The Integral Role of Pastoral Counseling by African-American Clergy in Community Mental Health

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Objective: **Little is currently known about the pastoral counseling work of pastors of African-American churches. The authors interviewed the pastors of nearly all African-American churches in a metropolitan area about their pastoral counseling work and related aspects of their ministry.** ***Methods:*** **Of 121 African-American pastors identified, 99 completed a semistructured interview describing their backgrounds, attitudes, concerns, and work. The interview included detailed queries about how they understood and carried out any pastoral counseling work.** ***Results:*** **The respondents averaged more than six hours of counseling work weekly and often addressed serious problems similar to those seen by secular mental health professionals, with whom they reported readily exchanging referrals. Many of the respondents reported having and maintaining specialized education for their counseling work, which they described as including both spiritual and psychological dimensions. Most of the pastors reported that they observe and address severe mental illness and substance abuse in their congregations and that they also counsel individuals outside their own denominations.** ***Conclusions:*** **African-American urban ministers functioning as pastoral counselors constitute an engaging and useful group with experiences and skills that can be tapped by interested secular professionals. Their work represents a significant mental health resource for persons who lack sufficient access to needed care. (*Psychiatric Services* 54:688–692, 2003)**

African-American churches place a high priority on the healing of psychological ills (1,2). Much of this healing takes place at liturgical rituals through which participants identify specific psychological symptoms that are eased or are replaced by positive feelings (3–5). However, very little is known about the quieter healing ministry of pastoral counseling work conducted by African-American clergy. We studied how these clergy identify and help individuals with problems that are amenable to pastoral counseling. In this article we describe how African-American clergy conceptualize, structure, and experience their pastoral counseling, including receiving and making referrals.

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The findings of a study of this nature have both local clinical significance and broader policy significance. At the local level, its findings can inform mental health professionals about the work of colleagues with whom they can build closer relations and exchange consultations and referrals. In terms of public health policy, public-sector resources have long been inadequate for the needs of persons with mental illness, especially ethnic minorities (6,7). It was our hope that by demonstrating in detail the rich endowment that African-American pastors provide, our findings would suggest specific strategies for advancing community mental health.

Methods

Participants

For practicality purposes and in order to obtain a comprehensive sample, we limited the study to a single metropolitan area, attempting to include the leader of every African-American church in the area. The New Haven Clergy Association, an African-American clergy group for south central Connecticut that covers New Haven and the contiguous towns of West Haven, Hamden, and North Haven, provided a list of African-American churches in the area. This list, along with some networking efforts, produced a sample of 121 eligible pastors, which is more than four times the number reported in an earlier study that used a clergy register covering the same area (8).

Between September 1991 and

March 1993, all but four pastors in the area were contacted. Of the pastors contacted, four declined to participate in the study and 14 did not complete interviews. Thus 99 clergy (82 percent) were included in the analysis. The participants provided informed consent in accordance with a procedure approved by the appropriate institutional review board. The interview format is available from the first author, and details have been described previously (9).

Measures

Face-to-face interviews took place in each participant's setting of choice. The interviews used a structured format that included opportunities for open-ended responses. The duration of the interviews ranged from 45 minutes to six hours; the median duration was 90 minutes. The pastors gave demographic information about their churches and themselves and also described their formal and ongoing education, including counseling specialization. Pastoral counseling was defined as counseling of more than 15 minutes' duration that was intended to "provide care, counseling, compassion, or advice mainly in relation to emotional, psychological, or moral problems." The interview questions covered four broad areas: overall structure of counseling, various problems encountered, the theory and techniques used during counseling sessions, and referral habits and experience.

Results

Church and clergy characteristics

Of the 99 responding pastors, 26 were women and 73 were men, ranging in age from 31 to 93 years. The women were significantly more likely to head poorer churches ($F=3.88$, $df=1, 97$, $p=.049$). The congregations led by women were also smaller: none of their congregations had more than 450 members, whereas nine congregations with more than 450 members were headed by men. Only three men headed congregations that had fewer than 30 members, compared with nine women who headed congregations of this size.

A total of 59 of the responding pastors were born in the South, 33 in the Northeast, and four in the Midwest. The average number of years of education was 14. Fifty-nine respondents had postsecondary education in a college or bible school, 24 ended their education after completing high school, and 16 had less than a high school education. Academic degrees held included bachelor's (15 respondents, master's (17 respondents), and doctorate-level (three respondents). A total of 48 pastors had training in counseling, mental health, or interpersonal communication, and 11 held degrees in counseling. Half of the respondents (49 pastors) had attended a counseling-related workshop or seminar in the previous two years; 87 had read related books during the previous year, and 29 had taken at least one general academic course within the previous five years, with an average of five courses.

