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ABSTRACT

People seeking help for personal problems usually turn to family, friends, and relatives first and then to sources such as neighborhood support systems, self-help groups, and community helpers such as physicians and clergy. These natural support systems need to be used and supported more by mental health professionals. One relationship which could be encouraged is the one between the clergy and self-help groups. The relationships and communications between these two groups were clarified in a two-part study. In the first part of the study, religious leaders (N=200), within Jewish, Catholic, Lutheran and Baptist organizations in Chicago were surveyed concerning their attitudes toward self-help groups. Results showed that 70 percent of the respondents (N=64) had made at least one referral to a self-help group and that the religious leaders had generally positive feelings towards these groups. Even though they felt that self-help groups would be helpful, the religious leaders were aware of specific self-help groups to whom they could refer for only 54 percent of the problems brought to them by congregation members. In the second part of the study, a consultation session was provided for a sample of the religious leaders who had never made a referral to a self-help group. The results showed an observable increase in activities involving self-help groups following consultation, suggesting that mental health professionals can provide the clergy with information and resources about self-help groups in their communities. (ABB)

Facilitating Collaboration between the Clergy and Self-Help

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Running head: THE CLERGY AND SELF-HELP

Abstract

Religious leaders were surveyed concerning their attitudes toward self-help groups. Seventy percent of the respondents had made at least one referral to a self-help group, and the religious leaders had generally positive feelings toward these groups. Even though the religious leaders felt that self-help groups would be helpful with many of the problems brought to them by their congregation members, the leaders knew of a specific self-help group to which a referral could be made for only 54% of the problems. A consultation session was provided for a sample of the religious leaders who had never made a referral to a self-help group. Following consultation, an increase in activities involving self-help groups was observed. This study suggests that mental health professionals can play a unique role in providing community gatekeepers, the clergy, with information and resources about self-help groups in their communities.

Facilitating Collaboration between the Clergy and Self-Help

It is now generally accepted that most people seek help for their personal problems from their natural support systems, and only later some might purchase services from mental health professionals (Cowen, 1982). For most, the first and major source of support comes from the family, friends and relatives (Lieberman & Mullan, 1978). Other frequently used sources of natural support include neighborhood based support systems (e.g., block association leaders), self-help groups, and community gatekeepers (e.g., physicians, clergy) (Gottlieb, 1976). While some mental health professionals have collaborated with these groups by sharpening communication skills in these natural helpers, helping to establish self-help groups or consulting with already established support systems (Baker, 1977), fewer efforts have been directed toward facilitating information exchanges and nurturing cooperative ventures among these distinctive types of support systems.

Self-help groups are one of the fastest growing sources of social support in the community. Gartner and Riessman (1977) cite the helper-therapy principle, the role of group process, the commitment to something beyond themselves and the increased consumer involvement as the active intervention agents within these groups. While evaluations of these types of support systems are still in the beginning phases (Barrett, 1978), mental health professionals are becoming more willing to make referrals to these groups (Levy, 1978). Other areas of collaboration are being considered (Jeger, Slotnick & Schure, 1980), and one of the more interesting involves the

strengthening of ties between self-help groups and other natural helpers.

The classic study by Gurin, Veroff and Feld (1960) found that of those seeking help, 42% consulted with the clergy. Religious denominations are the most organized support system in the community (Caplan, 1974). Recent investigations have begun shedding light on the nature of religious organizations and their roles in the lives of their members (Pargament et al., 1983). It is still unclear, however, what the attitudes of religious organizations are toward other sources of support within communities. It would be of interest, for example, to investigate the relationship between religious organizations and self-help groups in order to better understand the ways in which mental health professionals might facilitate collaborative efforts between these two important sources of social support.

