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Use of Ministers for a Serious Personal Problem Among African Americans: Findings from the National Survey of American Life (NSAL)

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Abstract

This study examined use of ministers for assistance with a serious personal problem within a nationally representative sample of African Americans (National Survey of American Life—2001–2003). Different perspectives on the use of ministers—social stratification, religious socialization, and clinical/problem-oriented approach—were proposed and tested using logistic regression analyses with demographic, religious involvement, and problem type factors as predictors. Study findings supported religious socialization and clinical/problem-oriented explanations indicating that persons who are heavily invested in religious pursuits and organizations (i.e., women, frequent attenders) are more likely than their counterparts to use ministerial assistance. Contrary to expectations from the social stratification perspective, positive income and education effects indicated that higher status individuals were more likely to report use of ministers. Finally, problems involving bereavement are especially suited for assistance from ministers owing to their inherent nature (e.g., questions of ultimate meaning) and the extensive array of ministerial support and church resources that are available to address the issue.

Keywords

ministers; African American men and women; National Survey of American Life; logistic regression; socioemotional support; religious socialization; social stratification; clinical/problem-oriented approach

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The U.S. Department of Health and Human Services (DHHS, 2001) reports that relative to Whites, ethnic and racial minority groups "have less access to and availability of care, and tend to receive poorer quality mental health services" (p. 5). These disparities in access and availability have resulted in unaddressed psychological needs (DHHS, 2001) and have raised compelling questions about the contexts in which African Americans can and do receive mental health care. Scholars have noted consistently that African Americans are less likely than members of other racial and ethnic groups to access or use formal mental health services including psychologists and psychiatrists (Alvidrez, 1999; Barrio, Yamada, Hough, Hawthorne, Garcia, & Jeste, 2003; DHHS, 2001; Padgett, Patrick, & Burns, 1994; Snowden, 2001; Wang et al., 2005). Further, when African Americans do access mental health services, it is in primary care contexts (e.g., emergency rooms) and from sources (e.g., emergency room physicians) that are not explicitly intended to provide such services (DHHS, 2001; Neighbors et al., 2007; Snowden, 1999). African American men are more likely to access mental health care through pathways such as the justice system (Takeuchi & Cheung, 1998). As a consequence, formal professional mental health services are both less desirable and less well-received. Further, receiving mental health services in general medical settings rather than mental health specialty venues is associated with inadequate mental health treatment (Wang et al., 2005). Overall, then, African Americans experience lower levels of access to professional services for mental health issues, and when care is available, it is of lower quality (DHHS, 2001; Wang et al., 2005).

Pathways to and Sources of Care

African American religious institutions have a long history of addressing a variety of adverse life circumstances facing African American communities. Ministers have been key players in providing mental health care for African Americans who encounter life problems and challenges, including serious mental illness (Bentz, 1970; Blank, Mahmood, Fox, & Guterbock, 2002; Levin, 1986; Mattis et al., 2007; Neighbors, Musick, & Williams, 1998; Rubin, Billingsley, & Caldwell, 1994; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Young, Griffith & Williams, 2003). Ministers play several roles in providing mental health care: helping to identify and counsel those experiencing psychological distress, functioning in important ways to prevent and reduce distress, and referring individuals to formal psychological services (Bentz, 1970; Blank, Mahmood, Fox, & Guterbock, 2002; Neighbors, Musick, & Williams, 1998; Young, Griffith, & Williams, 2003). African American ministers provide direct socio-emotional supports in response to a wide range of concerns including grief and bereavement, problems related to alcohol and other drug use and abuse, medical concerns, relational (e.g., marital and family conflict) and situational difficulties (e.g., financial stress, unemployment, and legal problems), and serious mental health (e.g., depression, anxiety, stress) problems (Mattis et al., 2007; Neighbors, Musick, & Williams, 1998; Taylor, Ellison, Chatters, Levin, & Lincoln 2000; Young, Griffith, & Williams, 2003).

The prominence and significance of ministerial assistance can be understood within the broader context of overall access to mental health care among African Americans. Racial and economic discrimination have irrevocably shaped access to, and use of, both medical and mental health care for African Americans. Owing to the combined effects of racism and classism, the mental health care afforded to African Americans often has ranged from insensitive and grossly incompetent to callously abusive (DHHS, 2001; Miller & Garran, 2007). Given this history of treatment, African Americans (particularly low-income African Americans who rely on public mental health services) have come to regard mental health professionals and institutions with suspicion and cultural mistrust (DHHS, 2001; Whaley, 2001).

