AN EXPLORATORY STUDY OF ROMAN CATHOLIC PRIESTS' AND DEACONS'

PERSPECTIVES ON MENTAL HEALTH TREATMENT


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**Abstract**

A substantial number of people with mental health problems do not receive treatment from mental health professionals (Substance Abuse and Mental Health Services Administration, 2013). Many of these people will seek out assistance from their clergy (VanderWaal, Hernandez, & Sandman, 2012). Despite a growing number of models developed to enhance collaboration between clergy members and mental health professionals, research shows that the majority of clergy members infrequently refer to mental health professionals (VanderWaal, Hernandez, & Sandman, 2012), but rather provide direct counseling (Bledsoe, Setterlund, Adams, Fok-Trela, & Conolly, 2013). This study began exploring this phenomenon by interviewing seven Roman Catholic priests and three Roman Catholic deacons about their experiences with people suffering from mental health problems and their perspectives on referring to mental health professionals. A grounded theory approach was used to analyze the responses of the participants (Corbin & Strauss, 2014). Findings included a limited tendency of the participants to make referrals, and a concern among many in the sample that mental health treatment could negatively impact the religious values of parishioners. The study found that most participants had limited connections to trusted professionals, but they saw professional mental health treatment as important and were interested in education regarding recognizing mental illness and identifying treatment resources. Suggestions on how professionals can address these issues are made based on extant literature and the study findings.

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be, my angel.

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## Chapter I

## Statement of the Problem

According to the Substance Abuse and Mental Health Services Administration

(SAMHSA), 28% of adults in the USA will have a diagnosable mental disorder in their lifetimes.

Of these adults, nearly 30% will not receive any treatment for their disorder (SAMHSA, 2013).

For many people the barriers to seeking professional help have included the stigma of mental

illness, the high cost of treatment, denial of the presence of a mental health disorder, guilt about

their behaviors and a lack of knowledge about their treatment options (SAMHSA, 2013).

Researchers have found that some 30% of people who do seek help for mental disorders do so

from members of their religious clergy (VanderWaal, Hernandez, & Sandman, 2012). This may

have been due to clergy's unique position to provide help without the same barriers which exist

for mental health workers. Clergy were often familiar with people who contact them for help,

which reduced stigma. Clergy often worked for free, rather than the fee-for-service model of

many mental health professionals. Clergy also addressed problems in a spiritual framework,

which may have been more acceptable and less stigmatizing for people than addressing problems

in a mental health framework. Finally, clergy were in a unique position of authority to address

guilt (Milstein, Manierre, Susman, & Bruce, 2008; VanderWaal, Hernandez, & Sandman, 2012).

The mental health community recognized the unique role of clergy, and researchers noted

that clergy members have the same amount of contact with people suffering from mental

disorders as any mental health professional (Hohmann, & Larson, 1993). Wang, Berglund, and

Kessler (2003) reviewed data from the National Comorbidity Survey which indicated that clergy

members were more sought after for assistance with mental health problems than psychiatrists or

general medical doctors. The data also indicated that many people with serious mental illnesses would often exclusively seek clergy for assistance. Researchers found that clergy often provide counseling to parishioners for stress, anger and depression (Bledsoe, Setterlund, Adams, Fok-Trela, & Conolly, 2013) although research demonstrates that clergy have limited knowledge about the recognition and treatment of mental illness (Leavey, Loewenthal, & King, 2007;Pillion, Reed, & Shetiman, 2012). Vanderwaal, Hernandez and Sandman (2012) asked clergy members about the frequency with which they referred people to treatment for mental health problems in a six month period and found that 29.9% had not referred anyone, while 47.1% endorsed referring between one and five people to treatment. These numbers suggest that despite the number of people seeking help from clergy, relatively few are referred to professionals for treatment.

This study begins by defining the terms "mental health professionals" as well as "Roman Catholic priest and deacons." The roles of priests and deacons are described. The study then describes the concepts which are part of the broader term "collaboration," including referral, consultation and shared treatment of cases. Research about the collaboration between mental health professionals and clergy members is reviewed and the advances in understanding and need for further research are highlighted. This study's unique contribution to knowledge in the field of psychology is described.

**Chapter II**

**Literature Review**

**Mental Health Professionals, Priests and Deacons**

  **Mental health professionals**. Mental health professionals are people with specific

training in treating, curing and preventing psychological disorders and assisting people in coping

with the stresses of life to increase their satisfaction with life and ability to work, have

relationships and enjoy themselves (World Health Organization, 2001). These professionals are

part of recognized groups such as psychologists, social workers, counselors, marriage and family

therapists, and psychiatrists. For the remainder of this study these mental health professionals

will be referred to simply as professionals, for the sake of brevity. Although some Roman

Catholic clergy do receive the training and credentials to be considered mental health

professionals, the clergy as a whole do not commonly receive this training and their functions are

different from those of the mental health professions.

  **Holy Orders.** The study participants were ministers within the Roman Catholic Church.

The Roman Catholic Church in the USA includes about 77 million lay people served by 37,192

priests (Center for Applied Research in the Apostolate, no date) and 14,588 permanent deacons

(Gautier & Gaunt, 2015). In 2010 the Catholic population was mostly non-Hispanic whites, with

about 42.5 million persons, and Hispanics, with 29.7 million persons (Gray, 2016). In the same

year a significant number of lay people identified as being born outside the USA (Gray, 2016)

and about 6,453 priests operating in US diocese were from other countries (United States

Conference of Catholic Bishops, 2011). Regionally, the ethnic composition of the Church varies,

with a non-Hispanic white majority in the North East and Midwest, and a Hispanic majority in

the West and South (Lipka, 2015). In a survey of ethnic parishes, Gray (2015) found that 22% of

respondents, mostly Hispanic and mixed-race Catholics, indicated some level of agreement with

the statement that "I often feel like an outsider at the parish because of my nationality, race,

ethnicity, language or culture." Despite this experience, 89% of the respondents in the study

indicated they felt some level of comfort "talking with the pastor" (Gray, 2015).

The study participants are Roman Catholic priests and deacons. These roles are described

by the church in terms of their liturgical functions and spiritual symbolism in the context of the

historical tradition of the church. These three roles are the three degrees of the Catholic

sacrament of Holy Orders (Libreria Editrice Vaticana, 1994). In the Catholic Church there are

seven sacraments: baptism, Holy Communion, reconciliation, confirmation, marriage, holy

orders, and extreme unction. In Catholic belief "the seven sacraments are the signs and

instruments by which the Holy Spirit spreads the grace of Christ" (Libreria Editrice Vaticana,

1994). The catechism describes the nature of the sacrament of Holy Orders as, "the sacramental

act which integrates a man into the order of bishops, presbyters, or deacons, and goes beyond a

simple election, designation, delegation, or institution by the community, for it confers a gift of

the Holy Spirit that permits the exercise of a 'sacred power'" (Libreria Editrice Vaticana, 1994).

This "sacred power" is believed to causes a permanent change to the soul of the person receiving

the sacrament. This change provides the person with the ability to fulfill their duties and can

never be removed. Even if one were to convert to another religion, they are considered to

continue being a bishop, priest, or deacon, although they may no longer wield a commiserate

authority within the church.

**Bishops.** The fullest degree of holy orders is a bishop. This degree of holy orders enables

a man to confer all the other sacraments. These are the leaders of the church and are considered

the spiritual successors of the original apostles of Christ. The catechism describes the "sacred power" of their ordination with these words, "a sacred character is impressed in such wise that bishops, in an eminent and visible manner, take the place of Christ himself, teacher, shepherd, and priest, and act as his representative" (Libreria Editrice Vaticana, 1994). Collectively the bishops govern the church, typically as regional leaders of many parish communities organized into diocese. Throughout the history of the church there have been councils of the church's bishops convened to discuss matters of concern to the church as a whole. The most recent of these councils was the Second Vatican Council which convened between 1962 and 1965. This council is notable for making numerous reforms to the structure of the church and practice of the liturgy. One detail of note regarding this council was its openness to the contribution of psychological science to the wellbeing of the Church's members (Paul VI, 1965). Although bishops are not included in this study, it is important to note that they are the only people capable of conferring holy orders on others. Therefore, every priest and deacon in the Catholic Church has been conferred by a Bishop.

**Priests.** Priests receive the sacrament of holy orders to a lesser degree than Bishops. Through Holy Orders priests "are signed with a special character and so are configured to Christ the priest in such a way that they are able to act in the person of Christ…" (Libreria Editrice Vaticana, 1994). For this reason a priest is often described as acting *in persona Christi,* or "in the person of Christ" so that the priest's act of consecration or absolution are understood as signifying that God has done these things. A priest is empowered to consecrate the bread and wine used in the Mass, which Catholics believe becomes the "body, blood, soul and divinity of Jesus Christ." Receiving this consecrated bread or wine in Holy Communion is believed by Catholics to be the preeminent source of God's grace (Libreria Editrice Vaticana, 1994).

God' forgiveness is received from priests acting in the role of Christ through the sacrament of reconciliation. Biblically Catholics point to the moment when Jesus commanded his apostles "Receive the Holy Spirit. If you forgive the sins of any, they are forgiven; if you retain the sins of any, they are retained," (Confraternity of Christian Doctrine, Inc., 2010) as the beginning of God empowering his church to forgive sins (Libreria Editrice Vaticana, 1994).  By confessing one's sins to a priest in the spirit of contrition a penitent is absolved from guilt. To encourage the confession of even the most grievous sins priests are bound by the Seal of Confession, which is an absolute prescription against sharing the information they learn within the confessional to any other person. The Catechism states, "The Church declares that every priest who hears confessions is bound under very severe penalties to keep absolute secrecy regarding the sins that his penitents have confessed to him" (Libreria Editrice Vaticana, 1994). This differs from the conditional form of confidentiality provided by mental health professionals regarding personal health information of clients, in that it requires confidentiality even regarding homicidal intentions, child abuse, and plans to commit suicide. According to Roman Catholic canon law: "The sacramental seal is inviolable; therefore it is absolutely forbidden for a confessor to betray in any way a penitent in words or in any manner and for any reason" (Code of Canon Law, 1998). The consequence of a priest disclosing the contents of a confession, for any reason, is excommunication from the church. The Seal is protected by "clergy-penitent privilege" laws in civil courts, although some state statutes do not allow this privilege in cases of child abuse or neglect (Child Welfare Information Gateway, 2015).

The duties of priests include witnessing and blessing marriages. Marriage in the Catholic tradition is considered more than a civil contract. It is a sacrament, a means of spreading God's grace. The Second Vatican Council stated that "God himself is the author of marriage" (Paul VI,

1965).  It is similar to Holy Orders, in that it marks the souls of its recipients with special graces. According to the Pastoral Constitution of the Catholic Church, "By virtue of this sacrament, as spouses fulfil their conjugal and family obligation, they are penetrated with the spirit of Christ, which suffuses their whole lives with faith, hope and charity. Thus they increasingly advance the perfection of their own personalities, as well as their mutual sanctification, and hence contribute jointly to the glory of God" (Paul VI, 1965). These beliefs motivate the Catholic Church's stance against divorce, which was reiterated in the letter *Marriage: Love and Life in the Divine Plan* published by the US Conference of Catholic Bishops (USCCB) (2009) which states, "Fidelity until death is what couples aspire to and what they promise to each other." The letter also refers to the statement by Jesus in the Gospel of Matthew, "…Because of the hardness of your hearts Moses allowed you to divorce your wives, but from the beginning it was not so. I say to you, whoever divorces his wife (unless the marriage is unlawful) and marries another commits adultery." (Matt. 8:9, New American Bible, Revised Edition). The letter notes that divorce may be the "only solution to a morally unacceptable situation," such as abuse of a spouse or children. Despite this recognition of the necessity of civil divorces, the Catholic Church does not recognize the dissolution of a marriage that is religiously valid. The Catholic Church does grant "declarations of nullity" through a tribunal process which examines written testimony from former spouses and third parties to determine if a marital union was religiously invalid (USCCB, 2017). The primary difference between these declarations, referred to at times as "annulments," and civil divorces is that an annulment is an official declaration that the marriage was never valid from the beginning. To attain an annulment a the tribunal must determine that one or both parties either did not understand the nature of marriage, were incapable of consent, or were deceived about the character of their spouse (Code of Canon Law, Canon 1095, 1998).

