

African-American Clergy's Perceptions of the Leading Health Problems in Their Communities and Their Role in Supporting Parishioners' Health

The Journal Of Pastoral Care & Counseling, Spring-Summer 2006, Vol. 60, Nos.1-2, pps 13-16

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Abstract

A study of Southern California pastors was conducted to learn their perceptions of the leading health problems in their congregations. A survey was hand-delivered to the pastors of 100 churches; additionally, some pastors completed surveys online. All 41 participants are members of regional associations of churches in California. Stress, overweight, and obesity were identified as the top three health indicators that most affect the health of their congregations. Tobacco use and substance abuse were listed among the top five. From a list of health problems, pastors felt that (from the pulpit) they could impact parishioners' responsible sexual behavior most. Tobacco use also ranked high. Pastors expressed their opinions about the reasons for certain maladies and addictions. These findings indicate room for improvement in building clergy's understanding of the nature of illness and addiction and in empowering them in their role of supporting healthy behaviors in the African-American community.

Introduction

Churches, as community institutions, are in a unique position to support parishioners in their efforts to achieve and maintain good health. Pastors, as servants of the church, are often the first place that an individual will go in search of help. Efforts to better understand clergy's perceptions of their role, with regard to supporting parishioners' health, are greatly needed. While a review of the literature reveals some investigation of clergy's attitudes on a variety of topics, there is little research on the role

of clergy in encouraging healthful practices in their congregations, and, more specifically, in the black church.

Methods

A study of Southern California pastors was conducted to learn their perceptions of the leading health problems in their congregations. Pastors were selected to participate in the survey because they are a representative sample of small and medium-sized churches in the state of California. All participants are members of regional associations of churches in California that have indicated an interest in grassroots interventions designed to address health indicators in their communities. They are all currently engaged in strategic planning and administrative improvement efforts in their respective congregations.

A survey, *Clergy of Small and Medium-Sized Churches Survey*, was hand-delivered to the pastors of 100 churches; additionally, some pastors completed their surveys online. The instrument, that contains multiple choice, ranking, and open-ended response formats, elicited clergy opinions about issues affected their parishioners' health and their role in prevention and health promotion. First, the survey asked about the demographics of the respondents' congregations (gender, age). Next, it asked pastors to rank the top three health indicators affecting the health of their congregations and those they could best impact from the pulpit. The next series of questions asked pastors to indicate their opinion of the causes of a number of health threats/maladies (from a list of five choices). Finally, the survey asked clergy to indicate the frequency with which they addressed a number of health concerns/problems – both in the *past 30 days* and in the

past year – from the pulpit and privately with individuals, couples, families or in small groups. Responses were tallied and percentages were calculated. Findings are reported narratively and in tables.

Participants

A total of 41 pastors from Southern California participated in the study. The sample consisted of 27 pastors from Los Angeles, 9 pastors from San Diego and 5 pastors from San Bernardino County. Of the 41 pastors participating, 35 are male and 6 are female. All of the participants identified Black (non-Hispanic) as their ethnic origin or descent. Additionally, all participants identified Black (non-Hispanic) as the ethnic origin or descent of most of their adult congregation (those attending regularly).

In the present survey, participants have been pastors for an average of 12.6 years and have been with their present churches for an average of 7.4 years. The average number of members per congregation was 239. The pastors indicated that their adult congregation members are mostly female (see Table 1). In addition, the majority stated that the percentage of children and adolescents in their congregation is between 10 and 25 percent. The majority of children and adolescents who attend regularly are female.

Results

Leading health indicators. Pastors were asked to rank the top three health indicators affecting the health of their parishioners. Pastors ranked stress (15%), overweight (13%), and obesity (13%) as the top three health concerns in their congregations. Tobacco use (12%) and substance abuse (9%) were among the top five health indicators (see Table 2). These findings support those of Coyne-Beasley (2000) who found that among African-American clergy in the southeastern U.S., pastors' highest priority issues were drugs,

violence, HIV/AIDS, pregnancy, and alcohol. Pastors in the present study were also asked to rank the health indicators that they feel they can impact most from the pulpit. In general, pastors felt they could impact responsible sexual behavior most (19%). This confirms Coyne-Beasley's findings (2000) that African-American churches are open to including sexuality education among their health education offerings for young adolescents and that the church should be considered as a potential forum for providing comprehensive sexuality education for African-American adolescents. In this study, tobacco use (16%) was also ranked among the top three areas by pastors. However, substance abuse (7%) was not listed among even the top five areas that pastors felt they could impact best from the pulpit.