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Despite African Americans' reliance on ministerial assistance in addressing mental health challenges, it would be inaccurate to characterize ministerial involvement in purely compensatory terms. Other social factors and characteristics might also be associated with the use of ministerial assistance and may provide a clearer picture of African Americans' access to and use of mental health care. Three perspectives—social stratification, religious involvement, and problem type—have been advanced to explain differences in the use of ministers.

Social Stratification

Much of the early research on social stratification examines class status as a central organizing force in social contexts. Recent research and theorizing focus on the ways and extent to which class – as well as other social identities including race, ethnicity, gender and religiosity – work independently or in concert to inform social practices and processes that lead to inequality in various spheres of life (see Anthias, 2001; Bourdieu, 1987; Lenski, 1994; Tickamyer, 2004). Research on pathways to psychological and psychiatric care and treatment trajectories (Rosenfield, 1984; Takeuchi & Cheung, 1998) indicates that social stratification determines the mental health problems that African Americans are likely to experience, how and whether they receive treatment, and the types and duration of formal mental health services received (Brown, 2003; Olfson, Cherry, & Lewis-Fernandez, 2009; Williams, & Williams-Morris, 2000).

The social stratification explanation argues that the pathways to resources (e.g., mental health services) are different for socially marginalized groups who have relatively little sociopolitical power (e.g., ethnic minorities, the poor, those with low levels of education), as compared to their more socially powerful or privileged counterparts (Anthias, 2001; Tickamyer, 2004). Consistent with the stratification argument, African Americans, particularly youth and men, are significantly more likely than other demographic groups to receive mental health care in connection with legal or judicial agencies (e.g., police contact) and to receive care in psychiatric in-patient hospital settings (Maschi, Hatcher, Schwalbe, & Rosato, 2008; Rosenfield, 1984; Takeuchi & Cheung, 1998). In times of crisis, persons occupying marginal social statuses and who typically experience compulsory and poor quality care may turn to alternative sources of assistance that exist outside the formal mental health sector because they are culturally familiar, trusted, and authoritative—namely, ministers.

Note, however, that prior research pertinent to the stratification hypothesis is mixed. Neighbors, Musick, and Williams (1998) found no relationship between education and income for African Americans' likelihood of using ministerial support for serious problems. Further, a recent analysis of service use for mental health problems among African Americans and Caribbean Blacks (Neighbors et al., 2007) found that income was unrelated to service use of any type. Education, however, was positively associated with use of all health-related services sectors (i.e., psychiatrists, psychologists, social workers, and counselors), but unrelated to seeking assistance from non-health providers (e.g., ministers). Finally, women were more likely than men to use (a) services of any type, (b) services in the general medical section, and (c) non-health services (including ministers) to address mental health issues. We anticipated that persons with lower social status positions (i.e., less educated, lower household incomes, women) will more likely seek care from ministers than their counterparts.

Religious Socialization

The religious socialization perspective argues that regardless of the content of their concerns, persons who are "churched" – that is, those who are embedded in church

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communities, and whose identities are deeply connected to church life – are more likely to seek support from ministers. Identity groups (e.g., women, older persons, and Southerners) whose roles and social environments are consistent with religious sentiments and sensibilities, and who are especially likely to attend church services, hold memberships in churches, and endorse religion as a means to cope with problems, are also more likely to seek out the support of ministers in times of distress (Chatters, Taylor, Jackson, & Lincoln, 2008; Pargament, Tarakeshwar, Ellison, & Wulff, 2001; Taylor, Chatters, & Levin, 2004). For instance, among both Caucasians and African Americans, women have higher levels of religious participation (Levin, Taylor, & Chatters, 1994; Smith, Denton, Faris, & Regnerus, 2002; Taylor, Chatters, & Jackson, 2007) which might increase their likelihood of seeking help from ministers. Similarly, because the institutions of religion and marriage share many common values, married individuals typically demonstrate higher levels of religious involvement than their non-married counterparts (Taylor, Chatters, & Levin, 2004). Prior research indicates that Pentecostals attend church more frequently than other groups (National Survey of American Life, unpublished data; Newport, 2006). Accordingly, we expect that members of more conservative religious traditions (i.e., persons identifying as Pentecostals) and those with high levels of church involvement (i.e., high attendance rates) will be more likely than their counterparts to turn to ministers for help. The consideration of both denomination and church attendance can assess whether they have independent and unique effects on ministers use. We hypothesized that women, married persons, individuals from the South, older persons, those identifying as Pentecostals, and persons who attend services frequently would seek care from ministers at higher levels than their counterparts.