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Pope Francis recently called attention to the priests who work as exorcists (Squires, 2014). The exorcist is a rare specialty reserved for priests with specific training and personal qualities who are appointed by their bishops to serve in this role within the diocese (Code of Canon Law, 1998). Exorcists are charged with investigating reports of evil spiritual forces residing in human beings, known as diabolical possession (Armstrong, 2017). This investigation involves observations by the exorcist and consultations with medical and mental health professionals to determine whether the behaviors attributed to an evil spirit are symptoms of a disease or a genuine case of possession (Libreria Editrice Vaticana, 1994). If an exorcist determines the case to be a genuine possession he will request the permission of his bishop to command the demon to leave the person's body. This permission is required because the church teaches that individuals have no authority over demons, only with the authority of the whole church can a possession be cured (Armstrong, 2017).

The duties of priests also extend beyond the liturgical. All clergy are called on to provide "pastoral care" for their parishioners (Libreria Editrice Vaticana, 1994), which may include direct counseling and mediating disputes. Priests are often instrumental in the process of marriage preparation for couples, which involves a Church approved curriculum of assessment and discussion of various features of married life, including discussion of substance use and mental health (USCCB, 2017). Another duty is a practice called spiritual direction, which involves ongoing counseling of an individual about how to live out their spirituality and have the best possible relationship with God (Barry, & Connolly, 1982). Instructors on the art of spiritual direction advise clergy to be attentive to the presence of emotional problems which disrupt a person's spiritual life, and to make referrals to professionals who can assist with these problems (Barrette, 2002).

**Deacons.** Deacons receive the third of the three degrees of the sacrament of Holy Orders. This spiritual gift is believed to mark their soul with a special character "which configures them to Christ, who made himself the "deacon" or servant of all" (Libreria Editrice Vaticana, 1994). Although the original position of deacon was permanent, in later years it became a transitional position for those pursuing priesthood. During the Second Vatican Council the permanent diaconate was reestablished and deacons were granted authority to assist during the liturgy, preach the Gospel and minister to the community (USCCB, 2005). The deacons included in this study are permanent deacons, distinguished from transitional deacons who are ordained as such while in training to become priests. Permanent deacons differ from priests in that they may be married and are not salaried by the church; they often are retirees or have full time employment along with their duties as deacons. Permanent deacons have roles and requirements which distinguish them from priests, and are said to be models of Christ the Servant, who washed the feet of the apostles before the Last Supper (USCCB, 2005).

Church tradition holds that the first deacons were ordained in the early days of the church in Jerusalem, as described in the book of Acts 6:1-6, to ensure the equitable distribution of food to Greek speaking widows and orphans (Confraternity of Christian Doctrine, Inc., 2010). Pope Benedict XVI commented on the mission of these original deacons, "the social service which they were meant to provide was absolutely concrete, yet at the same time it was also a spiritual service; theirs was a truly spiritual office which carried out an essential responsibility of the Church, namely a well-ordered love of neighbor" (Benedict XVI, 2005). This "well ordered love of neighbor" takes the form of service initiatives organized by deacons (USCCB, 2005). In an address to the deacons of the diocese of Trenton, New Jersey Bishop David O'Connell (2012) noted that the deacons serve as a connection between the lay people of the church and the ranks

of the clergy, quoting Pope Benedict XVI saying, "In this way, you give witness in the world of today, as well as in the working world, of the presence of faith, of the sacramental ministry and the diaconal dimension of the sacrament of Orders. This seems very important to me: the visibility of the diaconal dimension."

**Catholic Theology**

A basic understanding on Catholic morality and the topics of sin, grace, conversion, and transcendence will give context to the decision made when priests and deacons make referrals to mental health professionals. According to the Roman Catholic Church, God existed independently prior to all other things, and created everything, especially humans, to "share his own blessed life" (Libreria Editrice Vaticana, 1994). First God made the angels, and gave them a choice to love and obey him or to reject him. Those who chose God are the angels who help humanity. Those who rejected him are Satan and the demons seek to harm humans. Humanity was created in a deathless state of perfect harmony with God and nature, called "original justice" (Libreria Editrice Vaticana, 1994). The first humans were also given a choice to obey God or to reject him. Satan tempted the first humans to follow his example. In this way, Adam, the first man and the prototype of humanity, "let his trust in his Creator die in his heart and, abusing his freedom, disobeyed God's command" (Libreria Editrice Vaticana, 1994). This first sin permanently destroyed the harmony between human kind, God, nature and the harmony between humans and within an individual's own soul. This state of disharmony in known as Original Sin, and it has affected all humans throughout history. The first sin and the destruction of original justice is referred to as The Fall (Libreria Editrice Vaticana, 1994).

The Roman Catholic Church teaches that God intervened throughout history to counter the effects of sin in the world. The Church teaches that the incarnation of Jesus, along with his

preaching, death and resurrection gave access to greater graces than the state of original justice

that existed before the fall. The Church considers itself the "the mystical body of Christ"

(Libreria Editrice Vaticana, 1994) which transmits God's revealed truth throughout time and

space and provides access to divine grace. This grace is a necessary resource for humans to be

able to share God's "blessed life." As the pastoral constitution of the Catholic Church states,

"Since man's freedom has been damaged by sin, only by the aid of God's grace can he bring such

a relationship with God into full flower" (Paul VI, 1965). This grace is "the free and undeserved

help that God gives us to respond to his call to become children of God," (Libreria Editrice

Vaticana, 1994) and is classified either as "sanctifying" or "actual." Sanctifying grace is "the

permanent disposition to live and act in keeping with God's call" while actual graces are "God's

interventions, whether at the beginning of conversion or in the course of the work of

sanctification" (Libreria Editrice Vaticana, 1994). Through the sacraments humans are able to

access grace. Much of the work of bishops, priests, and deacons is to provide access to these

graces.

The Catholic Church teaches about the importance of "conversion," which involves the

acknowledgement of one's sins and a commitment to change one's behavior by not sinning again

(Orfield, 2003). Despite the presence of supernatural grace, human beings still live with the

effects of Original Sin and must avoid sin and live holy lives. The Catholic Church teaches that

sin is "disobedience toward God and lack of trust in his goodness" (Libreria Editrice Vaticana,

1994). The church teaches that the morality of acts is a matter of objective morality which

accounts for the action itself, the intention of the action, and the circumstances of the action

(Libreria Editrice Vaticana, 1994). Good and evil are objective in Church teaching; however, the

moral quality of an action is effected by its intention as well. Although an evil act cannot be

made good through intention, a good act can be spoiled by evil intentions and become evil.

Circumstances can mitigate a person's responsibility for an act, or else impact the degree of

goodness or evil of an act, but circumstances themselves do not determine if an act is good or

evil. This complex understanding of good and evil is enabled by the gift of grace and the

teaching of the Church, which provide adequate "formation" of the human conscience to be

"upright and truthful" (Libreria Editrice Vaticana, 1994). To overcome sin one must have a well

formed conscience, access to God's grace, and acknowledge the reality of sin and the specific

sins that one has committed (Libreria Editrice Vaticana, 1994). Without acknowledging sin,

humans cannot be forgiven of their sins and cannot share in God's life, as noted by the Book of

John: "If we say we have no sin, we deceive ourselves, and the truth is not in us. If we confess

our sins, he is faithful and just, and will forgive our sins and cleanse us from all unrighteousness"

(Confraternity of Christian Doctrine, Inc., 2010).

The Catholic Church teaches that God transcends physical reality and is unknowable to

human reason (Libreria Editrice Vaticana, 1994). One of the tasks of priests and deacons is to

demonstrate through their actions the otherwise incomprehensible love of God (Marmion, 2005).

The Catholic Church teaches that human beings are meant to transcend their current state and

become unified to God through the acceptance of his grace and living a moral life. Pope

Benedict XVI wrote about two models of understanding the progress of human transcendence on

both the personal level and the universal level. A model authored by Teilard de Chardin

conceives of the process of human transcendence as a progressive series of unions through

increasing love and grace. These unions produce synthesis and encourage continued spiritual

development until individual humans, and humanity as a whole, achieve spiritual union with

God. The consecrated bread and wine in the Catholic Mass, which Catholics believe to be the

body, soul, and divinity of Jesus, is the model of the ultimate physical and spiritual synthesis

toward which all creation progresses. The former pope also described a medieval model of the

process of transcendence involving the cycle of birth, development of moral will, and willing

return to God through obedience and morality. This cycle was described in terms of the

individual human life cycle and the cycle of time through seasons, the rising and falling of

civilization, and the beginning and ends of epochs. These models are a reminder that life is

directed at spiritual reality and that the end of all human activity should be a return to God

(Ratzinger, 2000). Within these conceptual models, all human activity is a form of moral activity

and Catholics are required to look beyond the concrete situations they experience to understand

the spiritual significance of their actions, this is especially true of those who receive Holy Orders

(Marmion, 2005).

**Collaboration**

Collaboration is the cooperation of two or more parties to achieve a common goal. In this

study the term collaboration includes a wide range of behaviors which have often been

considered separately in the research literature, but which are conceived in this work as parts of a

continuum of cooperative action. The least involved of these behaviors is the referral, which is

also the most commonly considered in the literature. Referral is most frequently considered as a

clergy member referring a parishioner to a mental health professional. This action requires a

minimum of cooperative action, but it does require a great deal of trust and some measure of a

shared perspective on the nature of psychological problems. Consultation is also a collaborative

behavior, and in the literature it is described as a mutual relationship between clergy members

and professionals who both share their specialized knowledge with the other to help solve a

problem (McMinn, Chaddock, Edwards, Lim & Campbell, 1998). Other collaborations may

include clergy members hosting professionals in their communities to provide education or treatment, or a professional involving a clergy member in the treatment of a client.

Several researchers have initiated programs to improve collaboration between professionals and clergy people to address issues such as nutrition (Allicock, Resnicow, Gerken Hooten, & Campbell, 2013), marriage preparation (Fincham and Beach, 2013) and mental health care provision (Bottaro, 2014; Milstein, Manierre, Susman, & Bruce, 2008; Rosmarin, Bigda-Peyton, Kertz, Smith, Rauch, & Björgvinsson, 2013). The successes of these programs provide examples of how a collaborative relationship can be initiated and sustained. They also provide examples of some of the common obstacles to collaboration. Finally, a review of this literature reveals some gaps in how researchers have studied the issue of collaboration between clergy, including Roman Catholic priests and deacons, and professionals (McMinn, et al. 1998; Plante, 2013).

**Approaches to collaboration.** The *APA Handbook of Religion and Psychology* (APA, 2013) details several interventions which relied on collaboration with religious groups. Allicock, Resnicow, Gerken Hooten, and Campbell (2013) discussed an intervention which used religious congregations to disseminate information about nutrition and recruit volunteers to be trained as nutrition counselors for their fellow parishioners. The researchers emphasized the importance of demonstrating respect for the community's religious practices by attending services and socializing with community members in addition to hosting informational sessions about the benefits the program would have for the community. Clergy collaboration was key to the program's successful dissemination, and the team worked diligently to recruit clergy and foster a strong working relationship with them.

Fincham and Beach (2013) demonstrated how psychological interventions could be modified to fit into a religious context in order to aid dissemination. They modified the empirically supported Prevention and Relationship Enhancement Program (PREP) premarital intervention to include references to scripture and the use of prayer as a therapeutic activity for the couples. Their intervention also relied on the respectful collaboration with church leaders in order to recruit participants and appropriately adapt the intervention material, especially the prayers, to be accessible to the community.

All of these interventions successfully recruited the resources of religious groups to support the dissemination of interventions from mental health professionals. The fact that these interventions were created by professionals and then marketed to religious communities limits the potential of this model of service delivery. These are manualized, primary prevention interventions with a general focus on health or relationships. A review of the researchers" manual and frank discussions about values with the researchers, along with the oversight provided by Institutional Review Boards, allows clergy members who partner with these programs to feel safe about the effect the intervention may have on the people under their spiritual charge. Treatment interventions directed at specific parties, which are kept secret by confidentiality laws and directed by professionals who may be complete strangers to clergy members, may pose a greater spiritual risk. Without knowing how the philosophies of a professional may impact the spiritual lives of their charges, clergy may be loath to refer. The respectful relationships with clergy members recommended by the dissemination researchers would be helpful, but other research suggests that even when relationships are not disrespectful, the concern about the spiritual impact of psychological treatment endures for many clergy (Plante, 2013).

