ABSTRACT

Extensions of Grace: An Examination of Clergy
as Gatekeepers in Youth Mental Health

David C. McClung, Ph.D.

Mentor: David K. Pooler, Ph.D.

Approximately half of all mental health concerns will begin by 14 years of age and 75% will develop by 24 years of age. Congregations are often a primary point of contact for individuals seeking support related to a mental health concern. Current research indicates, however, that clergy may frequently lack the mental health education and relationships with mental health professionals to provide adequate support. Some of the factors that are thought to create these divisions in service delivery include historical tensions regarding differences in interpretation of mental health, lack of awareness of available community resources, ambivalence surrounding the perceived risks and benefits of collaboration, and mistrust of the values and practices of mental health professionals. Nevertheless, the opportunity to further integrate clergy and their congregations within systems of care remains evident. The present dissertation seeks to further explore the role of congregations as it relates as to youth mental health.

Extensions of Grace: An Examination of Clergy as Gatekeepers in Youth Mental Health

by

David McClung, B.S., M.Div., M.S.W.

A Dissertation

Approved by Diana R. Garland School of Social Work

_____

Jon E. Singletary, Ph.D., Chairperson

Submitted to the Graduate Faculty of
Baylor University in Partial Fulfillment of the
Requirements for the Degree
of

Doctor of Philosophy

Approved by the Dissertation Committee

_____

David K. Pooler, Ph.D., Chairperson

_____

Edward C. Polson, Ph.D.

_____

Robin K. Rogers, Ph.D.

_____

Gaynor I. Yancey, D.S.W.

_____

R. Robert Creech, Ph.D.

Accepted by the Graduate School

May 2020

_____

J. Larry Lyon, Ph.D., Dean

Page bearing signatures is kept on file in the Graduate School.

TABLE OF CONTENTS

LIST OF FIGURES

ACKNOWLEDGMENTS

I would like to express my sincere appreciation to my committee for the expertise and wisdom that they have contributed to this dissertation. I would also like to extend a special thank you to my chair, Dr. David Pooler, for his continuous support and guidance every step of way. I am greatly indebted to the Diana R. Garland School of Social Work and Baylor University, whose professors have played a profound role in my life by nurturing my desire to learn and growing my concern for others. In particular, I am extremely grateful for the opportunity to have been one of Dr. Diana Garland's students and for the mentoring that she provided to me. I also wish to offer a special thank you to Rachel Gillespie for her assistance with conducting and transcribing interviews.

I would also like to express appreciation to my family and friends for their unwavering support. A special thank you to my beautiful wife, Lauren McClung, who has provided me with relentless patience, encouragement, and love. I am also thankful for my parents, Michael and Jackie McClung, who taught me to care for others with the love of Christ and who have always encouraged me to pursue my calling. An additional thank you to my aunt and uncle, Drs. Jim and Jean Goodwin, for their ongoing support. I would also like to thank the Stidham family for the supportive role that they have played throughout my life and that of my family.

I would like to express my appreciation to my colleagues at the University of Texas at Austin and throughout the country who have provided me with countless opportunities for growth and development. I am extremely grateful to the advocates,

peers, and mental health professionals who have dedicated their lives to serving others and creating responsive systems of care. A special thank you to Michael Cox, who showed me the value of my lived experience and the power of my voice.

DEDICATION

To the youth and young adults who have lacked the presence of supportive adults and responsive systems in their lives. You are not forgotten. Your voice and your experiences matter. Thank you for your courage and bravery to speak and advocate for one another. May your wisdom and lived experience ever continue to inspire and drive change.

CHAPTER ONE

Extensions of Grace: An Examination of Clergy as Gatekeepers in Youth Mental Health

Abstract

Although a growing number of Americans do not identify as religious, congregations remain a primary point of contact for individuals seeking mental health services (Ellison et al., 2006a; Hall & Gjesfjeld, 2013, 2013; Openshaw & Harr, 2009; Pew Research Center, 2015; Wang et al., 2003). Current research indicates, however, that clergy may frequently lack the mental health education and relationships with mental health professionals to provide adequate support. Some of the factors that create these divisions in service delivery include historical tensions regarding differences in interpretation of mental health, lack of awareness of available community resources, ambivalence surrounding the perceived risks and benefits of collaboration, and mistrust of the values and practices of mental health professionals. Nevertheless, evidence remains of valuable opportunity to be found in further integrations of clergy and their congregations within systems of care. The present dissertation seeks to further explore the role of congregations as it relates as to youth mental health. The dissertation includes a quantitative study on youth mental health literacy with Protestant clergy in Texas, a qualitative study with Baptist General Convention of Texas (BGCT) youth ministers' pastoral care practices as it relates to youth mental health, and a theoretical practice model for how clergy and mental health professionals may further collaborate to better support youth with mental health challenges.

Introduction

Although, a growing number of Americans do not identify as religious, congregations remain a primary point of contact for individuals seeking mental health services (Ellison et al., 2006a; Hall & Gjesfjeld, 2013, 2013; Openshaw & Harr, 2009; Pew Research Center, 2015; Wang et al., 2003). Current research indicates, however, that clergy may frequently lack the mental health education and relationships with mental health professionals to provide adequate support. Some of the factors thought to create these divisions in service delivery include historical tensions regarding differences in interpretation of mental health, lack of awareness of available community resources, ambivalence surrounding the perceived risks and benefits of collaboration, and mistrust of the values and practices of mental health professionals. Nevertheless, evidence remains of valuable opportunity to be found in further integrations of clergy and their congregations within systems of care.

The present dissertation seeks to further explore the role of congregations as it relates to youth mental health. This first chapter provides an overview of the existing literature, explore the gaps in current research and practice models, and outlines the three manuscripts developed for the completion of this dissertation. Chapter two is a quantitative study that used a custom 85-item instrument to assess youth metal healthy literacy with Protestant clergy in Texas. Chapter three consists of a qualitative study that was conducted with 13 Baptist youth ministers in Central Texas to explore pastoral care practices with youth who have experienced a mental health concern.

Utilizing the findings from these two studies, chapter four proposes a theoretical model for developing partnerships between clergy and mental health professionals. The dissertation concludes with a summary of findings, dissemination plan, discussion on limitations, and recommendations for future research.

Congregations as Gatekeepers in Mental Health

Mental health challenges may frequently be misunderstood or stigmatized, but their prevalence is undeniable. Approximately half of all mental health concerns will begin by 14 years of age and 75% will develop by 24 years of age (R C Kessler et al., 2001; Merikangas et al., 2011; New Freedom Commission on Mental Health, 2003). In the National Comorbidity Survey-Adolescent Supplement, researchers found the median age of onset to be age 6 for anxiety disorders, age 11 for behavior disorders, age 13 for mood disorders, and age 15 for substance abuse disorders (Merikangas et al., 2010). In addition, 40% of adolescents who met the criterion for one class of disorder also met the criterion for a disorder in another class (Merikangas et al., 2010).

Although mental health concerns may begin at an early age, the provision of mental health services may frequently be delayed. In an international study of patient advocate groups across 11 countries, less than half (40%) of the participants reported receiving services within the first year of onset. The remaining 60% of participants shared waiting a median of 8 years before accessing services (Christiana et al., 2000). These numbers may not account, however, for the nearly 50% of individuals who have a mental health challenge but will not access mental health services within their lifetime (New Freedom Commission on Mental Health, 2003). Inequities within mental health service delivery may also exist across diagnoses. For instance, a study of adolescents in

the United States found that while 36.2% of adolescents with mental disorders had received mental health services, less than 20% of adolescents with anxiety, eating, or substance use disorders reported receiving services (Merikangas et al., 2011).

Although clergy may commonly be overlooked in mental health coordination and service delivery, their role of congregations within systems of care remain significant. To the contrary, religious involvement may help to support well-being, coping, and provide a source of social support (Ellison et al., 2009; Koenig, 2009; Nooney & Woodrum, 2002). Research indicates that approximately 25% of individuals with a mental health concern will consult a clergy member for support, a frequency that is higher than the percentage in which psychiatrists (16.7%) or general medical doctors (16.7%) may be sought (Ellison et al., 2006b; Wang et al., 2003). Researchers estimate that approximately one quarter of mental health consultations with clergy will be with individuals who are experiencing the highest intensity of mental health challenges (Wang et al., 2003).

The implications of these interactions should not be underestimated. Valuable opportunity is found in supporting congregations as gatekeepers in youth mental health, however, potential for harm also exists. For example, consultations with clergy regarding a mental health concern may not always translate into being able to access mental health services. Wang, Berglund, and Kessler (2003) found that less than half (44%) of the individuals who had consulted clergy for support related to a mental health concern had also seen another provider type. These low rates of mental health service utilization may partially be attributed to low referral rates from clergy to mental health professionals, with clergy making referrals less than 10% of the time (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979).

Some of the factors that may contribute to low referral rates include clergy not knowing when or how to make a referral, lacking working relationships with mental health professionals, and having concerns about whether the guidance of mental health professionals align with the theological positions of clergy and their congregations (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). Nevertheless, other factors also help to support the ability of clergy to feel comfortable making mental health referrals. For instance, clergy reported that they are more likely to make referrals to mental health professionals who share similar theological beliefs and who are sensitive and respectful of client spirituality (Farrell & Goebert, 2008b; McMinn et al., 2005; Openshaw & Harr, 2009). Referrals may also occur when clergy recognize the mental health concern to be outside of their knowledge or practice. (Polson & Rogers, 2007). Low referral rates, however, indicate that clergy may not always recognize when these points of limitation have been reached.

While making a mental health referral does not necessitate having a comprehensive understanding of mental health, knowledge of such information is beneficial in knowing when and how to do so. Clergy, however may frequently lack access to mental health education, with 70-80% of clergy reporting that their seminary education did not provide them with adequate information about mental health (Farrell & Goebert, 2008c; Kaseman & Anderson, 1977; Virkler, 1979). These reports are substantiated by the low priority that seminaries have historically placed on mental health education. In a study of 70 North American seminary programs, 70% of the programs reported requiring less than two classes in counseling for the completion of a Master of

Divinity degree, while 12% of the seminaries did not address mental health in any part of their curriculum (Ross & Stanford, 2014).

Clergy may have the ability or resources to independently seek out mental health training, but little is known about whether such information would be welcomed and what channels might be most beneficial for dissemination of these materials. Furthermore, the likelihood that clergy will access such training is thought to be facilitated by a recognition of the need for and benefits of such information. In these respects, the old adage stands true: "You do not know what you do not know."

As such, clergy may frequently depend on their own knowledge and resources to try to support youth with mental health concerns through the provision of what is commonly termed pastoral care. Although a number of books and other literature are frequently cited that outline theological positions for the roles and responsibilities of clergy, including the provision of pastoral care, little empirical evidence exists for how these positions play out or align with pastoral care practice (Clark, 2011; Clebsch & Jaekle, 1994; Doehring, 2014; Joiner, 2009; Lyall, 2001; Powell et al., 2011; Root, 2009). Existing literature suggests that clergy may also struggle with knowing how to describe their work. For instance, in a study of college ministers, only 20% of clergy reported using biblical counseling/pastoral care (Hunter & Stanford, 2014). These numbers are surprising given the large number of practices that may fit under the framework of pastoral care and raise questions about what the other 80% of ministers are doing in their work.

Despite these ambiguities, the potential risks of working outside the realm of professional role and knowledge remain clear. Congregations have historically played a

significant role in the provision of social services, but notable examples of congregational abuse, neglect, and exploitation also appear (D'Antonio, 2014a; Garland & Yancey, 2014; Goldenberg, 2013a; Heimlich, 2011a). While pastoral care may play an important role in the healing and recovery process, the most well-intentioned clergy may also cause unintentional harm when they lack adequate mental health training, support, or coordination of services. In an online survey of Christians who had sought counseling from clergy, 30% reported a negative interaction, 36% reported that their faith was weakened, and 12.6% reported leaving their faith as a result of this interaction (Stanford, 2007). Whether these individuals also sought a mental health professional for support and the degree to which mental health professionals may have a negative impact on a person's religion or spirituality is unclear. And although a loss of faith or leaving a faith tradition may appear to only have implications for spiritual health, available research suggests implications for mental health. In a study of adolescents with depression, researchers found that loss of faith was a predictor of less improvement in depressive symptoms (Dew et al., 2010). The same systems that may be used to increase accessibility and coordination of mental health services may also be found as the coup de grâce to a mental health system that so often lacks the resources and partnerships desperately needed to adequately serve youth and families.

Overview of Dissertation

The manuscripts within this dissertation with the hope of filling some of the notable gaps in the existing literature. This research assumes that having additional information about clergy beliefs and practices in relationship to youth mental health will

contribute to the more effective design of culturally responsive, contextualized training and education materials.

Overview of Chapter Two

The field of mental health literacy provides a strong framework for understanding these attitudes, beliefs, and practices (A F Jorm et al., 1997; Anthony F. Jorm et al., 2010; O'Connor et al., 2014a; Reavley & Jorm, 2011a). Mental health literacy holds intrinsic value, but a challenge is that the term "mental health literacy" has also become an umbrella term that contains numerous, and sometimes ambiguous, constructs. A review of the literature also shows that many of the existing instruments on mental health literacy use vignettes to assess for whether individuals can identify mental health diagnoses. (O'Connor et al., 2014a; Yang & Link, 2015). Although vignettes may be beneficial for some populations, this methodology appears less relevant to clergy.

In chapter two, the researcher uses a custom 85-item instrument to examine the gatekeeping role of Protestant clergy in Texas, specifically exploring their mental health education, beliefs about causes of mental health challenges, perceived effectiveness of services to support youth mental health, the role of congregations in youth mental health, relationships with mental health professionals, and degree to which clergy practices encourage social inclusion and belonging. Purposive and snowball sampling methods were used to anonymously survey 170 clergy. The sample reports a willingness to answer mental health professionals' questions about religion and spirituality and being comfortable asking questions about mental health, however clergy also reported low amounts of trust in the ability for other professionals to adequately support youth with

mental health challenges, and low amounts of confidence in the accuracy of public information about mental health.

Overview of Chapter Three

Although chapter two provides insight into how Protestant clergy may generally perceive and understand youth mental health, chapter three seeks to understand how these beliefs may play into the pastoral care practices of ordained Baptist youth ministers in Central Texas. As described in the literature review, little empirical evidence is available to understand what activities may frequently be performed under the umbrella of pastoral care (Clebsch & Jaekle, 1994; Lyall, 2001). The absence of clear practice models and descriptions of pastoral care considerably raise the potential for misuse of power in the relationship between clergy and individuals seeking mental health support. These absences allow for any number of activities to be performed under the umbrella of pastoral care, even when doing so is outside of their knowledge or skill set.

Critical theory perspectives are concerned with empowering human beings to transcend the constraints placed on them by race, class, and gender" (Creswell, 2006, p. 27). Some of the themes that may be examined in critical theory are the historical role of social institutions and historical pathways for social isolation (Fay, 1987). In this study, critical theory is expanded to include religion and congregations as social institutions that may disempower or disenfranchise individuals from seeking adequate mental health services for fear of risking religious disassociation or isolation. In this qualitative study, researchers utilized critical phenomenology methods to conduct purposive, semi-structured interviews with 13 youth ministers who work in one of two selected Baptist General Convention of Texas (BGCT) associations. Findings indicate that clergy

frequently report being overwhelmed by the amount of responsibilities that they have been expected to fulfill by congregations. Although the power and authority bestowed upon clergy may be used within pastoral care to support youth with mental health challenges, this same power also holds potential to cause great and unintended harm.

Overview of Chapter Four

Studies in chapters three and four found significant gaps in service delivery coordination and coordination between clergy and mental health professionals. Social capital theory helps to explain how relationships may be used as a channel to gather, increase, and effectively utilize the collective knowledge, experiences, and resources that are found within a community. Relationships foster a sense of connection and belonging, providing an avenue for knowledge, information, and other forms of capital to be shared with one another. In chapter four, the researcher utilizes social capital theory to provide a practical model for how congregations and mental health professionals can develop working partnerships with one another as a pathway for supporting the mental health of individuals and communities. Chapter four concludes with a case study and questions that may be used within seminary courses or other educational settings to promote critical thinking about how the model might be applied to practice.

Overview of Chapter Five

Chapter five concludes the dissertation with a summary of findings, a dissemination plan, implications for research and practice, limitations of the study, and recommendations for future social work research, practice, and policy.

REFERENCES

Christiana, J. M., Gilman, S. E., Guardino, M., Mickelson, K., Morselli, P. L., Olfson, M., & Kessler, R. C. (2000). Duration between onset and time of obtaining initial treatment among people with anxiety and mood disorders: An international survey of members of mental health patient advocate groups. *Psychological Medicine*, *30*(3), 693–703.

Clark, C. (2011). *Hurt 2.0*. Baker Academic.

Clebsch, W. A., & Jaekle, C. R. (Eds.). (1994). *Pastoral care in historical perspective* (New edition). Jason Aronson, Inc.

Creswell, J. (2006). *Qualitative inquiry and research design: Choosing among five approaches* (2nd edition). SAGE Publications, Inc.

D'Antonio, M. (2014). *Mortal sins: Sex, crime, and the era of Catholic scandal* (Reprint edition). St. Martin's Griffin.

Dew, R. E., Daniel, S. S., Goldston, D. B., McCall, W. V., Kuchibhatla, M., Schleifer, C., Triplett, M. F., & Koenig, H. G. (2010). A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. *Journal of Affective Disorders*, *120*(1–3), 149–157. https://doi.org/10.1016/j.jad.2009.04.029

Doehring, C. (2014). *The practice of pastoral care,* (Revised and Expanded edition). Westminster John Knox Press.

Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006a). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 190–211.

Ellison, Zhang, W., Krause, N., & Marcum, J. P. (2009). Does negative interaction in the church increase psychological distress? Longitudinal findings from the Presbyterian panel survey. *Sociology of Religion*, *70*(4), 409–431. https://doi.org/10.1093/socrel/srp062

Farrell, J. L., & Goebert, D. A. (2008a). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, *59*(4), 437–440. https://doi.org/10.1176/ps.2008.59.4.437

Fay, B. (1987). *Critical social science: Liberation and its limits*. Cornell Univ Pr.

Garland, D. R., & Yancey, G. I. (2014). *Congregational social work: Christian perspectives* (First edition). North American Association of Christians in Social Work.

Goldenberg, R. (2013). Unholy clergy: Amending state child abuse reporting statutes to include clergy members as mandatory reporters in child sexual abuse cases. *Family Court Review*, *51*(2), 298–315. https://doi.org/10.1111/fcre.12028

Hall, S. A., & Gjesfjeld, C. D. (2013). Clergy: A partner in rural mental health? *Journal of Rural Mental Health*, *37*(1), 50–57. https://doi.org/10.1037/rmh0000006

Heimlich, J. (2011). *Breaking their will: Shedding light on religious child maltreatment*. Prometheus Books.

Hunter, W., & Stanford, M. (2014). Adolescent mental health: The role of youth and college pastors. *Mental Health, Religion & Culture*, *17*(10), 957–966. https://doi.org/10.1080/13674676.2014.966663

Joiner, R. (2009). *Think orange: Imagine the impact when church and family collide...* (New edition). David C. Cook.

Jorm, A F, Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). “Mental health literacy”: A survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, *166*(4), 182–186.

Jorm, Anthony F., Kitchener, B. A., Fischer, J.-A., & Cvetkovski, S. (2010). Mental health first aid training by e-learning: A randomized controlled trial. *The Australian and New Zealand Journal of Psychiatry*, *44*(12), 1072–1081. https://doi.org/10.3109/00048674.2010.516426

Kaseman, C. M., & Anderson, R. G. (1977). Clergy consultation as a community mental health program. *Community Mental Health Journal*, *13*(1), 84.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

Koenig, H. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatria*, *54*(5), 283–291.

Lyall, D. (2001). *Integrity of pastoral care*. The Society For Promoting Christian Knowledge.

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005, December 22). *Factors affecting clergy-psychologist referral patterns*. Journal of Psychology and Theology. http://link.galegroup.com/apps/doc/A142151269/AONE?sid=lms

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mollica, R. F., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*, *143*(3), 323–328. https://doi.org/10.1176/ajp.143.3.323

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS pub no SMA-03—3832). Department of Health and Human Services.