While AIDS rates among many groups have leveled off or declined in recent years, African Americans continue to be disproportionately diagnosed with the deadly disease; they constitute nearly half of reported AIDS cases in the U.S., but only 13 percent of the population (Swain, 1999). African-American Baptist ministers surveyed by Crawford et al. (1992) did not perceive HIV as being a significant risk to their communities. Swain suggests, "The black church has great potential for HIV prevention, despite religious stigmatism, because the institution is a touchstone for extended families."

In this study, pastors also indicated a relative lack of concern with AIDS in their congregations. Worse, Swain's findings suggest that clergy he studied were blamed by parishioners for prohibiting AIDS dialogue in their congregations. Swain (1999) found, however, that "AIDS dialogue can be stimulated in religious contexts through interpersonal interventions sensitively tailored to address condom use, AIDS stigma,

homosexual behaviors, and other religious taboos, while utilizing Christian principles such as evangelism, prayer, behavioral accountability, and divine guidance.” Drisenga (1992) found that orthodox religious beliefs and attitude toward homosexuality were significantly correlated with attitude toward people with AIDS. Therefore, dialogues about AIDS (and substance abuse and homosexuality) must address parishioners’ discomfort with discussing these religious taboos. In their study of pastors of conservative evangelical denominations, Kennedy and Whitlock (1997) found that pastors saw the role of the church as mainly to serve and influence the sexual practices of the people within the church. For these pastors, religion and sexuality were entirely compatible.

In one study (Crawford et al., 1992), ministers’ comfort level in counseling persons with AIDS was associated with previous HIV prevention/education training, a professional or college degree (were less likely to believe that AIDS was a punishment by God and that people with AIDS deserved their illness), and youth (older ministers tended to hold more pejorative attitudes toward homosexuals, HIV, and individuals with the virus than did their younger peers). Drisenga (1992) recommends educational and experiential programs that might aid in reducing fearful and non-accepting attitudes so that people with AIDS might receive improved pastoral care.

Reasons for illness and addiction. The survey asked pastors to indicate (from a list of five choices) their opinion of the reasons for certain maladies and addictions. The five choices were medical illness, learned behavior, sinful or immoral behavior, medical illness or sinful or immoral behavior, or Don’t Know.

In general, pastors believed that obesity and overweight are the result of a medical illness and sinful or immoral behavior (see Table 3). These findings fit with those of Yuker, Allison, and Faith (1995) who found that attitudes toward obese persons are strongly related to beliefs about the causes of obesity and the result of negative societal attitudes toward obese persons and obesity.

It is the opinion of the pastors in the present study that mental illness is the result of a medical illness. Richardson's study of Black pastors (1982) found that pastors held favorable attitudes toward the mentally ill, while lacking in knowledge about mental illness in general. Researchers (Hong & Wiehe, 1974; Mannon, 1994; Mannon & Crawford, 1996; Sandler, 1966; Wright, 1984) have found that clergy are generally confident in counseling across various mental health issues, except for severe mental illness issues, and are most confident in addressing spiritual, moral, and marriage and family issues. Givens (1976), however, found that clergy in churches of Christ frequently counseled their parishioners in alcohol and drug abuse and severe emotional problems. Mannon (1994) found that Black clergy felt more confident than their White counterparts to counsel people.