One route to addressing these concerns is to educate the clergy about mental health interventions and emphasize a mutually beneficial relationship between clergy and professionals in treating mental health concerns. The Clergy Outreach and Professional Engagement (C.O.P.E.) program (Milstein, Manierre, Susman, & Bruce, 2008) targets the care-giver burden of clergy and mental health professionals who are at risk for burnout from their work with community members suffering from mental illness. The program models a reciprocal relationship between clergy, who are experts in the day-to-day living of community members, and professionals, who are experts in helping with abnormal and extreme situations. Clergy members are in a unique position to identify a potential episode of mental illness and make referrals to professionals. The clergy also provides support for the parishioner while the professional engages in treatment of the problem. After treatment is completed, clergy members play the vital role of supporting the full reintegration of the parishioner into a supportive religious community. The primary caveat to this approach is that it will not work with people who have negative relationships with their religious communities. Otherwise, Milstein et al. (2008) report successful use of the program in a diverse sample of religious groups.

Other scholars have attempted to find similarities between Catholic philosophy and psychological perspectives of human nature as a means of fostering dialogue between religious leaders and mental health professionals. Blass (2012) discussed philosophical differences between Catholic concepts of spiritual conversion and therapeutic change. She noted that in some perspectives the spiritual transcendence necessary for conversion can seem at odds with the realistic coping which leads to psychological wellbeing. She discusses how conceptualizing problems as stemming from sin involves consideration of will power in the understanding of motivation, but when problems are conceived as pathologies they are understood as amoral

behaviors motivated by human needs, the environment and developmental history. She also offers a solution to this divide in the form of what she calls the "psychoanalytic bridge." She states that psychoanalysis can support a religious person in addressing problems through transcendence by offering a method of understanding self-deception and a conceptualization of human nature. She further states that psychoanalysis takes moral positions similar to Christianity, including fostering love and forgiveness.

Other researchers have looked to parallels between psychological theory and Catholic theology. Cottam (2011) described similarities between the Catholic belief in original sin and the dual process theory of cognition. In Catholic theology the original human condition was one of perfection, all human faculties and appetites were completely ruled by human reason which was in conformity with God's will. When Adam and Eve ate the fruit of the tree of knowledge of good and evil their sin caused all of humanity's appetites to become selfish, leading concupiscence "the movement of the sensitive appetite contrary to the operation of the human reason" (Catechism of the Catholic Church, Part 3, Section, Chapter 2, Article 9, Libreria Editrice Vaticana, 1994)). The dual process theory of cognition has many iterations, but Cottam focuses on the principle that one system of cognition acts outside of conscious awareness which effortlessly produces automatic thoughts which often conflict with a second system of consciously controlled and deliberate thoughts. He notes that the automatic thinking of the first system can be conceived in terms of concupiscence due to its nature of being associative and imagistic, in contrast to the logical and language based thinking of the second system, which can be associated with "human reason." For both Blass and Cottam, their work was directed at supporting a dialogue between psychology and religion to better understand human nature and enhance the work of those in religious and mental health roles.

Practitioners with strong religious beliefs have also made attempts to improve the engagement of mental health practitioners with religious communities. Rosmarin, Bigda-Peyton, Kertz, Smith, Rauch, and Björgvinsson (2013) have been involved in researching and treating the psychological challenges of Orthodox Jews. Their approach is an integration of religion and spirituality with empirically supported cognitive behavioral theory and practice. Bottaro (2014) has established a database of Catholic health professionals in order to assist Catholics interested in the services of someone who they can trust to understand their religious views. He has also established a telemental health practice to increase access for those interested people who may not have access to a Catholic practitioner. Interestingly, Dr. Bottaro was educated at The Institute for the Psychological Sciences, which is a professional psychology doctoral program established to educate psychologists who integrate the Catholic faith with their practice. The Institute's mission includes "the integration of the theoretical and empirical bases of psychology and a Catholic-Christian view of the human person," which addresses issues of trust between Catholic clergy and graduates of the program by establishing a shared religious perspective (Scrofani & Nordling, 2011). The establishment of this institute and the outreach of professionals like Dr. Bottaro represent systemic interventions by Catholic professionals to improve access to mental health services for other members of their religious community.

Researchers have attempted to address the issue of mental health stigma more generally by educating the general population about mental illness. Researchers have found that attitudes about mental health treatment often have more influence over whether people seek treatment than obstacles such as limited transportation (Mojtabai, Olfson, Sampson, & Jin, 2011). There are many research programs to address stigma through work place education, although many of these have not measured whether the education program impacts actual help seeking behavior

(Hanisch, Twomey, Szeto, Birner, Nowak, & Sabariego, 2016). Researchers in Australia have

created a program called Mental Health First Aid which has been widely disseminated and

provides information to increase "mental health literacy" in the general population (Jorm, &

Kitchener, 2011). Jorm (2012) noted the domains of mental health literacy include knowledge

about recognizing signs of mental illness, as well as knowledge of appropriate treatment

resources and their effectiveness, self-help skills, knowledge about prevention of mental illness

and training in behaviors that provide support to those suffering with mental illness. Mental

Health First Aid has been demonstrated to improve trainees' knowledge about these domains,

which is believed will result in decreased stigma and increased mental health treatment

utilization (Jorm, 2012).

      **Obstacles to collaboration.** Despite these innovative approaches to enhancing

collaboration, obstacles to widespread and effective collaboration endure. McMinn, Chaddock,

Edwards, Lim and Campbell (1998) found in a study comparing the attitudes of APA members

and clergy people that most psychologists and clergy tended to view collaboration as merely

involving referrals from clergy people to professionals. When rating the level of mutual

collaboration involved in innovative programs, clergy tended to give lower ratings than members

of the APA's Psychology of Religion Division. Given the limited tendency of clergy to make

referrals, (Vanderwaal, Hernandez, & Sandman, 2012) it seems that collaboration is the

exception rather than the rule. This is also reflected by the paucity of research into these

collaborative relationships in the psychological literature (McMinn, et al. 1998, Plante, 2013).

Plante (2013) observed that he only became an expert in collaboration with religious institutions

by accident, because he was the only psychologist in a large metropolitan area with an interest in

consulting with these organizations. The lack of interest in this field, coupled with its almost

overwhelming importance, requires a careful consideration of the obstacles to those involved even considering a collaboration.

Clergy and professionals have different philosophies about the nature of life and the goals of changing behavior which serve as barriers to collaboration. Professionals are interested in treating and preventing mental disorders and often view collaboration as a source of referrals or a way to expand the dissemination of evidence based programs to reach these goals. They see clergy as gatekeepers to communities and sources of referrals, but not as effective treatment providers. These motivations led professionals to investigate the referral practices of clergy and examine how professionals can operate under the auspices of religious institutions or else enlist the aid of clergy in providing referrals. Some professionals view clergy members as a resource to improve their clinical work and attempt to increase their consultation experiences with clergy (Masters, 2010). The overall goal of all these efforts is to treat mental disorders. Another way of putting it may be to say that professionals are often trying to enlist clergy in helping professionals do their work.

The reverse of this is often true of clergy. Rather than seeing themselves as a part of the professional field's program of treating and preventing mental disorders, they may see the professionals as ways of helping clergy improve the spiritual lives of the faithful. Specialists in spiritual direction call on spiritual directors to refer their parishioners to work with professionals to resolve emotional or mental disorders, but they view this as a way to facilitate spiritual direction (Barrette, 2002). Since professional treatment is in the service of spiritual wellbeing, many clergy are cautious when referring parishioners to professionals. Multiple studies have found that clergy refer to professionals who are known to them and who are known to be accepting and supportive of the religious values of parishioners (Bledsoe et al., 2013; McMinn et

al., 1998; Vanderwaal, Hernandez & Sandman, 2012, Wang, Berglund, & Kessler, 2003). There seems to be a concern that the influence of therapy could cause spiritual harm if a professional is indifferent or opposed to the religious beliefs a clergy member believes to be important (Miovic, 2004). It seems that this opinion extends to lay members of parishes as well. One study demonstrated that lay people prefer a clergy member to give them counseling. These lay people preferred clergy for help, even for problems that clergy members reported they were ill trained to address and would be best addressed by a professional (Kane, 2003).

A vital aspect to clergy-professional collaboration is trust. The issue of trust is discussed in every study and commentary on the subject of collaboration. Clergy are noted for referring only to professionals whom they believe will respect the religious beliefs of their clients. This preference may present a challenge to the referral process because research has consistently shown that psychologists and other mental health professionals tend to be less religiously involved than the average American (Bergin, & Jensen, 1990; Delaney, Miller, & Bisonò, 2007). Delaney et al. (2007) surveyed clinician members of the American Psychological Association and compared those answers to data from national polls. They found that the clinicians were only half as likely as other Americans to endorse the belief that "God really exists." Additionally, only 21% of the clinicians reported religion as "very important" in their life, compared to 55% of the general public. These results were reported as being comparable to previous studies of therapists. These results give an impression of professionals who generally have little personal experience or interest in religious practice. This impression may limit the treatment choices clergy will consider because of the difficulty finding professionals who seem to meet the criteria of being respectful of religious beliefs and practice. The tragedy of this impression is that Delaney et al. (2007) also found that the overwhelming majority of their respondents endorsed a

belief that religion had a generally positive impact on mental health. It seems that there may be

missed opportunities for collaboration between clergy looking for a therapist with similar beliefs

and non-believing professionals who respect the positive influence of religion.

## Chapter III

## Methods

**Participants**

Participants were recruited through a network sampling technique. Participants included were seven Roman Catholic priests and three deacons. They represented a variety of positions within the church. Three participants were pastors. Two were campus ministers. One was a contract chaplain for a prison facility and one was a chaplain for the military. One participant worked in a program to help people transition from jail to probation. Two were principals of parish elementary schools. One managed a program for volunteers visiting homebound members of the parish. One served on the board of a counseling center. None of the participants reported earning a degree in mental health treatment. The priests indicated they all received at least two graduate level courses in pastoral counseling, and the three deacons all indicated they received training on recognizing when to refer people to mental health services.

Seven of the respondents reported serving in middle class or wealthy parishes, while three reported working in lower SES parishes. Four respondents reported working primarily with ethnic minority populations, while the other six reported working primarily with White populations. The participants represented a range of experience, with the majority indicating they had careers prior to taking Holy Orders, while three respondents indicated they entered seminary immediately after high school. Two respondents reported being ordained for about five years, three were ordained for about ten years. One participant reported being ordained for fifteen years. Three reported being ordained for about twenty years. One participant stated he had been ordained for about thirty years.

PRIESTS' AND DEACONS' PERSPECTIVES

**Study design**

The study consisted of one-to-one interviews which were conducted in-person, over the phone, or via Skype. Interview times ranged from forty-five to ninety minutes. No participant was interviewed more than once. Participants were informed that their participation was confidential and strictly voluntary. All interviews were recorded and transcribed. Interviews consisted of basic demographic data and open ended questions relevant to the topics of participant's knowledge of the mental health field, their experiences with collaboration, their philosophical worldview, and their process of making referrals. All participants were asked the same questions from the interview protocol in Appendix A. All respondents were thanked for their time and informed that they could contact the researcher or Rutgers University at any time to ask questions or provide comments about the study.

**The researcher's role as interviewer**

Patton (2002) highlighted the special importance of establishing the researcher's credibility in qualitative research due to the researcher's direct role in gathering data. Concerns about the undue influence a researcher on the data must be addressed before the results are presented. Undue influence due to the researcher's presence is most often addressed by allowing time for the researcher and participant to "get to know each other" (Patton, 2002). Beginning the questionnaire with more conversational and unobtrusive questions allowed time for the researcher and participant to feel comfortable and develop a sense of trust which reduced the potential for the interview to feel coercive or result in deceptive answers. The issue of the researcher's competence also related to this concern. In the case of this study the researcher had been trained to quickly develop a trusting relationship with interviewees, even those who are experiencing anxiety, paranoia or the stigma of mental illness. This experience prepared the

researcher for developing similar levels of trust with volunteers for this study. The researcher

collaborated with faculty and students at Rutgers Graduate School of Applied and Professional

Psychology in designing a questionnaire which effectively addresses the research question in a

respectful and direct manner (See Appendix A). By following this standard script in each

interview the researcher ensured that every participant is asked the same questions. Furthermore,

the interviews were recorded and transcribed, reducing the chance that the interviewer

remembered the content selectively.

The researcher is a Roman Catholic, with acquaintances who are Catholic clergy. There

were potential benefits to the researcher's familiarity with Roman Catholicism and clergy. The

Roman Catholic Church is a vast institutional structure with various organizations operating

together across the planet. The author has some familiarity with the structure of the Church, its

hierarchy and internal rules. The researcher is also familiar with the beliefs and philosophy of the

Catholic Church, including the internal differences and debates between various Catholics which

may inform the opinions of the respondents. The researcher is also familiar with the roles of

various clergy members and religious orders, which are quite different from most careers in the

USA. This familiarity provided a rich understanding of the context in which the participants

function and allowed for a more nuanced interpretation of the data.