Clinical/Problem-Centered Approach

The clinical/problem-centered approach argues that the nature (i.e., the content and severity) of the psychological concern determines whether African Americans select formal or informal (i.e., ministers) sources of mental health care. Accordingly, ministerial support is more appropriate for confronting life challenges (e.g., death of a loved one) that tax an individual's emotional resources and embody profound questions of human existence (e.g., ultimate meaning of life, human suffering). Indeed, Neighbors, Musick, and Williams (1998) found that African Americans who experienced the death of a significant other were 3 times more likely than others (e.g., those reporting financial problems) to seek ministerial support. As Neighbors, Musick, and Williams (1998) noted, turning to ministers for help in times of grief and bereavement "is not surprising given that one of the primary functions of religion is to provide frameworks through which individuals can come to find meaning and understanding in suffering and death" (p.771). African American ministers do, in fact, address a variety of life problems, some of which are largely secular in nature (Mattis et al., 2007; Young, Griffith, & Williams, 2003). However, given the issues particular to bereavement (e.g., questions of ultimate meaning) and the specialized supportive functions ministers perform in these circumstances, we expect that persons facing the death of a loved one will seek ministerial assistance to a greater extent than those experiencing financial, interpersonal, emotional, or physical problems. Thus, we hypothesized that persons who experience the death of a loved one – as compared to financial, interpersonal, physical or emotional problems – would be more likely to seek assistance from a minister.

Focus of the Present Study

This study builds upon prior research by focusing specifically on African Americans' use of ministers in response to serious personal problems. As a part of the larger picture of mental health care, it is important to understand the circumstances under which African Americans utilize ministers as informal providers and how social location factors (e.g., income, education), religious involvement, and problem type are associated with the use of ministers. Accordingly, our specific hypotheses regarding ministerial assistance were derived from

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these three perspectives—social stratification, religious socialization, and clinical/problem-centered. We expected that ministerial assistance would be associated with lower levels of education and income; being female, married, older, and a resident of the South; frequent church attendance; identifying as Pentecostal; and having experienced the death of a loved one. We addressed these questions drawing on data from the National Survey of American Life (NSAL, 2001–2003).

Method

Sample

Data for the NSAL were collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research. The field work for the study was completed by the Institute of Social Research's Survey Research Center, in cooperation with the Program for Research on Black Americans. The data collection was conducted from 2001 to 2003. The NSAL sample has a national multistage probability design. The interviews were face-to-face and conducted within respondents' homes. Respondents were compensated for their time. A total of 6,082 interviews was conducted with persons 18 years of age and older. The analytic sample for this paper are African Americans who reported experiencing a personal problem in their lives that caused them a significant amount of distress ($N = 2{,}103$).

The African American sample is the core sample of the NSAL and consists of 64 primary sampling units (PSUs). Fifty-six of these primary areas overlap substantially with existing Survey Research Center's National Sample primary areas. The remaining eight primary areas were chosen from the South to ensure that the sample was representative of the national distribution of African Americans. The overall response rate was 72.3%. The response rate for African Americans was 70.7%. This response rate is excellent considering that African Americans (especially lower-income African Americans) are more likely to reside in major urban areas, where it is more difficult and much more expensive to collect interview data. Final response rates for the NSAL two-phase sample designs were computed using the American Association of Public Opinion Research (AAPOR) guidelines (for Response Rate 3) (AAPOR, 2006) (see Heeringa at al., 2004 and Jackson et al., 2004, for a more detailed discussion of the NSAL sample).

Measures

The section of the NSAL questionnaire designed to examine help-seeking issues focuses on the concept of a serious personal problem. Respondents were asked to report a personal problem they had experienced in their lives that had caused them a significant amount of distress. They were next asked to describe the nature of the problem and how they adapted to the stressful episode. They were presented a list of professional services and asked if they had talked to any of them about their problem. In particular, they were asked if they had talked to a psychiatrist, other mental health professional; a family doctor; any other doctor; any other health professional; a religious or spiritual advisor such as a minister, priest, rabbi or pastor; any other healer; gone to a self-help or other support group; or seen any other professional. The dependent variable in this analysis is whether the respondent sought help from a religious or spiritual advisor (because the vast majority of African Americans are Protestants we will use the term "minister").

Several independent variables are used in this analysis. The first variable, the type of problem, consists of five categories: physical (e.g., poor health, accident), emotional (e.g., depression, unhappiness, self-doubt), interpersonal (e.g., difficulties with close family and friends, divorce), economic (e.g., poor or declining financial status, loss of assets), and death

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of a loved one. Two religiosity variables are included in this analysis: frequency of religious service attendance and denomination. Frequency of religious service attendance is measured by combining two items—one that indicates basic frequency of attendance and one that identifies respondents who have not attended services since the age of 18. The categories for the attendance variable are: nearly every day, at least once a week, a few times a month, a few times a year, less than once a year and (except for weddings and funerals), and never attended services since the age of 18. This variable ranges from 1 (*never attended religious services since the age of 18*) to 6 (*nearly every day*).