Nooney, J., & Woodrum, E. (2002). Religious coping and church-based social support as predictors of mental health outcomes: Testing a conceptual model. *Journal for the Scientific Study of Religion*, *41*(2), 359–368. https://doi.org/10.1111/1468-5906.00122

O'Connor, M., Casey, L., & Clough, B. (2014). Measuring mental health literacy—A review of scale-based measures. *Journal of Mental Health (Abingdon, England)*, *23*(4), 197–204. https://doi.org/10.3109/09638237.2014.910646

Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, *36*(3), 301.

Pew Research Center, G. (2015). *America's changing religious landscape*. Pew Internet & American Life Project. http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

Polson, L. M., & Rogers, R. K. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, *34*(1). http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=07375778&AN=24474035&h=UEQjeHQKZen4QD3lware%2FvySzdZVOtZX20gW9zeQ8%2BschrZAXX1HGO4n7eaKTGoeEUL7Mz3xEnBydNXcF9689Q%3D%3D&crl=c

Powell, K. E., Clark, C., & Candy, J. O. and J. (2011). *Sticky faith: Everyday ideas to build lasting faith in your kids*. Zondervan.

Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: Findings from an Australian national survey of mental health literacy and stigma. *Australian and New Zealand Journal of Psychiatry*, *45*(11), 947–956. https://doi.org/10.3109/00048674.2011.621060

Root, A. (2009). *Revisiting relational youth ministry: From a strategy of influence to a theology of incarnation*. IVP Books.

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American master's of divinity students in relation to serious mental illness. *Journal of Research on Christian Education*, *23*(2), 176–186. https://doi.org/10.1080/10656219.2014.899480

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445–449. https://doi.org/10.1080/13674670600903049

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black church. *Social Work*, *45*(1), 73–87. https://doi.org/10.1093/sw/45.1.73

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology*, *7*(4), 271–280. https://doi.org/10.1177/009164717900700405

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647–673. https://doi.org/10.1111/1475-6773.00138

Yang, L. H., & Link, B. G. (2015). *Measurement of attitudes, beliefs and behaviors of mental health and mental illness*. http://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170048.pdf

CHAPTER TWO

An Examination of Texas Protestant Clergy Beliefs and Practices Related to Youth Mental Health

Abstract

The field of mental health literacy provides a strong framework for understanding the attitudes, beliefs, and practices of clergy related to youth mental health. The present study uses a custom 85-item instrument to examine the gatekeeping role of Protestant clergy in Texas, specifically exploring their mental health education, beliefs about causes of mental health challenges, perceived effectiveness of services to support youth mental health, the role of congregations in youth mental health, relationships with mental health professionals, and degree to which clergy practices encourage social inclusion and belonging. Purposive and snowball sampling methods were used to anonymously survey 170 clergy. The sample reported a willingness to answer mental health professionals' questions about religion and spirituality and being comfortable asking questions about mental health. In practice, however, clergy also reported low amounts of trust in the ability of other professionals to adequately support youth with mental health challenges, low amounts of confidence in the accuracy of publicly available information about mental health. Nevertheless, partnerships between clergy and mental health professionals play a valuable role in increasing access to mental health services and supports, cultural responsiveness of mental health services, and building a strong community-based system of care for children and adolescents.

Introduction

Families may frequently consult clergy about mental health concerns, but evidence suggests that clergy may infrequently refer individuals to mental health professionals for additional support. Some of the factors contributing to this disconnect include clergy lack of trust of other professionals to support congregational mental health, few working relationships with mental health professionals, limited amounts of mental health education, and differing perspectives on the causes of mental health challenges and types of services that are believed to be effective. Existing literature helps to substantiate and confirm the validity of these perceived challenges, however little research has been done concerning clergy attitudes, beliefs, and practices related to mental health and an even smaller body of literature exists specific to youth mental health.

Mental health literacy is a term commonly used to describe the knowledge, ideas, perceptions, and beliefs that individuals or a collection of individuals hold about mental health. The field of mental health literacy provides a strong framework for understanding the attitudes, beliefs, and practice of clergy related to youth mental health. The present study uses an author developed 85-item instrument to examine the gatekeeping role of Protestant clergy in Texas, specifically exploring their mental health education, beliefs about causes of mental health challenges, perceived effectiveness of services to support youth mental health, the role of congregations in youth mental health, relationships with mental health professionals, and degree to which clergy practices encourage social inclusion and belonging. Purposive and snowball sampling methods were used to anonymously survey 170 clergy. While the sample reports a willingness to answer mental

health professionals' questions about religion and spirituality and being comfortable asking questions about mental health, clergy also reported low levels of trust in the ability for other professionals to adequately support youth with mental health challenges, and low levels of confidence in the accuracy of public information about mental health. Nevertheless, partnerships between clergy and mental health professionals play a valuable role in increasing access to mental health services, cultural responsiveness of mental health services, and building a strong community-based system of care for children and adolescents.

A Review of the Literature

An Overview of Youth Mental Health

Despite being commonly overlooked in mental health program development and system coordination, the role of clergy and congregations in youth mental health is substantial. Research indicates that approximately 25% of individuals who seek mental health support will consult with a clergy member (Ellison et al., 2006b; Wang et al., 2003). Approximately, one quarter of these consultations will be initiated by individuals experiencing the highest intensity of mental health challenges (Wang et al., 2003).

While half of these mental health concerns will begin by 14 years of age and 75% will develop by 24 years of age, it is estimated that only half of individuals with a mental health challenge will receive mental health services within their lifetime (R C Kessler et al., 2001; Merikangas et al., 2011; New Freedom Commission on Mental Health, 2003). A study of adolescents in the United States found that although 36.2% of adolescents with mental disorders had received mental health services, less than 20% of adolescents

with anxiety, eating, or substance use disorders reported receiving services (Merikangas et al., 2011). These numbers are consistent with other research, which also suggests services may not always be sought at the point of onset. In a study of members of patient advocate groups from 11 countries, 40% of participants reported seeking treatment within the first year of onset, the remaining 60% of participants, however, reported waiting a median of 8 years before receiving services (Christiana et al., 2000).

Clergy Utilization of Mental Health Professionals

Several factors contribute to low utilization of mental health services including a small percentage of referrals, lack of mental health education, and mistrust of mental health professionals. For instance, although congregations may frequently be asked to serve as mental health gatekeepers, clergy have been shown to make referrals to mental health professionals less than 10% of the time (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979). Research suggests that clergy may lack a knowledge of when and how to make a referral and may lack strong relationships with mental health professionals to who they might make these referrals.

Theoretical and theological differences in understanding mental health also discourage individuals from seeking mental health support. For example, clergy are more like to make referrals to mental health professionals who share similar beliefs. (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). In a study conducted by Farrell and Goebert (2008), 41% of the responding pastors stated that shared religious beliefs between the client and the psychologist are ‘‘important’’ and another 15% of responding stated that those shared beliefs are ‘‘essential” (p. 439). Clergy are most likely to make referrals

when they recognize that the work is outside the scope of their knowledge or perceived role (Polson & Rogers, 2007).

Clergy Mental Health Education

Questions remain, however, as to whether clergy have enough formal education about mental health to know best practices for clergy to support youth experiencing mental health challenges and when the support of a mental health professional would be beneficial. In a study of 70 North American seminary programs, 70% of the programs reported requiring fewer than two classes in counseling for the completion of a Master of Divinity degree, while 12% of the survey seminaries did not address mental health in any part of their curriculum (Ross & Stanford, 2014). In turn, 70-80% of clergy report that their seminary education did not provide them with adequate information about mental health (Farrell & Goebert, 2008c; Kaseman & Anderson, 1977; Virkler, 1979). These numbers suggest an open and ongoing opportunity for further collaborative effort to promote mental health awareness and education. It is unclear, however, whether this information would be welcomed and what channels for dissemination would be most beneficial.

Despite these apparent obstacles, clergy and congregations remain viable resources as mediators in increasing prevention of traumas and their long-term effects, access to mental health services, and provision of support. Some current literature suggests that congregations may be readily available to help stand in this gap if congregants become aware that these types of mental health needs exist (Rogers et al., 2012). One of the steps that can be taken in preparing youth ministers to provide adequate

support to youth with a mental health concern and their families is to examine the attitudes and beliefs that clergy hold about youth and mental health.

Clergy and Mental Health Literacy

The field of mental health literacy provides a strong framework for understanding these attitudes and beliefs (A.F. Jorm et al., 1997, 2010; O'Connor et al., 2014b; Reavley & Jorm, 2011b). The term "mental health literacy" holds intrinsic value, but it has become an umbrella term containing numerous, and sometimes ambiguous, constructs. A review of the literature also shows that many of the existing instruments on mental health literacy use vignettes to assess whether individuals can identify mental health diagnoses. (O'Connor et al., 2014a; Yang & Link, 2015).

Although vignettes may be beneficial for some populations, this methodology appears less relevant to clergy. Instead, shift is needed in the literature for youth ministers to focus on the gaps in training that can help to increase their knowledge of mental health and referral rates, and help them to promote inclusivity of youth with mental health concerns within their ministries This study begins to fill in these gaps within the literature by examining the attitudes and beliefs that youth ministers have about youth and mental health.

Research Design and Methodology

Instrument Design

This non-experimental, cross-sectional study utilized purposive and snowballing sampling methods to survey Protestant clergy in Texas. An instrument was created to assess clergy mental health literacy, using existing mental health literacy

scales (A.F. Jorm et al., 1997, 2010; O'Connor et al., 2014b; Reavley & Jorm, 2011b). The Clergy Mental Health Scale is an 87-item instrument consisting of five constructs: Clergy Education and Knowledge of Mental Health (8 items), Mental Health Challenges and Prevention Factors (19 items), Perceived Effectiveness of Services and Supports (24 items), Mental Health and the Role of Congregations (11 items), Clergy Relationship with Mental Health Professionals (15 items), and Clergy Practices Related to Social Inclusion/Belonging (10 items). These constructs align well with the three larger constructs of mental health literacy: Recognition, Knowledge, and Attitudes (Jorm et al., 2010)

Each item in the Clergy Mental Health Literacy Scale used a 5-point Likert Scale to measure level of agreement ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). Special attention was given to language used throughout the instrument, with a focus on strength-based, person-centered language as much as possible. Some terminology, such as mental illness, was more difficult to place within these frameworks because the constructs found within the literature do not always align with these shifts in language. Although consideration was given as to whether terminology commonly used through the instrument needed to be defined, the current version of the instrument does not include definitions. After careful deliberation, a decision was made to exclude definitions because doing so might potentially add further response bias. Using operational definitions, which could be in opposition to the views and beliefs that clergy hold about mental health, was thought to potentially negatively impact participation, thereby increasing sample error. The decision to omit definitions also allowed for clergy to more

authentically engage with the instrument to allow for a clearer understanding of attitudes and beliefs about mental health, as they currently perceive and understand mental health.

Instrument Validity

Prior to completing the instrument, content experts were identified and asked to participate in a review process to increase face and content validity. Participants included a social worker with extensive research on congregational and community health, a social worker with research on clergy abuse, a nationally recognized psychiatrist with extensive experience working on wraparound implementation, and a nationally recognized certified family partner and family leader in children's mental health. The instrument was placed on Qualtrics and the design panel was asked to utilize a Likert scale based on each item's relevance, ranging from 1 (*Very Unimportant*) to 5 (*Very Important*), and need for revision, ranging from 1 (*No Revision*) to 3 (*Major Revision*). There was also space provided for the panel to make specific recommendations to change each item. Responses were compiled and average scores were analyzed to assess the need for change.

Relevance scores that averaged 4 or below and revision scores that averaged 2 or higher were given special attention. Using analysis to guide revisions, change in language were made to 23 items, two items were deleted, and 4 items were added, bringing the total number of items to 87 items. An additional eight demographic items were used to support data collection. A copy of the revised scale was placed into Qualtrics to ensure that participation could remain anonymous and confidential.

Sampling Method

Purposive and snowball sampling methods were used to identify Protestant clergy. The sample was limited to Protestant clergy to increase homogeneity of the sample for analytic purposes. Several denominations were contacted via phone and email to explore whether the denomination would be willing to share the survey with their congregations. Databases on denominational websites were used to reach congregations when the denomination was unable to send an overview of the study and a survey link directly to clergy on behalf of the researcher. Follow-up emails were sent to clergy and denomination leads using the Dillman method (Dillman et al., 2014). After data collection was complete, data were exported from Qualtrics into SPSS 26.

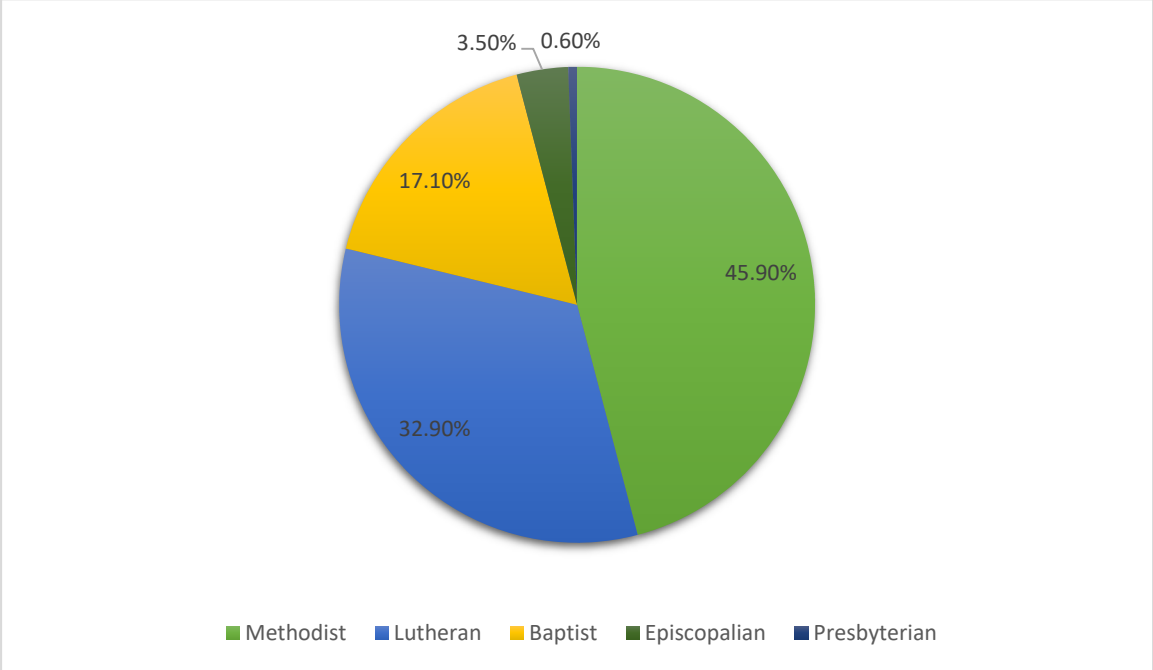
Findings

Subjects

Initial analysis found that 229 individuals opened the survey. While cleaning the data, it became evident that 35 individuals opened the survey but did not submit any data, an additional 15 people began to complete the survey but completed fewer than half of the questions, and 9 individuals were not clergy in a Protestant congregation. These 59 participants were excluded for the analysis. Twelve participants completed more than half of the survey but did not reach completion. These individuals were included in the analysis. After data cleaning, 170 responses (74.23% of the original sample) were included in the study. The sample consist of clergy from five denominations including Baptists (17.1%), Lutherans (32.9%), Episcopalians (3.5%), Methodists (45.9%), and a Presbyterian (.6%).

Figure 2.1

Denominations Represented Within the Sample Frame



Note. The following figure helps to provide a visual for the denominations represented within this study.

A review was done to explore potential causes for missing data and found that individuals who did not complete the survey all stopped at the end of a page. These common stopping points suggest that participants may have experienced survey fatigue.

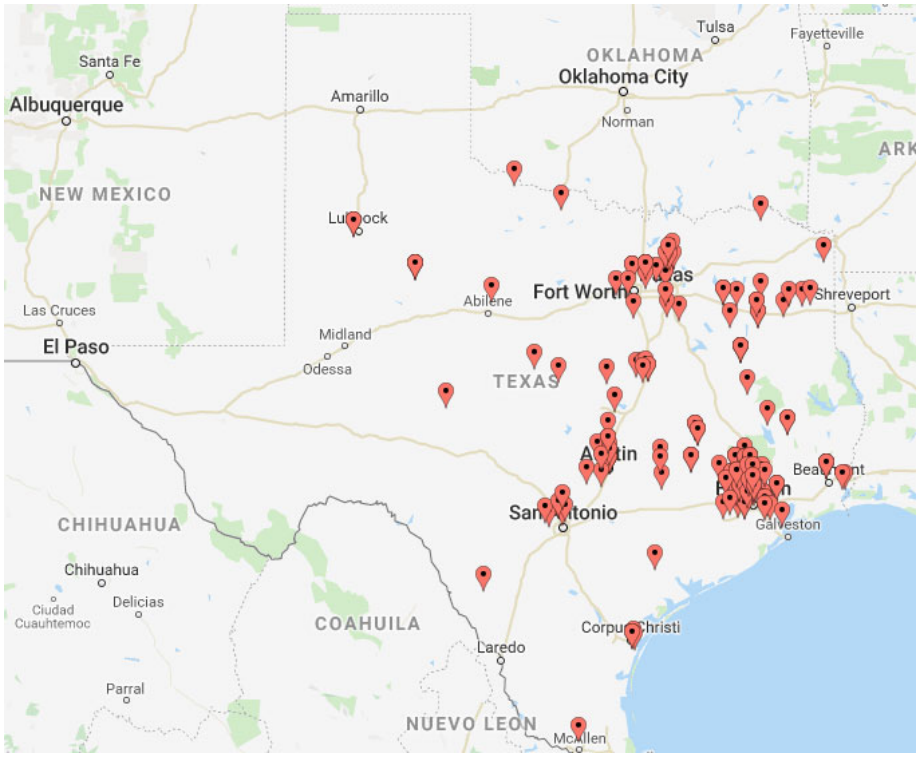
A descriptive analysis of the data showed that the clergy who participated in the survey held a large amount of experience, with clergy averaging 21 years in ministry. Responses ranged from less than a year all the way up to 65 years of experience in ministry. Analysis also revealed that respondents had typically spent a relatively large amount of time working in their current congregations, with participants averaging 7 years of work in their current place of employment.

An analysis was also done to assess the amount of time that respondents are paid for time working within their congregations each week. The majority of clergy reported working full time (88%). A smaller percentage shared that they worked 20-32 hours per week (7.69%) or fewer than 20 hours per week (4.73%). One person reported working as a volunteer and another clergy member did not answer this question.

A geo-map was created using the 160 coordinates that were available to visually assess the degree to which participants represent the state of Texas. Although computers may not be fully accurate in their location tracking, this visual is still believed to provide a valid snapshot of participant locations. The initial geo-map (Figure 2.2) indicates that the sample may not be fully representative of Texas and that many of the participants appear to live in or around large urban areas, including Dallas, Austin, and Houston.

Figure 2.2

Geo-Map of Participant Responses



Note. A visual analysis of respondent locations suggests that the sample is not fully representative of the state of Texas. A large amount of the sample appears to live in or around large urban areas, including, Houston, Austin, and Dallas.

Utilizing this data, a second geo-map (Figure 2.3) was created to assess whether individuals who reported working less than full time were more likely to live in rural areas of the state. A comparison of Figures 1 and 2 shows that participants who reported working less than full time were more likely to live in less populated parts of the state.

Figure 2.3

A Geo-Map of Participants Working Less than Full Time

Note. A comparison of Figures 1 and 2 suggest that respondents who reported working less than full time may be more likely to live in cities with smaller populations.

Higher Education

Clergy acquired high levels of graduate education, with 92.3% of participants holding at least a master's Degree and 92.34% of participants stating that they attended seminary. Eight participants reported that they hold a Doctor of Philosophy or other research-based degree (4.7%) and 26 of the participants stated that they have a Doctor of Ministry (15.38%). When asked about additional education, a notable number of clergy mentioned that they had received clinical pastoral education or chaplaincy training.

When considered together, the data suggests that the Master of Divinity is the education standard for the Protestant denominations that are represented.