**Confidentiality**

All participants were given informed consent forms approved by the Institutional Review

Board of Rutgers University to be reviewed in detail during the first meeting with the researcher

(see Appendix B). At this time, they were encouraged to ask any questions regarding the issue of

confidentiality. In addition, the researcher stressed the voluntary nature of their participation and

their right to end their involvement with the study at any time. The researcher discussed audio

recording of interviews with the participants and responded to participants' concerns before

obtaining written or oral consent to audio record sessions. All notes regarding participants used

numbers instead of names and were stored securely in a locked file.  Electronic audio recordings

were stored in a password protected computer secured at the researcher's residence. The

Department of Health and Human Services Policy for the Protection of Human Subjects (2009)

stated that data from qualitative research on human subject, including consent documents, should

be retained by researchers for three years. After this period the interviews will be deleted and any

written consent forms will be destroyed.

**Data Analysis**

This study applied a qualitative research approach to investigate the nature of clergy

member's perceptions of mental health professionals. A qualitative approach was chosen because

it allowed clergy to provide their expert opinions about their own experiences and perspectives

(Patton, 2002). The qualitative approach allowed an in depth analysis of the process the

participants used to determine whether to refer someone to a mental health professional or not. A

grounded theory approach to data analysis was used to analyze the data. This approach is used to

inductively generate theories based on data which are collected, and to test those theories against

the rest of the data, rather than attempting to support hypotheses created before collecting data.

(Corbin and Strauss, 2014.

Corbin and Strauss (2014) described the methodology of the grounded theory approach

utilized in this study. The researcher assigned codes to transcribed data based on an

interpretation of the meanings of particular responses in a process referred to as "open coding."

Through a process known as "axial coding" these codes were analyzed for how they related to

each other, and were grouped into conceptual categories. Categories considered the

communication process and contexts of the respondents. Through the process of selective coding, these categories were integrated through their relation to a core concept present throughout all the interviews in the study. The core concept and categories were described as themes and discussed in the wider context of past research. The recommendations resulting from this study were based on a combination of the data provided by the respondents and the information reflected in the literature (Corbin & Strauss, 2014).

A check to ensure a credible summarization of the clergy members' experiences, involved analyzing the data for cases which presented information contrary to the themes defined by the researcher. The researcher generated plausible alternative explanations of the data (Patton, 2002). Although the researcher acknowledged these contradictory data and alternative explanations, he also provided theoretically sound arguments for the choices that he made in analyzing the themes and making recommendations. The discussion of alternative explanations and contradictory information provides readers with an understanding of the limits of the analysis. It also allowed a starting point for troubleshooting challenges in implementing the suggestions offered at the end of the report. It is hoped that by including the investigation of contrary cases, the study will be a highly credible representation of the participants' relationships with mental health professionals.

Chapter IV

**Results**

**Overall themes of response across participants**

The participants' answers were considered thematically during analysis. The core category throughout the study was that most participants referred relatively few people to treatment, despite the report from all participants that they were trained to refer to mental health professionals in cases of mental illness. There were several other categories of responses. One included descriptions of perceived obstacles to referral. Another category included the processes participants used to decide whether an issue was related to mental illness or spiritual concerns. The ways in which participants understood where to refer people with mental health issues was another category. Another category described the importance participants placed on knowing how their parishioners fared in treatment after a referral was made. The final category detailed the gaps in participants' education, as well as their interest in learning about mental health topics and their limited experience with various forms of collaboration.

**Trained to refer and seldom make referrals**

All the participants (100%) in this study indicated an openness to referring people to mental health professionals. As one respondent reported:

> One thing we were trained to do is not, since we aren't professional counselors but we get people coming to us sometimes who need professional counseling, how to recognize when we're out of our element, when to refer people to professional counselling, especially if they need ongoing therapy or if they need a lot of counseling how to refer,

we're taught to refer actually when we see the signs of the need or it's something greater than what we are trained to do.

Others noted that they were warned against the potential legal implications of providing psychotherapy. One participant stated:

And sort of the fear was put into us that we can get into a lot of trouble if we go beyond our expertise and could open ourselves up to being accused of practicing medicine without a license, or something like that.

Despite this universal training to make referrals, the rate of referrals varied between the respondents. One indicated he has never made a referral due to limited access to mental health resources in his local area, "…it doesn't exist right now. Or if it exists it's a very small amount." Four participants (40%) indicated making three or fewer referrals a year. Three others (30%) reported making three to five referrals a year. Two participants (20%) reported making twenty or more referrals a year. Of the two participants who made referrals most frequently, one serves on the board of a local pastoral counseling clinic, and the other works as a contract chaplain in a prison system.

**Obstacles to referral**

The participants reported believing that mental health treatment would be beneficial for the parishioners with psychological problems. Despite the belief that treatment could be beneficial, some of the participants indicated they had their own concerns about referring to mental health providers. Three participants (30%) reported that they did not see any drawback in making a referral. The others reported concerns about the secular values they perceived in the psychological community. One participant noted

Fortunately there are just some really good people out there helping in this field, but unfortunately there are a few who aren't. Because of their own secular background or whatever. Sometimes the secular background is really great. It provides an informational, at the level of reason, where intellectual study has been really respected and the scientific method has been allowed to unfold and do its work without investigator bias. But unfortunately you have plenty out there who let their biases come in. We're all subject to, and there's gonna be a certain level anyways, but if you know it's there you can do something about it and be objective as much as possible. Even recognizing there's a certain subjectivity in anything that's said or done. But not everybody can do that.

Seven participants (70%) indicated a concern that secular therapists who either did not value religious beliefs or were ignorant of the importance of these beliefs might influence their patients to behave contrary to their faith. As one participant stated, "…so many professional areas in our culture are values neutral, which can place them at odds because "values neutral" is anything but neutral, and can easily place you at odds with a Christian perspective on things." Another participant noted how this concern can interfere with his decisions to make referrals to unfamiliar providers:

So we did have a list of counselors, but as a pastoral worker I think it's very important to understand a counselor, to have a relationship with that counselor, to understand where they are coming from because I am placing the care of the person, and we are dealing with a person as a whole, and that means their faith and everything about them. You can't just say, the counselor's gonna deal with the mind and I'm gonna deal with the spirit. No, they are intimately connected, and therefore if we aren't doing the same thing we could actually be tearing the person apart from two ends.

Three participants reported their concerns about referring couples to a therapist who might not share the Catholic Church's values regarding marriage and encourage a couple to divorce. As one participant stated, "So if I send someone to a marriage counselor I want them to work to preserve that marriage." Another participant also elaborated on this point by saying,

> There are other cases where if a marriage is having trouble or a relationship is in trouble you want to suggest a marriage counselor but you want to suggest a marriage counselor who has the idea that the marriage is important and must be saved. Not one who's going to say "well obviously you don't like each other anymore, so don't stay married."

Although they acknowledged spiritual risks associated with counseling, the respondents were willing to refer to providers they believed respected the Church's teachings on marriage. One participant discussed his view on couples who he had referred to treatment by professionals, stating,

> One of the spouses, or both of them, there are things which are not internal to the marriage which are causing problems in the marriage. In other words there are problems which developed prior to their marriage which are creating huge amounts of stress in their marriage for various reasons.

He indicated the importance he placed on the power of sacramental marriage, stating,

> I can think of a number of couples who… I've worked with or am working with, and because it was a sacramental marriage, and because they were rooted in the sacrament of marriage and because I was taking seriously their religious perspectives, so to speak…and I got them connected to really good counselors, and marriages that should have exploded disastrously into a miserable divorce they're working it through…and

often this will be something that each of the spouses going through his or her personal counseling, and couple's counseling and meeting with me on a regular basis, like monthly or whatever it is, but it works.

Half of the participants (50%) indicated that mental health professionals could harm the spiritual wellbeing of their individual patients by training them in a moral outlook which trivializes sin. This would serve as an obstacle to patients taking personal moral responsibility for their actions. One participant described his concern in this way:

You know, somebody may have gotten into drinking because their father beat them as a child, but they still have the responsibility not to abuse alcohol. And they become an alcoholic and they sort of have to take the responsibility for that with the help of God's grace and with the help of other people. Um, you know I think psychology, at least comes across as, psychology sometimes comes across as you haven't done anything wrong whatever, you just had bad programming, bad things that happened in your life that led you to this decision. And that's true but there is a moral responsibility regardless of what happened…

He added that an acknowledgement of sinfulness is a necessary step in healing:

Sometimes I think secular psychologists think that Christians, and Catholics in particular, are too focused on people recognizing their sinfulness. But it's not about recognizing sinfulness it's not that we want people to recognize their sinfulness because we want them to feel bad we want them to recognize it so they can give it to Jesus and be free.

One respondent discussed his concern about his own moral responsibility for referring parishioners to treatment with potential negative spiritual consequences. He stated,

…if I'm not sure of the psychologist's ethics are consistent with mine, he need not be Catholic but consistent with mine, then I'm very, very reluctant to send somebody in so fragile a position in to place themselves in an objectively evil situation which will lead to more pain and heart ache than what is already there. Then, in some ways not knowing that I may unknowingly, maybe even inculpably, uh, be contributing to that evil.

Four of these participants (40%) also noted concerns about the quality of mental health treatment provided by unfamiliar professionals. Concerns included worries that secular professionals may be unintentionally insensitive to the values of parishioners and alienate them through, as one participant described said, "an over psychologizing that doesn't recognize or respect the spiritual or faith component." One participant shared his experience of parishioners who had experienced this kind of treatment:

… a lot of people I know who have a deep Christian faith but go to a secular psychologist, that is a non-religious psychologist, and they'll talk and the psychologist is trying but they'll come back to me and say "this psychologist just doesn't get me…."

One of these respondents remarked on the difficulty he encountered attempting to determine the quality of local professionals, "And then you go online and look at so-and-so and … I see what they do and I don't think that's the best thing." Another participant reported being concerned about the interpersonal style of unfamiliar professionals, "you know there are some people who have some great credentials but they have the personality of a wet fish."

One participant gave an example of a time when he did intervene in the treatment of one of his parishioners out of concern for the parishioner's health.

And there was a problem with the local psychiatric practice… resorting too quickly to drugs and to electroshock therapy. So in one case I literally rescued a guy from the care of the local psychiatrist. He was an alcoholic who had been sober some time, but depressed. He ended up hospitalized on heavy meds undergoing shock treatment and his wife came to me in a panic and I said, get him out of the hospital. And he came to my office and in two sessions we figured out that, yeah he had an alcohol problem but he was also an adult child of an alcoholic. His mother had been a raving, humiliating alcoholic and in that case I resorted to a twelve step program and he went to al anon and got better. That's not always the best relationship. If I could get people dusted off and functioning again without referring to the local psychiatrist… I considered it a victory.

Four participants (40%) indicated that they believed the cost of psychological treatment was an obstacle for the people they have referred to therapy. One participant stated, "One of the obstacles is money, it can be expensive." He added, "Sometimes people can use priests as free counselors." One participant noted that he frequently assists parishioners in understanding their insurance policies,

I've also dealt with helping people find out what their health plan cover for that. You know in terms of mental health counseling and psychological resources available to them. Sometimes it's an issue with the insurance because you know the insurance pays for it. They won't do it unless the insurance covers it.

Another participant noted that his parish provided limited assistance for certain members seeking treatment,

If they are really destitute in some kind of way, we will assist and that's why… will go

for those things that the county will offer that are really reduced rates, not like they are

going to… some other professional office.

Another manifestation of financial barriers was described by a priest working with a population

with limited transportation resources. "So, I mean there was one person I tried to refer but they

didn't have transportation. They couldn't figure out how they were going to get there."

Two participants (20%) described a unique obstacle they encountered as priests,

…one obstacle can be when under the seal of confession I might get someone who

confesses, say, suicidal ideation or cutting or something, or maybe even some type of

abuse and all I can do is to encourage them to see me outside the confessional to get help

or give them information inside the confessional to get help. That doesn't happen a lot to

be honest, only a couple times.

One participant noted that the Seal of Confession prevented him from sharing anything he

learned through the sacrament of reconciliation with any other person. He stated,

I had somebody say that they were thinking about harming themselves. So, now, I can't

do anything with that because within the context of confession and the seal is absolute,

but I was able to at least say within that moment, I was able to ask, "Are you getting

counseling? Have you talked about this to anybody?" and just try to encourage them to

seek counseling if they're able to and you know, sometimes it feels like our hands are

tied in situations like that.

