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Differences between African Americans and Non-Hispanic Whites Utilization of Clergy for Counseling with Serious Personal Problems

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Abstract

There is a paradox in research on African Americans and non-Hispanic whites in the utilization of clergy. Research finds that African Americans have higher levels of religious service attendance and higher levels of contact with clergy. Research also finds that despite this, African Americans are less likely than non-Hispanic whites to seek out assistance from clergy for psychiatric disorders including depression and anxiety. The goal of this paper was to investigate race differences in the use of clergy for counseling for serious personal problems. It uses the National Survey of American Life. We find that non-Hispanic whites were more likely than African Americans to use clergy for a serious personal problem. The significant difference between African Americans and non-Hispanic whites appeared to be mediated by the fact that African Americans were more likely to have seen clergy in a religious setting and non-Hispanic whites were more likely to have seen clergy in other settings including hospitals.

Research on help-seeking behaviors demonstrates that people frequently turn to clergy to address serious life problems, mental health disorders, and substance misuse/abuse (Bohnert et al., 2010; Mattis et al., 2007; Taylor et al., 2011; Wang, Berglund & Kessler, 2003).

Although clergy operate outside of the formal mental health care system, their contributions as ‘natural helpers’ in providing informal mental health care are substantial and should not

be underestimated. National Comorbidity Study findings (Wang, Berglund & Kessler, 2003) indicate that Americans are more likely to seek help from clergy than **psychiatrists** who provide counseling for psychiatric disorders such as mood disorders (e.g., major depressive disorder, bipolar I and II, dysthymia) and anxiety disorders (e.g., PTSD, social phobia). Clergy perform a number of roles and functions to address serious life problems and mental health issues including (but not limited to) helping identify mental illness, helping prevent and reduce distress, counseling those who are in distress or bereaved, and making referrals to formal mental health services (Mattis et al., 2007; Murray-Swank et al., 2007; Neighbors et al., 1998; Taylor et al., 2000; Taylor et al., 2011; Wang, Berglund & Kessler, 2003; Stansbury & Schumacher, 2008; Young et al., 2003). Clergy use for mental health problems is particularly important among specific population groups (e.g., African Americans) who have established patterns of under-utilization of mental health services and resultant unmet need. These factors underscore the position of clergy as an important and critical part of the larger picture of informal or non-specialty mental health care.

One of the central paradoxes of this literature is that findings for black-white differences in the use of clergy are decidedly mixed. One body of research indicates that African Americans are more likely to use clergy, while other work indicates that non-Hispanic whites are more likely to use clergy. Studies in this area often focus on different types of problems (e.g., mental health, physical health, substance abuse) and employ various respondent samples (i.e., from national surveys, convenience and geographically-restricted samples). Further, a variety of demographic, social and, in some cases, religious factors, are used as control variables, all of which likely contribute to ambiguity regarding the nature of race differences in clergy use.

The goal of this study is to provide a more thorough examination of race differences in use of clergy for serious personal problems. We examine these questions among African Americans and Non-Hispanic whites, using survey information derived from nationally representative samples of these populations.

Race and the Use of Clergy

Religion and religious institutions occupy an historic and important position in the lives of African Americans who have higher levels of religious involvement than other groups in the U.S. (Chatters et al., 2009; Krause & Chatters, 2005; Taylor et al., 2004). However, only a limited amount of systematic research examines the use of clergy among this population group. In early work on help-seeking using the National Survey of Black Americans dataset (Neighbors et al., 1983), clergy were identified as frequent sources of help for persons with a serious personal problem, especially for those coping with bereavement (Neighbors, Musick & Williams, 1998). More recent research using data from the National Survey of American Life (Chatters, et al., 2011) confirms the importance of clergy with respect to bereavement issues among African Americans and further notes the importance of religious socialization and problem type as predictors of clergy use.

Findings from qualitative research also underscore the importance of clergy in the help seeking process for African Americans (Mattis et al., 2007; Taylor, Chatters & Levin, 2004).