Religious affiliation is measured by the question: "What is your current religion?" This variable was recoded into six categories: Baptists, Methodist, Pentecostal, Catholic, Other Religious Affiliations, and None. The coding scheme allows the opportunity to examine distinctions between three major categories of Black Protestants (i.e., Baptist, Methodist, and Pentecostal) and is preferable to other schemes that only include an omnibus category of Black Protestants. Demographic characteristics examined include age (18–29, 30–44, 45–54, 55+), household income (continuous ranging from $0 to $520,000), education (continuous ranging from 0 to 17 years), gender, employment status (working or not working), marital status (currently married, previously married, never married) and region (South or non-South). Although not included in the analysis, 4.8% of our analytic sample is rural. Income is coded in dollars. In the multivariate analysis, income is divided by 500 in order to increase effect sizes and provide a better understanding of the net impact of income. Missing data were imputed for family income and for education. These accounted for 205 cases (10% of the study sample) and five cases (.2% of the study sample), respectively. All models were run both with and without imputed data to determine if imputation had any significant effect on the results. There were no substantial differences between the models.

Analysis Strategy

Cross-tabulations are presented to illustrate the effect of each independent variable on the use of ministers. The Rao-Scott chi-square was used to test for the effect of categorical variables and a two-tailed *t*-test was used for continuous variables. Logistic regression analysis was used to test the influence of the type of problem, religiosity, and sociodemographic characteristics on the use of ministers. In addition, for each categorical variable, we conducted a design-corrected Wald chi-square test to minimize the likelihood of Type I error due to multiple comparisons. All statistical analyses were performed using the survey commands in STATA 10.0; these procedures take into account the complex multistage clustered design of the NSAL sample, unequal probabilities of selection, non-response, and poststratification to calculate weighted, nationally representative population estimates and standard errors.

Results

Bivariate analyses are presented in Table 1. Overall, 21% of respondents with a serious personal problem reported seeking help from a minister. This was the most frequent response to the question of what professionals individuals talked to about their problems. Family doctor was the next highest in frequency (16.1%) followed by psychiatrist (9.4%) and other mental health professional (8.7%). Compared to all other age groups, respondents 18–29 years of age are roughly half as likely (11%) to report using ministers. More females than males (26% vs. 16%) visited a minister. A smaller proportion of those never married (14%) used a minister compared to those who were currently married (23%) or previously married (28%). On average, those who used a minister had more years of education (M = 12.9, SD = 2.68 vs. M = 12.5, SD = 2.52), higher household incomes (M = $42,274, SD = $37,760 vs. M = $36,951, SD = $34,045), and attended church more frequently (M = 4.42, SD = 1.08 vs. M = 3.6, SD = 1.35) than those who did not use a minister. Compared to other

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denominations, Pentecostals reported use of ministers (35%) at higher rates. A significantly higher proportion of those who experienced the death of a loved one (28%) reported using a minister compared to other types of problems. Those experiencing an economic problem were least likely to report using a minister (12%).

The results of the logistic regression analysis are presented in Table 2. Three models are presented: the first presents the odds ratios of the impact of demographic variables and problem type on the use of ministers, the second model adds denomination, and the third model adds church attendance. An examination of Model 1 indicates that age, gender, education, household income, region, and problem type were all significantly associated with use of ministers. The addition of denomination in Model 2 indicates significantly higher odds for the use of ministers among Pentecostals compared to other groups, whereas age is no longer significant (based upon the design-corrected Wald Chi-square test). In Model 3, church attendance is significantly associated with use of ministers, but denomination and region are no longer significant. An examination of the odds ratios in Model 3 indicates that men are less likely to seek help from ministers than women, and increases in both education and income increase the odds of seeking help from ministers. Finally, respondents with economic problems are less likely to seek assistance from ministers than respondents who experienced the death of a loved one.

Discussion

Ministers are key figures in providing mental health care in the African American community. Reflecting the importance of ministers for mental health assistance, respondents in our study were more likely to seek help from ministers than family doctors, psychiatrists, and other mental health professionals. This study explored factors associated with African Americans' use of ministers in times of distress, with a focus on social stratification, problem type, and religious socialization perspectives. All three explanations were partially supported by the findings. The social stratification hypothesis asserted that access to formal sources of mental health care is determined, in part, by social location and social power (Rosenfield, 1984; Takeuchi & Cheung, 1998). Individuals who are marginalized in society (e.g., those with low levels of education and income) tend to receive mental health care that is compulsory and of poor quality. As a reaction to this, socially marginalized individuals voluntarily seek care from sources of support that are culturally familiar, acceptable, and authoritative—ministers.