This participant mentioned that he also encourages penitents to approach him for a private

meeting outside of confession; however, he states, "But it's rare that somebody will take that

step because then they're revealing their identity, even though the confidentiality, for us, is…

one step below confession." He indicated that at times he would address mental health issues

directly in confession, noting,

> There was at least one time that I actually made a referral in the context of a confession,
> and that's probably happened more than once actually, and handed the person
> information about who they could call, and once I think I even just handed around the
> screen, so I never saw the person…

One unique religious practice mentioned by three participants (30%) was the Rite of

Exorcism. One participant discussed a case which he believed to be a genuine diabolical

possession:

> So for example, when we had this young man who came to the church and started
> speaking in Latin. And when he manifested an understanding of something I said a few
> days before, which freaked me out. I mean, I was getting dressed a few days before and
> I'm like, "you know what, of all the Latin I know, I find it hard to pray in Latin because I
> have to do the pronunciations on the fly." And this kid turns to me and in this deep voice
> starts saying this string of Latin words, the last one ending in "mortis," which means
> death, and he goes, "and you can't even pray in Latin." And I'm like… I mean, oh my
> God! And we came back and he levitated in front of father… and father…, and I wasn't
> here to see that. You, I don't know any psychological pathology that can levitate
> somebody.

The participant noted that in some diocese there is an established procedure to investigate and

treat cases of possession. He reported,

The pastor goes to the diocese and say, "I see them, and they have a problem." And the diocese sends someone to evaluate them and they bring those findings to a team and they assess whether this person is a potential candidate. And the bishop gives the go ahead and they begin a process where the person gets psychological counseling, physical counseling, get sign off legally and so forth. And only when it meets certain criteria will the bishop give permission for the exorcist to perform the exorcism. And so it's, and by the way, the psychologist and the physician are nearby, if not there during the prayers of exorcism.

He noted the importance of mental health professionals in both the assessment of diabolical possession and the treatment of its after effects. As he put it, "we want to make sure in the church that we are dealing with somebody who genuinely has a diabolical problem and not a psychological problem. If it's just psychological we want them to get psychological help." Regarding treatment he stated, "So my point here is this: not that psychologists can now fix levitation, but the person, even when the person is freed from the demons, there are scars left. And so, and so, there's where the psychologists can come in."

Another participant noted that he had the experience of a parishioner who attributed their psychiatric symptoms to demonic possession. He noted,

…like we had somebody a couple of years ago, a young man who had been around for a while, and I guess this issue just manifested itself over time, as it often does for young adults… when he would come up for Communions at Mass, and he would receive from the chalice, he would drink almost all of it, and not leave any for the people behind him. And there were other things. He started showing up with big bottles full of water, asking for them to be blessed, and then drinking the blessed water. And it was his way of self-

medicating through his religious practice, and there were other things, too. He was

becoming rather like compulsive about confessions and the way he was talking about

things was making less and less sense. So there was clearly something not good

happening here.

The participant noted that when he advised the family to seek mental health assistance for this

parishioner, he was met with resistance. He stated, "I was talking with his mother and trying to

almost convince her that he needed a mental health intervention because she wanted to see it all

as a spiritual issue, like she wanted an exorcism for him." He reported the family sought an

exorcism at the diocesan level, but the issue was identified as a mental health concern.

Other barriers were identified based on the reactions of those being referred to being

informed that they should seek assistance from a mental health professional. Three participants

(30%) noted the issue of stigma related to seeking mental health treatment as an obstacle they

must often aid their parishioners in overcoming. One participant commented "Sometimes there's

a concern about stigma… it becomes a barrier even to coming to see the priest." Some of these

participants reported that they find it helpful to discuss their parishioners concerns openly and

provide them with realistic information regarding therapy and the participants' ability to assist

with the parishioners problems. An example of this approach is described by one participant,

I always tell people when I encourage them to go to a counselor and work it out I say this

is going to take at least six months. This is not going to be you go in and they fix

everything, and (I) explain the whole process to them so they are very at peace when they

go and see these people and they are very open to it.

One participant noted that he would even accompany anxious parishioners to the waiting room of a provider during their first appointment as a show of support. One of the participants, who was a person of color, discussed his experience of encountering people who were disinclined to follow his recommendations due to racial bias. He discussed his experience,

> It's very challenging, especially when you take a parish and you find so many parishioners have problems, and different cultures and different things they want the way they want and then you don't give them one, they are sensitive. Especially the racism, it's tough to say that, with the white ones here who hate you just for what you are. It's sad to say that, but it has happened.

**Differentiating between spiritual and psychological problems**

All participants indicated some amount of spiritual direction or pastoral counseling experience. Topics covered included theological questions, advice on how to change behaviors judged as sinful, guidance on how to develop a richer prayer life, and religiously based supportive counseling during grieving. One participant described this pastoral role as, "To be an unbiased ear, or biased to God and his love, which is even better." Participants described how they believed their roles impacted the mental health of others. Half the participants (50%) noted the healing nature of their spiritual work, especially by providing people with a means to make meaning after trauma and loss. One participant discussed his work with people whose marriages ended with annulments saying,

> And you see that faith plays a big part in how just, it's a catharsis thing that helps them shed things from their past. And I see a faith aspect along with a mental health aspect and they are very much intertwined.

Four participants indicated the importance of their work in showing people that they were loved by listening without judgment and accepting them into the church community. As one put it,

> Ours is a healing touch. We don't go to the reason why they are so depressed or why they behave this way but ours is mostly a kind of healing approach to help them with as much compassion as possible. To make them feel that they are not put aside or discriminated

All participants demonstrated an understanding that psychiatrists are able to prescribe medication while psychologists, social workers and counselors are not. Three participants (30%) indicated they were also comfortable treating some parishioners' mental health complaints with basic therapy skills, such as active listening, over limited periods of time. These respondents indicated that typically they treat short term adjustment issues and grief, and they prefer to refer their parishioners to mental health professionals if treatment requires frequent meetings or long treatment. As one such respondent noted, "if a person is not suicidal and functional I would work with the person myself unless they were already working with someone else or I found some reason to think I would need to refer them." Another respondent noted that he was sought out at times because his clients were concerned with seeking out support from a therapist.

> As chaplain for the … police department I understand it from, I'm not sure what you call it, it's not crisis counseling, but decompression type counseling…. They do have counseling available to them through their health insurance plans, and they are also provided counseling through the police department itself. But some of them choose, because of the nature of the job, that they don't want people to think they are not as rough and tough as they are. So they come to me, because all of our stuff is off the record, and it

doesn't get reported back and there's no report made on them. But it allows them to talk

when they need to talk.

Another participant's comment illustrates the limits of pastoral counseling:

And so, if we are seeing something that's gonna require some real supplemental help,

assistance, teamwork, depending on the situation, if it looks like something for a social

worker or a counselor to get involved in we'll point in that direction. If it looks like

something that could be a medical issue, an instability that could have a bit more

complicated medical involvement then we will bring a psychiatrist in.

The categories of problems which were consistently referred by all participants were

cases of suicidal ideation and symptoms of serious mental illness. Beyond these cases, each

individual judged their ability to assist with problems based on whether the problem was one

which they had some experience in treating through pastoral counseling. One participant

summarized his approach to determining the need to make a referral in this way:

There are three cases where I would refer, one is like I feel they need medication. There's

something very odd going on, something in the area of psychotic behavior, either

schizophrenia or something like that. The other is someone, who I feel like is struggling

with something that I'm just not the person to talk to because I don't have the personal

experience or background to be able to empathize as well. So I, so someone, a female

who's cutting, I just can't empathize with that because I don't get it. … I feel like it might

be better for you to talk to another female who has you know, maybe extreme confidence

issues or body image issues or rejection. Something where someone is better able to

empathize and better able to relate and understand than me, I will refer. The other case is

something where I really think it is something that requires long term counseling like, someone really needs like therapy, like a marriage is really falling apart.

A vital aspect of the participants' roles was understanding the boundary between spiritual problems and psychological problems. One participant discussed the process of determining the nature of a person's presenting problem. He noted that while meeting with one person, "she had a situation where her environment was knocking her down, her personality." He noted that, in his judgment, her concerns seemed to stem from a "low self-esteem." He indicated that,

But, it seems that in my book this was not a spiritual matter, this was not a faith issue. She was not questioning on the existence of God. She wasn't questioning on why she should be a Catholic. She was questioning on something outside the spiritual realm and immediately my sense is, "this is not your game. You've got to get her, if she's interested, to someone a professional, who can help her with this matter of self-esteem." I could talk to her until she's blue in the face, but I might not be making any head way. And she really needed to talk to a professional. And that's why I knew it was outside the spiritual realm, the pastoral concern was not with faith, the pastoral concern was with a personality, with her living environment, how to deal with family members so it was not a spiritual matter at all, and that's why I jumped onto counseling.

He reported that he was able to introduce the parishioner to his church's community program coordinator because "she has connections" to community mental health services in the area.

Participants noted that some of these counseling relationships were longstanding before leading to a situation which resulted in them making a decision to refer their parishioner. One

participant gave an example of a family with which he had a longstanding relationship through

spiritual direction with several members. He noted,

> And it's one of those situations where I know the family very well, all the members of the
>
> family very well, so I have to remove myself a little bit at the pastoral line and give them,
>
> and give myself, a certain level of distance. So it doesn't look like I am playing one side
>
> or the other even though I know pretty well what the family's communication issues are.
>
> Whether I'm the best person to communicate that or not. I can do it at one level, but
>
> having somebody from the outside. This is one area where having a mental health
>
> professional come in…. So it provides a certain level of objectivity and expertise.

One participant discussed a referral he considered making based on behaviors he

observed during a religion class. He noted that for a certain participant in the class "as he begins

to get engaged he goes off, way off in his own, and in a way that is beyond normal eccentricities

that one expects, just way off the charts." Due to this behavior the participant reported thinking

"this person needs more help than I can give them." The participant observed that for some

people in his parish he believed that, "what I can give them spiritually needs to be supplemented

by good mental health counseling and perhaps even drugs of some sort, which I'm not competent

to talk about."

The participants reported that the most frequent behavioral issue they encounter is marital

conflict, followed by drug and alcohol abuse, depression and grief. All of the participants

provided an example of a time when they had made the decision to refer someone they were

working with pastorally for mental health treatment. The categories of problems which were

consistently referred by all participants were cases of suicidal ideation and symptoms of serious

mental illness. As one participant noted,

And if I sense that there's a real complicated issue or a chemical imbalance or

inconsistencies in personality and expressions of behaviors at a personal level that seem

to require some more urgent attention, or suicide threats or things like that I will get a

psychologist involved, or psychiatrist involved.

Four participants (40%) indicated that they would refer people from pastoral counseling

if they noticed that the person's behaviors and thinking were not changing over the course of

their meetings, or if the duration of counseling was more than three or four meetings. As one

participant shared,

Usually what happens is my decision will be based on what I observe, and what I hear.

And the ones that I judge probably the first time I see them, not see them, but after the

first time we talk, is, if by the end of our conversation they have not heard anything that I

have said. Or they keep saying the same thing over and over and over again. Then that's

someone who needs much more help than I can give them.

He noted that he often refers parishioners to a local religious sister, a nun, who he reports "has

her master's in mental health counseling and so some of that could be sent to her and she could

determine what it was and if it was beyond her ability."

Five participants (50%) indicated that religious involvement aided mental health, but also

discussed the importance of mental health treatment in aiding people in their spiritual life. One

participant reflected on his work in prisons,

Because we come across, if you don't mind I'll repeat again people who are very

negative in their mind and their behavior but inside there is a bigger and more dignified

things hiding but this is not revealed. So such people we always tell them go to

counseling, go for this and that, no?

Most of the respondents reported they believed that a holistic approach to people as

physical and spiritual beings was vital for their spiritual and physical health. One described his

role as a priest in these terms, "It's my business to help them. Help them physically, help them

spiritually and help them emotionally. So I have to do whatever I can. Jesus ministered to the

whole person. He didn't minister to the part." One participant commented on how his position

within the church resulted in people seeking him out for various kinds of assistance,

> They're people of faith, and they often come 'cause they see me at Mass and they feel
>
> comfortable speaking with me. And that's why they come to see me. So, so we already
>
> have those who are predisposed to faith and so forth and many of that, it's like an EMT.
>
> They… "Broke their arm," I got to get it right. You go see your doctor. You cut yourself,
>
> bind it up and send you on your way. And often this doesn't require, nor do I really
>
> encourage, regular visits because I simply don't have the, the time and the ability to
>
> handle that kind of thing. If I did put a shingle out I would not get any work done
>
> whatsoever.

