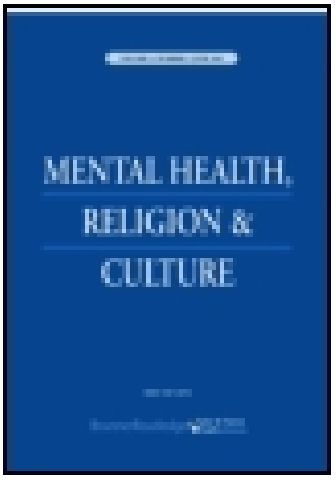

Mental Health, Religion & Culture
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/cmhr20

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Published online: 09 Oct 2014.

To cite this article: William Hunter & Matthew Stanford (2014): Adolescent mental health: the role of youth and college pastors, Mental Health, Religion & Culture, DOI: 10.1080/13674676.2014.966663

To link to this article: http://dx.doi.org/10.1080/13674676.2014.966663

Mental Health, Religion & Culture, 2014
http://dx.doi.org/10.1080/13674676.2014.966663

Adolescent mental health: the role of youth and college pastors

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(*Received 18 August 2014; accepted 15 September 2014*)

The present study investigates the gatekeeping role of youth and college pastors, specifically exploring their psychological training, perceptions, attitudes, and interactions concerning adolescent congregants' mental illness. Texas youth and college pastors were anonymously surveyed regarding referral patterns, mental health interventions and contact, adolescent mental health perceptions, and means of collaboration. While the sample reported actively working with numerous adolescent mental health issues, the majority did not feel qualified to work with significant psychopathology. Despite this, they reported using various intervention methods, with the most common being initial counselling followed by a referral. Although the sample frequently referred to other professionals, they described many perceived barriers in collaborating with others in the mental health field. Overall, a positive role exists for youth and college pastors in adolescent mental health; however, tensions and conflicts between pastors and mental health professionals hinder the usefulness of these unique gatekeepers. Implications and recommendations for mental health professionals are highlighted.

Keywords: adolescents; youth/college pastor; collaboration; referral

Introduction

Adolescence is a critical period in development when numerous changes occur that affect mental, social, physical, and emotional well-being. This period is marked by extensive brain development and growth, and individuals are especially receptive to environmental changes. Taken together, the shifts that occur during this transitional phase can increase adolescents' vulnerability to mental health issues and risky behaviour. The National Center for Children in Poverty (NCCP) highlights the risks of the adolescent experience as "a complex web of potential challenges to adolescents' healthy emotional and physical development" (Schwarz, 2009, p. 1). The NCCP also noted that 20% of adolescents have a diagnosable mental health disorder, with anxiety, depressive, and impulse control disorders first presenting during adolescence for a significant proportion of diagnosed individuals (Schwarz, 2009). Furthermore, suicide is the third leading cause of death for individuals between 15 and 24 years old (American Academy of Child and Adolescent Psychiatry, 2013; National Institute of Mental Health, n.d.). Miller and Kelley (2005) describe this phase of development as a "window of risk for concurrent or future psychopathology" (p. 467). The experience of biological changes, life events, and stressors contribute to the risk

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for such mental health issues, and if left untreated, these issues carry serious consequences into adulthood.

Despite these facts, adolescents largely underutilise mental health services. The National Comorbidity Study – Adolescent Supplement found that only 36% of youth with any lifetime mental health disorder received services, and 68% of those who did receive services had fewer than six visits with a provider in their lifetime (Merikangas et al., 2010). Another study of Dutch adolescents found that of those in the sample selected for having emotional and behavioural problems, only 16.5% had sought mental health services at some point (Zwaanswijk, van der Ende, Verhaak, Bensing, & Verhulst, 2007). This lack of access and utilisation is related to many factors, including insurance coverage, living conditions, and lack of referral services and specialised care (Chandra & Minkovitz, 2006; U.S. Department of Health and Human Services, 2001).

