Building Bridges: Qualitative Investigation into Bridging the Gap between Religion and Psychology to Improve Rural Mental Health

By

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Abstract

The literature on bridging the gap between rural religion and psychology focusing on collaboration between clergy and mental health professionals with specific examples of such collaboration was reviewed. In the current study, the researcher conducted interviews with rural religious leaders to explore their needs and preferences regarding collaboration with psychology, and to begin forming a collaborative relationship. Interviews were audio-recorded, transcribed, coded, and analyzed for themes, using grounded theory methodology. Therefore, data analysis involved a process of open-coding, axial coding, and selective coding to extract themes from the data with the goal of constructing a theory to inform effective collaboration between religion and psychology. Data analysis was completed, but an integrated theory was not proposed due to limitations of the current project. Themes identified as emerging from the data analysis included: clergy demonstrated awareness of psychological needs, clergy identified specific psychological needs in their work, clergy showed awareness of professional scope, clergy expressed a desire to collaborate, clergy described collaborative efforts, clergy discussed issues related to the process of collaboration, clergy mentioned existing relationships with field of psychology, clergy delineated professional responsibility to initiate collaboration, clergy shared a specific idea for collaboration, clergy discussed using the local pastoral associations, clergy referenced rural issues interfering, clergy discussed perceived mutual distrust, clergy identified lack of resource as barrier, and clergy recognized conserving status quo as barrier. The results are discussed in relation to the research questions. Limitations of the current study, future research, and recommendations are discussed in conclusion.

Keywords: *rural, mental health, religion, spirituality, collaboration, qualitative*

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Chapter 1

The existing literature indicates that spirituality and religion are important to the general population, that religion and spirituality generally have a positive impact on mental health, that rural areas have higher rates of religiosity with less mental health resources, and that collaboration between religion and psychology could be one way to address this problem. The current qualitative study explored the needs and preferences of rural religious leaders about forming collaborative relationships with mental health professionals in order to better care for their congregations and the people served by both professions.

Spirituality and Religion

The terms spirituality and religion historically have been used interchangeably, but recently there has been a trend toward separating them or making distinctions in the way each is defined. Hill and Pargament (2003) explained, however, that spirituality and religion represent related rather than independent concepts. They both involve what Pargament (1997) described as a search for significance in ways related to the sacred (Russell & Yarhouse, 2006). Spirituality has been broadly defined as the subjective experience of searching for and nourishing relationships with the divine (Kashdan & Nezlek, 2012). According to William James (1902/1997), religion encompasses experiential spirituality as well as inherited tradition. Religion can be thought of as the organized rule systems, rituals, and worship associated with spirituality (Larson, Swyers, & McCullough, 1997).

For the purposes of the current study, spirituality and religion will be considered separate but related concepts, following the current trend in this field of study. Therefore, spirituality is herein defined as the search for divine significance and religion is defined as experiential spirituality in an organized system with rules and rituals for worship. The questions then arise,

how common is this search for divine significance? Further, how common is this participation in systems of organized experiential spirituality?

Prevalence of Spirituality/Religion

Results of a 2011 Gallup poll showed that 92% of people surveyed reported a belief in God, a percentage that has remained rather steady for decades (Newport, 2011). Belief in God is a major component and manifestation of spirituality. Research has shown that 90% of the world's population report being religious or spiritual (Walsh, 2011). Considering religious practice, another recent Gallup poll indicated that 69% of people surveyed reported being either very or moderately religious (Newport, 2012). In the United States 140,000,000 (50.2%) belong to one of 260,000 religious congregations in 149 different denominations found in practically every community (Milstein et al., 2010).

Benefits of Spirituality/Religion

Research has shown many positive health outcomes associated with spirituality and religiosity (Newport et al., 2010). In a large meta-analysis, Koenig and colleagues concluded that religious beliefs and practices were consistently positively correlated with health outcomes (Koenig et al., 2001). Physical health benefits include reduced hypertension and nonspecific mortality rates. Weekly religious observers were found to live an average of seven years longer than the general population. Mediating and contributory factors may include service to others, social support, and meditation or relaxation (Walsh, 2011).

However, it should be noted that health outcomes may be dependent on the type of beliefs or spirituality, and that religion can produce positive and/or negative consequences. A benevolent appraisal of God was associated with lower depression scores; whereas, a punishing view of God was associated with higher depression scores (Koenig et al., 1998). Religiosity has

been found to produce positive outcomes when it centers on love and forgiveness, but negative outcomes when it centers on punishment and guilt (Walsh, 2011).

Spiritual/religious coping. Spiritual and religious practices can provide a significant means of coping with stress and illness (Newport et al., 2010). Features that are commonly found in religious communities and practices can serve as coping tools, such as prayer and meditation, social support, material resources, opportunities to engage in volunteer service to others, and many others. Spirituality and religion also can provide an understanding of deep existential issues. Mental health benefits include enhanced relational and marital well-being, reduced anxiety, reduced depression, and lower rates of substance abuse and suicide (Walsh, 2011).

Rural Spirituality/Religiosity

One place where spirituality and religiosity seem especially important is in the rural community. Because the majority of past research on rural religious issues focuses on Christianity and it is the predominant religion in the rural United States, this review will focus on Christianity. A central part of the culture in these rural communities tends to be a reliance on faith and religion, with a strong connection to religious communities (Arcury et al., 2000).

Krause (1997) noted the significance of faith for older adults. Recent national polls have verified that faith and religion are of greater importance to older adults (Newport, 2012). Given the importance of religion to older adults, and their higher representation in rural communities, the relationship between rurality and religiosity seems even stronger.

A Rural Issue

Rural settings have been described by different typologies, such as overall population size of a community or county, population density of a geographic area, measures of adjacency to a metropolitan area, measures of urbanization, commuting and employment patterns, and

economic and socio-demographic characteristics (Keller, Murray, & Hargrove, 1983; Schank & Skovholt, 2006). The U.S. Census (2010) currently labels as rural an area with open countryside or with a population density of 2,500 or fewer inhabitants. Rural areas represent approximately 80% of the land in the United States and 20% of the population (Werth et al., 2010).

Rural Mental Health

The mental health situation in rural areas is bleak. About 55% of the 3,075 counties in the U.S. have no practicing psychologists, psychiatrists, or social workers, and all of these are rural counties (Campbell et al., 2002). A significant lack of outpatient and inpatient psychiatric services exists in rural areas as well. Only 1% of non-metropolitan counties have inpatient psychiatric units (Fox et al., 1995). Coupled with this significant lack of mental health resources in rural areas, there also appear to be a number of characteristics and attitudes that may put rural residents at higher risk of mental health problems. Rural residents tend to avoid conflict and discussion of feelings, have limited tolerance for diversity, have high religious involvement, possess fatalistic and stoic attitudes, and are less likely to seek mental health services because of the stigma and lack of education about such services (Helbok, 2003; Werth et al., 2010).

Barriers to rural mental health. There are both internal and external barriers that prevent mental health treatment in rural communities. Campbell and colleagues (2002) discussed some of these barriers:

- One barrier is the distance to service providers. Even if mental health service providers are available, many rural residents would still have to travel great distances where public transportation does not exist. Furthermore, some families may not have access to vehicles or telephones to arrange transportation.

- Another barrier is the difficulty attracting and funding mental health providers and services in rural areas, although there have been attempts to entice and attract mental health service providers to these areas by federal programs that provide repayment of student loans and other benefits.
- In addition, it is less likely that rural residents have medical insurance and there is a lack of information about various entitlement programs.
- Other potential barriers are related to rural social norms and personal values or beliefs about health and illness. Some of these values and beliefs prevalent in rural communities include individualism, authoritarianism, self-reliance, and the belief that the community should care for its own.
- Finally, mental health problems are thought of as personal problems to stay within the confidentiality of family and church and are not to be shared with professionals who are not a part of the community.

Collaboration between Religion and Psychology

Given the prevalence of religious practice, clergy often serve as the front-line resource for those who suffer from distress and mental illness. In the United States, four out of 10 mentally ill individuals seek help from clergy first. More than 10,000 clergy serve as chaplains in hospitals and healthcare institutions. Clergy already bring hope, ease difficulties, facilitate informal treatment, and refer people to formal treatment (Thomas, 2012).

The literature suggests that relying on existing community resources such as religious leaders would be an effective way to improve mental health in rural communities (Weaver et al., 2003). Many religiously-oriented clients prefer therapy that in some way includes their belief

system. The vast majority of these clients also want religious values, practices, and themes to be addressed in therapy (Quackenbos et al., 1985).

Currently there appears to be little collaboration between religion and psychology. Some of the obstacles identified include a lack of trust on both sides, lack of awareness and education, lack of teamwork skills, and time restraints (McMinn et al., 2003; Thomas, 2012). Researchers have asked how much psychology knows about working with clergy. After searching over 22,000 articles in APA journals, it was found that only four articles contained the word "clergy" in the title. Although this methodology seems limited in answering the question, they concluded that psychology knows little about the topic (McMinn et al., 2003). However limited the knowledge that psychology possesses about clergy collaboration, there has been increased interest and research on this topic. Recently, some theories and models of effective collaboration with clergy have been proposed.

Theories and Models of Collaboration

Researchers suggest that there are certain principles of effective collaboration. Edwards and colleagues (1999) focused on developing relationships, having common goals, increasing effective communication, establishing trust, sharing respect, gaining expertise from the other side, having some common values, and increasing general awareness of spirituality. McMinn and colleagues (2003) proposed basic and advanced competencies in collaborating with religious leaders. Basic activities include sharing respect and increasing effective communication. Advanced activities include increased spiritual awareness and finding shared values. Some examples of collaborative activities proposed by these researchers included consultation, referrals, workshops, direct services, assessment, community education, and academic. Whereas

these collaborative activities are general and applicable to all theories and models, there are a few more specific models that have been quite well-developed.

Clergy Outreach and Professional Engagement (COPE) model. Milstein and colleagues (2008) developed the COPE model to improve continuity of mental health care. COPE provides a continuum of mental health care for persons of diverse religions, delineating boundaries between clinical care provided by mental health professionals and religious care provided by clergy, as well as pathways of collaboration across these boundaries (Milstein et al., 2010). COPE is a model that moves from the care already present in religious communities to professional clinical care, which works to return the person back to the care of their religious communities. The four parts of their model include recognizing the benefits of community membership, describing the spiritual and social support provided by religious communities in response to a person's life stressors, promoting professional clinical assessment and treatment for persons of diverse religions with serious emotional problems or mental disorders, and supporting the person's recovery through ongoing collaboration with her or his religious communities.

Clergy Academic and Mental Health Partnership (CAMP) model. Aten and colleagues (2012) developed the CAMP model in response to the Deep Water Horizon oil spill. It is collaborative in nature, based on the idea that more can be accomplished by joining with and learning from others. The researchers worked with other groups by leveraging complementary capabilities and expertise of community, faith, governmental and nongovernmental groups. CAMP is a strengths-based model that seeks to recognize and harness the unique knowledge, resources, skills, and abilities that each community partner possesses. It also attempts to empower and strengthen preexisting community infrastructures, resources, and natural and professional helpers. The framework of the CAMP model includes the following components:

Establish a learning collaborative to help promote networking and training among diverse community leaders. Develop summits or conferences that reflect the needs of the region and serve as an opportunity to reach large numbers of community professionals and expose attendees to a wide range of information and skills. Promote outreach activities, such as community-based presentations and media campaigns to help raise awareness about needs and possible resources available for help. Use targeted trainings for religious and mental health professionals to provide an in-depth focus on a particular topic, skill, or research. Arrange direct clinical services that will provide access to mental health care for vulnerable and underserved populations. Provide care for caregivers to prevent burnout and turnover among helping professionals and clergy. Finally, identify community needs, interventions, barriers to and strategies for collaboration.

Healthy Body Healthy Spirit. One specific example of collaboration between psychology and religion was found in the Healthy Body Healthy Spirit trial. This was a wellness promotion intervention that sought to increase fruit and vegetable consumption and physical activity delivered through Black churches. The multicultural literature tells us that African Americans rely heavily on their pastors for many of their needs, often seeking advice about health and mental health issues from them before any other source. African American clergy have been found to act in a "gatekeeper" role when it comes to the health and mental health of their communities. Often, African Americans will seek the advice of their pastor and solicit a referral to an appropriate provider, thus giving their pastor this power and influence as a "gatekeeper" (Blank et al., 2002; Mattis et al., 2007).

In this study, 16 Black churches were randomly assigned to three intervention conditions. Group one received standard educational materials, group two received culturally targeted self-help nutrition and materials about physical activity, and group three received the same

intervention as group two as well as four telephone counseling calls based on motivational interviewing delivered over the course of one year. At one-year follow-up, groups two and three showed significant changes in both their intake of fruit and vegetables and physical activity. Furthermore, changes were significantly greater for the motivational interviewing group (Resnicow et al., 2005).

Research Questions

Based on this review of the literature, there appears to be sufficient information on spirituality and religion in general, as well as information and examples of collaboration between religion and psychology. However, there seems to be a lack of information from the religious leaders' perspective on their preferences and needs in such a collaboration. Therefore, the purpose of the current study was to seek information to fill that gap in the knowledge on the topic. My intent was to explore the preferences and needs of religious leaders in collaboration with the field of psychology.

My research questions were:

1) What collaboration, if any, has the religious leader engaged in with area mental health professionals in the past?
2) What types of collaborative activities would the religious leader prefer to engage in with mental health professionals in the future?
3) What barriers does the religious leader predict in their collaborative efforts, and how would they hope to overcome those barriers?

The Study

The current study follows a grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1990). It is one of the most common designs in the qualitative literature within

the field of counseling psychology (Ponterotto, 2005) and is at the forefront of qualitative research generally (Charmaz, 2000; McLeod, 2001). It is exploratory in nature and provides a richness of information that is well-suited for a topic about which there may be a lack of knowledge (Strauss & Corbin, 1990). It has also been found to be useful in bridging the gap between theory and practice (Fassinger, 2005).

Participants were recruited based on specific inclusion criteria. The first criterion is that the participant be serving in the capacity of a religious leader for an established church community. Because the literature indicates that it is a common practice in this type of research, especially in rural areas, the participant pool will be limited to Christian religious leaders. Another inclusion criterion is that the religious leader be serving a church congregation in a rural or mixed rural community, as defined by Isserman (2005). Qualifying counties include those in which the county's population density is less than 500 people/square mile and a minimum of 90% of the county population is in a rural area, and the county has no urban area with a population of 10,000 or more. Participants were identified first through purposeful sampling, followed by snowball sampling. Eight participants joined the study.