Four of the participants indicated that they determined which providers were most

appropriate to receive referrals through consultation with other priests, or even parishioners who

were known to have received therapy. As one described the process, "…in the parishes that I've

been at in general we have on file a piece of paper with half a dozen or so of the local

counselors…" Two participants described referring people to members of the parish staff. One

other participant mentioned a religious sister who was a mental health professional.

Four participants referenced the US Catholic Church's domestic social services program, Catholic Charities, as an option for referral. Even considering Catholic Charities as an option, six participants noted that they preferred to refer to a provider who was known to them. These participants noted the importance of parishioners who were also mental health professionals. One participant stated,

> And it won't take me long to size up a counselor, in general, to see whether or not I feel comfortable sending somebody to them. If we begin having a serious conversation, and in particular if it's somebody who's already done church work, that normally puts it on a certain level where I can assess real quickly. And in this case here I can call her right up and say, "listen, I've got somebody. Are you taking on any more clients or whatever?

One participant described his experience working with people transitioning from jail to the community. He noted that the local probation and parole office was hard pressed to provide oversight to a massive case load and relied on community services like his program to connect those on probation and parole to community resources.  Unfortunately he was not aware of any mental health professionals who worked with people within this population who identified as having mental health concerns.

> And on the mental health side, we're dealing with one guy right now who claims to have agoraphobia. And he has no place to go, he's been kicked out of the house and so on. And what I'm finding is there's not much resource to help him. And there's not much work with that one. What I see most right now, not that there can't be other areas where we can help in the future, is the physical. Get them a license, get that an ID card or a job. Place to stay and that type of thing and that can include a family as well. Working with mental health workers, as I said, is non-existent right now but I can see in the future

where it would be a great boon for this community and across the country to help these people.

Two participants reported being approached by psychotherapy practices for formal "pitch meetings." One participant discussed an organization which offered a contract to provide counseling services to his parish.

What they're going to provide is everybody will have access to counselors in the parish by phone, uh, for four times. Uh, these would be professional counselors that they would have available to, to discuss things with. If the counselor, and this by the way goes into spiritual mentorship, too, so there will be spiritual direction and mentorship, and so forth. If the counselor has decided with the client that… there's something here that is something much bigger than what you can handle over the phone, the next thing they would do is find somebody locally for that person to see. Um, and what that does is relieve us.

Another participant discussed his meeting with a local mental health practice.

But they have offices all over and they are a Christian based counseling organization. So they were, they invited a lot of the pastors and clergy from the local parishes to their new offices… and I got a lot of stuff from them. And I said, well, if we are going to focus on counseling then maybe we want to focus on something that's Christian based. I mean it's not Catholic based, but it's Christian.

**Desire to know the  progress of people referred to treatment**

Eight of the participants (80%) in this study indicated their strong desire to know how the parishioners they referred to therapy fared in treatment. This was often described as complicated by the confidential nature of treatment. As on participant noted,

> But sometimes it would be nice to know, like how did things turn out? Was it a fruitful referral or was it a dead end? You know, most of the time I never find out. Actually I can't think of a situation where I've actually found out later how things went or what happened.

Some participants reported continuing to have regular meetings with parishioners for some time after the person began therapy in order to provide support and encouragement. As one stated,

> There are several couples whom I'm meeting with let's say monthly or so for over a year. And it can be coming in and checking in, because I care so I'm not doing counseling but more of an encouragement and a spiritual encouragement. So when I work with them my job is to be present to them and just listen and try to give whatever good spiritual advice that I can. And then um, the psychological work is done with these counselors. But again, typically, like say if a couple is really struggling with their marriage I might see them every two or three weeks every couple of months. And then as they sort of get settled into a counseling relationship and it's not in crisis mode anymore, once it goes past being in crisis mode then I meet with them for a month, excuse me, once a month as just sort of either individually or together sometimes, you know, but as things get better the meetings become less common but I stay in touch with them because these people are almost

invariably parishioners or students who I see on a regular basis so it's agreeable to stay in

touch.

Several others reported that their follow up was less formal, involving a simple question when

they encounter a parishioner in the course of their day. One described his experiences following

up with parishioners,

About half the people that I refer to counseling I might not see them again. But about half

are people I do see again and I can say, hey, did you see doctor at the counseling center,

how did that go, are they helping you?

The most structured follow up described by the participants involved securing a release of

information from the parishioner to their provider to share treatment progress with the referring

priest or deacon. As one participant described, "…if the client requests it then that client will

sign releases so that the pastoral counselor and I can talk about that person and the three of us

can talk about what's going on." One described his interest in remaining involved throughout the

initial month of therapy at least,

If I send someone to someone I want to see how they are doing, to keep tabs on them

because now that I'm aware that a problem exists I want to keep it monitored. I don't

want it to go back into the wood work and once it has disappeared and surprise me

because somebody hung themselves.

**Education and experience in mental health issues and collaboration**

Despite the necessity of discerning the nature of a parishioner's concern, the participants'

knowledge of mental illness and its treatment was limited. Only two participants (20%)

described receiving more than two courses in pastoral counseling, and two (20%) reported no

education at all in recognizing mental illness. Six of the participants (60%) indicated a desire for

increased education in recognizing mental illness. One participant described the workshops

offered by a local professional in his own parish,

> She has also done a couple of workshops for our staff on the issue of recognizing issues
>
> and knowing when to refer, but also how to use some of the tools of what we know about
>
> mental health in the pastoral setting…

Other participants proposed possible structures for such training in their own diocese,

> It could be like, a module, or something, that could provide assistance, give a little more
>
> deeper guidance on particular issues. It could be once a month. Something that comes up
>
> in an e-mail or a continuing education component that provides a little bit more insight.

As one participant stated,

> …maybe diocese need to be aware that there are mental health issues associated with
>
> pastoral issues, and having seminars for priests and deacons to help identify these
>
> problems and then having recourse to professional, a list of professionals that have been
>
> vetted by the diocese as being both professionally competent but also consistent with the
>
> Catholic faith that we could then take these people and we could provide them what they
>
> need.

The participants in the study reported that they were not exposed to models of

collaboration during their training in seminary. One participant's answer was typical of the

others, "I never saw that, I would love to see something like that" Those who collaborated with

mental health providers either learned models from previous careers, or learned about

collaborative models through the experience of working in a parish. One discussed the

development of his understanding of collaboration:

> as a graduate student I would work with I would occasionally teach classes and that sort
>
> of thing and I would, I would, somebody would come to me and say "I'm really
>
> struggling with this or I can't figure this out" and I would encourage them to go to
>
> counseling and they would come back to me and tell me about what the counselor said.
>
> And it just sort of developed over the years but in terms of, so, that collaborative
>
> arrangement really has only been a formal thing, really sort of a normative thing since
>
> I've been here….

Several participants shared their experiences collaborating with mental health

professionals during their careers. One discussed how he had "consulted at some length" with

mental health providers who were his acquaintances and aided him in making decisions

regarding whether to refer parishioners and how to counsel those he did not refer.  He described

two instances of collaboration in this way,

> I remember that same counselor at the seminary I mentioned to you. Referencing a
>
> problem that involved a case of severe narcissistic personality disorder almost certainly.
>
> And there was another case where I consulted with a colleague but not ordained. In the
>
> case of I was doing some marriage counseling and discovered that the groom's mom was
>
> a borderline personality and driving them nuts, but otherwise the marriage was pretty
>
> good. And so I don't know if I ever used the term. But when I saw the description I
>
> checked it out with another person who I had a lot of confidence in and they said that's
>
> probably what it is. So what the marriage counseling ended up being was designing
>
> tactics.

One participant described working in a multidisciplinary church ministry.

> Rachel's vineyards retreats is a very specialized sort of ministry to women who have had abortions who have been traumatized. Sometimes they come years later, sometimes decades later really for help because of all types of post traumatic symptoms. And I've been involved in that ministry as well. There's a psychologist… named Theresa Burke who's written a number of books in that area on post abortion counseling. And I've done some of that work as well where I've been part of the team that meets with women and we kind of go through guided scripture meditations and we pray and we allow them to go through their stories and we listen and just really offer support. And we offer sacramental support, so as a priest I can hear the confession and assure them of God's forgiveness and reunite them to the sacraments receiving communion and so forth in the church.

One participant discussed consulting with a mental health professional about how he could manage his own anxiety when working with parishioners in certain situations,

> I've been in hospital rooms where people have died right in front of me and I have to console their families, like that doesn't strike fear into me anymore like it did when I was first starting out. The one thing that still does is dealing with mentally unstable people. And I've actually talked with my counselor, who I told you about before, about this, like "Okay, I need some strategies here because I'm gripped by fear when I'm dealing with these situations."

Four participants (40%) noted that they have sought support for their own psychological problems. Three of them (30%) described their personal experiences in mental health treatment for issues related to grief, job stress and mood disorders. As one participant suggested

And priests, I'm sure I'm not alone, I don't think the majority of priests are on any

medication, but I'm sure there are some priests, especially between 10-20% who have

had some struggle in their own life whether it is with alcohol or some kind of depression

or an anxiety disorder of some kind because we can get under a lot of stress sometimes,

and we suffer from the same kind of family backgrounds and dysfunctions as anybody

else.

All the participants who reported having experienced their own therapy stated that it was a

positive experience which helped them cope with their problems.

## Chapter V

## Discussion

This study examined the perspectives of Roman Catholic priests and deacons regarding mental health professionals. The interview process explored the participants' training experience, pastoral experience, and religious and philosophical beliefs. This chapter discusses themes that emerged from the participants' responses to questions related to their experiences making referrals to mental health professions, including the obstacles they perceived in this process. Such themes included being trained to refer, referring relatively few people to professionals, obstacles to referrals, how participants identified mental health concerns, how they networked with professionals, and their education and interest in mental health issues, including models of collaboration.. Limitations to this study and implications for future research are also discussed in this section. Implications include areas for future research; and recommendations for mental health professionals and clergy.

**Themes**

**Making referrals.** All participants indicated that they received training to refer people with mental illnesses to professionals rather than treating these people independently. Participants indicated that they were warned about legal liability if they were "…accused of practicing medicine without a license, or something like that," as one said. All participants indicated an openness to making referrals. The responses of participants suggested that, as a whole, they tended to refer relatively few people to treatment. The majority of respondents reported referring five or fewer people to treatment in a year. These responses are consistent with past studies indicating a tendency of clergy members in general to not refer their parishioners to mental health treatment (Vanderwaal, Hernandez & Sandman, 2012). The participants who

reported more than five referrals in a year indicated that they made in excess of twenty referrals annually. These two participants also reported existing relationships with large groups of mental health providers, one through their employment as a prison chaplain, and the other through their work in a pastoral counseling center. Despite the efforts by researchers (Allicock, et al. 2013; Fincham & Beach, 2013), scholars (Blass, 2012; Cottam, 2011), and clinicians (Bottaro, 2014;Milstein, et al., 2008; Rosmarin, et al., 2013), the overall trend of these participants' responses indicated that their connections with therapists were informal, personal connections with a small group of clinicians, as suggested by Plante (1999) in his account of networking within local religious communities.

**Obstacles to referral.** Participants described doctrinal and practical obstacles to making referrals to mental health professionals. All participants voiced some concerns about obstacles to making referrals. Participants voiced concerns about material obstacles to people engaging with treatment. Their responses are generally consistent with past findings which found that financial cost, stigma, denial, and lack of knowledge about treatment options are common barriers to people accessing mental health treatment (Milstein, Manierre, Susman, & Bruce, 2008; VanderWaal, Hernandez, & Sandman, 2012). An interesting variation on the barrier involving lack of knowledge regarding treatment options is the theme of participants being reluctant to refer to providers without knowing the quality of their work. As one participant opined, "And then you go online and look at so-and-so and … I see what they do and I don't think that's the best thing." The challenge of interpreting the quality of care provided by an unfamiliar clinician is further complicated by concerns about how their approach to religious topics may impact their patients, as mentioned by the participant who stated, "They'll talk and the psychologist is trying but they'll come back to me and say "this psychologist just doesn't get me…." Questioning the

quality of mental health treatment is a wide spread phenomenon (Jorm, 2012), which may be best addressed by interventions which improve knowledge of mental illness and effective treatment (Jorm & Kitchener, 2011).

Other findings reflect the results of VanderWaal, Hernandez, and Sandman (2012). Four participants mentioned financial limitations as a barrier to receiving treatment. Two of these respondents mentioned ways in which they have assisted people in overcoming this barrier. One reported that his church offers financial assistance for those "destitute" members who would otherwise not be able to afford treatment. Another participant stated that he will sometimes review a parishioner's insurance information and help determine what treatment options are available through the person's insurance. The issue of stigma was a barrier for the person who was being referred to treatment. Participants noted that they routinely provided education about therapy in order to assuage their parishioners concerns, and one participant occasionally accompanied parishioners to their first session of treatment. In these ways the participants illustrated some means by which they are a resource facilitating access to mental health care.