However, our findings for use of ministerial support were not consistent with the tenets of the stratification hypothesis. Contrary to the notion that social marginalization and relative lack of sociopolitical power is related to use of ministerial support, our findings indicated that persons who reported using ministers had higher levels of educational attainment and household income than those who did not turn to ministers. In contrast, earlier work (Neighbors, Musick, & Williams, 1998) indicated that both income and education were unrelated to the use of ministers for personal problems. A recent analysis of service use among African Americans and Caribbean Blacks (Neighbors et al., 2007) found that education was associated with a greater likelihood of using professional, but not non-health services for mental health concerns, and income was unrelated to service use of any type. In discussing their findings, Neighbors et al. (2007) suggest that though related, income and education likely represent different aspects of socioeconomic position, with education serving as a proxy for greater levels of knowledge concerning mental health issues, as well as information and positive attitudes regarding seeking services (p. 492).

The present finding for both education and income effects indicates that each factor has independent, positive effects on the use of ministers. For persons of higher education and

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income statuses, ministerial support may serve as means for maintaining connections to the Black community and to the institutions that historically have supported African American survival. In some African American communities, ministers are among the best educated and best resourced individuals (Billingsley, 1999). Prior work (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000) indicates that helping relationships are enhanced and most effective when support recipients and providers have similar status group characteristics. Ministers may be suitable sources of support to African Americans who are in relatively advantaged social positions due to real or perceived commonalities in background.

We found that women were more likely than men to seek support from ministers, a finding that replicates other work (Neighbors & Howard, 1987; Neighbors et al., 2007) in which women seek services in both professional mental health and non-health (e.g., clergy) sectors at higher rates than men. Whether this finding supports the stratification hypothesis is, however, debatable. In the current historical moment, the range of vulnerabilities facing African American men (e.g., rates of incarceration, lower educational attainment relative to women) raises important questions about whether African American women hold less or more privileged social positions than men. Although this question cannot be resolved by a simple comparison and additive accounting of social oppressions, these social conditions do serve to highlight two important points that are relevant for understanding social stratification. First, for African Americans, dimensions of social stratification are not easily assessed and may possess different meanings and nuances in community settings and institutions. Second, because it is difficult to assess relative position with respect to socioeconomic and sociopolitical power, theories that rely on fairly traditional notions of stratification may be too simplistic to capture how these processes operate within the reality of African Americans' lived experiences.

Turning to religious socialization explanations, our findings provide partial support for this perspective on ministerial use. In particular, the finding that women are more likely than men to have sought help from a minister is consistent with prior work indicating that among both African Americans and Caucasians, women are more religiously involved overall and are more likely to be members of churches, attend religious services, engage in private devotional behaviors, and report higher levels of subjective religiosity (Levin, Taylor, & Chatters, 1994; Taylor & Chatters, 1991; Taylor, Chatters, & Levin, 2004; Taylor, Mattis, & Chatters, 1999). Scholars have argued that gender differences in religious involvement result from gender socialization experiences emphasizing women's roles in caring for the social and spiritual needs of families and communities (Taylor, Chatters, & Levin, 2004; Townsend Gilkes, 2001). Furthermore, traditional gender-based roles, norms, and behavioral expectations are largely consistent with religious teachings and reinforced within worship communities and practices (Townsend Gilkes, 2001). Consequently, because women are highly invested both in a religious identity and in church life, they may be more likely to view ministers as appropriate sources of assistance.

Findings with regard to age (Model 1 only) were also consistent with the religious socialization hypothesis. Individuals 30 years of age and older were more likely to use ministers which likely reflects the fact that relatively older individuals are more likely to face life difficulties (e.g., relationships and relational challenges, the loss of loved ones) that tax their emotional resources and compel them to seek support from ministers. Further, older individuals (over age 50) were socialized during a period in which experiences with racial discrimination and blocked opportunities were relatively commonplace. Within this context, religious institutions assumed important civic, educational, and social welfare functions within African American communities, thereby making seeking help from clergy a customary practice (Taylor, Chatters, & Levin, 2004). However, noted age effects for use of ministers were negated in the presence of denomination (Model 2). Regional effects for use

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of ministers (Models 1 and 2) are consistent with prior work which characterizes the southern United States as possessing a distinctive social character (i.e., Bible Belt) with respect to religious concerns (see Taylor, Chatters, & Levin, 2004). According to the religious socialization hypothesis, persons residing in the South are embedded in an environment in which religious concerns and pursuits are particularly heightened and form the fabric of community life. As such, ministers represent a familiar, acceptable, and authoritative resource in dealing with life problems.

