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Mental Health Referral Patterns of Rural Pastors

by

Alicia A. Clark

Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

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Mental Health Referral Patterns of Rural Pastors

by

Alicia A. Clark

has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the Psy.D. degree

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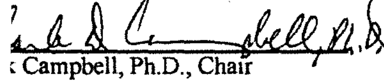

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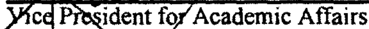

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Mental Health Referral Patterns of Rural Pastors

Alicia Clark

Graduate Student of Clinical Psychology

George Fox University

Newberg, OR

Abstract

This research evaluated the role of the rural pastor in making mental health referrals. A questionnaire was mailed to pastors in several rural California counties in order to assess the referral patterns of pastors to mental health professionals. The questionnaire consisted of demographic information and Likert-style questions inquiring about pastoral interaction, willingness to refer, and referral history with mental health professionals. It was expected that many variables including levels of education, counseling experience, exposure to mental health, specific denominations, and belief systems would affect the referral pattern to mental health professionals. It was also expected that all rural pastors would be more likely to refer to a religious versus a non-religious mental health professional.

Results of the findings were significant at .01-.05 levels. These rural pastors were significantly more willing to refer to a mental health professional with a similar belief system. Correlational results showed that several variables seemed to increase the likelihood to refer to an atheist, agnostic, non-Christian, Christian, or similar-believing mental health professional. The results suggest that while the mental health

professionals' belief system seems to be the most significant factor in a pastor's decision to refer, other variables may increase the pastor's willingness to consider a referral to those who have a dissimilar belief system and whom he or she does not know. Rural pastors appear to have some distrust of the mental health profession, but many of them are willing to refer if they do not feel capable in addressing the laymen's concerns. Therefore, for the rural mental health professional with a same or similar belief system as the pastor, building a relationship with the pastor would be an efficient means of initiating a referral source. The results indicate that the rural pastor is more likely to refer to a mental health professional with a dissimilar belief system if the pastor has had prior exposure to a mental health professional; mental health education; or experience in psychology, counseling, or mental health.

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This dissertation is dedicated also to my parents. It is very literally a tribute to you and your loving kindness. I chose a field that would continue to support people "like" my parents because I love you so much. This dissertation was designed to help meet the needs that you have voiced over the years. It is true that without your support, I could not have climbed this mountain; and it is also true that without you, I wouldn't have begun mountain climbing.

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Chapter 1

Introduction

Though psychology itself is a young science, emerging primarily within the last two centuries, the field of rural psychology is in its infancy, with its major works having emerged within the last two decades (Hargrove, 1982; Jordan & Hargrove, 1987; Keller & Murray, 1982; Weinhart & Long, 1990). Rural healthcare is of recent concern to the American Psychological Association (APA) and the US government, and many steps have been taken to address the needs of the rural population, including loan repayment programs, research grants, and written material addressing rural topics (Weinhart & Long, 1990). These recent attempts to facilitate the availability of quality healthcare in the rural populations create a need for mental health professionals (MHP's) serving rural residents. Therefore, understanding rural referral sources is both important and necessary for the rural mental health professional.

Defining Rural

One of the difficult issues in studying rural psychology is defining *rural*. Due to the recognition of need in rural America, researchers have sought to better define *rural* and to identify common characteristics of these unique populations (Hargrove, 1982; Jordan & Hargrove, 1987; Keller & Murray, 1982; Weinhart & Long, 1990). Arcury, Quandt, McDonald, and Bell (2000), Harvey, Bond, and Greenwood (1991), and Brody and Flor (1998) did not define *rural* in their studies about rural populations. Even in

studies helping to broadly portray the rural population, *rural* frequently is not defined (Brody, Stoneman, & Flor, 1996; Lock & Vincent, 1995; King, Elder, & Whitbeck, 1997; Mulder & Chang, 1997; Seivewright, Tyrer, Casey, & Seivewright, 1991).

Avoiding a definition of *rural* is problematic for two reasons: a) the inability to standardize *rural* as a variable in research, and b) the inability to duplicate studies or build on previous research (Jordan & Hargrove, 1987). Jordan and Hargrove (1987) found that most definitions of *rural* have come from the Bureau of the Census, which "did not derive these definitions for the purposes of social research" (p. 25). Therefore, *rural* and *urban* have historically been defined within the interests of population and voting distribution. This causes difficulty for social sciences to replicate studies in various rural and urban communities.

The confusion of *rural* definitions begins with government-related agencies. Weinhart & Long (1990) state "some government designations define rural as those living outside a Metropolitan Statistical Area" (p. 61). A *Metropolitan Statistical Area* (MSA) includes all geographical areas connected to a city with a population of at least 50,000 people (Keller & Murray, 1982). The purpose of the MSA is to account for very small towns within a close distance to a larger city. However, these same small towns are included as *Nonmetropolitan Areas* by the Office of Management and Budget (Weinhart & Long, 1990, p. 81). Unfortunately, a *Nonmetropolitan Area* also includes all rural areas. All of these definitions are arbitrarily written; population is based on population percentage per mile, and no definition accounts for geographic isolation. For example, if the definition was: "90 miles away from a city with a population of 50,000," it excludes geographic features, (e.g., mountains and rivers) or accessibility options such as public

services or transportation. These variables are important because, "population density and distribution affects service delivery" (DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989, p. 1301).

Jordan and Hargrove (1987) and Keller and Murray (1982) agreed that there is no satisfactory definition of *rural*. A complete definition would require consideration of variables such as ecological factors, group behaviors, the presence of organizational structures, personal characteristics of inhabitants, psychosocial attitudes, and primary occupation, particularly dependence on one major natural or proletarian industry (Fox, Merwin, & Blank, 1995; Jordan & Hargrove, 1987; Sarantakos, 2000). Including all of these factors accounts for the distinctiveness of rural life, particularly for the purposes of rural research, but it is not a practical definition of *rural*. Aside from being financially impractical, it does not truly serve the ideals of social sciences research. Instead of discovering the group behaviors of rural people, rural people would be defined by group behaviors. Therefore a smaller, self-isolated group with these characteristics existing within the center of a large metropolitan city could be considered rural.

For the purposes of this study it is important to operationalize a definition of *rural*. The most recent census revision of the criteria for *rural* is found in the 2000 U.S. census. It states:

> "Rural" consists of all territory, populations, and housing units located outside of UA's [urbanized areas] and UC's [urbanized clusters]. It contains both place and nonplace territory. Geographic entities, such as census tracts, counties, metropolitan areas, and the area outside metropolitan areas, often contain both urban and rural territory, population, and housing units. (U.S. Census Bureau)

UAs and UCs are considered to be core census groups that have a population density of at least 1,000 people per square mile. They also include surrounding census blocks that have an overall density of at least 500 people per square mile. These criteria have changed since the revisions in 1990, including a continuum of urban divisions, and the inclusion of "extended areas." Extended areas are suburban areas that are close enough to urban areas to split the arbitrary division of a rural and urban area. These are now included in UAs, since further development of transportation and technology allows for greater distance from another city (U.S. Census Bureau, 2000). The newest completed map of urban and rural delineations is expected in the second quarter of 2002. For the purposes of this study the definition of *rural* consists of "all territory, population, and housing units located outside of UA's and UC's" (U.S. Census Bureau, 2000).

Characteristics of Rural Americans

Demographics. Depending on the definition, 24-27% of the American population is considered to be rural (Bergland, 1988; DeLeon et al., 1989; Keller & Murray, 1982). Since 1975 there has been a higher migration rate to rural areas and a higher retention rate in rural areas of America (Keller & Murray,1982; Weinhart & Long, 1990). Even with the recent migration of younger, higher educated, and more racially diverse groups, the rural population is still "slightly older, slightly less educated, and more homogeneous in terms of race and ethnicity than the metropolitan area" (DeLeon et al., 1989, p. 1300). The rural population is still also disproportionately poor, "with a poverty rate estimated at somewhere between 16.9% and 18% in rural areas, compared to an urban poverty rate of about 12%" (DeLeon et al., 1989, p. 1299).

Income and employment. The unemployment rate is approximately 50% higher in rural populations than in urban populations (DeLeon et al., 1989). Rural areas contain "more than half of the nation's substandard housing units" (Keller & Murray, 1982, p. 7). The percentage of rural Americans employed strictly by farming and agriculture is lowering, and those who do farm have a lower income than nonfarming rural residents (Keller & Murray, 1982). However, in rural areas there may be the potential of additional sources of income that may assuage the impact of receiving less gross income than urban areas, such as a bartering system or utilizing work related resources for personal reasons such as produce or a vehicle.

Many studies have found that rural Americans show high levels of life-satisfaction. This is due to the sense of community, higher religious participation, and a slower pace of life (Harvey, Bond, & Greenwood, 1991; Keller & Murray, 1982; King et al., 1997; Mitchell & Weatherly, 2000). Several motivating factors for a recent migration trend to rural areas indicate that many people find rural life to be attractive and soothing compared to urban life (DeLeon et al., 1989). In fact, some studies have found that even with higher rates of illness and poverty, rural people are less likely to be dissatisfied with life or complain about life than urban residents (Harvey et al., 1991; Keller & Murray, 1982; King et al., 1997).

Geography and climate. One of the most common reasons why rural communities stay rural is because of the geographic obstacles that may impede natural population growth (Keller & Murray, 1982). The APA's *Rural Psych* outlines several significant factors related to geography in the rural population "including isolation, distance from major metropolitan centers, geographic barriers, inclement weather, ... and

limited opportunities for employment" (American Psychological Association [APA], 1999). Rural communities often have unique climate and unusual weather patterns. In logging industries, rainforest conditions often deter population growth, and oil or manufacturing companies dependent upon natural gas tend to locate themselves in more desert climates.

In spite of potential struggles, rural residents are likely to be emotionally attached to the geography around them. Weinhart and Long (1990) found that even though rural geography may lead to feelings of isolation and loneliness, "for many farm families the psychological tie to a place is so strong that they would rather take unsatisfying work in the local rural community than leave the area" (p. 63). For example, the two Northernmost counties of California (Siskiyou and Del Norte) are considered completely rural. They are isolated by several different mountain ranges (Coast Range, Siskiyou Mountains, Klamath Mountains, Trinity Alps, Cascade Range), the Pacific Ocean, several major rivers (Klamath River, Mad River, Trinity River, Van Duzen, Smith River, Eel River), and the national Redwood forests. It is considered one of the most beautiful places on earth, but due to the geography and distance from urban centers, there is substantially less population growth in these counties than in the central or southern California counties.

Prevalence of illness. Weinhart & Long (1990) found that rural Americans are "more likely to suffer from chronic disease conditions such as arthritis, visual and hearing impairments, ulcers, thyroid and kidney problems, heart disease, hypertension, and emphysema" (p. 62-63). Similarly, the APA's *Rural Psych* (1999) stated:

> Rural residents suffer higher incidences of chronic illness, experience greater disability and morbidity related to diabetes, cancer, hypertension, heart disease, stroke, and lung disease...They are [also] more likely to be involved in an injury-producing accident due to the more dangerous rural environment.

The 1999 report also recognizes higher exposure to toxic chemicals, higher likelihood of smoking, higher rates of being misdiagnosed by general practitioners, greater risks for obesity, higher rates of alcohol abuse and dependence, greater frequency of lethal suicide attempts, and higher prevalence of spousal abuse (APA).

Prevalence of mental illness in rural residents is difficult to study due to the limited availability of mental health treatment centers. Dohrenwend and Dohrenwend (1974) found higher rates of psychiatric disorders in urban areas, particularly psychotic disorders. Srole and Fischer (1977) critiqued the sampling problems in the Dohrenwend study, and contrasted "that a resident-metropolitan population emerges with a lesser prevalence of mental impairment than a demographically matched sample of ruralities" (p. 481). Seivewright et al., (1991) found a greater number of psychotic disorders in rural areas, but not significantly higher than urban areas. However, they also found that rural Americans visit their general practitioner with significantly higher frequency than their urban counterparts. Due to this finding, Seivewright et al., (1991) implied that there is a possibility some of their subjects' mental illnesses may have been treated by primary care physicians rather than by mental health professionals. Dohrenwend and Dohrenwend (1974) suggested that mental disorders are more closely linked to poverty than to the division of rural and urban, and also emphasized that higher rates of poverty exist within

rural areas. However, as Keller and Murray (1982) noted, "there is a substantial amount of psychopathology in rural areas" (p. 14), regardless of whether there is a higher prevalence in urban or rural populations.

Rural values and beliefs. Rural communities are generally viewed as more conservative, politically and religiously (Keller & Murray, 1982). Keller and Murray (1982) found four common rural values: "An emphasis on hard work and mastery of the physical environment, an emphasis on the importance of family and community ties, and an orientation toward traditional moral standards and conformity to group norms, and fatalism" (p. 8). Weinhart and Long (1990) suggested that occupation and mastery over the environment are often linked. The rural resident may feel both economic and psychological failure if forced to obtain a new occupation. They stated, "these families often withdraw socially, stop going to church, start avoiding school and community activities and simply don't want to face others, especially their creditors" (Weinhart & Long, 1990, p. 63).

There is a general understanding that rural populations are more religious than urban populations. Fischer (1982) studied the difference between rural and urban religiosity. He found that urban residents were less likely than rural adults to acknowledge and participate in a religion and to view religion as important. Functionally, the church played a much more significant role in rural areas as a "part of a family-neighborhood-church complex that lies at the heart of a traditional way of life" (Fischer, 1982, p. 114). Regarding the rural elderly, Arcury et al., (2000) said, "religion has a more central role in the belief systems of people who live in more rural places than in the culture of people who live in more urban places" (p. 56). Even across both

minority and majority cultures, Arcury et al., (2000) said that "the salience of religion in the culture or belief systems of the members of the rural communities is more powerful than it is among the members of urban communities" (p. 56). Brody and Flor (1998) found that African American rural families "identify the rural church, in particular, as a resource that provided nurturance and emotional support for mothers and a cultural identity for their children" (p. 803).

Mitchell and Weatherly (2000) extensively studied several variables measuring "religiosity" in rural Americans and found that "church attendance and participation in church-related activities were more common among younger, female, and African-American respondents than among older adults who are male and white" (p. 46). King et al. (1997) studied religious involvement in rural youth, and noted that "religion is more central to collective life in the rural Midwest than in other regions (p. 433). In many studies involving rural subjects, religiosity as a variable seems to indicate positive life experiences, particularly in the African-American cultures (Brody, et al., 1996; Brody & Flor, 1998) as well as the older rural populations (Arcury et al., 2000; Mitchell & Weatherly, 2000).

Psychology and Religion

There is a long history of tension between psychology and religious beliefs. Warnock (1989) attempted to capture the formerly common "anti-religion" spectrum of psychology:

> Through the years, religion has been viewed by psychologists and those in related professions in many ways: by Freud as an illusion, an obsession and a fulfillment of infantile wishes; by Jung as an Archetype; by Fromm as human love; by

> Erikson as an epigenetic virtue; by James as an intensely personal experience, by Sargant as a matter of classical conditioning; by Skinner as a matter of operant conditioning; by Allport as a matter of personal becoming; [and] by Maslow as a quest for man's higher nature. (p. 263)

Christian circles have not been without their resentments and retaliations. A popular Christian author and speaker, John MacArthur stated,

> The rush to embrace psychology within the Church is frankly mystifying. Psychology and Christianity have been enemies from the beginning... Those who followed Freud at first were uniformly hostile to Biblical belief. The foundational doctrines of the movement were therefore based on blatantly anti-Christian presuppositions... There may be no more serious threat to the life of the Church today than the stampede to embrace the doctrines of secular psychology. They are a mass of human ideas that Satan has placed in the Church as if they were powerful, life-changing truths from God... Though many psychologists call their techniques "Christian counseling" most of them are merely using secular theory to treat spiritual problems with biblical references tacked on. (MacArthur & Mack, 1994, p. 11)

Even with more recent bridges between these two dichotomous presentations of two worldviews, more conservative views are similar to these antagonistic beliefs. Since many of these views are printed by popular theologians and psychologists, the expectation that many rural citizens will not readily embrace psychology is reasonable (Carpenter, 1999; Keller & Murray,1982; Rumberger & Rogers, 1982). Carpenter's

(1999) research supported the idea that rural Christians generally hold more negative views of psychology than urban residents.

Pastors and mental health. Rumberger & Rogers (1982) defined "openness" as a "willingness... on the part of the clergy to involve themselves with the mental health field" (p. 338). They found significant correlates of open behaviors with the variables of "pastors' counseling activity, education, denominational affiliation, and style of ministry" (Rumberger & Rogers, 1982, p. 337). McMinn, Chaddock, Edwards, Linn, and Campbell (1998) similarly used the phrase "psychologist-clergy collaboration" to introduce the idea of reciprocal referrals and consultation rather than only clergy to psychologist initiation, implying mutual respect and equal competence (p. 564). Psychologist-clergy collaboration is "when a psychologist or clergyperson utilizes the other's expertise to address a professional task" (Edwards, Linn, & McMinn, 1999, p. 548).

The research on collaboration contains clergy referral data. McMinn et al. (1998) surveyed 76 clergy, 26 psychologists interested in religious issues, and 113 psychologists interested in clinical psychology. They found that clergy view the values of "shared beliefs and values" and "theological awareness" as much more important than either group of psychologists when considering collaboration with one another (p. 566). Chaddock and McMinn (1999) clarified which values and beliefs were deemed important to both clergy and psychologists both in collaboration and also in conceptualizing an individual client's mental health. Chaddock and McMinn (1999) found that clergy viewed "evangelical Christianity" the most important value for both mental health and collaboration (p. 323). The least important value for clergy was "self-awareness and

growth" (Chaddock & McMinn, 1999, p. 323). Contrastingly, psychologists viewed "freedom, autonomy, and responsibility" as the most valuable factor in both mental health practice and collaborating with clergy, and agreed that "evangelical Christianity" was the least valuable factor in approaching collaboration (Chaddock & McMinn, 1999, p. 323). Interestingly, clergy rated each potential value set higher than psychologists. This indicated that "psychologists and evangelical clergy have significantly different views about the importance for a mentally healthy lifestyle and whether it is important to share these values when collaborating with a person from the other profession" (Chaddock & McMinn, 1999, p. 326).

Both Carpenter (1999) and Rumberger and Rogers (1982) addressed the importance of pastoral involvement in community mental health referrals, labeling the pastor as "the gatekeeper" between psychology and Christian clients. "The gatekeeper" refered to the "active counseling and referral roles in the earliest stages of people's emotional distress" (Carpenter, 1999, pp. 337-338). Meylink and Gorsuch (1988) avoided the "gatekeeper model" to describe referral relationships because it implies clergy are not as competent as psychologists and describes only a unipolar direction of referrals as if clients require mental health guidance more than spiritual guidance. However, Meylink and Gorsuch (1988) agreed that the pastor is a vital resource in reaching the community.

Rural pastors and mental health. Regarding rural health, several studies acknowledge that reaching the rural community will require adaptation of services to fit a socially acceptable and efficacious model (Bergland, 1988; Fox et al., 1995; Hargrove, 1982, Keller & Murray, 1982; Weinhart & Long, 1990). Rumberger and Rogers (1982)

and Carpenter (1999) both acknowledged potential client referrals through pastors, as well as the importance of pastoral influence. McMinn, Meek, Canning, and Pozzi (2001) introduce the idea of a "Center for Church-Psychology Collaboration, with its mission to make sustained and relevant contributions to the research literature in psychology, train doctoral students in effective means of collaborating with religious organizations, and provide service to religious communities throughout the world" (p. 324). McMinn et al. (1998) found that common values are a significant factor in psychologist-clergy collaboration.

Purpose of this Study

Many recent programs by the APA and the U.S. government were created intending to motivate entry-level psychologists to serve rural areas, including loan repayment programs (The National Health Service Corps Loan Repayment Program), government financial support, and subsidies primarily in the form of grant funding for research (Fox et al., 1995). APA has made several attempts to create awareness of the rural communities as well as the rural population's need for mental health services APA, 1999; Morris, 1997; Stamm, 1995). Therefore, research into the needs of rural areas has been increasing. However, no research to date has specifically evaluated rural pastors and mental health referral patterns.

The purpose of this research project is two fold. First, this study attempts to recognize and define the pastor's valuable role in the mental health referral process within the rural communities. Second, this research aims to analyze a referral pattern from rural pastors by attempting to answer two questions: a) What are the characteristics of a rural pastor who has or is willing to refer to a mental health professional, and b)

according to most pastors, what characteristics of the mental health professionals determine whether or not a referral is made?

Hypotheses

This study's purpose is primarily exploratory in nature, however, there are several hypotheses made based on findings from the literature review.

Hypothesis one. The rural pastor will be more likely to refer to a mental health professional who is a Christian or a mental health professional with a similar belief system (theist) than to an atheistic or agnostic mental health professional, despite competency. This hypothesis is divided into 5 sub-hypotheses:

1-1. A rural pastor will be more likely to refer or have referred to a Christian mental health professional or a mental health professional with a similar belief system than to an atheistic or agnostic mental health professional.

1-2. A rural pastor will be more likely to refer or have referred to a Christian mental health professional than to an atheistic or agnostic whom the pastor deems competent.

1-3. A rural pastor will be more likely to refer or have referred to a mental health professional with a similar belief system than to an atheistic or agnostic mental health professional whom the pastor deems competent.

1-4. A rural pastor will be more willing to refer to a Christian mental health professional, with or without the term "competent," than to a non-Christian mental health professional.

1-5. A rural pastor will be more likely to refer or have referred to a mental health professional with a similar belief system (with or without perceived competency) than to a non-Christian mental health professional.

Hypothesis two. Education will effect the rural pastors' willingness to refer to a mental health professional. This hypothesis is divided into three sub-hypotheses:

2-1. Rural pastors with more years of higher education will be more likely to refer or have referred to a mental health professional than rural pastors with less education.

2-2. Rural pastors with recent higher education will be more likely to refer or have referred to a mental health professional than rural pastors with a less recent higher education.

2-3. Rural pastors who attend continuing education in counseling issues will be more likely to refer or have referred than rural pastors who do not attend continuing education.

Hypothesis three. A rural pastor will be more willing to refer or have referred to a mental health professional after he or she has had exposure to a mental health professional. This hypothesis is divided into five sub-hypotheses:

3-1. Rural pastors who have personally sought help from a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors who have not sought help from a mental health professional.

3-2. Rural pastors with a family member who have sought help from a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors without a family member who has sought help.

3-3. Rural pastors who have exchanged consultation services with a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors who have not exchanged consultation services with a mental health professional.

3-4. Rural pastors who have received a referral from a mental health professional will be more likely to refer or have referred than rural pastors who have not received a referral from a mental health professional.

3-5. Rural pastors who know of a mental health professional in the area will be more likely to refer or have referred than rural pastors who do not know of any mental health professionals in the area.

Hypothesis four. Pastors from different denominations will have statistically different responses to the referral pattern questionnaire (likeliness to refer or have referred).

Hypothesis five. Pastors who are experienced or trained in counseling will be more likely to refer or have referred to a mental health professional than those who are not. This hypothesis is divided into two sub-hypotheses:

5-1. Rural pastors who counsel will be more likely to refer or have referred than pastors who do not counsel.

5-2. Rural pastors who have training or education in counseling or psychology will be more likely to refer or have referred to a mental health professional than those who have none.

Chapter 2

Methods

This research was designed to discover referral patterns of rural pastors to mental health professionals. Chapter 2 sets out to describe the specific methods used to investigate these referral patterns.

Participants

Due to the expected redistricting of the rural and urban areas, many of the rural areas in the United States were questionable as to possible future rural classification. The rural counties in Northern California were in no danger of reclassification, and fit portrayals of rural areas including isolation, dependency on the environment and nature, and the income largely dominated by specific industries: Pelican Bay Prison, lumber, and fishing. Since the sample size initially appeared to be about 350, all churches in the Northern California counties were used as a potential sample. A recommended method of achieving a high return rate (Dillman, 1978) was utilized in order to attain representative sampling.

A total of 351 churches were listed in the national Qwest Dex Yellow Pages for northern California. Out of those listed, 56 were incomplete addresses, closed, or discontinued churches. An additional 23 churches were eliminated because they shared a pastor with another rural church. In these known cases, the pastor completed one survey and returned another in the same or a different envelope, but notified the author of the

double-listing. Out of the original church listing, 272 potential subjects remained. From the possible respondents, 137 pastors responded by completing and returning the survey with a return rate of 49.86%. An additional 17 respondents did not complete the survey, but sent tracts, typed or handwritten letters, business cards, or church bulletin samples.

