A spectrum of belief: a qualitative exploration of candid discussions of clergy on mental health and healing

Jennifer Shepard Payne & Krystal Hays

To cite this article: Jennifer Shepard Payne & Krystal Hays (2016): A spectrum of belief: a qualitative exploration of candid discussions of clergy on mental health and healing, Mental Health, Religion & Culture

To link to this article: http://dx.doi.org/10.1080/13674676.2016.1221916

Published online: 08 Sep 2016.
A spectrum of belief: a qualitative exploration of candid discussions of clergy on mental health and healing

Jennifer Shepard Payne and Krystal Hays

Department of Social Work, School of Behavioral and Applied Sciences, Azusa Pacific University, Azusa, CA, USA; School of Social Work, University of Southern California, Los Angeles, CA, USA

ABSTRACT
Since clergy are often first responders to mental health issues, it is important to understand clergy views on handling such issues. A discussion occurred in 2012 amongst clergy involved in a popular social utility network clergy’s group. One clergyperson asked peers: “If the church is where we are to come for healing, how do we handle people who are depressed, suicidal, suffering from PTSD or anxiety?” Over 140 comments were made during 13 days, and 35 clergy from the United States, Africa, and India contributed to the discussion. Data from this conversation were examined via classic grounded theory. Analysis revealed a spectrum of beliefs that clergy hold regarding the causes and best treatments for emotional issues. Findings shed light on the candid thoughts clergy have about mental health care. The findings provide greater understanding for mental health practitioners with clients who rely on their church for emotional support.

ARTICLE HISTORY
Received 19 February 2016
Accepted 4 August 2016

KEYWORDS
Pastors; clergy; mental health; depression; trauma

Introduction
Many individuals with mental health problems seek out clergy members for support. Clerics are important sources of social support and provide services that range from spiritual guidance to formal counselling (Leavey, Loewenthal, & King, 2007). However, much of the literature on mental health and clergy support focuses on the perspective of the help-seeker. Many studies investigate individual preferences for informal support over professional treatment (Jimenez, Bartels, Cardenas, Dhaliwal, & Alegría, 2012; Murry, Heflinger, Suiter, & Brody, 2011). However, there is a dearth of literature that explores clergy attitudes, perceptions, and beliefs about mental illness. Little is known about clergy members’ beliefs about the etiologic, course, and common responses to mental and emotional problems. This is an important area of exploration as the mental health literature suggests that the attitudes of the helper play a critical role in the therapeutic relationship and mental health outcomes of the help-seeker (Sandell et al., 2007). The attitudes and beliefs about mental illness held by clergy undoubtedly guide their interactions with the mentally ill individuals who come to them for help. Thus in order to fully understand the impact of social support provided by clergy members we must better understand the attitudes and beliefs they hold about mental illness.

CONTACT Jennifer Shepard Payne jspayne@apu.edu
© 2016 Informa UK Limited, trading as Taylor & Francis Group
Many individuals with mental illness prefer informal sources of support, like clergy, to help them manage their symptoms (Chalfant et al., 1990; Dupree, Watson, & Schneider, 2005; Murry et al., 2011). Several studies have suggested that individuals experiencing depression and other emotional stressors are likely to go to their religious/spiritual advisors for help instead of formal mental health professionals such as psychiatrists and social workers (Neighbors, Musick, & Williams, 1998; Woodward et al., 2008). Mental health support from clergy is especially important to older adults and those who are frequent church attendees (Ellison, Vaaler, Flannelly, & Weaver, 2006; Thompson, Bazile, & Akbar, 2004). There are several suggested reasons for this preference for clergy support including low cost, ease of access, trusted relationships, and cultural normativity (Blank, Mahmood, Fox, & Guterbock, 2002; Neighbors et al., 1998).

It is also important to understand the scope of supportive services provided by religious leaders. Research suggests that 59% of clergy have counselled someone with a mental illness such as depression, bipolar disorder, or depression (Smietana, 2014). Clergy provide a range of supportive services including individual and family counselling, spiritual advice, and referrals to community services (Hall & Gjesfjeld, 2013; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Religious leaders often serve as gatekeepers to more formal mental health services (VanderWaal, Hernandez, & Sandman, 2012). Although some studies suggest that some clergy have formal education and training in counselling individuals with mental illness (Langston, Privette, & Vodanovich, 1994), there is also evidence to suggest that a great proportion of clergy lack formal training and feel ill-equipped to manage the complex mental health issues brought to them (Payne, 2014; Smietana, 2014).