In their book, *Counseling Families Across the Stages of Life*, Weaver et al. (2002) present a text for those in training for pastoral ministry. In it the authors underscore the important role that clergy and the faith community play in the mental health of families. Winett, Majors, and Stewart's research (1979) reveals that clergy treated and referred their parishioners for help with their mental health problems, but had limited knowledge of mental health services and personnel. Perlmutter, Yudin, and Heinemann (1974) also found that clergy had little knowledge of the services available through its community

mental health system as compared to doctors and school counselors. Researchers (Clemens, Corradi, & Wasman, 1978; Gaston, 2000; Meylink & Gorsuch, 1988; Purdy et al., 1983) have found that although many people seeking help first approach clergy, less than 10% of those seeking help are referred to mental health professionals (Meylink & Gorsuch, 1988). Fultz (2002) and Lowe (1986) also found low referral rates among clergy. In addition to clergy's lack of knowledge of community mental health resources, Lamberton's research (1992) suggests that this low referral rate may be because clergy do not refer parishioners to mental health professionals when moral or religious issues are the presenting problem. For example, Mannon (1994) found that clergy were generally willing to make referrals to mental health professionals, but usually under certain conditions, such as the mental health professional being a Christian. In an interesting study of mental health valuations, Newberry and Tyler (1997) found that Catholic and Methodist clergy considered religious commitment to be more indicative of good mental health than did psychologists. These findings deserve further study.

Looking at the issue from the perspective of other mental health professionals, Presley (1992) theorized that counselors may avoid religious issues raised by clients based on factors of professional competence, informed consent, and effective therapy. Presley recommends that such counselors consult with ministers, because the welfare of the client/parishioner is of primary concern. Researchers (Colton, 1990; Lafuze et al., 2002; Lowe, 1986) agree that there exists a promising basis for useful communication and collaboration between pastors and psychiatrists and other mental health professionals. Virkler (1979) specifically recommends that clergy have more training in how to use community referral networks.

Azlin's research (1993) revealed a negative relationship between pastors' perceived competency in treating emotional disturbances and their attitudes toward mental health professionals and services; it appears that the greater the pastors' perceived competency to treat emotional disturbances, the less favorable were their attitudes toward mental health practitioners and services. Researchers (Colton, 1990; Mannon, 1994; Mannon & Crawford, 1996) have also found a relationship between congregation size and clergy's referral rate. Mannon (1994) and Mannon and Crawford (1996) found that clergy from larger congregations were more likely to refer their parishioners to mental health services than were those from smaller congregations. It is unclear whether referral rates are a function of clergy's time management or availability or other factors. White clergy were more likely to prefer referring their parishioners to psychologists, while Black clergy were more likely to prefer social workers, community mental health counselors, and physicians (Mannon, 1994). Sandler (1966) also reported that ministers generally refer their parishioners with problems of mental disease to a psychiatrist. In their study, Hong and Wiehe (1974) found that pastors referred their parishioners to psychologists and social workers 52% of the time, and to psychiatrists 36% of the time.

Mollica et al. (1986) believe that certain parish-based clergy, especially black clergy, function as a major mental health resource to communities with limited access to professional mental health care. Similarly, Hong and Wiehe (1974) found that pastoral counselors were viewed as important mental health therapists along with psychiatrists, psychologists, and social workers. Lyles' study (1992) revealed that Black pastors felt that helping emotionally troubled parishioners was a central role for the church, particularly the Black church.

Many researchers have documented the need for additional education and training in counseling parishioners in mental health issues. For example, Givens (1976) found that few clergy had an adequate educational background in psychology and most wanted to take a course in this area. Similarly, Clemens et al. (1978) learned that clergy feel inadequately prepared for therapeutic intervention. Correlations between counseling and academic background in psychology, perception of the importance of counseling, and acquaintance with mental health professionals, and between referral and attendance at a counseling workshop have also been found (Gilbert, 1981). In Gaston's needs assessment (2000), clergy reported that it would be helpful to receive additional training, including knowledge about symptoms of mental illness and skills in counseling people with mental illness. Fundamentalist pastors felt the need for professional assistance with most of their cases of emotional disturbance, while feeling that they also had a role to play in treatment (Lamberton, 1992). In contrast, Lafuze et al. (2002) found that pastors appeared to have an informed, scientifically-based understanding of the causes of mental disorders and of the importance of medications in effective treatment. Additionally, Burgess's findings (1998) revealed that pastors generally feel competent in their role as counselors. Interestingly, Bell et al. (1976) discovered that while pastors viewed their role as counselors as central to their ministry, less than 6% of their time was actually spent in such work. Wright (1984) found pastors' time allocation to counseling to be approximately seven hours per week.