Instrument

A 30-item questionnaire was developed by this author based on published research about rural psychology and pastoral collaboration with mental health (e.g., Arcury et al., 2000; Brody & Flor, 1998; McMinn et al., 1998; Mitchell & Weatherly, 2000; Rumberger & Rogers, 1982). The questionnaire consisted of demographic information, Likert-style questions inquiring about pastoral variables and referral patterns, and two qualitative questions asking the pastors their reasons for referring or not referring to a mental health professional. The referral pattern questions included history of referring, and several questions of willingness to refer to various mental health professionals with variants in belief systems and/or competency levels. The definition of mental health professional was also included the questionnaire, and is as follows: Anyone licensed or certified and practicing in an area related to mental health treatment or counseling. This includes but is not limited to: psychologists, psychiatrists, marriage and family therapists, licensed professional counselors, social workers, etc.

Demographic questions include age, gender, ethnicity, current marital status, number of years of education, highest degree earned, number of years in pastoral service, size of present church, and denominational affiliation. The name of the pastor was not requested to ensure anonymity and promote candidness. A cover letter with instructions

and informed consent was included. Appendix A includes the cover letter and questionnaire.

Procedures

The first procedure was sampling organized according to the Dillman method (1978). Having completed a list of the sample addresses, an introductory letter explaining the survey, volunteer participation and instructions was included in a packet with one numbered copy of the survey, a stamped and self-addressed return envelope, and one dollar as an incentive to complete the survey. The names of the pastors were not requested to promote candidness. An initial mailing was dated and sent on April 18, 2002. Two weeks later, a reminder was sent to everyone in the study, except for two addresses who had already returned their surveys. Four weeks after the additional mailing, a third, identical to the first except for the omission of the dollar bill, was sent to everyone whose survey was not returned. After seven weeks had passed, one final packet was sent to all non-respondents. The cut-off date for returned surveys was determined to be six weeks after the last mailing.

Design and Analysis

All statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) 10.0. Descriptive statistics and frequencies were generated for all variables in the study. Three paired-samples t-tests were conducted for hypothesis 1. Two one-way ANOVAs were conducted to determine if significant differences in the referral patterns were found between different denominational groups and between different groups of graduation years. Main effects and interactive effects were

determined to be significant to ≥ 0.05 level. All other hypotheses were evaluated using Pearson product moment correlation.

The qualitative questions at the conclusion of the survey were also analyzed. First, all responses were typed exactly as written. One pastor's response was illegible, and not included in the study. There were seven responses not included in the final analysis because they were unclear or too vague. One example was written partially in English and partially in Chinese. Another response only stated "too much." After those determined unclear or illegible were discarded from the sample being analyzed, the responses were coded into thematic groups by the primary author. The first qualitative question inquiring as to the pastor's reasons for referring to a mental health professional was grouped into three categories. The first category, entitled, "This (_________) needs mental health help", included three areas of responses:

1. The pastor refers for specific diagnoses, problem behaviors, disorders, and/or symptoms: e.g., drug and alcohol addictions, eating disorders, disorders beginning in childhood, behavior disorders, sexual disorders, personality disorders, suicidal ideation, self-harm, psychosis, abuse (of any kind), trauma, or chronic symptoms.
2. The individual has already been diagnosed by a physician.
3. The pastor feels the problem is obviously a mental illness, chemical imbalance, etc.

The second category of reasons for referring to a mental health professional, entitled, "It's not my job/ I'm not competent", had 5 types of responses:

1. The pastor feels presenting problem is beyond area of expertise, experience, or competence; feels mental health professional is better qualified, or is uncomfortable with presenting problem.
2. The pastor feels he or she is too busy, or client needs more long-term care.
3. There is a potential for legal liability, litigation, etc.
4. The individual needs confidentiality or objectivity.
5. The individual desires referral.

The final category for reasons to refer to a mental health professional, entitled, "I approve of mental health professionals, a specific mental health professional, or at least one aspect of profession" contained two types of responses:

1. An appropriate mental health professional is available (criterion determined by pastor: Christian, competent, etc.) or a mental health professional is in church or in nearby church or a pre-arranged counseling center.
2. There is a specific need for mental health screening, consultation, assessment, or medication.

The second qualitative question inquiring into the pastor's reasons for not referring to a mental health professional was grouped into six categories. The first category, entitled, "I solve it spiritually; it can be solved spiritually; the problem is of a spiritual nature" contained two types of responses:

1. The pastor sees the presenting problem as solely spiritual.

2. The pastor has a belief in alternative healing power: God, Jesus Christ, scripture.

The second group of reasons not to refer to a mental health professional entitled, "I can handle it; mental health services are not needed; this is within my competence" contained three types of responses:

1. The issue seems mundane, temporary, non-severe, easily resolved, or not serious enough for a referral.
2. The pastor doesn't think the person is mentally ill or in need of therapy or medication.
3. The pastor sees himself or herself as competent enough or the appropriate person to handle the presenting problem.

The third group entitled, "Availability issue" contained only responses that mentioned a problem with availability:

1. There is no mental health professional in the area, no Christian mental health professional in the area, or no competent mental health professional in the area.
2. The pastor doesn't like a specific aspect of the available mental health professional.
3. The available mental health professional does not make a good impression.

The fourth group of reasons for not referring to a mental health professional, entitled, "General or specific distrust or disapproval of the mental health profession" contained two types of responses:

1. The pastor disagrees with the mental health professional on a specific issue (e.g., homosexuality, abortion, divorce).
2. The pastor believes the mental health field is harmful or unhelpful.

The fifth group of reasons not to refer to a mental health professional, entitled, "I disapprove of at least one business aspect of mental health profession," contained four types of responses:

1. The financial expense of the treatment is too great.
2. The pastor objects to treatment solely by medication.
3. The pastor dislikes the high turnover rate and overworked mental health staff.
4. The pastor feels he or she is unwelcomed in treatment.

The final group of reasons not to refer to a mental health professional was titled, "This person doesn't want to or is uncooperative" and contained three types of responses:

1. The individual or family refuses referral.
2. The individual refuses to follow the pastor's advice first.
3. The individual wouldn't respond well to a referral.

Each of the responses were coded according to all appropriate groups, therefore a response could have multiple codes. After being grouped by the author of this research, the responses were divided among a research team of peers to determine inter-rater reliability. The reliability was determined by the amount of matched codings versus unmatched codings. The number of codings was expected to be larger than the amount of individuals responding to the question. This method was chosen to preserve the highest possible amount of responses.

After determining inter-rater reliability, the responses coded by the author were analyzed, accepting that there may be some potential for error in the codings. Frequencies and percentages of each of the groups of responses were computed using SPSS 10.0.

Chapter 3

Results

Sample Description

Of the 137 subjects who responded by completing the survey, only 16 (11.7%) of the pastors were female. The majority (120, 87.6%) of respondents were male, and one subject did not disclose gender. Regarding marital status, 119 (86.9%) respondents reported being married, 12 (8.8%) subjects endorsed being single, 4 (2.9%) reported being widowed, 1 (0.7%) declared divorce, and 1 respondent declined to respond. The majority of subjects (119) were of Caucasian ethnicity (86.9%). Out of the remaining respondents, 2 (1.5%) reported African American ethnicity, 2 (1.5%) reported Asian American ethnicity, 6 (4.4%) endorsed Native American ethnicity, 1 (0.7%) reported Hispanic American ethnicity, and 6 (4.4%) endorsed "other." A total of 122 (89.1%) respondents reported counseling as a part of their profession and 13 (10.2%) reported not currently counseling.

The average age of all pastors in the sample was 53.94 years (SD=10.52). The mean number of years of education after high school was 6.12, with a median of 6.20. The average year of college graduation is 1964 (SD=18.20). The survey participants were asked to estimate their weekly average church attendance. The mean estimate was 94.14 weekly attendants (SD= 100.19), but the median estimate was 62.50. Table 1 represents this demographic information. Table 2 has the frequency of pastors' reported

highest degrees earned. The mode of the highest degree earned was a Masters degree. Table 3 lists frequencies of all denominational groupings and their individual denomination subgroups under each assigned group. The largest single denomination represented in the sample was the interdenominational/non-denominational category with 18 (13.1%). However, when combined into their larger groups, the denomination with the largest representation is the Pentecostal group with 26 (19%).

Table 1

Demographic Information

Demographic Variable	Median	Mean	Mode	*SD*	Range
Age	53.00	53.94	48.00	10.52	34-86
Number of years of higher education	6.20	6.12	8.00	3.17	0-15
Year graduated	1981	1964	1975	18.20	1950-2002
Estimated weekly church attendance	62.50	94.14	50.00	100.19	10-600

Note. N = 137.

Table 2

Highest Degree Earned

Degree Level	Frequency	Percent
No degree	2	1.5%
High school	5	3.6%
Bachelors	34	24.8%
Masters	48	35.0%
Doctorate	9	6.6%
Other (various certifications)	20	14.6%
Unknown	19	13.9%

Note. N = 137.

Table 3

Denominational Groups

Denomination	Frequency	Percent
Pentecostal denomination	26	19.0%
Assemblies of God	13	9.8%
Foursquare	4	2.9%
Church of God	4	2.9%
Vineyard	1	0.7%

Table 3 (continued)

Denominational Groups

Denomination	Frequency	Percent
Calvary Chapel	1	0.7%
Full Gospel Restoration	2	1.5%
Baptist denominations	17	12.4%
Southern	4	2.9%
Conservative	2	1.5%
Baptist	11	8.0%
Mormon/LDS	5	3.6%
Christ Churches	6	4.4%
Churches of Christ	5	3.6%
Disciples of Christ	1	0.7%
Presbyterian	7	5.1%
United Methodist	7	5.1%
Non-denominational	21	15.3%
Inter/non-denominational	18	13.1%
Independent	3	2.2%
Nazarene	5	3.6%
Lutheran	6	4.4%
Seventh-Day Adventist	7	5.1%
High Churches	14	10.2%
Catholic	10	7.3%

Table 3 (continued)

Denominational Groups

Denomination	Frequency	Percent
Greek Orthodox	1	0.7%
Episcopalian	3	2.2%
Missions denominations	7	5.1%
Village Missions	3	2.2%
Missionary Alliance	4	2.9%
Other	5	3.6%
Friends/Quakers	1	0.7%
Evangelical Free	2	1.5%
Unitarian	1	0.7%
Community of Christ	1	0.7%
Unknown	4	2.9%

Note. N = 137.

The rural pastor referral patterns were determined using questions 7, 11, 12, 13, 14, 15, 16, and 17 on the questionnaire. These questions were on a likert-scale from one to sex, with one being *strongly disagree* and six being *strongly agree*. Table 4 lists the mean, median, and mode of the samples' responses to the referral pattern questions.

Table 4

Descriptive Statistics of Responses to Referral Pattern Questions

Referral Pattern Question	Mean	Median	Mode
(7) History of referrals	3.50	4.00	1.00
(11) Non-Christian	2.61	2.00	1.00
(12) Christian	5.01	5.50	6.00
(13) Comp Christian	5.35	6.00	6.00
(14) Sim. Belief	4.60	5.00	6.00
(15) Comp. Sim Belief	4.94	5.00	6.00
(16) Atheist/Agnostic	1.93	1.00	1.00
(17) Comp. Atheist/Agnostic	2.33	2.00	1.00

Note. Range = 1-6

Upon examining the relationship between the referral pattern questions, several correlations between the referral questions (questionnaire #'s 7, 11, 12, 13, 14, 15, 17) were significant, as seen in Table 5.

Table 5

Correlations Between the Referral Pattern Questions

Question	7	11	12	13	14	15	16	17
(7) History of referrals	1.00	-	-	-	-	-	-	-
(11) Non-Christian	.30**	1.00	-	-	-	-	-	-
(12) Christian	.20*	-.04	1.00	-	-	-	-	-
(13) Comp. Christian	.30**	.10	-.06	1.00	-	-	-	-
(14) Sim. Belief	.23**	.04	.40**	.46**	1.00	-	-	-
(15) Comp. Sim. Belief	.30**	.26**	.42**	.66**	.70*	1.00	-	-
(16) Atheist	.17	.59**	-.15	-.12	-.02	.10	1.00	-
(17) Comp. Atheist	.14	.62**	-.06	-.02	-.05	.15	.85**	1.00

Note. Comp. = competent, Sim. = Similar. * Significance is at the .05 level (2-tailed). ** Significance is at the .01 level (2-tailed).

Hypotheses Results

Hypothesis one. The rural pastor will be more likely to refer to a mental health professional who is a Christian or a mental health professional with a similar belief system (theist) than to an atheistic or agnostic mental health professional, despite competency. This hypothesis was divided into 5 sub-hypotheses, and the results are displayed in Table 6.

Sub-hypothesis 1-1 stated, "A rural pastor will be more likely to refer or have referred to a Christian mental health professional or a mental health professional with a similar belief system than to an atheistic or agnostic mental health professional." A paired-samples *t*-test was done, and a significant difference was found between referring to a Christian or a mental health professional with a similar belief system and referring to an atheistic or agnostic mental health professional, $t(133) = 16.51, p < .01$.

Sub-hypothesis: 1-2 stated, "A rural pastor will be more likely to refer or have referred to a Christian mental health professional than to an atheistic or agnostic whom the pastor deems competent." A paired-samples *t*-test was done to determine the results of this hypothesis. A significant difference was found between referring to a Christian mental health professional and referring to a competent atheist or agnostic, $t(133) = -15.04, p < .001$. See Table 6 for the results of this sub-hypothesis.

Sub-hypothesis 1-3 stated, "A rural pastor will be more likely to refer or have referred to a mental health professional with a similar belief system than to an atheistic or agnostic mental health professional whom the pastor deems competent." A paired-samples *t*-test was done to determine the results of this hypothesis. Table 6 shows a significant difference between referring to a mental health professional with a similar belief system and a competent atheist or agnostic mental health professional, $t(134) = 11.05, p < .001$.

Sub-hypothesis 1-4 stated, "A rural pastor will be more willing to refer to a Christian mental health professional, with or without the term "competent," than to a non-Christian mental health professional." Two paired-samples *t*-tests were done to determine the results of this hypothesis. As shown in Table 6, a significant difference

was found between referring to a non-Christian and referring to a Christian mental health professional, $t(135) = 12.80, p < .001$. A significant difference was also found between referring to competent Christian mental health professional and referring to a non-Christian, $t(135) = 16.11, p < .001$.

Sub-hypothesis 1-5 stated, "A rural pastor will be more likely to refer or have referred to a mental health professional with a similar belief system (with or without perceived competency) than to a non-Christian mental health professional." Two paired-samples *t*-tests were done to determine the results of this hypothesis. A significant difference was found between referring to a non-Christian mental health professional and one with a similar belief system, $t(135) = 10.14, p < .001$. A significant difference was also found between referring to a non-Christian mental health professional and referring to one with a similar belief system whom the pastor deems competent, $t(134) = 14.07, p < .001$.

Table 6

Hypothesis 1 T-Test Results

Paired Variables	Mean	*t*	*df*	Sig
Sub-Hypothesis 1-1				
Christian – Atheist	3.15	16.62	134	$\geq .01$
Sim. Belief – Atheist	2.66	14.01	135	$\geq .01$
Sub-Hypothesis 1-2				
Christian – Comp. Atheist	2.65	15.04	133	$\geq .01$
Sub-Hypothesis 1-3				
Sim. Belief – Comp. Atheist	2.26	11.05	134	$\geq .01$
Sub-Hypothesis 1-4				
Christian – Non-Christian	2.00	10.14	135	$\geq .01$
Comp. Christian – Non-Christian	2.36	14.07	134	$\geq .01$
Sub-Hypothesis 1-5				
Sim. Belief – Non-Christian	2.48	12.80	135	$\geq .01$
Comp. Sim. Belief – Non-Christian	2.74	16.11	135	$\geq .01$

Note. Comp. = competent, Sim. = Similar

Hypothesis two. Education will affect the rural pastor's willingness to refer to a mental health professional. This hypothesis was divided into three sub-hypotheses.

Sub-hypothesis 2-1 stated, "Rural pastors with more years of higher education will be more likely to refer or have referred to a mental health professional than rural pastors with less education." The number of years of education was correlated (using a Pearson product moment correlation) with each of the 8 variables determining past referrals and willingness to refer in the future (questions 7, 11, 12, 13, 14, 15, 16, and 17). See Table 7 under the heading "2-1" for the results of this correlation. There was a significant correlation between higher levels of education and willingness to refer to a non-Christian, $r = .31, p < .001$. There was a significant correlation between higher levels of education and willingness to refer to an atheist, $r = .24, p < .01$. There was also a significant correlation between higher levels of education and willingness to refer to an atheist whom the pastor deems competent, $r = .23, p < .01$

Sub-Hypothesis 2-2 stated, "Rural pastors with recent higher education will be more likely to refer or have referred to a mental health professional than rural pastors with a less recent higher education." Three attempts to discover the results of this hypothesis were made. First, the year graduated was correlated with each of the referral pattern questions, and no significant differences were found. However, the range of years represented in the sample was wide. Therefore, the second attempt recoded the years of education variable into categories of years graduated by: up to1950, 1951-1970, 1971-1990, and 1990-present and a one-way ANOVA was computed on SPSS to determine the differences between the recentness of education and the referral pattern questions. No significant differences were found. A third attempt to recode the variables by decade found no significant differences.

Sub-hypothesis 2-3 stated, "Rural pastors who attend continuing education in counseling issues will be more likely to refer or have referred than rural pastors who do not attend continuing education." The continuing education question was correlated with the referral pattern questions using a Pearson product moment correlation. See Table 7 under the heading "2-3" for the correlation results. There was a significant correlation between attendance of seminars and conferences on counseling and history of past referrals to mental health professionals, $r = .19, p < .05$. There was also a significant correlation between continuing education and willingness to refer to an agnostic or atheist whom the pastor deems competent, $r = .20, p < .05$.

Hypothesis three. A rural pastor will be more willing to refer or have referred to a mental health professional after he or she has had exposure to a mental health professional. This hypothesis was divided into five sub-hypotheses.

Sub-hypothesis 3-1 stated, "Rural pastors who have personally sought help from a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors who have not sought help from a mental health professional." Question 4 (pastor's receiving personal counseling) was correlated with the referral pattern questions using a Pearson product moment correlation. See Table 7 under the heading "3-1" for the correlation results. There was a significant correlation between receiving personal counseling and willingness to refer to an atheist, $r = .48, p < .001$. There was a significant correlation between question 4 and willingness to refer to a competent atheist, $r = .49, p < .001$. There was a significant correlation between willingness to refer to a non-Christian and question 4, $r = .50, p < .001$. There was also a

correlation between history of referring to mental health professionals and endorsement of receiving personal counseling, $r = .33, p < .001$.

Sub-hypothesis 3-2 stated, "Rural pastors with a family member who have sought help from a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors without a family member who has sought help." Question 5 (pastor's family receiving counseling) was correlated with the referral pattern questions using a Pearson product moment correlation. See Table 7 under the heading "3-2" for the correlation results. There was a significant correlation between family receiving counseling and willingness to refer to an atheist, $r = .29, p < .01$. There was a significant correlation between question 5 and willingness to refer to a competent atheist, $r = .27, p < .01$. There was a significant correlation between willingness to refer to a non-Christian and question 5, $r = .27, p < .01$. There was a significant correlation between family receiving counseling and willingness to refer to a competent mental health professional with a similar belief system, $r = .20, p < .05$. There was also a significant correlation between history of referring to mental health professionals and endorsement of family receiving counseling, $r = .31, p < .001$.

Sub-hypothesis 3-3 stated, "Rural pastors who have exchanged consultation services with a mental health professional will be more likely to refer or have referred to a mental health professional than rural pastors who have not exchanged consultation services with a mental health professional." Exchanging consultation services with a mental health professional, questions 3 and 8, were correlated with the referral pattern questions using Pearson product moment correlations. There was a significant correlation between consulting a mental health professional and willingness to refer to an

atheist, $r = .20, p < .05$. There was a significant correlation between consulting a mental health professional and willingness to refer to a non-Christian, $r = .18, p < .05$. There was also a significant correlation between history of referring and consulting with a mental health professional, $r = .53, p < .001$. See Table 7 for these correlation results under the heading "3-3a."

There was a significant correlation between giving a consultation to a mental health professional and willingness to refer to a non-Christian mental health professional, $r = .21, p < .01$. There was a significant correlation between history of referring to mental health professionals and receiving consultation requests from mental health professional, $r = .34, p < .001$. There were also significant correlations between receiving a consultation from a mental health professional and willingness to refer to both an atheist, $r = .32, p < .001$; and a competent atheist, $r = .28, p < 01$. The consultation variables (questions 3 and 8) were also significantly correlated, $r = .20, p < .05$. See Table 7 under the heading "3-3b" for these correlation results.

Sub-hypothesis 3-4 stated, "Rural pastors who have received a referral from a mental health professional will be more likely to refer or have referred than rural pastors who have not received a referral from a mental health professional." Pastors who have received a referral from a mental health professional (question 6) was correlated with the referral pattern questions using Pearson product moment correlation. There were significant correlations between receiving a referral from a mental health professional and willingness to refer to both an atheist, $r = .32, p < .001$; and a competent atheist, $r = .28, p < 001$. There was a significant correlation between receiving a referral and willingness to refer to a non-Christian, $r = .19, p < .05$. There was also a significant

correlation between history of referring and receiving a referral from a mental health professional, $r = .29, p < .01$. For these correlation results, see Table 7 under the heading "3-4."

Sub-hypothesis 3-5 stated, "Rural pastors who know of a mental health professional in the area will be more likely to refer or have referred than rural pastors who do not know of any mental health professionals in the area." A pastor's knowledge of a mental health professional in the area (question 10) was correlated with the referral pattern questions using Pearson product moment correlations. There was a significant correlation between knowing a mental health professional and willingness to refer to a non-Christian, $r = .29, p < .01$. There were significant correlations between knowing a mental health professional in the area and willingness to refer to both a mental health professional with a similar belief system, $r = .19, p < .05$; and a mental health professional with a similar belief system whom the pastor deems competent, $r = .21, p < .01$. There was also a significant correlation between knowledge of a mental health professional in the area and a history of referring, $r = .40, p < .001$. These correlation results are found under the heading "3-5" on Table 7.

Table 7

Correlations of Pastoral Factors and Referral Pattern Questions

		Hypothesis 2		Hypothesis 3					
#	Referral Pattern Question	2-1	2-3	3-1	3-2	3-3a	3-3b	3-4	3-5
7	Past Referrals	.09	.19*	.33**	.31**	.53**	.33**	.28**	.40**
11	Non-Christian	.31**	.16	.50**	.27**	.18*	.21*	.19*	.29**
12	Christian	.13	.13	-.12	.00	.05	-.01	-.09	.10
13	Competent Christian	.13	.07	-.04	.10	.06	-.04	-.08	.16
14	Similar Belief	-.07	.07	-.00	.13	.04	.00	-.00	.19*
15	Competent Similar Belief	.14	.13	.10	.20*	.07	.06	.06	.21*
16	Atheist/Agnostic	.24**	.10	.48**	.29**	.20*	.32**	.32**	.15
17	Competent Atheist/Agnostic	.27*	.20*	.49**	.23**	.16	.29**	.28**	.14

Note. * Correlation is significant at the .05 level (2-tailed). ** Correlation is significant at the .01 level (2-tailed).

Hypothesis four. Pastors from different denominations will have statistically different responses to the referral pattern questionnaire (likeliness to refer or have referred).

Due to the low frequency of several reported individual denominations, several denominations were combined. If the denomination frequency was less than 3, and a similar denomination was already accounted for (e.g., southern Baptist and American Baptist), they were combined under one category. Other churches that could not be combined to a church with similar theology or practice was placed in an "other" category (e.g., Friends, Jehovah's Witness) and not included in the final analysis since the data would have been indescribable. A one-way ANOVA was done with the denomination groups as the independent variable and the referral pattern questions as the dependent variables to determine the results of this hypothesis. No within group significant differences were found. There were significant differences found between denominational groups and referring to a non-Christian mental health professional (question 11), $f(12,120) = 2.72, p < .001$. There were significant differences found between the denominational groups and referring to an atheist or an agnostic (question 16), $f(12, 119) = 3.98, p < .001$. There were also significant differences found between denominational groups and referring to an atheist or agnostic mental health professional whom the pastor deems competent (question 17), $f(12,119) = 2.12, p < .05$. A Tukey HSD post hoc analysis was chosen because it was slightly more liberal, and it is important to identify all potential differences for future study, due to the limited current research of the field. However, this finding may not be significant under other post-hoc tests, and therefore is a potentially weaker statistical finding. A test of homogeneity of

variance was done and the Levene statistic was significant for question 16, Levene statistic (12,119) = 2.253, $p < .05$. Therefore, in addition to a Tukey HSD post hoc analysis, a Dunnett-C post hoc test was done for question 16. See Table 8 for Levene statistic and ANOVA results.