Given the impact of adolescent mental health treatment on future functioning and the apparent lack of utilisation of services, researchers have investigated various contexts in which adolescents spend time. The importance of the education sector has been highlighted as an entry point for adolescents' to receive mental health care, which is understandable given the amount of time that individuals spend in school (Farmer, Burns, Phillips, Angold, & Costello, 2003). Other important contexts include extracurricular activities, the home environment, and peer groups. However, in addition to these, a common sphere that is widely understudied includes the adolescent's religious community.

Researchers have discussed religious involvement in terms of identity and social development. Erikson (1950) noted that religion is a significant part of identity, and for adolescents, identity development is the primary task. Good and Willoughby (2008) describe adolescence as a "sensitive period" for spiritual development, as individuals' capacity for abstract thought and self-reflection increases. Religious exploration is significant in identity development, with researchers claiming that "the deepening spiritual faculty of adolescents, left unsupported or negated, may generate vulnerability" (Desrosiers, Kelley, & Miller, 2011, p. 40). Religion and spirituality are important domains within identity formation, as religious/spiritual exploration is highly personal and often related to self-worth (Markstrom, 1999). Social development may also coincide with religious development, as religious commitment often involves a community of peers (Marks, 2005). Large-scale surveys of youth indicate that adolescence is the stage of life in which conversion is most likely to occur (Smith, Denton, Faris, & Regnerus, 2002). Based on results from three such surveys (Monitoring the Future, Survey of Adolescent Health, and The Survey of Parents and Youth), researchers found that only 13% of the samples claimed no religious affiliation (Smith et al., 2002). They further noted that about half of American adolescents sampled regularly participate in religious organisations in the form of attending a religious service or involvement in a youth group. The social aspect of religious participation is significant, as the researchers found that in the Survey of Parents and Youth, 30% of those who did not identify with any religion still participated in a church's youth group (Smith et al., 2002).

Given the extensive participation of adolescents in religious groups and the psychosocial benefits that this involvement provides, it appears as though clergy who work with youth serve as unique gatekeepers to the mental health system. It has been shown that clergy function in this role for adults, as those with diagnosed mental health issues are more likely to seek services from clergy before any other professional group (Chalfant et al., 1990; Wang, Berglund, & Kessler, 2003). Furthermore, it is important to note that this has been found true for individuals from the general population and not a solely religious sample. Regardless of their intervention, clergy are clearly frontline gatekeepers involved in initial contact and service to those experiencing mental health issues and diagnosed mental illnesses.

Given the amount of contact that clergy who work with youth, such as youth and college pastors, have with adolescent congregants, they are in a similar position of being optimal gatekeepers. Weaver, Preston, and Jerome (1999) state that they are in a strategic situation because

of their interaction with adolescents, their peers, and their families. Unlike senior pastors, those who work with youth are expected to have more extensive contact with their congregants because this likely occurs outside of the church service. Furthermore, youth groups are a smaller subset of the congregation at large, which creates the possibility for deeper relationships to be formed between youth pastors and adolescents. Youth workers are also likely to encounter their adolescent congregants in multiple settings, such as one-on-one counselling, Bible study groups, mission trips and service opportunities, conferences, and other social events. Intended outcomes of youth ministry have been described as: learning about faith and moral behaviour, making the church relevant to youth, creating opportunities for social relationships with peers and the youth minister, facilitating religious and spiritual identity development (Magaldi-Dopman & Park-Taylor, 2010; Snell, 2009), and "creat[ing] a space of care and hospitality for [adolescents] in the larger faith community" (Hryniuk, 2005, p. 17). Furthermore, Jack and McRay (2005) sought to develop a profile of youth minister training programmes. According to the programmes sampled, the ideal education would include knowledge about the self, theology, psychology, sociology, ministry, and educational theory. Though programmes differ, the authors found that respondents mentioned psychology coursework that included not only theories of counselling, but also child and adolescent development (Jack & McRay, 2005).