In consulting with natural gatekeepers (clergy, school personnel, etc.), professionals have been effective in increasing sensitivity and understanding, and improving skills related to functioning on the job (Mannino & Shore, 1975). Psychologists have also been successful in training natural helpers to develop life skills (Danish, Galambos, & Laquatra, 1983) and to make appropriate referrals (Mathews & Fawcett, 1979). In Leutz's (1976) study, informal caregivers (clergy, merchants, etc.) were provided information about drug and alcohol treatment programs in their community. Sixty-one people over a 2-month period of time sought help among experimental caregivers

provided this consultation and control caregivers not provided the program. The experimental condition caregivers referred 52% of cases to a treatment program whereas the controls referred only 23% of the people to alcohol and drug treatment programs. While this study demonstrates that gatekeepers can be encouraged to channel help seekers into formal service delivery systems, caregivers could also be encouraged to refer to more natural support systems (Gottlieb, 1983).

Froland, Pancoast, Chapman and Kimboko (1981) identified strategies used by human service agencies in collaborating with helping networks. Examples include working with clients' personal networks, matching lay helpers to clients, developing links with individuals who share common problems, establishing ties to opinion leaders to improve services, and consulting to support existing patterns of neighborhood helping. This descriptive study by Froland et als. is one of the most thorough reports illustrating the possible linkages between mental health professionals and natural support systems. While there are several accounts of how mental health professionals can strengthen organized support systems in Froland et al's. study and elsewhere (Jason & Lattimore, 1982; Maton, 1982), fewer descriptions are available of how natural support systems interact among themselves, and how mental health professionals might strengthen such interchanges.

The present study focused on better understanding the relationship between a particular group of gatekeepers, the clergy, and another type of natural support system, self-help groups. As stated previously, the clergy and self-help groups represent ubiquitous sources of helping, however, the relationships and communications between these two types of supports are unclear. During the second phase of this study, a designated group of clergy were identified and efforts were made to increase their awareness of and contact with self-help groups.

Study 1

Method and Results

In the late Spring of 1984, a cover letter and 1-page questionnaire were sent to religious leaders within Jewish, Catholic, Lutheran, and Baptist organizations. Fifty organizations for each of the religious groups were randomly selected from the listings in the Chicago telephone directory. Of the 200 questionnaires sent out, 64 were returned (32%). The return rates for the 4 different groups were: Catholic, 48%; Lutheran, 40%; Jewish, 18%; and Baptist, 14%. (On four questionnaires, the name of the religious organization was not stated). On the dependent measures, to be described below, no significant differences were found among the 4 religious groups, so the data from the four groups were collapsed.[1]

The first question asked whether a referral had been made to a self-help group during the past 2 weeks. Twenty-eight percent

of the sample indicated a referral had been made. Referrals were made to 12 different groups, with the two most popular groups being Alcoholics Anonymous (n = 8 leaders made referrals) and Al-Anon (n = 4). Next, the religious leaders were asked if they had ever made a referral to a self-help group, and 70% said yes. Thirty-three different groups were mentioned, with the most popular ones being: Alcoholics Anonymous (n =35), Al-Anon (n = 11), Phoenix (n = 5), Alateen (n = 4), NAIM (n = 3), Gamblers Anonymous (n = 3), Divorce support group (n = 2), Compassionate friends (n = 2), Stop-smoking (n = 2), Recovery (n = 2), and Cancer support group (n = 2). When asked whether or not the person referred was helped, 88% of respondents indicated the person was helped.

The religious leaders were next asked what self-help groups they were aware of and 58 different groups were mentioned. The most frequently named were: Alcoholics Anonymous (n = 45), Al Anon (n = 20), Gamblers Anonymous (n = 8), Phoenix (n = 6), Recovery (n = 4), Alateen (n = 4), NAIM (n = 3), Divorce support group (n = 3), Compassionate friends (n = 3), and Cancer support group (n = 3).

Using a 5-point scale (from very positive to very negative), the religious leaders were next asked how they generally felt about self-help groups. Thirty-one percent indicated very positive; 57%, positive; 10%, neutral; and 2% negative. When asked if the values espoused by self-help groups were compatible with those in

their religious organization, 96% answered yes. The leaders were also asked whether they might be interested in consultation to provide them with information about self-help groups, and 52% answered yes, 11%, maybe; and 38%, no.