Table 8

Hypothesis 4 Levene test and ANOVA Results

	Levene Test		ANOVA				
Referral Pattern Question	*F*	Sig.	Sum of Squares	*df*	Mean Square	*F*	Sig.
Non-Christian	0.83	.62	86.80	12,120	7.23	2.72	≥.01
Atheist	2.25	≥.05	113.34	12,119	9.45	3.98	≥.01
Competent Atheist	1.29	.23	66.86	12,119	5.57	2.12	≥.05

All significant differences were found within the "high church" denominational category. Question 11 refers to the pastors' willingness to refer to a non-Christian. The mean response for the High Church denominational group was 4.36 (*SD*=1.91). The Pentecostal group (*M*=2.23, *SD*=1.50), Baptist group (*M*=2.12, *SD*=1.41), Interdenominational group (*M*=2.05, *SD*=1.53), Seventh-Day Adventist group (*M*=1.57, *SD*=1.33), and Missions group (*M*=1.71, *SD*=1.89) were each significantly different than the High Church group as revealed by Tukey post-hoc analysis. Question 16 refers to the

pastors' willingness to refer to an atheist or agnostic. The mean response for the high church group was 4.54 (SD=2.70). Dunnett C post-hoc analysis revealed a significant difference between High Church and Seventh-Day Adventist (M = 1.00, SD = 0.00) and Interdenominational groups (M=1.33, SD=1.15). Question 17 refers to the pastor's willingness to refer to a competent atheist or agnostic mental health professional. The High Church mean responses was 3.9, SD=1.98. Tukey post-hoc analysis revealed a significant difference between the responses of the High Church group and the Baptist (M=1.65, SD=1.41) as well as the Interdenominational group (M = 1.62, SD = 1.36). See Table 9 for mean differences in the significant post hoc results between the high church group and other denominational groups.

Table 9

Significant Mean Differences in Post-hoc Results for High Church Group

	Question 11		Question 16		Question 17	
Denomination Group	Tukey	Dunnet C	Tukey	Dunnet C	Tukey	Dunnet C
Pentecostal	2.13*	N/A	2.77*	2.77	1.58	N/A
Baptist	2.24*	N/A	3.07*	3.07	2.27*	N/A
Christ Churches	1.02	NA	2.88*	2.88	1.59	N/A
Interdenominational	2.31*	N/A	3.21*	3.21*	2.30*	N/A
Lutheran	1.02	N/A	2.37*	2.37*	1.42	N/A
Seventh-Day	2.80*	N/A	3.54	3.54	1.92	N/A
Missions	2.64*	N/A	2.40*	2.40	1.78	N/A

Note. * = Significant at the .05 level (2-tailed)

Hypothesis five. Pastors who are experienced or trained in counseling will be more likely to refer or have referred to a mental health professional than those who are not. This hypothesis was divided into two sub-hypotheses.

Sub-hypothesis 5-1 stated, “Rural pastors who counsel will be more likely to refer or have referred than pastors who do not counsel.” Both question 1 (pastor’s experience counseling laymen) and question 2 (pastor’s experience counseling a mental health professional) were correlated with the referral pattern questions using Pearson product moment correlations. There was a significant correlation between pastors who have

counseled laymen (question 1) and willingness to refer to a competent Christian mental health professional, $r = .20, p < .05$. There were significant correlations between pastors willingness to refer to a mental health professional with a similar belief system and experience counseling laymen, $r = .21, p < .05$. There were significant correlations between pastors willingness to refer to a mental health professional with a similar belief system whom the pastor deems competent and experience counseling laymen, $r = .19, p < .05$. There was a significant correlation between history of referring to a mental health professional and experience counseling laymen, $r = .23, p < .01$. There was also a significant negative correlation between pastors willingness to refer to a competent atheist or agnostic and pastor's experience counseling laymen, $r = -.21, p < .05$. See Table 10 under the heading "counsel" for these data.

Pastor's experience counseling a mental health professional (question 2) correlated significantly with pastor's history of referring to a mental health professional (question 7), $r = .50, p < .001$. There was a significant correlation between pastor's experience counseling a mental health professional and willingness to refer to a non-Christian, $r = .32, p < .001$. There were significant correlations between pastor's experience counseling a mental health professional and willingness to refer to both an atheistic mental health professional, $r = .35, p < .001$, and a competent atheist or agnostic mental health professional, $r = .37, p < .001$. See Table 10 under the heading "counsel MHP" for these correlational results.

Sub-hypothesis 5-2 stated, "Rural pastors who have training or education in counseling or psychology will be more likely to refer or have referred to a mental health professional than those who have none." Pastors training or education in counseling and

training in psychology or counseling (question 19) correlated with the referral pattern questions using a Pearson product moment correlation. There was a significant correlation between training in counseling and willingness to refer to an atheist or agnostic whom the pastor deems competent, $r = .19, p < .05$. See Table 10 under the heading "training" for these correlations.

Table 10

Hypothesis 5 Results: Correlations between Pastoral Variables and the Referral Pattern

#	Referral Pattern Question	Pastoral Variables		
		Counsel	Counsel MHP	Training
7	Past Referrals	.23**	.50**	.14
11	Non-Christian	-.04	.32**	.15
12	Christian	.13	.06	.15
13	Competent Christian	.20*	.10	-.02
14	Similar Belief	.21*	.11	.04
15	Competent Similar Belief	.19*	.16	.00
16	Atheist/Agnostic	-.12	.35**	.15
17	Competent Atheist/Agnostic	-.21*	.37**	.19*

Note. * Correlation is significant at the .05 level (2-tailed).** Correlation is significant at the .01 level (2-tailed).

After the Pearson product moment correlations were done to determine the results of hypotheses 2, 3, and 5, a step-wise regression was done to determine which factors had predictive weight in each of the referral pattern questions. Six factors predicted past referrals to mental health professionals (question 7): seeking consultation or advice from a mental health professional (question 3), acquaintances with a mental health professional (question 10), counseling a health professional (question 2), counseling laymen (question 1), attending mental health continuing education (question 18), and having a family member who has sought mental health treatment (question 5). These variables correlated strongly with history of referring to a mental health professional, *R* (1,120) = .68, R^2 = .46; adj. R^2 = .43.

Two factors predicted pastor's willingness to refer to a non-Christian mental health professional (question 11): personal experience receiving counseling from a mental health professional (question 4), and knowledge of a mental health professional (question 10), *R* (1,123) = .54, R^2 = .29; adj. R^2 = .28. No factors had predictive validity for question 12. Question 13, pastor's willingness to refer to a competent Christian, had one predictive variable: being friends or acquaintances with a mental health professional (question 9), *R* (1,125) = .24, R^2 = .06; adj. R^2 = .05. Question 14, pastor's willingness to refer to a similar believing mental health professional, had two predictive variables: counseling laymen (question 1), and knowledge of a mental health professional (question 10), *R* (1,124) = .28, R^2 = .08; adj. R^2 =.06.

Pastor's willingness to refer to a competent similar believing mental health professional (question 15) also had two predictive variables of knowing a mental health professional (question 10), and counseling laymen (question 1), *R* (1,124) = .28, R^2 = .08;

adj. R^2 = .06. Question 16, pastor's willingness to refer to an atheist had two predictive variables: pastor's personal experience in counseling (question 4), and question 8, receiving a consultation from a mental health professional, R (1,124) = .52, R^2 = .27; adj. R^2 = .26. Pastor's willingness to refer to a competent atheist or agnostic resulted in three predictive variables: question 4, pastor's personal experience in counseling, counseling laymen, and counseling a mental health professional R (1,123) = .49, R^2 = .24; adj. R^2 = .23. See Appendix B for raw data.

Qualitative Results

The entire content of the qualitative responses is included in Appendix C. Inter-rater reliability was determined for the two qualitative questions. For the first question of the pastor's reasons for referring to a mental health professional, 83 out of 94 responses were coded the same, a reliability of 88%. The second question of pastor's reasons for not referring to a mental health professional had 64 out of 74 responses coded the same, a reliability of 87%.

Frequencies and percentages of all of the responses were tallied. The frequencies of the categories of responses are listed in Table 11 followed by some initial examples.

As noted in Table 11, the most frequent response given (41.6%) when asked to list reasons for referring to a mental health professional was within the category of: "It's not my job, I'm not competent." Three different examples of responses coded in this category are listed below:

Table 11

Frequencies and Percentages of Qualitative Responses

Responses	Frequency	Percent
Reasons to Refer		
This (____) needs mental health help	36	25.5%
It's not my job/ I'm not competent	57	41.6%
I approve of MHP, a specific MHP, or at least one aspect of the profession	25	18.2%
Reasons not to Refer		
I solve it spiritually; it can be solved spiritually; The problem is of a spiritual nature	18	13.7%
I can handle it; MH services are not needed; This is within my competence	21	15.3%
Availability issue	9	6.6%
General or specific distrust of the MH profession	31	22.6%
I disapprove of a business aspect of MH profession	15	10.9%
This person doesn't want to or is uncooperative	8	5.8%

Note. Under the heading "reasons to refer" the 118 responses were given by an N =101. Under the heading "reasons not to refer," the 106 responses were given by an N= 84.

1. "I am only trained to do 3 sessions with someone and then its time to refer."
2. "I have no formal training when it comes to dealing with mental health issues, I believe that competent help is essential. I believe that to attempt things I know nothing about does much more harm than good."
3. "I'll always make a referral if someone comes to me with a problem beyond my competence. Though I've taken counseling classes I have no counseling-related degree. I make no pretense about knowing all the answers."

As shown in Table 11, the second most frequent reason given (25.5%) to refer was coded under the category, "This (___) needs mental health help." In this category pastors referred to specific diagnoses, disorders, or symptoms that they would not treat, or felt needed mental health care. An example is "eating disorders."

The third reason for referring to a mental health professional was given by 18.2% of the pastors who responded as shown in Table 11. This was a general approval of the mental health profession. An example of this response was "A good practitioner can be effective in his/her field of treatment as a good physician is in theirs."

As noted in Table 11, the most frequent reason given not to refer to a mental health professional was in the category of "General or specific distrust of the mental health profession." It accounted for 22.6% of the responses, and examples of responses given to this category are as follows:

1. "I do not agree with many of the anti-scriptural humanistic philosophies perpetrated by mental health systems and groups."
2. "Most are steeped in non-Biblically based belief systems and either purposefully or ignorantly practice paganism or witchcraft."

3. "I believe secular counseling is a farce."
4. "MH professional has voiced or demonstrated a disdain or lack of appreciation of spiritual things. The bible says we are body, souls and spirit, Secular therapy treats only 2/3 of the Christian, whose spirit is alive in Christ. 1 Cor 5:17, Hebrews 4:12."

The second most common response (as noted in Table 11) was in the category of "I can handle it..;" 15.3% of pastors listed these reasons as why they would not refer to a mental health professional. An example of this type of response is, "If the individual is a member of our church and it is an issue I feel competent to deal with effectively." Another example is, "If the person just needs a friend or a shoulder to cry on."

The third most common (13.7%) response coded was in the category of "I solve it spiritually...." An example of this type of response is, "As a Christian pastor, I would not. For the Christian, God has given us everything we need in his Word, the Bible, 2 Peter 1:3."

The category of "I disapprove of a business aspect of MH profession" was given by 10.9% of pastors. While the majority of responses included references to cost of therapy, another example of this type of response is, "Overworked mental health staff." Only 6.6% of pastors mentioned availability as a reason not to refer to a mental health professional, and 5.8% of pastor's responses included a reference to the parishioner's unwillingness to be referred.

Chapter 4

Discussion

This chapter contains the results of this research and the analysis of the data. Each hypothesis is analyzed, with several of sub-hypotheses discussed individually. Next, the qualitative data are discussed, followed by other exploratory findings. Implications of this study, research limitations, and suggestions for further study conclude Chapter 4.

Demographic Findings

DeLeon et al., 1989 described rural residents as "slightly less educated" than urban populations. This sample's average and most frequently listed level of education was a Master's degree, higher than expected. This finding could be indicative of an increase in higher educated individuals living in rural areas, or it could be due a high frequency of seminary attendance within our sample, and not necessarily representative of the overall rural population. The mean statistic does not include pastors who did not disclose years of education or those pastors who reported achievement of some form of certification without a degree. These pastors or other non-respondents may have lowered the average, had they been included.

The referral pattern questions were designed to elicit responses in order to correlate with other pastoral variables, but as seen in Chapter 3, the referral pattern questions produced significant results not otherwise described in the hypotheses. First, some of the pastors' responses to the referral pattern questions correlated with each other. Second,

the referral pattern questions had significant predictors accounting for the variability of responses. Of interest, history of making referrals had the most significantly correlated variables. Combined, willingness to refer to all dissimilar believing mental health professionals produced five predictors: pastors' personal counseling, knowledge of a mental health professional, receiving a consultation, counseling a mental health professional, and counseling laymen. Combined, willingness to refer to all similar or same believing mental health professionals produced only three predicting variables: being friends or acquaintances with an mental health professional, counseling laymen, and knowledge of a mental health professional in the area. These findings imply that many factors may contribute to pastors' past referrals and willingness to refer to a mental health professional with a dissimilar worldview.

In referring to a mental health professional with a same or similar worldview, the predicting variables are not as widespread. The first predictor, counseling laymen, was a question that all but 17 pastors endorsed. The variables of "knowledge of an mental health professional in the area" and "being friends with a mental health professional" have in common the potential relationship with the pastor. It is possible that fewer variables predict a willingness to refer to a mental health professional with a same or similar worldview than to one with a dissimilar worldview.

Hypotheses Findings

Hypothesis one. This hypothesis proposed that the rural pastor would be more likely to refer to a mental health professional who is a Christian or a mental health professional with a similar belief system (theist) than to an atheistic or agnostic mental health professional, despite competency. Results strongly support this hypothesis.

Findings for all sub-hypotheses were significant at the .01 alpha level. The data suggest that among the entire sample of rural pastors, there is a higher likelihood to refer to a mental health professional with a same or similar belief system than to a mental health professional professing an atheistic or agnostic belief system. There is a significant difference between a pastor's willingness to refer to a Christian mental health professional, and his or her willingness to refer to a non-Christian. There is also a significant difference between a pastor's willingness to refer to a similar believing mental health professional and his or her willingness to refer to a non-Christian. There is a significant difference between willingness to refer to a Christian mental health professional over a similar believing mental health professional despite competency. Results suggest that the rural pastor is much more willing to refer to a Christian mental health professional than a mental health professional with a different belief system despite competency.

Hypothesis two. This hypothesis proposed that level of education would affect the rural pastors willingness to refer to a mental health professional. Results partially support hypothesis 2. Within the sub-hypotheses, education was determined by years of education, recentness of education, and exposure to mental health continuing education. No significant relationship was found between referral patterns and recency of education. However, years of higher education was significantly correlated with referring to a non-Christian, atheist or agnostic, and competent atheist or agnostic mental health professionals. There were significant correlations between reported participation in continuing education and pastors' past history of referrals; as well as significant

correlations between participation in continuing education and willingness to refer to an atheist or agnostic mental health professional whom the pastor deems competent.

These results began a trend found in the remaining correlations results. While amount of education, like other pastoral variables, may indicate a higher willingness to refer to a mental health professional with a dissimilar worldview, it was not a predictor of willingness to refer to someone of the pastor's own or a similar worldview. These results may seem to contradict hypothesis 1, but upon closer inspection, the significance of these results is more statistical than tangible. Since the responses were formed according to a likert-type scale, the significant difference was one to two points. For example, those pastors with higher levels of education were more likely to circle "slightly disagree" versus "strongly disagree." This was a significant difference of responses, but the pastors still disagreed with a willingness to refer to a non-Christian, atheist/agnostic, or competent atheist/agnostic. Therefore, the statistics represented an increased willingness to refer, but not necessarily a willingness to refer.

Hypothesis three. This hypothesis proposed that a rural pastor would be more willing to refer or have referred to a mental health professional after he or she has had exposure to a mental health professional. Results from each of the sub-hypotheses support hypothesis 3. The pastor's past or current personal counseling was significantly correlated with the pastors' past history of referring. It was also related to willingness to refer to an atheist mental health professional, a competent atheist, and a non-Christian mental health professional. Similarly, pastor's family member's personal counseling significantly correlated with history of referring and willingness to refer to atheistic or agnostic mental health professionals, competent atheistic or agnostic mental health

professionals, competent similarly believing mental health professionals, and non-Christian mental health professionals.

Significant correlations were found between both receiving and giving consultation and history of referring as well as willingness to refer to both non-Christians and competent atheists. There was also a significant correlation between receiving a consultation from a mental health professional and willingness to refer to an atheistic mental health professional. Receiving a referral from a mental health professional had positive correlations with giving prior referrals to a mental health professional, referring to a non-Christian, and both referring to atheistic and competent atheistic mental health professionals. Knowledge of a mental health professional in the area correlated significantly with a history of referring and willingness to refer to non-Christian, similar-believing, and competent similar-believing mental health professionals.

The referral pattern trend found in hypothesis 2 continued and expanded in hypothesis 3. Exposure to a mental health professional, like education in general and education specifically in mental health, seems to have increased the likelihood of referring to a mental health professional with a dissimilar belief system, but did not increase the likelihood of referring to a Christian mental health professional. However, the statistical significance occurs between two likert-scale degrees, and both degrees are on the "disagree" end of the likert-scale continuum. In the hypothesis 3 findings, there are statistical significances between "strongly disagree" and "slightly disagree" responses. It seems that education and exposure to mental health both influence the pastors' willingness to refer, but do not necessarily to change his or her response to a complete willingness to refer.

An exception to the general correlation pattern was found with the variable "pastor's family member's experience of personal counseling." This was the only factor significantly correlated to willingness to refer to a mental health professional with a similar belief system. Thus, this could be a particularly influential factor. It seems that when a pastor's family member benefited from counseling, this created an increase in willingness to refer to dissimilar and non-descript similar believing mental health professionals, and an increased likelihood to have a history of referring. This variable significantly correlated with 5 of the referral pattern questions – more significant correlations than any other pastoral factor. It is possible that when a pastor is exposed to a mental health professional via the history of a family member, he or she is exposed in a particularly meaningful way. With this type of exposure, pastors may be more concerned about competency and less concerned about a belief system than pastors without this type of exposure to mental health.

Hypothesis four. This hypothesis proposed that pastors from different denominations will have statistically different responses to the referral pattern questionnaire (willingness to refer or have referred). Results supported this hypothesis, but only within the "high church" group. This group consists of Catholic, Anglican, and Episcopalian denominations. Pastors from those denominations tended to respond to the referral pattern questions differently than pastors from other denominations. Specifically, pastors from this denominational group responded higher to the willingness to refer to a non-Christian, atheistic or agnostic, or competent atheistic or agnostic mental health professional. This statistic was not extremely strong, and under the more conservative measures of an analysis of variance, it was not statistically significant. A more liberal

statistical measure was used because this study's purpose was exploratory, and any finding could be potentially valuable since the fields of pastoral psychology and rural psychology are open to consideration.

This hypothesis continued the statistical trend in that differences in referral patterns are primarily found within those groups that are most dissimilar to the pastor's own worldview. Pastors in this denominational group were more willing to refer to mental health professionals with dissimilar worldviews than pastors from other denominational groups. This continues the trend found in hypothesis 2 and 3. Pastors with this denominational background, like pastors who had education or exposure to mental health, may be more willing to refer to a mental health professional with a dissimilar belief system, but not willing enough to change his or her response completely.

Hypothesis five. This hypothesis proposed that pastors who are experienced or trained in counseling will be more likely to refer or have referred to a mental health professional than those who are not. Results supported this hypothesis. A pastor's experience counseling a mental health professional significantly correlated with a history of referring and willingness to refer to non-Christian, atheistic and competent atheistic mental health professionals. Similarly, those pastors who received training in psychology or mental health fields at some point, were more willing to refer to an atheistic or competent atheistic mental health professional, continuing the same correlational trend as seen in hypotheses 2, 3, and 4.

Pastors who endorsed currently counseling laymen significantly correlated with willingness to refer to a Christian mental health professional (with or without the term "competency") and a competent mental health professional with a similar belief system,

unique from the correlation trend in earlier hypotheses. All but thirteen pastors endorsed currently counseling laymen, and because of the high frequency, this finding may be representative of the entire sample. It is possible that currently counseling laymen was more representative of the entire group and therefore, this finding is similar to the findings in hypothesis 1. It is also possible that there was a particular quality about counseling one's own laymen that made the pastor more protective – willing to consider competent similar believing mental health professionals and others of a same belief system but not those of a dissimilar belief system.

Qualitative Findings

The first qualitative question asked pastors to describe reasons for referring to a mental health professional. Responses indicated that the pastor seems most likely to consider referring when he or she feels unqualified to handle the needs addressed. However, the most frequent reason endorsed for not referring to a mental health professional was a general or specific distrust of the mental health profession. These findings suggest that some pastors are ambivalent about referring. While rural pastors generally recognize a need for further mental health treatment for some of their parishioners, as a whole, they still distrust the mental health profession. Of interest, availability was not as significant an issue in meeting the needs of this rural population as expected. Only 25.7% of respondents endorsed that they do not know of a mental health professional in the area, and only 6.6% of pastors mentioned availability in their discussion of reasons for not referring to a mental health professional.

Implications of this Study

It is clear that there are two statistical trends in rural pastors' referral patterns. The first trend as demonstrated in hypothesis 1 (and possibly sub-hypothesis 5-1) suggests that as a whole, rural pastors are more likely to refer to mental health professionals with a similar belief system. In fact, in each *t*-test of hypothesis 1, the rural pastor was significantly more likely to refer to mental health professionals whose belief system was most similar to their own, with or without stated competency. These findings were applicable to the entire group and were strongly significant. These research findings support those of Chaddock and McMinn (1999) and McMinn et al. (1998) who found that pastors value the faith of those they are referring to above any other characteristic. Our findings concluded that pastors consistently expressed a preference to refer to a Christian mental health professional over those who profess any other belief system, despite competency. It is possible that the single most important factor in rural pastor referrals is the mental health professional's belief system.

The second trend as exhibited in hypotheses 3 and 4, and sub-hypotheses, 2-1, 2-3, and 5-2 suggests that variables of exposure to mental health, training in mental health, and education, particularly in mental health, correlate with an increase in willingness to refer to those mental health professionals with dissimilar worldviews. This trend is particularly evident in Table 7.

It is possible that the correlations between pastoral variables and the referral pattern questions are only demonstrative of statistical anomalies, but it is more likely that education, exposure, particular denomination, and experience in mental health do influence the rural pastors' willingness to consider referring to a mental health

professional with a dissimilar worldview, but do not make such a difference as to change the opinion of most pastors from strong disagreement to strong agreement. It is more likely to influence the pastors' opinions to change from strong disagreement to slight disagreement or possibly slight disagreement to slight agreement. As demonstrated in the regression equation discussed in the demographic section, it is possible many variables contribute to an increased willingness to refer to a mental health professional with a dissimilar belief system, and all of these may contribute to increased willingness to refer, but do not singularly determine a likelihood to refer. While this trend was seen in our entire sample, pastors within the denominational grouping of "high church" (Catholics, Anglicans, and Episcopalians) expressed a slightly higher willingness to refer to mental health professionals with dissimilar belief systems.

While both Carpenter (1999) and Keller and Murray (1982) emphasized the conservative nature of individuals in rural areas, our findings both supported and challenged this view of rural pastors. This research supports theirs in recognizing that rural pastors were most willing to refer to those of the same faith, and were thus deemed "conservative" by some definitions. However, some descriptions of religious rural individuals indicated that they were expected to be completely unwilling to consider referring to someone in the field of psychology (Carpenter, 1999; Keller & Murray, 1982; and Rumberger & Rogers, 1982). Given that the majority of pastors in this study were willing to consider referring to mental health professionals at all suggests that they were less conservative prior research might suggest. The pastors studied were "open" as defined by Carpenter (1999), to consider referrals when they felt they were not competent enough.

The qualitative data reinforces the finding that pastors are willing to refer for issues that they feel under-prepared to address, but they still may have a general distrust for the mental health profession. Distrust of the mental health profession was the most frequently mentioned reason (22.6%) not to refer to a mental health professional. These findings support Carpenter's (1999) research, suggesting that tension exists between mental health and religious circles. Certainly, some of the responses listed in Chapter 3 suggested strong animosity. However, 41.6% of the pastors responding indicated that they would refer if they were not feeling competent to handle the particular problem.

Much of the research on rural psychology contained the implications that rural areas are expected to be different from urban areas and that research in rural psychology should help "paint a picture" of rural life. These research findings helped "paint a picture" of rural pastors and their relationship to mental health, and there was an expectation that these findings would not completely generalize to urban pastors. Past research in rural areas mentioned unavailability of resources as a reason for its underserved status (e.g., Keller & Murray, 1982; Weinhart & Long, 1990). While availability was mentioned as a reason for not referring, it was not the most frequently mentioned reason. This could be due to the question's phrasing or that it is not as significant a hindrance as expected.