Current literature, however, suggests a need for more training for clergy in the field of mental health. Farrell and Gobert (2008) found that 71% of pastors surveyed felt inadequately trained to recognise mental illness even though 73% reported at least some training in the area. Yet in this same study, 90% of the pastors reported spending time each week counselling their congregants (Farrell & Gobert, 2008). Clearly, regardless of training or confidence level, a large majority of pastors are important figures in the mental health treatment. In summary, research suggests that individuals seek services for mental health issues from clergy, and most clergy generally respond with some kind of counselling; however, a majority of them feel unprepared to identify and treat mental illness, and a need and desire for more education is consistently highlighted (Holmes & Howard, 1980; Mannon & Crawford, 1996; McRay, McMinn, Wrightsman, Burnett, & Ho, 2001; Stanford & Philpott, 2011; Virkler, 1979). Although many studies have been devoted to investigating the referral patterns of clergy to mental health professionals (Farrell & Goebert, 2008; McMinn, Ruiz, Marx, Wright, & Gilbert, 2006), training pastors more effectively in recognising and responding to mental illness would allow them to serve as much more effective gatekeepers before they refer.

Research is unclear as to whether this same pattern occurs for youth and college pastors. Clearly they have a significant role in adolescent mental health, and based on findings from the aforementioned studies of general clergy, it is likely that their gatekeeping role is not as optimal as it could be. It is largely unknown as to whether or not youth pastors identify and respond to mental illness in their youth congregants, even though adolescence is a time when many disorders first present. With more knowledge in this area, mental health professionals can help equip youth pastors in recognising and treating mental illness, and they can bridge the gap for pastors' collaboration with and referrals to other mental health professionals.

The present study sought to investigate youth and college pastors specifically in relation to psychological training and perceptions, attitudes, and interactions regarding mental illness in their adolescent congregants. Existing research in this area is largely related to theological training, pastoral counselling, adolescent faith experiences, and mental health professionals' responses to religious adolescents. One particular study analysed pastors' responses to adolescents with mental health issues; however, it was generally anecdotal and specific to rural faith communities (Jones, Cassidy, & Heflinger, 2012). The present study sought to gain insights into the role that youth and college pastors serve as key components in adolescent mental health, in hopes of informing psychological training and assisting mental health professionals in working with them.

Method

Participants and recruitment

For this study, an online search was conducted of local Christian churches in the following Texas cities: Abilene, Austin, College Station, Dallas-Fort Worth metro area, Houston, Lubbock, Midland, San Antonio, the Temple-Killeen area, and Waco. The cities were chosen based on existing databases of churches and the presence of universities in the cities, in hopes that the churches would have existing youth and college fellowship groups. There was no discrimination based on denomination; however, only those college or youth pastors with functional email addresses were chosen to participate. The respective youth and college pastors were contacted through email and directed to an anonymous online questionnaire developed by the authors. Approximately one month after contact, a follow-up email was sent. Of the 347 pastors emailed, 94 youth and college pastors (27.1%) completed the questionnaire; however, a snowball sampling method was also utilised. In the initial email, pastors were encouraged to forward the questionnaire to other youth and college pastors with whom they work, so it is likely that the sample contains some individuals who were not directly emailed by the researchers. Finally, all measures and data collection methods were approved by the institutional review board, and all subjects gave consent prior to participation.

Instrument

The questionnaire collected information in the following areas: church and youth group profile, pastor demographics and education, pastor mental health background and referrals, mental health intervention and contact, adolescent mental health perceptions, and collaboration.

Mental health questions

In addition to the demographic and background questions about the church, youth group, and pastor, the participants were asked a series of questions regarding their mental health background and referral patterns. They were asked to rate on a 7-point scale (1 = "not likely" to 7 = "very likely") their likelihood of referring a youth congregant to a psychologist, Christian counsellor, and a psychiatrist. They also indicated their mental health training, referral history, and the perceived prevalence of mental illness among their congregants.

Intervention and contact

Participants were asked how they came to know that a youth congregant has a mental illness. Furthermore, they were asked to specify from a 16-item list the mental health issues that they have personally seen in one of their youth. This list contained a combination of known diagnoses, major stressors, and problem behaviours, and it was created with the help of local psychologists and pastors. Finally, the participants were asked the most prevalent mental health issue that they encounter among their youth group, and they were given the opportunity to write a personal anecdote of their general intervention.