The religious leaders were asked to list the types of problems they dealt with in counseling congregation members. Two hundred and thirty-four problems were listed. This group of problems were sorted into 10 categories (See Table 1). Two independent raters achieved interrater reliability of 91% in sorting these problems [the formula used to calculate reliability was Agreements/(Agreements plus dissagreements)]. For each of the listed problems, the religious leaders also indicated whether a self-help group might be helpful with the problem and whether they knew of a specific self-help group to which they could make a referral. The data in Table 1 indicate that the most prevalent problems dealt with concern marriage, alcohol and family issues. Of the 234 problems, self-help gorups were considered to be helpful for 140 of them (60%). However, for these 140 problems, the religious leaders knew of a self help group for only 76 of them (54%). For some areas like death, alcohol and family issues, many religious leaders are aware of specific self-help groups, but few are aware of self-help groups for topics such as jobs and sexual issues.

Study 2

In Study 1, the results indicated that religious leaders are generally positive in their feelings about self-help groups, and that many problems of congregation members that they deal with on a day-to-day basis would be appropriate for self-help groups. However, many of the respondents did not know of specific self-help groups in their communities where a person could be referred to. Study 2 was formulated to assess whether consultation from a mental health professional would be effective in providing information about self-help groups and encouraging religious leaders to disseminate this information to their congregation members.

Method

Of the respondents in Study 1 that had indicated an interest in a consultation on self-help groups, eight had stated that they had never made a referral to a self-help group. These eight religious leaders comprised the sample for Study 2. These respondents were selected because they had minimal prior contact with self-help groups, therefore it would be easier to assess the effects of consultation in increasing their interactions with self-help groups.

The eight respondents were randomly assigned to three groups, Group A, Group B, and Control. Groups A and B had 3 members, the Control group had only 2 members.[2] Self-help activities initiated by the religious leaders were the primary dependent

measure. These activities were broadly defined and included: making a referral to a self-help group, making efforts to start a self-help group, and publicizing the activities of self-help groups.

A multiple baseline design was employed. Approximately every two weeks, the religious leaders in Groups A and B were contacted by phone and asked to describe any activities that had been engaged in involving self-help groups. After three baseline data points had been collected for Group A, a consultation session was provided. A similar session was provided after 4 baseline data points for Group B. Groups A, and B and Controls were contacted at a three month follow-up period and again asked about self-help activities engaged in. In addition, religious leaders in Groups A and B were asked additional questions concerning their overall reaction to the consultation program.

The consultation session occurred at the religious leaders' work sites. The session lasted about 45 minutes. The first couple of minutes of the session were devoted to the first author talking about his interest in the area of self-help and a brief description of the self-help movement. After this introduction, the consultant played a 4-minute tape of an actual self-help group. In this tape of Tough-love, a group of parents were providing each other mutual support as they discussed ther children's acting-out problems. After a discussion of this tape, and the self-help principles demonstrated

in it, the consultant asked the religious leaders for the types of helping they provided to their congregation members. For each type of problem discussed, the consultant asked whether the religious leader felt self-help groups might be effective with the problem. If the religious leader said yes, a Self-Help Directory of groups in the Chicago area (Borman & Pesqualie, 1983) was shown to the consultees, and self-help groups in their community were identified. This Self-Help Directory provides information and addresses of hundreds of self-help groups in the Chicago Metropolitan area. At the end of the session, the consultant mentioned that he would call in a few weeks to assess if any further information was needed concerning self-help groups.

Results

Group A consisted of Lutheran, Catholic, and Baptist religious leaders. During the baseline period, none had initiated any self-help activities. When the Lutheran clergyman was shown the Self-Help Directory during the consultation session, he said: "I wasn't aware of this Directory and that there were so many self-help groups." During the 2 weeks following this session, he placed a notice in the Sunday newsletter giving brief descriptions of several self-help groups (Window-to-Window, Overeaters Anonymous, Alcoholics Anonymous, Al-Anon, Divorce Anonymous, and support groups for the elderly) and how they could be contacted. At the three month follow-up, a senior citizen,

self-help support group had been established at his church, and the group had already had six weekly sessions. The clergyman commented that "having this group here is terrific." (On Figure 1, the notice in the newsletter counted as one self-help activity, and starting the group counted as a second self-help activity.) The Baptist minister generally felt that psychological