Seminary education, however, may not always include adequate information about youth mental health. A small number of clergy (22.78%) reported that seminary prepared them to work with youth who have a mental health concern, and 66.26% of participants disagreed or strongly disagreed that their seminary education prepared them for this work. Some of these gaps in knowledge and skill building may be filled through other formal education. Over a third (35.35%) of the individuals who reported that their seminary education did not prepare them for working with youth who have a mental health concern reported that their formal education had done so. Nevertheless, 38.60% of participants who attended seminary reported that neither seminary nor formal education prepared them to work with youth who have a mental health challenge.

Accessing Mental Health Information

Despite notable gaps in clergy education related to youth mental health, 55.29% of clergy reported that they are generally aware of recent developments in mental health. This statistic raises a question about how clergy are accessing information related to mental health. Peer-reviewed research may appear to be one of the most reliable pathways for receiving mental health information, but 47.64% of clergy disagreed or expressed uncertainty that researchers can be trusted to provide accurate information about what mental health services and supports are effective or ineffective.

Although social media and mainstream news may be the most obvious pathways, 66.4% of clergy believe that the mainstream news cannot be trusted to provide accurate information about mental health and only 2 of the 170 clergy surveyed (1.17%) stated

that social media can be trusted to provide an accurate picture of mental health. In contrast, 64.11% of clergy stated that they trust clergy with similar theological perspectives to provide accurate information about mental health.

When assessing whether clergy receive mental health information from persons with similar theological perspectives, 41.17% of clergy reported that their denomination provides them with resources for working with youth who have a mental health challenge. The way in which clergy are using denomination resources to access information mental health and the accuracy of this information is unknown, but these numbers suggest that denomination resources could be a promising pathway for mental health education.

A Kruskal-Wallis H test was run to determine if there were differences reported in whether denominations provide resources needed for working with youth mental health between groups of Baptists, Lutherans, and Methodists. Distributions of denominational resource scores were similar for all groups, as assessed by visual inspection of a boxplot. Median denominational resource scores were not statistically significantly different between groups, $\chi^2(2) = 2.324$, $p = .313$.

Trust of Mental Health Services

Clergy who participated in this study preferred mental health information to come from their denomination and others with similar theological perspectives, which highlights questions about who clergy trust to provide mental health services. Clergy generally appear to trust mental health professionals. A large percentage (78.82%) of participants reported that mental health professionals are properly trained to help persons with mental health concerns. Additionally, 74.70% of clergy expressed that mental health

professionals have the right skills to help people with mental health concerns. Although 39.02% of clergy stated that they did not have or know of any mental health professionals in their congregation, 92% of the clergy who knew of mental health professionals in their congregation also reported having a working relationship with those individuals.

Clergy may be less likely, however, to know or trust mental health professionals who hold other theological or religious beliefs. While 73.17% of clergy reported having working relationships with a mental health professional from outside of their congregation, only 48.76% of clergy knew a mental health professional from another religion and a much smaller percentage (29.44%) of clergy reported having working relationships with a mental health professional from another religion. This information suggests that when clergy seek information about mental health from outside their congregation, they may also be looking for that information to come from someone who holds a similar theology.

Clergy also appear to mistrust the ability of youth-serving professionals, who do not work in mental health, to be able to support youth with mental health concerns. Although 57.05% of clergy reported that mental health hospitals are effective in helping people with mental health concerns, only 5.29% of clergy believed that emergency rooms are well equipped for helping people with a mental health crisis. Clergy also expressed low of levels of confidence in other professionals being well equipped for working with youth who have special mental health needs. A small 2.9% of participants reported juvenile detention centers are equipped, 5.88% stated that law enforcement is well equipped, and 8.82% expressed that teachers are well equipped.

Clergy as Gatekeepers

Clergy may not always be aware of how much power they hold as gatekeepers for youth mental health. Although the majority (72.22%) of clergy expressed that congregations are responsible for helping to meet the mental health needs of members in their congregations, other clergy were uncertain or disagreed with these tasks fitting into their role. Nearly two-thirds of clergy (65.66%) were unaware that individuals with a mental health concerns are more likely to go to a clergy member before going to a mental health professional. To a similar effect, 72.28% of clergy were not aware that individuals who go to a clergy member with a mental health concern are unlikely to go to a mental health professional unless they are referred by the clergy.

Only 37.34% of clergy thought that people may leave their faith as a result an interaction with a clergy about their mental health, and a slightly smaller percentage (31.32%) of clergy expressed that a person's faith could be weakened as a result of such an interaction. For comparison, in an online survey of Christians who had sought counseling from clergy, 30% reported a negative interaction, 36% reported that their faith was weakened, and 12.6% reported leaving their faith as a result of this interaction (Stanford, 2007).

Utilization of Mental Health Services

The cumulative effects of clergy mistrusting information about mental health from outsiders, lacking confidence in the ability for other youth systems to support youth with mental health concerns, and not understanding their own power as mental health gatekeepers is reflected in how clergy access mental health information and services. The majority of clergy (62.57%) agreed that they are more likely to make a referral to a

mental health professional who shares similar belief. Fewer than half of the clergy surveyed (49.70%) reported feeling comfortable making a referral to someone from a different religion. These findings are consistent with other research, which has found that clergy are more likely to make referrals to mental health professionals who share similar beliefs (Farrell & Goebert, 2008a; McMinn et al., 2005).

The presence of a relationship with a mental health professional plays an important role in whom a clergy uses for referrals. Only 4.29% of clergy stated that they regularly make referrals to mental health professionals whom they do not know. In contrast, 70.55% of clergy reported that they tend to make repeat referrals to the same mental health professionals.

Clergy Beliefs about Mental Health

Established relationships between clergy and mental health professionals may help to ensure that clergy have adequate knowledge to support youth who have mental health concerns. Although half of mental health concerns will develop by age 14, only 21.17% of clergy expressed agreement that mental health concerns are more likely to develop during childhood or early adolescence than later in life (Kessler et al., 2001; Merikangas et al., 2011). Evidence suggests that mental health challenges are associated with a lower life expectancy, but approximately half of the clergy surveyed (52.35%) were unaware of this fact (Chesney et al., 2014).

Clergy generally appear to understand the causes of mental health challenges and the relationship between mental health and other domains of health, but some clergy do not. For example, a small number of clergy (4.70%) reported believing that mental health concerns are likely to be caused as a result of bad behavior, and 11.76% of clergy

reported believing that mental illness is likely to be a result of a lack of discipline. In addition, 27.64% of clergy reported that good parenting can reduce the likelihood that a youth will have a mental health challenge and 18.82% of clergy shared the belief that persons with a strong spiritual health are less likely to have mental health challenges.

Opportunity for Collaboration

Fortunately, research indicates that clergy may be interested in developing stronger relationships and working on interdisciplinary teams with mental health professionals (Openshaw & Harr, 2009). Only 13.4% of the clergy surveyed in this study reported that they would not be comfortable serving as a supportive presence in a therapy session for a youth who was not in their congregation. Although 90.85% of clergy report that they are comfortable answering questions from mental health professionals about religion and spirituality, about half (48.78%) report that mental health professionals regularly ask these type of questions. Similarly, a large percentage of clergy (92.68%) report that they feel comfortable asking mental health professionals about mental health, but only about half (53.65%) do so on a regular basis. These numbers suggest an openness to collaboration but a hesitancy to do so in practice. Nevertheless, some reasons remain to be optimistic about the potential that these partnerships could hold for communities.

Implications

Accessing Mental Health Information

The findings suggest that the Master of Divinity remains a standard degree for clergy across many Protestant denominations. Clergy may also choose to pursue additional education, such as a Doctor of Ministry or a research-based doctorate degree. Despite these high levels of schooling, clergy frequently report that their education did not prepare them to work with youth who have mental health challenges.

Traditional pathways for disseminating information about mental health, such as peer-reviewed research and press releases, may not be perceived by clergy as trustworthy to provide accurate information. However, clergy may sometimes access information about mental health from their denomination. Analysis showed that there were no statistically significant differences across denominations in whether clergy report that their denomination provides information related to mental health. The data suggests that mental health education and awareness efforts may be most successful when partnerships between mental health professionals, seminaries, and denominational resources provide this information.

Trust of Mental Health Services

Although clergy were generally found to trust the ability and training of mental health professionals, a much larger level of mistrust exists in the ability of other professionals to support the mental health needs of youth. Connecting clergy with mental health professionals in their congregation is a promising practice for improving congregant access to mental health services.

Clergy are more likely to have working relationships with mental health professionals who hold similar beliefs, and clergy who are aware of mental health professionals in their congregation are also likely to have working relationships with those individuals. Clergy might well benefit from having support to identify mental health professionals who may be in their congregation and to provide resources on how to develop working relationships with these individuals.

Clergy as Gatekeepers

Nearly three-quarters of clergy report feeling that supporting congregational mental health falls within their role and responsibility. However, clergy may not be aware of the power that their words and actions may have on congregant health and on whether congregants access mental health services. Mental health education is important but incomplete if information is not included on pastoral care, clergy abuse of power, mandated reporting, and power dynamics. Denominations may also provide support to support to congregations on how to write pastoral care guidelines into congregation bylaws, policies, and denomination affiliation agreements.

Utilization of Mental Health Services

Clergy were found to have low referral rates to mental health professionals but were more likely to refer when there was an existing relationship with a mental health professional. Mental health education efforts should include information on when and how to make referrals to mental health professions. Data also showed that when making referrals, clergy are likely to utilize their established network of mental health professionals rather than referring to individuals with whom they may not have

established working relationships. Mental health professionals may use their social capital with other mental health professionals to support expansion of clergy referral networks. For example, mental health professionals could hold joint networking events for clergy and mental health professionals to convene for shared learning opportunities.

Opportunities for Collaboration

A large percentage of clergy (73.41%) reported that they would be comfortable serving on interdisciplinary teams to support youth with mental health challenges, even when those youth are not in their congregation. Clergy also reported that they are willing to answer questions from mental health professionals about religion or spirituality and to ask mental health professionals for information about mental health. The data, however, suggests that these types of collaborations occur infrequently. Efforts should be made to expand pathways for raising awareness and promoting dialogue between mental health professionals and clergy on how to best support youth and families with mental health challenges. Some of the channels that may provide opportunity include joint roundtable conversations in seminaries and denominational gatherings, interfaith meetings, mental health trainings, and neighborhood association meetings. Personal meetings to establish working relationships between clergy and mental health professionals often serves as a preliminary step toward these types of larger initiatives.

Limitations of the Study

One limitation of the study is the relatively small sample size. Some denominations who were contacted did not have policies allowing for research invitations to be shared with their congregations. Other denominations lack an administrative or

support structure that allows for easy identification of churches within the denomination. As a result, some of the denominations are overrepresented within the study, while others lack representation. Furthermore, the purposive and snowball sampling methods utilized did not allow for the ability to calculate a response rate. While demographic questions were utilized, this study did not capture information on clergy gender, race, or ethnicity. Without this information, it is difficult to know how certain populations or subgroups may have responded or chosen not to participate in the study.

Another known limitation of the study is the length of the instrument and apparent survey fatigue by some. A number of clergy members began the survey but failed to complete it. Further examination showed that clergy consistently stopped responding to questions at the end of a page. These factors suggest that the current version of the instrument is likely too long. Additional iterations of the instrument should consider ways to shorten the instrument and to validate small instruments subscales for independent use.

Suggestions for Further Research

This study examined attitudes, beliefs, and practices held by Protestant clergy in Texas related to youth mental health, but it only examined a subset of Protestant congregations. Additional studies with larger and more diverse sampling sizes will provide more complete understanding of the attitudes, beliefs, and practices that clergy hold. Reaching out to denominational staff with a request to provide assistance with survey dissemination was beneficial, but more time and conversations may have yielded more denomination support and a larger number of responses.

Although the instrument shows some initial validity, a complete validation study will aid in making additional revisions and modifications to the instrument. The language

used throughout the instrument may also be customized to be more culturally responsive and aligned with specific denominations. In addition, researchers may wish to utilize this instrument to further understand how specific clergy roles approach youth mental health and whether significant differences exist between roles. Little research exists to understand whether congregants are aware of the attitudes and beliefs that clergy hold about mental health and the degree to which congregants see these attitudes and beliefs play into practice. In particular, a large and notable gap in research exists on the attitudes, beliefs, and practices that congregants who volunteer with youth hold about mental health. Understanding these perspectives will assist in knowing how to best support youth with a community of supportive adults and natural supports.

Summary

This non-experimental, cross-sectional study assessed the attitudes, beliefs, and practices that Protestant clergy in Texas hold about youth mental health. A custom youth mental health literacy scale for clergy was designed and disseminated, utilizing purposive and snowballing sampling methods, via email to Protestant clergy. The findings indicate that clergy do not feel that their formal education prepared them for working with youth who experience a mental health challenge. Many clergy mistrust the accuracy of current mental health materials and the training and abilities of other professionals to support youth with mental health challenges. Clergy mistrust is evident is low referral rates and patterns in which they utilize existing mental health resources to help youth. Nevertheless, an opportunity remains for partnerships between mental health professionals and clergy to increase access to mental health services, cultural responsiveness of mental health services, and strong community-based systems of care

for children and adolescents. Recommendations have been made to explore pathways that increase mental health literacy and inter-professional dialogue, including joint roundtable conversations in seminaries and denominational gatherings, interfaith meetings, mental health trainings, and neighborhood association meetings, and one-on-one meetings.

REFERENCES

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, *13*(2), 153–160. https://doi.org/10.1002/wps.20128

Christiana, J. M., Gilman, S. E., Guardino, M., Mickelson, K., Morselli, P. L., Olfson, M., & Kessler, R. C. (2000). Duration between onset and time of obtaining initial treatment among people with anxiety and mood disorders: An international survey of members of mental health patient advocate groups. *Psychological Medicine*, *30*(3), 693–703.

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). *Internet, phone, mail, and mixed-mode surveys: The tailored design method* (4 edition). Wiley.

Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 190–211.

Farrell, J. L., & Goebert, D. A. (2008a). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, *59*(4), 437–440. https://doi.org/10.1176/ps.2008.59.4.437

Jorm, A. F., Kitchener, B. A., Fischer, J.-A., & Cvetkovski, S. (2010). Mental health first aid training by e-learning: A randomized controlled trial. *The Australian and New Zealand Journal of Psychiatry*, *44*(12), 1072–1081. https://doi.org/10.3109/00048674.2010.516426

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, *166*(4), 182–186.

Kaseman, C. M., & Anderson, R. G. (1977). Clergy consultation as a community mental health program. *Community Mental Health Journal*, *13*(1), 84.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005, December 22). Factors affecting clergy-psychologist referral patterns. *Journal of Psychology and Theology.* http://link.galegroup.com/apps/doc/A142151269/AONE?sid=lms

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mollica, R. F., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*, *143*(3), 323–328. https://doi.org/10.1176/ajp.143.3.323

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS pub no SMA-03—3832). Department of Health and Human Services.

O'Connor, M., Casey, L., & Clough, B. (2014a). Measuring mental health literacy—A review of scale-based measures. *Journal of Mental Health (Abingdon, England)*, *23*(4), 197–204. https://doi.org/10.3109/09638237.2014.910646

O'Connor, M., Casey, L., & Clough, B. (2014b). Measuring mental health literacy—A review of scale-based measures. *Journal of Mental Health (Abingdon, England)*, *23*(4), 197–204. https://doi.org/10.3109/09638237.2014.910646

Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, *36*(3), 301.

Polson, L. M., & Rogers, R. K. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, *34*(1). http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=07375778&AN=24474035&h=UEQjeHQKZen4QD3lware%2FvySzdZVOtZX20gW9zeQ8%2BschrZAXX1HGO4n7eaKTGoeEUL7Mz3xEnBydNXcF9689Q%3D%3D&crl=c

Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: Findings from an Australian national survey of mental health literacy and stigma. *Australian and New Zealand Journal of Psychiatry*, *45*(11), 947–956. https://doi.org/10.3109/00048674.2011.621060

Rogers, E. B., Stanford, M., & Garland, D. R. (2012). The effects of mental illness on families within faith communities. *Mental Health, Religion & Culture*, *15*(3), 301–313. https://doi.org/10.1080/13674676.2011.573474

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American master's of divinity students in relation to serious mental illness. *Journal of Research on Christian Education*, *23*(2), 176–186. https://doi.org/10.1080/10656219.2014.899480

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445–449. https://doi.org/10.1080/13674670600903049

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black church. *Social Work*, *45*(1), 73–87. https://doi.org/10.1093/sw/45.1.73

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology*, *7*(4), 271–280. https://doi.org/10.1177/009164717900700405

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647–673. https://doi.org/10.1111/1475-6773.00138

Yang, L. H., & Link, B. G. (2015). *Measurement of attitudes, beliefs and behaviors of mental health and mental illness*. http://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170048.pdf

CHAPTER THREE

Speaking for God: Exploring the Role of Power in Pastoral Care to Youth with a Mental Health Concern

Abstract

Congregations act as one of the first points of contact for individuals seeking support with a mental health concern. In response to these concerns and requests, clergy may provide what is referred to as "pastoral care." Although pastoral care is often a primary responsibility for clergy, little research exists on the scope and range of activities that may commonly be used within this framework. In particular, the research on the provision of pastoral care to youth with a mental health concern is nearly nonexistent. The present qualitative study utilizes a critical phenomenological framework for understanding how clergy experience the role of power and authority when providing pastoral care to youth with a mental health challenge. Using purposive sampling methods, semi-structured interviews were scheduled and conducted with 13 ordained youth ministers who work in congregations that hold affiliation with one of two selected Baptist General Convention of Texas (BGCT) associations. Findings indicate that clergy frequently report being overwhelmed by the responsibilities congregations have expected them to fulfill. Although the power and authority that bestowed upon clergy may be used within pastoral care to support youth with mental health challenges, this same power can potentially cause great and unintended harm.

Introduction

Congregations often act as one of the first points of contact for individuals seeking support with a mental health concern (Ellison, Vaaler, Flannelly, & Weaver, 2006; Hall & Gjesfjeld, 2013, 2013; Openshaw & Harr, 2009; Wang, Berglund, & Kessler, 2003). Provided with the opportunity to help direct individuals to mental health services and supports, clergy have the ability to serve as community mental health gatekeepers. Evidence suggests, however, that clergy may infrequently make referrals to mental health professionals (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979). Significant questions remain about what types of activities and approaches clergy use to care for individuals who request support related to mental health. Although pastoral care is often a primary responsibility for clergy, little research exists on the scope and range of activities that may commonly be used within this framework. In particular, the research on the provision of pastoral care to youth with a mental health concern is nearly nonexistent.

The present qualitative study utilizes a critical phenomenological framework for understanding how clergy experience the role of power and authority when providing pastoral care to youth with a mental health challenge. In this study, power is used to describe the ability that clergy have to direct or influence a person's thoughts or beliefs. Authority is used to describe the power, whether perceived or actual, that has been bestowed upon clergy. In this article, pastoral care is used as an umbrella to describe the variety of activities and approaches that clergy and persons of faith may use to provide biblical guidance or other support. Semi-structured interviews were scheduled and conducted with 13 ordained youth ministers who work in congregations that hold

affiliation with one of two selected Baptist General Convention of Texas (BGCT) associations. Findings indicate that clergy frequently report being overwhelmed by the amount of responsibilities that they have been expected to fulfill by congregations. Although the power and authority that bestowed upon clergy may be used within pastoral care to support youth with mental health challenges, this same power also holds potential to cause great and unintended harm.

A Review of the Literature

Congregations and Pastoral Care

Ministers frequently seek to support youth with mental health concerns by providing pastoral care. Although pastoral care is one of the primary functions of clergy, little is known about the types of supports or resources that may commonly be used within this framework (Clebsch & Jaekle, 1994; Lyall, 2001). A number of books and other resources provide theological positions for the roles and responsibilities of ministers (Clark, 2011; Doehring, 2014; Joiner, 2009; Powell et al., 2011; Root, 2009). Little empirical research has been done, however, on what this role typically entails as it relates to pastoral care or whether theological underpinnings of pastoral care are in alignment with the provision of pastoral care in practice.