All eight participants were living and working in a community classified as rural. Participants ranged in age from 30 to 72 years old. Three participants were female and five were male with all participants identifying as Caucasian or White. All participants worked as professional clergy for an established church. Participants' highest level of formal education ranged from high school diploma to doctoral degree. Five participants reported receiving a bachelor's degree or higher; and of the other three, two reported some college. All had completed formal religious education and certification. Participants reported their number of years working in the ministry, ranging from 1.5 to 43 years, (157.5) with an average of

approximately 20 years. They also reported estimates of their congregation attendance, ranging from 20 to 200 attendees, (810) with an average size of approximately 101 active attendees. The table below summarizes participant demographics.

Table 1. Participant Demographic Information

Participant #	Age	Sex	Race	Education Level	Experience	Congregation
1	39	M	W	Doctoral Degree	3 years	110
2	56	M	W	Doctoral Degree	30 years	200
3	72	F	W	Master's Degree	8 years	30
4	55	F	W	Master's Degree	14 years	25
5	30	M	W	Master's Degree	1.5 years	80
6	45	F	W	Some College	22 years	135
7	63	M	W	Some College	25 years	90
8	69	M	W	High School	43 years	140

Prior to initiation of this study, approval was obtained from the Radford University Institutional Review Board (IRB). Once approved by the IRB, I began using the purposeful sampling methods to identify an initial sample. When a participant agreed to join the study, I sent them the informed consent form and made arrangements to meet in person to conduct the interview. A semi-structured interview guide was used to conduct the interview with participants. Interviews lasted between 30 and 60 minutes. I audio-recorded, transcribed, and analyzed interview responses following established qualitative data analysis procedures.

Grounded theory methodology uses a process called coding for data analysis. According to Fassinger (2005), grounded theory coding involves three stages: (a) open coding, (b) axial coding, and (c) selective coding. This coding procedure produces a thematic hierarchy.

Results

Themes were included in the final results if three or more of the eight participants endorsed the theme (i.e., if at least 37.5% of participants discussed content related to the theme).

Quotations from interview transcripts are provided in order to give a more detailed account of participant experiences (e.g., P1 is participant 1) and to provide a thick description of the identified theme. In some cases where obvious subthemes emerged, I provided descriptions of them with quotes representing the subthemes.

In response to questions about past experiences of clergy working with psychology, participants provided responses that were classified into three themes: clergy identified specific psychological needs encountered in their work (8 participants), clergy showed awareness of professional scope and limitations (8), and clergy demonstrated awareness and/or assessment of psychological needs (7). All participants were able to articulate at least one past experience that was represented in these themes. Here is a more detailed description of these themes with several participant comments to illustrate the theme.

One of the clergy with relatively more experience collaborating with psychology made the following statements which represent this general theme very succinctly:

> Depression, loss of loved ones, struggling with grief to a point where it becomes unhealthy and where moving past general stages of grief to non-functioning. There has been a suicide since I've been here… A small congregation but lots of stuff to deal with folks. I've had people struggle with sexual identity issues that they needed additional assistance in talking with someone. I had someone go through a gender change. (P6)

The following comment by a now seasoned clergy, who was probably the most psychology-savvy participant of all having had considerable experience collaborating with psychology, was representative of the attitudes of all clergy I interviewed. He said, “Um, yeah, it’s in the early years of ministry I was just caught off guard, ‘cause I was not prepared to deal with it, and you strive to do things, but you didn’t know what to do” (P2). Later in the interview

he discussed learning by experience or "hard knocks" (P2) to work with the established social systems to meet the various needs of parishioners which fall outside of his role as clergy.

Many of the clergy went as far as discussing what seemed to be a semi-formal policy for parishioners who needed more than three to five visits with clergy to be referred to psychology.

In response to questions about current experiences of clergy working with psychology, participants provided responses that were classified into four themes: clergy expressed a desire to collaborate with psychology (5 participants), clergy described collaborative efforts to work with psychology (7), clergy discussed issues related to the process of collaboration (6), and clergy mentioned existing relationships with field of psychology (8). Here is a more detailed description of these themes with several participant comments to illustrate them.

All but one of the clergy voiced a desire to increase collaboration, whether they had been highly collaborative already or not up to this point. One said, "Okay, honestly, you know, working with healthcare professionals or psychology professionals, I haven't had a lot of interactions with, desiring to work with them, I have a lot of desire" (P1).

Several clergy described their desires to collaborate with psychology despite confidentiality issues that might prevent that collaboration. One clergy mentioned that she took the opportunity to call providers of psychological services to inform them further about a shared service recipient, with the understanding that the psychological professional would not even confirm that the person was a client. Most other clergy, however, described confidentiality issues as a barrier to overcome in seeking collaboration.

Some clergy talked about how their desire to collaborate with psychology was increasing for many reasons; they cited the current interview as a motivator. One clergy is quoted as saying:

And maybe I could be better at calling around and talking to some psychologist or

> whatever and finding out who is more willing to go down those lines. I haven't done that… and honestly again, maybe this is helping me seeing my own inaction… That I could probably be more diligent in maybe just getting out a phone book and saying who are my psychologists in the area. (P1)

The idea that collaboration with psychology could assist clergy in carrying out their religious duties more efficiently and effectively was evident in multiple interviews. This subtheme provided great insight into the burden that clergy bear in their frontline helper role.

A theme emerged in which clergy discussed various aspects of their current collaborative efforts. One experienced older female clergy wisely highlighted that collaboration truly takes effort, saying, "Do you think because in a rural area, maybe you have to be invested to know the resources? It doesn't all just come to you; you really have to work at the relationship. If you can do that and get help for your parishioners, your members, your flock, it's a blessing" (P3).

Another theme emerged when discussing clergy's current experiences in working with the field of psychology. This theme concerned the process of collaboration between religion and psychology. Whereas most of the clergy explicitly emphasized the importance of fostering mutual respect, all of them, at least implicitly, endorsed this concept. One clergy stated:

> With these two fields you have to have respect, mutually. Clergy have a bad habit of thinking they have to be everything to everybody, thinking they have all the answers and it's just dumb. You spent a lot of money and a lot of time to get to where you are. I'm not going to sit here and pretend to know what you have, to be an expert in your field, but I guess it's an ego issue, a pride issue. You know well I can take care of this so it's a break down on the clergy side. Now on the mental health professional side, there's not mutual respect to the person that can help them to the clients. (P2)

A final theme that emerged in the category of current experiences working with the field of psychology was developing and using existing relationships with professionals in the field of psychology. There were two subthemes within this theme, informal and formal relationships. All clergy endorsed this theme.

In response to questions about the clergy's perception of an ideal collaborative situation, participants provided responses that were classified into three themes: clergy delineated professional responsibility to initiate collaboration (4 participants), clergy shared a specific idea for an ideal collaboration with psychology (8), and clergy discussed using the local pastoral associations as an ideal context (4). Here is a more detailed description of these themes with several participant comments to illustrate them.

Clergy participants attempted to clarify, in many cases, where the responsibility to initiate collaboration rested. Some believed it should be equally shared between religion and psychology. Others, however, seemed to either explicitly or implicitly place the responsibility to initiate collaboration with either psychology or religion.

Another theme that emerged in the interviews when discussing ideal situations was that clergy had specific ideas for collaboration. This was different from previous themes in that it captured collaborative efforts because it represented clergy's specific ideas or requests from a hypothetical or ideal perspective. This theme fell into two subthemes, specific ideas about clergy training by mental health and the assembly or creation of a useful resource manual or referral list. All clergy shared at least one specific idea for collaboration, most of which also had at least one comment which fell into the subtheme of training. Most clergy shared the specific idea that resource and referral lists would be ideal ways to collaborate with psychology.

One of the most promising and universally-shared specific ideas for ideal collaboration

came in the form of the clergy suggestions that collaboration begin with the pastoral associations in each local community. A pastoral association is a monthly meeting of participating pastors in a geographical area, usually a county, to discuss pertinent issues. Many clergy brought this up, and all would have probably endorsed the idea if it had been presented to them first.

The following comment by one of the clergy, even the most traditional and seemingly least interested in collaborating with psychology of all eight clergy interviewed, illustrated the opportunity that exists with the pastoral association idea:

> It might be good sometime for me to invite you to one our Ministerial Association meetings, we meet the first Wednesday of every month. We meet with different folk. I think next meeting we're meeting with doctors that want to talk about drug problems in [this] county, or the human body. I think in February we are meeting with some Young Life Group from the [area]. You might want to come sometime in March and meet with the total Association. There's 15-20 of us and you could see what the group would be interested in learning more. (P8)

One category of themes emerged that did not fit into a specific question asked of participants. These themes were related to the obstacles and barriers perceived by clergy in collaboration with psychology. This category consists of four themes: clergy referenced rural issues interfering with psychology/collaboration (5 participants), clergy discussed perceived distrust between psychology and religion (6), clergy identified lack of resources as barrier to psychology/collaboration (7), and clergy recognized (or demonstrated) conserving status quo as barrier (4). Here is a more detailed description of these themes with several participant comments to illustrate them.

This theme focused on the barriers unique or relevant to rural areas that clergy brought

up. There were several topics included in this theme, but no specific subthemes were identified. Therefore, a variety of quotations from the interview transcript are provided to capture the theme adequately. This first comment highlights a few rural issues which contribute to obstacles preventing mental health and psychological collaboration:

> As far as that disconnect, I guess for myself, rural, I don't know just health services in general are less readily available in general. There is the hospital in [town] because in my experience it is really more of a trauma center, if you've been shot that's a great place to go. They have a rehab center there, physical rehabilitation that is helpful but in general, you're better off to go to [nearby city], a place where there is more resources, more people, and more money. I think it's a money thing. (P5)

This next comment on barriers related to rural issues comes from a very experienced male clergy in his mid-50s who had served the ministry in various rural communities for decades. He explained:

> In rural communities, now I'm not picking on rural communities, because my heart is there, otherwise I'd be somewhere else. You have people who do not feel empowered, and then you have people that feel empowered… a lot of Methodist clergy wear robes, a lot of the people out here think robes are a judge in a court room and so there's this whole mental perception, so I don't wear a robe. (P2)

Several clergy lamented the distrust that continues to exist -perhaps decreasing in recent years - between religion and psychology. There was acknowledgement by multiple clergy that this distrust travels a two-way street. The following comments illustrate this concept. One said:

> And then the distrust that probably would come from some pastors is that if you are really strong in your faith, sending someone to a person that exhibits no connection to faith

whatsoever would kinda be, maybe be a little reluctant, I know I am, because over the years, I have known a few psychologists that I knew they had no beliefs, no faith, and really truly, I suspected that part of their deal of counseling with somebody was trying to disprove any connection with faith that would offer them any help. (P7)

Another theme that emerged in the category of barriers preventing collaboration was clergy identifying a lack of psychological resources. Several clergy made statements that fell into a theme best described as conserving the status quo. These comments seemed to illustrate a barrier to collaboration in the idea that things are fine the way they are, no need to change things. One clergy made a statement about consulting with and learning from each other instead of from a professional because each field is "going to do their thing anyway" (P8). To put it in context, the full quote says:

> We, in the Ministerial Association, we talk about this a lot, kind of encourage each other, giving each other pointers you know, because the Ministerial Association is brethren from Baptist, Pentecostal, Methodist, whatever, we don't promote our denominational beliefs but we support each other and talk about how we can help each other when there is an issue, whether it be marriage or other emotional issues, or mental health issues. I think we learn more from each other than we would from a professional because most of us agree that they are going to do their thing anyway. We just turn people over to them that we think need professional help that we can't help with and let them do their thing. Our church family we have a lot of grief because of death, but we have people that are very supportive of people that lose loved ones because people have been there done that and know how to do that. (P8)

Limitations and Directions for Future Research

As with all research, there were certain limitations associated with both the study's design and its execution. This qualitative research was exploratory in nature, as opposed to confirmatory, and therefore not based upon a specific established theory. Instead, as Grounded Theory (Strauss & Corbin, 1998) research, this study sought to explore an unexamined area of the literature and possibly formulate a new theory. While the current study did not go as far as proposing a theory, it did lay the groundwork for further research in the area which may lead to a proposed theory.

Many of the typical limitations of qualitative research apply to the current study. There was a small sample, which was intentional and designed to meet the needs of the current project. As with all qualitative studies, the assumption should be made in this type of research that the goal is not generalizability of results, rather, depth of information about a targeted population on a relatively unknown topic (Strauss & Corbin, 1998). There were other sampling limitations. While there was quite a bit of gender diversity in the current sample, there was little other diversity. This limitation, however, was representative of the geographical areas studied.

Also, the assumption is made that a self-selecting sample bias probably resulted in limited results. The clergy who agreed to participate were probably the ones who already favored collaboration with psychology; therefore, the results reflect that bias. If the researcher had been able to reach and interview clergy who were even more traditional and located deeper in rural areas, the results might have reflected more ambivalence about working with psychology.

It is important to note that there was one significant technical difficulty with the interview process. During one interview, the digital recording device malfunctioned, leaving us without an audio recording of that interview. The researcher and participant decided to simply redo the interview and rescheduled to come back in a couple of weeks to record the entire interview

again. Repeating the interview may have given the participant time to reconsider his responses and thus changed his data. However, the content of the second interview seemed very similar to the first one.

In order to pursue the development of an integrated theory of effective collaboration between rural religious leaders and mental health professionals, future research could seek to discover how widely clergy hold the same opinions of collaboration as the current study's participants and how similar their experiences with collaboration have been. It might be helpful to narrow down some of the topics uncovered in the current study and find those that are most relevant to collaboration between the two fields. This would probably require a more detailed and targeted survey of a broader range of rural religious leaders after building survey questions based on the themes discovered in this current study.

A follow-up study should reach out to smaller, more rural, congregational and independent churches, in addition to the larger national mainstream churches whose religious leaders chose to participate in this study. This would allow another perspective and represent a larger segment of the rural religious leaders who were not included in this study. Furthermore, attempts could be made to apply the current study to other small communities. It would be interesting to see if similar findings result from studies of other cultural minorities, such as racial, ethnic, or sexual minorities. It seems important to investigate how psychology could collaborate with cultural groups representing racial or sexual minorities to improve service provision in a similar manner to that explored in the current study with religious clients.

While the current study had some characteristics and a flavor similar to participatory action research (PAR), it failed to fully reach the level of PAR in some important ways. It did not include the religious leaders themselves in the development and carrying out of the research

project. It did not join itself with the community stakeholders to create an advisory board that designed and oversaw the completion of the research together. It seems that one of the best and most empowering ways to make this line of research meaningful going forward is to take it to the community, join with stakeholders and participants in the way described above and in a way more consistent with PAR to actually improve collaboration simultaneously to researching it (see Aten et al, 2011).