To further distinguish rurality from urban populations, rural pastors can reasonably be expected to experience a higher level of distrust, unavailability, and lack of experience or exposure to mental health than their urban counterparts due to the greater isolation from both education and mental health services (Rumberger & Rogers, 1982). Due to the expectation that ruralites are more conservative than urbanites, rural pastors

can be expected to be less willing to refer to anyone, and maintain a higher level of distrust for the mental health professional (Keller & Murray, 1982). Therefore, while all pastors may value belief system of their potential referral source, rural pastors may emphasize these with greater intensity or want more specific, detailed, or comparable information in determining a like belief system. Lastly, a higher response rate may be found in urban communities due to a potentially lower "distrust level" in participating with a mental health dissertation (Carpenter, 1999).

If a rural mental health professional desires pastoral referrals, he or she should make attempts to create relationships with pastors and establish competency. Since the other pastoral variables are out of the mental health professional's ability to impact (i.e., education, prior exposure), requesting a consultation, referring to the pastor for spiritual counseling, or some other means of establishing relationship is likely to have a positive effect. These results were found throughout all denominations; however, the "high church" category (Catholic, Anglican, and Episcopalian) was slightly more willing to refer to those with dissimilar belief systems than other denominational groups. These findings are encouraging in that many pastors expressed a willingness to refer to mental health professionals especially when they felt the problem was out of their area of expertise. Some attempt at establishing the competence of the mental health professional is important for the pastor in order to entrust laymen into their hands. However, our research findings indicated that shared worldview is still the most important variable.

Limitations of this Study

This study's survey was face valid, and if desired, the responses could be distorted from the pastor's true responses. The sample was within three rural northern California

counties; while this area was chosen because it seems to be representative, there may be specific factors that do not generalize to other rural counties. Likewise, it is possible that pastors of these counties may posses certain unique characteristics that would not generalize to other rural pastors in different counties. Similarly, the rural pastors who did not return the survey may have represented a specific group of pastors who would have significantly altered the findings had they provided their responses and demographic information. Although significant effort was made to understand each response, it is possible that the qualitative responses were interpreted in a manner that the writers did not intend.

Suggestions for Further Research

The field of rural psychology is wide open for further study. Research in the relationship of pastors to mental health is scarce, and further study may produce valuable findings. Comparing the referral patterns of urban pastors to rural pastors would be an interesting and helpful analysis. Much of the literature notes that those living in rural areas tend to be more conservative than urban areas (e.g., Fischer, 1982). Understanding the differences between rural and urban pastors may be helpful in meeting the needs of both communities. Designing a method to obtain the participation of those pastors who are least likely to return a survey or interact with the mental health community may be necessary in order to gain a complete picture of rural pastors. For example, presenting a survey in person, or conducting a phone interview may provide the opportunity for rapport that a mailed survey cannot convey.

There were several pastors who did not complete the survey, but instead sent in letters, sermon notes, tracts, or notes. Many of these letters and tracts were conservative

in nature, and it would have been helpful to receive their survey responses. It could be that the psychological nature of the survey deterred some respondents whose feedback would have been most helpful in understanding more conservative rural pastors. Likewise, those pastors who did not return the surveys may have been the same pastors who were least willing to consider referring to a mental health professional. After reviewing the qualitative responses, and those letters, sermons, and tracts, it is this author's assumption that those pastors desired to communicate information, but were unwilling to provide the specific feedback requested. These pastors may have responded to a personal interaction like a phone call or visit in order to give the information they desired to communicate without going through a form.

Personality variables and pastoral willingness to interact with the mental health field may produce helpful findings in determining the most significant factors of referral willingness. The qualitative data produced an opportunity to interact with the study, and personality styles were evident in the varying responses. Several pastors listed their contact information in order to discuss the research topics further. This suggests that the pastors' personalities may be significant influences in deciding whether or not to refer. Similarly, pastoral leadership styles may influence willingness to refer to mental health professionals. Potentially, both areas of research may produce valuable findings.

While much of the research on rural areas suggests that rural areas are underserved and isolated from resources (Jordan & Hargrove, 1987; Keller & Murray, 1982; DeLeon et al., 1989), our findings did not support this as the most frequently listed reason for not referring to a mental health professional. Further research could be done to

determine how significant isolation is to those living in rural areas in terms of receiving mental health treatment.

Conclusion

As expected, this research found that rural pastors were willing to refer to a mental health professional when they felt they were unable to effectively treat the issue at hand, however, the belief system of the mental health professional was very important in determining to whom the referral was given. There was still some lingering distrust between rural pastors and their views of mental health. If a mental health professional holding a similar or same belief system is not available, other criteria including relationship, exposure, education, and reception of consultation or referrals are somewhat influential in increasing the pastors' willingness to refer. Denomination is less of a significant factor, however, Catholics, Episcopalians, and Anglicans seem more willing to consider referring to mental health professionals with less similar belief systems.

Lingering general distrust between the fields hinders only those who are in need of help, and does not assist either the clergy or the mental health professional in better serving the public or understanding each other. Both fields are in search of truth and deeply committed to the ideals of meeting human needs. Restorative work is still required to preserve the relationship between those in the professions of helping people. Mutual referrals are signs of building bridges for those broken-hearted to walk upon.

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Appendix A

Letter and Questionnaire

Dear Pastor:

I am a graduate student in clinical psychology at George Fox University. I am currently doing a study about rural pastors and patterns of referrals to and from mental health professionals. Your church was one of many listed in several rural counties of Northern California. The most important part of my study is up to you. I am asking for about five minutes of your time to fill out this 30-item survey. There is a self-addressed, stamped envelope included that the survey can be returned in, and one dollar as a small token of my appreciation for your participation.

Your participation is voluntary, but I really hope you will return my survey. Your responses will be very helpful in trying to gain an accurate picture, and clarifying ways to better serve the rural community. This returned survey will be used with many others to complete the data and formulate observations in research. I hope to accurately represent the rural area you live in, and eventually clarify which resources and obstacles exist. This helps to build better working relationships between rural churches and mental health services. Your responses are very valuable to me. All information is confidential, and no individual responses will be discussed in the research study or publication. By completing and returning the survey, you are giving your consent to participate.

Thank you so much for your time and effort. Should you need any information, feel free to contact me or my supervisor at George Fox University. Our phone numbers are listed below. If you would like a copy of the study's findings include a self-addressed, stamped envelope when you return your survey.

Sincerely,

Alicia A. Chandler, MA
(503) 654-7696
George Fox University

Supervised by:
Clark D. Campbell, Ph. D.
(503) 554-2753

~ *Rural Pastoral Mental Health Referral Questionnaire* ~

For the following questions, the definition of "mental health professional" is:

Anyone licensed or certified and practicing in an area related to mental health treatment or counseling. This includes but is not limited to: psychologists, psychiatrists, marriage and family therapists, licensed professional counselors, social workers, etc.

Please circle the response that best fits your own experience

1=strongly disagree 2 = disagree 3 = slightly disagree 4= slightly agree 5 = agree 6= strongly agree

1. I have counseled people since I have been at this church. 1 2 3 4 5 6

2. I have counseled a mental health professional................................ 1 2 3 4 5 6

3. Since I have been at this church, I have visited with a mental health professional for consultation or advice about someone I am counseling 1 2 3 4 5 6

4. I have sought help from a mental health professional for personal counseling 1 2 3 4 5 6

5. Someone in my family has sought help from a mental health professional for personal counseling or advice. 1 2 3 4 5 6

6. Since I have been at this church, I have received a referral from a mental health professional 1 2 3 4 5 6

7. Since I have been at this church, I have referred someone to a mental health professional. 1 2 3 4 5 6

8. Since I have been at this church, a mental health professional has contacted me for consultation or advice.................................. 1 2 3 4 5 6

9. I am friends or acquaintances with a mental health professional 1 2 3 4 5 6

10. I know of a mental health professional in the area........................ 1 2 3 4 5 6

11. I would refer someone who came to me for counseling to a non-Christian mental health professional 1 2 3 4 5 6

12. I would refer someone who came to me for counseling to a Christian mental health professional 1 2 3 4 5 6

1=strongly disagree... 6= strongly agree

13. I would refer someone who came to me for counseling to a Christian mental health professional, if I thought he/she was competent....... 1 2 3 4 5 6

14. I would refer someone to a mental health professional who expressed a similar belief system to my own 1 2 3 4 5 6

15. I would refer someone who came to me for counseling to a mental health professional who expressed a similar belief system to my own, if I thought he/she was competent....... 1 2 3 4 5 6

16. I would refer to an agnostic or atheistic mental health professional....... 1 2 3 4 5 6

17. I would refer someone who came to me for counseling to a agnostic or atheistic mental health professional, if I thought that he or she was competent....... 1 2 3 4 5 6

18. I attend educational seminars, trainings, or conventions about mental health issues or concerns 1 2 3 4 5 6

19. I have had formal training in counseling or psychology 1 2 3 4 5 6

Please answer the following questions

20. Age in years ______

21. Gender (circle one) M F

22. Current Marital Status (check one):

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced

23. Which one category most closely represents your ethnicity: (check one)

- ❑ African American
- ❑ Asian American
- ❑ Native American
- ❑ Hispanic American
- ❑ Caucasian/European American
- ❑ Other:__________________

24. Number of years of education after high school ________

25. Highest degree earned (check one):

- ☐ Bachelors
- ☐ Masters
- ☐ Doctorate
- ☐ Other (please specify) _______________

26. In what year did you complete your formal education? _______

27. Denominational or Religious Affiliation:________________________________

28. Approximately how many people attend your current church in average weekly attendance? _______

29. Number of years you have been a pastor of any church? _____

30a. Please describe your reasons for referring to a mental health professional:

30b. Please describe your reasons for not referring to a mental health professional:

Appendix B

Raw Data Tables

Variable Code	Label
Subject	Subject Number
Q1	Survey Question 1
Q2	Survey Question 2
Q3	Survey Question 3
Q4	Survey Question 4
Q5	Survey Question 5
Q6	Survey Question 6
Q7	Survey Question 7
Q8	Survey Question 8
Q9	Survey Question 9
Q10	Survey Question 10
Q11	Survey Question 11
Q13	Survey Question 13
Q14	Survey Question 14
Q15	Survey Question 15
Q16	Survey Question 16
Q17	Survey Question 17
Q18	Survey Question 18
Q19	Survey Question 19
age	Respondent's age
gender	Respondent's gender
marital	Respondent's marital status
ethnicit	Respondent's ethnicity
school	Respondent's years of higher education
degree	Respondent's highest degree earned
degoth	Respondent's response on "other" category of degree
recented	Respondent's last year of education
yrgrad	Respondent's year of graduation with higher education degree
denom	Respondent's denomination
attend	Respondent's reported number of attenders
yrpast	Respondent's number of years in the pastorate
coun	Respondent's answer whether or not he or she counsels laymen
pos_e	Recoding of "coun" to determine whether or not the pastor answered positively "yes" they do counsel laymen.
groups	Respondent's denominational group – recoding of denominational categories
refer_aa	Respondent's response on qualitative reasons to refer as coded in the "a" group by the author
refer_ab	Respondent's response on qualitative reasons to refer as coded in the "b" group by the author
refer_ac	Respondent's response on qualitative reasons to refer as coded in the "c" group by the author
nrefer_aa	Respondent's response on qualitative reasons not to refer as coded in the "a" group by the author

nrefer_ab	Respondent's response on qualitative reasons not to refer as coded in the "b" group by the author
nrefer_ac	Respondent's response on qualitative reasons not to refer as coded in the "c" group by the author
nrefer_ad	Respondent's response on qualitative reasons not to refer as coded in the "d" group by the author
nrefer_ae	Respondent's response on qualitative reasons not to refer as coded in the "e" group by the author
nrefer_af	Respondent's response on qualitative reasons not to refer as coded in the "f" group by the author
refer_oa	Respondent's response on qualitative reasons to refer as coded in the "a" group by the interrater
refer_ob	Respondent's response on qualitative reasons to refer as coded in the "b" group by the interrater
refer_oc	Respondent's response on qualitative reasons to refer as coded in the "c" group by the interrater
nrefer_oa	Respondent's response on qualitative reasons not to refer as coded in the "a" group by the interrater
nrefer_ob	Respondent's response on qualitative reasons not to refer as coded in the "b" group by the interrater
nrefer_oc	Respondent's response on qualitative reasons not to refer as coded in the "c" group by the interrater
nrefer_od	Respondent's response on qualitative reasons not to refer as coded in the "d" group by the interrater
nrefer_oe	Respondent's response on qualitative reasons not to refer as coded in the "e" group by the interrater
nrefer_of	Respondent's response on qualitative reasons not to refer as coded in the "f" group by the interrater
matching	an unused coding
hyp3_1	Means of pastors responses to whether or not they refer to a Christian or similar believing mental health professional
hyp3_1b	Means of pastors responses to whether or not they refer to an atheistic or agnostic mental health professional

Subject #	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18
1	5.0	2.0	1.0	1.0	1.0	2.0	2.0	1.0	2.0	2.0	2.0	6.0	6.0	5.0	6.0	1.0	2.0	2.00
2	6.0	5.0	6.0	5.0	0.0	2.0	6.0	2.0	6.0	6.0	5.0	5.0	6.0	5.0	5.0	1.0	1.0	3.00
3	6.0	1.0	1.0	1.0	1.0	1.0	6.0	1.0	2.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
4	1.0	1.0	1.0	1.0	6.0	1.0	1.0	1.0	6.0	6.0	1.0	6.0	6.0	4.0	4.0	1.0	1.0	4.00
5	4.0	6.0	1.0	6.0	1.0	1.0	1.0	1.0	6.0	6.0	1.0	4.0	4.0	3.0	2.0	1.0	1.0	5.00
6	6.0	4.0	6.0	2.0	5.0	6.0	6.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	2.0	2.0	4.00
7	6.0	6.0	6.0	6.0	6.0	1.0	6.0	1.0	6.0	6.0	6.0	1.0	4.0	6.0	6.0	6.0	6.0	6.00
8	5.0	2.0	2.0	5.0	2.0	2.0	2.0	2.0	2.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	2.0	2.00
9	5.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	1.0	6.0	5.0	5.0	1.0	1.0	1.0	2.00
10	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	2.00
11	6.0	6.0	1.0	6.0	6.0	1.0	6.0	1.0	1.0	1.0	3.0	6.0	6.0	6.0	6.0	1.0	5.0	4.00
12	6.0	6.0	6.0	1.0	4.0	4.0	6.0	3.0	5.0	5.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	4.00
13	6.0	1.0	1.0	1.0	6.0	1.0	4.0	1.0	5.0	4.0	2.0	6.0	6.0	2.0	3.0	1.0	1.0	2.00
14	6.0	1.0	5.0	1.0	1.0	4.0	6.0	1.0	5.0	6.0	3.0	5.0	6.0	5.0	6.0	1.0	1.0	2.00
15	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	5.0	5.0	6.0	6.0	1.0	1.0	2.00
16	4.0	6.0	6.0	6.0	6.0	1.0	6.0	1.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	2.0	3.0	3.00
17	5.0	1.0	1.0	1.0	5.0	1.0	1.0	1.0	1.0	5.0	2.0	5.0	6.0	4.0	4.0	1.0	1.0	2.00
18	6.0	1.0	1.0	1.0	1.0	1.0	4.0	1.0	5.0	6.0	1.0	4.0	5.0	5.0	5.0	1.0	1.0	3.00
19	5.0	5.0	1.0	5.0	6.0	1.0	5.0	1.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	1.00
20	4.0	4.0	3.0	2.0	2.0	2.0	5.0	4.0	4.0	3.0	4.0	4.0	4.0	4.0	4.0	2.0	2.0	3.00
21	6.0	6.0	6.0	6.0	6.0	1.0	6.0	1.0	4.0	6.0	5.0	5.0	5.0	5.0	5.0	2.0	2.0	5.00
22	6.0	6.0	5.0	2.0	6.0	4.0	6.0	5.0	6.0	6.0	1.0	6.0	6.0	2.0	4.0	1.0	1.0	2.00
23	6.0	6.0	2.0	1.0	1.0	1.0	6.0	5.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	4.0	6.0	5.00
24	5.0	2.0	5.0	2.0	2.0	2.0	2.0	2.0	5.0	2.0	2.0	5.0	5.0	4.0	5.0	1.0	4.0	2.00
25	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.00
26	5.0	2.0	2.0	5.0	5.0	2.0	5.0	2.0	5.0	5.0	5.0	5.0	5.0	4.0	5.0	5.0	5.0	4.00
27	6.0	0.0	3.0	6.0	0.0	1.0	1.0	3.0	5.0	6.0	6.0	6.0	6.0	1.0	6.0	5.0	6.0	2.00
28	6.0	6.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	6.0	3.0	5.0	6.0	2.0	5.0	4.0	6.0	5.00
29	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	5.0	1.0	4.0	1.0	1.0	1.00
30	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	4.0	1.0	1.0	1.0	1.0	5.00
31	5.0	2.0	1.0	1.0	1.0	1.0	6.0	2.0	4.0	4.0	1.0	6.0	5.0	5.0	4.0	1.0	2.0	1.00
32	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
33	5.0	2.0	4.0	4.0	1.0	1.0	4.0	1.0	4.0	4.0	1.0	6.0	6.0	4.0	4.0	1.0	1.0	4.00
34	1.0	6.0	6.0	6.0	6.0	6.0	1.0	6.0	6.0	6.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	6.00
35	6.0	4.0	3.0	3.0	2.0	4.0	3.0	6.0	6.0	6.0	1.0	5.0	5.0	5.0	5.0	1.0	1.0	5.00
36	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	4.0	4.0	6.0	4.0	6.0	3.0	3.0	6.00
37	6.0	1.0	5.0	4.0	4.0	2.0	5.0	4.0	4.0	2.0	1.0	6.0	6.0	4.0	4.0	1.0	1.0	5.00
38	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	5.0	5.0	1.00
39	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	5.0	6.0	6.0	6.0	0.0	0.0	0.0	0.00
40	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	3.0	5.0	5.0	5.0	5.0	1.0	1.0	5.00
41	5.0	2.0	3.0	1.0	1.0	3.0	4.0	1.0	4.0	5.0	2.0	6.0	5.0	5.0	6.0	1.0	2.0	4.00
42	5.0	2.0	2.0	2.0	2.0	2.0	5.0	5.0	5.0	5.0	5.0	5.0	6.0	5.0	6.0	2.0	2.0	5.00
43	6.0	6.0	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	1.0	6.0	6.0	1.0	1.0	1.0	1.0	1.00
44	6.0	1.0	4.0	1.0	1.0	1.0	1.0	1.0	4.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	5.00
45	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	3.0	4.0	3.0	4.0	4.0	4.0	1.0	1.0	1.00
46	6.0	2.0	2.0	1.0	2.0	4.0	3.0	2.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
47	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	4.0	4.0	4.0	1.0	1.0	1.00
48	6.0	4.0	3.0	2.0	1.0	4.0	5.0	4.0	5.0	6.0	1.0	5.0	6.0	5.0	5.0	1.0	2.0	2.00
49	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	4.0	1.0	6.0	6.0	4.0	4.0	1.0	1.0	6.00
50	6.0	4.0	4.0	2.0	5.0	2.0	4.0	2.0	4.0	5.0	5.0	5.0	5.0	4.0	5.0	4.0	5.0	5.00

#	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18
51	6.0	1.0	1.0	1.0	6.0	1.0	1.0	1.0	1.0	1.0	1.0	5.0	6.0	5.0	5.0	1.0	1.0	4.00
52	6.0	6.0	6.0	1.0	1.0	1.0	4.0	1.0	5.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	2.0	3.00
53	6.0	4.0	4.0	3.0	2.0	2.0	2.0	2.0	4.0	4.0	2.0	4.0	5.0	5.0	4.0	2.0	3.0	4.00
54	6.0	6.0	6.0	1.0	1.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.00
55	6.0	0.0	6.0	6.0	1.0	6.0	6.0	4.0	6.0	6.0	4.0	6.0	6.0	6.0	6.0	3.0	4.0	6.00
56	6.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	2.0	2.00
57	5.0	4.0	3.0	4.0	5.0	2.0	4.0	1.0	1.0	3.0	3.0	5.0	5.0	4.0	5.0	1.0	2.0	2.00
58	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	5.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	5.00
59	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
60	6.0	1.0	1.0	1.0	1.0	6.0	1.0	4.0	6.0	6.0	1.0	4.0	4.0	5.0	5.0	1.0	1.0	4.00
61	6.0	6.0	6.0	1.0	1.0	1.0	6.0	1.0	6.0	6.0	3.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
62	5.0	3.0	2.0	3.0	5.0	4.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	5.0	5.0	1.0	1.0	4.00
63	6.0	2.0	1.0	1.0	1.0	2.0	1.0	2.0	1.0	4.0	1.0	5.0	5.0	5.0	5.0	1.0	1.0	4.00
64	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	3.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.00
65	5.0	2.0	2.0	2.0	2.0	2.0	5.0	2.0	2.0	5.0	2.0	5.0	6.0	6.0	6.0	1.0	2.0	2.00
66	6.0	4.0	4.0	1.0	5.0	1.0	4.0	1.0	3.0	3.0	1.0	6.0	6.0	6.0	6.0	6.0	3.0	1.00
67	6.0	1.0	1.0	1.0	6.0	1.0	1.0	1.0	6.0	6.0	1.0	6.0	6.0	3.0	4.0	1.0	1.0	6.00
68	5.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0	1.0	3.0	3.0	6.0	6.0	6.0	6.0	3.0	3.0	3.00
69	6.0	4.0	1.0	4.0	1.0	4.0	3.0	4.0	5.0	6.0	3.0	4.0	6.0	6.0	6.0	1.0	2.0	2.00
70	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
71	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	1.0	1.00
72	5.0	1.5	1.0	1.0	1.0	1.0	2.0	1.0	2.0	4.0	2.0	5.0	5.0	5.0	5.0	1.0	2.0	4.00
73	6.0	6.0	6.0	6.0	5.0	5.0	6.0	6.0	6.0	6.0	3.0	6.0	5.0	5.0	6.0	4.0	3.0	6.00
74	5.0	5.0	5.0	3.0	2.0	2.0	6.0	1.0	5.0	5.0	4.0	5.0	5.0	5.0	5.0	3.0	4.0	5.00
75	5.0	3.0	4.0	1.0	2.0	1.0	2.0	1.0	5.0	5.0	1.0	5.0	5.0	5.0	5.0	1.0	1.0	4.00
76	6.0	3.0	3.0	1.0	1.0	2.0	2.0	1.0	2.0	2.0	1.0	5.0	6.0	5.0	5.0	1.0	1.0	4.00
77	6.0	6.0	6.0	4.0	5.0	5.0	5.0	5.0	2.0	5.0	1.0	5.0	5.0	6.0	6.0	1.0	1.0	2.00
78	6.0	6.0	2.0	2.0	6.0	0.0	1.0	1.0	6.0	6.0	4.0	6.0	6.0	5.0	6.0	4.0	5.0	6.00
79	6.0	6.0	1.0	6.0	6.0	1.0	1.0	1.0	6.0	1.0	5.0	6.0	6.0	3.0	6.0	3.0	5.0	6.00
80	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	4.0	6.0	6.0	6.0	6.0	1.0	4.0	2.00
81	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	2.0	1.00
82	5.0	1.0	1.0	6.0	6.0	1.0	5.0	1.0	6.0	6.0	4.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
83	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	4.0	6.0	6.0	6.0	6.0	1.0	1.0	2.00
84	6.0	5.0	2.0	1.0	1.0	1.0	6.0	1.0	1.0	5.0	4.0	6.0	6.0	6.0	6.0	2.0	2.0	1.00
85	6.0	6.0	1.0	6.0	4.0	2.0	6.0	2.0	5.0	5.0	5.0	6.0	6.0	5.0	5.0	4.0	3.0	4.00
86	6.0	5.0	6.0	6.0	6.0	5.0	4.0	6.0	6.0	6.0	5.0	6.0	6.0	6.0	6.0	1.0	2.0	5.00
87	5.0	5.0	2.0	2.0	2.0	2.0	5.0	2.0	2.0	2.0	2.0	5.0	5.0	5.0	5.0	2.0	3.0	2.00
88	3.0	2.0	1.0	4.0	5.0	1.0	5.0	1.0	1.0	5.0	4.0	5.0	6.0	5.0	6.0	2.0	3.0	1.00
89	6.0	1.0	1.0	1.0	6.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
90	6.0	0.0	5.0	2.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	2.0	5.00
91	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.00
92	6.0	4.0	3.0	3.0	1.0	3.0	1.0	3.0	5.0	6.0	1.0	5.0	5.0	5.0	3.0	1.0	1.0	0.00
93	6.0	6.0	6.0	6.0	6.0	3.0	6.0	5.0	6.0	6.0	4.0	4.0	6.0	4.0	6.0	1.0	2.0	5.00
94	5.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	4.0	6.0	1.0	5.0	5.0	3.5	4.0	1.0	1.0	5.00
95	5.0	1.0	5.0	1.0	1.0	1.0	5.0	1.0	5.0	5.0	1.0	6.0	6.0	4.0	3.0	1.0	0.0	0.00
96	6.0	3.0	4.0	1.0	6.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	4.00
97	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	4.00
98	5.0	5.0	2.0	1.0	1.0	5.0	5.0	1.0	4.0	5.0	2.0	5.0	5.0	5.0	5.0	1.0	1.0	2.00
99	4.0	4.0	3.0	3.0	4.0	3.0	3.0	3.0	2.0	2.0	1.0	5.0	4.0	6.0	4.0	4.0	4.0	4.00
100	5.0	2.0	2.0	1.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.00