The responding pastors' congregations ranged in size from eight to more than 2,000 members. A majority (52 percent) of congregations were Pentecostal; 19 percent were Baptist, reflecting the northeastern location. The other congregations were principally African Methodist Episcopal or other Protestant denominations, with a few nondenominational or interdenominational churches. When asked to identify the majority social class of their congregants, 29 pastors replied that the members of their congregation were middle class, 54 that they were working class, and 12 that they were poor. Forty pastors reported supporting themselves through secular work outside the church, and 44 stated that their church had no salaried minister.

Pastoral counseling structures

Participants averaged 43.6 hours per week doing pastoral work, devoting an average of 6.2 hours to counseling. The number of counseling hours ranged from 1 to 38, with 11 respondents reporting no involvement in counseling. More than half of the pastors (52 respondents) reported that they devoted no more than four hours a week to pastoral counseling. Twenty-two pastors said they spent more than eight hours, including five who spent 20 hours or more. Many (34 respondents) said they spent less time counseling than they wanted to; these pastors spent an average of six hours counseling per week. Only three pastors said they thought their investment in counseling was too much; these pastors averaged 3.3 hours per week. The 55 pastors who described their investment of time as "just about right" averaged 6.7 hours per week.

Pastors who classified their congregations as poor spent an average of nearly nine hours a week on pastoral counseling, compared with six hours a week by pastors who classified their congregations as either working class or middle class. This difference was not statistically significant. Pastors with a church budget of more than $60,000 per year (34 pastors) were involved with counseling for an average of 7.5 hours per week, but those with an annual budget of less than $60,000 (51 pastors) averaged 5.2 hours per week. This difference represents a trend and was not statistically significant.

The pastors scheduled their counseling hours in diverse ways. A total of 52 pastors had a regular schedule for counseling sessions, whereas 42 pastors did not. Among the pastors who reported regular scheduling, six (12 percent) said that they met once a month or less with an individual. The other respondents were about equally divided into three groups: those who met once a week or more, those who met two or three times a month, and those with some other routine. A total of 69 pastors reported that their sessions were between 30 minutes and one hour in duration. Only nine pastors reported that their sessions lasted less than 30 minutes, and 16 said they usually went beyond an hour. The bulk of the pastors' counseling work was relatively short term: a quarter of respondents (24 pastors) reported that an individual attended counseling for less than a month, 39 pastors reported a duration of one to three months, and 15 pastors reported a duration of four to six months. Seven pastors reported a counseling duration of between seven and 12 months, six pastors a duration of between one and two years, and two pastors beyond two years.

Problems encountered

Two out of five pastors (39 respondents) reported that their congregations included individuals with severe mental illness, and two-thirds (65 respondents) said they saw significant substance abuse in their congregations. Two-thirds (67 respondents) reported involvement with suicidal individuals, and 63 pastors had personally counseled individuals whom they considered to be dangerous to others. Two out of five pastors (38 respondents) reported spending more than one-tenth of their pastoral counseling time performing crisis intervention, including 14 pastors who reported that they conducted such interventions at least half the time.

We presented the study participants with a list of 18 classes of problems, asking the pastors whether they dealt with each class very often, fairly often, not too often, or never. The predominant classes of problems encountered very often were difficulties of a religious or spiritual nature (53 respondents), alcoholism and drug addiction (39 respondents), adolescent problems (39 respondents), unemployment or work-related problems (36 respondents), marital or family problems (34 respondents, or 34 percent), and grief (33 respondents). More than two-thirds of the pastors identified seven of the problem classes as being encountered very often or fairly often: religious and spiritual problems (84 pastors), grief (81 pastors), marital or family problems (76 pastors), physical illness (75 pastors), alcoholism and drug addiction (70 pastors), unemployment or work-related problems (69 pastors), and adolescent problems (67 pastors).

Therapeutic approaches

The pastors were asked an open-ended question: "When people come to you for help with personal problems, what do you do that seems to work?" A total of 53 pastors replied in psychotherapeutic terms, such as "mainly listen," "support and show care," and "counsel and hear"; 33 pastors gave answers that combined spiritual and psychological themes, such as "listen to the problem and pray with them," "don't make judgmental statements and share the word of God," and "let them know I care and share scripture if the individual believes in God." An additional 13 respondents described religious or spiritual strategies, such as "advise them to meditate on the word," "prayer to seek God's guidance," and "showing how Christ can make a difference in their lives."