Consistent with the religious socialization perspective, denomination was associated with the use of ministerial support (Model 2). Compared to other denominations, Pentecostals were more likely to engage a minister for help with a personal problem. The tendency of members of more conservative religious groups to rely on God and on ministers in times of distress suggests that ministerial support is a particularly viable option for Pentecostals. Pentecostals' overall high levels of church attendance are supported by specific doctrines, practices, and traditions that endorse active participation (Newport, 2006). Consequently, members have strong investments in religious identities and communities that increase the likelihood of adhering to a religious worldview for understanding life problems and in relying on ministers during periods of distress. Finally, persons who attended church more frequently were more likely to use ministerial support as compared to those who attended less frequently (Model 3). People who attend religious services frequently may have a longer history and greater social investment in a relationship with the minister (e.g., access, trust). In addition, they potentially have more knowledge of the minister's competencies and resources and, therefore, may be more likely to rely on ministers in response to personal problems. In assessing the overall utility of the religious socialization perspective, women and those who attended religious services more frequently were more likely to report seeking assistance from ministers, irrespective of denomination and region (Model 3).

Findings pertinent to the clinical/problem-centered perspective indicate that a significantly higher proportion of persons experiencing death of a loved one reported using a minister (28%) compared to other types of problems (Neighbors, Musick, & Williams, 1998). These findings support the view that the problem itself (i.e., the content and severity) is significant for the selection of formal versus informal (i.e., ministers) sources of mental health care. The unique competencies that ministers bring to the problem of bereavement make them especially important resources for those who have experienced loss. During these times, ministers and churches mobilize an incredible array of informational, emotional, spiritual, financial, and tangible supports that can be transformative for those who are experiencing grief. The efficiency and immediacy with which these supports are implemented help to explain why ministers are pivotal resources in responding to loss and bereavement.

Taken as a whole, the findings provided some support for social stratification and religious socialization explanations for the use of ministers. However, it is important to take into account the full context of these findings. Namely, that several significant relationships were not maintained after the inclusion of denomination (in Model 2) and church attendance (in Model 3) in the regression models. For example, the age effect that was significant in Model 1 was rendered insignificant with the inclusion of denomination in Model 2, indicating that the age effect is accounted for by differential patterns of denominational affiliation. Similarly, region and denomination effects in Model 2 were insignificant with the inclusion of church attendance in Model 3, which indicates that their influences on the use of ministers are accounted for by higher levels of church attendance among Southerners and Pentecostals (Newport, 2006). Importantly, five predictors—gender, education, household income, church attendance, and problem type—were significantly related to use of ministers in the full model (controlling for other demographic and religious involvement factors). This

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finding suggests that aspects of social stratification, religious socialization, and clinical/problem-centered explanations were important for understanding use of ministers.

Finally, noted positive education and income effects were contrary to expectations from the social stratification perspective which predicts that socially disadvantaged and marginalized groups turn to ministers to address unmet needs for formal mental health care and services. Our findings suggest that African Americans of lower status may be disadvantaged with respect to the use of ministers for personal problems. Although prior work documents the prominence of church-based support networks among African Americans (Taylor, Ellison, Chatters, Levin, & Lincoln, 2004), the process of help-seeking may be socially stratified such that persons of higher status seek assistance directly from the minister, and persons with lower levels of income and education obtain assistance from other church officials (e.g., deacons), lay leaders, and fellow church members. Additional research is needed to better understand how social status factors operate in decisions to seek help from ministers and other sources of informal assistance within churches. Explorations of the dynamics of social location from the vantage point of ministers and other religious leaders can enhance our understanding of help-seeking patterns within churches.

Implications for Practice

As noted by the number of respondents who seek help from ministers, clergy are pivotal actors and gatekeepers in recognizing and responding to personal distress and the help-seeking process. Consequently, it is important for mental health professionals to reach out to clergy and involve them in collaborative partnerships to better address the needs of disadvantaged persons. Mental health professionals can be involved in active outreach efforts to churches and communities to familiarize clergy, lay leaders, and church members with the types of services available and referral procedures at mental health agencies. In addition, mental health professionals can use outreach activities to individual churches and community-wide ministerial alliances to garner useful information about congregation demographics and clergy characteristics (e.g., educational background, religious/pastoral training, orientation to mental health issues and treatment), as well as existing church programs and services and similar initiatives organized by city, state, and federal agencies. These efforts could be useful in identifying church resources and capacities, as well as opportunities for collaborative partnerships (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