Because of the behavioural health workforce shortage and the need to reach unsourced populations, there is a nationwide trend in the United States (and a global shift) to provide mental health service through nontraditional vocations. Mental health service provision can occur by training those in occupations without formal mental health training such as teachers, police, peer specialists, bartenders, and clergy, among others (Jorm, Kitchener, Sawyer, Scales, & Cvetkovski, 2010; Kazdin & Rabbitt, 2013; Kisely et al., 2010). Shifting service provision to these groups is a way to fill the gap, thus it is important to determine a baseline regarding clergy thoughts and attitudes on the subject of mental health and wellness.

There exists a small body of research that offers general insights into the thoughts clergy members have about mental illness and treatment. A study of Christian pastors assessed clergy members’ exposure to mental illness and thoughts about treatment. The results suggest that 56% of pastors strongly agreed that local churches have a responsibility to provide resources and support to individuals with mental illness (Smietana, 2014). Further, they concluded that 40% of pastors believe that medications should be used to treat mental illness and only 2% thought that psychotherapy should not be used (Smietana, 2014). Other studies tend to focus on measuring clergy’s feelings of self-efficacy in providing counselling (Hedman, 2014; Pickard, 2012) or their attitudes towards providing referrals (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013). Although generally informative, these results focus on clergy’s feelings about the work they do and not on their schemas and deeply held beliefs about mental illness itself.

One study by Stanford and Philpott (2011) attempted to identify the perceptions Baptist ministers held about the causes and treatment of mental illness. They found that while senior pastors embraced biological causes and treatments for mental illness
as most important and effective, their perceptions of psychosocial and spiritual factors varied greatly (Stanford & Philpott, 2011). Although this study provided an important first step in highlighting variations in clergy perceptions of mental illness it was limited in that the authors reported data from a sample that primarily consisted of large, affluent congregations in suburban settings. This limits the generalisability of the findings to more socioeconomically diverse populations, given that low-income and poorly resourced congregations have different challenges than highly resourced ones. Studies like this have been generally helpful for highlighting the practices, knowledge, and perceptions religious leaders have regarding mental and emotional problems. However, they have been unable to elucidate the firmly rooted attitudes and beliefs clergy hold towards mental illness.

To illuminate this currently underexplored area of the mental health literature, we analysed conversational data from clergy members derived from a popular social utility network. A grounded theory approach (Glaser & Strauss, 1967) was utilised to analyse the qualitative responses of several clergy members who participated in an online discussion group. Through a process of theory abstraction and development emerged various beliefs and attitudes towards mental illness held by clerics. Thus study is unique in that the qualitative data allowed for an exploration of the unrefined comments made by ministers. Since the data are from a conversation amongst clergy rather than a research project soliciting subjects, the data itself are not affected by demand characteristics or respondent bias.

**Method**

**Study design and data collection**

This study is focused on a conversation between clergy that occurred via a popular social utility website in an unspecified clergy’s social networking group. Pastors and ministers from across the globe have joined as members of this particular networking group; the group has over 20,000 members. In April 2012, one of the group members posed a naturally occurring question to the other ministers in the group and asked “If the church is where we are to come for healing, how do we handle people who are depressed, suicidal, suffering from PTSD or anxiety?” What resulted was a 13-day-long back and forth discussion between clergy on this very question. A group of 35 clergy participated in this conversation, and over a 13-day period 142 comments were made. This discussion occurred in April and May of 2012. Since the social networking group and the posts that were on it were public domain, a human subjects Institutional Review Board exception was requested and obtained.

**Participants**

This is an analysis of observational data based on a conversation which occurred in a clergy’s group on a popular social networking utility, thus a limited amount of demographic information was available. The 35 participants in this conversation were all professing Christian clergy and/or pastors with churches in a variety of locations throughout the world. The majority – 75% – were from the United States. Forty-three per cent of the US
clergy were white, 26% of the clergy were black, and 6% were Latino. A total of 17% of the clergy participating stated that they were from outside of the United States. Of the international clergy, 14% were from Africa and 3% had a church in India. The remainder – 8% – did not disclose their location.