Understanding the activities and responsibilities of clergy is important because clergy are most often seen as persons in position of power, whose words and guidance may frequently be trusted as a source of authority. Although clergy may have the ability to form strong relationships and be positive influences with their use of power, in some notable instances, pastoral authority that has been bestowed upon ministers has been

misused for abuse, neglect, and exploitation (D'Antonio, 2014; Goldenberg, 2013; Heimlich, 2011)

One of the clearest descriptions of the roles of clergy comes from a study of college ministers in which 20% of clergy reported using biblical counselling/pastoral care (Hunter & Stanford, 2014). This percentage may appear to be relatively small given that a large number of activities may potentially fit within the framework of biblical counselling or pastoral care. As such, questions remain about what the other 80% of ministers are doing to support these students and their families. Youth ministers and clergy may not always have access to resources or relationships with mental health professionals to offer adequate support. In a qualitative study of clergy in rural areas, clergy frequently expressed that the only resources they had available were to talk to youth or to pray for them (Jones et al., 2012). Although these options may not be harmful in and of themselves, they are unlikely to provide adequate mental health services and support.

Additionally, clergy may not always be held to the same mandated reporting standards as mental health professionals. Legislation may often differ across states and lack clarity in whether clergy are mandated reporters and the degree to which privileges have been granted for pastoral communications (Child Welfare Information Gateway, 2019). Clergy may also lack an understanding of their role as mandated reporters and knowledge of how to file a report when abuse or neglect is suspected or known to exist. Furthermore, the types of services and guidance that are offered under the umbrella of pastoral care is often unclear. Activities of congregations and clergy frequently fall

outside the jurisdiction of state departments, even in regards to practices, such as conversion therapy.

Clergy as Mental Health Gatekeepers

Despite these potential challenges, clergy hold great potential to serve as mental health gatekeepers. Youth may commonly experience mental health concerns while also participating in a youth ministry. Although half of mental health concerns begin by 14 years of age and 75% will develop by 24 years of age, only half of individuals with a mental health challenge will receive mental health services within their lifetime (R C Kessler et al., 2001; Merikangas et al., 2011; New Freedom Commission on Mental Health, 2003). A study of adolescents in the United States found that only 36.2% of adolescents with mental disorders had received mental health services and that these services gaps were greatest in adolescent with anxiety, eating, or substance use with disorders, with less than 20% of those adolescents reporting that they had received services (Merikangas et al., 2011).

Although little information specific to youth exists, research indicates that approximately 25% of individuals who seek mental health support will consult with a clergy member (Ellison et al., 2006b; Wang et al., 2003). Approximately, one quarter of these consultations will be initiated by individuals experiencing the highest intensity of mental health challenges (Wang et al., 2003). Youth ministers may be particularly well suited for helping youth to receive services closer to the point of onset because of the types of relationships that they have the opportunity to form with youth, which other clergy may not be afforded (Hunter & Stanford, 2014).

For instance, youth ministers may participate with their youth in in activities like lock-ins, retreats, small group studies, and summer camps. This time together is essential in being able to develop strong positive relationships that can encourage mental wellness and promote mental health literacy. Furthermore, youth ministers may also be able to serve the larger family unit if youth ministry is also understood to be family ministry in which the roles and responsibilities of service as youth minister extend to the larger family unit as well (Garland, 2012).

Although the idea of youth ministers as gatekeepers and contributors to the effectiveness of youth mental health service delivery systems may appear unusual, congregations have a historical investment in the well-being of congregants and the larger community. For example, congregations have historically played a significant public health role in meeting the needs of communities through the provision of programs with food pantries and health clinics (Garland & Yancey, 2014). In this respect, the idea of congregations and youth ministers supporting families with mental health challenges is alignment with the historical identity of many congregations.

Clergy Knowledge of Youth Mental Health

Youth ministers often lack formal mental health training to adequately serve as mental health gatekeepers. In a study of 30 North American seminary programs, 70% reported requiring fewer than two classes in counseling for the completion of a Master of Divinity degree, and 12% of the seminaries did not address mental health in any part of their curriculum (Ross & Stanford, 2014). This statistic helps to explain why research frequently finds between 70-80% of clergy reporting that their seminary education did

not provide them with adequate mental health training (Farrell & Goebert, 2008c; Kaseman & Anderson, 1977; Virkler, 1979).

Utilization of Mental Health Professionals

Despite this lack of education preparation, clergy may frequently rely on their existing knowledge and skills to provide pastoral care. Without adequate mental health training, clergy may have difficulty being able to distinguish when the support of a mental health professional is needed. For example, families may seek spiritual guidance from clergy members when their family is experiencing relationship or behavior challenges, but may rarely associate these experiences with a mental health concern. Although clergy are not responsible for being able to diagnose a mental health challenge, clergy need to have enough information to know when a referral to a mental health professional may be needed.

Available research suggests that clergy refer to mental health professionals less than 10% of the time (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979). Some of the factors that may contribute to this low utilization rate include clergy not knowing when or how to make a referral, lacking working relationships with mental health professionals, and having concerns about whether the guidance of mental health professionals align with the theological positions of clergy and their congregations (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). Additionally, the use of power and authority in the provision of pastoral care to youth with mental health concerns raises questions. This is the focus of the study.

Research Design and Methodology

Critical Phenomenology

In this qualitative study, the two researchers utilized critical phenomenology methods to conduct purposive, semi-structured interviews with 13 youth ministers who work in one of two selected Baptist General Convention of Texas (BGCT) associations. "Critical theory perspectives are concerned with empowering human beings to transcend the constraints placed on them by race, class, and gender" (Creswell, 2006, p. 27). Some of the themes that may be examined in critical theory are the historical role of social institutions and historical pathways for social isolation (Fay, 1987). In this study, critical theory is expanded to include religion and congregations as social institutions that may disempower or disenfranchise individuals from seeking adequate mental health services for fear of risking religious disassociation or isolation.

Individuals may have negative interactions when consulting ministers about their mental health concerns. For example, persons seeking counsel from a minister may be told that their mental health concern is a result of a lack of faith or sin or that their mental health condition does not actually exist (Stanford, 2007). This type of interaction may lead the individual to go against mental health professional recommendations, including changing medication intake, disengaging from mental health services, or refusing to consult a mental health professional in the future. These types of responses are important when considering congregants may often believe clergy to have been given power and authority by God - including in areas, such as mental health, where there may be a lack of formal training.

Transcendental or psychological phenomenology was utilized, as described by Clark Moustakas (1994). As Creswell (2006) explains, this type of phenomenological research involves the researcher working to separate their own experience from the experience of participants as much as possible. In this sense, the researcher works to understand what the participant is saying as if this is the first time that the researcher has heard anything about the topic. The theory behind this approach is that the researcher is able to have a fresh perspective on the subject and is better able to communicate what the research has found, rather than using a hermeneutical approach in which the researcher uses his/her experience as a lens for interpreting the participants' responses.

Critical phenomenological research may be understood as a "phenomenologically inclined account … which attends at once to the concerns and lifeworlds of [our ethnographic subjects] and to the inter-related social, discursive, and political forces that underpinned those concerns and lifeworlds" (Desjarlais, 2005, p. 369). Acritical framework would normally remove the researcher's interpretation of events and seek to understand the experiences as they are expressed by the disenfranchised. In this study, however, researchers attempted to understand the role of power from the perspectives of ministers with authority to provide pastoral care. This approach is admittedly somewhat different, since critical theory tends to focus on those whose power has been taken or limited. Still, the researchers sought to understand whether youth ministers are thinking about or aware of power dynamics within the provision of pastoral care.

Sampling Methodology

When using phenomenology, Creswell (2006) emphasizes that all participants need to have a shared common experience. Researchers utilized a purposive convenience

sample of youth ministers who held at least a bachelor's degree, had experience providing pastoral care to youth, and whose congregations were in one of two BGCT associations in Texas. The offices of the first association were located in a rural county whose population density is less than 1,000 persons per square miles, while the second association's offices were in an urban county whose population density exceeds 1,000 persons per square mile.

Although each participant worked for a congregation that holds affiliation with the BGCT, many of the congregations represented also held additional affiliation with either the Cooperative Baptist Fellowship, Southern Baptist Convention, or Southern Baptist Convention of Texas. These additional affiliations allowed for an increased amount of diversity in theological perspectives and understandings of pastoral care. After the associations were selected, the researchers connected with the directors of each association and utilized the association's website to identify potential participants. Youth ministers received personal emails and phone calls from one of the two researchers asking them to consider participating in a semi-structured interview, lasting approximately one hour. A semi-structured research protocol was designed by the primary researcher, who provided a 90 minute-training to the second researcher on how to utilize the protocol for personal interviews.

Data Analysis

All interviews were recorded on a designated digital recorder and transferred to a secure online platform. As interviews were completed, a verbatim of each interview was transcribed. A Master of Social Work student who had already completed the Master of Divinity degree was utilized as a research assistant for this study to aid in conducting

interviews and analysis of the transcripts. The transcriptions were entered and analyzed using Atlas.ti 8. Using Creswell's (2006) prescribed phenomenological method, researchers jointly examined interview transcripts for significant statements, sentences, or quotes that describe youth ministers' experience providing pastoral care to youth with a mental health concern. After this step, known as horizonalization, statements were grouped into categories, clusters of meaning, to describe the common experiences (Moustakas, 1994). As these clusters were being identified, researchers worked together to identify the essential, invariant structures, or essence, of the experience of what it means to be a BGCT youth minister who provides pastoral care to youth with a mental health concern. Researchers spent approximately four-and-a-half hours coding the first two interviews to ensure that there were common definitions and understandings of each code. After this process was completed, researchers divided and coded the remaining interviews. At the conclusion of analysis, researchers had identified a total of 1,102 quotations across 62 different codes.

Findings

Relationships with Students

There were 50 instances in which the 13 clergy expressed that relationships with youth are at the center of their work and the provision of pastoral care. Youth ministers shared that building these relationships often requires working nontraditional and extended hours attending football games, theater performances, recitals, and other extracurricular activities. Ministers also talked about taking lunch to students' schools and using text messaging throughout the day to ensure opportunities exist for continuous

support across different facets of students' lives. In these respects, the role of youth minister is somewhat unique. "I think it's different than any other ministry. At a smaller church it's much more personal and relational. You're surrounded by the students more and integrated to the community more"
(Interview 3, 1:1186-1372).

Youth ministers conveyed that the range of activities described above allow for a substantial amount of trust to be established between them and the youth whom they serve. Through this foundation of trust, youth ministers are able to be present in the lives of youth during challenging times. For example, ministers shared stories about visiting youth at the hospital, comforting youth after the loss of a family member, consoling youth who are being bullied, giving support to youth after they tried to end their life, and providing guidance to youth on how to navigate conflicts with their parents.

Ministers reported that these relationships are qualitatively different in comparison to the relationships that youth may have with other supportive adults. For instance, clergy frequently shared a belief that their relationships with youth allow them to be straight forward and authentic in the way that they provide guidance and direction to students. Ministers conveyed an ability to have deep and challenging conversations with youth on topics such as their behavior, goals, aspirations, and personal freedoms, even though similar conversations between students and their parents may not be well received by the youth. The relationship between youth ministers and their students may often lay a foundation of respect and care for what youth ministers have to say, even when their guidance is not otherwise welcome. In turn, ministers may also show similar respect to their students by showing concern and listening to understand the experiences

and perspectives of the youth. Such relationships are transformative. As one minister expounded, “Usually through pastoral care, you create deep relationships because they show vulnerability and share a part of their lives, they don’t normally show people. It cuts through all the barriers and gets to the real moment. It changes that relationship” (Interview 7, 6:1750-2139).

Diffuse Boundaries/Role Blurring

Although personal relationships serve as a foundation for pastoral care, these relationships must also contain professional boundaries. As described above, ministers may often have deep involvement in student’s lives for extended amounts of time. Although offering support and counsel within the context of these relationships holds potential, if ministers are not intentional in continually clarifying their role and purpose, the nature of the relationship may become blurred. For example, some of the identities that ministers compared their role to include a “brother/sister or even mother/father figure that those kids might not have” (Interview 3, 1:1526-1825), “a big kid” (Interview 4, 1:2488-2496), and a “friend with a twist of like family and mentor” (Interview 1: 2193-2233).

Drawing these comparisons may help to provide an image of pastoral care, but the boundaries between brothers compared to a relationship between a supportive adult and a youth hold clear distinctions. Unclear boundaries pose considerable risk for role confusion and potential burnout. For instance, the following quote provides an example of how youth ministers may sometimes struggle to balance their professional and personal roles.

> If you're not careful, you can find yourself getting in the middle of all this, and you want to empathize and sympathize. I've had to learn how to realize at what point I can empathize and sympathize without getting emotionally involved. If I do that, it's not fair to my family, my wife and children - to be emotionally involved in all these students' cases. That's something that happened early. I can still be their minister and empathize, but I don't have to get attached. That is a huge danger (Interview 7, 2:1476-1988).

Burnout and blurred boundaries are also though to increase risk of misusing or abusing power when policies or practices are not in place for sharing their power. Clergy shared that they often have unilateral decision-making authority regarding programming, messaging, and pastoral care practices. In addition to spending countless hours with students, many clergy reported that they spend at least one day a week committed to planning. Congregations also frequently hold expectations for youth ministers to be involved in congregational life beyond youth ministry.

Managing Congregational Expectations

Simultaneously, each of the youth ministers reported that congregations have high expectations. Clergy may be expected to be present anytime a crisis occurs, possess strong relationships with each youth, maintain strong familiarity of current literature on youth ministry and best practices for working with youth, and be able to do so while overseeing the activities and direction of the youth ministry. Youth ministers shared that despite having good intentions, congregations may often put too high of trust in the ability of clergy to be able to satisfy these extensive demands and expectations by themselves. Despite working nearly every day of their career, including scheduled days off, youth ministers shared that keeping up with the work is extremely challenging.

Sharing Power

Youth ministers frequently seek to meet these demands for time, energy, and resources by recruiting and delegating tasks to volunteers. Across the interviews, there were 33 instances in which 12 of the ministers referenced the important role that volunteers play within the life of the youth ministry, including baking home goods, bringing snacks, leading small groups, talking with families, leading games, hosting events in their homes, and providing encouragement to students. Male clergy frequently noted that they were thankful to have females who could help female students. These clergy also often reported having at least one female present when counseling a female youth.

Several of the youth ministers shared that they have a committee of supportive adults, often comprised of congregation members and parents of youth, which helps to assist in program and curriculum design. The frequency these committees meet ranged from once a month to every three months. Several clergy also reported having the ability to hire interns, specifically during summer months, to assist with activities. These additional supports play a positive role in helping ministers to better manage programming and organize activities, but how much decision-making authority these committees and interns were given without the minister's approval is unclear.

At times, however, volunteers provide challenges. In particular, ministers noted that it can sometimes be difficult to ensure that volunteers are the best fit for their roles within the youth ministry and that volunteers have the training and knowledge to support the youth with whom they are working.

> I have strong leaders who often butt heads. The problem is they see the youth ministry a certain way. As we try to reinvent it *[sic the youth ministry],* one of the

> challenges is there isn't a lot of room for more leads. There are some people who have asked to help, which is awesome, but it's challenging because in a couple years I might have to evaluate and ask them if it's time to serve elsewhere. (Interview 2, 3:1593-3:2414)

Although background checks and church safety measures help to reduce immediate danger to youth, there remains a need for providing supportive adults with information on topics that include youth development, mandated reporting, and pastoral care. In turn, ministers often become volunteer coordinators and trainers in addition to other responsibilities. "We have a small group leaders, so a lot of my job is equipping our leaders and following up on conversations and showing up to games (Interview 6, 1:2037-2171)."

Clergy Mental Health Literacy

The ability to adequately train volunteers becomes difficult, however, given the scope of work that youth ministers are already asked to perform and the limited amount of training that ministers have related to mental health. Although several of the ministers received a course in family ministry or biblical counseling, none had taken a class specific to mental health. Eight of the ministers reported that they began a position in youth ministry during seminary but expected to spend their careers in other ministry roles. In these respects, clergy may not always be prepared for working with youth who have experienced a mental health challenge. Transitioning into different areas of ministry may require additional training that is specific to their role. When such training is not readily available and accessible, youth ministers may turn to intuition and the training they have received in order to guide them.

> I feel like I'm not the best advice giver…Kids come to ask me for advice, and I give them what comes off the top of my head, and later I think of the right thing to say. I'm not very good at giving on the spot counsel (Interview 7, 5:1378-5:1758).

Approaches to Pastoral Care

To further complicate matters, youth ministers may view current mental health research and practices as contradictory to theological beliefs and spiritual practices. Three of the ministers shared a belief that many mental health challenges are based in challenges with spiritual health and a belief that mental health challenges are frequently over diagnosed. These clergy indicated that they feel a sense of personal and professional responsibility for distinguishing between mental health and spiritual health concerns. The approach that youth ministers use may change when clergy self-determine that a challenge is spiritual in nature instead of being based in mental health.

There were notable differences in pastoral care practices between the 9 youth ministers who held views that primarily saw mental health and spiritual health being complementary compared to the 4 youth ministers who tended to perceive mental health challenges to be spiritual in nature. Ministers who perceived mental health issues as being spiritual in nature appeared more likely to make fewer referrals to mental health professionals, hold pastoral care sessions with youth more frequently, and continue pastoral care sessions for a longer length of time than their youth minister counterparts. These ministers also expressed more concern that their referral sources hold similar theological beliefs as their own. These differences in practice may be linked to notable differences in theological belief about Scripture.

Ministers who believe mental health concerns to be spiritual in nature may be more likely to hold a belief in biblical infallibility and inerrancy. As such, scripture is

believed to be sufficient in and of itself, without the need for outside interpretation or insight from social science fields. For these ministers, the role and purpose of pastoral care is to help lead students to "real truth" and away from "wrong belief."

> I guess my problem is how we are defining mental health. My issue is with the mental part. We all have issues. We can all be labeled crazy at some point. Does that mean we are truly crazy are we just battling something spiritual? Does it just mean we are out of whack due to a wrong belief system we are having? For ages, we have looked at the biological side of the situation without any importance at all on the spiritual aspect of the individual. We've always looked at it and said it's only biologically, physically, or psychologically involved. That's wrong. We have not done justice in the western society. In my mind, it's because we have been so afraid to say there is a God. In our effort to say there is no God, no soul exists in mankind. Then you're left with one answer – a biochemical reaction. Then we fix it chemically only to realize that without those chemicals, an individual is impossible of living a daily life. What caused them to go into a depressive state? Is it because of wrong beliefs? We label things as mental issues that really are simply labeled a wrong belief issue. Let's start believing correct. Granted there are truly mental issues, but we have got to be cautious because we have a tendency to throw everything into a mental health spectrum (Interview 8, 6:2751-7:1012).

These differences in beliefs about the nature of pastoral care and scripture also change how pastoral care is approached. Ministers who held a view that scripture is largely incompatible with social science fields also reported using scripture more frequently to guide youth. Their approach was also more directive and prescriptive in nature, whereas other ministers reported spending more time listening to and validating youth in their experiences. For instance, one youth minister shared becoming frustrated with a youth who they felt was self-centered and "nipped it in the bud real fast" (Interview 3, 6:379-6:406) when this same student shared that they were struggling with thoughts of suicide. Another youth minister proudly reported that he and elders were not satisfied with the progress that a student who had experienced sexual trauma and mental

health challenge had made in addressing these feelings. In this instance, the student eventually left the church and did not return.

Discussion

These narratives raise questions about the ethics of pastoral care when addressing mental health concerns. Although the relationships youth ministers develop with students may be leveraged to connect youth and their families to mental health professionals, these relationships may also prevent youth from seeking mental health support. As described above, youth and families are often reported to have an expectation that youth ministers have the knowledge and skills needed to provide pastoral care to youth with mental health challenges.

Youth ministers shared, however, that they often have not received training specific to mental health and may sometimes rely on their intuition and theological education to guide these interactions. Similar findings have also been substantiated in previous studies (Farrell & Goebert, 2008c; Kaseman & Anderson, 1977; Virkler, 1979). Although the available research indicates that clergy are frequently consulted by individuals for mental health support, youth ministers often believe that families are seeking them out for spiritual support. In turn, youth ministers may sometimes approach mental health challenges as being spiritual issues. Understanding that clergy may confuse the nature or purpose of families consulting them for mental health support, may help to explain why clergy infrequently make referrals to mental health professionals (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979).