Importantly, this work provides some of the reasons that African Americans do not seek assistance from clergy. This research finds that African Americans are less likely to seek assistance from clergy for specific personal problems such as domestic or spousal abuse (Mattis et al., 2007) and are less likely to solicit advice about gender-related physical health problems (e.g., hysterectomies) (Taylor, Chatters & Levin, 2004). Several pivotal factors are associated with reduced levels of clergy help-seeking including issues of stigma, particularly around sensitive personal issues (e.g., sexual health), as well as beliefs about and assessments of the minister's competence, appropriate skill set, and personal character (e.g., concerns about privacy and confidentiality).

African Americans' use of clergy for counseling is often characterized as a combination of constraining and facilitating factors (Chatters et al., 2011). That is, African Americans' help-seeking behaviors are actively shaped by unfavorable attitudes about mental health issues, financial barriers to receiving care, and poor treatment experiences and interactions within formal health care settings (Cai & Robst, 2016; Snowden, 1999). Thus, they are less likely than other groups to access and use formal mental health services such as psychiatrists and psychologists (Alvidrez, 1999; Barrio et al., 2003; Padgett et al., 1994; Snowden, 2012; Wang et al., 2005). When they do seek formal help, services are often provided in settings and from sources (e.g., emergency room physicians) that are not explicitly intended or trained to provide specialty mental health care (Neighbors et al., 2007; Snowden, 1999). As a result, African Americans have higher levels of unmet need from formal services, coupled with lower quality of mental health care overall (Wang et al., 2005). This unfavorable characterization of mental health status and access to and experiences with formal services, together with a sense of cultural distrust of mental health providers, is thought to increase the likelihood that African Americans will access clergy for mental health care (Blank et al., 2002; Chatters et al., 2011; Hardy, 2014; Mattis et al., 2007; Neighbors et al., 1998; Taylor et al., 2000; Young et al., 2003). In addition, the central role and familiarity of religious institutions and figures in African American community life and the relative ease of accessing clergy assistance (Taylor et al., 2000), are important factors that facilitate the use of clergy for confronting life problems, including mental health issues.

Given a context of higher levels of religious participation, coupled with the central role of religious institutions, one would expect higher rates of utilizing clergy among African Americans as compared to non-Hispanic whites (Chatters et al., 2009). As noted previously, however, findings on black-white differences in the use of clergy are mixed. Overall, African Americans have more interactions with clergy (Murray-Swank et al., 2007; Krause, 2008) and are more likely to receive both emotional support (e.g., express concern in well-being) and tangible assistance (e.g., help get community services, like financial assistance or medical care) from clergy (Krause & Batisda, 2011). African Americans are also more likely to use clergy for alcohol abuse problems than are whites (Bohnert et al., 2010). Similarly, for persons with co-occurring psychiatric disorders and Type 2 diabetes, African Americans are more likely than whites to utilize clergy (Murray-Swank et al., 2007). Studies of clergy indicate that African American clergy report greater involvement in counseling work than clergy of other ethnic backgrounds (Mollica et al., 1986; Young et al., 2003). This profile of greater clergy involvement is in contrast to other work indicating no race differences in use of clergy (Ayalon & Young, 2005: college student sample) or that the higher likelihood of

clergy use among African Americans is negated when controls for religious involvement are used (Ellison et al., 2006). Finally, in one of the few studies examining clergy use in connection with DSM-IV psychiatric disorders, Wang et al. (2003) found that black respondents were less likely than whites to contact clergy for mental or substance abuse disorders. However, this study did not control for religious participation which is a known confounder.

In our present analysis, we seek to clarify the nature of race differences in use of clergy services for personal problems among African American and non-Hispanic whites, while taking into account sociodemographic, problem type, and religious involvement factors. Given that the prior literature and paradoxical findings on this topic focus specifically on clergy use among African Americans and non-Hispanic whites, we examine racial comparisons for these two groups. However, the specific dataset used also includes a national sample of Black Caribbeans and to date there are extremely few papers that investigate clergy use among this population (Taylor et al., 2011; Woodward et al., 2015). Consequently, we have taken this opportunity to also examine differences by race (African American and Black Caribbean compared to non-Hispanic whites) and ethnicity (African American vs. Black Caribbean) in the use of clergy for a serious personal problem.