Some participants shared unique barriers to treatment in their religious context. The issue of denial of a mental illness became problematic when symptoms of mental illness were attributed to spiritual or moral problems. One participant shared an example of an instance when a parishioner demonstrated a progression of bizarre behaviors including drinking bottles of holy water and becoming "compulsive" about confessions. Although he reported that he strongly recommended the parishioner's family members contact a mental health professional, they persisted in the belief that the matter was spiritual and an exorcism was required. The participant noted that the family was slow to accept that the problem was psychiatric rather than diabolical. Research demonstrates that spiritual interventions are considered to be less stigmatized than

psychological treatment (Milstien, et al. 2008), although in the case of diabolical possession the

Catholic Church has an established process to differentiate between natural phenomenon and

demonic influence (Code of Canon Law, Canon 1172 §1, 1998, Libreria Editrice Vaticana,

1994).

Reports of psychological problems in the course of confession were a particularly unique

and problematic situation described by two participants. These participants noted the sanction

against sharing any information they learned about people through the sacrament of

reconciliation (Canon Law, Canon 983 §1, 1998). They discussed their attempts to provide

information in the setting of confession when they learned of self-injurious or suicidal behaviors.

They noted attempts to encourage penitents to meet with them in an alternate setting. Although

the absolute nature of the confessional seal was a hindrance in connecting people to professional

care in these instances, both participants agreed with the necessity of providing people an

assurance of absolute secrecy to encourage absolute candidness when confessing sins. The nature

of this absolute seal is taught to Catholics at a young age when they first receive the sacrament,

so it is likely that the penitents in these cases understood that there would no referrals made in

that context. Past research has demonstrated that some priests offer counseling through within

the setting of the confessional although they did not make referrals based on information shared

in these confessions (Orfield, 2003; Galvin, 2008).

The sole participant who identified as a person of color noted that some people he

encouraged to attend therapy discounted his advice because of discriminatory attitudes they held

toward him due his race.  Although underrepresented in this sample, a large number of Roman

Catholic priests are immigrants and people of color (USCCB, 2011). Racial bias and anti-

immigrant sentiment may complicate communication about a topic as stigmatized as mental

health. Although this barrier is not unique to the Catholic experience it demonstrates the impact

that larger social issues have on this group.

Seven participants voiced concerns related to the potential for psychotherapy to change a

person's attitudes in ways that would prevent them from living religiously moral lives. These

concerns were generally related to the perception of mental health professionals as "secular" and

unconcerned for religious matters. This finding is in line with the research by Delaney, Miller,

and Bisonò (2007) supporting the premise that psychologists were generally less religious than

the general population of the USA. The perception of this secular worldview concerned

participants who stated that psychotherapy which challenged religious beliefs may damage the

spiritual life of patients. One participant noted that if immoral behavior is normalized it may

prevent the recognition of sin necessary for proper conversion. Orfield (2003) demonstrated that

priests view recognition of sin and conversion as necessary to receive the forgiveness of God and

the grace necessary to enter heaven.

Moral concerns extended to married couples referred for couple's therapy. Half the

participants indicated that they were concerned that secular providers might advise divorce to

couples in situations where clergy would not. The belief that the sacrament of marriage in the

Catholic Church provides the spiritual power to maintain a fruitful and loving lifelong

relationship (Libreria Editrice Vaticana, 1994) was demonstrated by one participant who noted

he believed that some marriages which would otherwise have ended in divorce were sustained by

the power of the sacrament which helped the couple resolve their problems. The United States

Conference of Catholic Bishops (2009) reiterated the permanence of marriage after a civil

divorce, even in situations in which divorce is deemed by church authorities to be "only solution

to a morally unacceptable situation," such as abusive or otherwise dangerous relationships. When

considering options to help their parishioners, the participants prioritized the spiritual wellbeing

of their parishioners, except in the cases with a high potential for physical harm such as suicidal

ideation or psychosis. One participant indicated his sense of being responsible for the spiritual

and psychological outcomes of therapy which leads to violations of Catholic morality, stating,

"I'm very, very reluctant to send somebody in so fragile a position in to place themselves in an

objectively evil situation which will lead to more pain and heart ache than what is already there."

Miovic (2004) pointed out this concern for moral outcomes as an obstacle for religious

persons in treatment. Participants in this study shared this view that along with the potential for

moral harm, a mental health professional who does not demonstrate respect for the religious

values of their patients risks alienating them. Several participants indicated a concern that this

sense of alienation has disinclined some parishioners from seeking professional treatment ever

again. Pargament (2013) and Masters (2010) have previously advised psychologists to respect

diversity in religious values as well as other domains. One participant made a statement in a

similar vein, "Sometimes the secular background is really great. It provides an informational, at

the level of reason, where intellectual study has been really respected and the scientific method

has been allowed to unfold and do its work without investigator bias." He noted his concern that

some providers may not be aware of their own biases. Regarding the potential of secular science

to bias one against religion, Miovic (2004) pointed out that a secular viewpoint does not

necessitate a materialistic and atheistic perspective. He argues for an agnostic approach to

spiritual subjects, in which the limits of natural science regarding spiritual matters are

acknowledged and the provider is open to the perspective of the believer that these spiritual

aspects are indeed real.

**Differentiating between psychological and spiritual concerns.** Researchers have demonstrated that clergy members in general (Leavey, Loewenthal, & King, 2007) and Catholic priests specifically (Pillion, Reed, & Shetiman, 2012), are not trained in the recognition or treatment of mental illness. Participants from this study noted that they would refer people to treatment in the case of overt and risky symptoms such as suicidal ideation, psychosis, or apparent delirium. In most other cases the decision to refer a person to treatment seemed to be made on the basis of whether the participant believed himself to be capable of assisting the person in making changes and how many meetings it would require to assist the person in making those changes. For some participants they saw any non-religious matter as outside of their ability to help, while others chose to help with behavioral concerns as long as these concerns were responsive to brief counseling.

All the participants noted their own experience providing spiritual direction and counseling. The act of spiritual direction is considered an important part of pastoral work and involves a continuous process of assisting those under direction in discerning between the will of God and the urges of temptation (Barrette, 2002). Most of the participants noted that they believed their pastoral work provided mental health benefits. Some participants noted that during the process of spiritual direction they would encounter behavioral issues which were not responsive to their approach and indicated a need to refer their parishioner to a mental health professional. These issues could involve ongoing problems, such as the family "communication" problems mentioned by one participant who was concerned about how his pre-existing relationship with the family members could complicate any effort he made to help them resolve their problems. This concern motivated him to seek outside resources for the family's treatment to preserve his boundaries and relationship with them.

**Connections with mental health providers.** The majority of the participants in the study stated that they relied on informal networks to make referrals to professionals. Most respondents reported that they relied heavily on their own experience of interacting with a provider, or else relied on the recommendation of others with experience interacting with a provider, when making a decision to refer to someone. These findings are consistent with Plante's (1999) description of his experience networking with clergy members. Allicock et al. (2013) commented on how their participation in services and personal interactions with clergy members facilitated the implementation of their program. The participants in this study exhibit a similar interest in knowing providers personally before trusting them with referrals. The exception to this approach was in cases where participants operated within a system with established protocols for making referrals to mental health providers within the system, as was the case for the participant working within the prison system. Two participants described being contacted by mental health practices which presented themselves as respectful of religious values and competent in providing care. In these cases the organization seemed to have made an impression that its providers could be a reliable resource, as one participant stated, to "relieve us." This approach of presenting professionals as a relief for priests and deacons trying to help parishioners echoes the approach the Milstein et al. (2008) reported as being an effective means of recruiting clergy to the C.O.P.E. program.

**Training in mental health topics.** As mentioned earlier, past research has demonstrated that many clergy members and Roman Catholic priests are not trained in recognizing mental illness, and research has suggested that they are not trained in providing mental health treatment. The participants in this study acknowledged the limits of their education and most stated that they were interested in additional information about the recognition of mental illness and

treatment resources in their community. Mental Health First Aid (Jorm, 2012; Jorm & Kitchener, 2011) have been used to educate workplaces, schools, and the general public about symptoms of mental illness, as well as appropriate resources for the treatment of mental illness. For priests and deacons, who will have more intimate and perhaps long term connections with people seeking help, additional information about subtle signs of mental illness and local treatment resources could be a boon for local professionals and clergy.

**Training in collaboration.** Psychologists have been striving to make their practices more sensitive to religious diversity. Researchers have developed approaches to pointing out similarities between psychological and religious approaches to behavior change (Blass, 2012; Cottam, 2011) and have adapted treatment approaches to integrate spiritual coping (Rosmarin et al., 2013). Others have made steps to appeal directly to Catholics seeking treatment by advertising themselves as respectful co-religionists (Bottaro, 2014) while programs like C.O.P.E. (Milstein et al., 2008) have sought to recruit clergy directly into a collaborative relationship. None of the participants were educated in these, or any models of collaboration during their education in seminary. Those who indicated that they had collaborated with professionals, besides making referrals, stated that they had developed these approaches in prior careers or else as they worked in pastoral settings. Educating priests and deacons about these or other effective models of collaboration during seminary or at the beginning of their pastoral careers should be combined with educating more mental health professionals about models of collaboration. As Plante (1999) noted, he developed in his role as a consultant to churches partially due to being the only psychologist in his locale with interest in working with the Catholic Church.

**Participants wanted to know the outcome of referrals.** Participants in this study voiced their interest in knowing the outcome of referrals. They noted an interest in the wellbeing

of their parishioners and the quality of the help provided by professionals. The participants noted

that they would ask their parishioners about their status and their general experience of therapy.

One participant noted that he actively encouraged couples he referred to treatment to continue.

Another participant noted his concern that a problem could be overlooked if he did not ensure

that people were in treatment. Although the participants did not always know whether the people

they referred to help followed through with the referral, they did indicate their hope for these

people's health.

**Limitation of the study**

The sample size of this study was small. The results should not be generalized to a

broader population, although they provide examples of how some priests and deacons perceive

mental health professionals. Seven of the participants were priests and three were deacons.

Although both groups serve in some similar functions, they are significant differences between

the two groups. Priests are unmarried and work full time in their positions as clergy, while

deacons may be married and are often either retirees or work full time at a conventional job and

part time as clergy. These, and other differences between the groups, may well have an impact

on each groups' perspectives on mental health professionals. Another limitation was that

participants were from several locations in the USA. A sample based on diocese or regions

would provide more information about the variance in perspectives in areas with similar

resources. Demographically the sample was 90% White, and the experiences of these

participants will likely not generalize to priests and deacons of color, and may not capture the

experiences of those clergy serving the growing number of Catholics who identify as people of

color (Gray, 2015). One final limitation to note in this study is the possibility of investigator bias,

since the researcher was the creator of the interview protocol, and collector and interpreter of the

data. In addition, the researcher has a great deal of interest in the topic presented. The degree of involvement of the researcher's interest in the design, implementation and data analysis may relate to possible investigator bias, and should be considered when interpreting the findings of this study. Despite these limitations, this study provides a current, in depth sample of how Roman Catholic priests and deacons perceive mental health professionals.

**Implications**

**Implications for future research.** The goal of this research was to identify how Roman Catholic priests' and deacons' perceptions of mental health professionals influenced their decisions regarding making referrals and collaborating with professionals. Researching this topic is essential to address the needs of people with diagnosable mental illnesses who initially, or solely, seek help from Roman Catholic clergy. Future research of this topic is necessary to fully understand these perceptions.

The responses of the participants in this study are similar to past research findings regarding the knowledge clergy have of mental health issues and the likelihood they will refer parishioners to professional treatment (Bledsoe et al. 2013; Leavey et al., 2007; Vanderwaal, Hernandez & Sandman, 2012), as discussed above. This tendency to not refer people to treatment has endured despite recent trends in the field of psychology to increase engagement with religious communities. It will be important to investigate the degree to which these trends, in the form of theoretical studies, treatment programs, and community outreach efforts have affected the perception of psychology among Roman Catholic clergy.

The education of Roman Catholic clergy in issues pertaining to mental health, including how to recognize signs of mental illness and collaborate with local treatment resources is an important area for study. The Roman Catholic Church is a large organization which has

standards for the education of its clergy. Future studies could identify ways to improve the education of priests and deacons either in the seminary or through continuing education.

