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ORIGINAL PAPER

Help-Seeking from Clergy and Spiritual Counselors Among Veterans with Depression and PTSD in Primary Care

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Abstract Little is known about the prevalence or predictors of seeking help for depression and PTSD from spiritual counselors and clergy. We describe openness to and actual help-seeking from spiritual counselors among primary care patients with depression. We screened consecutive VA primary care patients for depression; 761 Veterans with probable major

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depression participated in telephone surveys (at baseline, 7 months, and 18 months). Participants were asked about (1) openness to seeking help for emotional problems from spiritual counselors/clergy and (2) actual contact with spiritual counselors/clergy in the past 6 months. At baseline, almost half of the participants, 359 (47.2 %), endorsed being "very" or "somewhat likely" to seek help for emotional problems from spiritual counselors; 498 (65.4 %) were open to a primary care provider, 486 (63.9 %) to a psychiatrist, and 409 (66.5 %) to another type of mental health provider. Ninety-one participants (12 %) reported actual spiritual counselor/clergy consultation. Ninety-five (10.3 %) participants reported that their VA providers had recently asked them about spiritual support; the majority of these found this discussion helpful. Participants with current PTSD symptoms, and those with a mental health visit in the past 6 months, were more likely to report openness to and actual help-seeking from clergy. Veterans with depression and PTSD are amenable to receiving help from spiritual counselors/clergy and other providers. Integration of spiritual counselors/clergy into care teams may be helpful to Veterans with PTSD. Training of such providers to address PTSD specifically may also be desirable.

Keywords Depression · PTSD · Clergy

Introduction

Veterans with depression (Young et al. 2001) and posttraumatic stress disorder (PTSD; Fontana and Rosenheck 2005; Sigmund 2003) receive help from formal and informal providers, including primary care providers, mental health specialists and spiritual counselors, such as clergy, among others. The increasingly prevalent patient-centered primary care models, such as the patient-centered medical home (PCMH) (American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association 2007) or the Department of Veterans Affairs (VA) Patient-Aligned Care Team (PACT) initiative (Department of Veterans Affairs 2011a), are designed to incorporate patient preferences and community support into health care. PACT in particular includes a focus on mental health. These models, however, have yet to explicitly address the issue of spiritual support, either in general or for emotional problems. In this study, we describe the extent to which VA primary care patients with depression desire and use help from spiritual counselors and clergy. Spiritual counseling may be provided by formally trained clergy members, peer ministers, and other individuals; we use the term "spiritual counselors" to encompass all of these provider types. We also explore what factors are most strongly associated with the desire to seek spiritual help among primary care Veterans with depression and to what extent they have actually used such help.

The Department of Veterans Affairs (VA) has recently initiated a program to educate community clergy about Veterans' mental health needs (VA 2011b). VA also includes information about spiritual reactions to trauma on its patient health education portal, MyHealth*e*Vet (Department of Veterans Affairs 2011c). This study aims to assist primary care and mental health practitioners in understanding patient preferences related to spiritual care for mental health disorders.

Help-Seeking from Clergy Among Veterans with Depression in Primary Care

There are a variety of reasons to integrate spiritual care into mental health care. First, patients may view seeking help from spiritual counselors as less stigmatizing than

consulting mental health specialists. For example, Veterans in particular may have concerns that receiving formal mental health care or mental health diagnoses will compromise their careers (Kim et al. 2010). In addition, spiritual counselors may be able to engage social support resources for emotional issues (Sigmund 2003). Access to social support may in turn protect against PTSD (Polusny et al. 2011), reduce suicide risk (Jakupcak et al. 2010), and improve PTSD psychotherapy outcomes (Thrasher et al. 2010). Finally, some evidence suggests that incorporating spirituality into emotional care may improve outcomes. For example, more religious practice and religious coping may be associated with decreased depression (Bosworth et al. 2003). An experiment with college students (Chen and Contrada 2009) demonstrated that framing disturbing experiences from a religious perspective was associated with fewer symptoms of depression on follow-up.