Methods

Sample

The National Survey of American Life: Coping with Stress in the 21st Century (NSAL) was collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research (Jackson et al., 2004). The field work for the study was completed by the Institute for Social Research's Survey Research Center, in cooperation with the Program for Research on Black Americans. A total of 6,082 interviews were conducted with persons aged 18 or older, including 3,570 African Americans, 891 non-Hispanic whites, and 1,621 Black Caribbeans. The data collection was conducted from 2001 to 2003.

The NSAL includes the first major probability sample of Black Caribbeans ever conducted. For the purposes of this study, Black Caribbeans are defined as persons who trace their ethnic heritage to a Caribbean country, but who now reside in the United States, are racially classified as Black, and who are English-speaking (but may also speak another language). The overall response rate was 72.3%. Response rates for individual subgroups were 70.7% for African Americans, 77.7% for Black Caribbeans, and 69.7% for non-Hispanic Whites. Final response rates for the NSAL two-phase sample designs were computed using the American Association of Public Opinion Research (AAPOR) guidelines (for Response Rate 3 samples) (AAPOR 2006). The NSAL data collection was approved by the University of Michigan Institutional Review Board. Respondents were compensated for their time.

The African American sample is the core sample of the NSAL. The core sample consists of 64 primary sampling units (PSU's). Fifty-six of these primary areas overlap substantially with existing Survey Research Center's National Sample primary areas. The remaining eight primary areas were chosen from the South in order for the sample to represent African Americans in the proportion in which they are distributed nationally. The Black Caribbean

sample was selected from two area probability sample frames: the core NSAL sample and an area probability sample of housing units from geographic areas with a relatively high density of persons of Caribbean descent.

In both the African American and Black Caribbean samples, it was necessary for respondents to self-identify their race as Black. Those self-identifying as Black were included in the Black Caribbean sample if they answered affirmatively when asked if they were of West Indian or Caribbean descent, if they said they were from a country included on a list of Caribbean area countries presented by the interviewers, or indicated that their parents or grandparents were born in a Caribbean area country (See Jackson et al., 2004 and Heeringa et al., 2004 for a more detailed discussion of the NSAL sample). The analytic sample for this paper includes African Americans, Black Caribbeans and non-Hispanic whites who reported experiencing a personal problem in their lives that caused them a significant amount of distress ($n=3937$), defined below. Consistent with the available literature on race differences in clergy use, our specific focus is on differences between African Americans and non-Hispanic whites. In addition, information on differences in clergy use for personal problems between African Americans, non-Hispanic whites and Black Caribbeans is presented.

Measures

The section of the NSAL questionnaire designed to examine help seeking issues focuses on the concept of a serious personal problem. The strategy and procedures surrounding help-seeking for a serious personal problem emerged from a line of work by Neighbors (1985) and earlier work by Veroff et al. (1981). This work focused on professional and lay conceptualizations of mental health issues and how individuals themselves define personal problems and their self-reported actions and behaviors used to address these concerns. This strategy centers on the concept of a “stressful episode” in which respondents are asked to: 1) identify a personal problem they had experienced in their lives that had caused them a significant amount of distress, 2) describe the nature of the problem and 3) provide information on who they sought for help including both professional and informal sources of assistance (Woodward et al., 2010). An advantage to this approach is that it provides information on a broader group of individuals that is typically seen by mental health practitioners (e.g., persons who do not have a psychiatric disorder, but may have serious marital difficulties).

Within the NSAL, respondents who indicated that they had experienced a serious personal problem were presented a list of types of professional service providers and asked to name which types they had talked to about their problem. This list included: psychiatrist, other mental health professional, family doctor, any other doctor, any other health professional, religious or spiritual advisor, any other healer, a self-help or other support group, and any other professional. The main dependent variable in this analysis is whether or not the respondent sought help from a religious or spiritual advisor (i.e., clergy). Individuals who indicated that they sought help from clergy were also asked the race of the clergy member and the location of the counseling with clergy.