Providing spiritual guidance frequently falls within the normative role of clergy, and providing advice regarding mental health may sometimes occur under the umbrella

of pastoral care. Families may believe that ministers have been selected by God to be a voice prophetic voice of truth – instruments of God. The way that ministers describe mental health and the guidance that is offered to youth experiencing mental health challenges may be taken as absolute, prescriptive truth from God. The trust that youth establish with clergy may lead to mistrusting ministers when they are told that their mental health challenge is spiritual in nature, is sinful, or does not actually exist (Stanford, 2007).

Similarly, the words and actions of youth ministers may prevent individuals from seeking out mental health resources for fear of harm to their personal relationship with God, harm to their relationship with the minister, or retribution from their congregation (Barney et al., 2006). The mental health of an individual may be negatively impacted when their behavior or beliefs fall outside of the accepted normality of a congregation or denomination (Mannheimer & Hill, 2014).

Despite good intentions and pastoral care approaches based in mainstream theological perspectives, there remains considerable potential for pastoral care to cause great and irreparable harm to youth experiencing mental challenges. I would argue that potential for harm increases when clergy are not provided with strong resources for professionals and channels for support, such as relationships with other clergy members who they can consult. Given the broad scope of responsibilities with which youth ministers are frequently tasked, youth ministers may not always have capacity to provide quality pastoral care. The time that youth ministers spend preparing messages, organizing events, and managing projects may naturally lead to less time being available to prepare for sessions, arrange referrals, and increase competency in the provision of pastoral care.

As a result, guidance or instruction may be issued without youth ministers fully understanding the ramifications of their words or actions. Countless hours of work are also thought to potentially increase compassion fatigue and burnout, which further increases potential for pastoral care interactions to be harmful. The effects of compassion fatigue may lead ministers to lack self-awareness. Operating from a place of burnout and survival mode, youth ministers may turn to using approaches that are familiar. Clergy may intuitively operate from their own base of knowledge and skills, without consulting mental health professionals as a source of expertise. If this thesis is accurate, youth ministers must be intentional in establishing relationships with mental health professionals before a referral source is needed. Without such relationships, ministers may risk misusing the trust that families and youth have developed.

Similarly, the need for congregations to have policies that ensure the health of a youth ministry should not solely depend on the youth minister is clearly evident. Clergy may utilize volunteers to share power and authority to make ministry decisions. As described above, volunteers may be used to design curriculum, lead groups, host events, develop supportive relationships with students, and lead a wide array of other ministerial functions. Without using these natural support systems to their fullest extent, youth ministers may be misperceived to have a larger amount of authority and expertise in mental health. As such, youth and families may heavily depend on youth ministers to be a primary source of support when experiencing a mental health challenge.

Congregations ought to provide mental health education to both youth ministers and their volunteers. Although information on youth development, adverse childhood experiences, and soft skills for providing pastoral care with youth are important,

supportive adults need to have working relationships with mental health professionals. A comprehensive training model should provide supportive adults with an understanding of available community resources and seek to develop strong systems of care by intentionally providing opportunities for mental health professionals and supportive adults to dialogue and learn from one another.

Limitations of Study

Although this study helps to provide insight into how youth ministers may utilize power when providing pastoral care to youth who are experiencing a mental health challenge, the types of activities that may fall within the realm of pastoral care need to be better understood. A notable gap exists in the literature that often results in pastoral care being described as a working framework rather than skill sets with standardized competencies. As a result, many operational constructs potentially fit under the umbrella of pastoral care. The design of this study utilized a methodology that allowed for participants to describe their pastoral care practices using their own definitions. Although participants shared similar denominational identities, this approach to the research allowed for diversity within the definitions and pastoral care practices represented. A more targeted approach to recruitment and sample size may have allowed for further specificity and insight for pastoral care practices within specific subcultures of pastoral care within Baptist youth ministries.

Interpreting the data poses some challenges. Although resources on critical theory and literature on using phenomenological methods within qualitative research abound, these resources contain limited descriptions of critical phenomenology. As qualitative research methods become more sophisticated, additional operational definitions and

descriptions of methods for conducting critical phenomenological research become necessary. Without this degree of sophistication, the methods for interpreting data under this approach are more limited than desired. Although the interpretive methods used within this study fit within current understanding of critical phenomenology, the method utilized could potentially fall outside of these boundaries in the future.

Recommendations for Future Research

In the future, researchers may wish to utilize the interview protocol designed for this study with individuals who have adopted a particular model for pastoral care. For example, a researcher may want to strictly examine the role of power within a particular model of biblical counseling. There may be challenges in being able to recruit a sample using such a design, but this approach would also allow for more specificity and sophistication than was provided within the current study.

A better understanding of the types of activities that fall within the framework of pastoral care is also needed. Ministers may perceive a seemingly endless number of activities to fall under pastoral care. Additional research may allow for operational definitions of pastoral care to be developed. In turn, opportunities may also be presented for developing competencies and ethical standards for various models of pastoral care. Researchers are encouraged to conduct similar studies with other denominations and with larger attention to subcultures within denominational groups, allowing for contextual models of pastoral care to emerge that are based within specific theological perspectives and pastoral practices, rather than being lumped together into a singular framework.

Summary

In conclusion, this qualitative study utilized critical phenomenology to explore how Baptist youth ministers in central Texas to provide pastoral care to youth with mental health challenges. An interview protocol was developed and utilized to conduct 13 interviews, each lasting approximately one hour in length. After interviews were transcribed, researchers collaborated to identify and operationalize coding. Researchers spent time coding two of the interviews together and the rest of the interviews were cross-checked to ensure consistency and fidelity of coding.

Findings indicate that youth ministers may frequently be tasked with a broad scope of responsibility and hold unilateral decision-making power in the life of youth ministries. Youth ministers frequently understand relationships to be a core foundation of pastoral care and spend large amounts of hours working to develop relationships with students. The trust that is developed within these relationships may be used as a channel for providing guidance and support to youth. Students and their families may often have a great amount of trust that ministers have knowledge and skills in supporting youth with mental health challenges even though youth ministers frequently report having limited amounts of formal training in pastoral care and mental health. Despite these acknowledgements, ministers often seek to provide pastoral care to youth with mental health challenges and may not have or leverage relationships with mental health professionals to support these families. Potential for burnout and compassion substantially increases the risk of harm within pastoral care interactions. Utilization of volunteers may help to allow for sharing of power and allow for more positive pastoral care interactions.

REFERENCES

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *The Australian and New Zealand Journal of Psychiatry*, *40*(1), 51–54. https://doi.org/10.1111/j.1440-1614.2006.01741.x

Child Welfare Information Gateway. (2019). *Clergy as mandated reporters of child abuse and neglect*. U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/clergymandated.pdf

Clark, C. (2011). *Hurt 2.0*. Baker Academic.

Clebsch, W. A., & Jaekle, C. R. (Eds.). (1994). *Pastoral care in historical perspective* (New Ed edition). Jason Aronson, Inc.

Creswell, J. (2006). *Qualitative inquiry and research design: Choosing among five approaches* (2nd edition). SAGE Publications, Inc.

D'Antonio, M. (2014). *Mortal sins: Sex, crime, and the era of Catholic scandal* (Reprint edition). St. Martin's Griffin.

Desjarlais, R. (2005). Movement, stillness: On the sensory world of a shelter for the "homeless mentally ill." *Empire of the senses: The sensual culture reader*. Bloomsbury Academic.

Doehring, C. (2014). *The practice of pastoral care,* (Revised and Expanded edition). Westminster John Knox Press.

Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006a). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 190–211.

Farrell, J. L., & Goebert, D. A. (2008a). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, *59*(4), 437–440. https://doi.org/10.1176/ps.2008.59.4.437

Fay, B. (1987). *Critical social science: Liberation and its limits*. Cornell Univ Pr.

Garland, D. R. (2012). *Family ministry: A comprehensive guide* (02 edition). IVP Academic.

Goldenberg, R. (2013). Unholy clergy: Amending state child abuse reporting statutes to include clergy members as mandatory reporters in child sexual abuse cases. *Family Court Review*, *51*(2), 298–315. https://doi.org/10.1111/fcre.12028

Hall, S. A., & Gjesfjeld, C. D. (2013). Clergy: A partner in rural mental health? *Journal of Rural Mental Health*, *37*(1), 50–57. https://doi.org/10.1037/rmh0000006

Heimlich, J. (2011). *Breaking their will: Shedding light on religious child maltreatment*. Prometheus Books.

Hunter, W., & Stanford, M. (2014). Adolescent mental health: The role of youth and college pastors. *Mental Health, Religion & Culture*, *17*(10), 957–966. https://doi.org/10.1080/13674676.2014.966663

Joiner, R. (2009). *Think orange: Imagine the impact when church and family collide...* (New edition). David C. Cook.

Jones, D. L., Cassidy, L., & Heflinger, C. A. (2012). "You can talk to them. You can pray": Rural clergy responses to adolescents with mental health concerns. *Journal of Rural Mental Health*, *36*(1), 24–33. https://doi.org/10.1037/h0094777

Kaseman, C. M., & Anderson, R. G. (1977). Clergy consultation as a community mental health program. *Community Mental Health Journal*, *13*(1), 84.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

Lyall, D. (2001). *Integrity of pastoral care*. The Society For Promoting Christian Knowledge.

Mannheimer, A. H., & Hill, T. D. (2014). Deviating from religious norms and the mental health of conservative Protestants. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-014-9951-y

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005, December 22). *Factors affecting clergy-psychologist referral patterns*. Journal of Psychology and Theology. http://link.galegroup.com/apps/doc/A142151269/AONE?sid=lms

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mollica, R. F., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*, *143*(3), 323–328. https://doi.org/10.1176/ajp.143.3.323

Moustakas, C. (1994). *Phenomenological research methods* (1st edition). SAGE Publications, Inc.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS pub no SMA-03—3832). Department of Health and Human Services.

Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, *36*(3), 301.

Polson, L. M., & Rogers, R. K. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, *34*(1). http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=07375778&AN=24474035&h=UEQjeHQKZen4QD3lware%2FvySzdZVOtZX20gW9zeQ8%2BschrZAXX1HGO4n7eaKTGoeEUL7Mz3xEnBydNXcF9689Q%3D%3D&crl=c

Powell, K. E., Clark, C., & Candy, J. O. and J. (2011). *Sticky faith: Everyday ideas to build lasting faith in your kids*. Zondervan.

Root, A. (2009). *Revisiting relational youth ministry: From a strategy of influence to a theology of incarnation*. IVP Books.

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American master's of divinity students in relation to serious mental illness. *Journal of Research on Christian Education*, *23*(2), 176–186. https://doi.org/10.1080/10656219.2014.899480

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445–449. https://doi.org/10.1080/13674670600903049

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black church. *Social Work*, *45*(1), 73–87. https://doi.org/10.1093/sw/45.1.73

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology*, *7*(4), 271–280. https://doi.org/10.1177/009164717900700405

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647–673. https://doi.org/10.1111/1475-6773.00138

CHAPTER FOUR

An Exploratory Practice Model for Developing Relationships Between Clergy and Mental Health Professionals

Abstract

Mental health concerns may begin during childhood and early adolescence, but available research suggests that treatment may not occur at the point of onset. Families frequently consult clergy with these concerns but limited mental health training and connection to mental health professionals is negatively impacts the number of referrals that clergy make to mental health professionals. This manuscript is intended to provide a practical model for congregations and mental health professionals to develop working partnerships with one another as a pathway for supporting the mental health of individuals and communities. The article begins with a review of existing literature, introduces a conceptual model for developing partnerships (Figure 1), and concludes with a case study to promote critical thinking about how the model might be applied to practice.

Introduction

Although clergy are frequently consulted for mental health services, clergy and mental health professionals frequently lack working relationships that are needed to holistically support individuals and families who have experienced mental health challenges. These divisions in service delivery are driven by historical tensions regarding differences in interpretation of mental health, gaps in education, lack of awareness of

available community resources, and ambivalence surrounding the perceived risks and benefits of collaboration. Limited communication and partnership between clergy and mental health professionals significantly impact the accessibility and utilization of mental health services, decreasing life expectancy and quality of life for individuals with mental health concerns.

This manuscript is intended to provide a practical model for congregations and mental health professionals to develop working partnerships with one another as a pathway for supporting the mental health of individuals and communities. Although a large portion of the literature review utilizes a prevention lens and addresses youth mental health, the conceptual model may be utilized as a framework for collaboration to support the mental health of individuals at any stage of life. The model proposed within this manuscript is designed to be adaptive, understanding that context may frequently serve to inform the approach that is most suitable for relationship development. The manuscript closes with a case study, which is provided to begin conversation within seminaries, classrooms, supervision meetings, congregations, and mental health agencies about how collaboration might help to support community mental health and what approaches might be suitable within their context.

A Review of the Literature

Mental Health and Congregations

Approximately half of all Americans will experience a mental health disorder in their life, half of which will begin by 14 years of age and three fourths of which will develop by 24 years of age (Ronald C Kessler et al., 2005) In the National Comorbidity

Survey-Adolescent Supplement, researchers found the median age of onset to be age 6 for anxiety disorders, age 11 for behavior disorders, age 13 for mood disorders, and age 15 for substance abuse disorders (Merikangas et al., 2010) In addition, 40% of adolescents who met the criterion for one class of disorder also met the criterion for a disorder in another class (Merikangas et al., 2010).

Despite the high provenance of mental health challenges, it is estimated that only half of individuals with a mental health problem will receive mental health treatment within their lifetime (R C Kessler et al., 2001; New Freedom Commission on Mental Health, 2003). A study of adolescents in the United States found that while 36.2% of adolescents with mental disorders had received mental health services, less than 20% of adolescents with anxiety, eating, or substance use disorders reported receiving services (Merikangas et al., 2011). These numbers are consistent with other research, which also suggests services may not always be sought at the point of onset. In a study of members of patient advocate groups from 11 countries, although 40% of participants reported seeking treatment within the first year of onset, the remaining 60% of participants reported waiting a median of 8 years before receiving services (Christiana et al., 2000).

Congregations may frequently serve in the role of gatekeeper for youth with mental health concerns. In the National Comorbidity Survey, approximately 25% of the participants who sought mental health treatment had consulted a clergy member, a higher percentage than those who sought a psychiatrist (16.7%) or a general medical doctor (16.7%) (Ellison et al., 2006b; Wang et al., 2003). Furthermore, 56% of participants, who

had sought clergy in the last year, reported that they did not see another provider (Wang et al., 2003).

These results are unsurprising given that clergy refer clients to mental health professionals less than 10% of the time (Mollica et al., 1986; Polson & Rogers, 2007; Taylor et al., 2000; Virkler, 1979). This small percentage of referrals is disconcerting when noting that clergy may frequently have limited amounts of mental health training or education and limited ability to identify severe mental health concerns (Farrell & Goebert, 2008a; Ross & Stanford, 2014; Weaver, 1995). Although clergy members may recognize the need for additional training, paradoxically, this awareness does not appear to translate into an increase in referral rates (Farrell & Goebert, 2008a; Polson & Rogers, 2007).

Clergy make referrals when they recognize that a challenge is outside of their scope of knowledge or practice (Polson & Rogers, 2007). Openshaw and Harr (2009) found that clergy desired to make referrals to mental health professionals who are sensitive and respectful of client spirituality. Clergy also expressed that they would be interested in developing stronger relationships and working on interdisciplinary teams with mental health professionals (Openshaw & Harr, 2009). In turn, mental health professionals and clergy are encouraged to develop working relationships with one another.

Clergy may unintentionally do harm when they do not have access to mental health professionals to consult or training on best practices for supporting youth with mental health challenges. In an online survey of Christians who had sought counseling from clergy, 30% reported a negative interaction, 36% reported that their faith was

weakened, and 12.6% reported leaving their faith as a result of this interaction (Stanford, 2007). Although a loss of faith or leaving a faith tradition may appear to only have implications for spiritual health, available research suggests implications for mental health. In a study of adolescents with depression, researchers found that loss of faith was a predictor of less improvement in depressive symptoms (Dew et al., 2010). These numbers are particularly concerning when considering that religious involvement may help to support well-being, coping, and provide a source of social support (Ellison et al., 2009; Koenig, 2009; Nooney & Woodrum, 2002).

Social Capital Theory

Social capital theory is a mid-twentieth century theory that seeks to explain how social interactions and networks may serve to elevate the well-being of communities and promote the common good. Although social capital is a relatively new construct, the study of what it means to be in relationship and live in community with one another may be dated back several centuries. Among others, Emile Durkheim, Max Weber, Ferdinand Tonnies, and Alexis de Tocqueville are frequently cited as early contributors to the development and conceptualization of contemporary social capital theory (Farr, 2004; Ferragina, 2010; Recker & Moore, 2016; Watson & Papamarcos, 2002). These multi-disciplinary origins often lead to a diversity in perspectives on what is included within the definition of social capital theory and how social capital theory may be utilized in practice.

Some common themes that frequently emerge across studies of social capital include the importance of mutuality, reciprocity, trust, social networking, and shared interest. Today, social capital is frequently studied for the role that it plays in producing

positive outcomes related to health, education, workforce development, and civic participation. Pierre Bourdieu (Bourdieu, 1986) emphasizes that social capital may be used by those in power to either increase or decrease the social and economic mobility of individuals and social classes. As a result of these linkages, studies of social capital theory often include focused conversation on the relationship that social capital shares with cultural and economic capital. These connections also help to explain the commonalities that social capital theory shares with social exchange theory.

Social capital theory helps to explain how relationships may be used as a channel to gather, increase, and effectively utilize the collective knowledge, experiences, and resources that are found within a community. Relationships foster a sense of connection and belonging, providing an avenue for knowledge, information, and other forms of capital to be shared with one another. When relationships are at their best, social capital may be shared to increase quality of life. As described above, families may frequently turn to clergy for support with mental health concerns. Families often trust clergy with these concerns because they have established mutual relationships, social capital, with clergy over time. When families are unaware of what community resources exist or how to access these services, potential is thought to exist for clergy to serve as a pathway for receiving the needed support. Families consult clergy on these matters because they trust and expect that clergy have the knowledge and resources needed to provide this support. In turn, families may frequently follow the advice or guidance that a clergy member provides. Although clergy are frequently consulted by individuals experiencing mental health concerns, whether families make these consultations with an awareness that their concern is related to a mental health challenge.

Clergy may, however, frequently lack knowledge of what mental health services are available or how to access these services. Furthermore, clergy may not have working relationships with mental health professionals in their community. In turn, clergy members may frequently rely on their limited knowledge of mental health to provide whatever support they determine to be needed or appropriate. As a result, clergy frequently operate outside of their scope of knowledge and expertise. Clergy members violate the trust that families have placed in them when this lack of lack of training is not openly disclosed to families and a referral is not made to a mental health professional. In this sense, social capital between clergy and family members may be used to prevent families from being able to access mental health services.

In contrast, social capital may also be used as a channel for clergy and mental health professionals to elevate the mental health of youth, families, and communities. Social capital may serve as a bridge of support to cover gaps in knowledge or understanding of how to access mental health services. When clergy and mental health professionals have working relationships with one another, clergy may be more likely to make a referral and connect youth and families to community mental health services. Such partnerships may also help to ensure continuity in care so that families do not feel abandoned in their search for mental health support.

Working relationships between mental health professionals and clergy may help to assure that mental health professionals have support to provide culturally services that understand and are responsive to a youth or family's religion and spirituality. Potential also exists for clergy to serve as partners on interdisciplinary teams to support youth and

their families. In doing so, community members are provided with further opportunity to select and receive mental health services that align with their religious beliefs and values.

Furthermore, mental health professionals and agencies are given opportunity to utilize new channels for increasing community health and mental health literacy by partnering with congregations in a series of early prevention and intervention initiatives. Some of the possibilities for meaningful collaboration include developing a strong interfaith network to inform and support organization and community decision making, creating materials on topics specific to mental health and religious sensitivity, supporting congregations in developing referral policies and pastoral care practices, providing culturally responsive training on mental health and how to access available resources, and implementing evaluation to comprehensively include measures on client satisfaction, spiritual well-being, and the impact of including clergy in service delivery.