Although the literature generally supports a positive relationship between religious involvement and mental health, there remain some concerns about possible negative aspects of this association. For example, when Koening et al. (2012) reviewed the literature examining the links between religion/spirituality and depression, they reported that the majority of prior studies found an inverse relationship between depression and religious involvement, but some studies found the opposite. In addition, Johnson et al. (2011) found that prior negative religious experiences might be associated with increased anxiety and depression among patients with severe illness. Similarly, negative religious coping (e.g., questioning God's love) may be associated with worse anxiety and depression, especially in the context of recent illness or injury (McConnell et al. 2006). Conversely, however, negative religious thoughts or experiences could potentially be helped by contact with spiritual counselors. Spiritual providers may require mental health training in order to provide optimal care to patients with complex mental health concerns, such as suicide risk (Weaver and Koenig 1996).

In the context of recent efforts by the VA to support clergy involvement in mental health care for Veterans (VA 2011b), we describe preferences for spiritual care among VA primary care patients with depression. Understanding and accommodating patient preferences may help VA clinicians and administrators design and implement patient-centered care teams. We addressed the following research questions about a representative sample of patients with depression cared for in VA primary settings:

1. How many patients *would be open to* receiving help for emotional problems from a spiritual counselor such as a clergy member?
2. What proportion of patients *actually sought* help for emotional problems from a spiritual counselor?
3. What patient characteristics were associated with openness to or actual use of spiritual counselors?
4. Was openness to or accessing spiritual care linked to better depression outcomes at 7 and 18 months?

Methods

The Well-being Among Veterans Enhancement Study (WAVES) study was a patient-level evaluation of the Translating Initiatives in Depression into Effective Solutions (TIDES) depression quality improvement project (Chaney et al. 2011; Liu et al. 2009), conducted in ten VA primary care clinics dispersed through three geographic regions in five states. In this project, clinics were randomly assigned to usual care or to the quality improvement intervention. The intervention included provider education about best practices for depression, collaboration between primary care and mental health, and a 6-month nurse

care management protocol (Chaney et al. 2011; Liu et al. 2009). The nurse care manager provided patient education, supported patient self-management, and tracked patient progress throughout the 6-month intervention period.

Study staff mailed information about the study, including phone and postcard refusal options, to VA patients with consecutive appointments in the participating VA primary care clinics. Ten days after the mailing, trained interviewers contacted these potential participants and administered a 2-item depression screen adapted from a validated depression screening instrument, the 9-item Patient Health Questionnaire (PHQ-9) (Kroenke et al. 2001) via telephone. Patients who endorsed one or both of the initial screening items were administered the complete PHQ-9; those who scored in the range suggesting depression (PHQ-9 $\geq$ 10) were invited to enroll in the study and to respond to additional survey questions. Because patients who did not screen positive for depression were not asked additional questions, minimal information (age and gender) is available about non-enrollees. At baseline, the majority of variables had 99 % valid data, precluding the need for imputation of missing data (Yano et al. 2012).

Patients from intervention sites who enrolled in the study were referred to the nurse care management protocol described above; patients from usual care sites received usual care but were not referred to nurse care management. Follow-up surveys were conducted 7 months and 18 months after enrollment. At 18 months, one site had been lost to follow-up due to Hurricane Katrina.

Measures

Dependent Variables

To assess openness to choosing help from clergy, participants were asked, "If you were depressed or had other emotional troubles and could choose who would help you with these problems, how likely would you be to choose each of the following types of providers?" The provider types were "primary care physician," "psychiatrist," "another mental health specialist," and "spiritual counselor, such as a clergy member or another type of devotional leader." Respondents rated each provider type separately on separate 5-point Likert-type scales ranging from "very likely" to "very unlikely." Because participants rated each provider type separately, participants could report "very likely" (or any other response) for multiple provider types. Respondents were not asked to compare or rank provider types. Because we were interested in general openness to help-seeking and not in gradations of openness to help-seeking, responses were dichotomized as "very/somewhat likely" or "uncertain/somewhat unlikely/very unlikely." Participants were then asked whether they had actually sought help for emotional problems from a spiritual counselor within the past 6 months. We measured receiving mental health specialty care based on whether the participant reported "a visit, either in person or by telephone, with any mental health specialist" during the past 6 months. We measured whether the clinician asked about spiritual support based on the question "Over the past 6 months has a VA health care provider asked you about the kinds of spiritual support currently available to you?" Participants who replied "yes" were then asked, "Was this discussion helpful to you?"