Clergy efforts could include in-service trainings to mental health professionals concerning how religious beliefs and practices influence the experience and resolution of personal problems, particularly those involving issues of loss (e.g., major illness, death) that are particularly difficult and challenge core beliefs. Given long-term relationships with church members, clergy have knowledge about individual and family circumstances that are consequential for individual and family adjustment. Possible collaborative models involving clergy and mental health professionals include developing a mental health liaison position to connect churches and mental health agencies. By partnering with clergy, mental health liaisons gain both increased access to the congregation and enhanced legitimacy. In addition, mental health liaisons could capitalize on clergy's roles as gatekeepers to formal services and benefit from their specialized knowledge regarding life circumstances (e.g., financial resources) and attitudes that affect members' use of formal services. These are just a few examples of collaborative partnerships between clergy and mental health professionals that capitalize upon their specific skills, training, and resources to address the needs of underserved population groups (see Taylor, Ellison, Chatters, Levin, & Lincoln, 2000, for an expanded discussion of practice implications).

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Directions for Future Research

Future research should focus on the connections between faith communities and formal service delivery. Specific research areas include examining the counseling and referral practices of clergy and how they vary by educational level and training, assessing clergy's knowledge of and connections to professional mental health services within the local community, and identifying the types and quality of services that are provided. Ideological and theological perspectives (i.e., conservative vs. liberal) of clergy may have an important impact on whether members approach them for assistance. In addition to clergy, faith communities provide a rich source of assistance to persons in need – a 'matrix of religious support' – that includes lay leaders and other church members (Mattis et al., 2007). We need additional research to examine how clergy assistance operates in relation to potential differences in congregation size (e.g., megachurches) and available supports and resources. Further, questions regarding how lay leaders and other church members impact the decision to seek assistance from the minister should be explored.

Given the pivotal role of clergy as gatekeepers in the help-seeking process, it is important to examine whether clergy respond to specific types of problems in characteristic ways. For example, prior work suggests that both clergy and church members are reluctant to discuss issues related to sexuality, sexual health, and intimate partner violence (Mattis et al., 2007). On the other hand, clergy interventions in situations of bereavement are particularly timely, comprehensive, and well-suited to address individual and family crises and needs associated with the death of a loved one. We know little, however, about how clergy respond to longer-term bereavement situations in which there is unresolved grief, a prolonged grief reaction, or particularly high levels of psychological distress. At what point would clergy seek an outside referral for professional mental health services? Do persons who have been referred to professional mental health services by their ministers then receive both forms of assistance (secular and religious/spiritual)? Stated another way, we might explore whether mental health services are more culturally acceptable and effective when clergy are able to function within both secular (i.e., mental health) and religious/spiritual frameworks in addressing personal distress.

Limitations and Conclusions

The study has several advantages and limitations that are worth noting. The use of a 'serious personal problem' as a focal event has the advantage of designating a life occurrence that is both particularly salient and accompanied by a level of distress sufficient to trigger the help-seeking process. As such, this approach is a useful strategy to elicit information and perceptions concerning significant personal events (e.g., problem type) and the attendant actions (e.g., informal and formal help-seeking) that respondents take to address them. However, for the purposes of analysis, it was necessary to categorize serious personal problems into discrete groups that reflected the broad nature of these issues (e.g., economic, interpersonal, death of loved one). As such, the full range of concerns for which people tend to turn to ministers was somewhat constrained.

Despite clear preferences for using ministers to address bereavement issues, we should not overlook the fact that roughly 20% of persons experiencing problems in the areas of interpersonal relationships, physical health, and emotional concerns indicated that they sought ministerial aid in response to these problems. Ministerial assistance is attractive for a number of reasons including the fact that it is free and readily accessible; clergy may be particularly important during periods of high unemployment when individuals are less likely to have insurance which covers mental health treatment. Ministers are embedded in roles and in institutions that are public, highly valued, and have historical meaning for the communities they serve. These combined factors make ministerial assistance a particularly

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viable source of support in time of distress (Mattis et al., 2007; Neighbors, Musick, & Williams, 1998; Taylor, Chatters, & Levin, 2004; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

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Table 1

Bivariate Relationship Between Use of Ministers, Demographic Variables, Church Attendance, and Denomination Among African Americans (N = 2,224)

	Used minister n = 506		Did not use minister n = 1,718				
Variables	***n* / *M***	**% / *SD***	***n* / *M***	**% / *SD***	χ^2	***df***	***t*-test**
Age							
18–29	61	11.3	425	88.7	10.59^{***}	3	
30–44	204	23.4	623	76.6			
45–54	109	24.8	325	75.2			
55 and older	132	25.9	345	74.1			
Gender							
Female	374	25.5	1078	74.5	16.23^{***}	1	
Male	132	15.8	640	84.2			
Marital status							
Currently married	179	22.5	574	77.5	12.2^{***}	2	
Previously married	217	27.7	544	72.3			
Never married	110	13.8	600	86.2			
Education	12.9	2.68	12.5	2.52			3.46^{***}
Employment status							
Working	334	21.4	1115	78.6	0.04	1	
Not working	172	21	603	79			
Household income	42274	37760	36951	34045			2.74^{**}
Region							
South	333	12.3	1032	39.9	3.84	1	
Not South	173	9	686	38.8			
Type of problem							
Physical	74	22	239	78	8.06^{***}	4	
Interpersonal	137	23.5	427	76.6			
Emotional	68	21.5	217	78.5			