Independent variables include demographic characteristics, the type of problem experienced and measures of religious involvement. Demographic characteristics include sex, marital status (currently married, previously married, never married), years of education, and continuous measures of age and household income. Type of problem has five categories: physical (e.g., poor health, accident), emotional (e.g., depression, unhappiness, self-doubt), interpersonal (e.g., difficulties with close family and friends, divorce), economic (e.g., poor or declining financial status, loss of assets), and death of a loved one. In multivariate analyses, death of a loved one is the reference category. The designation of death of loved one as the reference category was based on prior research indicating that clergy support during bereavement is substantial in its scope and depth (Neighbors et al., 1998; Chatters et al., 2011).

Two measures of religious involvement—service attendance and denomination—are used in the analysis as independent variables. Frequency of service attendance was constructed by combining two items—one that indicates frequency of attendance and another that identifies respondents who (except for weddings and funerals) have not attended services since the age of 18. The resulting categories for service attendance are: attend nearly every day, at least once a week, a few times a month, a few times a year, less than once a year, and never attended services since the age of 18. Denomination is recoded into 8 categories (Baptist, Catholic, Episcopalian, Methodist, Pentecostal, Other Protestant (e.g., Lutheran, Presbyterian), Other Religion (e.g., Jewish) and no current religious denomination; Baptist is the reference category in multivariate analyses. Finally, the location of the clergy encounter includes a religious setting, a private home, hospital, or jail.

Analysis Strategy

The Rao-Scott chi-square was used in bivariate analysis to test for the effect of categorical variables and a two-tailed t-test was used for continuous variables. Logistic regression analysis was used to test the influence of sociodemographic characteristics, the type of problem, and religious involvement variables on the use of clergy. All statistical analyses account for the complex multistage clustered design of the NSAL sample, unequal probabilities of selection, nonresponse, and poststratification to calculate weighted, nationally representative population estimates and standard errors. In the logistic regression analysis we tested three models. The first model only includes race/ethnicity which is our major independent variable of interest. The second model adds the demographic and problem type variables which is consistent with previous research (Neighbors et al., 1998) examining these factors. Finally, the third model further adds the two religious involvement variables.

Results

Table 1 provides the bivariate relationships between use of clergy and type of problem, and demographic and religious involvement variables. A higher proportion of non-Hispanic whites than both African Americans and Black Caribbeans used clergy in connection with a serious personal problem. Women were more likely than men to use clergy and never married respondents were less likely than their currently married and previously married

counterparts to use clergy. Respondents who were dealing with bereavement issues were more likely to seek help from clergy, whereas those with economic problems were least likely to seek assistance from clergy. Among the religious participation variables, frequency of service attendance was positively associated with use of clergy. Pentecostals were the more likely to seek help from clergy and those with no religion and other religions were less likely to seek help from clergy (as compared to Baptists).

Table 2 presents the logistic regression analysis of the use of clergy for counseling help during a stressful episode (African American is the reference category). The results in Model 1 indicate that Black Caribbeans are less likely to seek help from clergy than African Americans, whereas non-Hispanic whites are more likely to seek help from clergy than African Americans. These findings are unchanged with the inclusion of the demographic and problem type variables in Model 2, as well as with the addition of the religious involvement variables in Model 3. Given the study's focus on differences between African Americans and non-Hispanic whites, the findings for other variables are presented in the tables, but are not discussed.

Table 3 presents the bivariate analysis of race/ethnicity and the location where respondents received help from clergy. As expected, a religious setting is the most frequent location with two-thirds of respondents (67.53%) indicating that they received assistance from clergy in churches, synagogues, temples or other religious settings. Twelve percent (12.28%) of respondents report encounters with clergy in private homes, 9.62% report a hospital, and 1% report jail as the location. Black Caribbeans are the most likely to have seen clergy in a religious setting, followed by African Americans and non-Hispanic whites. Similarly, non-Hispanic whites are more likely than the other two groups to seek assistance from clergy in hospitals/outpatient clinics. Although only suggestive, these bivariate findings on the location of clergy use potentially explain the paradox in the literature indicating that African Americans have higher levels of interactions with clergy, but are less likely than non-Hispanic whites to seek help from clergy. We tested this with additional logistic regression analyses (Table 4) for the use of clergy for respondents who sought assistance in a religious setting (e.g., church, synagogue). Results for Model 1 indicate that there is no significant difference between African Americans and non-Hispanic whites in clergy use specifically in religious settings. This is also the case in Model 2 when the type of problem and demographic variables are controlled. Finally, when controlling for the religious involvement variables in Model 3, the odds ratio for African Americans is now significant indicating that when controlling for religious involvement, non-Hispanic whites are more likely to utilize clergy in religious settings. In essence, because African Americans have higher levels of religious involvement overall, controlling for this factor eliminates the clergy use benefit associated with frequent service attendance noted in prior results (Table 2).