Conclusions

The existing literature indicates that spirituality and religion are important to the general population, that religion and spirituality generally have a positive impact on mental health, that rural areas have higher rates of religiosity with less mental health resources, and that collaboration between religion and psychology could be one way to address that problem. The current qualitative study explored the needs and preferences of rural religious leaders about forming collaborative relationships with mental health professionals in order to better care for their congregations and the people served by both professions.

Exploration took the form of in-depth interviews with rural religious leaders to discuss possible issues from their perspective. Interviews were audio recorded and transcribed to allow for coding and analysis, following a grounded theory methodology (Strauss & Corbin, 1998). Results of the data analysis indicated that rural religious leaders who chose to participate in this study recognized mental health needs, desired increased collaboration, in many cases already engaged in some form of basic collaboration, and had a lot of good ideas about how to move forward with collaboration between religion and psychology.

In conclusion, I offer some recommendations for the application of this research. I encourage that, first and foremost, we reject the idea that psychology and religion are

incompatible. This is a self-imposed limitation on both professions that hinders our ability to help people in need. To paraphrase one participant of the current study, it will require investment and effort, but it will help us on both sides of this gap and will bless the individuals we both serve with better mental health and increased life satisfaction.

Furthermore, I propose that we, as mental health professionals, take the first step toward this collaborative effort. We have been trained to work within social systems and institutions, and we should put that training to use in working with our frontline referral sources and social support assets, including the community clergy and churches. We can begin by simply finding the contact information for our county pastoral association and making a brief phone call to ask if we could attend one of the upcoming meetings. The results of this study indicate that we will be welcomed in that outreach. Finally, the existing literature and this current study suggest that as we work closer with the clergy in our communities, we will have greater success in our professional services.

Chapter 2: Literature Review

In this chapter I review the literature relevant to the topic of collaboration between religious leaders and psychology and set the stage for the current study. I begin by providing background from the literature to define spirituality and religion. Then, I discuss the relationship between psychology and religion. I explore the application of this topic to rural areas and how it may be tied to rural mental health. I provide information on some of the relevant theories and models proposed in the literature. I include a review of examples of collaboration between religious leaders and psychology. Finally, I conclude this chapter with rationale for the current study and my research questions.

Spirituality and Religion

The terms spirituality and religion historically have been used interchangeably, but recently there has been a trend toward separating them or making distinctions in the way each is defined. Hill and Pargament (2003) explained, however, that spirituality and religion represent related rather than independent concepts. They both involve what Pargament (1997) described as a search for significance in ways related to the sacred (Russell & Yarhouse, 2006).

Spirituality has been broadly defined as the subjective experience of searching for and nourishing relationships with the divine (Kashdan & Nezlek, 2012). It also has been described as the feelings, thoughts, and behaviors that arise from a search for that which is associated with divinity (Hill & Pargament, 2003).

According to William James (1902/1997), religion encompasses experiential spirituality as well as inherited tradition. Religion can be thought of as the organized rule systems, rituals, and worship associated with spirituality (Larson, Swyers, & McCullough, 1997).

For the purposes of the current study, spirituality and religion will be considered separate but related concepts, following the current trend in this field of study. Therefore, spirituality is herein defined as the search for divine significance and religion is defined as experiential spirituality in an organized system with rules and rituals for worship.

The questions then arise, how common is this search for divine significance? Further, how common is this participation in systems of organized experiential spirituality?

Prevalence of spirituality/religion. Results of a 2011 Gallup poll showed that 92% of people surveyed reported a belief in God, a percentage that has remained rather steady for decades (Newport, 2011). Belief in God is a major component and manifestation of spirituality. Research has shown that 90% of the world population report being religious or spiritual (Walsh, 2011).

Considering religious practice, another recent Gallup poll indicated that 69% of people surveyed reported being either very or moderately religious (Newport, 2012). In the United States 140,000,000 (50.2%) belong to one of 260,000 religious congregations in 149 different denominations found in practically every community (Milstein et al., 2010).

There are 500,000 churches, temples, and mosques. About four out of 10 people report attending a religious service weekly, six out of 10 attend monthly, and nine out of 10 pray at least occasionally (Moran et al., 2005).

Benefits of spirituality/religion. Research has shown many positive health outcomes associated with spirituality and religiosity (Newport et al., 2010). In a large meta-analysis, Koenig and his colleagues concluded that religious beliefs and practices were consistently positively correlated with health outcomes (Koenig et al., 2001). Physical health benefits include reduced hypertension and nonspecific mortality rates. Weekly religious observers were found to

live an average of seven years longer than the general population. Mediating and contributory factors may include service to others, social support, and meditation or relaxation (Walsh, 2011).

However, it should be noted that health outcomes may be dependent on the type of beliefs or spirituality, and that religion can produce positive and/or negative consequences. A benevolent appraisal of God was associated with lower depression scores; whereas, a punishing view of God was associated with higher depression scores (Koenig et al., 1998). Religiosity has been found to produce positive outcomes when it centers on love and forgiveness, but negative outcomes when it centers on punishment and guilt (Walsh, 2011).

Spiritual/religious coping. Spiritual and religious practices can provide a significant means of coping with stress and illness (Newport et al., 2010). Features that are commonly found in religious communities and practices can serve as helpful coping tools, such as prayer and meditation, social support, material resources, opportunities to engage in volunteer service to others, and many others (Walsh, 2011).

Spirituality and religion also can provide an understanding of deep existential issues. Mental health benefits include enhanced relational and marital well-being, reduced anxiety, reduced depression, and lower rates of substance abuse and suicide (Walsh, 2011).

Rural spirituality/religiosity. One place where spirituality and religiosity seem especially important is in the rural community. Because the majority of past research on rural religious issues focuses on Christianity and it is the predominant religion in the rural United States, this review will focus on Christianity. A central part of the culture in these rural communities tends to be a reliance on faith and religion, with a strong connection to religious communities forming a network for most rural people (Arcury et al., 2000).

Rural residents are more likely than urban residents to claim a religion, attend church services, and say that religion is important to them (Fischer, 1982; Campbell et al., 2002). Given the importance of religion to rural communities, it is essential to understand these religious beliefs to understand rural culture.

Religion and spirituality are strong resources in many rural American communities. This strength characterizes several regions of the United States including Appalachia, the South, the Midwest, and the Mountain West, among others (Campbell et al., 2002).

Krause (1997) also noted the significance of faith for older adults. Recent national polls have verified that faith and religion are of greater importance to older adults than other demographic groups, as has been the case historically (Newport, 2012). Given that religion is more important to older adults, and they represent a significant portion of the population in rural communities, the relationship between rurality and religiosity seems even stronger.

A Rural Issue

Rural settings have been described by different typologies such as; overall population size of a community or county, population density of a geographic area, measures of adjacency to a metropolitan area, measures of urbanization, commuting and employment patterns, and economic and socio-demographic characteristics (Keller, Murray, & Hargrove, 1983; Schank & Skovholt, 2006).

The U.S. Census (2010) currently labels as rural an area with open countryside or with a population density of 2,500 or fewer habitants. Rural areas represent approximately 80% of the land in the United States and 20% of the population (Werth et al., 2010).

Rural mental health. The mental health situation in rural areas is bleak. About 55% of the 3,075 counties in the U.S. have no practicing psychologists, psychiatrists, or social workers,

and all of these are rural counties (Campbell et al., 2002). A significant lack of outpatient and inpatient psychiatric services exists in rural areas as well. Only 1% of non-metropolitan counties have inpatient psychiatric units (Fox et al., 1995). Coupled with this significant lack of mental health resources in rural areas, there also appear to be a number of characteristics and attitudes that may put rural residents at higher risk of mental health problems.

Rural residents tend to avoid conflict and discussion of feelings, have limited tolerance for diversity, have high religious involvement, possess fatalistic and stoic attitudes, and are less likely to seek mental health services because of the stigma and lack of education about such services (Helbok, 2003; Werth et al., 2010).

Barriers to rural mental health. There are both internal and external barriers that prevent mental health treatment in rural communities. Campbell and colleagues (2002) discussed some of these barriers:

- One barrier is the distance to service providers. Even if mental health service providers are available, many rural residents would still have to travel great distances where public transportation does not exist. Furthermore, some families may not have access to vehicles or telephones to arrange transportation.
- Another barrier is the difficulty attracting and funding mental health providers and services in rural areas, although there have been attempts to entice and attract mental health service providers to these areas by federal programs that provide repayment of student loans and other benefits.
- In addition, it is less likely that rural residents have medical insurance and there is a lack of information about various entitlement programs.

- Other potential barriers are related to rural social norms and personal values or beliefs about health and illness. Some of these values and beliefs prevalent in rural communities include individualism, authoritarianism, self-reliance, and the belief that the community should care for its own.
- Finally, mental health problems are thought of as personal problems to stay within the confidentiality of family and church and are not to be shared with professionals who are not a part of the community.

Religious Multicultural Competence

Over 90% of psychologists report that religious issues are rarely, if ever, addressed in education and training (Shafranske, 1996; Shafranske & Maloney, 1990). Crook-Lyon and colleagues (2012), in their research on spirituality's place in the training of counselors and psychologists, found that most respondents supported the inclusion of spiritual and religious issues in graduate training. Most also agreed that religion and spirituality are multicultural issues, and were in favor of including religious and spiritual issues in existing multicultural training. These findings reflect the trend in the profession overall toward including religion and spirituality within ethical standards and multicultural guidelines (Smith & Richards, 2005).

Olson (2008) found that 81% of doctoral students in counseling psychology programs indicated that religion and spirituality should be integrated into multicultural coursework. In exploring how to integrate these issues into graduate training, Crook-Lyon and colleagues (2012) found that participants in their study were generally opposed to creating a separate course or practicum experience to accommodate spiritual and religious material, citing reasons such as time constraints. Considering these findings, it seems more practical and feasible to integrate

spiritual and religious issues into existing courses and existing practicum experiences, maybe exploring these issues specifically in supervision.

Supervision of spiritual/religious issues. Aten and Hernandez (2004) set out conceptual guidelines for developing supervisee competence in regard to working with religious clients and issues. They sought to identify supervisor actions that promote supervisee competence using the eight domains from Stoltenberg and Delworth's (1987) integrative developmental model as a template. These eight domains include intervention skills competence, assessment, interpersonal assessment, client conceptualization, individual and cultural differences, theoretical orientation, treatment goals and plans, and professional ethics.

Aten and Hernandez (2004) listed their six primary assumptions:

- Spirituality and religion can be a powerful source of therapeutic gain.
- If relevant to the clients' experience, spirituality and religion should be addressed in clinical supervision.
- Supervisors and supervisees should not assume a person holds certain beliefs simply because of the person's religious affiliation, but should gather information on all clients without making early assumptions based on religious stereotypes.
- Spirituality and religion are not always appropriate topics for psychotherapy.
- The mastery of therapist skills in a given area of cultural competence may vary as a function of the client population.
- Compared with other diversity issues, most supervisees will not be well prepared to address spirituality and religion given current training trends.

The authors' hope was that the conceptual nature of the ideas presented will encourage other supervisors to incorporate spirituality and religious beliefs as part of their own standard supervisory practices (Aten & Hernandez, 2004).

Collaboration between Religion and Psychology

Given the prevalence of religious practice, clergy often serve as the front-line resource for those who suffer from distress and mental illness. There are approximately 353,000 Jewish and Christian clergy in United States (Moran et al., 2005). Clergy are among the most trusted professionals in society. In the United States, four out of 10 mentally ill individuals seek help from clergy first. More than 10,000 clergy serve as chaplains in hospitals and healthcare institutions. Clergy already bring hope, ease difficulties, facilitate informal treatment, and refer people to formal treatment (Thomas, 2012).

The literature suggests that relying on existing community resources such as religious leaders would be an effective way to improve mental health in rural communities (Weaver et al., 2003). Many religiously-oriented clients prefer therapy that in some way includes their belief system. The vast majority of these clients also want religious values, practices, and themes to be addressed in therapy (Quackenbos et al., 1985).

Currently there appears to be little collaboration between religion and psychology. Some of the obstacles identified include a lack of trust on both sides, lack of awareness and education, lack of teamwork skills, and time restraints (McMinn et al., 2003; Thomas, 2012). Researchers have asked how much psychology knows about working with clergy.

After searching over 22,000 articles in APA journals, it was found that only four articles contained the word "clergy" in the title. Although this methodology seems limited in answering the question, they concluded that psychology knows little about the topic (McMinn et al., 2003).

However limited the knowledge that psychology possesses about clergy collaboration, there has been increased interest and research on this topic. Recently, some theories and models of effective collaboration with clergy have been proposed.

Theories and models of collaboration. Researchers suggest that there are certain principles of effective collaboration. Edwards and colleagues (1999) focused on developing relationships, having common goals, increasing effective communication, establishing trust, sharing respect, gaining expertise from the other side, having some common values, and increasing general awareness of spirituality.

McMinn and colleagues (2003) proposed basic and advanced competencies in collaborating with religious leaders. Basic activities include sharing respect and increasing effective communication. Advanced activities include increased spiritual awareness and finding shared values. Some examples of collaborative activities proposed by these researchers included consultation, referrals, workshops, direct services, assessment, community education, and academic. Whereas these collaborative activities are general and applicable to all theories and models, there are a few more specific models that have been quite well-developed.

Clergy Outreach and Professional Engagement (COPE) model. Milstein and colleagues (2008) developed the COPE model to improve continuity of mental health care. COPE provides a continuum of mental health care for persons of diverse religions, delineating boundaries between clinical care provided by mental health professionals and religious care provided by clergy, as well as pathways of collaboration across these boundaries (Milstein et al., 2010). COPE is a model that moves from the care already present in religious communities to professional clinical care, which works to returns the person back to the care of their religious communities.

The four parts of their model include recognizing the benefits of community membership, describing the spiritual and social support provided by religious communities in response to a person's life stressors, promoting professional clinical assessment and treatment for persons of diverse religions with serious emotional problems or mental disorders, and supporting the person's recovery through ongoing collaboration with her or his religious communities.

Clergy Academic and Mental Health Partnership (CAMP) model. Aten and colleagues (2012) developed the CAMP model in response to the Deep Water Horizon oil spill. It is collaborative in nature, based on the idea that more can be accomplished by joining with and learning from others. The researchers worked with other groups by leveraging complementary capabilities and expertise of community, faith, governmental and nongovernmental groups.

CAMP is a strengths-based model that seeks to recognize and harness the unique knowledge, resources, skills, and abilities that each community partner possesses. It also attempts to empower and strengthen preexisting community infrastructures, resources, and natural and professional helpers. The framework of the CAMP model includes:

- Establish a learning collaborative to help promote networking and training among diverse community leaders.
- Summits or conferences are developed that reflect the needs of the region and serve as an opportunity to reach large numbers of community professionals and expose attendees to a wide range of information and skills.
- Outreach activities, such as community-based presentations and media campaigns, are used to help raise awareness about needs and possible resources available for help.