Independent Variables

We assessed probable major depression with the PHQ-9 (Kroenke et al. 2001). This survey asks participants to rate the frequency of the 9 DSM-IV-TR (American Psychiatric

Association (APA) 2000) symptoms of depression (0 = "not at all"; 3 = "every day/nearly every day") within the past 2 weeks. Possible scores range from 0 to 27, with scores ≥10 indicating probable major depression. All participants by definition scored ≥10 at baseline.

We used the primary care PTSD screen (Prins et al. 2003), which uses 4 PTSD symptoms (nightmares/intrusive thoughts, avoidance, hypervigilance, and detachment) to assess current PTSD. A cut score of 3 positive symptoms yields a sensitivity of 0.78 and a specificity of 0.87 for PTSD diagnosis, is recommended by Prins et al. (2003) as a reasonable indicator of present PTSD, and is used here to identify patients with current PTSD.

We assessed social support using 8 items adapted from the Modified Social Support Survey (Sherbourne and Stewart 1991), which assesses instrumental and emotional aspects of social support. Participants were asked "how much do you feel you can count on…" someone to provide each aspect. They responded using a 5-item Likert-type scale ranging from "completely" to "not at all"; social support scales were coded such that higher scores indicated more perceived support.

We used the Seattle Index of Comorbidity (SIC) to assess health status (Fan et al. 2002). This index includes age, smoking status, cancer, pneumonia, myocardial infarction, chronic lung disease, diabetes, stroke, and congestive heart failure. Participants were also asked to rate their own general health on a 5-point Likert-type scale ranging from "excellent" to "poor" (Kazis et al. 1999). We used the Alcohol Use Disorders Identification Test alcohol consumption questions (AUDIT-C) (Bush et al. 1998) to screen for alcohol abuse. This instrument includes 3 questions about frequency and volume of alcohol consumption: how often alcohol is consumed, how many drinks are typically consumed, and how often males consumed more than 5 drinks or females consumed more than 3 drinks on one occasion.

Study procedures were approved by Institutional Review Boards at the University of Washington and participating VA sites.

Data Analysis

For descriptive analyses, we used χ^2 to test associations between categorical variables. We used linear regression to test associations between baseline PTSD and depression severity, adjusting for differential enrollment by age and gender. We used multivariable logistic regression analyses to test associations between help-seeking from clergy and patient characteristics. To test the association between depression outcomes and accessing spiritual care, we used multivariable linear regression to assess depression symptoms at 7 months and separately at 18 months. Because assignment to the quality improvement intervention, including nurse care management, could potentially affect depression symptoms at 7 and 18 months, we conducted 7- and 18-month analyses including treatment group assignment. As described by Chaney et al. 2011, we adjusted baseline analyses based on probability of enrollment by age and gender, using demographic data obtained from VA administrative databases for non-participants. Potential participants could decline enrollment without providing additional information. Therefore, we were not able to adjust for enrollment bias using any other variables. Follow-up analyses were also adjusted for attrition using sample weights based on baseline depression, mental health symptoms, general health, age, sex, education, race, and social support. We report unadjusted descriptive statistics and adjusted results for regression analyses and other comparisons.

Results

Participants

Of 10,929 VA patients who were screened for depression, 1,313 screened positive and 761 consented to participate. Participant baseline characteristics are shown in Table 1. The sample was mostly male and White, with a mean age about 60 years; the majority of participants rated their overall health as "fair" or "poor." Over one-third of the participants screened positive for current PTSD symptoms. We used linear regression to test the association between baseline PTSD and depression severity. Participants who screened positive for current PTSD had more severe depression at baseline ($N = 761$, $F(1, 760) = 65.71$, $p < .001$, $R^2 = 0.09$) and at 18 months ($N = 370$, $F(1, 369) = 39.95$, $p < .001$, $R^2 = 0.11$).

