things I look for in referral is ethnicity, that is very important.

Also worth mentioning is that counseling referrals are handled differently that the other types of referrals that pastors make.

They’re just more intimate, more difficult, and they weigh more heavily on me than any other referral. I know I can feed people. I don’t know if I can keep people from being suicidal or if I can help people walk through sexual abuse or if I can help people find people to walk them through their gender identity issues.
I’m more delicate. Um, I talk to them in the office whereas if someone just asks me you know um with someone going, having problems, legal problems, I talk to them in the office as well, but some people just come up and say well reverend do you know of a real estate agent I say she’s just right over there, you know. That’s not so personal.

Most participants also stated there are few reasons they would not make a referral.

I would always try to see if I can make a referral. Maybe the only reason would be the person’s own willingness to follow through with a referral and it depends on what is really happening.

Barriers

Once a pastor has decided that a referral is needed and appropriate, there may be barriers that prevent that referral from actualizing. Barriers include internal factors involving the pastor as well as the parishioner affording and wanting professional counseling services.

No one wants to say they don’t have the answer. I mean can you imagine someone being so brutally honest saying well I don’t know that. And certainly in the Black church we make up stuff as we go. No one really wants to say I don’t know that, this is a mystery to me. Can we just be okay with the mystery?… It’s the messiah complex.

I was trying to fix every bodies problems and it became very frustrating for me because I didn’t, I wouldn’t accept that it was out of my fear. It was out of my fear. I needed to send it where it belonged so it would get the proper help.

A lot of it has to do with the fact that it might be a little expensive you know and for the most part there has been out of pocket expense of going to see a therapist is pretty incredible.

I had to work on a lot of people did not have health insurance and now with affordable health care we had the enrollment time here at the church to make sure people got signed up.

Follow-Up

Once a member has agreed to see a counselor and/or started receiving services, pastors may follow-up with a member in a variety of ways.

I follow up to make sure they have called. I usually give between maybe three to seven days before I start asking the question of if they’ve made that contact and its obvious if a person doesn’t come to church than I know there’s something deeper going on and I know that they haven’t made that contact with the therapist and I call and try to figure out what is going on.
That looks like, hey so you have your session today, and most of the time they do choose to share with me if they’re going outside when their sessions are. Um, so I call and say hey you’re having your session today, you want me to come and sit outside and wait for you. Sometimes yes, sometimes no. So doing that. Always a call afterwards. Say hey how did it go. You feel comfortable. Everything alright. Do you like them.

For individuals given a referral, but decide not to follow-through with that referral, the pastor may also respond in different ways.

I keep following through with them and try to see if I can get them to change, to change their initial thought about seeking professional help. I think sometimes people just want to be comfortable in knowing that whoever they are going to talk to other then their pastor

You learn to not look at rejection as a personal thing. You take nothing personal cause it’s not me that he rejected, it was the service I was offering. It wasn’t me, he still loves me, he still hugs me, he’s still able to do service and you know that goes back to everybody, um, there’s a season for everything. You know, this just wasn’t his season. I’m not going to hold it against him.

And all of these correspondences remain confidential.

Very confidential. I don’t, if someone comes to me with a problem and if I ask them do you want me to share it with someone else, most people say no. They have um, there’s a very uh confidential relationship that exists between the pastor and the members. Actually it’s the same thing as a lawyer, if someone tells me something under certain conditions, I’m not even in court, I’m free, I’m obligated not to tell.

Questions
1. Is there anything missing from this model that you believe is critical for understanding the counseling referral process for clergy?
2. Listed are barriers preventing referral. Are there any supports?
3. Is the sequence presented here accurate? Does any part of the process loop back or rely on other important conditions?
4. Any other feedback?
Appendix F

Data Analysis Example

<table>
<thead>
<tr>
<th>Themes</th>
<th>Mark</th>
<th>Lorna</th>
<th>Jeff</th>
<th>Mary</th>
<th>Nina</th>
<th>Angela</th>
<th>Tori</th>
<th>Zane</th>
<th>Milt</th>
<th>Focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>About</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonnel Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Role</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Categories</th>
<th>Accepting Limitations: Understanding Self</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Understanding self</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>