Subject #	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18
101	1.0	6.0	1.0	6.0	6.0	1.0	1.0	1.0	1.0	6.0	5.0	1.0	4.0	6.0	6.0	5.0	5.0	1.00
102	5.0	5.0	6.0	5.0	5.0	2.0	6.0	2.0	5.0	6.0	4.0	6.0	6.0	6.0	6.0	1.0	1.0	3.00
103	2.0	1.0	1.0	1.0	1.0	1.0	5.0	1.0	5.0	6.0	3.0	6.0	6.0	3.0	5.0	2.0	2.0	4.00
104	6.0	6.0	1.0	5.0	6.0	1.0	4.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	4.00
105	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	6.0	6.0	2.0	5.0	6.0	5.0	5.0	2.0	2.0	4.00
106	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	6.0	6.0	1.0	1.0	1.0	1.0	1.00
107	4.0	3.0	2.0	3.0	2.0	2.0	1.0	3.0	5.0	3.0	5.0	5.0	5.0	5.0	5.0	2.0	3.0	4.00
108	6.0	5.0	1.0	3.0	1.0	1.0	4.0	1.0	1.0	4.0	3.0	5.0	6.0	6.0	5.0	1.0	1.0	1.00
109	6.0	6.0	6.0	2.0	2.0	4.0	5.0	3.0	6.0	6.0	4.0	5.0	6.0	4.0	5.0	2.0	2.0	4.00
110	1.0	1.0	4.0	6.0	6.0	6.0	2.0	6.0	4.0	4.0	6.0	1.0	1.0	2.0	1.0	6.0	6.0	4.00
111	6.0	5.0	5.0	1.0	1.0	1.0	1.0	2.0	5.0	6.0	2.0	6.0	6.0	4.0	4.0	1.0	2.0	5.00
112	6.0	1.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.00
113	5.0	5.0	6.0	6.0	1.0	1.0	6.0	1.0	5.0	5.0	2.0	5.0	5.0	5.0	5.0	2.0	4.0	5.00
114	5.0	5.0	4.0	3.0	4.0	5.0	5.0	5.0	6.0	6.0	2.0	6.0	5.0	4.0	5.0	1.0	1.0	5.00
115	6.0	5.0	2.0	3.0	6.0	1.0	1.0	1.0	4.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
116	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	6.0	6.0	4.0	1.0	6.0	6.0	6.0	1.0	1.0	3.00
117	6.0	6.0	5.0	3.0	6.0	1.0	5.0	1.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	2.0	3.0	6.00
118	6.0	6.0	1.0	6.0	6.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	4.0	5.00
119	5.0	5.0	4.0	5.0	5.0	5.0	5.0	1.0	5.0	6.0	5.0	3.0	6.0	3.0	6.0	5.0	5.0	4.00
120	3.0	1.0	1.0	1.0	1.0	2.0	2.0	2.0	6.0	6.0	6.0	6.0	6.0	1.0	6.0	1.0	6.0	6.00
121	4.0	1.0	1.0	2.0	1.0	1.0	5.0	1.0	1.0	6.0	0.0	0.0	5.0	3.0	4.0	1.0	1.0	5.00
122	5.0	2.0	2.0	2.0	2.0	2.0	4.0	2.0	5.0	5.0	5.0	5.0	5.0	2.0	5.0	5.0	5.0	3.00
123	3.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	1.0	6.0	3.0	6.0	6.0	6.0	6.0	1.0	1.0	3.00
124	6.0	6.0	6.0	2.0	6.0	6.0	6.0	6.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	2.0	4.0	5.00
125	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
126	6.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	6.0	6.0	2.0	5.0	5.0	5.0	5.0	1.0	1.0	5.00
127	6.0	6.0	6.0	1.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	6.00
128	6.0	1.0	1.0	1.0	2.0	1.0	4.0	2.0	5.0	6.0	2.0	4.0	4.0	4.0	4.0	1.0	1.0	3.00
129	2.0	1.0	1.0	1.0	4.0	1.0	1.0	2.0	1.0	1.0	4.0	5.0	6.0	5.0	6.0	3.0	4.0	2.00
130	5.0	1.0	1.0	2.0	1.0	3.0	2.0	1.0	2.0	1.0	3.0	4.0	5.0	5.0	5.0	1.0	3.0	1.00
131	5.0	2.0	1.0	1.0	1.0	1.0	2.0	1.0	2.0	5.0	1.0	6.0	6.0	5.0	6.0	1.0	1.0	4.00
132	6.0	6.0	6.0	1.0	1.0	1.0	6.0	6.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	4.00
133	6.0	1.0	1.0	1.0	6.0	1.0	6.0	1.0	6.0	6.0	1.0	6.0	6.0	6.0	6.0	1.0	1.0	1.00
134	6.0	4.0	4.0	2.0	1.0	1.0	6.0	1.0	4.0	2.0	1.0	6.0	6.0	2.0	4.0	1.0	1.0	5.00
135	6.0	5.0	3.0	5.0	5.0	2.0	5.0	2.0	3.0	5.0	3.0	5.0	5.0	4.0	6.0	2.0	2.0	4.00
136	1.0	3.0	1.0	1.0	2.0	1.0	1.0	1.0	6.0	6.0	1.0	6.0	6.0	3.0	3.0	1.0	6.0	1.00
137	5.0	5.0	2.0	5.0	5.0	2.0	5.0	4.0	5.0	5.0	5.0	5.0	5.0	2.0	4.0	5.0	5.0	2.00

t#	Q19	AGE	GENDER	MARITAL	ETHNICIT	SCHOOL	DEGREE	DEGOTH	RECENTED
1	4.0	49.0	1.0	2.0	5.0	6.0	1.0	no	0.00
2	3.0	61.0	2.0	2.0	5.0	2.0	4.0	coun	1.00
3	1.0	71.0	1.0	3.0	5.0	6.0	4.0	d.c.	1.00
4	3.0	45.0	1.0	2.0	4.0	0.0	6.0	no de	0.00
5	6.0	47.0	2.0	2.0	5.0	14.0	2.0	3ma's	5.00
6	5.0	59.0	2.0	1.0	5.0	14.0	2.0	2ma's	4.00
7	6.0	56.0	2.0	2.0	3.0	0.0	3.0	no	3.00
8	2.0	48.0	1.0	2.0	5.0	7.0	1.0	no	4.00
9	2.0	65.0	1.0	2.0	5.0	6.0	2.0	no	3.00
10	2.0	57.0	1.0	2.0	1.0	8.0	2.0	no	5.00
11	6.0	52.0	1.0	2.0	5.0	10.0	2.0	no	3.00
12	6.0	55.0	1.0	2.0	5.0	8.0	0.0	no	0.00
13	6.0	60.0	1.0	2.0	5.0	7.0	2.0	no	3.00
14	2.0	70.0	1.0	2.0	5.0	3.0	0.0	no	4.00
15	4.0	37.0	1.0	2.0	5.0	8.0	2.0	no	5.00
16	6.0	51.0	2.0	2.0	5.0	8.0	1.0	bsm	4.00
17	2.0	42.0	1.0	2.0	5.0	1.0	5.0	no	0.00
18	6.0	64.0	1.0	2.0	5.0	5.0	1.0	no	3.00
19	6.0	60.0	1.0	2.0	5.0	9.0	2.0	no	2.00
20	5.0	58.0	1.0	1.0	6.0	7.0	4.0	no	2.00
21	2.0	51.0	2.0	2.0	5.0	8.0	2.0	ordai	5.00
22	3.0	46.0	1.0	2.0	5.0	9.0	3.0	no	5.00
23	5.0	38.0	1.0	2.0	5.0	2.0	4.0	min.	5.00
24	5.0	74.0	1.0	2.0	5.0	4.0	1.0	no	1.00
25	6.0	44.0	1.0	2.0	5.0	8.0	2.0	no	4.00
26	3.0	56.0	1.0	1.0	5.0	10.0	2.0	no	4.00
27	5.0	66.0	1.0	1.0	5.0	15.0	3.0	2ba2m	4.00
28	1.0	52.0	2.0	2.0	5.0	8.0	2.0	no	5.00
29	1.0	68.0	1.0	2.0	5.0	10.0	1.0	62-99	5.00
30	4.0	51.0	1.0	2.0	5.0	4.0	1.0	no	5.00
31	1.0	50.0	1.0	2.0	5.0	0.0	0.0	no	0.00
32	5.0	64.0	1.0	2.0	5.0	2.0	4.0	life	1.00
33	4.0	48.0	1.0	2.0	5.0	0.0	4.0	30+gl	5.00
34	6.0	50.0	1.0	2.0	5.0	4.0	4.0	lic.	0.00
35	6.0	42.0	1.0	2.0	5.0	6.0	1.0	credc	5.00
36	6.0	55.0	1.0	2.0	5.0	9.0	2.0	2	5.00
37	4.0	49.0	1.0	2.0	3.0	4.0	1.0	no	5.00
38	4.0	54.0	1.0	1.0	5.0	7.0	1.0	no	3.00
39	0.0	72.0	1.0	3.0	5.0	8.0	2.0	no	5.00
40	4.0	57.0	1.0	2.0	5.0	7.0	2.0	no	3.00
41	5.0	53.0	1.0	2.0	5.0	5.0	1.0	exta	3.00
42	2.0	40.0	1.0	2.0	5.0	12.0	2.0	curre	5.00
43	1.0	68.0	1.0	2.0	5.0	2.0	4.0	AA	3.00
44	5.0	55.0	1.0	2.0	5.0	2.0	0.0	no	2.00
45	6.0	79.0	1.0	2.0	5.0	10.0	2.0	no	3.00
46	1.0	56.0	1.0	2.0	3.0	0.0	0.0	no	0.00
47	1.0	46.0	1.0	2.0	5.0	0.0	0.0	no	0.00
48	5.0	42.0	1.0	2.0	5.0	7.0	2.0	no	4.00
49	6.0	39.0	1.0	2.0	5.0	4.0	1.0	no	5.00
50	5.0	48.0	1.0	2.0	5.0	13.0	4.0	no	5.00

Subject #	Q19	AGE	GENDER	MARITAL	ETHNICIT	SCHOOL	DEGREE	DEGOTH	RECENTED
51	1.0	72.0	1.0	2.0	5.0	5.5	0.0	no	3.00
52	5.0	47.0	1.0	2.0	5.0	8.0	2.0	no	3.00
53	3.0	70.0	1.0	2.0	5.0	2.0	4.0	certi	3.00
54	6.0	47.0	1.0	2.0	5.0	12.0	3.0	Phdp&	4.00
55	4.0	51.0	1.0	2.0	5.0	4.0	1.0	no	4.00
56	5.0	47.0	1.0	2.0	5.0	6.0	5.0	2yrin	3.00
57	2.0	63.0	1.0	2.0	5.0	3.0	4.0	inspr	0.00
58	5.0	73.0	1.0	2.0	5.0	3.0	2.0	no	4.00
59	1.0	55.0	1.0	2.0	6.0	4.0	5.0	no	3.00
60	1.0	34.0	1.0	2.0	5.0	4.5	4.0	cert	4.00
61	6.0	47.0	1.0	2.0	5.0	5.0	1.0	Psych	4.00
62	4.0	80.0	1.0	2.0	5.0	4.0	1.0	no	5.00
63	5.0	44.0	1.0	2.0	6.0	4.0	1.0	no	4.00
64	1.0	37.0	2.0	1.0	3.0	1.0	0.0	no	4.00
65	4.0	49.0	1.0	2.0	5.0	6.0	1.0	ma pe	3.00
66	5.0	50.0	1.0	1.0	5.0	8.0	2.0	no	4.00
67	6.0	57.0	1.0	2.0	5.0	8.0	3.0	no	3.00
68	1.0	43.0	2.0	2.0	5.0	0.0	4.0	ordai	0.00
69	6.0	48.0	1.0	2.0	5.0	5.5	1.0	no	3.00
70	6.0	63.0	1.0	2.0	5.0	8.0	1.0	no	2.00
71	5.0	37.0	1.0	2.0	5.0	2.0	4.0	Bible	4.00
72	3.0	53.0	1.0	2.0	5.0	3.0	0.0	no	0.00
73	6.0	65.0	1.0	2.0	5.0	11.0	2.0	3gra	4.00
74	5.0	53.0	2.0	2.0	5.0	8.0	2.0	no	4.00
75	1.0	48.0	1.0	2.0	5.0	1.0	4.0	1yr c	3.00
76	1.0	57.0	1.0	2.0	5.0	2.0	0.0	no	2.00
77	2.0	44.0	1.0	2.0	5.0	5.0	1.0	no	4.00
78	6.0	52.0	1.0	2.0	5.0	7.0	2.0	no	3.00
79	6.0	56.0	1.0	2.0	6.0	11.0	2.0	no	4.00
80	1.0	43.0	1.0	2.0	5.0	2.0	4.0	curr	0.00
81	1.0	54.0	1.0	2.0	5.0	4.0	1.0	no	2.00
82	1.0	48.0	1.0	2.0	5.0	8.0	2.0	no	5.00
83	1.0	42.0	1.0	2.0	3.0	5.0	1.0	no	4.00
84	1.0	45.0	1.0	2.0	5.0	1.0	4.0	1yr c	3.00
85	5.0	42.0	1.0	1.0	5.0	10.0	2.0	no	5.00
86	4.0	60.0	1.0	2.0	5.0	9.0	2.0	no	3.00
87	2.0	72.0	1.0	2.0	5.0	3.0	5.0	no	1.00
88	1.0	60.0	1.0	2.0	5.0	8.0	1.0	no	4.00
89	4.0	64.0	1.0	2.0	5.0	7.0	2.0	no	2.00
90	5.0	56.0	1.0	2.0	5.0	4.0	1.0	no	5.00
91	1.0	67.0	1.0	2.0	5.0	6.0	1.0	no	3.00
92	4.0	70.0	1.0	2.0	5.0	7.0	2.0	no	3.00
93	4.0	42.0	1.0	2.0	5.0	6.5	1.0	no	4.00
94	0.0	0.0	0.0	0.0	0.0	6.0	1.0	certc	5.00
95	0.0	40.0	1.0	2.0	5.0	8.0	0.0	no	0.00
96	1.0	57.0	2.0	2.0	5.0	0.0	0.0	somec	3.00
97	6.0	49.0	1.0	2.0	5.0	15.0	3.0	no	5.00
98	3.0	54.0	1.0	2.0	5.0	2.0	0.0	no	2.00
99	4.0	40.0	1.0	2.0	2.0	6.0	1.0	no	5.00
100	2.0	51.0	1.0	2.0	2.0	0.0	0.0	no	3.00

#	Q19	AGE	GENDER	MARITAL	ETHNICIT	SCHOOL	DEGREE	DEGOTH	RECENTED
01	1.0	66.0	2.0	2.0	5.0	7.0	2.0	no	3.00
02	3.0	48.0	1.0	2.0	5.0	2.0	0.0	no	3.00
03	4.0	54.0	2.0	2.0	5.0	9.0	2.0	no	5.00
104	1.0	38.0	2.0	1.0	5.0	8.0	2.0	no	5.00
105	2.0	49.0	1.0	2.0	5.0	7.0	2.0	no	0.00
106	1.0	64.0	1.0	1.0	5.0	6.0	0.0	no	2.00
107	4.0	48.0	1.0	2.0	6.0	4.0	2.0	no	4.00
108	2.0	60.0	1.0	2.0	5.0	5.0	4.0	-3cre	2.00
109	5.0	56.0	1.0	2.0	5.0	7.0	2.0	no	2.00
110	4.0	51.0	1.0	2.0	5.0	4.0	1.0	no	3.00
111	5.0	51.0	1.0	2.0	5.0	5.0	1.0	no	3.00
112	6.0	48.0	1.0	2.0	5.0	7.0	2.0	no	3.00
113	5.0	42.0	1.0	1.0	5.0	8.0	2.0	no	4.00
114	6.0	64.0	1.0	4.0	5.0	6.0	2.0	no	4.00
115	6.0	76.0	2.0	3.0	1.0	8.0	1.0	cert.	0.00
116	6.0	55.0	1.0	2.0	5.0	12.0	3.0	no	5.00
117	6.0	36.0	1.0	2.0	5.0	6.5	2.0	no	5.00
118	0.0	64.0	1.0	2.0	5.0	2.0	6.0	no	0.00
119	6.0	68.0	1.0	2.0	5.0	9.0	3.0	no	2.00
120	6.0	59.0	1.0	3.0	5.0	8.0	3.0	phdPr	3.00
121	5.0	86.0	1.0	2.0	6.0	7.0	2.0	babsm	2.00
122	3.0	46.0	1.0	2.0	5.0	8.0	2.0	no	4.00
123	1.0	58.0	1.0	2.0	5.0	0.0	5.0	no	0.00
124	5.0	62.0	1.0	2.0	5.0	5.0	1.0	no	4.00
125	5.0	64.0	1.0	2.0	5.0	2.0	0.0	lifem	1.00
126	4.0	57.0	1.0	2.0	5.0	7.0	2.0	no	3.00
127	6.0	58.0	1.0	2.0	5.0	6.0	2.0	no	3.00
128	3.0	56.0	1.0	2.0	5.0	8.0	1.0	no	3.00
129	1.0	39.0	1.0	2.0	5.0	7.0	2.0	no	4.00
130	5.0	46.0	1.0	2.0	5.0	2.5	0.0	no	0.00
131	2.0	53.0	1.0	2.0	5.0	5.0	1.0	no	3.00
132	6.0	37.0	1.0	2.0	3.0	4.0	4.0	carr	5.00
133	1.0	42.0	1.0	2.0	5.0	3.5	4.0	AA	0.00
134	5.0	55.0	1.0	2.0	5.0	7.0	2.0	no	5.00
135	4.0	46.0	1.0	2.0	5.0	10.0	2.0	X2	5.00
136	1.0	47.0	2.0	2.0	5.0	7.0	0.0	no	3.00
137	5.0	69.0	1.0	1.0	5.0	7.0	2.0	no	1.00

Subject #	YRGRAD	DENOM	ATTEND	YRPAST	COUNSEL	POS_EXP	GROUPS	REFER_AA
1	0.0	26.0	10.0	10.0	2.00	1.00	1.00	2.0
2	1,959.0	1.0	30.0	2.0	2.00	2.00	1.00	1.0
3	1,958.0	9.0	275.0	2.0	2.00	1.00	11.00	2.0
4	0.0	10.0	100.0	15.0	1.00	2.00	2.00	2.0
5	1,998.0	11.0	23.0	3.5	2.00	2.00	5.00	2.0
6	1,982.0	9.0	45.0	1.6	2.00	2.00	11.00	2.0
7	1,978.0	12.0	60.0	26.0	2.00	2.00	7.00	1.0
8	1,980.0	13.0	35.0	7.0	2.00	1.00	8.00	2.0
9	1,975.0	13.0	65.0	33.0	2.00	1.00	8.00	2.0
10	1,999.0	11.0	50.0	3.0	2.00	1.00	5.00	2.0
11	1,976.0	1.0	250.0	26.0	2.00	1.00	1.00	2.0
12	0.0	4.0	30.0	16.0	2.00	2.00	1.00	1.0
13	1,980.0	4.0	80.0	3.0	2.00	2.00	1.00	2.0
14	1,982.0	2.0	10.0	1.0	2.00	2.00	2.00	1.0
15	1,991.0	14.0	135.0	11.0	2.00	1.00	9.00	2.0
16	1,981.0	15.0	30.0	0.0	2.00	2.00	13.00	2.0
17	0.0	16.0	0.0	5.0	2.00	1.00	7.00	2.0
18	1,976.0	10.0	70.0	3.0	2.00	2.00	2.00	2.0
19	1,968.0	11.0	20.0	34.0	2.00	2.00	5.00	2.0
20	1,969.0	9.0	120.0	8.0	2.00	2.00	11.00	2.00
21	1,997.0	14.0	40.0	5.0	2.00	2.00	9.00	1.00
22	2,002.0	5.0	150.0	17.0	2.00	2.00	13.00	1.00
23	1,993.0	1.0	61.0	8.0	2.00	2.00	1.00	2.00
24	1,950.0	17.0	40.0	10.0	2.00	2.00	10.00	2.00
25	1,984.0	18.0	100.0	12.0	2.00	2.00	11.00	2.00
26	1,984.0	9.0	600.0	14.0	2.00	2.00	11.00	2.00
27	1,988.0	9.0	600.0	40.0	2.00	2.00	11.00	2.00
28	2,000.0	19.0	0.0	6.0	2.00	2.00	6.00	2.00
29	1,999.0	19.0	40.0	9.0	1.00	1.00	6.00	2.00
30	1,993.0	20.0	120.0	9.0	2.00	1.00	12.00	2.00
31	0.0	1.0	50.0	2.0	2.00	2.00	1.00	2.00
32	1,958.0	17.0	30.0	10.0	2.00	2.00	10.00	2.00
33	2,001.0	1.0	40.0	3.0	2.00	2.00	1.00	2.00
34	0.0	1.0	75.0	4.0	1.00	2.00	1.00	1.00
35	1,996.0	16.0	45.0	2.0	2.00	2.00	7.00	1.00
36	1,994.0	11.0	50.0	9.0	2.00	2.00	5.00	1.00
37	1,990.0	1.0	20.0	8.0	2.00	2.00	1.00	2.00
38	1,974.0	9.0	150.0	8.0	2.00	1.00	11.00	2.00
39	1,994.0	9.0	180.0	6.0	2.00	1.00	11.00	2.00
40	1,977.0	10.0	10.0	2.5	2.00	2.00	2.00	1.00
41	1,972.0	1.0	105.0	33.0	2.00	2.00	1.00	2.00
42	1,998.0	14.0	180.0	4.0	2.00	2.00	9.00	1.00
43	1,975.0	7.0	260.0	3.5	2.00	2.00	3.00	2.00
44	1,969.0	7.0	75.0	3.0	2.00	2.00	3.00	2.00
45	1,971.0	11.0	33.0	6.0	2.00	1.00	5.00	2.00
46	0.0	12.0	60.0	6.0	2.00	1.00	7.00	1.00
47	0.0	2.0	55.0	9.5	2.00	1.00	2.00	2.00
48	1,988.0	12.0	500.0	16.0	2.00	2.00	7.00	2.00
49	1,995.0	21.0	90.0	8.0	2.00	2.00	1.00	2.00
50	1,994.0	8.0	45.0	21.0	2.00	2.00	4.00	2.00

t #	YRGRAD	DENOM	ATTEND	YRPAST	COUNSEL	POS_EXP	GROUPS	REFER_AA
51	1,977.0	2.0	60.0	17.0	2.00	1.00	2.00	2.00
52	1,980.0	2.0	150.0	8.5	2.00	2.00	2.00	2.00
53	1,977.0	10.0	35.0	25.0	2.00	2.00	2.00	2.00
54	1,981.0	22.0	100.0	2.0	2.00	2.00	12.00	1.00
55	1,997.0	12.0	150.0	12.0	2.00	2.00	7.00	2.00
56	1,976.0	4.0	65.0	25.0	2.00	1.00	1.00	1.00
57	0.0	8.0	15.0	40.0	2.00	1.00	4.00	1.00
58	1,982.0	12.0	70.0	19.0	2.00	1.00	7.00	2.00
59	1,979.0	12.0	25.0	22.0	1.00	1.00	7.00	2.00
60	1,987.0	12.0	50.0	3.0	2.00	2.00	7.00	1.00
61	1,982.0	2.0	90.0	2.0	2.00	2.00	2.00	2.00
62	1,991.0	2.0	35.0	7.0	2.00	1.00	2.00	2.00
63	1,983.0	4.0	105.0	24.0	2.00	1.00	1.00	2.00
64	1,984.0	12.0	15.0	1.0	2.00	1.00	7.00	2.00
65	1,974.0	1.0	10.0	15.0	2.00	1.00	1.00	2.00
66	1,981.0	9.0	200.0	20.0	2.00	1.00	11.00	1.00
67	1,975.0	23.0	80.0	35.0	2.00	2.00	1.00	2.00
68	0.0	24.0	12.0	3.0	2.00	1.00	1.00	2.00
69	1,976.0	12.0	40.0	20.0	2.00	2.00	7.00	2.00
70	1,965.0	17.0	150.0	35.0	2.00	2.00	10.00	2.00
71	1,983.0	24.0	70.0	12.0	2.00	2.00	1.00	1.00
72	0.0	1.0	40.0	9.0	2.00	1.00	1.00	1.00
73	1,988.0	7.0	98.0	5.0	2.00	2.00	3.00	1.00
74	1,982.0	19.0	100.0	20.0	2.00	2.00	6.00	2.00
75	1,973.0	17.0	25.0	2.5	2.00	2.00	10.00	2.00
76	1,970.0	12.0	70.0	2.0	2.00	1.00	7.00	2.00
77	1,981.0	20.0	150.0	20.0	2.00	1.00	12.00	2.00
78	1,979.0	25.0	40.0	11.0	2.00	2.00	1.00	2.00
79	1,988.0	0.0	35.0	14.0	2.00	2.00	2.00	2.00
80	0.0	16.0	78.0	3.5	2.00	2.00	7.00	2.00
81	1,970.0	8.0	12.0	0.0	1.00	2.00	4.00	2.00
82	1,995.0	12.0	30.0	30.0	2.00	2.00	7.00	1.00
83	1,986.0	8.0	50.0	16.0	2.00	1.00	4.00	2.00
84	1,975.0	7.0	130.0	3.0	2.00	1.00	3.00	2.00
85	1,993.0	9.0	200.0	5.0	2.00	2.00	11.00	1.00
86	1,980.0	13.0	130.0	21.0	2.00	2.00	8.00	2.00
87	1,959.0	7.0	64.0	4.5	2.00	1.00	3.00	2.00
88	1,985.0	13.0	50.0	19.0	1.00	1.00	8.00	2.00
89	1,962.0	20.0	35.0	32.0	2.00	1.00	12.00	2.00
90	2,000.0	26.0	200.0	22.0	2.00	2.00	1.00	1.00
91	1,979.0	12.0	50.0	23.0	2.00	1.00	7.00	2.00
92	1,973.0	3.0	39.0	39.0	2.00	2.00	2.00	2.00
93	1,988.0	17.0	65.0	12.0	2.00	2.00	10.00	2.00
94	2,001.0	12.0	20.0	7.0	2.00	2.00	7.00	2.00
95	0.0	0.0	0.0	0.0	2.00	2.00	0.00	2.00
96	1,980.0	2.0	50.0	20.0	2.00	2.00	2.00	2.00
97	1,994.0	22.0	120.0	18.0	2.00	2.00	12.00	2.00
98	1,970.0	24.0	80.0	27.0	2.00	2.00	1.00	1.00
99	1,995.0	22.0	180.0	10.0	2.00	1.00	12.00	1.00
100	1,975.0	22.0	83.0	27.0	2.00	1.00	12.00	2.00