Table 1 Sample characteristics ($N = 761$)

Characteristic	*n* (%) or mean (SD)
Age	60.34 (11.9)
Male	715 (93.96)
Race/ethnicity	
White or Caucasian	646 (84.89)
Black or African American	60 (7.88)
Native American or Alaskan Native	18 (2.37)
Asian, Asian American or Pacific Islander	4 (.53)
Multi or biracial	20 (2.63)
Other	9 (1.18)
Do not know	1 (.13)
Refused	3 (.39)
Latin American origin or descent	31 (4.07)
Self-rating of general health	
Excellent	11 (1.45)
Very good	25 (3.29)
Good	113 (14.87)
Fair	271 (35.66)
Poor	340 (44.74)
PTSD current prevalence (3 or 4 of 4 symptoms)	294 (38.63)
Mental health specialist visit within past 6 months	341 (44.81)
Sought help from spiritual counselor within past 6 months	90 (11.83)
PHQ-9 score	15.84 (4.25)
Baseline total social support (summary score, reverse-coded)	3.64 (1.17)
Seattle index of comorbidity	7.07 (3.32)
AUDIT-C	2.02 (3.10)

Openness to Seeking Help from a Spiritual Counselor

Of the entire sample, 47.2 % ($n = 359$) endorsed being "very" or "somewhat" likely to choose "a spiritual counselor, such as a clergy member or another type of devotional leader" for help with depression or emotional troubles. A total of 498 participants (65.4 %) endorsed likelihood of consulting a primary care physician, 486 (63.9 %) endorsed likelihood of choosing a psychiatrist, and 506 (66.5 %) another mental health specialist. Participants could endorse openness to multiple sources of care and 571 (75 %) did so.

There was a positive association between endorsed likelihood of seeking help from clergy and endorsed likelihood of seeking help from other care providers, including a primary care physician ($\chi^2(1) = 40.2$, $p < .001$, $N = 748$), a psychiatrist ($\chi^2(1) = 11.9$; $p = .002$, $N = 755$), and another mental health specialist ($\chi^2(1) = 22.6$, $p < .001$, $N = 754$). Endorsed likelihood of choosing a spiritual counselor did not vary by geographic region ($\chi^2(2) = 3.5$, $p = .21$, $N = 759$) and did not demonstrate an association with mean baseline depression severity, $R^2 = 0.0014$; $p = .89$, nor to the presence of PTSD ($\chi^2(1) = 0.0001$, $p = .99$, $N = 759$). In adjusted linear regression analysis, participants with higher total social support were more open to getting help from a spiritual counselor ($F(1, 742) = 18.17$, $p \leq .001$, $R^2 = 0.03$).

A minority of participants, $N = 95$ (12.5 %), reported that their VA health care providers had recently asked about spiritual support. Among those whose providers had asked, 78 (82 %) found it helpful.

Actually Seeking Help from a Spiritual Counselor

Ninety Veterans (11.8 %) endorsed actually having sought help for emotional problems from a spiritual counselor in the past 6 months, while 341 (44.8 %) reported receiving mental health specialty care during the same period. Participants who reported greater openness to seeking help from a spiritual counselor were significantly more likely to report actually having sought such help ($\chi^2(4) = 59.99$; $p < .001$, $N = 759$).

Participants who had received mental health specialty care were significantly more likely to report having sought help from a spiritual counselor ($\chi^2(1) = 27.5$, $p < .001$, $N = 756$). A relatively large proportion, $N = 278$ (36.5 %), of participants sought help only from a mental health specialist, and a smaller proportion, $N = 63$ (8.3 %), reported seeking help from both a mental health specialist and a spiritual counselor. A small group, $N = 27$ (3.6 %), sought help only from a spiritual counselor.

Variables Associated with Seeking Help from a Spiritual Counselor

Of 294 participants with PTSD, 50 (17.01 %) sought help from a spiritual counselor within the past 6 months, compared to 40 (8.57 %) of the 467 without PTSD. In adjusted comparisons, current PTSD, ($\chi^2(1) = 18.86$, $p < .001$, $N = 761$), but not depression severity ($F = 2.54$, $p = .11$) or social support ($F = 0.27$, $p = .60$), was significantly associated with seeking help from a spiritual counselor in the past 6 months.