**Implications for mental health professionals.** The relatively low number of referrals reported by participants seems to be related to a combination of doctrinal and practical obstacles, challenges identifying symptoms of subtle mental illness, and limited knowledge of mental health resources in the local area. Most respondents reported an example of a personal acquaintance or familiar agency who they trusted to be a respectful, quality clinician. The importance of the personal approach has been discussed in past research (Allicock et al. 2013; Plante, 1999) and seems to be relevant for the participants in this study. The concerns about doctrinal pitfalls in treatment or poor interpersonal skills of clinicians are alleviated by knowing about a person through direct experience. Personal outreach by professionals also offers an opportunity to support priests in deacons through education about mental illness, psychotherapy, and models of collaboration. The responses of clergy and data from past research suggest that personal engagement should be focused on building trust and demonstrating the professional's ability to address the needs of both parishioners and the clergy (Milstein et al., 2008).

Researchers have noted the importance of clinicians developing cultural competence to improve the health outcomes of clients (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). One means of establishing trust could be to take a "positive approach" to learning about the religious values of Catholics. Lev (2004) described a "transpositive approach" in the context of mental health professionals working with transgender clients, and similar methods can apply to any category of diversity. The concept of the approach is to move beyond the passive role of learning about a person's experience solely through asking them about their identity. This approach requires the professional to actively seek out information about the identity group of

the client, to learn about the historical context of the group, their vocabulary, and their common

concerns. Starting with this basic knowledge the professional then learns other relevant

information from their client. Many participants in this study stated that they would refer to a

professional regardless of religion if they were confident that the professional would be

respectful of a patient's religious values. When approaching a religious community such as

Roman Catholic clergy it could be beneficial to learn some basic information about their belief

system to demonstrate an interest and respect for their values. This respect could be further

communicated by professionals who attend religious functions, as Allicock et al. demonstrated in

their research (2013).

Communicating respect could include addressing the concerns of priests and deacons

about the potential for therapy leading to moral problems. Professionals could communicate the

ethical guidelines abjuring professionals to be respectful of diversity, including religious

diversity, such as the APA Ethics Code (APA, 2010). Professionals could share research

discussing the positive psychological benefits of religious involvement (Pargament, 2013) to

communicate the current state of the relationship between psychology and religion, as opposed to

the famously anti-religious messages of Freud (1927/1990) and Ellis (1980). Professionals could

use the concepts of scholars such as Blass (2012) or Cottam (2011) to illustrate common ground

shared by psychology and religion. Communicating clearly about the therapeutic approach of the

professional could serve to demystify the process and address any stigma about treatment that

particular priests or deacons may have (Jorm, 2012).

Professionals could address clergy interests by demonstrating how their work could

benefit priests and deacons by addressing the time consuming and stressful problems posed by

parishioners with mental illnesses. Milstein et al. (2008) found success when presenting clergy

with the stress reducing benefits of their COPE program. One participant reported his own interest in a program which offered a program which could "relieve us." Professionals could present on the potential benefits of therapy for parishioners. Professionals could benefit from sharing information about the effectiveness of treatment in addressing various disorders. Priests and deacons may be especially interested in data regarding the effectiveness of Behavioral Couples Therapy and Emotionally Focused Therapy in addressing relationship issues within marriages (Snyder, & Halford, 2012).

Providing education for priests and deacons could be beneficial to professionals and the people they train. Presentations about recognizing mental illness, local mental health resources and types of treatments for mental illness could educate clergy and improve their level of trust with professionals. Education could be a resource for priests and deacons attempting to address the concerns about stigma mentioned by participants in this study. Masters (2010) recommends networking with clergy as a clinical resource for consultation, so education could be a two way street. Finally, education initiatives such as the programs demonstrated by Fincham and Beech (2013) or Yan (2011) could allow professionals direct access to parishioners through the church.

**Implication for priests.** Participants in this study demonstrated a variety of working relationships with mental health professionals. Within some parishes it may be that several professionals are involved and visible members. Without these naturally occurring trustworthy resources it seems that many pastors either learn through word of mouth about competent providers or must make the best possible choice about referral options with limited information. All pastors are in stressful settings, even more so for those with clusters of parishes or who work with populations who have limited resources. Participants made creative use of resources, including one who was involved with a local counseling center, and another who sought

consultation from past professors when dealing with difficult counseling situations. Pastors would benefit from reaching out to local professionals or past contacts to establish professional supports.

**Implications for deacons.** Deacons are called to be symbols of service for the Church (Benedict XVI, 2005; USCCB, 2005) and often the people they serve are suffering from psychological pain. Developing a network of professionals who can be resources for referral, training, consultation, or programming may be beneficial to any deacon. The balance or work, home life and religious duty is delicate. The use of a professional network could address the stress related to this balance, and keep time free for loved ones. Due to their unique connection to their bishop (USCCB, 2005) deacons may be in a unique position to encourage diocesan initiatives regarding mental health education and programming.

**Conclusions**

This study was designed to investigate the perspectives of Roman Catholic priests and deacons about mental illness and making referrals to mental health professionals. Through the interview process, participants reflected on their experiences making referrals and their perceptions of various obstacles to making referrals. Many of the participants offered information that was consistent with the literature on the topic clergy members collaborating with mental health professionals.

Although the sample size was small and therefore cannot be generalized to the Roman Catholic priests and deacons throughout the USA, this study provides useful information. First, consistent with the literature, the participants were generally unlikely to refer parishioners to professional treatment, despite generally positive perspectives on mental health treatment and being trained to make referrals. Participants noted obstacles such as the cost of treatment, concerns about the quality of treatment providers, and they noted concerns that treatment could adversely affect the spiritual life of those being referred. Participants discussed how they determined whether a person required a referral for professional treatment and they discussed the limits of their knowledge of mental illness and their interest in receiving training about mental health issues.

The study has implications for mental health professionals and Catholic clergy. Participants stated that they preferred making referrals to professionals who they personally knew and trusted to be competent and respectful of parishioner's religious beliefs. They noted an interest in being trained by professionals to better recognize mental illness and appropriate resources for treatment. Professionals' relationships with Catholic priests and deacons would benefit from learning about Catholic religious practices and beliefs. Professionals would further

benefit from establishing personal connections with clergy and educating them on the efficacy of

treatment and the respectful treatment of religion in therapy. Finally, professionals could address

the issue of clergy stress directly by demonstrating how their services could reduce the workload

of clergy members who provide pastoral counseling. In this way the professional community can

demonstrate their value as supports to religious communities and leaders, rather than religious

communities and leaders acting as means of disseminating treatments or as networks for

professionals.

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Appendix A

Interview Protocol

Please tell me about your current position as a priest/deacon.

1) Are you in a religious order or do you work for a diocese?

2) What roles do you currently fulfill?

3) How long have been doing these things?

4) What other places have you worked?

5) What other roles have you fulfilled?

6) What careers did you have before you became a priest/deacon?

7) What kind of people do you work with now? What social class? What ethnicities? What family make-up?

Please tell me about your knowledge of the mental health field.

1) What do you know about the different roles played by various mental health professionals? For example, the different roles played by social workers, psychologists, counselors and psychiatrists?

2) What kind of relationships do you have with mental health professionals?

    a. What personal relationships do have with people who work in the mental health field?

    b. What professional relationships do you have in the mental health field?

3) What training have you received in recognizing mental illness?

4) What kind of training have you had in providing mental health treatment?

Please tell me about some of your experiences with mental health issues and mental health professionals.

1) What kind of mental health issues have you encountered in your role as a priest/deacon?

2) What do you think about working with mental health professionals?

    a. Please give me an example of a collaborative relationship you have had.

    b. What models have you seen for this type of relationship in your training or other professional experience?

3) What kind of collaboration have you experienced with mental health professionals?

    a. How often have you referred parishioners to mental health professionals?

    b. How often have you consulted with a mental health professional?

    c. How do you see yourself working with mental health professionals in the future?

4) Could you give me an example of a time when you made a decision about whether to refer someone to mental health treatment?

    a. If not, in what kind of situations could you imagine making such a decision?

    b. What factors have you considered, or do you imagine considering, when making a decision about whether to refer?

        i. What factors serve as obstacles to referral?

        ii. What factors make referral easier?

        iii. Do you have examples of these?

5) How often do you make these decisions about whether or not to refer?

6) How often do you continue to provide direct care to someone you have referred to a mental health professional for services?

7) What are some of the benefits of referring?

8) What are some of the drawbacks?

Just for my information, what is your comfort level with the English language?


Now I will ask you some questions about your worldview.

1) What is your personal belief about your role as a priest/deacon?

2) What is your religious perspective on what motivates people to think, feel and act the way that they do? How do you understand human nature from a religious perspective?

3) What is your psychological perspective on what motivates people to think, feel and act the way they do? How do you understand human nature from a psychological perspective?

4) How do these perspectives affect your decisions about referring people, or otherwise working with mental health professionals?

5) What is your personal belief about the nature of psychological problems?

    a. How do they originate?

        b.   What kind of people have them?

        c.   What are the best ways to deal with them?

6)  How does your religious work relate to mental health?

Thank you for sharing this with me. You have told  me a great deal, and I appreciate your time.

What would you like me to know about your experience that I did not ask about? 5

PRIESTS' AND DEACONS' PERSPECTIVES

Appendix B

**INFORMED CONSENT AGREEMENT**

**"An exploratory study of Roman Catholic clergy members' professional relationships with mental health workers"**

You are invited to participate in a research study. Before you agree to participate in this study, you should know enough about it to make an informed decision. The principal investigator, Isaiah Ares-Batko, is a doctoral candidate in the Graduate School of Applied and Professional Psychology at Rutgers University. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.

**Purpose**: The purpose of this study is to investigate the nature of Roman Catholic clergy members' relationships with mental health workers by interviewing Catholic clergy about their experiences. The goal is to demonstrate some of the issues which improve these relationships, or else serve as obstacles to these relationships.

**Participants**: This study will use a network sample of approximately 10-15 Roman Catholic priests and deacons. Interviews will be conducted on the phone, via Skype, or in-person at various settings. All participants must complete the Informed Consent Agreement in order to participate.

**Procedure**: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location, or if you prefer, over the telephone or via Skype. Interviews will last approximately 60-90 minutes. You will be asked to complete a brief demographic questionnaire and then be interviewed about your experiences. All interviews will be audio-recorded and notes will be taken in order to ensure the accuracy of your report. With the researcher, you will discuss your knowledge of the mental health field, your experiences making referrals to mental health professionals, your experiences of collaborating with mental health professionals and your beliefs about what factors make collaboration more or less difficult. The researcher will also ask about your beliefs about the nature of what motivates human behavior and thought from your perspective.

**Research Standards and Rights of Participants**: Participation in this study is **VOLUNTARY**. You may choose to withdraw at any time during the interview without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable. If you indicate at any time that you want to stop the interview, you will be thanked for your participate and will be free to go home. This NOT connected with any government agency. Copies of the results of this research shall be made available to you upon request.

**Risk/Benefit**: There are minimal risks associated with your consent and participation in this research study. If you are uncomfortable with the interview at any time, you can indicate that you would like to stop the interview. Participation in this study may not benefit you directly; however you will play a major role in helping other researchers, policy makers, mental health workers, and others to understand the experiences of Roman Catholic clergy.

Participant's Initials: _____

**Permission to audio record interviews.** Participation in this research study requires that the interviews be recorded for later analysis.  You will always have the option to refuse the recording of the interview, or any portion of it.  Codes, rather than names, will be placed on all recordings.  Audio recordings will not be presented for conferences.  All recordings will be destroyed when the study is complete

**Confidentiality**: This research is confidential. The research records will include some information about you and this information will be stored such that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, gender, present location and job title. Please note that we will keep this information confidential by limiting individual's access to the research data and keeping it in a secure location at the researcher's residence.  Your responses will be grouped with other participants' responses and analyzed collectively.  All identifying information will be disguised to protect your confidentiality.  All study data will be kept for three years after the completion of the research, and all documents with identifying information and field notes will be shredded or burned and any audio recordings will be erased by the researcher after publication.

If you have any questions or concerns or comments about the research, you may contact me, Isaiah Ares-Batko, at 518-879-9250 or email me at isaiaharesbatko@verizon.net. You can also contact my dissertation faculty chairperson, Dr. Brenna Bry, at (848) 445-3977 or email her at bbry@rutgers.edu.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:
Rutgers University, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848-932-0150
Email: humansubjects@orsp.rutgers.edu

**I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project**.

Participant Name (Print) _____
Participant Signature _____ Date _____
Investigator Signature _____ Date _____

Thank you for your participation in this research project.  Your involvement is greatly appreciated.

PRIESTS' AND DEACONS' PERSPECTIVES