When asked "Why do you think it works?" 66 respondents referred directly to human agency—for example, "because individuals want to feel close to someone before they talk," "because a relationship and trust have developed," and "because of sincerity and people feel you care and are not being judgmental." A total of 24 respondents gave answers stressing divine intervention alone—for example, "because scripture provides the answers that people are looking for," "by letting them know they need God in their lives; God can help," and "it gives a chance for the individual to listen to the Lord and experience prayer." The remaining nine pastors combined divine and human agency in answers such as "when you know what they feel, you can determine through God what advice needs to be given."

Presented with a list of five statements on why counseling works and asked which best fit his or her opinion, 33 pastors selected "leading to a more authentic relationship with God," 22 favored "expression of deep feelings," 22 chose "replacement of maladaptive thinking with a positive mental attitude," 12 opted for "concentration on ways to change behavior," and eight selected "the relationship between counselor and counseled."

The interviewers also inquired about explicitly religious approaches. Prayer headed the list of responses to this question, being used very often or fairly often during counseling sessions by 92 responding pastors. The next most frequent response was faith healing (76 pastors). Other responses were confession (62 respondents) and meditation (57 respondents). Regarding what they said during sessions, 86 pastors said they always or often recommended that their clients increase their church attendance and participation in church activities, and 68 said they always or often quoted scripture.

Some pastors reported using direct interventions. A total of 55 reported that, when they saw a need, they provided food very often, and 38 reported that they did so fairly often. Transportation was very often provided by 31 respondents and fairly often by 44 respondents. Also high on some lists were financial assistance, offered very often by 21 pastors and fairly often by 42 pastors, and employment counseling, provided very often by 18 pastors and fairly often by 38 pastors.

Finally, the pastors were asked to rate the contribution of each of several items as a cause of mental illness. Highest-rated was "stresses in living," rated by 89 pastors as often or fairly often being the cause of mental illness, followed by "unhealthy early family relationships" (84 pastors), "not being in a right relationship with God" (72 pastors), "stunted spiritual growth" (61 pastors), "biological disorder" (59 pastors), "unconfessed sin" (59 pastors), and "widespread and disruptive social forces" (57 pastors). Of note, 29 pastors expressed a belief that unconfessed sin never causes mental illness. Also, 39 pastors agreed and nine strongly agreed with the statement that people suffering from severe anxiety or depression can cure themselves if they put their mind to it, whereas 40 disagreed and nine strongly disagreed with this statement.

Referrals

When asked about the manner in which troubled individuals came to them for help, 14 pastors (14 percent) stated that they very often came by referral, and 36 pastors said that they came by referral fairly often. A total of 54 pastors stated that individuals came for help on their own very often, and 35 that they came on their own fairly often. Some pastors reported actively seeking out troubled individuals very often (34 pastors) and fairly often (33 pastors). Forty-four respondents reported receiving referrals from health professionals or agencies, predominantly social workers, other ministers, and pastoral counselors. Eighty-four pastors re-

ported having counseled people outside their own denominations.

When asked about making referrals, 57 pastors responded affirmatively, including six who made referrals up to several times a month, 21 who did so once or twice a year, and 22 who did so less than once a year. Most referrals were to a social worker or hospital emergency department (27 respondents for each), followed by another minister (26 pastors) and a public mental health center (22 pastors). Between 10 percent and 20 percent of the pastors named five classes of professionals to whom they referred clients very often or fairly often: medical or surgical physicians (18 pastors), pastoral counselors (16 pastors), psychiatrists (14 pastors), psychologists (13 pastors), and institutional chaplains (12 pastors). Also, 68 pastors responded that they knew of a mental health agency or professional to whom they would be comfortable making a referral. For 46 respondents, this agency was a public mental health center. Also, 57 pastors endorsed an item asking whether they personally knew a psychiatrist, psychologist, or social worker, and 56 pastors personally knew a pastoral counselor, defined as a minister who spends most of his or her time doing this work.

Discussion and conclusions

Through their responses, the African-American pastors who participated in this study spoke directly to us about their approaches to requests for help with mental problems. In their own words, they described experiences ranging from a mainly religious focus on problems and solutions to a more clinical approach to psychological issues. As a group, these pastors cover the pastoral counseling spectrum that we have described previously (10). Their understanding fits a growing recognition that high-quality care for people who complain of psychological pain includes addressing religious experience (11,12).