Religious denominational representation was diverse, given the sample size of 35. A total of 20% of the clergy considered themselves “non-denominational”. There were 8% who self-identified as Baptist, 8% as Pentecostal, and 8% as inter-denominational. There were 6% who self-identified as Nazarene, 6% as Anglican, and 6% as Assemblies of God. A total of 20% of the clergy identified under the “other” category, which consisted of one clergy each from seven groups – United Methodist, Calvary Chapel, Church of God, Southern Baptist, Intervarsity Christian, Methodist, and Catholic. Finally, 18% of the clergy did not state a denomination.

**Study design and epistemology**

Glaser’s definition of grounded theory is “a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area” (Glaser, 1992, p. 16). The classic grounded theory methodology (CGT) has its roots in the original works of Glaser and Strauss (1965, 1967). CGT was chosen because it was a good fit for our research aims. Glaser (1992) stressed that in many fields (he mentioned education, health care, and management, but this can also be stated for the fields of social work and mental health) effective leaders must be attuned to the importance of not preconceiving what their clients or customers want. Unfortunately, much of the published empirical literature by mental health researchers suggests preconceived ideas about clergy attitudes on mental illness without having talked with clergy themselves (Payne, 2014). CGT reminds the reader of the importance of studying not “what ought to be” but “what is” (Glaser, 1992). Our goal with this work was to develop theory around the mental health attitudes and perceptions of clergy, and CGT is the best choice for that endeavour. Many supporters of CGT see the methodology as offering the greatest amount of freedom when it comes to the development of substantive theory (Deady, 2011; Glaser, 1999; Loy, 2011; Simmons, 2011). One of the unique contributions of CGT is that it allows the literature review (which comes after theory development) and researcher bias (via memos and notes) to be considered as another variable, without placing unnecessary structure on the data (Deady, 2011).

**Reflexivity and data analysis**

As Glaser (1965, 1967) suggests, we attempted to let go of our preconceptions. In order to accomplish this, we first needed awareness of our standing and stance in relation to the data. We spent significant time reflecting on our own positions as it relates to being African American, being female, and being privileged (i.e., our professional and socioeconomic status). We remained aware of our stance as researchers, as church leaders and participants, social workers, and mental health clinicians. As researchers utilising CGT, we continuously asked ourselves the questions “What perspective do I represent?” and “How may this perspective influence my reading … and how should I factor it out?”
(Deady, 2011, p. 51). Our memoing allowed us to document first impressions and reactions to the data.

We first engaged in substantive coding (Glaser & Strauss, 1967), broken down into sub phases of open coding and selective coding (Hernandez & Andrews, 2012; Walker & Myrick, 2006). We initially engaged in open coding of the text towards the emergence of core categories and related concepts. We then moved to selective coding and theoretical sampling. Through the constant comparative process, we theoretically coded via the core and related concepts until saturation. Throughout, we constantly compared incidents (core data) to incidents, concepts (related constructs) to more incidents, and lastly concepts to concepts through theoretical coding (Glaser & Strauss, 1967; Holton, 2007). Our goal was to produce abstractions of patterns rather than mere descriptions (Glaser, 2007), thus from this process we generated a conceptual theory regarding clergy views on mental health and healing.

**Rigour**

We triangulated our approach to the data by using three tools – coding by hand, coding through the use of Atlas.ti, and coding through the use of Dedoose. However, we still remained true to the CGT methodology, since the software was used merely to organise the data for constant comparison and to discover patterns. We coded separately and then we came together at several time points to achieve consensus. We kept detailed audit trails – code memos, theory memos, and memos of our own reactions and observations. Theory emerged through the constant comparative process.

**Results**

**Theory: a spectrum of belief**

It became evident to us as we engaged in the data and moved toward theory that clergy had strong views on mental health and healing. Two issues they discussed are presented here – (1) the etiologic or cause of what we term as “disorder”, and (2) the best ways to treat or respond to mental health issues such as posttraumatic stress disorder (PTSD) and depression. Clergy views on these issues can best be described as falling on a continuum or a spectrum of belief, where strict adherence to a spiritual healing focus is on one end of the spectrum and a stringent medical or psychological focus is on the other end of the spectrum.