PTSD was also significantly associated with receiving mental health specialty care ($\chi^2(1) = 119.1$, $p < .001$, $N = 756$). To address the possibility that PTSD was related to general help-seeking from multiple sources, we analyzed the association between PTSD, actual use of a spiritual counselor, and actual use of specialty mental health care. Among patients who reported actual help-seeking from a spiritual counselor, current PTSD was

Table 2 Multivariable logistic regression assessing explanatory variables of actual help-seeking from clergy at baseline ($N = 733$)

	OR	95 % CI	*p*
			.00
Current PTSD	2.01	1.13, 3.59	.018
Baseline depression severity	1.01	.95, 1.08	.68
Total social support	1.13	.92, 1.40	.25
Mental health specialty care	2.41	1.35, 4.30	.003
Seattle comorbidity index	.98	.91, 1.07	.69
General health	.83	.63, 1.11	.21
AUDIT-C	.94	.86, 1.02	.14

Analysis adjusted for differential enrollment by age and gender

OR odds ratio, *CI* confidence interval

more prevalent among those who also sought help from mental health ($\chi^2(1) = 7.35$, $p = .015$, $N = 90$).

In multivariable logistic regression including baseline depression severity, total social support, self-report of receiving mental health specialty care, medical comorbidity, general health, and alcohol use, both current PTSD and mental health specialist care remained significantly and independently associated with the outcome variable, actually seeking help from clergy (Table 2). There was no significant interaction between social support and the presence of PTSD (OR = 0.96, $p = .84$ for the interaction term) in predicting seeking help from a spiritual counselor. Goodness of fit was assessed using the Hosmer–Lemeshow test with unadjusted data ($\chi^2(720) = 716.3$, $p = .5325$).

At 7 months, 546 Veterans completed the follow-up survey. Openness to choosing a spiritual counselor did not predict depression severity at 7-month follow-up ($F(4, 540) = 1.21$, $p = .30$, $R^2 = 0.01$) in an adjusted linear regression analysis. Actual help-seeking from a spiritual counselor also did not predict depression severity at 7-month follow-up ($F(1, 545) = 3.26$, $p = .07$, $R^2 = 0.01$). Assignment to the quality improvement intervention, including nurse care management, did not change this association ($F(2, 544) = 1.63$, $p = .07$, $R^2 = 0.01$).

At 18 months, 370 Veterans completed the follow-up survey. In linear regression analysis adjusted for baseline depression severity, general health, mental health symptoms, age, sex, race, education, and social support, there was no significant association between openness to seeking help from a spiritual counselor ($F(4, 364) = 1.02$, $p = .40$, $N = 368$, $R^2 = 0.01$) and depression severity at 18 months. There was a trend toward worse 18-month depression among those who had reported actual clergy help-seeking at baseline,

Table 3 Linear regression assessing help-seeking from clergy at baseline and 18-month depression severity ($N = 370$)

	Adjusted mean PHQ-9	95 % CI	$F(2, 368)$	*p*
Actual help-seeking from clergy: yes	13.32	11.16–15.49	2.13	.054
Actual help-seeking from clergy: no	11.08	10.37–11.8		

Analysis adjusted for differential enrollment by age, gender, baseline depression severity, general health, mental health symptoms, age, sex, race, education, social support, and treatment group. $R^2 = 0.01$

when treatment group (i.e., assignment to the quality improvement intervention, including nurse care management) was controlled (Table 3).

Discussion

VA patients treated for depression in primary care turn to spiritual counselors as a complement or an alternative to formal mental health care. The relatively small proportion (12 %) of VA patients who actually sought help from spiritual counselors nevertheless represents a large number of the overall population of Veterans with depression. Almost half the sample (approximately 47 %) reported openness to seeking help from spiritual counselors such as clergy. The discrepancy between willingness to seek help and actual behavior may indicate lack of access to spiritual providers; further research is needed to better understand this possibility.

A relatively low proportion of participants reported that their VA providers inquired about the availability of spiritual support. Most of this group, however, found it helpful to be asked. VA clinicians might consider asking about spiritual support among primary care patients with depression.

Strengths of this study include the large representative sample of primary care patients with depression and the large amount of information obtained from each participant. Depression was identified based on patient endorsement of symptoms rather than using ICD-9 codes; identifying depression in this way potentially captures data from patients who would not have been identified by providers. This large dataset allowed exploration of the associations between openness to spiritual support and numerous other variables, including physical and mental health conditions and social support. Finally, it is important that primary care patients were sampled, as many patients with mood and anxiety disorders present to primary care rather than specialty mental health (e.g., Young et al. 2001).