Lastly, we also investigated race of the clergy member (analysis not shown). Eight out of ten (82.9%) of African Americans reported that the clergy member that they saw was Black American and 15.3% stated their clergy was non-Hispanic White. Nine out of ten (89.5%) of non-Hispanic Whites indicated that the clergy member they sought help from was white and 7.5% said African American. Among Black Caribbeans, seven out of ten (70.4%) reported

that they saw a Black American clergy for assistance and 26.2% reported that they sought help from a white clergy member.

Discussion

The goal of this study was to further explore the black-white paradox in the use of clergy for serious personal problems. That is, several studies find that African Americans have higher levels of religious service attendance (Chatters et al., 2011) and higher levels of interaction with clergy (Krause, 2008) than do whites, and further, that religious participation is strongly associated with seeking help from clergy (Chatters et al., 2011, Taylor et al., 2011). However, in some studies, African Americans report lower levels of seeking help from clergy than do non-Hispanic Whites (Wang et al., 2003). Our study used a national sample specifically designed to answer questions of African-American and Non-Hispanic white racial differences in mental health and help-seeking behaviors and clearly showed that Non-Hispanic Whites were the most likely to use clergy for a serious personal problem, followed by African Americans and Black Caribbeans. The significant difference between African Americans and non-Hispanic whites appeared to be mediated by the fact that African Americans were more likely to see clergy in a religious setting, while non-Hispanic whites were more likely to see clergy in other settings including hospitals.

This study's findings, in conjunction with previous research, suggest that in comparison with non-Hispanic whites, African Americans have more general interactions with clergy and receive more overall support from clergy, but are less likely to seek out help from clergy for a specific difficult problem (the Bohnert et al., 2012 study is a notable exception). There are several potential explanations for these findings. First, both our study and the Wang et al., (2003) study focus on respondents who are seeking help for problems that have been self-reported as serious. Wang et al., (2003) examined help seeking for psychiatric disorders such as depression, social phobia and generalized anxiety disorders, while in our study respondents are asked to identify a personal problem they had experienced in their lives that had caused them a significant amount of psychological distress. Although clergy members have an advantage over other professional helpers by having established relationships with congregation members, some African Americans may be less likely to discuss serious problems with clergy members precisely because of their personal familiarity with them. For instance, a married couple with a close and long standing relationship with their pastor may be less likely to seek help for marital problems. Findings from a qualitative study of clergy use (Mattis et al., 2007) indicate that some church members are cautious about sharing personal information with clergy. Respondents in these focus groups express concerns about confidentiality, privacy, and potential interpersonal repercussions from sharing personal information (even with clergy) within these relatively small and densely connected social networks.

Findings by Krause and Batisda (2011) also note that although African Americans receive more emotional support from clergy they also have more negative interactions with clergy (e.g., clergy critical of them). This finding indicates that overall frequency of interaction with support network members is associated with the frequency of negative interactions with them as well (Lincoln et al., 2013). This may also partially explain why African Americans

are less likely to seek help from clergy despite high levels of interaction with them. Thus, with regards to seeking help from clergy, the stronger ties that African Americans have with clergy, which would presumably predispose them to seek assistance from clergy, may be partially offset by their more frequent negative interactions with clergy.

The closer ties that African Americans have with their clergy may help explain why African Americans in this study are less likely to use clergy for serious problems. In contrast, Bohnert et al., (2010) found that African Americans are more likely to seek assistance from clergy, specifically for alcohol problems. Problems such as depression and marital difficulties may be less visible and recognizable, whereas alcoholism (particularly behaviors that are disruptive to family and other social roles) may be more public and openly observed. Consequently, family members may refer an individual to their clergy members and clergy members themselves may reach out to congregants who clearly display the symptoms of alcoholism.