— Insert Figure 1 about here —

problems could be handled through faith, and that he was in the best position to help his congregation members. During the consultation session, he did indicate that one of his members could use an Alcoholics Anonymous group, and by the fourth week after the consultation session, he had referred this person to the group. At the 3-month follow-up, he reported that she was in the self-help group. The Roman Catholic priest stated during the consultation session that "not being aware of self-help is an impediment to using them." This priest was interested in Hispanic self-help groups and the consultant provided him the names and locations of Spanish speaking groups for Alcoholics Anonymous, Overeaters Anonymous, an Unemployment support group, and a parent support group. He listed one of these groups in each of 4 Sunday newsletters in order to provide information to his congregration members. (Listings in 4 separate newsletters were counted as 4 separate self-help activities.) This priest expressed interest in actually setting up a group at his church, but unfortunately, he was transferred to another church four weeks after the consultation session.

When contacted at the 3 month follow-up, the religious leaders from Group A were asked "How did you feel about the consultation session on self-help?" and were provided a 5-point scale (very positive, positive, neutral, negative, and very negative). All three leaders indicated very positive. One stated "It made me aware of different groups in the area," and another said "I'm aware of a lot of them. Self-help groups are for everything." Group A leaders were initially aware of one self-help group; by the follow-up, they were aware of 21 different groups.

Three Lutheran clergymen comprised Group B. During the baseline phase, none of these clergymen had initiated any self-help activities. During the consultation session with the first religious leader in this group, he wrote down 2 telephone numbers, one for a loss of spouse self-help group, the other for a divorce support group. By the three month follow-up, he indicated that he had not yet had an occasion to give these numbers to any members of his congregation. For the second clergyman, during the consultation session he was given information and the phone numbers of the following groups: Alcoholics Anonymous, Al Anon, Divorce Anonymous, Narcotics Anonymous, and Single Moms. During the next contact with the religious leader, one of his congregation members had been referred to Alcoholics Anonymous and was attending meetings. The third clergyman was very interested in starting a self-help group for children of

alcoholics. During the next telephone contact with this religious leader, he indicated that he was talking to several youth about forming such a group. (This effort was counted as a self-help activity on Figure 1). During the three month contact, plans were underway to begin two groups at a school setting.

At the three month follow-up, when the religious leaders in Group B were asked how they felt about the consultation session, two stated "positive" and one said "very positive." One indicated he was now aware of more groups in his area and another invited the consultant to meet with several other workers at his church to inform them of self-help opportunities in the community. At the beginning of the study, Group B religious leaders were aware of 4 self-help groups, by the follow-up, they were aware of 13 different groups.

The control group consisted of a Rabbi and a Lutheran minister. Neither of these individuals had initiated any self-help activities at the pre or follow-up points. They were aware of two self-help groups at the prepoint and the same groups at the follow-up point.

Discussion

Study 1 found that religious leaders are generally positively disposed toward self-help groups, although it appears many are not aware of the location of self-help groups in their communities. The second study indicated that religious leaders who are provided a consultation session are able to gain information about

self-help groups and as a consequence, they will initiate a variety of self-help activities, including referring congregation members to groups, starting up groups, and publicizing self-help groups. In addition, the consultees rated the consultation services in generally positive terms. These findings suggest that mental health professionals can play a key role in providing natural gatekeepers information about self-help groups in their communities.

The religious leaders providing consultation were rather diverse in their roles as natural helpers. Some felt that they were responsible for tending to the material, spiritual and psychological needs of their members. These leaders were active in counseling and providing support to their congregation. Others stated that they were not trained to provide psychological help to their members, and they felt uncomfortable when placed in this role. When serious psychological problems were encountered, for example suicide attempts, all the religious leaders were willing to make referrals to mental health professionals, and all had several individuals or institutions where at least some level of trust had been established. These religious leaders, however, were not aware of self-help groups that were available to their congregation members. Each religious leader requested at least several phone numbers of self-help groups during the consultation session. This sub-sample of religious leaders were very willing to work with self-help groups, but first they needed information about these groups.