Current PTSD and mental health care engagement were associated with contact with clergy. This observation suggests that Veterans with PTSD are more likely than Veterans with less complicated depression to recognize their needs for mental health care and to actively seek out multiple sources of care, including spiritual counselors. Also, given that PTSD arises from a traumatic event, which may result in questioning of core beliefs, values, and spirituality (Fontana and Rosenheck 2005; Weaver et al. 1996), PTSD may especially predispose patients to seek help from clergy. Given the critical importance of PTSD in the VA patient population, and Veterans' desire to consult clergy, integration of spiritual counselors into VA care teams may be desirable.

All participants by definition reported significant depressive symptomatology, and many also screened positive for PTSD. Therefore, it is not surprising that almost 45 % of the sample reported a mental health visit within the past 6 months. Individuals with actual help-seeking from mental health specialty providers were more likely than others to report help-seeking from spiritual counselors. We found a positive relationship between openness to help from spiritual counselors and openness to help from other providers, and a higher proportion of participants with both spiritual and mental health contacts than those with spiritual contacts alone. Contact with spiritual counselors in most cases reflects openness to care from multiple sources, rather than preferring to receive care only from spiritual counselors. If Veterans with PTSD or depression express an interest in receiving care from spiritual providers, clinicians can encourage them to do so in conjunction with formal mental health services.

Participants with higher social support endorsed greater openness to help-seeking from clergy, but not more actual help-seeking from clergy. Individuals with greater social support may have support from a faith community and therefore have access to clergy, regardless of whether they consult clergy during a given time period. Further research is needed to better discern the relationships among these variables.

It is interesting that there was a trend toward slightly worse 18-month depression among individuals who sought help from clergy at baseline, despite the similar levels of depression at baseline and 7 months. These individuals were also more likely than others to have sought mental health care at baseline and to have PTSD at baseline. When considering these findings, it is important to note that the absolute difference in depression scores between those who did and did not seek help from clergy was small and, thus, of questionable clinical significance. One possible explanation for this finding is that coexisting PTSD may complicate recovery from depression or complicate treatment delivery (Campbell et al. 2007). Alternatively, it may be that suboptimal collaboration between spiritual counselors and mental health specialty care providers for depressed patients affected patient outcomes. Future studies are needed to explore this possibility.

Some limitations require consideration. Our sampling strategy over-represents frequent users of medical care, but it is important to note that such patients comprise a large proportion of the VA primary care population (Lee et al. 2002). Another limitation of the survey was the use of a 4-item PTSD screen rather than a full PTSD diagnostic assessment. Formal diagnosis of PTSD will be important in future research. Further, we did not ask Veterans the reasons for their preferences for different provider types. Also, participants did not describe their experiences with clergy or formal mental health providers in detail, and we lack information about participants' religious denominations and degrees of religious participation. As stated earlier, "spiritual counselors" could encompass a wide variety of practitioners; we do not know which type of clergy or spiritual counselor each Veteran preferred. This sample was largely White and male; results may not be generalizable to other groups. Finally, these data address PTSD in VA patients; we do not know whether similar findings would occur in other groups with PTSD. Despite these limitations, these findings provide preliminary descriptive information about the help-seeking behaviors of primary care patients with depression and PTSD.

Conclusions

Almost half of VA patients surveyed were open to seeking help from clergy, and 12 % reported actual clergy consultation for mental health issues. Veterans who sought help from clergy consulted other VA providers as well, including mental health providers. This observation suggests that Veterans desire help from multiple sources and that most participants sought clergy as a complement to rather than a substitute for mental health care. Future research should investigate the reasons for Veterans' choice of clergy for mental health support. At the same time, because PTSD was associated with spiritual provider contact, continued training in mental health, particularly PTSD, will be important for clergy members who provide counseling for Veterans, and primary care providers can assess availability of clergy as part of the support network for Veterans, particularly in cases of comorbid depression and PTSD. Finally, health care system administrators may want to incorporate access to clergy into the increasingly prevalent patient-centered care models.

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Conflict of interest The authors declare that they have no conflict of interest.

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