Second, our study found that the location for seeking help from clergy likely mediates the relationships between use of clergy and race. There is an assumption in the literature that individuals only seek help from clergy in religious settings such as churches, temples or mosques. This is a reasonable assumption considering that one of the strengths of using clergy is that there is likely an established relationship between an individual and their clergy member. In fact, our findings indicate that 2 out of 3 respondents received assistance from clergy at their place of worship. However, people also interact and receive assistance from clergy that they do not know and in places other than religious settings such as hospitals and jails, where there is a critical need for spiritual support. African Americans were more likely to receive help from clergy in religious settings (e.g., churches) indicating that, for the most part, they had an ongoing relationship with these clergy members. Non-Hispanic whites were more likely to receive assistance from clergy in a healthcare setting (e.g., hospital). Most hospitals have chaplains and/or pastoral care departments that administer to the spiritual needs of patients and their families during a health crisis and provide help during bereavement. Pastoral care counselors in these settings generally do not have long standing relationships with the patients and their interactions are typically limited to the hospital stay. Clergy who are associated with religious institutions in the community (e.g., churches, synagogues, mosques) visit congregation members who are hospitalized. However, individuals who have a long standing relationship with their clergy and have sought assistance from them will be more likely to identify the context of this assistance as being in a religious vs. a health care setting. Although not a definitive explanation, future studies that take into account the location of clergy assistance, seriousness of the type of problem (and potential reticence in disclosing sensitive information), and religious involvement factors may help to better understand the black-white paradox in the use of clergy.

In addition to our main study objectives, other findings indicated that Black Caribbeans were less likely than both African Americans and non-Hispanic Whites to utilize clergy for a personal problem. In part, Black Caribbeans may utilize clergy less because many of them are first generation immigrants who have migrated in the last 5 years and, as such, have not found a “church home” or established a relationship with clergy (Taylor et al., 2011). As the

goal of this study was to better understand differences in the use of clergy between African Americans and non-Hispanic Whites, we do not discuss other findings pertaining to Black Caribbeans. See Taylor et al. (2011) for an in-depth investigation of the use of clergy among Black Caribbeans as well as other research on help seeking for mental health problems among this population (Jackson et al., 2007; Neighbors et al., 2007; Woodward et al., 2008).

When discussing the use of clergy it is important to keep in mind several contextual factors. First, many individuals with a serious personal problem or a psychiatric disorder do not seek help from anyone. Second, in considering the implications of these findings it is important to bear in mind that clergy are not mental health professionals and the vast majority of clergy have little mental health training. As such, they are not trained to conduct mental health screenings or to formally diagnose psychiatric disorders or suicidal risks. Because clergy are not well-integrated into the mental health delivery system they are not able to provide referrals to specialty mental health providers. Further, when considering clergy who serve African American communities or poor rural communities, it is important to recognize that many do not have college degrees (Payne, 2014).

Finally, although it is important to keep in mind the limitations of clergy training when dealing with serious life issues and mental disorders, we should acknowledge that Americans are more likely to seek help for psychiatric disorders from clergy than from psychiatrists and psychologists (Wang et al., 2003). In our analysis 1 out of 4 respondents sought assistance for emotional problems and only medical doctors were used more frequently than clergy. Clergy are particularly important as an accessible and acceptable source of counseling for low-income groups and individuals without health insurance. Clergy assistance can be helpful in resolving and recovering from the death of a loved one. Clergy counseling and associated religious resources and coping strategies can be very effective in helping bereaved individuals make sense of their loss within the context of important religious and spiritual frameworks, values and beliefs (Gilbert, 1992). Thus, while acknowledging the limited mental health training that clergy receive, we should not underestimate the prominent and vital role that clergy play in addressing difficult life situations for many Americans.