During the consultation sessions, it quickly became apparent that several religious organizations were actively providing an extraordinary amount of support for their entire communities. For example, in one low income area, the pastor regularly walked the streets to meet community members. If he noticed buildings beginning to deteriorate, his church would put pressure on the owner to rectify the problems. When the only supermarket in the community threatened to close down, his church picketed the owners to insure that it stayed open. This paster not only saw his congregation as part of a large family, but the entire community was perceived as part of his extended family. This clergyman had enormous influence in his community as he was perceived as an advocate for constructive change. This clergyman was not aware of any self-help groups in his community, and in fact in this low income area, there were none. However, in surrounding communities, active self-help groups did exist, and the location of these groups were provided to the pastor.

The religious leaders appreciated the information provided them during the consultation session. Most felt that the self-help groups were a source of social support that had not been previously tapped. Since most of the groups had no costs associated with them, they were perceived as particularly appropriate for low-income congregation members. In addition, the underlying assumptions of the groups (i.e., by helping others

one gets help for oneself, helping is based on direct experience with a problem) were attractive to and compatible with the values of the religious leaders. When contacts were made with self-help groups, either in the form of obtaining advice in setting up their own groups or in gathering information before making a referral, the religious leaders felt comfortable and satisfied with their interactions. The enthusiasm of the religious leaders to this new resource was in part reflected in invitations extended to the first author by two leaders to talk with their peers about self-help opportunities in the community.

Because only 64 religious leaders answered the original questionnaire, it could be argued that the sample was not representative of religious leaders. In addition, since consultation was provided to only a smaller sample who had little prior contact with self-help groups, this group of leaders might also not be representative of religious groups. Still, this study represents a preliminary effort to assess attitudes of religious leaders toward self-help groups. The findings might encourage other investigators to mount larger scale studies. Future research might also attempt to collect data that independently confirms the religious leaders' self-reports concerning self-help initiated activities.

As stated in the introduction, natural support systems provide the first avenue of help for most people experiencing distress or emotional problems. Natural gatekeepers, such as physicians and

the clergy, often are brought problems at early points in their evolution. While past consultation programs to these gatekeepers have successfully enhanced their interpersonal skills and competencies, and helped them make referrals to professional organizations, few efforts have been directed toward enhancing their linkages with other sources of natural support within the community. Given the present climate of dwindling federal and state funding for mental health initiatives, more attention might usefully be directed toward exploring ways to increase communications and facilitate the sharing of resources among the many natural helpers within our communities.

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Footnotes

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[1] No significant differences between the four groups emerged on the following measures: whether a referral to a self-help group was made in the last 2 weeks [$x^2(3) = .65$], whether a referral to a self-help group was ever made [$x^2(3) = 2.10$], whether the referred person was helped [$x^2(3) = 2.15$], whether the values of self-help groups were compatible with their values [$x^2(3) = 4.56$], whether they were interested in consultation [$x^2(6) = 8.23$], the number of self-help groups they were aware of [$F(3/56) = 1.42$], and how they felt about self-help groups [$F(3/53) = 1.01$].

[2] Members of the Control group as well as other respondents in Study 1 were provided a written description of the major findings in the study. In addition, they were provided the first author's phone number to call if either they had questions about the study or requested further information.