Mental health perceptions

Participants were given the same 16-item list of mental health issues, and asked to identify the three they believe to be the most important issues that adolescents in general face. Additionally, they rated on a 5-point scale (1 = "no effect" to 5 = "very significant effect") the effect that mental health issues have on the spiritual development of youth and college students.

Collaboration

Participants rated on a 5-point scale (1 = "not at all likely" to 5 = "extremely likely") their likelihood of collaborating with mental health professionals in the future. They were also asked about their collaboration history, and finally, participants were given the chance to write a personal response about the barriers they perceive that prevent them from working with mental health professionals.

Results

Church and youth group profile

The churches represented in this sample varied in size, with an average weekly attendance ranging from 45 to 8000 members (median = 1121). The estimated median age of the congregations ranged widely as well, from 19 to 70 years old (median = 45), and the median annual budget of churches was $1,000,000 (range $100,000–$15,000,000). Furthermore, 19.1% of the churches reported being non-denominational, and a majority of respondents indicated that they served suburban churches (66%), followed by urban (30%) and rural (4%). The youth groups that the pastors led consisted of middle/high school students (90%), college students only (7%), and middle school through college (3%). Finally, the median reported size of the youth ministries was 60 individuals (range 10–1000). It should be noted that the larger youth groups often were led by multiple pastors.

Pastor demographics and education

The age of the respondents ranged from 21 to 61 years old, with an average age of 33 years. The highest levels of education reported were the following: 61.7% master's degree, 30.9% bachelor's degree, 6.3% some college (no degree), and 1.1% professional degree. A majority of the respondents reported that they attended seminary (67.7%). Participants characterised their theology (7-point scale, 1 = "very conservative" to 7 = "very liberal") as more conservative ($M = 3.43$, SD = 1.41, range 1–7). The median length of service as a youth pastor was eight years (range 1–40 years). Finally, 88.3% of the respondents indicated that they offered pastoral counselling to their congregants.

Pastoral mental health background and referrals

Exactly half of the respondents indicated that they had received previous training related to mental illness (50.0%), while only 26% of the total sample reported that they currently feel qualified to work with adolescents who are experiencing significant mental health issues. Only 6.4% reported not working with any youth who were experiencing mental health issues, while the vast majority (78.7%) worked with 1–10 adolescents per year whom they knew or perceived to have mental health issues.

When asked about their referral history, 76% had previously referred an adolescent congregant to a Christian counsellor, 51% to a psychologist, and 34% to a psychiatrist. The participants characterised their overall likelihood of referring (7-point scale, 1 = "not likely" to 7 = "very likely") to each of these mental health workers, and they were most likely to refer to a Christian counsellor ($M = 6.04$, SD = 1.44), followed by a psychologist ($M = 5.24$, SD = 1.70), and a psychiatrist ($M = 4.96$, SD = 1.71).

Intervention and contact

The participants were asked to note the multiple means by which they discovered that a congregant was experiencing mental health issues. Eighty-nine percent of the respondents indicated that

their primary method was through talking with the parents or family members of the adolescent. This was followed by talking with the adolescent (81%) and using their own judgement (70%), consulting with a mental health professional (31%), and talking with someone from the adolescent's school (15%).

From the 16-item list of mental health issues, that included diagnoses, stressors, and problem behaviours, participants selected items that they had personally seen in a youth congregant with whom they had counselled. All items were endorsed by at least one participant, and Table 1 presents their prevalence rates. The subjects also rated the single item which they believed to be the most prevalent in their youth congregants. The results were varied, as 25% of the respondents indicated that they most often identified youth with depression. This was followed by youth experiencing issues with pornography use (17%), anxiety (14%), Attention Deficit Hyperactivity Disorder (ADHD; 12%), and issues related to sexual behaviour (10%).

After identifying the most prevalent mental health issue that their youth congregants experience, the respondents wrote a description of their general intervention when working with individuals with that particular issue. Ninety-one subjects (97%) wrote a response, and a content analysis was conducted to categorise the responses. If descriptions involved multiple techniques, the primary method was recorded. The methods fell into seven main categories: initial intervention with a referral to a mental health-care provider (22%), Biblical counselling/pastoral care (20%), individual counselling with primarily psychological concepts (15%), general support/encouragement (14%), setting up Bible study/peer group programming (11%), family involvement (10%), and prayer/passive availability (8%).