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Table 1
Bivariate analysis of demographic, problem type and religious involvement variables on the use of clergy, among African Americans, Black Caribbeans and Non-Hispanic Whites (n=3937)

Used clergy n =879			Did not use clergy n =3058			$\chi^2_{(df)}$ / t-test	p-value
Variables	n / M	% / SD	n / M	% / SD			
Race/Ethnicity							
African American	506	21.29	1718	78.71	24.62 ₍₂₎	<0.0001	
Black Caribbean	157	13.33	800	86.67			
Non-Hispanic White	216	27.81	540	72.19			
Age	879/47.21	17.42	3058/42.20	17.26	-4.2	<0.0001	
Sex							
Male	261	21.85	1176	78.15	8.58 ₍₁₎	0.003	
Female	618	27.16	1882	72.84			
Marital status							
Currently married	342	26.80	1169	73.20	20.45 ₍₂₎	<0.0001	
Previously married	366	29.92	895	70.08			
Never married	171	15.23	992	84.77			
Education	879/13.08	2.87	3058/13.12	2.73	0.15	0.88	
Household income	879/47490.06	55568.04	3058/43076.99	40852.19	-1.7	0.09	
Type of problem							
Physical	146	29.48	405	70.52	17.87 ₍₅₎	0.003	
Interpersonal	245	25.81	797	74.19			
Emotional	116	24.54	418	75.46			
Death of loved one	235	31.39	544	68.61			
Economic	101	15.61	727	84.39			
Other	36	16.54	167	83.46			
Religious Service Attendance	878/4.28	1.27	3056/3.36	1.46	-13.21	<0.0001	
Denomination							
Catholic	98	28.40	390	71.60	28.04 ₍₇₎	0.0002	
Episcopalian	14	21.78	63	78.22			

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Variables	Used clergy n =879		Did not use clergy n =3058		$\chi^2_{(df)}$ / t-test	p-value
	n / M	% / SD	n / M	% / SD		
Methodist	66	27.20	176	72.80		
Pentecostal	107	37.97	200	62.03		
Other Protestant	204	28.58	581	71.42		
Other Religion	16	10.83	103	89.17		
Baptist	326	24.79	1160	75.21		
No Religion	47	13.96	377	86.04		

Unweighted n's (Weighted %s)

n=Number of Cases

M=mean SD=Standard Deviation

χ^2 = Chi Square df = degrees of freedom

Table 2

Logistic regression analysis of the use of clergy

	Model 1		Model 2		Model 3	
Race/Ethnicity	OR	CI	OR	CI	OR	CI
African American	1		1		1	
Black Caribbean	0.57***	0.45-0.73	0.59***	0.48-0.74	0.59***	0.45-0.79
Non-Hispanic White	1.42**	1.15-1.77	1.32*	1.06-1.65	1.77***	1.36-2.32
Age	--	--	1.01*	1.00-1.02	1.01	0.99-1.02
Sex						
Female	--	--	1		1	
Male	--	--	0.74***	0.62-0.88	0.97	0.79-1.19
Marital status						
Currently married	--	--	1		1	
Previously married	--	--	1.04	0.81-1.32	1.34*	1.06-1.71
Never married	--	--	0.63	0.40-1.00	0.74	0.45-1.23
Education	--	--	0.99	0.91-1.08	0.99	0.92-1.08
Household income	--	--	1.01*	1.00-1.02	1.01	1.00-1.03
Type of problem						
Death of loved one	--	--	1		1	
Physical	--	--	0.90	0.51-1.57	0.90	0.53-1.50
Interpersonal	--	--	0.80	0.63-1.02	0.75*	0.56-0.99
Emotional	--	--	0.78	0.50-1.21	0.88	0.56-1.40
Economic	--	--	0.48**	0.28-0.80	0.46**	0.29-0.74
Other	--	--	0.50*	0.28-0.90	0.52*	0.29-0.92
Religious Service Attendance	--	--	--	--	1.75***	1.62-1.88
Denomination						
Baptist	--	--	--	--	1	
Catholic	--	--	--	--	1.04	0.82-1.33
Episcopalian	--	--	--	--	0.79	0.32-1.98
Methodist	--	--	--	--	0.87	0.52-1.46

	Model 1		Model 2		Model 3	
	OR	CI	OR	CI	OR	CI
Pentecostal	--	--	--	--	1.54*	1.04-2.29
Other Protestant	--	--	--	--	1.06	0.77-1.46
Other Religion	--	--	--	--	0.48*	0.24-0.97
No Religion	--	--	--	--	0.91	0.45-1.82
N	3937		3926		3925	

OR = Odds ratio

CI = Confidence interval

$p < .05$;

** $p < .01$;

*** $p < .001$

Several independent variables are represented by dummy variables; Race/Ethnicity, African American is the comparison category, Gender, Female is the comparison category; Marital Status, currently married is the comparison category; Type of problem, Death of a loved one is the comparison category; Denomination, Baptist is the comparison category.