- Targeted trainings for religious and mental health professionals are used to provide an in-depth focus on a particular topic, skill, or research.
- Direct clinical services that will provide access to mental health care for vulnerable and underserved populations.
- Care for caregivers to prevent burnout and turnover among helping professionals and clergy.
- Finally, identify community needs, interventions, barriers to and strategies for collaboration.

The authors recommended forming an advisory board with working groups that include religious leaders, mental health professionals, and other community personnel for implementing the CAMP model. They emphasized the importance of developing clear missions, goals, and tasks such as addressing emotional and spiritual needs. They outlined a comprehensive plan for accomplishing the objectives of the CAMP model, including instructions to plan summits and self-care retreats for mental health providers and clergy. They recommended community presentations, media outreach, and direct services (Aten et al., 2012).

Healthy Body Healthy Spirit. One specific example of collaboration between psychology and religion was found in the Healthy Body Healthy Spirit trial. This was a wellness promotion intervention that sought to increase fruit and vegetable consumption and physical activity delivered through Black churches.

The multicultural literature tells us that African Americans rely heavily on their pastors for many of their needs, often seeking advice about health and mental health issues from them before any other source. African American clergy have been found to act in a "gatekeeper" role when it comes to the health and mental health of their communities. Often African Americans

will seek the advice of their pastor and solicit a referral to an appropriate provider, thus giving their pastor this power and influence as a "gatekeeper" (Blank et al., 2002; Mattis et al., 2007).

In this study, 16 Black churches were randomly assigned to three intervention conditions. Group one received standard educational materials, group two received culturally targeted self-help nutrition and materials about physical activity, and group three received the same intervention as group two as well as four telephone counseling calls based on motivational interviewing delivered over the course of one year. At one-year follow-up, groups two and three showed significant changes in both their intake of fruit and vegetables and physical activity. Furthermore, changes were significantly greater for the motivational interviewing group (Resnicow et al., 2005). The most relevant and important implication of this study to the current topic is that it provides an excellent illustration of how psychologists can effectively collaborate with religious communities to reach people who may not otherwise be accessible. Although there appear to be relatively few examples of collaboration between psychologists and religious leaders, it is important to closely examine the examples that are present.

Extended examples of collaboration. Following Hurricane Katrina, researchers sought to meet the mental health demands of the area by collaborating with local clergy. Aten and colleagues (2011) discussed the vast devastation caused by hurricane Katrina to the area of southern Mississippi. They explored the importance of clergy, especially in African American communities, in dealing with the mental health issues that arise from these types of crises and disasters. They explained that African American clergy can be a valuable asset in addressing minority health disparities and disseminating medical and mental health information to their communities, especially during a time of crisis.

To accomplish their purposes, the researchers used a participatory action research approach, a type of research that focuses on the betterment of the communities studied. In this methodology, researchers often immerse themselves in the community and collaborate with it in order to better address the specific needs identified by the members of the community.

The research questions addressed in this study were: what are the disaster mental health training needs of African American clergy and churches affected by Hurricane Katrina? How can mental health professionals deliver training to African American clergy and churches affected by Hurricane Katrina that will help address minority mental health needs?

The authors conducted qualitative interviews with 41 African American clergy one year after Hurricane Katrina in severely affected areas of southern Mississippi. The purpose of the interviews was to gather information from these community leaders about more effective collaboration in order to meet the health and mental health needs of their communities.

Based on their analysis of the clergy interview data, the authors proposed a three-tier training model for collaborating with African American clergy and churches. In tier one, researchers train the clergy and church membership in disaster mental health issues. In tier two, researchers collaborate with clergy to train the congregations in disaster mental health. Tier three involves clergy and congregation members reaching out to the rest of the community to disseminate information on disaster mental health.

This study suggests that religious and spiritual responses, as well as collaboration between clergy and mental health professionals, may be beneficial in helping to buffer negative psychological reactions. It is important to note that what helped was not how religious or spiritual one was, but rather, how one utilized religion or spirituality after devastation (Aten et al., 2011).

Conclusion and Research Questions

According to the literature presented here, it is clear that collaboration between religious leaders and psychology is important. Although important, the process of collaborating with religious leaders can be complicated and complex. Spirituality and religion are related to mental health, usually in a positive way. Religion is a common characteristic of rural communities where mental health services are lacking. Because spirituality and religion are important in rural areas, and due to the positive relationship between spirituality/religion and mental health, the field of psychology should collaborate with religious leaders to meet rural mental health needs.

Based on this review of the literature, there appears to be sufficient information on spirituality and religion in general, as well as information and examples of collaboration between religion and psychology. However, there seems to be a lack of information from the religious leaders' perspective on their preferences and needs in such a collaboration. Therefore, the purpose of the current study was to seek information to fill that gap in the knowledge on the topic. My intent was to explore the preferences and needs of religious leaders in collaboration with the field of psychology. My research questions were:

1. What collaboration, if any, has the religious leader engaged in with area mental health professionals in the past?
2. What types of collaborative activities would the religious leader prefer to engage in with mental health professionals in the future?
3. What barriers does the religious leader predict in their collaborative efforts, and how would they hope to overcome those barriers?

Chapter 3: Methods

In order to begin answering these questions, I designed and developed a qualitative study that utilized data from the sample of interest to formulate a theory of effective collaboration between psychology and religion. In this chapter I provide a detailed description of the methods I used to perform this study. I begin with an overview of the study. I provide information on the participants and how they were selected and recruited. I then describe the instruments used in the study and the procedures that were followed. Finally, I explain the data analysis process, including a discussion of trustworthiness and the coding procedure.

Design Rationale

My overall research design follows a grounded theory methodology (Glaser & Strauss, 1967). I chose this design for a number of reasons. It is one of the most common designs in the qualitative literature within the field of counseling psychology (Ponterotto, 2005) and is at the forefront of qualitative research generally (Charmaz, 2000; McLeod, 2001). It is exploratory in nature and provides a richness of information that is well-suited for a topic about which there may be a lack of knowledge (Strauss & Corbin, 1990). It has also been found to be useful in bridging the gap between theory and practice (Fassinger, 2005), an important component of this research study in particular.

Perhaps the most important rationale for using grounded theory methodology is that the central idea of this design is to construct an overarching theory that comes from and is based on the lived experiences of people participating in the study (Strauss & Corbin, 1990; Fassinger, 2005; Creswell, 2007). My intent was that this study would allow me to construct such a theory for effective collaboration between psychology and religion.

Participants

Participants were recruited based on specific inclusion criteria. The first criterion is that the participant be serving in the capacity of a religious leader for an established church community. Because the literature indicates that it is a common practice in this type of research, especially in rural areas, the participant pool will be limited to Christian religious leaders.

Another inclusion criterion is that the religious leader be serving a church congregation in a rural or mixed rural community, as defined by Isserman (2005). Qualifying counties include those in which the county's population density is less than 500 people/square mile and a minimum of 90% of the county population is in a rural area, and the county has no urban area with a population of 10,000 or more.

Participants were identified first through purposeful sampling, followed by snowball sampling. Purposeful sampling was used to identify and recruit "information-rich" participants. Patton (2002) stated that, "Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling" (p. 46).

I anticipated a higher likelihood of finding information-rich cases in religious leaders who had an established relationship with professionals in higher education or even mental health. Therefore, the researcher utilized relationships with colleagues who may have personal and professional networks with religious leaders in rural areas to recruit participants.

Once information-rich participants were identified and recruited through purposeful sampling, I utilized snowball sampling to identify additional participants who were similar in the richness and depth of their experience with the topic of study. I believed that once I was able to complete interviews with information-rich participants and they had shared their experiences for the study, they would be willing to refer their like-minded colleagues to me as additional

participants. This strategy was successful. Thus, snowball sampling was a way to locate additional information-rich participants in a convenient and more certain manner.

Typically, qualitative research does not specify a certain minimum or maximum number of participants (Patton, 2002). Specifically in grounded theory, the goal in terms of number of participants or amount of data collected is what we call saturation. This occurs when new participants are no longer providing information that contributes to new themes, or when new data simply repeats data already collected (Strauss & Corbin, 1998).

Saturation of themes typically occurs within eight to 15 interviews (Morrow & Smith, 2000). However, it is possible that data may not become saturated after 20 or more participants. Therefore, given the necessity of completing the project, I planned ahead to conduct a maximum of eight interviews. In this study, data was saturated after the planned eight interviews.

All eight participants were living and working in a community classified as rural. Participants ranged in age from 30 to 72 years old. Three participants were female and five were male with all participants identifying as Caucasian or White. All participants worked as professional clergy for an established church. Participants' highest level of formal education ranged from high school diploma to doctoral degree. Five participants reported receiving a bachelor's degree or higher; and of the other three, two reported some college. All had completed formal religious education and certification. Participants reported their number of years working in the ministry, ranging from 1.5 to 43 years, (157.5) with an average of approximately 20 years. They also reported estimates of their congregation attendance, ranging from 20 to 200 attendees, (810) with an average size of approximately 101 active attendees. See Table 1 for a summary of participant demographics.

Instruments

Demographic information form. I prepared a demographic questionnaire to gather information, such as age, sex, ethnicity, years in ministry, educational level, and congregation size. I completed this form with participants prior to beginning the informed consent procedure. This information was used to ensure that participants met the inclusion criteria and to provide a basic description in this paper of the study participants.

Semi-structured interview. I developed a semi-structured interview based on information and guidance from existing literature, my own observations and experiences as a rural mental health professional and religious leader, and consultation with other mental health professionals and religious leaders. After creating and editing the semi-structured interview guide, I shared the draft with my advisor and other professionals to obtain feedback. Based on this feedback, I made necessary changes to the final interview guide which was used in data collection. The basic outline was:

1. What has been your experience in the past with collaboration between your church and psychology or mental health? What has been good about those experiences? What has been bad about those experiences?
2. What, if any, collaboration of this nature do you currently enjoy in your work? If none, how would you explain the lack of collaboration? If so, what seems to be helpful to you in your work?
3. How would you describe ideal collaboration between your church and psychology or mental health? How likely would that be for you? What could be done on both sides to increase the likelihood?

My plan was to ask the first participant for feedback about the interview and to consult with my advisor to determine whether any changes to the interview should be made. If

significant changes needed to be made to the interview guide, then I would make those changes and the first interview would not be included in the final data analysis. In keeping with the plan, upon completing the first interview, I asked the participant for his reactions and thoughts. His feedback was positive and he could not identify any needed changes. Therefore, no changes were made to the interview process and his data was included in the final analysis.

Researcher as instrument. Within qualitative research, an important component of the process is the role of the researcher as an instrument for investigation (Fassinger, 2005; Morrow & Smith, 2000; Patton, 2002). Because the researcher creates the interview guide and interacts with the participant during the interview, giving prompts and asking follow-up questions, the researcher becomes an influential instrument in the process to shape the data. Even beyond data collection, the researcher interprets and analyzes the data, which provides other opportunities for researcher bias to influence the results. Because of this likelihood for bias, it is important for the researcher to be reflexive (Patton, 2002):

> Reflexivity reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voice as well as the perspective and voices of those one interviews and those to whom one reports. (p. 65)

To accomplish this purpose, Morrow (2005) provided some recommendations for researchers to follow in their attempts to remain reflexive. She suggested exploring the researcher's assumptions from his or her experience and from the literature. She also suggested exploring emotional involvement related to the area of investigation. And finally, she recommended monitoring the continuous impact on the researcher resulting from interactions with participants.

Based on Morrow's (2005) suggestion, I now provide a description of my personal experiences as they are relevant to the current study. I am a White male in my early 30's, currently married with four biological children. I was raised in a variety of places, ranging from rural to suburban, but feel more of a connection by preference and background to rural settings.

I come from a traditionally religious family. I have been active and involved in my religious denomination since childhood, and have been asked to serve in various leadership capacities within my religion. I served a two-year volunteer mission for my church in rural South America, during which time I obtained a significant appreciation for how faith communities can support rural areas that lack many resources that are abundant in more urban areas.

I returned from this experience to begin working on an undergraduate degree in psychology and Spanish from a university in rural Southwest Virginia. Upon completion of undergraduate studies, I earned a graduate degree in educational psychology and counselor education from a university in rural Central Tennessee. I worked as a Master's-level practitioner doing in-home family therapy in a rural area for a short time before returning to the university in Southwest Virginia to complete a doctoral degree.

Throughout my academic and professional life I have felt a significant divide between the worlds of academia and religion, which I have frequently found myself straddling. Especially in psychology, there has been a sense of antagonism, or at least misunderstanding toward religion. Similarly, I have found myself in an awkward position within my religious community, being confronted and feeling a need to defend psychology as a field from the religious world.

However, there have been occasions, albeit very few, in which I have experienced a mutually-beneficial relationship between religion and psychology. I have been privileged to see firsthand how helpful psychology can be to religious communities, and how religion can

complement the field of psychology. Therefore, I understand both the challenges and the potential benefits that can result from collaboration between religion and psychology.

Procedures

Prior to initiation of this study, approval was obtained from the Radford University Institutional Review Board (IRB). Once approved by the IRB, I began using the purposeful sampling methods described above to identify an initial sample. I mailed the potential participants a letter requesting their inclusion in the study. The letter outlined the purpose and the basic procedures involved. One week after sending the initial letter, I attempted to reach potential participants by telephone to follow up and discuss questions or concerns.

When a participant agreed to join the study, I sent them the informed consent form and made arrangements to meet in person to conduct the interview. The interviews were conducted in a location convenient to the participant. This location ideally was, in all cases except one, the participant's office or church. Alternatively, with one participant, a room was secured at Radford University to conduct the interview.

The semi-structured interview guide was used to conduct the interview with the first participant. After completion of this first interview, I solicited feedback and suggestions from the participant for future interviews. No feedback was provided, so the same interview guide was used going forward with other participants. I then used snowball sampling to recruit other potential participants for the study.

At the in-person meeting, prior to beginning an interview, I spent several minutes establishing rapport by introducing myself and discussing my background, and then reviewing the participants' demographic information. I thanked the participants for their willingness to be part of this study and provided them with a brief overview of the study procedures.

I then reviewed the informed consent form and gave them another opportunity to ask questions and withdraw. I informed the participants that they may contact me with any other questions following the interview. I clearly stated the purposes of the study, any potential risks and benefits, emphasized that their participation was voluntary and could be withdrawn at any time, and then proceeded with the interview.

I followed the semi-structured interview guide that had been prepared. Interviews lasted between 30 and 60 minutes. I audio-recorded, transcribed, and analyzed interview responses. After data analysis was complete, the results were shared with participants, who were asked to comment regarding the data's representation of their experiences.