Subject #	YRGRAD	DENOM	ATTEND	YRPAST	COUNSEL	POS_EXP	GROUPS	REFER_AA
101	1,977.0	27.0	40.0	0.0	1.00	1.00	13.00	2.00
102	1,974.0	12.0	120.0	13.0	2.00	2.00	7.00	2.00
103	1,996.0	19.0	85.0	6.0	1.00	2.00	6.00	2.00
104	1,991.0	18.0	120.0	8.0	2.00	2.00	11.00	1.00
105	0.0	11.0	160.0	23.0	2.00	2.00	5.00	0.00
106	1,964.0	9.0	200.0	34.0	0.00	0.00	11.00	2.00
107	1,982.0	19.0	65.0	10.0	2.00	2.00	6.00	2.00
108	1,967.0	2.0	50.0	33.0	2.00	1.00	2.00	2.00
109	1,970.0	19.0	60.0	32.0	2.00	2.00	6.00	2.00
110	1,973.0	1.0	80.0	23.0	1.00	2.00	1.00	1.00
111	1,975.0	1.0	85.0	30.0	2.00	2.00	1.00	2.00
112	1,978.0	2.0	500.0	23.0	2.00	2.00	2.00	2.00
113	1,989.0	14.0	27.0	12.0	2.00	2.00	9.00	2.00
114	1,989.0	14.0	50.0	14.0	2.00	2.00	9.00	1.00
115	0.0	28.0	22.0	10.0	2.00	2.00	4.00	2.00
116	2,001.0	2.0	60.0	26.0	2.00	2.00	2.00	2.00
117	1,997.0	8.0	110.0	12.0	2.00	2.00	4.00	1.00
118	0.0	17.0	200.0	10.0	2.00	2.00	10.00	2.00
119	1,969.0	19.0	50.0	22.0	2.00	2.00	6.00	2.00
120	1,975.0	29.0	0.0	20.0	1.00	2.00	11.00	2.00
121	1,964.0	0.0	45.0	35.0	2.00	1.00	0.00	2.00
122	1,982.0	14.0	21.0	20.0	2.00	2.00	9.00	2.00
123	0.0	12.0	65.0	15.0	1.00	1.00	7.00	2.00
124	1,985.0	3.0	70.0	17.0	2.00	2.00	2.00	1.00
125	1,958.0	17.0	50.0	10.0	2.00	2.00	10.00	2.00
126	1,976.0	2.0	35.0	26.0	2.00	2.00	2.00	1.00
127	1,975.0	12.0	200.0	22.0	2.00	2.00	7.00	2.00
128	1,971.0	0.0	150.0	30.0	2.00	2.00	0.00	2.00
129	1,989.0	11.0	60.0	12.0	1.00	1.00	5.00	2.00
130	0.0	1.0	200.0	12.0	2.00	1.00	1.00	2.00
131	1,972.0	13.0	25.0	6.0	2.00	1.00	8.00	2.00
132	2,001.0	12.0	200.0	3.0	2.00	2.00	7.00	1.00
133	0.0	24.0	150.0	16.0	2.00	2.00	1.00	2.00
134	1,998.0	12.0	55.0	7.0	2.00	2.00	7.00	1.00
135	1,994.0	5.0	180.0	6.5	2.00	1.00	13.00	1.00
136	1,972.0	30.0	12.0	6.0	1.00	2.00	13.00	2.00
137	1,957.0	18.0	20.0	40.0	1.00	1.00	11.00	1.00

#	REFER_AB	REFER_AC	NREFE_AA	NREFE_AB	NREFE_AC	NREFE_AD	NREFE_AE
1	2.00	2.00	2.00	2.00	1.00	2.00	1.00
2	2.00	2.00	2.00	2.00	2.00	2.00	2.00
3	2.00	2.00	2.00	2.00	2.00	2.00	2.00
4	2.00	1.00	2.00	2.00	2.00	1.00	2.00
5	1.00	2.00	2.00	2.00	2.00	2.00	2.00
6	2.00	1.00	2.00	2.00	2.00	1.00	2.00
7	2.00	2.00	2.00	2.00	2.00	1.00	1.00
8	2.00	2.00	2.00	2.00	2.00	2.00	2.00
9	2.00	2.00	2.00	2.00	2.00	2.00	2.00
10	1.00	2.00	2.00	1.00	2.00	2.00	2.00
11	1.00	2.00	2.00	2.00	2.00	1.00	2.00
12	1.00	2.00	2.00	2.00	2.00	2.00	2.00
13	2.00	2.00	2.00	2.00	2.00	2.00	2.00
14	2.00	2.00	2.00	2.00	2.00	2.00	1.00
15	1.00	2.00	2.00	2.00	2.00	1.00	2.00
16	1.00	2.00	2.00	2.00	2.00	2.00	2.00
17	2.00	2.00	2.00	2.00	2.00	2.00	2.00
18	2.00	1.00	2.00	1.00	2.00	2.00	2.00
19	1.00	1.00	2.00	1.00	2.00	1.00	2.00
20	2.00	1.00	1.00	1.00	2.00	2.00	2.00
21	2.00	2.00	1.00	1.00	2.00	2.00	1.00
22	1.00	2.00	2.00	2.00	2.00	1.00	1.00
23	2.00	2.00	2.00	2.00	2.00	2.00	2.00
24	1.00	2.00	1.00	1.00	2.00	2.00	2.00
25	1.00	2.00	2.00	2.00	2.00	2.00	2.00
26	1.00	2.00	2.00	2.00	2.00	2.00	3.00
27	1.00	2.00	2.00	2.00	2.00	2.00	2.00
28	1.00	2.00	2.00	2.00	2.00	1.00	2.00
29	2.00	2.00	2.00	2.00	2.00	2.00	2.00
30	2.00	2.00	2.00	2.00	2.00	2.00	2.00
31	2.00	2.00	2.00	2.00	2.00	2.00	2.00
32	2.00	1.00	2.00	2.00	2.00	2.00	2.00
33	2.00	1.00	2.00	2.00	2.00	2.00	1.00
34	2.00	2.00	2.00	1.00	2.00	2.00	2.00
35	2.00	2.00	2.00	2.00	2.00	1.00	1.00
36	1.00	2.00	2.00	2.00	2.00	1.00	2.00
37	2.00	2.00	2.00	2.00	2.00	2.00	2.00
38	2.00	2.00	2.00	2.00	2.00	2.00	2.00
39	2.00	2.00	2.00	2.00	2.00	2.00	2.00
40	2.00	2.00	2.00	2.00	2.00	2.00	2.00
41	2.00	2.00	2.00	2.00	2.00	2.00	2.00
42	1.00	2.00	2.00	2.00	2.00	1.00	2.00
43	1.00	2.00	2.00	2.00	2.00	2.00	2.00
44	2.00	2.00	2.00	2.00	2.00	2.00	2.00
45	2.00	1.00	2.00	2.00	1.00	2.00	2.00
46	2.00	2.00	1.00	2.00	2.00	2.00	2.00
47	2.00	2.00	2.00	2.00	2.00	2.00	2.00
48	1.00	2.00	2.00	2.00	2.00	1.00	2.00
49	1.00	2.00	2.00	2.00	2.00	2.00	1.00
50	1.00	2.00	2.00	2.00	2.00	1.00	2.00

Subject #	REFER_AB	REFER_AC	NREFE_AA	NREFE_AB	NREFE_AC	NREFE_AD	NREFE_AE
51	1.00	2.00	2.00	2.00	2.00	2.00	2.00
52	2.00	2.00	2.00	2.00	2.00	2.00	2.00
53	2.00	1.00	2.00	2.00	3.00	3.00	2.00
54	2.00	2.00	2.00	1.00	2.00	2.00	2.00
55	2.00	2.00	2.00	2.00	2.00	2.00	2.00
56	2.00	2.00	2.00	2.00	2.00	2.00	2.00
57	2.00	2.00	2.00	2.00	3.00	2.00	2.00
58	2.00	2.00	1.00	2.00	2.00	2.00	2.00
59	2.00	2.00	2.00	2.00	2.00	2.00	2.00
60	2.00	2.00	1.00	2.00	2.00	1.00	2.00
61	1.00	2.00	2.00	2.00	2.00	1.00	2.00
62	2.00	2.00	2.00	2.00	2.00	2.00	2.00
63	2.00	2.00	1.00	22.00	2.00	2.00	2.00
64	2.00	2.00	2.00	2.00	2.00	2.00	2.00
65	1.00	2.00	2.00	2.00	2.00	2.00	2.00
66	1.00	1.00	2.00	2.00	2.00	2.00	1.00
67	2.00	2.00	2.00	2.00	2.00	1.00	2.00
68	2.00	2.00	2.00	2.00	1.00	1.00	2.00
69	2.00	2.00	2.00	2.00	2.00	2.00	2.00
70	2.00	2.00	2.00	2.00	2.00	2.00	2.00
71	2.00	2.00	1.00	2.00	2.00	2.00	2.00
72	1.00	2.00	1.00	2.00	2.00	2.00	2.00
73	2.00	2.00	1.00	1.00	2.00	2.00	2.00
74	2.00	2.00	2.00	1.00	2.00	1.00	2.00
75	2.00	2.00	2.00	2.00	2.00	2.00	2.00
76	2.00	2.00	2.00	2.00	2.00	2.00	2.00
77	1.00	2.00	2.00	2.00	2.00	2.00	2.00
78	1.00	2.00	2.00	2.00	2.00	1.00	2.00
79	2.00	1.00	2.00	2.00	1.00	2.00	2.00
80	2.00	1.00	2.00	1.00	2.00	2.00	1.00
81	2.00	2.00	2.00	1.00	2.00	2.00	2.00
82	2.00	2.00	2.00	2.00	2.00	2.00	2.00
83	2.00	2.00	2.00	2.00	2.00	2.00	2.00
84	1.00	1.00	2.00	2.00	2.00	2.00	2.00
85	2.00	2.00	1.00	2.00	2.00	2.00	2.00
86	1.00	2.00	1.00	2.00	2.00	2.00	2.00
87	1.00	2.00	2.00	2.00	2.00	2.00	2.00
88	1.00	2.00	2.00	2.00	2.00	1.00	2.00
89	1.00	2.00	1.00	2.00	2.00	2.00	2.00
90	1.00	2.00	2.00	2.00	2.00	2.00	2.00
91	2.00	2.00	1.00	1.00	2.00	2.00	2.00
92	1.00	2.00	2.00	2.00	2.00	1.00	2.00
93	1.00	2.00	2.00	2.00	2.00	2.00	1.00
94	2.00	2.00	2.00	2.00	1.00	1.00	2.00
95	2.00	2.00	2.00	2.00	2.00	2.00	2.00
96	2.00	2.00	2.00	2.00	2.00	2.00	2.00
97	1.00	1.00	2.00	2.00	2.00	1.00	2.00
98	2.00	1.00	2.00	2.00	2.00	2.00	1.00
99	2.00	2.00	2.00	2.00	2.00	2.00	3.00
100	2.00	2.00	2.00	2.00	2.00	2.00	2.00

#	REFER_AB	REFER_AC	NREFE_AA	NREFE_AB	NREFE_AC	NREFE_AD	NREFE_AE
01	1.00	1.00	2.00	2.00	1.00	2.00	2.00
02	1.00	2.00	2.00	2.00	2.00	2.00	2.00
03	1.00	2.00	2.00	2.00	2.00	2.00	2.00
04	1.00	2.00	1.00	1.00	2.00	2.00	2.00
05	1.00	2.00	2.00	2.00	2.00	1.00	2.00
06	2.00	2.00	2.00	2.00	2.00	2.00	2.00
07	1.00	2.00	2.00	2.00	2.00	2.00	2.00
08	1.00	2.00	2.00	2.00	2.00	1.00	2.00
09	1.00	2.00	2.00	2.00	2.00	2.00	2.00
10	1.00	2.00	2.00	2.00	2.00	2.00	2.00
11	1.00	1.00	2.00	2.00	2.00	1.00	2.00
12	1.00	2.00	2.00	1.00	1.00	2.00	1.00
13	2.00	2.00	2.00	2.00	2.00	2.00	2.00
14	2.00	2.00	1.00	2.00	2.00	2.00	2.00
15	1.00	2.00	2.00	2.00	2.00	2.00	2.00
16	1.00	2.00	2.00	2.00	2.00	1.00	2.00
17	2.00	1.00	2.00	2.00	2.00	1.00	2.00
18	2.00	1.00	2.00	2.00	2.00	2.00	2.00
19	2.00	1.00	2.00	2.00	2.00	1.00	2.00
120	1.00	2.00	2.00	2.00	2.00	2.00	2.00
121	2.00	2.00	2.00	1.00	2.00	2.00	2.00
122	1.00	2.00	2.00	2.00	2.00	2.00	2.00
123	2.00	2.00	2.00	2.00	2.00	2.00	1.00
124	1.00	2.00	2.00	2.00	2.00	2.00	2.00
125	2.00	1.00	2.00	2.00	2.00	2.00	2.00
126	2.00	1.00	2.00	1.00	2.00	2.00	2.00
127	1.00	2.00	2.00	1.00	2.00	2.00	2.00
128	2.00	2.00	2.00	2.00	2.00	2.00	2.00
129	1.00	1.00	1.00	1.00	2.00	1.00	2.00
130	2.00	1.00	1.00	2.00	1.00	2.00	2.00
131	1.00	2.00	2.00	2.00	2.00	2.00	2.00
132	2.00	2.00	2.00	2.00	2.00	2.00	2.00
133	1.00	2.00	2.00	2.00	2.00	1.00	2.00
134	2.00	1.00	2.00	2.00	2.00	2.00	1.00
135	1.00	2.00	2.00	1.00	2.00	2.00	2.00
136	2.00	2.00	2.00	2.00	2.00	2.00	2.00
137	1.00	2.00	2.00	2.00	1.00	2.00	2.00

Subject #	NREFE_AF	REFER_OA	REFER_OB	REFER_OC	NREFE_OA	NREFE_OB	NREFE_OC
1	2.00	2.00	2.00	2.00	0.00	0.00	1.00
2	2.00	1.00	2.00	2.00	2.00	2.00	2.00
3	2.00	2.00	2.00	2.00	2.00	2.00	2.00
4	2.00	0.00	0.00	1.00	1.00	2.00	2.00
5	2.00	0.00	1.00	0.00	2.00	2.00	2.00
6	2.00	0.00	1.00	0.00	2.00	2.00	2.00
7	2.00	1.00	0.00	0.00	2.00	2.00	2.00
8	2.00	2.00	2.00	2.00	2.00	2.00	2.00
9	2.00	2.00	2.00	2.00	2.00	2.00	2.00
10	2.00	0.00	1.00	0.00	2.00	1.00	2.00
11	2.00	0.00	1.00	0.00	2.00	2.00	2.00
12	2.00	1.00	0.00	0.00	2.00	2.00	2.00
13	2.00	2.00	2.00	2.00	2.00	2.00	2.00
14	2.00	1.00	0.00	0.00	2.00	0.00	2.00
15	2.00	0.00	1.00	1.00	2.00	2.00	2.00
16	2.00	0.00	1.00	1.00	2.00	1.00	2.00
17	2.00	2.00	2.00	2.00	2.00	2.00	2.00
18	2.00	0.00	0.00	1.00	2.00	1.00	2.00
19	2.00	0.00	1.00	1.00	2.00	1.00	2.00
20	2.00	1.00	1.00	1.00	1.00	1.00	2.00
21	1.00	1.00	1.00	0.00	1.00	1.00	2.00
22	2.00	1.00	1.00	0.00	2.00	2.00	1.00
23	2.00	2.00	2.00	2.00	2.00	2.00	2.00
24	2.00	0.00	1.00	1.00	1.00	1.00	2.00
25	2.00	2.00	1.00	0.00	2.00	2.00	2.00
26	2.00	0.00	1.00	0.00	2.00	2.00	2.00
27	2.00	0.00	1.00	1.00	2.00	2.00	2.00
28	2.00	2.00	1.00	2.00	2.00	2.00	1.00
29	2.00	2.00	2.00	2.00	2.00	2.00	2.00
30	2.00	1.00	2.00	2.00	2.00	2.00	2.00
31	2.00	2.00	2.00	2.00	2.00	2.00	2.00
32	2.00	2.00	2.00	1.00	2.00	2.00	2.00
33	2.00	2.00	2.00	1.00	1.00	2.00	2.00
34	2.00	1.00	2.00	2.00	2.00	1.00	2.00
35	2.00	1.00	2.00	2.00	1.00	2.00	2.00
36	2.00	1.00	1.00	1.00	2.00	2.00	2.00
37	2.00	2.00	1.00	2.00	2.00	2.00	2.00
38	2.00	2.00	2.00	2.00	2.00	2.00	2.00
39	2.00	2.00	2.00	2.00	2.00	2.00	2.00
40	2.00	1.00	2.00	2.00	2.00	2.00	1.00
41	2.00	2.00	2.00	2.00	2.00	2.00	2.00
42	2.00	1.00	1.00	2.00	2.00	2.00	2.00
43	1.00	2.00	1.00	2.00	2.00	2.00	2.00
44	2.00	2.00	2.00	2.00	2.00	2.00	2.00
45	2.00	2.00	2.00	1.00	2.00	2.00	1.00
46	2.00	1.00	2.00	2.00	1.00	2.00	2.00
47	2.00	2.00	2.00	2.00	2.00	2.00	2.00
48	2.00	2.00	1.00	2.00	2.00	2.00	2.00
49	2.00	2.00	1.00	2.00	2.00	2.00	2.00
50	2.00	1.00	1.00	2.00	2.00	2.00	2.00

#	NREFE_AF	REFER_OA	REFER_OB	REFER_OC	NREFE_OA	NREFE_OB	NREFE_OC
51	2.00	2.00	1.00	2.00	2.00	2.00	2.00
52	2.00	2.00	2.00	2.00	2.00	2.00	2.00
53	2.00	1.00	2.00	2.00	2.00	2.00	2.00
54	2.00	1.00	2.00	2.00	2.00	1.00	2.00
55	2.00	2.00	2.00	2.00	2.00	2.00	2.00
56	1.00	1.00	1.00	2.00	1.00	2.00	2.00
57	2.00	1.00	2.00	2.00	2.00	2.00	2.00
58	2.00	2.00	2.00	2.00	1.00	2.00	2.00
59	2.00	2.00	2.00	2.00	2.00	2.00	2.00
60	2.00	1.00	2.00	2.00	1.00	2.00	2.00
61	2.00	1.00	2.00	2.00	2.00	2.00	2.00
62	2.00	2.00	2.00	2.00	2.00	2.00	2.00
63	2.00	2.00	2.00	2.00	1.00	2.00	2.00
64	2.00	2.00	2.00	2.00	2.00	2.00	2.00
65	2.00	0.00	1.00	2.00	2.00	2.00	2.00
66	1.00	1.00	1.00	2.00	2.00	1.00	2.00
67	2.00	2.00	1.00	2.00	2.00	2.00	2.00
68	2.00	2.00	2.00	2.00	2.00	2.00	1.00
69	2.00	2.00	2.00	2.00	2.00	2.00	2.00
70	2.00	2.00	2.00	2.00	2.00	2.00	2.00
71	2.00	1.00	2.00	2.00	1.00	2.00	2.00
72	2.00	1.00	2.00	2.00	1.00	2.00	2.00
73	2.00	1.00	1.00	2.00	1.00	2.00	2.00
74	2.00	1.00	2.00	2.00	1.00	2.00	2.00
75	2.00	2.00	2.00	2.00	2.00	2.00	2.00
76	2.00	2.00	2.00	2.00	2.00	2.00	2.00
77	2.00	1.00	2.00	2.00	1.00	2.00	2.00
78	2.00	2.00	1.00	2.00	2.00	2.00	1.00
79	2.00	2.00	2.00	1.00	2.00	2.00	1.00
80	2.00	2.00	2.00	1.00	2.00	2.00	2.00
81	2.00	2.00	2.00	2.00	1.00	2.00	2.00
82	2.00	1.00	0.00	2.00	2.00	2.00	2.00
83	2.00	2.00	2.00	2.00	2.00	2.00	2.00
84	2.00	2.00	1.00	1.00	2.00	2.00	2.00
85	2.00	1.00	2.00	2.00	1.00	2.00	2.00
86	2.00	2.00	1.00	2.00	1.00	2.00	2.00
87	2.00	2.00	1.00	2.00	2.00	1.00	2.00
88	2.00	2.00	1.00	2.00	2.00	2.00	2.00
89	2.00	2.00	1.00	2.00	1.00	2.00	2.00
90	2.00	1.00	1.00	1.00	2.00	2.00	2.00
91	2.00	2.00	2.00	2.00	1.00	2.00	2.00
92	2.00	2.00	1.00	2.00	2.00	2.00	2.00
93	1.00	2.00	1.00	2.00	2.00	2.00	1.00
94	2.00	2.00	2.00	2.00	2.00	2.00	2.00
95	2.00	2.00	2.00	2.00	2.00	2.00	2.00
96	2.00	2.00	2.00	2.00	2.00	2.00	2.00
97	2.00	2.00	1.00	1.00	2.00	2.00	2.00
98	2.00	1.00	1.00	1.00	2.00	2.00	2.00
99	2.00	1.00	2.00	2.00	2.00	2.00	2.00
100	2.00	2.00	2.00	2.00	2.00	1.00	2.00