**Clergy beliefs about the cause of emotional issues**

When examining what clergy viewed as the causes of disorders such as PTSD or depression, there were some clergy who made statements falling on the far end of the spiritual side of the spectrum (see Figure 1). For instance, a few clergy believed that the cause of chronic PTSD or depression was due to demonic oppression, sin or ungodliness, strongholds passed down through generations, or due to the person being “worldly” or “carnal-minded” rather than spiritual minded. Also, a few clergy said that they felt that people may be assigned to a specific suffering experience by God … in that regard,
they mentioned the example of the Apostle Paul in the Bible, who had a “thorn in the flesh” (2 Corinthians 12:7). All of these were beliefs situated on the far side of the spectrum toward a purely spiritual viewpoint. As an example representing the spectrum’s spiritual end, Pastor M. K. defined depression as a spirit by stating:

... I agree with you that depression is a spirit just like the ones our Saviour used to cast out. The thing is [that] He is still in control and is able to cast out demons even today but there is unbelief even in religious leaders. However, there might be faith which is not enough to even try to rebuke anything. Yet Jesus said that if we had faith even as little as the mustard seed, we would remove mountains. Depression and anxiety are such mountains regardless of the earthly cause. Our God is peace, if He has given you the peace of God that surpasses all understanding, why should you be anxious [enough] to get clinical depression? The bible tells us to seek God first, and everything else will be added unto us but we are seeking wrong things, especially money, that is stopping us from seeking God enough for Him to use us for healing. What fearing individuals do not know, is that it is not them who heal, it is God’s power that delivers people through His believers ...

As another example of a pastor’s belief on the far side of the spiritual spectrum, Minister S.W. describes seeking help from doctors or psychiatrists as a lack of faith for those who are believers:

Those that are Believers and are hurting should go to the Elders that they lay hands on them and pray. Now do we believe or not? If not, then by all means go to a doctor. But at some point we must do a self-examination. Do we believe or not? If we say we do, then walk in faith and see it happen.

Don’t get me wrong, I believe that doctors are a blessing of God. not to replace faith but to help those who don’t believe. A believer should turn to the real One who heals. That is Jesus Christ.
Opposite to the spiritual end of the spectrum was the belief that depression or PTSD was due purely to a biological cause. We included this perspective as a possible viewpoint on the continuum as it seemed to most starkly contrast the spiritual point of view. However, there were no comments in the data that represented a purely biological or physiological concept of mental illness, depression, or PTSD. We felt that this absence of subscribers to an absolute biological perspective was noteworthy.

A fair amount of ministers’ comments fell somewhere between the midpoint of the spectrum and the biological end. These ministers argued that the cause of PTSD is definitely not demonic oppression. Instead, they felt that PTSD and depression occurred due to a person’s life circumstances, handling disappointments or adversities, going through something specifically traumatic, or even due to avoiding issues when they arise and refraining from discussing them. As an example of a quote from near this area of the spectrum, Minister N.S. went on to discuss her own PTSD issues at the hand of 9/11 (the attacks on the World Trade Centre in New York, USA on 11 September 2001). The minister explained that she was present in the New York area at the time of the disaster. She also stated that her present symptoms, many years later, are not indicative of sin in her life, and that ministers and pastors should not “blame the victim”:

I have a slight concern about a perception in this discussion that needs to be addressed. The desire and willingness to want deliverance from the things such as anxiety, depression and PTSD- specifically speaking about PTSD. It can be caused by situations beyond your control and it will affect your brain function. Yes, I believe God is a healer, but the process of healing is not limited to a desire and it will take time. I’m not depressed, anxious or suffering because of sin, being out of the will of God, or anything attributed to that at all—my sufferings have been at the hand of 9/11. The fact that the tragedy is such on a national scale hinders healing. For the record, I am typing this at 2am in the morning because I can’t sleep at night. Believe me, I’d rather be sleeping but I simply cannot.

Why am I saying this—base on the turn of this discussion, we must always be careful to not place blame or fault on the one seeking help. Trust me, I know healing is possible—I’ve been healed, delivered and set free from other issues so I know to wait patiently as I stand in expectation, speak to the Lord while I am unable to sleep, intercede for others who don’t know God the way I know God and praise Him for the day where I will sleep 8 hours again… But until then, we must be careful not to judge but to simply be there and be led of the Spirit for the Father will instruct us.

A lively discourse ensued where pastors revealed beliefs across the spectrum about the cause of mental/emotional issues such as depression and PTSD. Most clergy fell closer to the middle of the spectrum rather than either extreme end, where they viewed the cause as some combination of spiritual and biological/psychological means.

