

Spring 2019

Let the Church say amen! A qualitative study exploring the experiences of African American pastors providing mental health support

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Let the Church Say Amen! A Qualitative Study Exploring the Experiences of African

American Pastors Providing Mental Health Support

Tiffanie D. Sutherlin

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Philosophy

Department of Graduate Psychology

May 2019

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Dedication

This dissertation is dedicated to Robert H Sutherlin Sr. You passed away two months after my birth but I feel your presence every day. Through the stories I've been told, I know you and I would have been inseparable. You will forever be my guardian angel and I will always be your "sniff sniff".

Acknowledgements

I would first like to give God all the honor, glory, and praise. Without him I would not be where I am today nor would I have been blessed with this dissertation topic. God has been my biggest cheerleader and has opened doors that I never thought imaginable while on my journey to earn my Ph.D. There have been many times where I just wanted to give it up but I could feel his presence helping to motivate me and push me along.

I would like to thank my family who has supported me endlessly. To my parents, Myron and Gillian, you two have been my angels on earth. There have been so many times where I did not know if I would make it and you both prayed for me and were my strength when I was weak. I would not be here without you both. Thank you for always supporting me and doing everything possible to make my dreams come true. To my sister, Monica. You have always been my biggest cheerleader and have challenged me to go harder and at times when I just could not handle it you were my shoulder to lean on. I thank you for the genuine and unconditional love and support that you have always shown me.

I would like to thank my dissertation chair Dr. Michele Kielty for always being there for me and helping me to navigate some of the most important years of my life. You have shown me so much support and kindness. You dedicated so much time to ensuring I would not only be successful but that I would thrive in any and every thing that I intend to do. I would like to thank my committee members, Dr. Renee Staton and Dr. Robin Anderson, for their support and guidance during my time at James Madison University. I

would also like to thank Dr. Lennis Echterling who has been supportive since the first day I entered the program. I am grateful to have not only learned from you but to have shared priceless moments of endless laughter and conversation.

I thank my cohort members “The Fab Four” Mina Attia, Cierra Davis, and Kristy Koser.

We have been on a journey that not many can relate to. I thank you for the endless support, long nights of studying, and commitment to uplifting one another from beginning to end. We did it!

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Abstract

The purpose of this qualitative study was to understand how African American Pastors experience their role as mental health supporters. Researchers are continuing to conduct research to better understand some of the challenges and barriers African Americans may experience that impacts their attitudes towards mental health services. Many African Americans identify as spiritual or religious and implement coping skills based on their spiritual or religious connection to a High Power. This researcher focused on four male and four female Pastors who identified as African American and were located in the Eastern Region of the United States. The participants engaged in one semi-structured interview with the researcher. Open coding and axial coding were used to analyze the data and identify themes that emerged from the interviews. The following research questions were used to guide the study: (1) What are African Americans Pastors' experiences of mental health issues in the Black church (2) What are African Americans Pastors' beliefs in referring members to clinicians in the community (3) What are African Americans Pastors' experiences with clinicians in the mental health community and (4) What approaches can the mental health community can take in building relationships with local churches.

Chapter 1: Introduction

Issues Unique to the African American Population

African Americans have been underrepresented in utilizing mental health services as compared to other ethnic minority and majority groups (Avent, Cashwell, & Brown-Jeffy, 2015). Researchers are continuing to conduct research to better understand some of the challenges and barriers African Americans may experience that impacts their attitudes towards mental health services. Specifically, more research has been conducted that examines if there is a relationship between the discrimination of African Americans and their overall wellbeing. Racial discrimination is defined as an intentional act that affects the self-esteem of racially identified people or those who have historically experienced oppression (Dulin-Keita, Hannon, Fernandez, & Cockerman, 2011; Sowell, 1986). African Americans have a long history of experiencing discrimination during the slavery era and during the era of the Civil Rights Movement. The experiences of discrimination can have both short term and long term effects that can impact African Americans health physically, psychologically, and emotionally. Scholars have further researched if there is a relationship between the racial identity of African Americans and overall wellbeing. Hughes, Kiecolt, Keith, and Demo (2015) concluded that African Americans rated higher on overall wellbeing, higher self-esteem, and decreased depressive symptoms when they were able to racially identify with their group and feel socially accepted amongst other African Americans.