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	Used minister $n = 506$		Did not use minister $n = 1{,}718$				
Variables	***n* / *M***	**% / *SD***	***n* / *M***	**% / *SD***	χ^2	*df*	***t*-test**
Death of loved one	150	28	351	72			
Economic	56	12.3	384	87.7			
Church attendance	4.42	1.08	3.6	1.35			12.12***
Denomination							
Baptist	240	20.6	901	79.4	5.8***	5	
Methodist	37	24.3	100	75.7			
Pentecostal	72	34.9	125	65.1			
Catholic	33	21.6	103	78.4			
Other	100	22	317	78			
No religion	24	10	171	90.4			

Note. Unweighted *n*'s (Weighted %s). 120 cases missing because respondent did not specify the type of problem.

** $p < .01$.

*** $p < .001$

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Table 2

Logistic Regression Analysis Predicting Use of Ministers (N = 2,104)

	Model 1		Model 2		Model 3	
	OR	**95% CI**	***OR***	**95% CI**	***OR***	**95% CI**
Age						
18–29	1.00		1.00		1.00	
30–44	1.85**	1.21 – 2.81	1.71*	1.11 – 2.64	1.62*	1.08 – 2.45
45–54	1.83*	1.13 – 2.97	1.76*	1.06 – 2.92	1.56	.95 – 2.55
55 and older	1.84*	1.15 – 2.95	1.76*	1.08 – 2.87	1.43	.88 – 2.33
χ^2 (df = 3)	3.10*		2.32		1.82	
Gender						
Female	1.00		1.00		1.00	
Male	.53***	.39 – .73	.56**	.41 – .77	.66*	.48 – .91
χ^2 (df = 1)	16.34***		13.39***		6.89*	
Marital status						
Currently married	1.00		1.00		1.00	
Previously married	1.25	.91 – 1.72	1.3	.93 – 1.81	1.4	.98 – 2.00
Never married	0.73	.47 – 1.13	0.77	.50 – 1.18	0.84	.54 – 1.31
χ^2 (df = 2)	2.85		2.71		2.92	
Education	1.06**	1.02 – 1.11	1.06**	1.02 –1.11	1.05*	1.00 – 1.09
Employment status						
Working	1.05	.81 – 1.36	1.05	.80 – 1.39	1.03	.76 –1.40
Not working	1.00		1.00		1.00	
χ^2 (df = 1)	0.16		0.16		0.04	
Household income	1.00**	1.00 – 1.00	1.00**	1.00 –1.00	1.00**	1.00 – 1.00
Region						
South	1.40*	1.06 – 1.84	1.38*	1.05 – 1.83	1.21	.90 – 1.61
Not South	1.00		1.00		1.00	
χ^2 (df = 1)	6.15*		5.61*		1.74	
Type of problem						

	Model 1		Model 2		Model 3	
	OR	**95% CI**	***OR***	**95% CI**	***OR***	**95% CI**
Physical	.75*	.56 – .98	.76*	.56 – 1.01	0.75	.56 – 1.01
Interpersonal	0.76	.55 – 1.05	0.76	.55 – 1.05	0.76	.53 – 1.08
Emotional	0.83	.56 – 1.23	0.84	.56 –1.25	0.85	.56 – 1.29
Economic	0.37***	.24 – .57	.37***	.24 – .58	.40***	.25 – .62
Death of loved one	1.00		1.00		1.00	
$\chi^2(df = 4)$	5.61**		5.06**		4.37**	
Denomination						
Baptist	--		.45**	.28 – .72	.59*	.36 – .96
Methodist	--		0.51	.24 – 1.08	0.66	.29 – 1.48
Catholic	--		.45**	.26 – .78	0.56	.32 – 1.01
Other	--		.47**	.31 – .72	.53**	.33 – .83
No religion	--		.28***	.15 – .51	.51*	.26 – .97
Pentecostal	--		1.00		1.00	
χ^2 $(df = 5)$			4.27**		1.73	
Church attendance	--		--		1.55***	1.41 – 1.71

Note. Design-corrected Wald χ^2 test. CI = confidence interval.

* $p < .05$.

** $p < .01$.

*** $p < .001$

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