Subject #	NREFE_AF	REFER_OA	REFER_OB	REFER_OC	NREFE_OA	NREFE_OB	NREFE_OC
101	2.00	2.00	1.00	2.00	2.00	2.00	2.00
102	2.00	2.00	2.00	1.00	2.00	2.00	2.00
103	2.00	2.00	1.00	2.00	2.00	2.00	2.00
104	2.00	1.00	1.00	2.00	1.00	1.00	2.00
105	2.00	2.00	1.00	1.00	2.00	2.00	2.00
106	2.00	2.00	1.00	2.00	2.00	2.00	2.00
107	2.00	2.00	1.00	1.00	2.00	2.00	2.00
108	2.00	2.00	1.00	2.00	2.00	2.00	2.00
109	2.00	2.00	1.00	2.00	2.00	1.00	2.00
110	2.00	1.00	1.00	2.00	2.00	2.00	2.00
111	2.00	12.00	1.00	1.00	2.00	2.00	2.00
112	1.00	2.00	1.00	2.00	2.00	2.00	2.00
113	2.00	2.00	2.00	2.00	2.00	2.00	2.00
114	2.00	1.00	2.00	2.00	1.00	2.00	2.00
115	1.00	2.00	1.00	2.00	2.00	2.00	2.00
116	2.00	2.00	1.00	2.00	2.00	2.00	2.00
117	2.00	2.00	1.00	2.00	2.00	2.00	2.00
118	2.00	2.00	2.00	1.00	2.00	2.00	2.00
119	2.00	2.00	2.00	1.00	2.00	2.00	1.00
120	2.00	2.00	1.00	2.00	2.00	2.00	2.00
121	2.00	2.00	2.00	2.00	2.00	1.00	2.00
122	1.00	1.00	1.00	2.00	2.00	2.00	1.00
123	2.00	2.00	2.00	2.00	2.00	2.00	2.00
124	2.00	1.00	1.00	2.00	2.00	1.00	2.00
125	2.00	2.00	2.00	1.00	2.00	2.00	2.00
126	2.00	1.00	2.00	1.00	1.00	1.00	2.00
127	2.00	2.00	1.00	2.00	2.00	1.00	2.00
128	2.00	2.00	2.00	2.00	2.00	2.00	2.00
129	2.00	2.00	1.00	1.00	1.00	1.00	1.00
130	2.00	2.00	1.00	1.00	1.00	2.00	1.00
131	2.00	2.00	1.00	2.00	2.00	2.00	2.00
132	2.00	1.00	2.00	2.00	2.00	2.00	2.00
133	2.00	2.00	1.00	2.00	2.00	2.00	2.00
134	2.00	1.00	1.00	2.00	2.00	2.00	1.00
135	2.00	1.00	1.00	1.00	2.00	1.00	2.00
136	2.00	2.00	2.00	2.00	2.00	2.00	2.00
137	2.00	1.00	1.00	2.00	2.00	2.00	1.00

#	NREFE_OD	NREFE_OE	NREFE_OF	MATCHING	HYP3_1	HYP3_1B
1	0.00	1.00	0.00	2.00	5.75	1.67
2	2.00	2.00	2.00	1.00	5.25	2.33
3	2.00	2.00	2.00	2.00	6.00	1.00
4	1.00	2.00	2.00	2.00	5.00	1.00
5	2.00	2.00	2.00	2.00	3.25	1.00
6	1.00	2.00	2.00	2.00	5.00	3.00
7	2.00	1.00	2.00	2.00	4.25	6.00
8	2.00	2.00	2.00	2.00	5.00	2.00
9	2.00	2.00	2.00	2.00	4.25	1.00
10	2.00	2.00	2.00	2.00	6.00	1.00
11	1.00	2.00	2.00	2.00	6.00	3.00
12	2.00	2.00	2.00	2.00	6.00	1.00
13	2.00	2.00	2.00	2.00	4.25	1.33
14	2.00	1.00	2.00	2.00	5.50	1.67
15	1.00	2.00	2.00	2.00	5.50	1.00
16	2.00	2.00	2.00	2.00	6.00	3.67
17	2.00	2.00	2.00	2.00	4.75	1.33
18	2.00	2.00	2.00	2.00	4.75	1.00
19	1.00	2.00	2.00	2.00	5.00	5.00
20	2.00	2.00	2.00	2.00	4.00	2.67
21	2.00	1.00	1.00	2.00	5.00	3.00
22	1.00	1.00	2.00	2.00	4.50	1.00
23	2.00	2.00	2.00	2.00	6.00	5.33
24	2.00	2.00	2.00	2.00	4.75	2.33
25	2.00	2.00	2.00	2.00	6.00	6.00
26	2.00	2.00	2.00	2.00	4.75	5.00
27	2.00	2.00	2.00	2.00	4.75	5.67
28	2.00	2.00	2.00	2.00	4.50	4.33
29	2.00	2.00	2.00	2.00	4.00	1.00
30	2.00	2.00	2.00	2.00	2.50	1.00
31	2.00	2.00	2.00	2.00	5.00	1.33
32	2.00	2.00	2.00	2.00	6.00	1.00
33	1.00	2.00	2.00	2.00	5.00	1.00
34	2.00	2.00	2.00	2.00	1.00	4.33
35	1.00	1.00	2.00	2.00	5.00	1.00
36	1.00	2.00	2.00	2.00	5.00	3.33
37	2.00	2.00	2.00	2.00	5.00	1.00
38	2.00	2.00	2.00	2.00	6.00	3.67
39	2.00	2.00	2.00	2.00	0.00	0.00
40	2.00	2.00	2.00	2.00	5.00	1.67
41	2.00	2.00	2.00	2.00	5.50	1.67
42	1.00	2.00	2.00	2.00	5.50	3.00
43	2.00	2.00	1.00	2.00	3.50	1.00
44	2.00	2.00	2.00	2.00	6.00	1.00
45	2.00	2.00	2.00	2.00	3.75	2.00
46	2.00	2.00	1.00	2.00	6.00	1.00
47	2.00	2.00	2.00	2.00	4.00	1.00
48	1.00	2.00	2.00	2.00	5.25	1.33
49	2.00	1.00	0.00	2.00	5.00	1.00
50	1.00	2.00	2.00	2.00	4.75	4.67

Subject #	NREFE_OD	NREFE_OE	NREFE_OF	MATCHING	HYP3_1	HYP3_1B
51	2.00	2.00	2.00	2.00	5.25	1.00
52	2.00	2.00	2.00	2.00	5.00	2.00
53	2.00	2.00	2.00	2.00	4.50	2.33
54	2.00	2.00	2.00	2.00	6.00	6.00
55	2.00	2.00	2.00	2.00	6.00	3.67
56	1.00	2.00	1.00	2.00	5.00	2.00
57	2.00	2.00	2.00	2.00	4.75	2.00
58	2.00	2.00	2.00	2.00	1.00	1.00
59	2.00	2.00	2.00	2.00	6.00	1.00
60	2.00	2.00	2.00	2.00	4.50	1.00
61	1.00	2.00	2.00	2.00	6.00	1.67
62	2.00	2.00	2.00	2.00	5.50	1.00
63	2.00	2.00	2.00	2.00	5.00	1.00
64	2.00	2.00	2.00	2.00	1.00	1.00
65	2.00	2.00	2.00	2.00	5.75	1.67
66	2.00	1.00	1.00	2.00	6.00	3.33
67	1.00	2.00	2.00	2.00	4.75	1.00
68	1.00	2.00	2.00	2.00	6.00	3.00
69	2.00	2.00	2.00	2.00	5.50	2.00
70	2.00	2.00	2.00	2.00	6.00	1.00
71	2.00	2.00	2.00	2.00	3.50	1.00
72	2.00	2.00	2.00	2.00	5.00	1.67
73	2.00	2.00	2.00	2.00	5.50	3.33
74	2.00	2.00	2.00	2.00	5.00	3.67
75	2.00	2.00	2.00	2.00	5.00	1.00
76	2.00	2.00	2.00	2.00	5.25	1.00
77	2.00	2.00	2.00	2.00	5.50	1.00
78	1.00	2.00	2.00	2.00	5.75	4.33
79	2.00	2.00	2.00	2.00	5.25	4.33
80	2.00	1.00	2.00	2.00	6.00	3.00
81	2.00	0.00	2.00	2.00	6.00	1.33
82	2.00	2.00	2.00	2.00	6.00	2.00
83	2.00	2.00	2.00	2.00	6.00	2.00
84	2.00	2.00	2.00	2.00	6.00	2.67
85	2.00	2.00	2.00	2.00	5.50	4.00
86	2.00	2.00	2.00	2.00	6.00	2.67
87	2.00	2.00	2.00	2.00	5.00	2.33
88	1.00	2.00	2.00	2.00	5.50	3.00
89	2.00	2.00	2.00	2.00	6.00	1.00
90	2.00	2.00	2.00	2.00	5.00	2.00
91	1.00	2.00	2.00	2.00	1.00	1.00
92	2.00	2.00	2.00	2.00	4.50	1.00
93	2.00	1.00	1.00	2.00	5.00	2.33
94	2.00	2.00	2.00	2.00	4.38	1.00
95	2.00	2.00	2.00	2.00	4.75	0.00
96	2.00	2.00	2.00	2.00	6.00	1.00
97	1.00	2.00	2.00	2.00	6.00	1.00
98	2.00	1.00	2.00	2.00	5.00	1.33
99	2.00	2.00	2.00	2.00	4.75	3.00
100	2.00	2.00	2.00	2.00	1.00	1.00

	NREFE_OD	NREFE_OE	NREFE_OF	MATCHING	HYP3_1	HYP3_1B
1	2.00	2.00	1.00	2.00	4.25	5.00
2	2.00	2.00	2.00	2.00	6.00	2.00
3	2.00	2.00	2.00	2.00	5.00	2.33
4	2.00	2.00	2.00	2.00	6.00	6.00
5	1.00	2.00	2.00	2.00	5.25	2.00
6	2.00	2.00	2.00	2.00	3.50	5.67
7	2.00	2.00	2.00	2.00	5.00	3.33
8	1.00	2.00	2.00	2.00	5.50	1.67
9	2.00	2.00	2.00	2.00	5.00	2.67
10	2.00	2.00	1.00	2.00	1.25	6.00
11	1.00	2.00	2.00	2.00	5.00	1.67
12	0.00	1.00	1.00	2.00	6.00	6.00
13	2.00	2.00	2.00	2.00	5.00	2.67
14	2.00	2.00	2.00	2.00	5.00	1.33
15	2.00	2.00	1.00	2.00	6.00	1.00
16	2.00	2.00	2.00	2.00	4.75	2.00
17	1.00	2.00	2.00	2.00	6.00	3.67
18	2.00	2.00	2.00	2.00	6.00	2.00
19	2.00	2.00	2.00	2.00	4.50	5.00
20	2.00	2.00	2.00	2.00	4.75	4.33
21	2.00	2.00	2.00	2.00	0.00	0.00
22	2.00	2.00	1.00	2.00	4.25	5.00
23	2.00	1.00	2.00	2.00	6.00	1.67
24	2.00	2.00	2.00	2.00	6.00	2.33
25	2.00	2.00	2.00	2.00	6.00	1.00
26	2.00	2.00	2.00	2.00	5.00	1.33
27	2.00	2.00	2.00	2.00	6.00	1.00
28	2.00	2.00	2.00	2.00	4.00	1.33
29	2.00	2.00	2.00	2.00	5.50	3.67
30	2.00	2.00	2.00	2.00	4.75	2.33
31	2.00	2.00	2.00	2.00	5.75	1.00
32	2.00	2.00	2.00	2.00	6.00	1.00
33	1.00	2.00	2.00	2.00	6.00	1.00
34	2.00	1.00	2.00	2.00	4.50	1.00
35	2.00	2.00	2.00	2.00	5.00	2.33
36	2.00	2.00	2.00	2.00	4.50	2.67
37	2.00	2.00	2.00	2.00	4.00	5.00

Appendix C

Qualitative Raw Data

Qualitative Raw Data

'his section contains each pastor's responses exactly as they were written to the last |ualitative question listed on the survey. Each pastor's response was given a number, ınd the response to the first question was titled "a." The response to the second question vas titled "b." The pastor could respond to either or both parts. The question reads, '30a. Please describe your reasons for referring to a mental health professional:" and '30b. Please describe your reasons for not referring to a mental health professional:"

b. We live 80 miles from closest Christian Mental health professionals. People here who are most in need or emotional and mental health counseling can not afford a private Christian mental health professional.

!a. People often need different kinds of help. In this area addiction recovery is a big issue.

ia. To assist
ib. unnecessary

la. I cannot recall ever referring someone to non-Christian counseling. If someone I am counseling is ılready meeting with a non-Christian counselor, I do not dissuade them but do my part in their life as well. recognize that people can gain practical help from non-Christian counselors.
lb. I personally struggle over the differences in worldview described by the Bible of the character and ıature of humanity with its Biblical solutions as the worldview of the modern mental health institutions vho rely heavily on theories from men like Freud and Jung rather than Jesus, Paul and others within the :ontext of Christianity. I recognize that Today many Christian counselors also study and implement these nen's teaching (Freud and Jung) but I am very uncomfortable with the differences between my Christian vorldview and the worldview of the majority of mental health professionals.

5a. I am only trained to do 3 sessions with someone and then its time to refer

5a. To help people resolve their issues and for help from someone outside the local area. Confidentiality is ı problem in such a small and close community.
5b. Don't trust them or they abuse their profession.

7a. In marriage and family affairs – for 3rd party "objective" opinions. Symptoms of extreme psychosis; lrugs and alcohol abuse, child and/or spousal abuse. Harm to themselves and/or others.
7b. 1. High cost fees. That NO ONE CAN AFFORD! 2. the "medicate and release" syndrome that is ɔervasive in mental health – 3. Drug them up but don't deal with the real issues and problems; also no lisclosures on the terrible "side effects" of so-called "legal" drugs.

10a. My inability to cope with the person being counseled.
10b. Person does not seem (appear) to have any mental disabilities.

11a. 1. needed for long-term (more than 2-3 sessions) 2. specialized need beyond my competence
11b. lack of similar or even supportive belief system.

12. Note: as a pastor, not a licensed counselor, we are only able to coach not counsel, so please every time you have counsel it means coach to me.
12a. for possible chemical imbalance.

14a. Drug and alcohol is very relevant in this area – also too much "fly by night" religious practitioners have spread distrust before leaving the area.
14b. Overworked mental health staff.

15a. Although we received some training in counseling at our seminary, I am not an expert in the field by any means. If I perceive that a church member has a condition that requires medical attention or extensive counseling I will refer them to a Christian counselor or psychiatrist.
15b. I wouldn't refer anyone to a non-Christian counselor. My experience has been that non-Christian therapists tend to make light of Christian teachings , and can instill doubts in the minds of Christian people. Sometimes they have counseled members to get a divorce, for example, even though I as a pastor, have tried to keep the marriage together. Obviously, atheists aren't interested in doing what is pleasing to God, so that's a problem.

16a. mental health professionals can help when an individual needs to feel that confidentiality is paramount (privacy even including from pastor of a church). Mental health professionals have medical background, often necessary.

18a. I will and have referred troubled individuals to psychiatric care when it appears there is a need for treatment with medications which only a doctor can provide.
18b. It is not my belief that a psychologist can provide any significant service that I am not able to provide. The pastor of this church recently passed away. I have only been this pastor for this congregation for a short period of time. I am sorry for the delay in response but there was no pastor here to respond for two months.

19a. 1. People who do things all the time tend to be better than people who are part-time. 2. Objectivity may be better. 3. ability to prescribe medications.
19b. Does not appear to be severe or organic problem. 2. Would not send a person to a health professional who saw faith as a part of the problem rather than part of the support system.

20a. Some cases need medications for severe depression, and some people need professional assistance and counseling will not be sufficient alone.
20b. Some cases just need spiritual guidance, counseling about marriage problems, or just someone to talk to and need a good listener who is not judgmental and is patient and caring enough. Some just need someone to help them to pray, encourage them, or reassure them.

21a. ~ When significant depression exists
~ When requested by the parishioner to do so
~ In the case of eating disorders
~ When I think there are also medical (i.e. hormonal) issues involved
21b. ~When the person's issue(s) are spiritual
~ When the problem (s) are not too complex and can be handled in 1-3 sessions by myself
~ When the parishioner is not amenable to it or doesn't have any insurance or other funds or pay.

22a. A person's anxiety level, the complexity of their issues, time and energy constraints of my own, severity of crisis. There are certain areas of counseling I am not comfortable and/or not competent to handle.
22b. Lack of resources and skill sets in available counselors skepticism of pharmacology-based approaches. Biblical values and commitment of the available counselors. As counselors might be skeptical of ministers regarding their counseling skills or training, the reverse is also true.

24a. Some people need specific help which I am not qualified or able to give.
24b. Some people simply need assurance that God loves them and that there are other people who care for them.

25a. Because of need for on-going support and counseling
25b. In cases where c** is prohibitive, or where pastoral counseling is unwanted

26a. I'll always make a referral if someone comes to be with a problem beyond my competence. Thought I've taken counseling classes I have no counseling-related degree. I make no pretense about knowing all the answers.

b. see 30a

'a. when I recognize that the "client" needs help that I cannot provide, I would (and do) readily refer that rson to an M.H. professional for their well-being.

ia. I have no formal training when it comes to dealing with mental health issues, I believe that competent elp is essential. I believe that to attempt things I know nothing about does much more harm than good.
ib. Only if I know the mental health professional to be professionally incompetent.

)a. After much prayer, if the Lord would lead me in this direction. First I would try applying God's ord.

2a. need for skilled professional assessment and answers

3a. I have had a couple situations which I need professional Christian counseling for individuals in need f help I have a Pastor in a neighboring town with a license in counseling and that is who I have used for elp.
3b. Secular mental health professionals come from a directions that helps people very little at all. Most iat I have any experience with have hurt patients more than help them, by enforcing selfishness and self-enteredness, rather than teaching them to treat others as they would want tot be treated. Christ really does hange people and set them free of bondages, if people will make a total commitment to him.

4a. If the person is hearing voices of receiving perceived rationale from irrational sources
4b. If the person engages in rational thoughts and actions

5a. Almost all referrals are to experienced counselors in the area of parenting skills concerning child iscipline techniques. Other referrals related to drug and alcohol dependency.
5b. Many are highly educated incompetents. Poor people skills. Excessive Costs. Many are irreligious. 'ew Christian counselors counsel like Christ is the solution.

i6a. I would refer people with Axis II dx, particularly Borderlines, etc. Chronic and severe depression equiring medication, e.g. Bipolars, major depressives and suicidal ideation, because of litigation in xtreme circumstances I'm uncomfortable counseling women unless I know them, so would refer to a emale therapist.
16b. Incompetence, poor reputation, inexperience.

17a. I sought a professional who could help bring truth into a situation where a lie was believed. Many attle within their minds with lies Satan brings and need help finding the truth which sets them free. Since lesus is truth, he is the one to bring truth (the light)_into a dark situation.

39a. as needed based on a counseling session.

40a. Someone with serious mental problems
40b. may not have spiritual background.

42a. I have referred to mental health professional when I have encountered issues in counseling that are outside of my training as a pastor. I view my role in counseling primarily as one of providing spiritual comfort to those in distress and spiritual guidance. When I believe I am encountering mental illness, I refer to a mental health professional as they are better trained to treat such illness. When I encounter behavioral problems that seem entrenched in someone's life, I refer to a mental health professional. Whenever I encounter a problem that is beyond my training/ability, I refer elsewhere.
b. I would not refer to a mental health professional when I believed was incompetent or trustworthy. This has happened once during my ministry. Thus for questions 12 and 14, I am assuming competence, or I would answer 2 instead of 5. I would avoid non-Christian agnostic, or atheistic professionals if only I believed their belief system was a part of their treatment program. Thus far, I have only referred to openly Christian mental health professionals.

43a. problems beyond my expertise
43b. objections from family

45a. the availability of a mental health professional.
45b. the lack of availability.

46a. if there was unstable activity in their lives or were suicidal.
46b. I believe in the health and deliverance ministry of Jesus Christ of Nazareth. Sometimes, though, people don't want to change themselves or their ways, if they are unwilling to change then they need professional help.

48a. – for reasons of confidentiality
for reasons that a m.h.p. has more experience handling a particular area of counseling
for reasons that a party paying a m.h.p. may be more able to follow through on commitments
48b. lack of competence due to a non-xian belief system
focus of m.h.p. as self-centered approach to counseling vs. a God-centered approach
**** that a m.h.p. rather than *** a married couple to come together would further complicate the relationship

49a. when a situation is over my head or my area of expertise.
49b. if cost is an issue.

50a. 1. if the persons problems are more of a mental health issue than a spiritual issue.
the amount of time required. With my other responsibilities, short-term counseling is something I can realistically offer
If the person of I think that we won't make a good "fit." (so that the person can best benefit from the work involved).
If I feel that I am "over my head" in terms of the issues involved

50b. 1. If the professional is antagonistic to religion.
If the professional is only professional and not personally caring.
If the professional is, in my judgment, incompetent.
If the professional has a clear pattern of personally being unable to live what he/she is counseling others to do.
51a. I have limited counseling training and/or experience except for premarital.

53a. In doing foster care some 14 yrs. Many times it took us several days to get the kids settled down and back up to the point there were before, so we used Christian ones as often as possible and that helped a lot.
53b. Part A of above.

54a. Specialized issues such as eating disorders, entrenched personality disorders, acute psychosis, psychosis not yet maintained by medication, sexual disorders, etc.
54b. If the individual is a member of our church and it is an issue I feel competent to deal with effectively.

56a. If I could see in the course of counseling that the person had other problems such as physical that had a bearing on a mental need.
56b. Either no confidence in the professional or the person sees the problem and the Biblical solution but is unwilling to do anything about it, (not unable).

57a. Depression and marital problems.
57b. Have no reasons not to.

58a. As a Christian pastor, I would not
58b. For the Christian, God has given us everything we need in his Word, the Bible, 2 Peter 1:3

0a. The only time I would do that is if the said person was look at by a physician and proved to have erious mental or physiological problems that could only be helped by medication. I have found that many eople on prozack, paxil, etc. really have no emotional problems, but are unwilling to deal with life's roblems or difficulties. However, people with previous drug abuse I have found to have damage to parts f their brains because of that abuse. Those people I have noticed benefit from these drugs and help. hose forementioned usually suffer more than they had to begin with.

0b. Most deal with head problems and not heart problems! I.e. "ere you abused a s a child?" – what to hem is abuse? Taking out the trash, going to bed at 9:00 pm, etc. The door is too wide. The real problem oday is that people don't want to obey the Lord. Story – a lady came to a Pastor suffering from depression le prayed with her, but still suffered. She journalled all of her prayers to the Lord. Finally convinced by a riend to take prozack, she felt great – however, she realized after 1 year of being on meds, she had stopped raying, journaling, and caring about the things of the Lord. So she slowly quit taking them and though she egan to feel the depression come again she was also on her knees in prayer. Jesus is the Great physician, nd he has a plan for each of us we just need to be OBEDIENT to he and his word. He will bake our paths traight. Thank you, pastor *****.

51a. Related issues are beyond my scope and ability. Long-term prognosis may require more time or commitment than I can give.

51b. MH professional has voiced or demonstrated a disdain or lack of appreciation of spiritual things. The bible says we are body, souls and spirit, Secular therapy treats only 2/3 or the Christian, whose spirit is alive in Christ. 1 cor 5:17, Hebrews 4:12.

53b. Mental health, is, in many cases, a spiritual matter that needs to be addressed with prayer and changing of habitual patterns. It is not always the answer-to medicate or to counsel apart from God's involvement in our lives through the Holy Spirit.

55a. I would refer to a mental health professional with the client I am working with is agreeable and requires counseling/advice I am unable to provide.

56a. When I realize that the personality problems are not rooted in sin, guilt, and shame, but rather are irrational or paranoia I refer them to someone who is qualified to handle these problems. We have branches of Catholic social Services in our divorces and I refer the person to them for help, especially when their financial resources are limited.

66b. If the person can't afford it.
The person has a bad attitude and won't take the advice.
The person is looking for attention and doesn't want to face reality.

67a. Only if person does not want Biblical counseling.
67b. I believe secular counseling is a farce.

68b. After wife died, needed someone to talk to. Specific counselor involved (only one in the instance available) was pro-homosexual.

71b. The majority of problems in a persons life is a result of a persons spiritual relationship with God. There are times when medication can help because of chemical imbalances.

72a. mental illness.
72b. many times things assumed to be mental illness are in fact spiritual problems.

73a. If there is a suspected chemical imbalance I refer for a second opinion. Certain issues such as eating disorders and some forms of domestic violence need expertise beyond my capability.

73b. Most moral and ethical issues are best addressed by myself because they involve doctrine.

74a. I refer when someone clearly is showing suicidal tendencies. Also if a person seems out of touch with reality.

74b. When the issue is about spiritual struggle and growth issues and there are none of the above tendencies.

75b. I don't run into the situation very often.

77a. Problems too severe or needing long term care.

77b. Concern about values/Christianity.