The clergy who participated in this study described a tendency to pray and quote scripture in their sessions and to include some references to confession and faith healing. They did tend to classify the problems they encountered among members of their congregations as religious or spiritual—nearly three-quarters of the pastors identified a faulty relationship with God as a significant cause of mental illness. However, nine out of ten respondents pointed to stresses in living, and almost as many mentioned unhealthy early family relationships.

When asked to state what in particular they do in their sessions that seems to work, two-thirds of the pastors gave answers attributing their success primarily to human rather than divine intervention. Their descriptions communicate how they approach interactions between the spiritual and secular aspects of their work and how their relationship with each client works to integrate these aspects. Using this information, mental health professionals can plan intelligently and comfortably their own approach to utilizing the resources available from the work of African-American ministers.

These resources have important implications for public health policy. African-American clergy are more involved in counseling work than clergy in general, as demonstrated by a literature review (13), another survey conducted in the greater New Haven area (8), and a national survey (14). Also, African-American clergy members exchange referrals with their secular counterparts more readily than is usual for the clergy in general (13,15,16). They also lead their churches in providing and supporting mental health services for the elderly (17), sex education (18), and general health care screening, education, and referral (9,19,20).

The positive effects of pastoral counseling work in African-American churches may help to explain a crucial paradox: Compared with white persons, black individuals do poorly in terms of physical health status, but they enjoy at least roughly similar levels of mental health. For example, African Americans have higher rates of death from 13 of the 15 leading causes of death in the United States compared with whites (21). At the same time, data from the Epidemiologic Catchment Area study, the largest study of psychiatric disorders ever conducted in the United States, indicate that both current and lifetime rates of the most commonly occurring psychiatric disorders—with the possible exceptions of schizophrenia and phobias—are similar for African Americans and whites (22).

Data from the first study to use a national probability survey to assess psychiatric disorders in the United States are even more striking (23). In this study of more than 8,000 adults, rates of mental illness among African Americans were similar to or lower than those among white persons. Lower rates among African Americans are particularly pronounced for the affective disorders and substance use disorders. Thus, although African Americans confront social conditions that are risk factors for mental illness and are disadvantaged in terms of physical health, their rates of suicide and mental illness are no higher than for the general population.

These findings and possibilities emphasize the need to study the health-promoting resources of the African-American population, including the church's role. For example, religious involvement may support behavior that is more conducive to health (24). Indirect health benefits may accrue from involvement in church (25) and community (26). The shared religious culture between counselor and client can be helpful (27). Also, the willingness on the part of African-American clergy to make mental health referrals adds to the resources available to the African-American community (28).

The chief strength of this study was that it used a thorough sampling method to yield an unusually detailed view of the African-American clergy's pastoral counseling work. The sample incorporated the smaller, poorer, and more-isolated churches, many headed by women pastors, which tend to be invisible to investigators. Including these churches is important for a complete and valid sense of how African-American churches promote community mental health. The results of this study thus add comprehensively to our understanding of the structure and level of clergy involvement and the range of problems addressed by clergy in their daily work. At the same time, this study had the

limitation of covering only a single metropolitan area. It has provided only cross-sectional data from a single short period, and it is limited to the pastors' perspective.

Further studies are needed to evaluate whether the New Haven situation is unique or whether African-American churches in other cities are similarly involved in promoting mental health. If the pattern of involvement seen elsewhere is different, it would then be very important to ascertain the reasons for the difference in order to encourage optimal developments throughout the United States. Also, it would be informative to extend comparisons to include the African-American clergy in rural areas. Certainly the perspectives of church members and other observers are needed to supplement those of the clergy, especially regarding outcome. Because the role of the clergy is now known to be large, effectiveness becomes a crucial issue. Similarly, more needs to be known about the pastoral counseling work of a majority of clergy in both urban and rural settings.

Finally, the data from this study make clear the need for supporting the mental health–promotion efforts of the African-American clergy. For example, efforts to enhance the continuing education available to them would contribute greatly to the quality of services they are providing. Finding practical structures support requires some creativity. One example of proven value is incorporating a clergy presence directly in secular mental health settings (29). Responsible bodies—including church authorities, seminary officials, and foundation boards—can all make a contribution in this regard. The results presented here provide both a basis and a direction for the public and private support of faith-based organizations. The increasing pressure on public and private mental health care resources may mandate integration of the work of secular mental health professionals with that of their African-American clergy colleagues. ♦

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