Analyses

Grounded theory methodology uses a process called coding for data analysis. According to Fassinger (2005), grounded theory coding involves three stages: (a) open coding, (b) axial coding, and (c) selective coding. During each of these stages of coding, researchers should be engaged in a process of constant comparisons:

> comparing and relating subcategories to categories, comparing categories to new data, expanding the density and complexity of the categories by describing their properties (attributes of a category) and dimensions (ordering of the properties along a continuum), and exploring variations (e.g., disconfirming instances) in the data and reconceptualizing the categories and their relationships as necessary. (Fassinger, 2005, p. 160)

Coding allows researchers to make meaning by creating themes and categories out of narrative data from the transcribed interviews. The themes and categories are then used to create a theory, grounded in the data reported by the participants from their lived experiences (Fassinger, 2005).

Coding. Open coding, according to Strauss and Corbin (1998, p. 101), is the "analytic process through which concepts are identified and their properties and dimensions are discovered in data." Concepts are abstract representations of an action, object, or event within the data that is branded as significant by the researcher. Once concepts are given a label, they are analyzed for possible alternative meanings (Fassinger, 2005). Concepts are grouped together to form categories, which explain why the concept exists. As additional data are gathered, the various themes undergo any necessary modification or placement into new categories.

The second level of coding involves axial coding, which is "the process of relating categories to their subcategories, termed [axial] because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (Strauss & Corbin, 1998, p. 123). The main goal of this stage is to contemplate explanations as well as gain an understanding of the phenomena (Strauss & Corbin, 1998). Axial coding involves putting back together the pieces of information that were identified during open coding. The concepts identified through open coding are grouped into categories that are essentially the building blocks of the eventual theory (Strauss & Corbin, 1998).

The final stage of coding in grounded theory is selective coding. The goal of this level of coding is to create a substantive theory, when possible. The most relevant and important aspects of the data are integrated to create a central category. A central category is related to all other major categories, appears frequently in the data, is logically related to other categories, and is able to explain variation as well as the main point (Strauss & Corbin, 1998).

The researcher repeatedly refers to the original transcript data to ensure that the themes, key categories, and subcategories are accurately represented. The goal of this stage of coding is to identify and validate an emerging theory. Refinement of this theory occurs through "reviewing

the scheme for internal consistency and for gaps in logic, filling in poorly developed categories and trimming excess ones, and validating the scheme" (Strauss & Corbin, 1998, p. 156).

Upon completion of this stage of coding, if there are gaps in the theory, additional interviews may be performed to look for data which fills those gaps. However, because of the nature of this project, no more than eight interviews were performed regardless of gaps that appeared in the theory.

Trustworthiness. One of the major concerns with qualitative research is trustworthiness, as a result of the subjective and biased nature of this type of research. Trustworthiness in qualitative research can be considered equivalent to discussions of validity and reliability in quantitative methods (Morrow, 2005). Trustworthiness is demonstrated by providing evidence that the researcher has performed the study following the standard acceptable procedures for this type of research with as much validity and reliability as possible. Specifically, this is accomplished by having an established rationale for the study, a clear description of the data collection procedures and data analytic methods, and providing information on how the data were interpreted (Choudhuri, Glauser, & Peregoy, 2004).

I sought to increase trustworthiness by using an outside auditor. Fassinger (2005) described the process of auditing the data as "monitoring the overall process and product (usually substantive theory) of the inquiry to ensure that it has been conducted in adherence to acceptable procedures" (p. 163). I enlisted the help of an auditor who has extensive background and experience in grounded theory and who was involved in the data analysis process.

Another way of addressing trustworthiness is through memos. I maintained notes and records that included thoughts, questions, assumptions, insights, and interpretations that occurred to me during the research process, including reactions related to the interviews as they were

conducted (Fassinger, 2005; Strauss & Corbin, 1998). These memos can also be used to review the researcher's methods and process of data analysis, and thereby engender trust.

Finally, I sought to improve trustworthiness by following Strauss and Corbin's (1998) suggestion of providing participants with a copy of the analysis and soliciting their comments regarding its representation of their experience. Although results of the final analysis were not a perfect representation of each participant's experience because the analysis is a combination of all participants, the interviewees were still able to see it as a reasonable explanation of their perspectives on the topic.

According to the standards and generally accepted procedures outlined in the qualitative methodology literature, these measures should provide the reader with a sense of trust in the process used to obtain and analyze the data.

Operational Definitions

For the purposes of this study, the following terms were operationally defined to allow for consistent communication. Although the terms *religion* and *spirituality* were defined in more depth previously, I provide a reminder here. *Spirituality* was defined as our relating to the divine. *Religion* was organized spirituality. The term *clergy* is defined as religious leaders, regardless of denomination, including pastors, ministers, bishops, priests, and so on. The term *parishioner* is defined as recipients of any service provided by clergy, including official and unofficial members of a religion or church community, and visitors to the church, as well as any other person being served by the clergy. The term *psychology* is used to refer to professional mental health services or service providers, including the fields of psychology, counseling, social work, family therapy and so on. And the term *collaboration* is used to describe any activity that involves professionals working together in their complementary roles for a united purpose; in

this case, clergy and psychology working together to improve rural mental health.

Conclusion

The methods described in this chapter were followed in order to study the preferences and needs of rural religious leaders in their collaboration with mental health professionals. Although there is a significant body of research exploring and explaining factors related to effective collaboration between religion and psychology, there is a notable lack of qualitative research examining the collaboration preferences and needs of rural religious leaders from their own perspective, with little in-depth information on the subject from the religious side of this collaborative relationship. Therefore, I conducted the current study to fill this gap in the knowledge.

Chapter 4: Results

In this section I discuss the results of the research. The data analysis and results allowed several important themes describing the participants' views on collaboration between psychology and religion to emerge. Further, it was apparent that these themes, instead of being general ideas which developed over the course of entire interviews and across participants, followed the questions asked in a similar pattern for each participant. Therefore, the results are organized according to the questions that were asked of participants. The table below summarizes results.

Table 2. Results of Data Analysis

Interview Question, Thematic Category, or Theme	*Participant Represented in Theme*							
What is your ***past*** experience with psychology in your service to the church and in helping parishioners?	P1	P2	P3	P4	P5	P6	P7	P8
Clergy demonstrated ***awareness/assessment*** of psychological ***needs (P.Na, 7)***	xx	xx	xx		xx	xx	xx	xx
Clergy identified specific psychological ***needs*** encountered in work ***(P.Ns, 8)***	xx	xx	xx	xx	xx	xx	xx	xx
Clergy showed awareness of professional ***scope*** and limitations ***(P.Sc, 8)***	xx	xx	xx	xx	xx	xx	xx	xx
What is your ***current*** experience cooperating with professionals in the field of psychology in your work as clergy?	P1	P2	P3	P4	P5	P6	P7	P8
Clergy expressed a ***desire*** to ***collaborate*** with psychology ***(C.Dc, 5)***	xx			xx	xx	xx	xx	
Clergy described ***collaborative efforts*** to work with psychology ***(C.Ce, 7)***	xx	xx	xx		xx	xx	xx	xx
Clergy discussed issues related to the ***process*** of ***collaboration (C.Cp, 6)***	xx	xx	xx	xx			xx	xx
Clergy mentioned ***existing relationships*** with field of psychology ***(C.Er, 8)***	xx	xx	xx	xx	xx	xx	xx	xx
How would you describe an ***ideal*** situation where clergy and psychology cooperate or complement each other?	P1	P2	P3	P4	P5	P6	P7	P8
Clergy delineated professional ***responsibility*** to ***initiate*** collaboration ***(I.Ri, 4)***	xx				xx	xx	xx	
Clergy shared a ***specific idea*** for ideal collaboration with psychology ***(I.Si, 8)***	xx	xx	xx	xx	xx	xx	xx	xx
Clergy discussed using the local ***pastoral associations*** as ideal context ***(I.Pa, 4)***	xx			xx		xx		xx
Perceived obstacles or ***barriers*** which might prevent clergy and psychology working together (cross-cutting theme)	P1	P2	P3	P4	P5	P6	P7	P8
Clergy referenced ***rural issues*** interfering with psychology/collaboration ***(B.Ri, 5)***	xx	xx		xx	xx	xx		
Clergy discussed ***perceived distrust*** between psychology and religion ***(B.Pd, 6)***	xx	xx		xx	xx		xx	xx
Clergy identified ***lack*** of ***resource*** as barrier to psychology/collaboration ***(B.Lr, 7)***	xx	xx	xx	xx	xx	xx	xx	
Clergy recognized (or demonstrated) conserving ***status quo*** as barrier ***(B.Sq, 4)***	xx		xx				xx	xx

Themes were included in the final results if three or more of the eight participants endorsed the theme (i.e., if at least 37.5% of participants discussed content related to the theme). Quotations from interview transcripts are provided in order to give a more detailed account of participant experiences (e.g., P1 is participant 1) and to provide a thick description of the identified theme. In some cases where obvious subthemes emerged, I provided descriptions of them with quotes representing the subthemes.

The section headings are the questions I asked or the general ideas behind a series of questions. Within each section there is a brief summary of themes identified, followed by a breakdown of each theme, with subthemes if applicable, and quotations to illustrate the theme.

What is Your Past Experience with Psychology in Your Service to the Church and in Helping Parishioners?

In response to questions about past experiences of clergy working with psychology, participants provided responses that were classified into three themes: clergy identified specific psychological needs encountered in their work (8 participants), clergy showed awareness of professional scope and limitations (8), and clergy demonstrated awareness and/or assessment of psychological needs (7). All participants were able to articulate at least one past experience that was represented in these themes. Here is a more detailed description of these themes with several participant comments to illustrate the theme.

Clergy identified specific psychological needs encountered in their work. All clergy interviewed in this study discussed encountering and identifying some degree of mental health problems in their work. Most of the clergy were quick to cite a long list of psychological issues that they had dealt with, and were insightful in their ability to appropriately attribute problems their parishioners presented to them as mental health problems. One interviewee appeared to rely

on a more faith-based and less psychological perspective in viewing parishioner problems, but even he discussed issues representative of this theme.

One of the clergy with relatively more experience collaborating with psychology made the following statements which represent this general theme very succinctly:

> Depression, loss of loved ones, struggling with grief to a point where it becomes unhealthy and where moving past general stages of grief to non-functioning. There has been a suicide since I've been here… A small congregation but lots of stuff to deal with folks. I've had people struggle with sexual identity issues that they needed additional assistance in talking with someone. I had someone go through a gender change. Lots going on here. (P6)

Another clergy, a male in his mid-60s working full-time in his ministry, who had limited experience collaborating with psychology but was very interested in improving such collaborative efforts, commented on his process of identifying needs during religious services:

> I may have told you this story, but it was kinda funny, but she would bring her husband to church every Sunday and he would sit in the same place every Sunday, and when I first really became aware that something wasn't just exactly on the up and up, was he came up one Sunday, because we do communion by intention, and that's where we use the cup and give people a piece of bread and they dip it, well he came up, and he ate the bread and he took it and he took a drink out of the cup, and it embarrassed her, and she came and talked to me, and that's when she explained what was going on. (P7.

Clergy showed awareness of professional scope and limitations. The next theme that emerged in this category had to do with participants understanding their role as clergy and not mental health professionals and practicing their profession within the scope of their training. All

of the clergy, in one way or another, discussed their limitations in dealing with mental health issues, even though some of them reported having more training and experience with mental health and might feel more confident providing mental health care.

The following comment by a now seasoned clergy, who was probably the most psychology-savvy participant of all having had considerable experience collaborating with psychology, was representative of the attitudes of all clergy I interviewed. He said, "Um, yeah, it's in the early years of ministry I was just caught off guard, 'cause I was not prepared to deal with it, and you strive to do things, but you didn't know what to do" (P2). Later in the interview he discussed learning by experience or "hard knocks" (P2) to work with the established social systems to meet the various needs of parishioners which fall outside of his role as clergy.

Another clergy takes this theme a step further with her comments about seeking guidance from a friend in the mental health field to assess when a parishioner may be presenting an issue that falls outside her scope of expertise as clergy. She said:

> Or I could call my friend who was an LCSW and say here's the situation what should I do. It's more informal but it helps to have someone like my friend who has worked with all kinds, working from children to adults. If I described a situation she could say this person needs to be hospitalized or this person needs to work with this person and give me advice. I don't feel a need to try to handle it all myself. I am aware of my limitations. As a priest what am I able to do? In seminary we had classes on counseling theory and we did a lot of mental health, tried to recognize different types of mental health issues. For the sake of if we saw some of those symptoms of things we needed to be aware of, or those are some of those things that needed to be referred. We saw what was outside of our realm, pastoral care versus mental health. (P4)

Policy limiting clergy counseling to a limited number of sessions before referring to psychology. Many of the clergy went as far as discussing what seemed to be a semi-formal policy for parishioners who needed more than three to five visits with clergy to be referred to psychology. One such comment was made by a relatively young and new full-time professional clergy, stating:

> My second Sunday, was a gentlemen who approached me after church wanting some counseling assistance, marital strife. I did my very best; I met with him at a few different locations and a few times beyond that. I was sensing it was a little more than I could handle. I tried to refer him to the [church] down the road here, or the one in [a nearby town] that shares the same minister. They offer some sort of counseling program, and that's sort of the rule of thumb that I've come up with. If I need to meet with someone about something, other than pre-marital counseling or that sort of thing, I need to meet with them more than 3 times, I refer them to a professiona.l (P5)

Clergy demonstrated awareness/assessment of psychological needs. One of the eight clergy may have had a lack of information about the possible psychological needs that tend to exist in congregations in general, yet he did not appear dismissive of psychology. He said, “In this area we've never had any people with real problems that we know that's had mental issues. I know in [this] county there certainly are but not in my ministry that I can recall in neither one of the churches. We are blessed in that regard.” However, he continues in the same comment to identify marital issues as mental health problems that he had encountered. He continued:

> Nothing more than just sometimes the husbands or wives have some issues, usually if I meet with them, and I meet with both of them when I can… I haven't been trained professionally in that but you learn as you go along… Sometimes I guess the advantage I

do have is being around so long I pretty well know people's lives, more than somebody that just came a while from another community and stays a couple years and then leaves out. I pretty much know what's going on in their lives and families already and I kind of know how to deal with things like that… I do think it's important that a pastor knows the needs of his flock if they have mental health issues or not. (P8)

Though the level of their perceptions of mental health issues varied amongst them, the other seven clergy had a keen awareness of a multitude of psychological needs in their congregations and parishioners, as represented by this comment:

> When I was at the church in [nearby city], I was a pastor to a therapist and she was another person I would go to. She would put me in touch with the right person. There was a young woman who had an eating disorder and different things like that. Then there was another woman with Post Traumatic Stress Disorder, and then there's Bipolar, there's a lot. I'm grateful that there is help out there. (P3)

Several subthemes emerged within this theme of clergy awareness and assessing of psychological needs. A few participants discussed the idea that clergy awareness of needs depended on the level of a parishioner's involvement with the church. Similarly, participants explained that their awareness and assessment of needs depended on the frequency and intensity of crisis situations. Finally, it seemed that clergy perceived greater needs in the earlier parts of their careers.