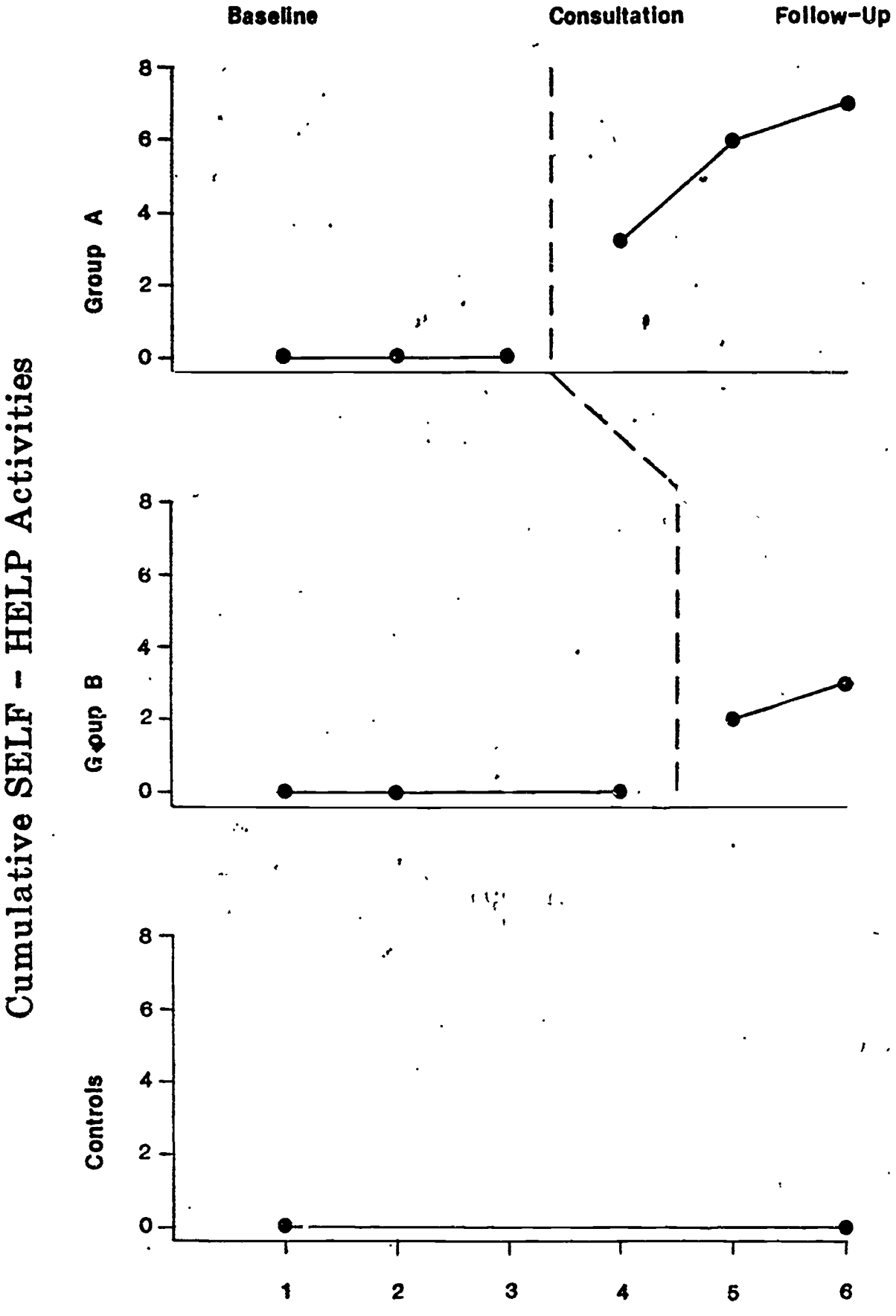
Table 1

Types of Problems, and Effectiveness and Availability of Self-help

	Number of problems	Number Self-help effective	Number Know of group	Know of group / Self-help effective
Marriage	48	35	15	$\frac{15}{35} = 43\%$
Alcohol	43	37	26	$\frac{26}{37} = 70\%$
Family	41	19	13	$\frac{13}{19} = 68\%$
Psychological	26	15	5	$\frac{5}{15} = 33\%$
Job	24	8	1	$\frac{1}{8} = 13\%$
Death	19	9	9	$\frac{9}{9} = 100\%$
Other	10	4	1	$\frac{1}{4} = 25\%$
Religion	9	4	2	$\frac{2}{4} = 50\%$
Health	8	5	3	$\frac{3}{5} = 60\%$
Sexual	6	4	1	$\frac{1}{4} = 25\%$
	234	140	76	

Figure Caption

Figure 1. Number of self-help related activities engaged in over time for the three groups of religious leaders.


Cumulative SELF - HELP Activities
Baseline
Consultation
Follow-Up
Group A
Group B
Controls
0
2
4
6
8
1
2
3
4
5
6