Gaston (2000) suggests that the need for resource and training to minister to people with serious mental illness is so substantial and common among clergy that additional resources and training seem not only appropriate, but necessary. Lunn (1980)

reported that ministers recognize their limitations and desire improvements both personally and in seminary counseling curricula. Similarly, Bentz (1970) discovered that clergy's lack of confidence and competence in detecting mental illness in their parishioners affects their ability to effectively perform their counseling function. Bentz stresses that a pastor's "recognition of his ability limitations and establishment of community liaison enable him to make appropriate referrals."

In his study of Protestant ministers, Virkler (1979) describes the need for seminary and continuing education courses to meet their counseling demands. Lee (1976) found that clergy referrals were more numerous if the pastor had some psychiatric training, was able to recognize cases needing referral, was well-adjusted himself, did not fear that the source to which he referred a parishioner would give inappropriate or ineffective help, and did not feel that referral implied inability on his part to deal with a problem. In an interesting finding, Azlin (1993) reports that the more semester hours of psychology and counseling coursework pastors had completed, the less competent clergy felt to treat emotional disturbances; it seems that greater understanding of the nature of mental health issues may intimidate pastors from addressing these with their parishioners and increase their referral rate. Bentz (1967) also found that less-educated ministers were more willing to cope with a greater variety of problems and to tackle the more serious problems of mental illness more often than a minister who had attained a relatively higher educational level. Bentz reports that the better-educated minister is more knowledgeable as to the existence of and functions performed by other community health resources and is more likely to refer a person who exhibits symptoms of a serious mental illness to another community health agency.

According to researchers, pastors constitute a “fertile source of referral of clients to mental health professionals” (Colton, 1990) and an “unusual reservoir of time, energy, skill, and wisdom” (Robertson et al., 1969). Unfortunately, Abramczyk’s study of clergy training (1981) found that clergy’s satisfaction with their training in the counseling function was low. In Sandler’s study (1966), ministers had obtained their training in counseling from self-study, seminary seminars, and postgraduate courses. Robertson et al. (1969) distinguish the role of the parish minister from that of the pastoral counseling specialist and suggest that preparation in these roles requires a “different viewpoint and a different body of knowledge.” Purdy et al. (1983) suggest that the pastor plays “a more complex role than that of the traditional spiritual leader and counselor.” Finally, Johnson (1973) suggest how religious leaders can respond in a comprehensive way to the mental health needs of their parishioners by: 1) becoming effective ministers through continuing education; 2) joining community leaders in providing counseling services to people under acute stress; 3) cooperating with community mental health services; and 4) participating in health activities. Fairchild (1980) believes that pastoral care for depressed persons involves the whole congregation.

The pastors in the present study believe that addiction to alcohol and other drugs is the result of a learned behavior. Merrigan found that among Roman Catholic clergy alcohol abuse was believed to be a pastoral issue that should be addressed at the local parish level. However, most preferred not to intervene directly with persons experiencing alcohol problems until such individuals requested assistance. Further, actions related to assisting parishioners with alcohol-related problems (including counseling, offers of food and shelter, and financial assistance and support) were associated with perceived

availability of referral resources, previous training in alcohol studies, belief that alcohol abuse is a major factor in family disorganization, and knowledge about the symptoms of alcoholism and treatment approaches. Similarly, King (1992) found that Southern Baptist ministers' attitudes regarding principles of addiction were related to education level, number of courses in counseling, full-time ministry, and recognition of other addictive behaviors. Overall, these pastors had a moderately positive attitude regarding principles of addiction. In his study, Burgess (1998) found that United Methodist pastors assisted their parishioners with a variety of issues; substance abuse counseling was one of the most typical. Cavanaugh (1991) underscores the importance of ministers who work with alcoholics and their families being aware of what science can tell us about alcoholism. Ministers can help people understand that treatment outcome depends more on the alcoholic's motivation to change, the content of the intervention, and environmental supports than on the treatment setting or how long the treatment lasts.