Clergy awareness of mental health needs depends on the level of parishioner activity and involvement with clergy or church. One clergy comment illustrated this idea perfectly:

> You know, with one of them, one of them was pretty inactive, in fact, two of the three were, one was very active, one was very less-active, and one had just moved into our

> [church], um, she was a distant relative of [church] members here, um, kinda knew going into it that she had suicidal tendencies, and depressive type issues, self-mutilation, and, so kinda knew that she was coming into this [church] with a lot of struggles, I had met with her once, um, prior to her acting out, um, but yeah, not a lot… And then, with the one that was very less-active, I hadn't had any real interactions with her beforehand, um, and there the family wasn't surprised by it at all, um, I guess they kinda felt like she had been threatening and things like that a lot. (P1)

Clergy awareness of mental health needs depends on the level of severity, and increases when encountering parishioner crisis. Clergy explained that their awareness and assessment of psychological needs increased during and after encountering a crisis situation. One said, "And it depends on what the need is, there's times that the individual has such a severe inability to cope with what is going on that you need to go to a more assertive agency" (P2). Another clergy explained, "I guess I hadn't realized that it was to that degree [suicide attempt], so it was a little bit of a surprise to me, and the family felt like it was a surprise to them too, I don't think they really felt like they saw it coming" (P1).

Early career intensity but decreased after initial adjustment period. Multiple clergy mentioned that they perceived psychological needs to be greater during the initial parts of their careers. The following comment describes this perception; "It seems like in my time here those kinds of counseling conversations were kind of front-loaded. I ran into that when I first got here and then again a month or so later" (P5).

What is Your Current Experience Cooperating with Professionals in the Field of Psychology in Your Work as Clergy?

In response to questions about current experiences of clergy working with psychology,

participants provided responses that were classified into four themes: clergy expressed a desire to collaborate with psychology (5 participants), clergy described collaborative efforts to work with psychology (7), clergy discussed issues related to the process of collaboration (6), and clergy mentioned existing relationships with field of psychology (8). Here is a more detailed description of these themes with several participant comments to illustrate them.

Clergy expressed a desire to collaborate with psychology. All but one of the clergy voiced a desire to increase collaboration, whether they had been highly collaborative already or not up to this point. One said, "Okay, honestly, you know, working with healthcare professionals or psychology professionals, I haven't had a lot of interactions with, desiring to work with them, I have a lot of desire" (P1).

Confidentiality issues. Several clergy described their desires to collaborate with psychology despite confidentiality issues that might prevent that collaboration. One clergy mentioned that she took the opportunity to call providers of psychological services to inform them further about a shared service recipient, with the understanding that the psychological professional would not even confirm that the person was a client. She stated:

> I have had in the past, not at this church but I have had someone in the past that I was concerned and I was concerned that they weren't being forthright with their counselor and I just called and said I know you can't talk to me but, I just want to tell you some things that I have experienced and said would you be willing to listen, and they did. But I made it clear up front that I knew they couldn't tell me anything but I wanted to share some things I thought might be helpful with you treating this person. (P4)

Increasing desire. Some clergy talked about how their desire to collaborate with psychology was increasing for many reasons; they cited the current interview as a motivator.

One clergy is quoted as saying:

> And maybe I could be better at calling around and talking to some psychologist or whatever and finding out who is more willing to go down those lines. I haven't done that… and honestly again, maybe this is helping me seeing my own inaction… That I could probably be more diligent in maybe just getting out a phone book and saying who are my psychologists in the area. (P1)

Religious duties. The idea that collaboration with psychology could assist clergy in carrying out their religious duties more efficiently and effectively was evident in multiple interviews. This subtheme provided great insight into the burden that clergy bear in their frontline helper role. One clergy humbly explained:

> That I see that as a golden opportunity to reach out and really be helpful, not only are you helping individuals, you're probably helping out these poor pastors and ministers a lot, that find themselves in situations similar to mine, where… you know, if you're freeing up, if you're a psychologist or psychiatrist, helping the more difficult situations, you're also freeing up those pastors and ministers to help the less serious situations, and help more of them, and get them, or keep them in better situations. Whether it be with suicide or marriage situations, or depression or bipolar, you know, whatever it may be. (P1)

Clergy described collaborative efforts to work with psychology. A theme emerged in which clergy discussed various aspects of their current collaborative efforts. One experienced older female clergy wisely highlighted that collaboration truly takes effort, saying, "Do you think because in a rural area, maybe you have to be invested to know the resources? It doesn't all just come to you; you really have to work at the relationship. If you can do that and get help for your parishioners, your members, your flock, it's a blessing" (P3).

Collaborative efforts lacking. Even though one clergy was less involved in efforts to collaborate than the others, all participants, to some degree, discussed a similar lack of collaboration; this was illustrated by the following comment:

> Not really. Most of the times I just send people or refer people to them. It's just in their ball park so to speak, of course if they decide they want to come back later and speak to me they will. I really don't try to cross paths with those professionals because they do their thing and they could probably care less about what we do as pastors. Some of them probably are Christians and some of them probably aren't. (P8)

Collaborating with community. Most clergy commented about collaborating with various community agencies, organizations, or resources. One said:

> There are wonderful things like that. I try to make people aware of the things that [the community] offers. Now they have the brown bag lunches. I just got that email and I just thought I want people to be aware of those things. I want everyone to go to those things and we can all learn and grow. I also wanted something that dealt with Post Traumatic Stress Disorder because not only do I have veterans but I have other people from life experiences that have been traumatic and are dealing with that. There are resources that are out there I'd like to make people aware of. One thing we are really wanting to do in this church is to maybe offer a place of hospitality for families of loved ones who are dealing with addictions. I think there's a real need for that. I need to explore that further and see who could come. (P3)

Collaborating with hospitals. Several clergy mentioned collaborating with hospitals, both medical and psychiatric, in various capacities. One clergy provided a very creative and interesting way for crisis, legal, and hospital systems to collaborate with clergy:

> The two big places that we took people, you know, often it was involuntary committal because of situations, the hygiene judge would make the declaration and sheriff's department would make the call and say "hey would you go with us 'cause they'll settle down in the back seat" so there was that kind of indirect, kinda chaperoning to a facility, that we had a lot. (P2)

Collaborating directly with providers. Many clergy shared how they had formed relationships with providers of psychological services, either as members of their congregations or had, outside the church, forged personal and professional friendships. However, one clergy sought a formal partnership with a nearby psychological group practice. This clergy describes the partnership this way:

> We have a partnership with an organization called [private practice therapy group]. We signed up many years ago because I was very concerned as a brand new minister… So right out of the gate I put in place, I researched it, I got online to see partnerships and [therapy group], and you know you're familiar with them. There are groups, you know in [nearby city], in [nearby town], all over, and then our church pays for anyone who needs to go see them… they are willing to partner with churches, that they are willing to allow a deep discount. It is $50 a session. That partnership, if you sign up for that, they have a form for that and its $50 a session. (P6)

Clergy discussed issues related to the process of collaboration. Another theme emerged when discussing clergy's current experiences in working with the field of psychology. This theme concerned the process of collaboration between religion and psychology.

Mutual respect. Whereas most of the clergy explicitly emphasized the importance of fostering mutual respect between religion and psychology, all of them, at least implicitly,

endorsed this concept. One clergy stated:

> With these two fields you have to have respect, mutually. Clergy have a bad habit of thinking they have to be everything to everybody, thinking they have all the answers and it's just dumb. You spent a lot of money and a lot of time to get to where you are. I'm not going to sit here and pretend to know what you have, to be an expert in your field, but I guess it's an ego issue, a pride issue. You know well I can take care of this so it's a break down on the clergy side. Now on the mental health professional side, there's not mutual respect to the person that can help them to the clients. (P2)

Another experienced clergy elaborated on that idea when she made the following comment, which seemed to help define mutual respect:

> I really have been blessed because I've had some wonderful people to work with. I feel valued as a religious leader and not like "oh you possibly can't know anything". It really has been a wonderful give and take. I'm sure that that's not always the case, maybe I'm just fortunate with people I know, that helps. The ideal is that there is genuine regard and respect for our individual backgrounds and understandings and our concern for those that are struggling with mental health issues. They aren't just a label, a person, a Child of God that needs to be treated with love and respect. (P3)

Referral in the collaborative process. An older male clergy who had worked hard to establish an informal relationship with a nearby mental health professional to whom he had been making frequent referrals for years described his referral process in great detail:

> The people that I have referred to her, or have readily gone to her, and have, and like I said, she will, I will call her and say, hey I've got someone I'd like for you to see, and of course, she and I both know that she won't take them as far as me referring them, I mean,

> that helps, but they have to call and make the appointment, I can't call and make an appointment with her for them… calling her up and saying, can you take them, and, that does give them a direct in, because she knows, I'll give them her name, give her their name, and they will then, then they have to call, and by them calling that means, it lets her know, number one, I'm not pushing them to her, they're willing to come and make their own appointment, and of course I get tickled, she will not call and tell me, or we're not, if I ever talk to her, she won't say, well, hey, old so-and-so that you sent to me, came and saw me, but they, people that I refer inevitably will come and tell me that, hey, we went and saw that lady you asked to go to, and things are really going good. (P7)

The role of clergy mental health training in the process. Some of the clergy discussed current experiences with training, and most discussed the hypothetical benefit of training. One of the clergy who currently enjoys regular mental health training stated, "women who have been abused by families, I just think that's another issue too that I have gone for training there. Some of the things like abuse, which was elder abuse… I'm always grateful for the trainings." (P3).

Clergy mentioned existing relationships with psychology professionals. A final theme that emerged in the category of current experiences working with the field of psychology was developing and using existing relationship with professionals in the field of psychology. There were two subthemes within this theme, informal and formal relationships. All clergy endorsed this theme.

Informal relationship with mental health professionals. Comments like the one that follows were very representative of the shared experiences of these clergy:

> Most of my education, I had some from courses as a teacher and then I got a lot in seminary and then I got a lot from my friend. When she got her bachelor's in psych and

then got her master's in social work and then went through the whole process of becoming an LCSW I learned a lot watching her going through the whole process and learning what the difference is, seeing her. When she worked for a community services board and see the hurdles she had to jump through just trying to get her clients the help they needed. I learned a lot from just watching her job. There's a lot of priests out there that don't have a friend that they watched do all that so they might not even know the differences. I didn't before I knew her. (P4)

***Formal relationship with mental health professionals*.** Some clergy had taken this collaborative process a step further by establishing a formal relationship with psychology to meet the mental health needs of parishioners. Comments like the one that follows shed light on clergy's experiences with formal relationships, especially official church mental health programs:

> I guess I really turned to the [official church organization] a lot, and kinda talked to them about, you know, what options we have as far as [church] family services, and things like that. I guess my impression of that is that it is very limited, really. You know, in bigger cities we have access to [church] family services, trained professionals that are trained to combine [church] beliefs with psychology, but here, I don't. (P1)

How Would You Describe an Ideal Situation Where Clergy and Psychology Cooperate or Complement Each Other?

In response to questions about the clergy's perception of an ideal collaborative situation, participants provided responses that were classified into three themes: clergy delineated professional responsibility to initiate collaboration (4 participants), clergy shared a specific idea for an ideal collaboration with psychology (8), and clergy discussed using the local pastoral

associations as an ideal context (4). Here is a more detailed description of these themes with several participant comments to illustrate them.

Clergy delineated professional responsibility to initiate collaboration. Clergy participants attempted to clarify, in many cases, where the responsibility to initiate collaboration rested. Some believed it should be equally shared between religion and psychology. Others, however, seemed to either explicitly or implicitly place the responsibility to initiate collaboration with either psychology or religion.

Equally shared responsibility. One clergy made a comment that represented the other clergy comments about sharing responsibility for initiating collaboration:

> I guess I've probably more turned it back to the families and let them do their own research and finding and things like that, but probably as a religious leader, there's probably a place for me to feel out who's out there, and, maybe it's on the shoulders of the health providers as well, to kind of have a meeting in the middle type thing. (P1)

Another clergy elaborated on this concept of shared responsibility and working together to initiate collaboration:

> But in realizing that the change in a rural area to mental health and in the church to look at it as a long running process, not a product that is going to happen. But if we can look at it as a process and that we are changing this huge ship that's been going one direction when it goes out, it makes a wide turn to go another direction and I think that's what we've got to do. Whether it's faith based or mental health or combined effort, it's a slow gradual redirect in people's lives. (P2)

Psychology has responsibility. Some clergy shared sentiments that the responsibility to initiate collaboration rests more with psychology. One stated:

> Somehow open up the lines of communication. I mean, you know, communication solves a lot of things… We actually had a lady come from… [nearby town], and she's involved with a group that's called [home health and hospice] group… And they actually came up and sat and talked with us and told us what they could do as far as helping… And I actually in talking with the lady, I talked with her quite extensively, and I've actually got a couple that I'm going to probably introduce her to… But somehow or another, maybe something like that… someone to come out and say, hey, you know, I'm not trying to dig up business but this is what we do, this is how we do it. (P7)

Clergy has responsibility. Other clergy seemed to accept some responsibility for initiating collaboration. They made comments like this one:

> Yeah, yeah, so, again, there's probably both ways, I kinda mentioned the mental health professional reaching out to the pastoral association. The opposite could take place too. The pastoral association reaching out to psychiatrists, and saying, hey, why don't you come speak to us, and… giving us some counsel on how we deal with some of these issues, as they arise in our congregations. Me, as an individual leader of a congregation, I could reach out to individual practitioners and educate myself more and get to know, you know, if I want to achieve this situation where I know someone, then I'm just as able as they are to reach out and get to know them and develop a relationship there. (P1)

Clergy shared a specific idea for ideal collaboration with psychology. Another theme that emerged in the interviews when discussing ideal situations was that clergy had specific ideas for collaboration. This was different from previous themes which captured collaborative efforts because it represented clergy's specific ideas or requests from a hypothetical or ideal perspective. This theme fell into two subthemes, specific ideas about clergy training by mental health and the

assembly or creation of a useful resource manual or referral list.