**Clergy beliefs about the best treatment for emotional issues**

Another common theme that emerged from the data was regarding beliefs about the best treatment or response to emotional problems. When discussing preferred treatments, again, discussion fell along a spectrum from extremely spiritual to more biological/psychology-oriented beliefs based on a medical model (see Figure 2). On the purely spiritual end, some clergy disparaged psychology and believed that faith and leaning on psychology did not mix. Instead, at times, demons may need to be “cast out”, hands need to be “laid” on individuals, the emotionally challenged need to be prayed for, and individuals
need to repent and “be saved” in order to be fully healed. As a purely spiritual example, Pastor L.A. said:

Yes, our beloved Messiah cast out quite a lot of demons out of people who were sick … in our times it would be mental sickness, any mental sickness, and physical diseases. Depression is a spirit that must be dealt with and cast out, as are other spirits …

Pastor S.A. discussed his view that help for emotional issues comes purely from the Lord; all healing comes from God, without the need for assistance from man:

But I would answer it this way, what did Jesus say to do? Have we gotten so worldly that we no longer think God heals without some help from us? When He said to lay hands on the sick and they would recover, was that just a statement to make us feel good because we really don’t believe that He will heal. We need to get back to the basics.

Closer to the purely spiritual side of the spectrum but not completely to the end of it, clergy discussed treatment methods such as deliverance ministries, the spirit of discernment, prayer, fasting, and applying the Word of God.

Toward the psychological/secular end of the spectrum, there were clergy who embraced secular training as a tool. They discussed the need for qualified counsellors, especially qualified counsellors who were church members so they could have particular sensitivity to the needs of the church. For instance, Pastor H.B. said “… I agree that every church should have a pool of qualified councillors, who can deal with the vast sea of hurt out there. Pastors are very seldom trained in this area, and so the hurting continue to hurt … ” Some of the ministers discussed the need for pastors to receive their own additional training in secular counselling topics. Minister N.B. said:
I believe it is necessary for a pastor to have some classes in crisis management and counselling, psychology and healing. It will serve as a tremendous asset in the ministry. I’ve seen too many young people hurt by bad information at the hands of “church leadership”, especially as it relates to sexual assault. We must take the calling more seriously.

Some discussants mentioned that clergy should network with other clergy to ensure they had referral resources, and that they should work alongside with therapists while as pastors knowing their own strengths and limitations. As Pastor T. R. states:

Since many have high expectations of ministers, we too often try to live up to what may not be realistic to us as individuals, [by] disregarding our own shortcomings. Knowing what you cannot do is just as important as knowing what you can do. Otherwise, we can allow our well-intentioned shortcomings to cause harm to those we are trying to help. Surely we do not want our good to be evily spoken of. We must always be ready and willing to use our helping hands but sometimes that hand needs to be a pointer to someone more suitable to the crisis as hand.

But again, many pastors can be found somewhere on the spectrum, toward the middle or either end, incorporating both spirituality and some level of mental health understanding.

**Discussion**

The purpose of this study was to observe the attitudes and opinions that clergy members hold toward mental and emotional problems. The results demonstrate diverse opinions regarding the etiologic of mental illness and available response options to those suffering from mental problems. While limited in generalisability, the major strength of this exploration is that it examines the true voice of clergy in-vivo; it examines the opinions of clergy speaking to other clergy about this topic. In comparison, studies that survey clergy about their views on causes of mental illness (James, Igbinomwanhia, & Omoaregba, 2014; Payne, 2009, 2014) have been limited by potential sampling bias, as clergy who were “pro-psychiatry” tended to respond to survey questions while those who were “anti-psychiatry” declined to complete the surveys (James et al., 2014). In this study, examining in-vivo discussions between pastors minimises demand characteristic sampling bias.

Another strength of the current study is the use of data obtained in the public domain (via social media). Studies have shown that individuals on group social media are often disinhibited on a public forum, and thus self-disclose personal opinions more freely (Barak & Gluck-Ofri, 2007; Bazarova & Choi, 2014). This suggests that the data utilised in this study represents the true opinions of clergy without the biases often noted with other qualitative and quantitative data. However, it is possible that clergy who self-select to participate in social utility networking groups may differ in significant ways from clergy who do not (McKenna & Bargh, 1999), thus generalisability is limited.