Table 3

Bivariate analysis of race/ethnicity by the location where clergy were seen.

	Total		African Americans		Black Caribbeans		Non-Hispanic Whites		χ^2 (df)
	%	n	%	n	%	n	%	n	
Church, Synagogue, Mosque	67.53	636	72.74	369	83.87	122	64.31	145	8.96 ₍₂₎ *
Hospital	9.62	51	4.51	25	0.58	2	12.61	24	30.39 ₍₂₎ ***
Private Home	12.28	106	12.89	62	4.72	14	12.14	30	1.02 ₍₂₎
Private Office	4.97	37	3.27	19	6.36	7	5.85	11	2.21 ₍₂₎
Jail	1.01	5	0.84	3	0.34	1	1.11	1	0.17 ₍₂₎
Telephone	1.00	21	2.79	15	2.24	6	0.0	0	.
Other (Public Place, Social service agency)	3.60	22	2.95	12	1.89	5	3.99	5	0.67 ₍₂₎

Table 4
Logistic regression of the use of clergy exclusively among respondents who saw clergy at their place of worship

	Model 1		Model 2		Model 3	
Race/Ethnicity	OR	CI	OR	CI	OR	CI
African American	1		1		1	
Black Caribbean	0.66**	0.50-0.86	0.69**	0.55-0.87	0.75	0.54-1.04
Non-Hispanic White	1.26	0.95-1.68	1.15	0.88-1.51	1.78***	1.27-2.49
Age	--	--	1.01	1.00-1.02	1.00	0.99-1.02
Sex						
Female	--	--	1		1	
Male	--	--	0.61***	0.47-0.78	0.83	0.61-1.11
Marital status						
Currently married	--	--	1		1	
Previously married	--	--	1.07	0.70-1.65	1.52*	1.06-2.18
Never married	--	--	0.71	0.49-1.04	0.95	0.66-1.37
Education	--	--	1.01	0.93-1.10	1.03	0.96-1.10
Household income	--	--	1.01	0.99-1.03	1.01	0.99-1.04
Type of problem						
Death of loved one	--	--	1		1	
Physical	--	--	0.75	0.41-1.37	0.76	0.43-1.33
Interpersonal	--	--	1.01	0.74-1.38	0.99	0.70-1.38
Emotional	--	--	0.89	0.55-1.46	1.09	0.63-1.87
Economic	--	--	0.47**	0.27-0.81	0.46**	0.26-0.83
Other	--	--	0.50	0.24-1.05	0.53	0.25-1.11
Religious Service Attendance	--	--	--	--	2.09***	1.75-2.49
Denomination						
Baptist	--	--	--	--	1	
Catholic	--	--	--	--	0.70	0.39-1.28
Episcopalian	--	--	--	--	0.39*	0.18-0.82

	Model 1		Model 2		Model 3	
	OR	CI	OR	CI	OR	CI
Methodist	--	--	--	--	0.84	0.46-1.55
Pentecostal	--	--	--	--	1.88**	1.20-2.94
Other Protestant	--	--	--	--	0.99	0.63-1.54
Other Religion	--	--	--	--	0.40*	0.17-0.95
No Religion	--	--	--	--	0.80	0.33-1.97
N	3694		3692		3684	

OR = Odds ratio

CI = Confidence interval

* $p < .05$;

** $p < .01$;

*** $p < .001$

Several independent variables are represented by dummy variables; Race/Ethnicity, African American is the comparison category, Gender, Female is the comparison category; Marital Status, currently married is the comparison category; Type of problem, Death of a loved one is the comparison category; Denomination, Baptist is the comparison category.