Mental health perceptions

With the previously mentioned list of 16 mental health issues, respondents indicated what they believed to be the top three that adolescents in general face. All of the items were endorsed by

Table 1. Prevalence of adolescent mental health issues, stressors, and problem behaviours identified by youth and college pastors.

Item	Respondents ($n = 94$)
Depression	84.0%
Pornography	76.6%
Grief/bereavement	74.5%
Anxiety	71.3%
Aggression/anger issues	70.2%
Sexual behaviour	70.2%
Alcohol/drug use or abuse	62.8%
ADHD	61.7%
Emotional abuse	58.5%
Eating disorders	57.4%
Stress from having a family member with a mental health issue	47.9%
Domestic violence/spousal abuse, violence in the home	41.5%
Juvenile delinquency	41.5%
Gender identity	40.4%
Sexual assault/abuse	38.3%
Physical abuse	37.2%
Others[a]	13.8%

Note: Respondents were asked to select all that apply.
[a]Responses included: Suicidal ideation/attempt, self-harm, neglect, stress from parents' divorce, bipolar disorder, autism spectrum disorder, cancer, sexual orientation discrimination, and faith crisis.

at least one respondent, and the most frequently mentioned was depression (included by 63% of the participants). This was followed by issues with pornography (44%), issues relating to sexual behaviour (39%), and anxiety (34%). In terms of their perception of how mental health issues affect the spiritual development of adolescents and college students (1 = "no effect", 5 = "very significant effect"), the respondents perceived a significant effect ($M = 4.35$, $SD = 0.67$, range 2–5).

Collaboration

Sixty-four percent of the respondents indicated that they had collaborated with a mental health professional regarding one of their youth congregants. The participants were also asked on a 5-point scale (1 = "not at all likely", 5 = "extremely likely") how likely they were to collaborate with a mental health professional in the future if given the opportunity. Overall, the sample noted that they were very likely ($M = 4.38$, SD = 0.84, range 2–5).

Finally, 94 respondents (100%) wrote an account of what they see as the primary barrier to working with mental health professionals. A content analysis was conducted to categorise the responses. The perceived barriers fell into the following main categories: lack of connection to mental health professionals (28%), differences in religious beliefs (26%), and client constraints (client's lack of money, time, or interest in seeing a professional; 18%). Respondents also mentioned a lack of trust (10%), their own lack of training and knowledge of how/when to collaborate or refer (9%), and no perceived barriers existing (8%).

Discussion

Overall, the sample included pastors from large, suburban churches. The youth pastors themselves were younger than samples of senior pastors used in previous research (Stanford & Philpott, 2011). They were theologically conservative and well educated. The response rate (27.1%) is consistent with previous email surveys to clergy (Stanford & Philpott, 2011); however, with this limitation, the results should be interpreted with caution. Furthermore, the current study is descriptive and based on a specific geographic region. This sample was limited to individuals in Texas, and the Southern United States tends to be more conservative than other regions in the country in many domains, including religion (Cooper & Knotts, 2010).

As gatekeepers, youth, and college pastors play a significant role in adolescent mental health. The results of this study show that they actively work with youth in their congregation who may be dealing with a wide variety of mental health issues. A large majority of the pastors offered counselling, and almost the entire sample reported recognising mental health issues in their adolescent congregants. The main means by which pastors became aware of these issues were talking with family or the adolescent and by using their own judgement. Only half of the pastors stated that they had received mental health training in their education, so it is likely that their own "judgement" in these situations relied on expertise and previous experience. Although youth ministry training likely includes some psychological background (Jack & McRay, 2005), the nature of this training may vary in that three-quarters of the pastors did not feel qualified to work with adolescents experiencing significant mental health issues. This lack of confidence to work with serious psychopathology has been demonstrated in other research of clergy (Farrell & Goebert, 2008; Mannon & Crawford, 1996). In this sense, it is encouraging that almost all of the individuals had referred to another mental health professional at some point.