Specific idea for training. All clergy shared at least one specific idea for collaboration, most of which also had at least one comment which fell into the subtheme of training. This comment illustrates their ideas about training:

> Or if there is some kind of special session they are offering, maybe on grief, or some kind of workshop they are offering. It would be helpful, I don't know if counseling organizations in this area would collaborate, do some kind of workshops, some for clergy, some for folks that, for instance what we are doing. On the 21st we are having a service for anyone that is missing a loved one. It's one of those longest nights services. We've had several losses here in the church and we thought we'd open it up to the community. Things that are addressing particular issues that we are seeing a lot of and we could say okay, such and such organization is sponsoring this forum or this session to give you more information. (P6)

Specific idea for resource and referral lists. Most clergy shared the specific idea that resource and referral lists would be ideal ways to collaborate with psychology. One clergy said, "but I also think a resource, I don't know when this was last updated but, [a resource manual], to have these things updated" (P3). Another clergy comment supported this idea:

> I don't know how it would work but I think it would be great if there was somebody, you know how with insurance companies they have a 24 hour nurse that you could call and say this is what's going on, tell me what I should do. You don't want someone who is going to say you need to get them to the ER because you don't want somebody whose goal is to cover their own butt because the answer then is always take them to the hospital or call 911. But we want somebody you could call and say this is the situation, can you

> give me some suggestions or some resources in this area. Are there psychologists or therapists or psychiatrists that you could give me a list of referrals? To give advice that has some connection with the mental health providers in this area that may be providers that specialize in marriage counseling or teenagers, or children or older adults and if there was some kind of resources that could provide that information. (P4)

Clergy discussed using the local pastoral associations as an ideal context. One of the most promising and universally-shared specific ideas for ideal collaboration came in the form of the clergy suggestions that collaboration begin with the pastoral associations in each local community. A pastoral association is a monthly meeting of participating pastors in a geographical area, usually a county, to discuss pertinent issues. Many clergy brought this up, and all would have probably endorsed the idea if it had been presented to them first.

The following comment by one of the clergy, even the most traditional and seemingly least interested in collaborating with psychology of all eight clergy interviewed, illustrated the opportunity that exists with the pastoral association idea:

> It might be good sometime for me to invite you to one our Ministerial Association meetings, we meet the first Wednesday of every month. We meet with different folk. I think next meeting we're meeting with doctors that want to talk about drug problems in [this] county, or the human body. I think in February we are meeting with some Young Life Group from the [area]. You might want to come sometime in March and meet with the total Association. There's 15-20 of us and you could see what that the group would be interested in learning more. (P8)

Cross-Cutting Theme of Perceived Obstacles or Barriers which Might Prevent Clergy and Psychology Working Together

One category of themes emerged that did not fit into a specific question asked of participants. These themes were related to the obstacles and barriers perceived by clergy in collaboration with psychology. This category consists of four themes: clergy referenced rural issues interfering with psychology/collaboration (5 participants), clergy discussed perceived distrust between psychology and religion (6), clergy identified lack of resources as barrier to psychology/collaboration (7), and clergy recognized (or demonstrated) conserving status quo as barrier (4). Here is a more detailed description of these themes with several participant comments to illustrate them.

Clergy referenced rural issues interfering with psychology/collaboration. This theme focused on the barriers unique or relevant to rural areas that clergy brought up. There were several topics included in this theme, but no specific subthemes were identified. Therefore, a variety of quotations from the interview transcript are provided to capture the theme adequately. This first comment highlights a few rural issues which contribute to obstacles preventing mental health and psychological collaboration:

> As far as that disconnect, I guess for myself, rural, I don't know just health services in general are less readily available in general. There is the hospital in [town] because in my experience it is really more of a trauma center, if you've been shot that's a great place to go. They have a rehab center there, physical rehabilitation that is helpful but in general, you're better off to go to [nearby city], a place where there is more resources, more people, and more money. I think it's a money thing. This is a retirement community right now, the older population for a lot of them are fairly well to do compared to the people who are middle age or younger. I think a lot of that has to do with out here [downsized factory] used to employ, I have heard a lot of conflicting numbers but I think at one point

around 6,000 people and now it employs about a tenth of that. Because of automation and changing market and all those sorts of things, you have all these shops down town that used to be thriving. People in my church will say, we used to have our own pharmacy and our own bank, our own movie theater and there is none of that now. Sadly I think a lot of health related services similarly can't be supported here, so you have to drive to get them. They are available, in worst case scenario within 50 minutes driving time, but I think that also contributes to ignorance about the need for a lot of health stuff but particularly mental health stuff. (P5)

This next comment on barriers related to rural issues comes from a very experienced male clergy in his mid-50s who had served the ministry in various rural communities for decades. He explained:

In rural communities, now I'm not picking on rural communities, because my heart is there, otherwise I'd be somewhere else. You have people who do not feel empowered, and then you have people that feel empowered… a lot of Methodist clergy wear robes, a lot of the people out here think robes are a judge in a court room and so there's this whole mental perception, so I don't wear a robe. If I am reaching to the whole community, there are people who don't understand what that robe means and it doesn't mean the same thing today as it did a hundred years ago or something. So that's the same way, in the medical world whether it's the physical body or the mental health, the people have power, they'll do things with me or, to use the word meditation. I never thought about that, what is he talking about? I meditate all the time, I meditate on the sun coming up. It's a reflection of what you have, it's an education, it's a training, it's a power and other folks feel like they are the have-nots. How do you build that bridge? Cuz if you can't build a bridge you'll

never help them. (P2)

Clergy discussed perceived distrust between psychology and religion. Several clergy lamented the distrust that continues to exist - perhaps decreasing in recent years - between religion and psychology. There was acknowledgement by multiple clergy that this distrust travels a two-way street. The following comments illustrate this concept. One said:

> And then the distrust that probably would come from some pastors is that if you are really strong in your faith, sending someone to a person that exhibits no connection to faith whatsoever would kinda be, maybe be a little reluctant, I know I am, because over the years, I have known a few psychologists that I knew they had no beliefs, no faith, and really truly, I suspected that part of their deal of counseling with somebody was trying to disprove any connection with faith that would offer them any help. (P7)

And from another participant:

> I am speaking in part for, there are certain people in my church and in this community, I don't want to say an aversion to anything coming out of universities, but there is this sort of, there are a lot of folks this is not true for, but there a lot of folks that do feel this way. I had a conversation recently with somebody who was convinced that the Smithsonian Institute was actively covering up the existence of giants that were talked about in Genesis. There's this sense of this agenda that is against all things Christian. I don't know why that's the case, it is the case and in certain circles have been warranted. But I feel like perhaps that could contribute to a sense of we're better off just doing things ourselves instead of going out and finding people who may or may not be actively undermining our faith. I say all that to say if mental health professionals could make it clear to rural health congregations that they are not in fact trying to dismantle their religion. (P5)

Clergy identified lack of resource as barrier to psychology/collaboration. Another theme that emerged in the category of barriers preventing collaboration was clergy identifying a lack of psychological resources. The following comment is representative:

> And again, I think providers are so few and far between here that, I mean they were making suggestions of, yeah, like, in fact, I think their recommendation that they gave to me was Richmond. And I think I talked to them about the likelihood of there being counselors in Charlotte, being a big metropolitan place, I would think that they have counselors down there, and I think the guy I was talking to was a regional [church] social service guy, I think he was based in Washington DC area. We're an interesting place, we're at the bottom corner of not only our [local area], but also our [larger area], and also the region. So we find ourselves actually sometimes closer to other metropolitan places that really aren't considered in a lot of these other… really, Winston-Salem and Greensborough and Charlotte are pretty big metropolitan places that probably have these services but the regional guy really had no help there. Seems like I called the guy in Charlotte at one point and it just got him really out of his comfort zone to be counseling someone outside of his region. At least that's the impression that I got, you know, he was [church] social or family services, and he knew that I was living in VA or that I was a [clergy] in VA and he was like you should really be working with this guy up in DC or whatever. So, yeah, I don't know that I ever really got any direction on who to send to in Winston-Salem, and again, I probably didn't put forth all the effort that I could have. (P1)

Clergy recognized (or demonstrated) conserving status quo as barrier. Several clergy made statements that fell into a theme best described as conserving the status quo. These comments seemed to illustrate a barrier to collaboration in the idea that things are fine the way

they are, no need to change things. One clergy made a statement about consulting with and learning from each other instead of from a professional because each field is "going to do their thing anyway" (P8). To put it in context, the full quote says:

> We, in the Ministerial Association, we talk about this a lot, kind of encourage each other, giving each other pointers you know, because the Ministerial Association is brethren from Baptist, Pentecostal, Methodist, whatever, we don't promote our denominational beliefs but we support each other and talk about how we can help each other when there is an issue, whether it be marriage or other emotional issues, or mental health issues. I think we learn more from each other than we would from a professional because most of us agree that they are going to do their thing anyway. We just turn people over to them that we think need professional help that we can't help with and let them do their thing. Our church family we have a lot of grief because of death, but we have people that are very supportive of people that lose loved ones because people have been there done that and know how to do that. (P8)

Summary

In this chapter I provided a summary of the results. The data analysis revealed that themes evolved as a direct result of the questions asked. Therefore, this chapter outlined the questions asked in clergy interviews, listed as section headings, with the pertinent themes for each question included with quotations for further detailed description.

In response to questions about past experiences working with psychological issues, clergy identified specific psychological needs encountered in their work, showed awareness of their professional scope and limitations, and demonstrated awareness and/or assessment of psychological needs.

In response to questions about their current experiences of working with mental health care providers, clergy expressed a desire to collaborate with them, clergy described collaborative efforts to work with providers, clergy discussed issues related to the process of collaboration, and they mentioned existing relationships with professionals in the field of psychology.

In response to questions about the clergy's perception of an ideal collaborative situation, clergy delineated their perceptions of the professional responsibility to initiate collaboration, shared a specific idea for ideal collaboration with psychology, and discussed using the local pastoral associations as an ideal collaborative context.

In the final thematic category related to obstacles and barriers perceived by clergy in collaboration with psychology, participants referenced rural constraints interfering with collaboration, they discussed perceived distrust between psychology and religion, clergy identified lack of resource as barrier to collaboration, and recognized conserving status quo as barrier.

In the next chapter I will discuss the implications of the results and place them in a larger context, attempting to combine the existing literature with the current research to answer the original research questions. I will also discuss this study's unique contributions to the body of knowledge and its limitations, as well as suggest directions for future research.

Chapter 5: Discussion

In this chapter I discuss the results of the research in terms of the original set of research questions. First, I return to the existing research and consider complimentary ways in which the current study fits into the body of literature. Next, I review the themes that developed from the interviews and how they addressed the research questions. Finally, I conclude with the current study's limitations and some possibilities for future research.

Current Study and the Existing Literature

According to the existing literature presented previously, it is clear that spirituality and religion are a big part of life for most of the general population (Milstein et al., 2010; Moran et al., 2005; Newport, 2011; Newport, 2012; Walsh, 2011). The literature also indicates that there are mental health benefits of spirituality and religion (Koenig et al., 1998; Koenig et al., 2001; Newport et al., 2010; Walsh, 2011). Furthermore, there is a rapidly growing body of literature that shows how relevant and important the issues of religion and mental health are for rural areas especially (Arcury et al., 2000; Campbell et al., 2002; Fischer, 1982; Fox et al., 1995; Helbok, 2003; Keller, Murray, & Hargrove, 1983; Krause, 1997; Newport, 2012; Schank & Skovholt, 2006; Werth et al., 2010).

Furthermore, rural specialists (Aten et al., 2012; Campbell et al., 2002; Fox et al., 1995) have called for collaboration between psychology and religion in order to meet the mental health needs of rural residents in a culturally competent way and to promote integrated and resilient communities. There has been some research exploring these ideas (see Aten & Hernandez, 2004; Aten et al., 2012; Blank et al., 2002; Mattis et al., 2007; McMinn et al., 2003; Milstein et al., 2010; Quackenbos et al., 1985; Resnicow et al., 2005; Thomas, 2012), however, the research remains disconnected from its practical application. There appear to be several gaps in the

literature, one of which my study addressed – what would rural religious leaders themselves say about working with professionals in the field of psychology? The current study is the first qualitative in-depth exploration of rural clergy's perceptions of collaboration with mental health professionals.

Answering the Research Questions

In this section I provide the research questions as sub-headings and use the results of the current study to answer the questions. The themes that emerged from the data adequately answered the research questions. In this discussion I provide an explanation of how the results with various themes can be applied to answer the questions.

Research question #1: What collaboration, if any, has the religious leader engaged in with area mental health professionals in the past? First, we learned from the current study that clergy did identify specific psychological needs encountered in their work, showed awareness of their own professional scope and limitations, and demonstrated awareness and further assessment of psychological needs.

One clergy highlighted the needs identified and the limitations of clergy to address the needs, when he said, "I guess I hadn't realized that it was to that degree [suicide attempt], so it was a little bit of a surprise to me, and the family felt like it was a surprise to them too, I don't think they really felt like they saw it coming" (P1).

In a situation like the one described by this clergy, the COPE model proposed by Milstein and colleagues (2008) might provide some guidance for clergy and psychology. This model was developed to help improve continuity of mental health care. As previously explained, the COPE model provides a continuum of mental health care for persons of diverse religions delineating boundaries between clinical care provided by mental health professionals and religious care

provided by clergy, as well as pathways of collaboration across these boundaries. COPE is a model that moves from the care already present in religious communities to professional clinical care, which works to return the person back to the care of their religious communities. The four parts of the model include recognizing the benefits of community membership, describing the spiritual and social support provided by religious communities in response to a person's life stressors, promoting professional clinical assessment and treatment for persons of diverse religions with serious emotional problems or mental disorders, and supporting the person's recovery through ongoing collaboration with religious communities (Milstein et al., 2010).

Applying this COPE model to the situation presented by the clergy, the suicidal client would be referred to psychology professionals who recognize the benefits of her involvement with a religious community, provide professional treatment which is culturally sensitive to her religious identity, and return her to the care of her religious community while maintaining an ongoing collaborative relationship with her clergy to support recovery.

Furthermore, we learned that most of the religious leaders interviewed expressed a desire to collaborate with mental health care providers, most described current collaborative efforts to work with professionals, some were able to discuss specific issues related to their process of collaboration, and most mentioned some type of existing relationships, either formal or informal, with a professional in the field of psychology.

Some clergy in the current study mentioned that they perceived psychological needs to be greater during their early career and decreased later in their career. The following comment describes this; "It seems like in my time here those kinds of counseling conversations were kind of front-loaded. I ran into that when I first got here and then again a month or so later" (P5).

In attempting to explain this phenomenon, I came up with a number of questions with

few answers. I wondered if this may be a time when a congregation is evaluating a clergy's ability, willingness, or comfort level in dealing with mental health issues. Then, when needs arise in the future, depending on the clergy's initial response, they decide to either bring those needs to the clergy (if the initial response was satisfying) or stop bringing them (if not initially satisfied). That may be one possible explanation of this phenomenon.