A Conceptual Model for Partnership

Bridging the Communication Gap

With these benefits and caveats in mind, how might mental health professionals and clergy navigate partnerships with one another? Historical tensions between mental health and faith communities often lead to a lack of communication between respective parties. In turn, professionals across professions might find that it is difficult to listen to one another or understand one another's perspectives. The value of collaboration is not found in coming to complete agreement or being able to offer the same resources but the ability to work toward common outcomes despite different assumptions and worldviews.

The ability to have these conversations and to collaborate effectively is limited when relationships between clergy and mental health professionals are not already established.

Establishing these relationships may be difficult, even when clergy and mental health professionals have the desire to collaborate. In many communities, discussing the role that religion and spirituality can play in supporting mental health may be considered taboo. For example, clergy members may feel uncomfortable discussing mental health with their congregation members. Mental health professionals may feel uncomfortable discussing the role that religion or spirituality plays in the life of a youth or their family (Oxhandler et al., 2018; Oxhandler & Ellor, 2017). Public mental health agencies may also be hesitant to align their efforts with congregations out of concern that these partnerships may be viewed as favoritism or an endorsement of a specific congregation or faith tradition. Historically, institutions of higher learning and professional associations have discouraged these types of conversations. San Martin-Rodriguez, Beauleiu, D'Amour, and Ferrada (2005) also note that, "members of each profession know very little of the practices, expertise, responsibilities, skills, values and theoretical perspectives of professionals in other disciplines" (p. 137).

Nevertheless, the benefits of partnership between mental health professionals and clergy remains clear. Working relationships of this type are likely to take a significant amount of time and questions about the purpose of collaboration will certainly arise, but courageous conversations can save lives. Without partnership, the gap between mental health professionals and clergy remains and is left to widen. Families, who may already hold a mistrust for clergy or mental health professionals, are left to navigate systems and

services without the support that is needed. With this understanding, collaboration may be seen as a necessity for the health and wellbeing of communities.

Beginning Courageous Conversation

Courageous conversations often require a level of boldness and intentionality. Although clergy may have mental health professionals in their congregation, a conversation about how a partnership between clergy and mental health professionals could support the mental health of the congregation may be lacking. Similarly, mental health professionals may often counsel youth and families who find that their religion or spirituality provides a sense of meaning or purpose, but do not ask about whether having a partnership with their faith community could better support their mental health. Mental health professionals and clergy may often participate in conferences, trainings, and networking events but rarely participate in professional development opportunities together. These scenarios represent missed opportunities to learn from one another.

If clergy and mental health professionals are to have working relationships, someone must first be willing to "cross the aisle" and initiate communication. As Choi and Pak (2007) explain, "in this world with demands to solve complex problems in a short time frame, it may not always be possible to wait for the establishment of self-generated collaborations" (p. 15). Without a driving force to begin dialogue, there may be little momentum for conversation or exploring partnership. Effective partnerships may begin with two individuals but are often best supported through commitment and shared interest of numerous people. Although either mental health professionals or clergy members may initiate dialogue, community members may also use their own social capital with clergy and mental health professionals to encourage conversation. Clergy and

mental health professionals may be more likely to meet with one another if they have a relationship with a trusted person who can provide an introduction. The existence of such trust is dependent on positive experiences of working together over an extended period of time (San Martín-Rodríguez L et al., 2005).

Clergy and mental health professionals are encouraged to consider who in their network could help make these linkages. Communities often have at least a few people who are highly trusted and respected by the community and who often serve as community gatekeepers. If someone in the existing network cannot be identified, they can think about who might fit this description and what can be done to initiate a conversation with this person.

When beginning conversation, it is important to be clear about the purpose and desired outcomes of meeting together. Having a clear rationale and a willingness to start small increases the effectiveness of change initiatives (Langley et al., 2009). A conversation with the sole purpose of learning more about what programs or services exist within a congregation or mental health agency may look significantly different than a conversation that has a larger goal of developing a working partnership. If partnership is part of the goal of meeting, participants should consider the benefits of forming such a collaboration. Clergy and mental health professionals are often extremely busy and may be less likely to agree to a meeting if the benefits of meeting together are not understood. Partnerships are most effective when they address mutual interests and benefits.

Before initiating conversation, be sure to review the congregation or mental health agency's website to learn more about the history of the entity, what programs, services, and supports are offered, the background of the person with whom you will be meeting,

and who else works within the agency. Review pages that describe the mission, vision, purpose, values, and beliefs of an agency can be beneficial. Hill (2013) argues that "correctly assessing the culture helps to identify key partners for relationship building" (p. 190). Having a working knowledge of this information will assist in thinking about opportunities for collaboration and about questions that may not already be answered in the available materials. Preliminary research helps to demonstrate a genuine degree of interest and commitment to partnering.

Next, utilize this information to begin forming a quick introduction that can be used to introduce yourself. The ideal welcome includes a greeting, quick introduction of yourself to let the person on the other line know who they are speaking to, and a reason for why a call is being made. Again, it is extremely important to keep this introduction brief. Longer introductions may confuse the other person or result in their feeling unheard. Mental health agencies and congregations may frequently have administrative support to answer phone calls. Consider ways to tailor your introduction so that administrative staff can best understand the reason for your call and be sure that you are clear about with whom you are wishing to speak. Although an email introduction may sometimes suffice, a phone call may often feel more personal.

After providing your introduction and reason for calling, it is important to stop speaking and listen. Ministers and mental health professionals often have additional questions or thoughts about meeting together. Take the time to fully listen to what the other person has to say, paying particular attention to the tone that is being used. Active listening has been shown to be associated with feeling that it is safe to openly thoughts

and ideas, without fear of judgement or how the other person will respond (Castro et al., 2018; Weger et al., 2014).

As the conversation progresses, there will likely be a natural time and space in the conversation to suggest meeting in person. When this opportunity is presented, be sure to ask questions about what times and meeting locations would be best for the other person. A shorter meeting may be enough to begin conversation, but setting aside an hour to meet may indicate that you are willing to invest a larger amount of time to have deeper discussion. Meeting in a neutral location or in the other person's office may often feel more comfortable for others and signify that you are willing to meet them where they are and on their terms and conditions. Flexibility in scheduling may also help the other person to feel more confident that a working relationship is possible.

Preparing for the Meeting

Once a meeting time and location has been determined, consider sending an event invitation by email. Taking this step helps to demonstrate that you are serious about meeting. If the event is scheduled a few days or a week in advance, consider sending an email the day before to confirm that you are still scheduled to meet. A simple, "Good afternoon, I enjoyed talking with you the other day and look forward to meeting tomorrow at (name of location and time)" will suffice. You may also consider providing your cell phone number so that you can keep in touch on the day of the meeting and easily identify one another. While your research may allow for you to know what the other person looks like, the other person may not have been able to do the same research ahead of time.

The day before the meeting, you may also want to begin gathering any informational materials that can be given to the person. Although these materials may be cheap to produce, providing physical copies of materials may help to demonstrate a willingness to invest resources into the partnership. More importantly, flyers and pamphlets provide the other person with information to look at and share with coworkers after the meeting is over. Store these materials in a binder or folder to protect materials from wrinkles, tears, and stains. This degree of care helps to demonstrate that you are attentive to details and hold a commitment to ensuring integrity and quality are embedded throughout your work.

On the day of the event, plan on arriving 10-15 minutes earlier than the time that you are scheduled to meet. Familiarize yourself with the surrounding area, taking into account what else is on your schedule before and after the meeting, how you plan on getting to the location, whether any factors could affect travel time, where you plan to park, and the distance that you will have to travel from the place you park to the place that you are meeting. Give yourself plenty of time to get where you need to go. Arriving early will allow for you to take a deep breath and do one final walkthrough of the meeting in your head. An early arrival also signifies that you are serious about meeting and that you are professional in your communication. If you arrive at your location earlier than 15 minutes, consider waiting to enter the building until the time is closer to when you are scheduled to meet. Arriving too early may result in the other person feeling unprepared to meet or embarrassed that they were not ready to meet at an earlier time.

Be mindful that what you choose to wear to a meeting may also communicate your intentions for partnership. Take into consideration who you are meeting with, what

the other person may normally wear, and where you will be meeting to determine what to wear. Although a business formal code of dress may give an appearance of professionalism, a style of dress that is too formal may be perceived as an attempt to assert authority. Some research suggests that attire may be used as a pathway to assess for an individual's dominance and empathy (Küster, Krumhuber, & Hess, 2019). Similarly, a style of dress that is too casual may send a message that you have not taken time to understand the culture of a mental health agency or congregation. Attention to dress code is particularly important when meeting in congregations, where meeting space and style of dress have historically been considered sacred (Garver, 2018). If the type of clothing to wear is unclear, business casual is generally acceptable.

Meeting with a Purpose

When you arrive at the location, consider giving yourself one final "look over" to ensure that your appearance is as desired. Take a minute to walk through the conversation in your head and what you hope to communicate. If you feel anxious, you may also find it helpful to take a few deep breaths. As you walk from your vehicle to the door, work to ensure that your body language matches the tone that you wish to have in your verbal communication. Standing and sitting tall, with your back straightened and shoulders back, may help for others to perceive you as confident and competent.

When you enter the building, you are likely to first communicate with an administrative assistant. Begin by introducing yourself, including your name, job title, with whom you are meeting, and the time that the meeting is scheduled. Anticipate the possibility of needing to wait in a lobby or office area for a few minutes. During the waiting period, you may choose to quietly use your phone, but be certain that your phone

use does not cause a distraction. You may also choose to get to know the administrative assistant, but be aware that extended conversation may also prevent him or her from being able to complete their work. However you choose to spend your time waiting, be sure that you maintain a strong posture.

After the allotted amount of time, the person with whom you are meeting is likely to come and greet you to begin the meeting. Be sure to stand up from your chair to introduce yourself. As you do so, pay special attention to assure that your handshake is firm and that you maintain eye contact while doing so. Research suggests that a handshake helps to build a sense of trust and confidence in further collaborative efforts while eye contact may indicate emotional responsiveness (Dolcos et al., 2012; Dowell & Berman, 2013; Thayer & Schiff, 1974).

At this point, you are likely to be led into an office or meeting space. Resist the urge to begin talking about meeting material too quickly; doing so may raise suspicion that you are only interested in forming a relationship for your own benefit. Instead, consider making small talk to get to know the person. When you enter the space where you will be meeting, take a few seconds to quickly examine the room. The organization and decoration of a meeting space may help to inform the tone and the degree to which people are able to focus their attention on the meeting itself (Leach et al., 2009). If the room contains multiple chairs, be sure that you know where to sit. Try to take into account any decorations, pictures on the wall, or books on the shelves. Use these contextual clues to get to know the person and find common points of interest or shared experiences. For example, you may have read the same book or have children who are close in age. Identifying these commonalities requires a level of vulnerability. This

approach may appear time consuming, but a slow and intentional approach may help to build trust and level of comfort with one another.

When you have taken a sufficient amount of time to begin learning about one another, slowly transition in a conversation to explore a working partnership. As you begin this part of the meeting, you may want to provide a brief statement that captures the work that you are doing and what you hope to accomplish through the meeting. This information may have already been in phone calls or emails, but a quick overview will help to assure that everyone holds a common understanding and intention for meeting. Avoid the temptation to jump into a long presentation of your work. Although background information may help to provide a better understanding of what a partnership could entail, too much information may leave the other person feeling unheard.

Take time to sincerely listen and learn about the other person. Consider what kinds of goals would hold mutual benefits to both parties and where current activities may overlap. Social exchanges are often more meaningful and last longer when both parties see that investing in the relationship holds value (Stafford, 2008). When people share a common vision and support work that is already being done, they are more interested in partnering together. In order to better understand opportunities for partnerships, you may want to ask questions about what brought the person into their current work, what they enjoy about their job, what types of services and supports their agency provides, what populations are most commonly served, what kinds of resources are available to support their work, and the types of challenge that may commonly limit or restrict their effectiveness.

Be careful that your questions are not overly intrusive and that partnering together is not presented as the perfect solution to unmet needs. Collaboration often requires vulnerability and a willingness to admit limitations. The value of partnership is not found within the knowledge, expertise, and resources of a single entity, but in the collective assets of parties who are committed to reaching common goals and supporting shared visions. Discussing the resource limitations, gaps in services, policies, and other challenges that keep you up at night is not wrong. Sharing with this level of vulnerability may often be difficult but invites others to help us problem solve, presents a clear rationale for where partnership would be beneficial, and allows others to feel comfortable sharing their own the areas of struggle.

Getting to the Details

As you continue working to identify common goals and objectives, begin to think about and discuss the kinds of activities and strategies that a partnership could offer to best support those goals. Clear roles and responsibilities increase the effectiveness of collaboration (Choi & Pak, 2007). Without attention to this level of detail, relationships may appear to lack purpose or cause role confusion. Furthermore, having clear roles and responsibilities helps each party to feel that their contribution is valuable. When thinking about assigning roles and responsibilities, be mindful about what kinds of activities are best matched with a person's knowledge, skills, and expertise.

Also, be aware of whether t additional people or resources are needed at the table for a partnership to be most effective. A clergy or mental health professional may not always be able to make a strong commitment to partnering together without further discussion with their coworkers and supervisors. These external factors should not serve

to discourage but rather demonstrate the opportunity to continue moving forward in conversations. An initial meeting may begin with a small number of people and grow into a larger partnership over a period of time. Defining roles and responsibilities after a first meeting may be as simple as sharing information from the meeting with other team members, emailing relevant resources, helping to connect a clergy member or mental health professional with someone who is doing similar work, and setting a time for a future meeting. Regardless of the scope of work, be sure that each person has clear tasks with specific and measurable outcomes.

Closing the Meeting

As you begin to end the conversation, be certain a plan is place for a future meeting. If possible, take time to explore what times may be available to meet, what each person hopes to accomplish next time, and whether any work needs to be done in preparation. If additional people will be joining, or a time cannot be easily identified, consider utilizing an online scheduling assistant to determine which times may work best. Be sure everyone holds a clear understanding of who will be responsible for sending out the scheduling assistant link and when this link can be expected. Clearly defined roles and responsibilities strengthen the effectiveness of partnerships (Bourdages et al., 2003; Seaton et al., 2018).

Close the meeting by providing a quick summary including what you discussed, identified roles and responsibilities, any additional takeaways, and plans for moving forward. Thank the person that you have met with for their time and consideration given to exploring a partnership. Giving an additional firm handshake may be seen as an act of good faith in moving forward. As you walk out of the meeting space and prepare to leave

the building, provide an additional word of appreciation. On your way out, you may also want to consider thanking the administrative assistant and wishing them a good day. Maintain a strong posture as you walk to your vehicle and slowly exit the premises in a timely manner. If you need to make any phone calls or check emails, wait to do so until you can safely park somewhere a little further down the road.

The Follow-Up

When you get back in the office, be sure to follow-up your conversation with a quick email of appreciation for the meeting. You may also wish to share what you enjoyed most about the conversation and that you look forward to meeting again in the future. Also, be sure to attach any documents that you said would be sent. You may also want to consider sending a physical letter of appreciation in the mail. While this step is not always necessary, taking the time to write a letter may be greatly appreciated, particularly when factors that might have prevented the meeting from occurring in the past.

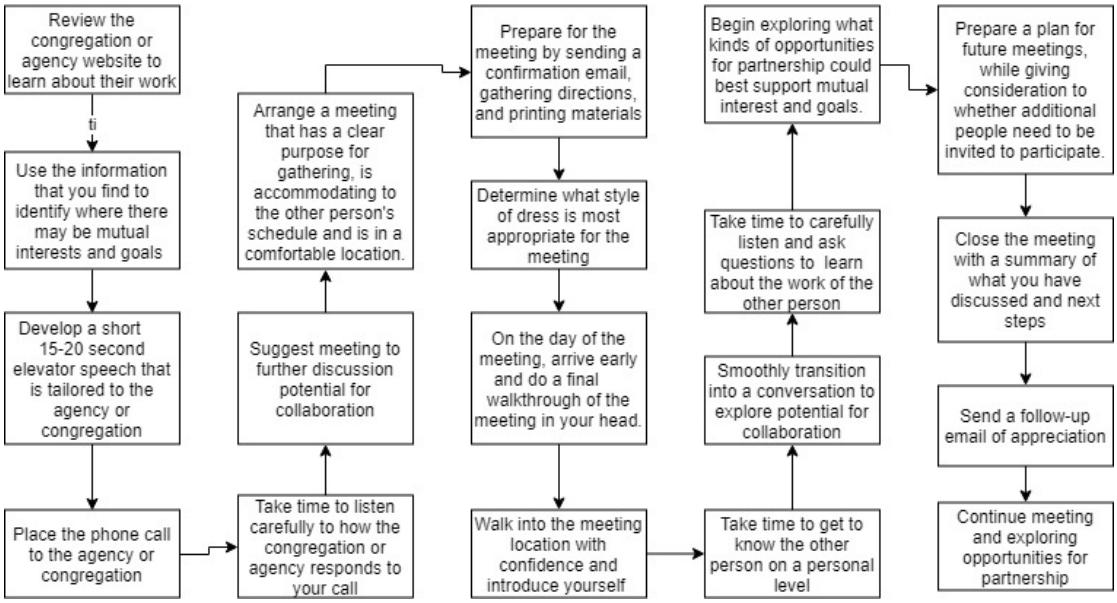
Summary of the Model

In summary, the proposed model provides a framework for exploring opportunities for clergy and mental health professionals to collaborate. Rather than being prescriptive in nature, this model serve as an adaptable framework that can be contextualized to local communities and congregational settings. Seminary professors may wish to use this model as a guide for classroom discussion, while mental health professionals may choose to utilize the model to expand the continuum of care by working with clergy to ensure that services are culturally responsive to the faith and

spirituality of the families whom they serve. Figure 1 has been created as a reference guide for clergy and mental health professionals on howto move forward in developing working collaborations.

Figure 4.1

Relationships Between Clergy and Mental Health Professionals



Note. The following chart provides a reference guide for developing collaborations between clergy and mental health professionals.

Applying the Model

The following case study is intended to provide an opportunity to reflect on how the model described above can be applied to practice. As you read through the case study, consider the values of each individual and entity. Where do these values align and where might these values conflict? What are some of Shannon's physical, emotional, mental, and spiritual needs? How could a partnership between Travis and a mental health professional have changed this narrative? Given the information provided with the case

study, how might a mental health professional support Shannon and her mom in a way that is culturally responsive?

A Case Study

As the alarm on her phone relentlessly goes off, Shannon forces her eyes open to approach another school day. A junior in high school, Shannon anxiously awaits the day that she will be able to move away from home. Peaceful dreams and the hope for independence, however, can often seem elusive. Two years ago, Shannon was a victim of sexual trauma at the hands of a longtime neighbor. Although time has passed, feelings of powerlessness and guilt persist. Her abuser remains incarcerated, but Shannon often struggles to sleep at night, fearful of the recurring nightmares that plague her dreams. In the rare moments that Shannon does sleep, she often awakes to cold sweats and the sound of her own screams and cries for escape.

Shannon often struggles to concentrate or pay attention in school. Loud and sudden noises, such as the sound of an electric pencil sharpener, can be terrifying. Shannon has also found developing friendships to be difficult, often mistrusting the motives and intentions of those around her. In turn, Shannon has slowly withdrawn from the extracurricular activities that she used to enjoy. Shannon's teachers have observed that Shannon appears detached from the course lessons and from her peers but also perceive her to be a creative and compassionate student leader who genuinely cares for the wellbeing of her classmates.

At the end of the school day, Shannon boards the bus to head home, which loudly resonates with the yells and laughter of her peers. Shannon buries her head in her jacket and closes her eyes in an attempt to drown out the excruciating noise. When the bus

finally arrives at the right stop, Shannon frantically goes home as fast as she can, seeking to avoid any attention or notice that might be given to her. Shannon quickly unlocks the front door and rushes to her room, throwing her backpack on the bed and slamming the bedroom door behind her. Here, she is able to release the flood of angry tears that she has held back from releasing at school. Shannon spends most nights in her bedroom. The limited room space can feel trapping, but Shannon also feels safest here. Over the next few hours, Shannon will listen to music and occasionally watch an episode of her favorite television show. Shannon is exhausted but resists sleep for fear of what nightmare will haunt her sleep tonight and knowing that she will have to awake to another day of such hell tomorrow.