The youth pastors described a wide range of interventional methods, and the most commonly reported method involved the youth pastor initially meeting with the adolescent and then referring to practitioner mental health professional if necessary. Also, while many pastors described using Biblical counselling methods, a subset of pastors described counselling with primarily

psychological concepts. Such pastors included methods like talking through coping skills, behavioural strategies, role-playing, and cognitive reframing. The use of such techniques are encouraging and should be expected, as Stanford and Philpott (2011) found that Baptist senior pastors' perceptions of mental illness were based on biomedical knowledge in addition to religious beliefs. Continuing to emphasise pastoral counselling and contemporary psychological techniques may not only bolster the treatment that adolescents receive, but also bridge the gap between clergy and mental health professionals.

In terms of working with mental health professionals, the sample was most likely to refer to Christian counsellors, which is similar to previous research demonstrating that senior pastors are most likely to refer to individuals with whom they share values (Farrell & Goebert, 2008; Stanford & Philpott, 2011). However, it is encouraging that the youth pastors were likely to refer to psychologists and psychiatrists as well. Previous research has indicated that referral patterns likely differ based on whether the client is experiencing a "religious issue" (McMinn et al., 2006); however, the current study did not differentiate between reasons why they referred to different professionals. While a majority of the sample had collaborated with other mental health workers and claimed a desire to collaborate in the future, the respondents mentioned different barriers that prevent them from optimally serving as gatekeepers. Some pastors appeared sceptical and distrustful of mental health professionals; however, the overall picture is more encouraging, in that the most common barrier was that they simply do not have contacts or connections to mental health professionals. A number of pastors mentioned having counsellors employed by their church or having personal contacts with mental health workers; however, the formation of these connections may take effort from both parties.

The sample of youth pastors largely believe that psychological well-being affects adolescents' spiritual development, and they perceive mood disorders and sexual issues as being especially significant for this population. The picture of their role in the overall realm of adolescent mental health is more positive than initially thought, in that they do notice when their congregants are facing some kind of mental health issue, and they do attempt to provide some type of intervention. However, a lack of confidence and training and perceived barriers to interacting with the mental health system suggest that their unique role as gatekeepers can be improved, and there are recommendations for mental health professionals in this arena. First, mental health professionals working with religious adolescents should consider the role of the youth pastor in enhancing spiritual development. Successful collaboration allows each individual to serve a specific role, recognising the skills that each possesses. The pastors in this sample seemed open to working with mental health professionals; however, some were concerned that those providers would not collaborate with them once a referral was made. This lack of connection only serves to further the perceived divide between the two parties.

Furthermore, mental health professionals who are willing to work with clergy should strive to reach out to faith communities. McMinn, Runner, Fairchild, Lefler, and Suntay (2005) note that collaboration is based more on relationships than demographic characteristics, titles, or spiritual practices. In the current study, many youth pastors who embraced the field of psychology indicated that they were unaware of mental health professionals with whom to work, and many did not know what psychotherapy for their congregants would entail (including time, cost, and scope of services). Increasing a presence in the community can also benefit pastors and congregations by increasing mental health awareness. Outreach will allow the pastor and mental health professional to gain an understanding of the other while becoming familiar with each other's "language" and view of mental health (McMinn et al., 2005). There is a greater need for more psychological education for youth pastors, and it has been found that pastors were highly interested in knowing more about counselling adolescents as well (McRay et al., 2001). The unique

knowledge that mental health professionals can offer, especially in terms of psychopathology and development, may benefit pastors and parents alike, regardless of religious views.

In summary, the outlook of the relationship between youth pastors and mental health professionals is positive, although tensions and conflicts do exist. Future studies should focus on expanding and exploring the variables used here in order to investigate the relationships and barriers between youth pastors and mental health professionals more closely. As with previous studies, the results highlight the importance of mutual respect, communication, and appreciated values, and the area of adolescent mental health would greatly benefit from mental health professionals working with these distinctive gatekeepers.

Acknowledgements

This study was not subject to external funding, and the authors have declared that they have no competing or potential conflicts of interest.

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