Therefore, to answer the research question, it seems that religious leaders do engage in some collaboration with psychology to help care for members of their congregations, the clergy do want more collaboration, but they may not know how to go about building or improving bridges between the two fields.

Research question #2: what types of collaborative activities would the religious leader prefer to engage in with mental health professionals in the future? In discussing the types of collaborative activities in which clergy would prefer to engage with psychology professionals under ideal circumstances, the study provided some clear answers as well. Participants had ideas about which party should initiate collaboration between the two, however, most seemed to agree that the responsibility to initiate the process was shared between both parties.

The existing literature reviewed earlier in this paper provides an important backdrop for the results obtained in the current study related to proposed collaborative activities. Edwards and colleagues (1999) suggested specific recommendations for collaboration to include developing relationships, having common goals, increasing effective communication, establishing trust, sharing respect, gaining expertise from the other side, having some common values, and increasing general awareness of spirituality.

McMinn and colleagues (2003) proposed some basic and advanced competencies in

collaborating with religious leaders. Basic activities include sharing respect and increasing effective communication. Advanced activities include increased spiritual awareness and finding shared values. Some examples of collaborative activities proposed by these researchers included consultation, referrals, workshops, direct services, assessment, community education, and academic collaborations.

All religious leaders in the current study shared a specific idea for an ideal psychology and religion collaboration; they suggested therapists could provide workshops to educate clergy about possible mental health issues and available services, they wondered about creating resource and referral manuals to share between clergy and psychology, and forming official partnerships with providers as well as relying on informal social or parishioner connections to talk about mental health issues and cases. Finally, many clergy discussed using the local pastoral associations as an ideal context to begin the collaborative process. It would be a safe assumption, based on the interactions and discussions with these clergy, that all participants would endorse this idea of using pastoral associations as a good starting point to improve collaboration between psychology and religion.

It became obvious when comparing the existing literature reviewed to the results of the current study, that there was significant overlap or agreement, indicating that the current study confirmed the specific suggestions for collaboration in the existing literature. Therefore, I would like to add my endorsement of these ideas, both from the literature and my current study. More specifically, I encourage clergy and psychology professionals to work together to achieve the basic and advanced collaborative competencies (McMinn et al, 2003) and to engage in specific collaborative activities of consultation, referral, workshops, direct services, assessment, community education, and academic collaborations. Furthermore, I accept and reiterate the

suggestions of the current study participants to create and develop a resource manual or referral list, to provide workshops, and to establish formal and informal partnership with psychology professionals. The current study's suggestion to use local pastoral associations as a starting point for collaboration appears to be a novel finding as it did not come up in the existing literature reviewed. I offer that suggestion as a new idea for initiating collaboration.

Research question #3: what barriers does the religious leader predict in their collaborative efforts, and how would they hope to overcome those barriers? When asked about barriers or obstacles to collaboration, most clergy in the current study referenced specific rural issues, including cultural factors, interfering with rural psychology and collaboration. Most clergy discussed a perceived mutual distrust between psychology and religion creating an obstacle for collaboration. The participants identified a lack of psychological and general health resources as a barrier to adequate psychological services and collaboration. A final barrier was identified in the beliefs and behaviors of some clergy, whether intentional or not, which functioned to conserve the status quo.

There appeared to be some similarities between the results of the current study and the literature reviewed on general barriers to rural mental health. While the current study focused on barriers to collaboration, the similarities are noteworthy. Campbell and colleagues (2002) discussed some of these barriers. They cited distance to service providers as a major barrier. Even if mental health service providers are available, many rural residents would still have to travel great distances where public transportation does not exist. And some families may not have access to vehicles or telephones to arrange transportation. Another barrier they mention is the difficulty attracting and funding mental health providers and services in rural areas, although there have been attempts to entice and attract mental health service providers to these areas by

federal programs that provide repayment of student loans and other benefits. In addition, it is less likely that rural residents have medical insurance and there is a lack of information about various entitlement programs. Other potential barriers they discussed are related to rural social norms and personal values or beliefs about health and illness. Some of these values and beliefs prevalent in rural communities include individualism, authoritarianism, self-reliance, and the belief that the community should care for its own. Finally, their research stated that mental health problems are thought of as personal problems to stay within the confidentiality of family and church and are not to be shared with professionals who are not a part of the community. All of these barriers discussed by Campbell and colleagues (2002) were cited as barriers to rural mental health in general, but when comparing them to the results of the current study, they seem quite relevant and applicable.

Limitations and Directions for Future Research

As with all research, there were certain limitations associated with both the study's design and its execution. This qualitative research was exploratory in nature, as opposed to confirmatory, and therefore not based upon a specific established theory. Instead, as grounded theory (Strauss & Corbin, 1998) research, this study sought to explore an unexamined area of the literature and possibly formulate a new theory. While the current study did not go as far as proposing a theory, it did lay the groundwork for further research in the area which may lead to a proposed theory.

Many of the typical limitations of qualitative research apply to the current study. There was a small sample, which was intentional and designed to meet the needs of the current project. As with all qualitative studies, the assumption should be made in this type of research that the goal is not generalizability of results, rather, depth of information about a targeted population on

a relatively unknown topic (Strauss & Corbin, 1998). There were other sampling limitations. While there was quite a bit of gender diversity in the current sample, there was little other diversity. This limitation, however, was representative of the geographical areas studied.

Also, the assumption is made that a self-selecting sample bias probably resulted in limited results. The clergy who agreed to participate were probably the ones who already favored collaboration with psychology; therefore, the results reflect that bias. If the researcher had been able to reach and interview clergy who were even more traditional and located deeper in rural areas, the results might have reflected more ambivalence about working with psychology.

It is important to note that there was one significant technical difficulty with the interview process. During one interview, the digital recording device malfunctioned, leaving us without an audio recording of that interview. The researcher and participant decided to simply redo the interview and rescheduled to come back in a couple of weeks to record the entire interview again. Repeating the interview may have given the participant time to reconsider his responses and thus changed his data. However, the content of the second interview seemed very similar to the first one.

In order to pursue the development of an integrated theory of effective collaboration between rural religious leaders and mental health professionals, future research could seek to discover how widely clergy hold the same opinions of collaboration as the current study's participants and how similar their experiences with collaboration have been. It might be helpful to narrow down some of the topics uncovered in the current study and find those that are most relevant to collaboration between the two fields. This would probably require a more detailed and targeted survey of a broader range of rural religious leaders after building survey questions based on the themes discovered in this current study.

A follow-up study should reach out to smaller, more rural, congregational and independent churches, in addition to the larger national mainstream churches whose religious leaders chose to participate in this study. This would allow another perspective and represent a large segment of the rural religious leaders who were not included in this study. Furthermore, attempts could be made to apply the current study to other small communities. It would be interesting to see if similar findings result from studies of other cultural minorities, such as racial or ethnic, or sexual minorities. It seems important to investigate how psychology could collaborate with cultural groups like racial or sexual minority groups to improve service provision in a similar manner to that explored in the current study with religious clients.

While the current study had some characteristics and a flavor similar to participatory action research (PAR), it failed to fully reach the level of PAR in some important ways. It did not include the religious leaders themselves in the development and carrying out of the research project. It did not join itself with the community stakeholders to create an advisory board that designed and oversaw the completion of the research together. It seems that one of the best and most empowering ways to make this line of research meaningful going forward is to take it to the community, join with stakeholders and participants in the way described above and in a way more consistent with PAR to actually improve collaboration simultaneously to researching it (see Aten et al, 2011).

Conclusions

The existing literature indicates that spirituality and religion are important to the general population, that religion and spirituality generally have a positive impact on mental health, that rural areas have higher rates of religiosity with less mental health resources, and that collaboration between religion and psychology could be one way to address that problem. The

current qualitative study explored the needs and preferences of rural religious leaders about forming collaborative relationships with mental health professionals in order to better care for their congregations and the people served by both professions.

Exploration took the form of in-depth interviews with rural religious leaders to discuss possible issues from their perspective. Interviews were audio recorded and transcribed to allow for coding and analysis, following a grounded theory methodology (Strauss & Corbin, 1998). Results of the data analysis indicated that rural religious leaders who chose to participate in this study recognized mental health needs, desired increased collaboration, in many cases already engaged in some form of basic collaboration, and had a lot of good ideas about how to move forward with collaboration between religion and psychology.

In conclusion, I offer some recommendations for the application of this research. I encourage that, first and foremost, we reject the idea that psychology and religion are incompatible. This is a self-imposed limitation on both professions that hinders our ability to help people in need. To paraphrase one participant of the current study, it will require investment and effort, but it will help us on both sides of this gap and will bless the individuals we both serve with better mental health and increased life satisfaction.

Furthermore, I propose that we, as mental health professionals, take the first step toward this collaborative effort. We have been trained to work within social systems and institutions, and we should put that training to use in working with our frontline referral sources and social support assets, including the community clergy and churches. We can begin by simply finding the contact information for our county pastoral association and making a brief phone call to ask if we could attend one of the upcoming meetings. The results of this study indicate that we will be welcomed in that outreach. Finally, the existing literature and this current study suggest that

as we work closer with the clergy in our communities, we will have greater success in our professional services.

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Appendix A: Demographic Questionnaire

Participant Age _____

Participant Sex _____

Ethnicity _____

Educational Level _____

Years in Ministry _____

Years in Congregation _____

Congregation Size _____

Rural Home (Y/N) _____

Rural Work (Y/N) _____

Appendix B: Semi-structured Interview

The basic outline and format of the semi-structured interview will be:

1) What has been your past experience in cooperation or working with the field of psychology or mental health in your work as a religious leader?
    a. What has been good about those experiences?
    b. What has been bad about those experiences?
2) What, if any, cooperation or work of this nature do you currently enjoy in your work?
    a. If none, how would you explain the lack of cooperation?
    b. If so, what seems to be helpful to you in this work?
3) How would you describe the ideal experience for you working together with the field of psychology or mental health?
    a. How likely would that be for you?
    b. What could be done on both sides to increase that likelihood?

Appendix C: Letter Requesting Participation

Date

Dear

I am a student in the Doctor of Psychology (Psy.D.) program at Radford University and I am writing to request your assistance in the completion of my research study – Building Bridges: Qualitative Investigation into Bridging the Gap between Religion and Psychology to Improve Rural Mental Health. The reason you are being contacted is that you are a religious leader who works in a rural area and therefore have valuable knowledge about this unique issue. My research will explore the needs and preferences of rural religious leaders in working together with mental health professionals to address the mental health needs of the people we both serve. My own work in rural communities as both a mental health professional and religious leader has shown me some of the challenges of working in rural areas from both perspectives, and the potential benefits from this cooperation. I am therefore interested in learning about your perspective on the way in which mental health and religion can work together to improve mental health.

If you agree to participate in this research then I will interview you for about 60 minutes (depending on how much you have to say) regarding your experiences as a religious leader encountering mental health needs in your rural congregation and how you could work together with mental health professionals cooperatively to meet these needs. All information obtained related to the interview will be reported anonymously. If you are willing to be interviewed, I can meet with you at your office, Radford University, or another mutually agreeable location. You may contact me at the phone and/or email below, or I will contact you by telephone within the next week to answer any questions and ask about your willingness to participate. If you agree to participate when I contact you by phone, I will ask you some demographic questions at that time. This will help me determine if your experience fits the population I am studying. If you do meet these criteria then I hope that we can schedule an interview meeting during this phone call.

This study has been approved by my dissertation committee and the Radford University Institutional Review Board. My advisor, Dr. Ruth Riding-Malon is also available to answer any questions you may have.

Sincerely,

Adam Smith, M.A.
Psy.D. Student
Radford University
Phone: 540-831-6816
Email: aesmith@radford.edu

Ruth Riding-Malon., Ph.D.
Assistant Professor of Psychology
Radford University
Phone: 540-831-6892
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Appendix D: Adult Informed Consent – Nonsurvey research

Title of Research – Building Bridges: Qualitative Investigation into Bridging the Gap between Religion and Psychology to Improve Rural Mental Health

Researcher(s) – Adam Smith, Ruth Riding-Malon

We ask you to be in a research study that will explore the needs and preferences of rural religious leaders in working with the field of mental health. Specifically, from this study we hope to learn about the ways in which mental health professionals and rural religious leaders might more effectively work together to improve the mental health of rural residents we both serve. You were selected because you are a religious leader in a rural area. If you choose to be in the study, you will be asked to participate in a semi-structured interview lasting approximately 60 to 90 minutes dependent on how much you have to say. The interview will be audiotaped to allow for transcription and analysis of the interview. The audio recordings will be deleted after transcription has been completed and verified for accuracy. All data will be presented anonymously in final form and will be in no way linked with you the participant. If you agree to participate, you will first be asked to confirm the demographic information that you provided earlier, and then you will be asked a series of open ended questions.

This study has no more risk than you may find in daily life.

If you decide to be in this study you may benefit from being a part of it. Some benefits to you may be the potential for increased insight into more effective ways to help the people you serve and the ability to meet the demands of your service as a religious leader.

You can choose not to be in this study. Your decision whether to participate will not affect your future relations with Radford University. If you decide to be in this study, you may choose not to answer certain questions or not to be involved in parts of this study. You may also choose to stop being in or withdraw from this study at any time without any penalty to you.

If you decide to be in this study, what you tell us will be kept private unless required by law to tell. The researcher is a mandated reporter and is therefore subject to a duty to report any incidents of abuse, neglect, or exploitation of children or elderly and incapacitated adults. The audiotapes of the interview will be transcribed as soon as possible and then erased once the transcripts have been verified for accuracy. Transcripts will be given a participant number and not linked with your name. All other data will also be given the same participant number and in no way linked with your name. All data is kept securely in a locked cabinet within a secure research lab. We will present the results of this study, but your name will not be linked in any way to what we present.

If at any time you want to withdraw from or stop being in this study, you may leave the study without penalty or loss of benefits by contacting Dr. Ruth Riding-Malon rridingmalon@radford.edu (540-831-6892) or Adam Smith aesmith@radford.edu.

If you have questions now about this study, ask before you sign this form.

If you have any questions later, you may talk with Ruth Riding-Malon or Adam Smith.

This study was approved by the Radford University Committee for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Dr. Dennis Grady, Dean, College of Graduate and Professional Studies, Radford University, dgrady4@radford.edu, 1-540-831-7163.

Being in this study is your choice and choosing whether or not to take part in this study will not affect any current or future relationship with Radford University.

If all of your questions have been answered and you would like to take part in this study, then please sign below.

_____ _____

Date Signature

I/We have explained the study to the person signing above, have allowed an opportunity for questions, and have answered all of his/her questions. I/We believe that the subject understands this information.

_____ _____

Signature of Researcher(s) Date

Note: A signed copy of this form will be given to the subject for the subject's records.