Respondents believed that HIV/AIDS infection is the result of sinful or immoral behavior. These findings are consistent with McCleen (1992) who studied clergy's homophobia (fear of homosexuals) and found a statistically significant correlation between the degree of their homophobia and clergy's attitudes towards AIDS. Given pastors' general lack of knowledge about alcohol and drug addiction, this opinion is not surprising. Ellens (1987) says, "AIDS provokes fear and denial in the professional medical community as well as general population. There is a danger that such fear and denial may undermine pastoring of persons with AIDS." Drisenga (1992) believes that the spiritual care of the person with AIDS may be negatively affected if the pastor has a

negative attitude toward that person or toward AIDS in general. Fortunato (1987) calls for a “spiritual response.”

Pastors in the present study believe that violence in the community is a learned behavior. In a similar study, Thompson (1989) describes the overall reluctance of ministers to deal with the problems of domestic violence and sexual assault among members of their congregations. She suggests that initiating conversations about these issues can be facilitated if the minister remains objective and offers a variety of alternatives that do not disturb the victim’s faith in God or the minister. Meadows (1971), in critiquing contemporary theories of aggression, anger, and violence, suggests that all change agents, including ministers, must obtain a working grasp of the dynamics of planned change. According to Meadows, part of this understanding will include an appreciation and grasp of the dynamics of anger, aggression, and violence.

Looking at the pastors’ opinions as a whole, it appears that, in general, the pastors felt they could impact most those behaviors that resulted from learned behavior, and could impact least those illnesses that resulted from medical illness. However, there were some exceptions. It may be that pastors’ perceptions of their efficacy in addressing certain issues among parishioners had more to do with their own comfort level than with any objective criteria about how effective they might be in their change efforts.

The pastor’s role in addressing health issues. The pastors indicated that they address a variety of issues from the pulpit each week: community violence, alcohol and drug addiction, physical activity/diet, mental illness and HIV/AIDS. These topics had been addressed from the pulpit approximately two to five days in the last 30 days (see Table 4). In fact, this sample of pastors indicated that they had addressed most of these issues as

many as five times in the past year. Specifically, issues related to alcohol and drug addiction had been addressed more than 10 times in the past year by the majority of pastors (see Table 5). Similar results were found when clergy were asked how often they address these issues with parishioners privately, in individual, couples, family or small group meetings.

Discussion

This study highlights a number of important points about the role of clergy in supporting parishioners' health. First, pastors need more information about community resources and the referral process in order to better assist their parishioners' in accessing the specialized help they may require. Second, pastors need more training in mental health diagnosis and counseling, as well as medical conditions, including HIV/AIDS and substance abuse. Finally, the research supports collaborations between clergy and mental health, medical and community outreach efforts to address the health problems facing their communities.

Attempts to engage clergy in a dialogue about health concerns in their congregations and perceptions of their role is a first step in the process of empowering them to play a more active role in supporting parishioners' health. When we better understand the ways in which their training in pastoral ministry and their religious beliefs affect their perceptions of their role and their relationships with parishioners', we open the door to their improved functioning. Specifically, this study's findings warrant a closer examination of clergy's pastoral counseling role with regard to their religious beliefs to uncover any conflicts between the two. The research indicates that pastors are often the first point of contact for troubled individuals; clergy should be helped to better appreciate

the significance of that fact and help their parishioners to disclose the nature of their troubles with the expectation that help, and appropriate referrals (as indicated), will be forthcoming. Further, clergy can be assisted in examining their current practices to learn how their time is currently being spent and what changes they would like to make in their use of time. Specifically, clergy might be guided in thinking about the frequency with which they address certain health issues from the pulpit and in private conversations with parishioners and track the changes in parishioners' health over time. In addition, efforts to collaborate with others in the community to effect change in the health of their congregations are advised. Having clergy avail themselves of current information about health issues is an important way to communicate their support to parishioners.