Shannon's mom has growing concerns about Shannon's mental and emotional well-being but does not know where else to turn for help. Approximately a year ago, Shannon's mom brought these concerns to Travis, a young youth minister at the local church Shannon and her mom have attended for the last five years. After hearing about Shannon's experience of trauma, Travis and two of the church elders agreed to begin meeting with Shannon on a weekly basis. Drawing upon seven years of ministry experience and seminary as a reference, Travis determined that some of Shannon's struggles may be related to a spiritual concern. Travis suggested that the team begin working through a curriculum, which he said would provide Biblical wisdom for dealing with feelings of depression and anxiety.

After the first three months of meeting, Travis and the elders were encouraged that Shannon appeared to show some of the desired improvements. Similarly, Shannon reported that she had experienced a small increase in her sense of meaning and purpose

through their time together. Over the next two months, however, Shannon continued to wrestle with symptoms of severe post-traumatic stress disorder, including recurring nightmares and high anxiety. Travis and the elders growing continually frustrated eventually decided that Shannon's decline was a result of a lack of faith and that meetings with Shannon would not be continued.

Feeling abandoned and rejected by the church, Shannon and her mom have declared that they will never return to the church again, despite the network of friendships and supports that they have gained over the years. This experience has also driven a sense of disconnection between Shannon and her mom. Shannon understands that her mom was trying to be supportive but holds feelings of resentment over the experience described above. Similarly, Shannon's mom feels guilty about her daughter's experience with the church but does not know how to better provide the help that her daughter so desperately needs.

Conclusion

While the case study affords an opportunity for reflection and consideration, narratives such as the one above continue to play out in congregations, mental health agencies, and communities on a daily basis. When the positive impact that collaboration can provide is understood, a point may come in which clergy and mental health professionals begin to consider whether differences in perspective and feelings of ambivalence surrounding a potential partnership are worth putting aside to better support the mental health of their communities. Relationship development is almost certain to have some difficulties, but individuals with mental health challenges depend on the willingness of clergy and mental health professionals to initiate such courageous

conversations and prioritize a person's wellbeing over differences. Mutual goals, respect, open mind, and careful listening to one another will serve as helpful tools for collaboration. Have a little faith, trust the process, and embrace the messiness of community development.

The impact of partnerships between mental health professionals and clergy cannot be overstated. The way in which clergy and mental health professionals use their social capital holds significant implications for whether youth with mental health challenges are able to access community-based and culturally responsive mental health services and supports. While traditional models for mental health coordination have operated in silos, these approaches are not able to provide comprehensive care that is responsive to the whole person, including their religion or spirituality. Working partnerships between mental health professional and clergy serve as a pathway for referrals, information sharing, community collaboration, and training models. Furthermore, when these relationships are utilized effectively, youth and families may have access to higher quality services by being able to better navigate the available community resources and supports that are available.

REFERENCES

Bourdages, J., Sauvageau, L., & Lepage, C. (2003). Factors in creating sustainable intersectoral community mobilization for prevention of heart and lung disease. *Health Promotion International*, *18*(2), 135–144. https://doi.org/10.1093/heapro/18.2.135

Bourdieu, P. (1986). The forms of capital. *Handbook of theory and research for the sociology of education* (pp. 241–258). Greenwood Press.

Castro, D. R., Anseel, F., Kluger, A. N., Lloyd, K. J., & Turjeman-Levi, Y. (2018). Mere listening effect on creativity and the mediating role of psychological safety. *Psychology of Aesthetics, Creativity, and the Arts*, *12*(4), 489–502. https://doi.org/10.1037/aca0000177

Choi, B. C. K., & Pak, A. W. P. (2007). Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: Promotors, barriers, and strategies of enhancement. *Clinical & Investigative Medicine*, *30*(6), 224. https://doi.org/10.25011/cim.v30i6.2950

Christiana, J. M., Gilman, S. E., Guardino, M., Mickelson, K., Morselli, P. L., Olfson, M., & Kessler, R. C. (2000). Duration between onset and time of obtaining initial treatment among people with anxiety and mood disorders: An international survey of members of mental health patient advocate groups. *Psychological Medicine*, *30*(3), 693–703.

Dew, R. E., Daniel, S. S., Goldston, D. B., McCall, W. V., Kuchibhatla, M., Schleifer, C., Triplett, M. F., & Koenig, H. G. (2010). A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. *Journal of Affective Disorders*, *120*(1–3), 149–157. https://doi.org/10.1016/j.jad.2009.04.029

Dolcos, S., Sung, K., Argo, J. J., Flor-Henry, S., & Dolcos, F. (2012). The power of a handshake: Neural correlates of evaluative judgments in observed social interactions. *Journal of Cognitive Neuroscience*, *24*(12), 2292–2305. https://doi.org/10.1162/jocn_a_00295

Dowell, N. M., & Berman, J. S. (2013). Therapist nonverbal behavior and perceptions of empathy, alliance, and treatment credibility. *Journal of Psychotherapy Integration*, *23*(2), 158–165. https://doi.org/10.1037/a0031421

Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 190–211.

Ellison, Zhang, W., Krause, N., & Marcum, J. P. (2009). Does negative interaction in the church increase psychological distress? Longitudinal findings from the Presbyterian panel survey. *Sociology of Religion*, *70*(4), 409–431. https://doi.org/10.1093/socrel/srp062

Farr, J. (2004). Social capital: A conceptual history. *Political Theory*, *32*(1), 6–33. JSTOR.

Farrell, J. L., & Goebert, D. A. (2008). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, *59*(4), 437–440. https://doi.org/10.1176/ps.2008.59.4.437

Ferragina, E. (2010). Social capital and equality: Tocqueville's legacy: Rethinking social capital in relation with income inequalities. *The Tocqueville Review/La Revue Tocqueville*, *31*(1), 73–98. https://doi.org/10.1353/toc.0.0030

Garver, V. L. (2018). Go humbly dressed as befits servants of God: Alcuin, clerical identity, and sartorial anxieties. *Early Medieval Europe*, *26*(2), 203–230. https://doi.org/10.1111/emed.12265

Hill, J. K. (2013). Partnering with a purpose: Psychologists as advocates in organizations. *Professional Psychology: Research & Practice*, *44*(4), 187–192. https://doi.org/10.1037/a0033120

Kessler, R C, Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

Kessler, Ronald C, Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

Koenig, H. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatria*, *54*(5), 283–291.

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: A practical approach to enhancing organizational performance* (2nd edition). Jossey-Bass.

Leach, D. J., Rogelberg, S. G., Warr, P. B., & Burnfield, J. L. (2009). Perceived meeting effectiveness: The role of design characteristics. *Journal of Business & Psychology*, *24*(1), 65–76. https://doi.org/10.1007/s10869-009-9092-6

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication–adolescent supplement (ncs-a). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mollica, R. F., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*, *143*(3), 323–328. https://doi.org/10.1176/ajp.143.3.323

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS pub no SMA-03—3832). Department of Health and Human Services.

Nooney, J., & Woodrum, E. (2002). Religious coping and church-based social support as predictors of mental health outcomes: Testing a conceptual model. *Journal for the Scientific Study of Religion*, *41*(2), 359–368. https://doi.org/10.1111/1468-5906.00122

Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, *36*(3), 301.

Oxhandler, H. K., & Ellor, J. W. (2017). Christian social workers' views and integration of clients' religion and spirituality in practice. *Social Work & Christianity*, *44*(3), 3–24.

Oxhandler, H. K., Moffatt, K. M., & Giardina, T. D. (2018). Clinical helping professionals' perceived support, barriers, and training to integrate clients' religion/spirituality in practice. *Spirituality in Clinical Practice*. https://doi.org/10.1037/scp0000189

Polson, L. M., & Rogers, R. K. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, *34*(1). http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=07375778&AN=24474035&h=UEQjeHQKZen4QD3lware%2FvySzdZVOtZX20gW9zeQ8%2BschrZAXX1HGO4n7eaKTGoeEUL7Mz3xEnBydNXcF9689Q%3D%3D&crl=c

Recker, N. L., & Moore, M. D. (2016). Durkheim, social capital, and suicide rates across US counties. *Health Sociology Review; Abingdon*, *25*(1), 78–91. http://dx.doi.org/10.1080/14461242.2015.1101703

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American master's of divinity students in relation to serious mental illness. *Journal of Research on Christian Education*, *23*(2), 176–186. https://doi.org/10.1080/10656219.2014.899480

San Martín-Rodríguez L, Beaulieu M, D'Amour D, & Ferrada-Videla M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, *19*, 132–147.

Seaton, C. L., Holm, N., Bottorff, J. L., Jones-Bricker, M., Errey, S., Caperchione, C. M., Lamont, S., Johnson, S. T., & Healy, T. (2018). Factors that impact the success of interorganizational health promotion collaborations: A scoping review. *American Journal of Health Promotion*, *32*(4), 1095–1109. https://doi.org/10.1177/0890117117710875

Stafford, L. (2008). Social exchange theories: Calculating the rewards and costs of personal relationships. *Engaging Theories in Interpersonal Communication: Multiple Perspectives* (pp. 377–390). SAGE Publications, Inc. https://doi.org/10.4135/9781483329529

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445–449. https://doi.org/10.1080/13674670600903049

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black church. *Social Work*, *45*(1), 73–87. https://doi.org/10.1093/sw/45.1.73

Thayer, S., & Schiff, W. (1974). Observer judgment of social interaction: Eye contact and relationship inferences. *Journal of Personality and Social Psychology*, *30*(1), 110–114. https://doi.org/10.1037/h0036647

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology*, *7*(4), 271–280. https://doi.org/10.1177/009164717900700405

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647–673. https://doi.org/10.1111/1475-6773.00138

Watson, G. W., & Papamarcos, S. D. (2002). Social capital and organizational commitment. *Journal of Business and Psychology*, *16*(4), 537–552. https://doi.org/10.1023/A:1015498101372

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

Weger, H., Castle Bell, G., Minei, Elizabeth M., & Robinson, Melissa C. (2014). The relative effectiveness of active listening in initial interactions. *International Journal of Listening*, *28*(1), 13–31. https://doi.org/10.1080/10904018.2013.813234

CHAPTER FIVE

Finding Grace: Where Do We Go From Here?

Concluding Statements

Chapter five is perhaps the most personal chapter, exploring how each of the findings from this dissertation may be used to inform and drive changes in research, practice, and policy. As is often the case, where great need exists, so do opportunities.

Summary of Dissertation

Chapter one provided a review of existing literature on youth mental health and the role of congregations in supporting youth with mental health challenges. The information from the review was used to provide a brief rationale, justification, and outline of the three manuscripts that followed. In Chapter Two, the researcher conducted a quantitative study, using a custom 85-item instrument, to examine the youth mental health literacy of 170 Protestant clergy in Texas. A substantial majority of clergy (66.26%) reported that their seminary education did not prepare them to work with youth who have a mental health challenge. While a subsection of these individuals shared that these gaps in education were filled through other formal education, 38.60% of participants who attended seminary reported that neither seminary nor other formal education prepared them to work with youth who have a mental health challenge.

These gaps in education are acknowledged, but awareness of these limitations does not appear to be associated with increased reliance on other professional types to support youth with mental health concerns. While 57.05% of clergy reported that mental

health hospitals are effective in helping people with mental health concerns, much smaller percentages of clergy trusted emergency rooms (5.29%), juvenile detention centers (2.9%), law enforcement (5.88%), and teachers (8.82%) to have the mental health knowledge and skills needed to adequately support these youth. Similar percentages of clergy reported mistrust of researchers (47.64%), mainstream news (66.4%), and social media (98.83%) to provide accurate information about mental health.

Nevertheless, clergy appear open to further conversations about mental health. The majority of clergy (64.11%) reported trusting clergy with similar theological perspectives to provide accurate information about mental health. In some cases, this trust was also extended to mental health professionals. Although about half of the clergy surveyed (49.70%) reported feeling comfortable with making a referral to someone from a different religion, the majority of clergy (62.57%) shared that that they are more likely to make a referral to a mental health professional who shares similar theological understandings.

An openness to conversation about mental health, however, does not always translate into practice. Almost all (90.85%) shared that they are comfortable answering questions from mental health professionals about religion and spirituality, but less than half of the participants (48.78%) reported that mental health professionals regularly ask these types of questions. Similarly, most (92.68%) shared that they feel comfortable asking mental health professionals about mental health, but about half (53.65%) do so on a regular basis. The evidence suggests that a lack of relationships with mental health professionals may contribute to these discrepancies. More than one-third of participants (39.02%) stated that they did not have or know of any mental health professionals in their

congregation. However, 92% of the clergy who knew of mental health professionals in their congregation also reported having a working relationship with those individuals.

Burnout and compassion fatigue may prevent or discourage clergy from seeking additional mental health education or working relationships with mental health professionals. In chapter three, researchers utilized critical phenomenology methods to conduct purposive, semi-structured interviews with 13 youth ministers who work in one of two selected Baptist General Convention of Texas (BGCT) associations. Findings indicate that clergy frequently report being overwhelmed by the amount of responsibilities that they have been expected to fulfill by congregations. In addition to preparing messages, supporting administrative functions across the congregations, and facilitating congregation service, youth ministers shared that they frequently work nontraditional and extensive hours in a wide array of activities to facilitate supportive relationships with youth including attending football games, theater performances, recitals, and other extracurricular activities.

Along with these tasks come expectations from youth, their families, and other congregants that youth ministers have the knowledge and skills needed to utilize these relationships to adequately support the mental health needs of the youth whom they serve. As found in chapter two, these expectations may not always be well founded. Findings from the study confirm that clergy may hold beliefs about mental health and hold pastoral practices that could discourage youth and their families from seeking additional mental health services or support beyond their interaction with clergy. In hopes of meetings these expectations, ministers may sometimes feel obligated to provide

consultation, even when recognizing that the concerns of a youth or family fall outside the realm of their pastoral knowledge and scope of practice.

Words of guidance that are issued within these interactions may be consider authoritative and prescriptively followed, even if these instructions run counter to mental health best practice.

These matters are further complicated by the extensive amount of time and other resources that youth ministers invest in their students. Although traditional mental health roles often have standards for ethical practice, including standards on establishing professional boundaries, ethical standards for pastoral roles and responsibilities may vary widely across congregations and denominations. The extent and intensity of time that youth ministers spend with youth to develop relationships may sometimes cause role confusion. For example, some of the identities that ministers compared their role to include a brother, a father figure, a big kid, and a friend with a twist of family and mentor. These descriptions may help to provide a conceptual imagery of pastoral care, but are confusing in practice. Considerable risks for misusing and abusing power exists when clear boundaries have not been established.

Youth ministers may frequently seek to mitigate these risks by utilizing volunteers and interns. Some of the ways that adults were reported to provide support include baking home goods, bringing snacks, leading small groups, talking with families, leading games, hosting events in their homes, and providing encouragement to students. Male clergy frequently noted that they were thankful to have females who could help female students. These clergy also often reported having at least one female present when meeting with a female youth. These additional supports were largely said to play a

positive role in helping ministers to better manage programming and organize activities, but how much decision-making ability these committees and interns were given to make decisions without the minister's approval is unclear. Although volunteers and interns provide a helpful channel for ministers to share power, questions remain about whether congregations have the capacity needed to adequately train, oversee, and support these adults, given the responsibilities that ministers are already expected to perform.

Again, building systems of care to adequately support youth with mental health concerns requires working relationships and collaborations between clergy and mental health professionals. To support these goals, the researcher utilized social capital theory, in chapter four, to propose a practical model for how congregations and mental health professionals can develop working partnerships with one another as a pathway for supporting the mental health of individuals and communities.

The model includes practical strategies for bridging communication gaps, initiating courageous conversations, preparing for the initial meeting, navigating the initial conversation, finishing the initial dialogue, and following up. The research also provided a case study and questions for consideration which may be used in seminary courses or other educational settings to promote critical thinking and dialogue on how to navigate relationships between clergy and mental health professionals. Readers are encouraged to use this model as a guide that may be contextualized to individual settings, rather than a prescription for navigating community relationships.

Contributions and Integrative Summary

The chapters of this dissertation form a cohesive picture of the opportunities and challenges to congregations serving as gatekeepers in youth mental health. Although researchers have previously sought to examine mental health literacy in a number of different populations, the majority of these studies have utilized vignettes to assess knowledge of mental health, often focusing on the ability to identify whether a person meets specific diagnosis criterion (O'Connor et al., 2014a; Yang & Link, 2015). Utilizing this approach with clergy carries a significant risk. Clergy are responsible not to determine whether a youth meets the clinical criterion for a mental health diagnosis, but to provide pastoral care and referral to mental health professionals - those who have the training needed to support the mental health of these youth and their families. The use of traditional mental health literacy scales may unintentionally communicate an expectation that clergy should be able to perform such tasks.

The mental health literacy scale that was developed for this dissertation draws from validated instruments (Anthony F. Jorm et al., 2010; O'Connor et al., 2014a) to better understand the attitudes, beliefs, and practices that clergy hold about youth mental health. This instrument is the first mental health literacy scale to specifically focus on youth mental health and to have been designed for use with clergy. The focus on youth mental health is important given the unique differences in theory, practices, and policies that occur in the systems and context around youth (congregations and the mental health systems). The instrument's designed focus on clergy allows for a more thorough understanding of how theological beliefs may inform understandings and practices related to youth mental health. Without this specific design, researchers, who are not

accustomed to working with congregations, may miss some of the nuances and misinterpret the intersections of faith and pastoral care practices.

The qualitative interview protocol that was used for this study also provides an important contribution to existing literature. Although there have been a few qualitative studies have explored how clergy seek to meet the mental health needs of youth, these studies often lacked sophistication in selecting a specific design and methodology for collecting and interpreting data. This study is the first known qualitative study to examine the role of power dynamics within pastoral care interactions between clergy and youth who have a mental health concern. This utilization of conflict theory and attention to power dynamics is important given the potential for clergy to cause unintentional traumatization or other harm within these interactions. The focus on youth ministers is also significant given the unique distinctions in the role that youth ministers may frequently play in students' lives compared to other ministerial roles. The decision to focus on Baptist youth ministers allows for more a targeted and deeper understanding of what pastoral care may look like within Baptist life than a study of youth ministers in general would have allowed.

The practice model that is presented in chapter four provides practical strategies for navigating working relationships between clergy and mental health professionals. Although partnerships between clergy and mental health professionals are clearly beneficial, navigating these conversations and relationships may often be difficult. The information contained within the model may be considered common practice knowledge but may not appear within the curriculum that clergy and mental health professionals encounter in seminary or education programs. This manuscript may be used within

seminary, university, and other educational settings to promote critical thinking and dialogue about what these relationships could look like when contextualized to local communities. Without these types of resources families who may already hold a mistrust of mental health systems may frequently be left to navigate service delivery systems and support on their own.

Most importantly, the manuscripts in this dissertation provide compelling insight into the factors that contribute to clergy lacking a knowledge of current research and best practices in youth mental health. These studies help to explain why clergy may frequently mistrust other provider types to support youth with mental health challenges and how this mistrust may translate into low referral rates by clergy to mental health professionals. Furthermore, this research sheds light on potential pathways for increasing mental health literacy and improving service coordination to better support youth with mental health challenges. The methodologies used throughout the dissertation allow for these studies to be repeated and for the findings to be contextualized to specific denominations and congregations. These approaches allow for the creation of materials that are responsive to religious beliefs about mental health rather than simply dismissing the way that theological perspectives may influence practice, as trainings for clergy have traditionally done. In turn, perhaps congregations and faith communities may better serve youth with mental health concerns than has historically been possible.

Limitations

The dissertation research has some overarching limitations. Although efforts have been made to ensure the validity of findings, each manuscript includes the creation of a custom instrument, protocol, or model. Each item has been put through a screening

mechanism to build content and face validities. Additional analysis is needed to assess for criterion validity. Although additional studied would be beneficial, these studies were intentionally designed to allow for some clergy interpretation of the terminology and questions in the instruments. This approach allows for a more subjective and responsive process for assessing clergy understanding of mental health literacy and pastoral care practices but does not allow for operational definitions to be used or applied throughout the research process. As such, the validity of findings and their interpretations may be constrained by the clergy's current understanding of mental health.