The theory that emerged from the data is that the attitudes and perceptions clergy members hold toward mental illness fall along a continuum or spectrum of belief, with views that range from strictly spiritual in nature to those that incorporate medical and psychological perspectives. These findings are in line with an emerging line of research that suggests that views of mental health among clergy are heterogeneous and include a focus on informal, alternative, or complimentary forms of mental health services (James et al., 2014; Payne, 2014). Also, some prior studies suggest that clergy views vary in the extent to which they attribute spiritual, psychosocial, or biological causes to
various disorders (Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013; Matthews, Corrigan, Smith, & Aranda, 2006; Stanford & Philpott, 2011). However, this current study adds to the existing research by providing nuanced details of clergy views as they appear on a spectrum of belief.

It is interesting to note that no clergy expressed the cause of emotional problems as a purely biological cause. In addition, all pastors/clergy expressed that they do have a role in treatment, even if the role is to coordinate and collaborate with mental health practitioners. Many clergy discussed that they felt they would benefit from their own training on the secularised topics of mental health and illness, or that they should have individuals in each church who are trained on mental illness topics – individuals who they trust who can successfully navigate between secular and spiritual topics. Yet, at no point did they state that clergy do not have a role in treatment. Although the degree to which religion should be relied on to manage emotional problems varied, all participants expressed some incorporation of spirituality when addressing emotional issues. Thus, this study points to an absence of a strictly biomedical perspective when considering clergy views on the cause and treatments of mental illness. This is in stark contrast to the medical and psychological fields that continue to question or minimise the role of religion and spirituality in the understanding and treatment of mental diseases (Pargament & Lomax, 2013).

Implications

There are important research and practice implications for this work. First, this analysis suggests essential considerations when conducting mental health research with clergy. This analysis utilised cross-sectional data – a slice of discussion at one point in time. However, some limited evidence exists that clergy views on the spectrum are dynamic and not static. For example, one of the clergy in this study had views near the far side of the spiritual continuum at the time of this discussion. At that time (2012), this clergy person was adamant that God needs no help, and that psychology was a hindrance to God at best, and evil at its worst. However, our grounded theory examination of this 2012 data occurred in 2015. In our 2015 exploration of the demographics of each member (as evidenced by their social utility information), we found that after the 2012 discussion that same clergy member had since enrolled in school to obtain counselling certification and a graduate degree in psychology. Thus, his view on etiologic and treatment issues shifted dramatically after his participation in this conversation. It is important to understanding that the views clergy hold (their place on the continuum) can shift. This suggests that a reflection-in-action epistemology may be very fruitful when researchers and practitioners approach clergy on the topic of mental health (Schön, 1983), and it suggests that views can potentially be changed.

There are also several practice-level implications of this study. First, there were no clergy members who subscribed to a purely biological/psychological viewpoint on mental illness and most respondents felt that religion/spirituality should be incorporated in mental health treatment to varying degrees. Thus, it is likely that clergy who refer parishioners to formal mental health services would want to be included as an important part of the treatment plan. This is important to note given that mental health professionals often neglect to incorporate religion and spiritual leaders into clients’ treatment (Pargament &
Lomax, 2013). Mental health professionals should strive to incorporate religious leaders into clinical treatment as collateral support when appropriate.

Second, the incorporation of religion into clinical mental health treatment will be facilitated by improved collaborations and partnerships between churches and mental health agencies. Collaborative faith-based mental health interventions have shown promise in increasing knowledge around mental health and improving symptoms within a faith-based context (Hays & Aranda, 2015). The literature on church-based mental health promotion continues to grow and tools have been developed to assist researchers in identifying congregations that have the capacity to engage in mental health promotion (Hays, 2015). Thus, culturally specific ways of approaching clergy on issues of mental health emotional wellbeing must continue.

Lastly, mental health practitioners should seek to better understand religion and the role it plays in the lives of clients. Religion should be treated as a sociocultural factor that impacts the lives of many individuals in the same way that race, gender, and socioeconomic status does (Payne, 2009). Mental health clinicians must strive to be reflective of their own religious position and their perceptions of religion and spirituality’s role in mental health care.

Disclosure statement
No potential conflict of interest was reported by the authors.

Note
1. Observational social research of public data found on social utility websites is growing in popularity and is now an established practice with the new global age of technology (Murthy, Gross, & Pensavalle, 2015; Wilson, Gosling, & Graham, 2012). Examination of web-based data on clergy has been done in the past (Payne, 2008).

References