Conclusion

As a follow-up to the present study, it might be useful to reconvene participants to process their responses as a group. This meeting might allow for a fuller exploration of clergy's perceptions of the reasons for certain maladies: learned behavior, sinful behavior, or disease. These findings are limited by a small sample size of only 41 pastors. Future research with a larger number of pastors might yield different results. If a common understanding about the nature of illness and addiction can be reached, clergy's ability to support healthy behaviors in the African-American community would be greatly improved. Research supports the role of the black church as a community health resource, especially in ministering to those with limited access to health care. The church's role to serve and influence the health of parishioners is evident and necessary. Future research also might focus on how clergy can use the pulpit more effectively to educate, inform, and transform parishioners' health.

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Table 1 Parishioner Demographics

| Category | Percentage |
|-------------------------------|-------------------|
| Gender | |
| Mostly male | 12 |
| Mostly female | 81 |
| Evenly distributed | 7 |
| Percentage of children | |
| 0-10% | 15 |
| 10-25% | 51 |
| 25-50% | 34 |
| Gender of children | |
| Mostly male | 5 |
| Mostly female | 54 |
| Evenly distributed | 41 |

Table 2 Pastors' Perceptions of Health Indicators Affecting Parishioners' Health

| Health Indicator | Percentage of Pastors Prioritizing Health Indicator | Rank | Percentage of Pastors Who Feel They Can Impact This From the Pulpit | Rank |
|------------------------------------|--|-------------|--|-------------|
| Stress | 15 | 1 | 18 | 2 |
| Physical activity | 13 | 2 | 3 | 9 |
| Overweight and obesity | 13 | 2 | 8 | 6 |
| Tobacco use | 12 | 3 | 16 | 3 |
| Substance abuse | 9 | 4 | 7 | 7 |
| Responsible sexual behavior | 9 | 4 | 19 | 1 |
| Injury and violence | 8 | 5 | 11 | 4 |
| Access to health care | 7 | 4 | 6 | 8 |
| HIV/AIDS | 5 | 7 | -- | -- |
| Immunization | 4 | 8 | 3 | 9 |
| Mental health | -- | -- | 9 | 5 |

Table 3 Percentage of Pastors Who Gave the Following Reasons for Maladies and Addictions

| Malady or Addiction | Medical Illnesses | Learned Behavior | Sinful or Immoral Behavior | Medical Illness and Sinful or Immoral Behavior | Don't Know |
|----------------------------------|--------------------------|-------------------------|-----------------------------------|---|-------------------|
| Obesity | 7 | 32 | 2 | 57 | 2 |
| Mental Illness | 54 | 0 | 9 | 21 | 16 |
| Addiction | 4 | 50 | 26 | 20 | 0 |
| HIV/AIDS | 4 | 33 | 47 | 9 | 7 |
| Violence in the Community | 4 | 60 | 30 | 4 | 0 |

Table 4 Number of Days in the *past 30 days* that Pastors Addressed Selected Problems with their Parishioners

| Problem | Average Number of Days Problem Addressed from Pulpit | Number of Days Problem Addressed (Total) |
|------------------------|---|---|
| Community Violence | 5 | 5.6 |
| Alcohol/Drug Addiction | 4.3 | 5.3 |
| Physical Activity/Diet | 3.3 | 4.6 |
| Mental Illness | 2 | 4 |
| HIV/AIDS | 2 | 2 |

Table 5 Percentage of Pastors Who Addressed Selected Problems with their Parishioners in the *past year*

| | From the Pulpit | | | Total | | |
|------------------------|------------------------|-------------------|---------------------------|------------------|-------------------|---------------------------|
| Problem | 1-5 times | 6-10 times | More than 10 times | 1-5 times | 6-10 times | More than 10 times |
| Physical Activity/Diet | 44 | 32 | 24 | 40 | 32 | 28 |
| Mental Illness | 72 | 10 | 18 | 60 | 18 | 22 |
| Alcohol/Drug Addiction | 37 | 7 | 56 | 34 | 10 | 56 |
| HIV/AIDS | 62 | 15 | 23 | 75 | 10 | 15 |