Similarly, there may also be some concerns about response bias. Although efforts were made to allow for equitable representation in the research, by using purposive and snowball sampling methods, assessing whether the clergy who participated in this research are representative of who serve in the same geographic area or ones with similar socio-economic characteristics, fulfill the same ministerial role, share affiliation as Baptists, or are members of other Protestant denominations is difficult. Additional research specific to these subpopulations may allow for a better understanding of the degree to which sample bias and response bias exists within the dissertation.

The degree to which these findings may be used to inform mental health policy and practices in local communities have some limitation. Although the findings from this study hold significant implications for how congregations and communities may choose to approach these conversations, the barriers to service coordination between clergy and mental health professionals have been shown to exist for some clear reasons. The ability to use the information contained within these manuscripts to change policy and practices is dependent on the ability to successfully navigate difficult conversations about why

these barriers have historically existed. Such conversations will likely require significant investments of time and effort. Acknowledgement of these limitations is not intended to inhibit such investments but rather to acknowledge and affirm that any undertaking of significant value is also likely to include significant challenges. As such, this dissertation also holds several implications.

Implications

In the time that this dissertation was being written, youth and families have consulted clergy for support related to a mental health concern. In many of these cases, clergy will not have had adequate knowledge or training to know how to best support the mental health needs of these individuals. There will have been times that these youth and families were told that they did not have a mental health concern and that their experiences were merely a result of not having enough faith. There will have been instances in which students were told that their thoughts of suicide were selfish and sinful. There will have been moments in which youth and families saw their faith weakened as a result of these interactions, perhaps even to the point of families leaving their communities of faith. There will have been times in which clergy misused relationships of trust with youth by offering guidance that ministers knew was outside of their scope of knowledge or practice.

There will have been mental health professionals whose congregations could have been of additional support but did not know how to approach such conversations with their minister or congregation. There have been mental health professionals who provided mental health services but failed to understand the role that faith may play within the lives of the individuals with whom they have worked. There will have been seminaries

who sought to prepare students for careers in transformative ministries but never discussed or provided training to students on mental health.

The results of these small moments will not have been without consequence. There will have been youth who feel misunderstood and alienated from the same communities that claim to love them. There will have been families who are forced to navigate a complex mental health system on their own, despite knowing individuals who could have been gatekeepers of support. There will have been youth who, as a result of their experience, will have questioned whether life was worth living and whether God exists. There will have been youth who died because clergy and mental health professionals could not find a way to work together.

When the evidence suggests that clergy do not have adequate education about mental health, seminaries must begin to include information regarding youth mental health into the curriculum that is required for the completion of a Master of Divinity. When the literature shows that clergy are frequently consulted by individuals with the highest intensity of mental health challenges but do not frequently refer individuals to mental health professionals, mental health professionals must begin to ask why these gaps in referrals exist and present themselves as a resource.

Training materials that are culturally and linguistically responsive must be developed and provided to congregations. When clergy are likely to have more trust in the accuracy of information when it is presented by someone who shares similar theological beliefs, there must be intentional efforts to make sure that training materials have been created and can be delivered by such individuals. When congregations are often seen as a credible source, training agencies should seek to partner with

denominations to provide mental health resources. When the research reveals that volunteers are frequently utilized by youth ministers to support students, congregations and education agencies must seek to ensure that volunteers have adequate mental health training. When quality research on the role of congregations is found to be insufficient, there must be an intentional commitment to continue exploring how research in this area may be used to support congregations as gatekeepers in youth mental health. The responsibility for these actions does not fall on a single person or entity, but on communities as a whole. The risks of anything that falls short of this call to action are all too clear.

Recommendations

This research provides clarity on what can be done to improve coordination and accessibility of the youth mental health system. First and foremost, the ability for youth and family members may sometimes be dependent on the existence of relationships between clergy and mental health professionals. Clergy are encouraged to examine the available mental health resources in the local community and to develop working partnerships with mental health providers from these agencies. Using these relationships, clergy should develop a spreadsheet of referrals and ensure that this spreadsheet is readily accessible to all congregants and individuals seeking mental health support from the congregation. Clergy are also encouraged to pursue additional training and professional opportunities to advance the latest research and available information on youth development and mental health.

To a similar effect, congregations should seek to provide ongoing training opportunities to volunteers, family members, and youth on how to best support

individuals who are experiencing a mental health challenge. Volunteers and family members should also be able to access training materials on topics such as crisis management, parenting, youth development, substance use, and how to help youth develop healthy relationships. Congregation policies regarding pastoral care practices should be examined and updated on an annual basis, with support from denominational leaders and other community agencies who specialize in serving children and youth. Some of the topics that should be examined during these discussions include requirements for mandated reporting, background checks for volunteers, procedures for making referrals, and safety procedures. Denominations should assist in these efforts by providing mental health resources and pastoral care policy guidelines to their congregations.

Seminaries frequently lack information about youth mental health in their curriculum. Seminaries are encouraged to expand their curriculum to include course material that is specific to youth mental health and the provision of pastoral care. Seminaries may also wish to identify pathways for providing continuing education opportunities for alumni to receive this information, such as seminars and information in newsletters. As a part of these efforts, seminary professors and administrators should seek to include mental health professionals and families who have experienced mental health challenges in the planning of these activities.

College and universities may frequently lack an emphasis on the role of faith and spirituality in providing culturally responsive mental health services and supports. University departments and their professors should examine pathways for including additional information on the role of faith and spirituality as it relates to social

determinants of health and coordination of mental health services. Universities are also encouraged to collaborate with seminaries and local congregations to assist in these efforts.

Social workers have traditionally placed significant focus on the importance of human relationships, dignity and worth of the human, and competence. In recognizing these values, the National Association of Social Workers and other social work associations should regularly provide professional opportunities on the ethical integration of faith and practice and how to partner with congregations. When periodic updates are made to existing ethical codes, reviews should also seek to provide guidelines on cultural responsiveness as it relates to faith and spirituality. Training opportunities, such as annual conferences, should also seek to include presentations and discussions on these topics.

Social workers and other mental health professionals should seek to include meaningful questions about religion and spirituality within psychosocial evaluations. Mental health professionals should ensure that treatments plans and other primary documents include action steps that are in alignment with the values and beliefs of youth and their families. When youth and their families state that their faith or spirituality is important to them, mental health professionals should ask whether they clergy or anybody else from their congregation in their services. For example, clergy and youth ministry volunteers may serve as members of wraparound teams. The role that these individuals perform may be determined by the youth and their family, with support from the rest of the team.

This research also holds implications for policy makers and youth advocates. While the separation of church and state allows for the provision of pastoral care without

licensing requirements, legislators are encouraged to routinely review mandated reporting mandated reporting requirements for clergy and congregations. Legislators and youth may also wish to examine whether additional laws or policies are needed to ensure that pastoral care practices of clergy and other congregational leaders are distinctive in their role and function from counseling and other regulated social services. There may also be consideration given to whether specific practices are allowable or require additional oversight from the state.

REFERENCES

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *The Australian and New Zealand Journal of Psychiatry*, *40*(1), 51–54. https://doi.org/10.1111/j.1440-1614.2006.01741.x

Bourdages, J., Sauvageau, L., & Lepage, C. (2003). Factors in creating sustainable intersectoral community mobilization for prevention of heart and lung disease. *Health Promotion International*, *18*(2), 135–144. https://doi.org/10.1093/heapro/18.2.135

Bourdieu, P. (1986). The forms of capital. In J. Richardson, *Handbook of theory and research for the sociology of education* (pp. 241–258). Greenwood Press.

Castro, D. R., Anseel, F., Kluger, A. N., Lloyd, K. J., & Turjeman-Levi, Y. (2018). Mere listening effect on creativity and the mediating role of psychological safety. *Psychology of Aesthetics, Creativity, and the Arts*, *12*(4), 489–502. https://doi.org/10.1037/aca0000177

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, *13*(2), 153–160. https://doi.org/10.1002/wps.20128

Child Welfare Information Gateway. (2019). *Clergy as mandated reporters of child abuse and neglect*. U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/clergymandated.pdf

Choi, B. C. K., & Pak, A. W. P. (2007). Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: Promotors, barriers, and strategies of enhancement. *Clinical & Investigative Medicine*, *30*(6), 224. https://doi.org/10.25011/cim.v30i6.2950

Christiana, J. M., Gilman, S. E., Guardino, M., Mickelson, K., Morselli, P. L., Olfson, M., & Kessler, R. C. (2000). Duration between onset and time of obtaining initial treatment among people with anxiety and mood disorders: An international survey of members of mental health patient advocate groups. *Psychological Medicine*, *30*(3), 693–703.

Clark, C. (2011). *Hurt 2.0*. Baker Academic.

Clebsch, W. A., & Jaekle, C. R. (Eds.). (1994). *Pastoral care in historical perspective* (New edition). Jason Aronson, Inc.

Creswell, J. (2006). *Qualitative inquiry and research design: Choosing among five approaches* (2nd edition). SAGE Publications, Inc.

D'Antonio, M. (2014a). *Mortal sins: Sex, crime, and the era of Catholic scandal* (Reprint edition). St. Martin's Griffin.

Desjarlais, R. (2005). Movement, stillness: On the sensory world of a shelter for the "homeless mentally ill." *Empire of the senses: The senusal culture reader*. Bloomsbury Academic

Dew, R. E., Daniel, S. S., Goldston, D. B., McCall, W. V., Kuchibhatla, M., Schleifer, C., Triplett, M. F., & Koenig, H. G. (2010). A prospective study of religion/spirituality and depressive symptoms among adolescent psychiatric patients. *Journal of Affective Disorders*, *120*(1–3), 149–157. https://doi.org/10.1016/j.jad.2009.04.029

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). *Internet, phone, mail, and mixed-mode surveys: The tailored design method* (4th edition). Wiley.

Doehring, C. (2014). *The practice of pastoral care,* (Revised and Expanded edition). Westminster John Knox Press.

Dolcos, S., Sung, K., Argo, J. J., Flor-Henry, S., & Dolcos, F. (2012). The power of a handshake: Neural correlates of evaluative judgments in observed social interactions. *Journal of Cognitive Neuroscience*, *24*(12), 2292–2305. https://doi.org/10.1162/jocn_a_00295

Dowell, N. M., & Berman, J. S. (2013). Therapist nonverbal behavior and perceptions of empathy, alliance, and treatment credibility. *Journal of Psychotherapy Integration*, *23*(2), 158–165. https://doi.org/10.1037/a0031421

Ellison, C. G., Vaaler, M. L., Flannelly, K. J., & Weaver, A. J. (2006a). The clergy as a source of mental health assistance: What Americans believe. *Review of Religious Research*, 190–211

Ellison, Zhang, W., Krause, N., & Marcum, J. P. (2009). Does negative interaction in the church increase psychological distress? Longitudinal findings from the Presbyterian panel survey. *Sociology of Religion*, *70*(4), 409–431. https://doi.org/10.1093/socrel/srp062

Farr, J. (2004). Social capital: A conceptual history. *Political Theory*, *32*(1), 6–33. JSTOR.

Farrell, J. L., & Goebert, D. A. (2008a). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, *59*(4), 437–440. https://doi.org/10.1176/ps.2008.59.4.437

Fay, B. (1987). *Critical social science: Liberation and its limits*. Cornell Univ Pr.

Ferragina, E. (2010). Social capital and equality: Tocqueville's legacy: Rethinking social capital in relation with income inequalities. *The Tocqueville Review/La Revue Tocqueville*, *31*(1), 73–98. https://doi.org/10.1353/toc.0.0030

Garland, D. R. (2012). *Family ministry: A comprehensive guide* (02 edition). IVP Academic.

Garland, D. R., & Yancey, G. I. (2014). *Congregational social work: Christian perspectives* (First edition). North American Association of Christians in Social Work.

Garver, V. L. (2018). Go humbly dressed as befits servants of God: Alcuin, clerical identity, and sartorial anxieties. *Early Medieval Europe*, *26*(2), 203–230. https://doi.org/10.1111/emed.12265

Goldenberg, R. (2013a). Unholy clergy: Amending state child abuse reporting statutes to include clergy members as mandatory reporters in child sexual abuse cases. *Family Court Review*, *51*(2), 298–315. https://doi.org/10.1111/fcre.12028

Hall, S. A., & Gjesfjeld, C. D. (2013). Clergy: A partner in rural mental health? *Journal of Rural Mental Health*, *37*(1), 50–57. https://doi.org/10.1037/rmh0000006

Heimlich, J. (2011a). *Breaking their will: Shedding light on religious child maltreatment*. Prometheus Books.

Hill, J. K. (2013). Partnering with a purpose: Psychologists as advocates in organizations. *Professional Psychology: Research & Practice*, *44*(4), 187–192. https://doi.org/10.1037/a0033120

Hunter, W., & Stanford, M. (2014). Adolescent mental health: The role of youth and college pastors. *Mental Health, Religion & Culture*, *17*(10), 957–966. https://doi.org/10.1080/13674676.2014.966663

Joiner, R. (2009). *Think orange: Imagine the impact when church and family collide...* (New edition). David C. Cook.

Jones, D. L., Cassidy, L., & Heflinger, C. A. (2012). "You can talk to them. You can pray": Rural clergy responses to adolescents with mental health concerns. *Journal of Rural Mental Health*, *36*(1), 24–33. https://doi.org/10.1037/h0094777

Jorm, A F, Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). “Mental health literacy”: A survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, *166*(4), 182–186.

Jorm, A.F., Kitchener, B. A., Fischer, J.-A., & Cvetkovski, S. (2010). Mental health first aid training by e-learning: A randomized controlled trial. *The Australian and New Zealand Journal of Psychiatry*, *44*(12), 1072–1081. https://doi.org/10.3109/00048674.2010.516426

Jorm, A.F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). “Mental health literacy”: A survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, *166*(4), 182–186.

Kaseman, C. M., & Anderson, R. G. (1977). Clergy consultation as a community mental health program. *Community Mental Health Journal*, *13*(1), 84.

Kessler, R C, Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

Kessler, Ronald C, Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

Koenig, H. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatria*, *54*(5), 283–291.

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: A practical approach to enhancing organizational performance* (2 edition). Jossey-Bass.

Leach, D. J., Rogelberg, S. G., Warr, P. B., & Burnfield, J. L. (2009). Perceived meeting effectiveness: The role of design characteristics. *Journal of Business & Psychology*, *24*(1), 65–76. https://doi.org/10.1007/s10869-009-9092-6

Lyall, D. (2001). *Integrity of pastoral care*. The Society For Promoting Christian Knowledge.

Mannheimer, A. H., & Hill, T. D. (2014). Deviating from religious norms and the mental health of conservative Protestants. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-014-9951-y

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005, December 22). *Factors affecting clergy-psychologist referral patterns*. Journal of Psychology and Theology. http://link.galegroup.com/apps/doc/A142151269/AONE?sid=lms

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity survey–adolescent supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 32–45. https://doi.org/10.1016/j.jaac.2010.10.006

Mollica, R. F., Streets, F. J., Boscarino, J., & Redlich, F. C. (1986). A community study of formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*, *143*(3), 323–328. https://doi.org/10.1176/ajp.143.3.323

Moustakas, C. (1994). *Phenomenological research methods* (1st edition). SAGE Publications, Inc.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America* (DHHS pub no SMA-03—3832). Department of Health and Human Services.

Nooney, J., & Woodrum, E. (2002). Religious coping and church-based social support as predictors of mental health outcomes: Testing a conceptual model. *Journal for the Scientific Study of Religion*, *41*(2), 359–368. https://doi.org/10.1111/1468-5906.00122

O'Connor, M., Casey, L., & Clough, B. (2014a). Measuring mental health literacy—A review of scale-based measures. *Journal of Mental Health (Abingdon, England)*, *23*(4), 197–204. https://doi.org/10.3109/09638237.2014.910646

Openshaw, L., & Harr, C. (2009). Exploring the relationship between clergy and mental health professionals. *Social Work and Christianity*, *36*(3), 301.

Oxhandler, H. K., & Ellor, J. W. (2017). Christian social workers' views and integration of clients' religion and spirituality in practice. *Social Work & Christianity*, *44*(3), 3–24.

Oxhandler, H. K., Moffatt, K. M., & Giardina, T. D. (2018). Clinical helping professionals' perceived support, barriers, and training to integrate clients' religion/spirituality in practice. *Spirituality in Clinical Practice*. https://doi.org/10.1037/scp0000189

Pew Research Center, G. (2015). *America's changing religious landscape*. Pew Internet & American Life Project. http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/

Polson, L. M., & Rogers, R. K. (2007). Counseling and mental health referral practices of church staff. *Social Work & Christianity*, *34*(1). http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=07375778&AN=24474035&h=UEQjeHQKZen4QD3lware%2FvySzdZVOtZX20gW9zeQ8%2BschrZAXX1HGO4n7eaKTGoeEUL7Mz3xEnBydNXcF9689Q%3D%3D&crl=c

Powell, K. E., Clark, C., & Candy, J. O. and J. (2011). *Sticky faith: Everyday ideas to build lasting faith in your kids*. Zondervan.

Reavley, N. J., & Jorm, A. F. (2011a). Recognition of mental disorders and beliefs about treatment and outcome: Findings from an Australian national survey of mental health literacy and stigma. *Australian and New Zealand Journal of Psychiatry*, *45*(11), 947–956. https://doi.org/10.3109/00048674.2011.621060

Recker, N. L., & Moore, M. D. (2016). Durkheim, social capital, and suicide rates across US counties. *Health Sociology Review; Abingdon*, *25*(1), 78–91. http://dx.doi.org/10.1080/14461242.2015.1101703

Rogers, E. B., Stanford, M., & Garland, D. R. (2012). The effects of mental illness on families within faith communities. *Mental Health, Religion & Culture*, *15*(3), 301–313. https://doi.org/10.1080/13674676.2011.573474

Root, A. (2009). *Revisiting relational youth ministry: From a strategy of influence to a theology of incarnation*. IVP Books.

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American master's of divinity students in relation to serious mental illness. *Journal of Research on Christian Education*, *23*(2), 176–186. https://doi.org/10.1080/10656219.2014.899480

San Martín-Rodríguez L, Beaulieu M, D'Amour D, & Ferrada-Videla M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, *19*, 132–147.

Seaton, C. L., Holm, N., Bottorff, J. L., Jones-Bricker, M., Errey, S., Caperchione, C. M., Lamont, S., Johnson, S. T., & Healy, T. (2018). Factors that impact the success of interorganizational health promotion collaborations: A scoping review. *American Journal of Health Promotion*, *32*(4), 1095–1109. https://doi.org/10.1177/0890117117710875

Stafford, L. (2008). Social exchange theories: Calculating the rewards and costs of personal relationships. *Engaging Theories in Interpersonal Communication: Multiple Perspectives* (pp. 377–390). SAGE Publications, Inc. https://doi.org/10.4135/9781483329529

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445–449. https://doi.org/10.1080/13674670600903049

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black church. *Social Work*, *45*(1), 73–87. https://doi.org/10.1093/sw/45.1.73

Thayer, S., & Schiff, W. (1974). Observer judgment of social interaction: Eye contact and relationship inferences. *Journal of Personality and Social Psychology*, *30*(1), 110–114. https://doi.org/10.1037/h0036647

Virkler, H. A. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology and Theology*, *7*(4), 271–280. https://doi.org/10.1177/009164717900700405

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647–673. https://doi.org/10.1111/1475-6773.00138

Watson, G. W., & Papamarcos, S. D. (2002). Social capital and organizational commitment. *Journal of Business and Psychology*, *16*(4), 537–552. https://doi.org/10.1023/A:1015498101372

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

Weger, H., Castle Bell, G., Minei, Elizabeth M., & Robinson, Melissa C. (2014). The relative effectiveness of active listening in initial interactions. *International Journal of Listening*, *28*(1), 13–31. https://doi.org/10.1080/10904018.2013.813234

Yang, L. H., & Link, B. G. (2015). *Measurement of attitudes, beliefs and behaviors of mental health and mental illness*. http://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_170048.pdf