78a. I will refer for reasons:

1. If problem is beyond my scope or ability.
2. If I lack the time to treat.
3. For reasons to maintain objectivity in my pastoral role

78b. I will not refer to mental health professionals who are antagonistic to Christian values, or to counselors who I do not find to be competent to treat people effectively.

79ab. A good practitioner can be effective in his/her field of treatment as a good physician is in theirs. When I refer to mental health professionals, I always ask the person receiving treatment to sign a waiver giving me access to their clinical data. I want to continue pastoral -spiritual care alongside their therapy. One difficulty - I have recently come to 2 small isolated communities where good mental health care is hardly available without a long drive.

80a. If it was something that after prayer and counseling on my own, I would seek advice from a mental health professional.

80b. I would try at first to solve the problem in my house. Many people don't have the funds. Health professional have too many cases to be personal .

81b. No one in this congregation has any training in counseling, also there is a liability issue. Everyone has problems to deal with but I have not met anyone at church who required professional help. Should such a situation arise, we would inquire locally for assistance. I would definitely favor a Christian counselor, but would not totally rule out a non-Christian.

82a. Marital/family counseling
Sexual/Physical abuse issues
Substance/Alcohol Abuse counseling

83a. I have not referred as of yet, but if I had a better relationship with practicing mhp, I would probably refer more serious cases.
83b. Don't know them or for privacy reasons.

84a. When the challenges that people face exceed my own experience. IN the church, we have our own mental health professionals who also understand and can counsel individuals who share common beliefs. There is more to life than what is understood by most mental health professionals.

84b. If there was a need I wouldn't hesitate.

85a. Not sure I understand what you mean.) Psychiatric problems/disorders
Marriage counseling
Grief counseling
Family/Child counseling

b. Strictly religious /spiritual issues

a. For issues and factors beyond my educational or training expertise.

ib. Sometimes I am able to discern that the problem is primarily spiritual.

'a. I am not qualified to handle it.

'b. We have out own system of psychologists within our church for help to the members.

la. My skills are limited. I'm a good listener but not a mental health expert.

lb. I would only refuse if I had no confidence in the mental health professional

)a. I would refer a person to a mental health professional if I felt the person was beyond my ability to elp.

)b. If I felt the persons problem was primarily of a spiritual nature, I would not be quick to refer the erson to a mental health professional.

0a. Areas outside my own competency i.e. child cutting themselves. I referred this one out to a Christian sychologist.

1a. I do not refer to them.

1b. I believe in the Bible as the only counseling tool. God's word is sufficient. Psychiatry/Psychology re flawed in that every model is based on a theistic method and not matter how many Bible verses are icked on, it is still an anti-Christian system.

2a. I would have to be sure they need more professional help than I could provide.

2b. "mental health professionals" are in many ways like "pastors" in that one the surface you do not eally know what they have been exposed to in their training. We have mental health professionals who are ruly Christians. On the other hand we have CHRISTIAN mental health professionals. I would not be eally interested in sending someone to a "Christian" mental health professional who was not biblically ualified to serve as an elder 1 Timothy 3:1-7 & Titus 1:7-9.

)3a. If they are beyond my ability
Time-if I have enough
If I have done all I could
If they request it.

)3b. No one to refer to for what they need.
They don't want it
They don't have the money - I still suggest they try to work something out.

)4b. Most are steeped in non-Biblically based belief systems and either purposefully or ignorantly practice paganism or witchcraft.

97a. If I would do this, It would be cases that required long-term care

97b. Not sure of competency of Biblical beliefs.

FYI: We are opening a Christian counseling center here at the church. I have a MFFCC degree but I am referring more people to our counseling center.

98a. There are times when a person has a chemical imbalance and needs professional care with medication. I seek out care-givers who use medication in a very restrictive environment.

98b. The logic of the hour in many areas of mental heal is to simply medicate, medicate, medicate.

99a. Really have mental health problems.

99b. Have other problems relate.

100a. none.

100b. because not any mental people in my church Pastor ****.

101a. 1. Concern for well being of person
2. Lack of expertise
3. Positive personal experience with marriage counselor

101b. Lack of a broad knowledge of people (profs) available.
Probably wouldn't be approached by a member for this purpose.

102a. They have the training and tools as well as the time to work with people with certain difficulties.

103a. I will counsel people in spiritual matters and in an emergency setting but will refer persons needing on-going professional help to a trained counselor. I have had basic and crisis counseling training but it is not my field.

103b. I would refer because I am not trained for on-going counseling, I haven't the time and I don't want to risk being sued.

104a. If someone has a n obvious clinical problem.
I someone needs more than I have training for.
I f there is an any kind of abuse, drug, violence, or any issue that society would consider the venue of the health professional.

104b. I f the problem is spiritual.
I f there person just needs a friend or a shoulder to cry on.
If the problem is pastoral or life-cycle related (birth, marriage, kids, teens, death, divorce, etc.)

105a. Mental health professionals have training and experience that I do not. When I meet with persons, I tell them that I offer pastoral care but am not trained as a counselor. Mental health professionals are also prepared (set up) to do long-term work with a client if that is needed. I also think that the financial investment made to am mental health professional often causes a client to take more seriously the work the my put in to their recovery.

105b. My only reason for not referring would be if I am suspect of a particular mental health professionals core beliefs or values or ethics.

106a. I do not counsel mental health. I counsel spiritual health.

107a. If I feel it is beyond my ability to handle it, I would refer people to a professional based on competency - but if a Christian and a non-Christian have the same level of competency and training and ethical practice, I would choose a Christian.

108a. I would refer for areas I feel are beyond my ability to handle or where time would prevent proper care to meet the needs of the person. Understand: Counseling is not by strength, but something that is trust

pon me by nature of my position. Even then, it is mostly premarital counseling. Spiritual counsel for life irection is more one on one, not someone wanting "counseling" In my office.

08b. Some of the people I have met in the professional mental health occupation impress me as ›anipulative and unstable themselves. Event their appearance turns people away. But these are the xception. Many mean well and impress me as capable people.

09a. When a person whom I am counseling has problems and/or needs beyond my capabilities, I will efer to whatever professional expertise that person needs. Sometimes a mental health professional.

09b. If the persons problems and or needs are within my scope of expertise and capabilities, I do not efer.

10a. I refer often because I feel unqualified to deal with deeper emotional issues. I have referred for exual dysfunction, irreconcilable marriage issues. I do not counsel often. Much of my pulpit ministry ddress inner spiritual and emotional need from a biblical foundation. Many of those needs are also met vhen people actively pursue vial relationships in the body of Christ.

10b. I don't refer when people seem unwilling to pursue their healing by fulfilling basic "homework" ıssignments I have them. I also do not continue until they make such commitments.

11a. I would refer to a mental health professional if the individual is a Christian, and if I have confidence n them. These might be mental or emotional problems out of my realm of expertise.

11b. I do not agree with many of the anti-scriptural humanistic philosophies perpetrated by mental health ;ystems and groups. If I know and trust the individual, which you are able to do in rural areas, I may go ıhead.

112a. When counselee needs more specialized help than I have provide.

112b. Unavailable/too expensive
Counselee won't go.

114a. In areas of sexual abuse, where there has been much childhood trauma, and I feel victim should be seen by a professional.

114b. If presenting problem deals with spiritual issues, I will work with the person.

115a. If I cannot help someone I refer them to someone who can.

115b. Only if my Biblical counseling goes unheeded.

116a. 1. If it (the problem) is out of my expertise (training and experience) then I refer.
2. If the person is too "close" to me and it would be more comfortable to them or me to talk to someone else.

116b. 1. Different "worldviews"
2. Some are really incompetent.

117a. If I felt it was beyond my scope of practice or beyond resources i.e. crisis requiring psychiatric hospitalization, wanting evaluation for psychotropic medication.

117b. Not familiar with therapist or mental health clinic. If mental health therapist promotes divorce.

118a. Most of them have insights and a few simple questions and observations that can help pin-point the basic issues quickly.

119a. I have had clinical training working toward a ph. D. in psychology. I firmly believe in the value of therapy with a competent therapist who is also gifted.

119b. In my opinion, many are not competent or gifted.

120a. If I am consulted by a believer with emotional or psychological problems that go beyond issues of a purely religious kind, I always suggest that he or she contact a competent counselor, psychologist, or psychiatrist.

120b. None. Anyone needing counseling should consult a competent mental health professional, in my opinion.

121a. a social worker helped a particular problem.

121b. Few cases needed mental health therapy.

122a. If I feel the person I am in conversation with is in need of care outside of my ability and if I felt that person would help my conversation partner, then I would have no reason to delay in referring.

122b. If, however, the person I am in conversation with is not ready/willing/able and especially if the mental health professional is not competent then I would be more hesitant.

123a. Identification with problem for relative cure; social, mental, physical, spiritual

123b. Drug pushers.

124a. drug and alcohol abuse
instances beyond my abilities
children needing help
specialized needs
some abusive relationships
those which I don't seem to be helping or who aren't making progress

124b. those willing to work and respond
those growing with the counseling offered
those without specific specialized problems

125a. need for skilled professional assessment and answers.

126a. As well as serving as a pastor, I am also serving as a law enforcement chaplain. I would refer a person to counseling if I thought they needed to be evaluated for a mental illness. Those who have been diagnosed with a mental illness and showed signs of being violent, I would also refer to a specialist.

126b. I feel confident in my ability to give Biblical counsel to my church members and other counsel to members of the community as well. The church has been counseling people long before mental health professionals. Spiritual counseling is still valid for people of faith. Most mental health counseling is secular. I believe if people are going to improve themselves they need two things: 1) Believe is someone bigger than themselves (God) and 2) They need to be involved in helping others (ministry).

127a. Cases where I felt an individual needed a professionally trained person. When I had cases that I felt went "over my head."

127b. When it was situations I felt were not of a serious nature and I felt competent to help.

129a. If a person needs help that is beyond limited experience

If a person needs help that is not obviously just of a spiritual (rather than psychological) nature
If that mental health professional will work with , rather than against, the Christian faith

9b. If a person needs only simple help.
If a person needs only spiritual advice
If available mental health professional are antagonistic towards Christian faith.

0a. If individual was not willing or able to receive the ministry of our church.
If I know of a competent person.

0b. Belief in God's power to transform lives.
New to this pastorate and I do not know a mental health professional

1a. Because I am not qualified to help persons beyond premarital, marital (to a point) or normal pastoral unseling

32a. Mental health issues

33a. If they wouldn't accept Biblical principles to overcome issues

33b. Secular humanism that has infiltrated the counseling profession

34a. When counseling is obviously a mental illness or requires medication. Most of my counseling is arital or family relationship problems.

34b. See above. Also, because there are few Christian counselors who are reasonable in cost.

35a. Problems that are out of my scope of ability to deal with e.g. eating disorders, psychoses, etc.
Family situations requiring long-term close attention
If I have confidence that the counselor will be able to deal with them differently

35b. Temporary interruptions in an otherwise stable situation.
Unbelievers tend to be all over the board in terms of values. Believers are hard enough to figure ut.

37a. More technical and up to date skills than I have
Certain areas of mental health in which I do not feel competent
i.e. child abuse or extreme mental illness

37b. None unless none competent in area

Appendix D

Curriculum Vitae

CURRICULUM VITAE

for

ALICIA ANN CLARK, M.A.

135 Fox Point Loop Rd.
Evanston, WY 82930
(307) 789-2675 or e-mail: aachandl@georgefox.edu

I. Education

2001-Present **Clinical Psychology Preintern, Psy.D. expected 2005**
Graduate School of Clinical Psychology, *APA accredited*
George Fox University
Newberg, OR
2002 Richter Scholars Grant
2002 Ministerial Service Award

1999-2001 **Master of Arts in Clinical Psychology**
Graduate School of Clinical Psychology, *APA accredited*
George Fox University
Newberg, OR

1999 (May – June) **Archeology Expedition: Israel Department of Antiquities**
Hardin-Simmons University (by affiliation)
Kuriat Shemona, Northern Galilee, Israel, Tel Banias

1995-1999 **Bachelor of Arts: Biblical Studies,** ***Magna Cum Laude***
Hardin-Simmons University's Logsdon School of Theology
Abilene, Texas
2000 Outstanding Achievement in Old Testament Studies
1996-1999 President List Scholarship
1999 Dean's List Scholarship
1995-1999 ACT Academic Scholarship

II. Clinical Experience

Sept 2003- Present **The Children's Center**
Pre-intern student therapist at preschooler's attachment clinic
- Provide individual play therapy, parent-child, therapy, and testing
- Develop treatment plans, therapy, observation, and testing
- Weekly individual supervision with Doug Goldsmith, Ph.D.

Aug 2002- May 2003 **Tualatin Valley Mental Health,** *APA accredited*
Pre-intern student therapist at a large community mental health
- Provided individual adult therapy, co-lead girl's art group for traumatized 8-10 year-olds, and couples therapy
- Intakes, treatment planning, consultation to a multidisciplinary team
- Specialized training in DBT and alcohol and drug treatment
- Weekly individual supervision with Ken Ihli, Ph.D. and group supervision with James Gurule, M.A.

Sept 2002- May 2003 **Oregon Psychoanalytic Institute's Foundation Clinic**
Pre-intern and volunteer therapist at adult outpatient clinic
- Provided twice weekly long-term psychotherapy for low-income clients
- 3½ hours of bi-monthly supervision with analyst Betsy Iaunnacello, LCSW and analyst Harold Boverman, M.D.

Sept 2001- Dec 2001 **ParentCare**
Practicum II student and co-facilitator of outpatient group
- Lead psychoeducational groups for parents of children ages 0-4 years, facilitated personality testing
- Weekly supervision by Terry Bennick Ph.D.

Sept 2001- May 2002 **Newberg Independent School District**
Practicum II student/Testing clinician
- Conducted assessments of children in grades K-12 for the diagnosis and treatment planning of learning disabilities
- Presented assessment findings to teachers and parents
- Weekly supervision with school psychologist Dionne Bradley, M.A.

Aug 2001- May 2002 **George Fox University: Health and Counseling Center**
Practicum II student therapist at a university counseling center
- Provided intakes, reports, testing, treatment planning, and weekly therapy with undergraduate adults and couples
- Weekly group and individual supervision with Bill Buhrow, Jr., Psy.D.

Feb 2000- June 2001 **Pacific Gateway Hospital**
Practicum I student and Mental Health Professional for an inpatient, acute and sub-acute mental health hospital for adolescents, adults, and geriatric
- Provided individual, process and psychoeducational group therapy, intakes and biopsychosocial reports, treatment planning, milieu therapy
- Weekly and bi-monthly supervision by Art Kowitch, Ph.D. and George Howard, Psy.D.

III. Relevant Clinical Training and Work Experience

Sept 2003- Present **Children's Trauma Team Network** *West Wyoming Division*
Mental Health Practitioner serving in the community
- Participate in national training and outreach organizations
- Bi-monthly meeting attendance with local and regional members
- Semi-annual conference gatherings

Aug 2002- May 2003 **George Fox University Graduate School of Clinical Psychology**
Pre-intern Overseer
- Monitored clinical skills of graduate students by providing weekly supervision and consultation, reviewing cases, and regular evaluations
- Received weekly supervision with Nancy Thurston, Psy.D. and Carol Dell'Oliver, Ph.D

Sept 2002 - **Psychodynamic Group Seminar**
May 2003 Co-lead monthly psychodynamic seminar for graduate students
- Focused on application of object relations theories to clinical cases
- Joined by Kurt Free, Ph.D.

Sept 2002 **Service Externship to California: "We Care Crescent City"**
- Directed and organized a group of graduate students on an externship
- Intended to provide low-income, underserved individuals with basic psychoeducational materials and resources and group follow-up
- Upon a tragedy, provided crisis debriefing and acute stress management
- Joined by Clark Campbell, Ph.D.

July 2002 - **American Psychoanalytic Society: Mentoring Program**
May 2003 Graduate student mentee of the American Psychoanalytic Society
- Bi-monthly meetings of case supervision, literature review, education, and professional development with a certified training analyst
- Mentored by analyst Lee Shershow, M.D.

July 2001- **Mental Health Partners**
April 2003 Qualified Mental Health Professional with four inpatient hospitals
- Intakes, psychosocial reports, individual and group therapy, crisis management; milieu management
- Promoted to Team Lead, on-call
- Supervised individual shifts, reorganized group system
- Supervision with Kay Endures, M.A.

April 2001 - **Stanford-Binet Restandardization Technician**
May 2002 Testing clinician for the national standardization of the Stanford-Binet V
- Gave the Stanford-Binet IV and Bender-Gestalt III to people aged 2-80, matching the 2001 United States census demographics
- Supervised by Gale Roid, Ph.D. and Rachele Floyd, M.A.

Jan 1997- **Hendrick Medical Hospital**
May 1997 Critical/Intensive Care Attendant for medical hospital PICU unit
- Provided support for family members experiencing crises
- Consulted with multidisciplinary medical, nursing, and chaplain treatment team

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III. Administrative Employment

July 1999- **Warnaco, Calvin Klein Incorporated**
Feb 2000 Key Managed Calvin Klein outlet retail store
- Supervise and train employees in retail procedures, manage store profits and maintain accounting/book-keeping duties, open and close store

Oct 1997- **Stage Stores Incorporated**
June 1999 Customer and service sales representative
- Maintain register and floor sales, manage customer service desk, conduct opening and closing procedures for the store

V. Publications and Presentations

Clark, A. (2003). *Mental Health Referral Patterns of Rural Pastors.* Richter Scholars Presentation: Newberg, OR

Chandler, A. (2003). *We care Crescent City: Outreach and ministerial service and crisis debriefing.* George Fox University's Graduate School of Clinical Psychology: Newberg, OR.

Campbell, C. D., Gordon, M. C., & **Chandler, A. A.** (2002). Wide open spaces: Meeting mental health needs in underserved rural areas. *Journal of Psychology and Christianity, 21,*325-332.

Chandler, A. (2002). *Barriers to benefits: Religion as a resource for the rural woman.* National Rural Woman's Health Conference: Washington, DC.

VI. Research Experience

"Mental Health Referral Patterns of Rural Pastors" Doctoral Dissertation
Committee: Clark Campbell, Ph.D., Rodger Bufford, Ph.D., Bill Buhrows, Psy.D.
Preliminary Oral: February, 2002 Final Defense: May 15, 2003
Current Standing: Full Pass Newberg, OR

Research Vertical Team at George Fox University
Participation in faculty-led team of students researching social responsibility, marital and family systems, and rural psychology. Supervised by Clark Campbell, Ph.D.
2000-2003 Newberg, OR

VI. Teaching Experience

Fall 2002- Spring 2003 **Graduate Assistant**
Introduction to Counseling
Taught classes in basic clinical skills, supervised lab, graded courses, upper-level undergraduate course in counseling and psychotherapy

Fall 2002 **Guest Lecturer**
Personality Theory
"Freud and Psychoanalysis" for graduate students in clinical psychology

Fall 2001 **Guest Lecturer**
Theories of Psychology
"Existential therapy and Rollo May" for upper-level undergraduate students

Fall 2000- Spring 2001 **Regular Guest Lecturer**
General Clinical Psychology
"The Practice of Psychotherapy" for undergraduate students at public university

Fall 2001 **Guest Lecturer**
Introduction to Psychology
"Learning and Memory" for undergraduate psychology students

Spring 2000 **Guest Lecturer**
Introduction to Psychology
"The Application of Psychology to Everyday Life" for undergraduate students

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VII. Additional Clinical Training

"2nd Annual Child Trauma Treatment Network – Intermountain West Conference"
"Working together to improve the treatment for abused children" September, 2003
Hosted by: National Child Trauma Treatment Network Snowbird, UT

"HIPPA Compliance" April, 2003
Speaker: Rodger Bufford, Ph.D. Newberg, OR

"Eating Disorders: Awareness and Treatment" February, 2003
Hosted by: University of Virginia Counseling and Psychological Charlottesville, VA

"The Intergenerational Transmission of Trauma" February, 2003
Speaker: Stephen Seligman, M.D. Portland, OR

"Contemporary Psychodynamic Treatment of Eating Disorders" January, 2003
Speaker: Katherine Zerbe, M.D Portland, OR

"Integration of Religion and Psychotherapy: Explicit, Implicit, or What? October 2002
Speaker: Robert Lovinger, Ph.D., ABPP Newberg, OR

"Assessment and Treatment of Traumatized Children" October 2002
Speaker: Sophie Lovinger, Ph.D., ABPP Newberg, OR

"Attachment Disorder, Posttraumatic Stress, and Intergenerational Trauma: Etiological Implications for Brain Functioning in Tribal/Native Behavioral Health Treatments"
Speaker: Joseph B. Stone, Ph.D., CAC III, ICEADC April 2002
Newberg, OR

"Prevalence Rates of Full and Partial PTSD in Lifetime Trauma in a Sample of Adult Members of an American Indian Tribe" April, 2002
Speaker: Thomas J. Ball, Ph.D. Newberg, OR

National Rural Women's Health Conference (3 day conference) September, 2002
Hosted by: Pennsylvania State University Washington, D.C.

"Contemporary Psychoanalytic Diagnosis and Treatment Implications." March, 2002
Nancy McWilliams, Ph.D. Seattle, WA

"Age Specific Interventions for Inpatient and Outpatient Clients" & "Treatment Considerations for a Chemically Dependent Patient in an Inpatient Setting" Michael Brashears, Ph.D.	April, 2001 Portland, OR
"Substance Abuse Disorders: Diagnosis, Treatment, and Co-morbidity" Speaker: Shayne Hayden, Ph.D.	March, 2001 Newberg, OR
"Finding God in Prozac" Speaker: Michael Bovin, Ph.D.	February, 2001 Newberg, OR
"Neuroscience and Memory: Contemporary Studies" Speaker: James L. McGaugh, Ph.D.	October, 2000 OMSI, Portland
"Shalom: Entering God's Rest in a Restless World" Presented by: CAPS West Conference	September, 2000 S. Valley, CA
"Integration in the Peace Church Tradition" Speaker: Hendrika VandeKamp, Ph.D.	March, 2000 Newberg, OR
"Considerations for Treatment with African American Clients" Speaker: Kumea Gooden, Ph.D.	January, 2000 Newberg, OR
"Psychotherapy with Geriatric Patients" Speaker: Cliff Singer, Ph.D	August, 1999 Newberg, OR

XIII. Professional Affiliations

Children's Trauma Team Network
West Wyoming active team member
American Psychological Association, graduate student affiliate
Christian Association for Psychological Studies, graduate student affiliate
Sigma Alpha Iota, alumni affiliate
Rose and Honors Chair
Alpha Iota Omega, alumni affiliate
Chaplain, Social Chair, Special Events Chair
George Fox University – Peer Mentor, Chapel Worship Leader
Mazamas Mountaineering Club

IX. Testing Log

ADULT ASSESSMENT LOG

Name of Test	# Administered and Scored	# of Reports Written
Bender Gestalt	15	2
California Verbal Learning Test	3	5
Complex Figure Drawing	3	1
Halstead-Reitan Neuropsychological Battery (portions)	2	1
Hooper Visual Organization Test	1	1

Millon Clinical Multi-Axial Inventory III (MCMI)	5	6
Minnesota Multiphasic Personality Inventory II (MMPI)	8	10
Myers-Briggs Type Indicator I (MBI)	2	1
Personality Assessment Inventory (PAI)	4	2
Projective Sentences	5	3
Projective Drawings	3	5
Purdue Peg Board	3	2
Reitan-Indiana Aphasia Screening Test	1	1
Rorschach (scoring system: Exner)	7	9
Self-report measures of symptoms / disorders	18	20
Stanford-Binet 5	6	1
Structured Diagnostic Interviews	7	9
Thematic Apperception Test (TAT)	2	2
Trail Making Test A & B	4	6
Wechsler Adult Intelligence Scale III (WAIS)	14	17
Wechsler Memory Scale III (WMS)	2	2
Wisconsin Card Sort	3	1
W (WIAT)	10	11
Wide Range Achievement Test (WRAT)	2	5
16 Personality Factor (16PF)	3	3

Child and Adolescent Assessment Log

California Verbal Learning Test	1	1
Child Apperception Test (CAT)	3	2
Connors Scales (ADD assessment)	2	1
Diagnostic Interviews	19	19
Hooper Visual Organization Test	1	2
Incomplete Sentences Tests	4	3
Minnesota Multiphasic Personality Inventory A (MMPI)	5	2
Parent Report Measures	5	4
Projective Drawing Tests	10	12
Reitan-Indiana Aphasia Screening Test	1	1
Rorschach (scoring system: Exner)	3	2
Stanford-Binet 5	3	1
Weschler Intelligence Scale for Children III (WISC)	23	24
Weschler Preschool Population Scale of Intelligence R (WPPSI)	4	4
Wide Range Achievement Test (WRAT)	2	3
Wide Range Assessment of Memory and Learning (WRAML)	3	2