Discrimination can take its toll physically, emotionally, and psychologically on an individual. Researchers have noticed a possible connection between discrimination and symptoms of anxiety and depression. The Diagnostic and Statistical Manual of Mental

Disorders (5th ed.; DSM-5) defines anxiety as when one experiences fear as an emotional response to a real or perceived immediate threat, and anxiety is the anticipation of a perceivable threat (American Psychiatric Association, 2013). With anxiety there may be an excessive amount of worry that is often uncontrollable and includes the tendency to fixate the worry on a specific event or situations (Dugas & Koerner, 2005). In most instances, a person experiencing anxiety will attempt to avoid the stimuli or situation that produces the anxiety. According to the National Alliance on Mental Health (NAMI), African Americans are 20 percent more likely to experience mental health issues (“African American mental health”, n.d.). Researchers are beginning to examine the lived experiences of African Americans and how this may contribute to experiencing anxiety symptoms (Carter, Sbrocco, & Carter, 1996).

It has been found that experiencing racial discrimination can increase the psychological symptoms for African Americans (Jackson, Brown, Williams, Torres, Sellers, & Brown, 1996). Smith, Allen, and Danley (2007) founded the term “racial battle fatigue” which is a psychological response that presents as stress or emotional withdrawal when experiencing a microaggression. These symptoms can often mirror the symptoms present in an anxiety disorder such as muscle tension, restlessness, difficulty sleeping, and excessive worrying (Huppert & Sanderson, 2005; Soto, Dawson-Andoh, & BeLue, 2011). Salami and Walker (2014) found that hopelessness was a recurring component in African Americans’ experience of anxiety. Hopelessness can be defined as, “the perception that one had no control over what was going to happen and by absolute certainty that an important bad outcome was going to occur or that a highly desired good outcome was not going to occur” (Carson, Butcher, & Mineka, 2000, p. 239).

The DSM-5 identifies sadness, feeling empty, or irritable mood paired with somatic and cognitive changes that can severely impact a person's ability to function as the major characteristics of depression (American Psychiatric Association, 2013). According to the National Institute of Mental Health (NIMH) 16.2 million adults have experienced at least one major depressive episode with 5 percent of African Americans having experienced a major depressive episode ("Major Depression", 2017). Researchers have found that the etiology of depression for African Americans may stem from experiences of racism or unequal treatment (Williams, Chapman, Wong, & Turkheimer, 2012). It is also suspected that if an individual is not able to successfully connect to their ethnic identity, symptoms of loneliness and depression can manifest (Williams et. al).

As previously mentioned, researchers are conducting more research to examine the barriers that may contribute to African Americans' underutilization of mental health services.

These barriers may include availability of counseling, accessibility issues, cost, personal and cultural attitudes, stigma, and lack of knowledge or awareness about the mental health resources available (Copeland & Synder, 2011). Although the counseling field continues to grow and expand, services are still not available to several individuals.

Approximately 60 million Americans live in rural communities with 12 percent of those residents identifying as African American (Probst, Samuels, Jespersen, Willert, Swann, & McDuffie, 2002). If mental health services are not available in a certain location, an individual may have to travel an extensive distance or will choose to not receive services (Turpin, Bartlett, Kavanagh, & Gallois, 2007). African Americans may also have a preference to receive support from counselors of a similar cultural or racial background

(Cabral & Smith, 2011). Although research does not directly support the claim that matching African American clients based on cultural or racial background will lead to a better treatment outcome, it has been found that such a matching positively correlates to the duration of the treatment (Takeuchi, Sue, & Yeh, 1995).

Research has shown that having positive attitudes towards receiving mental health services results in positive treatment outcomes (Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016). Stigma can be defined as, “a collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders” (Gary, 2005, p. 980). Labels can cause African Americans to refuse seeking mental health treatment for fear of experiencing a double stigma (Gary, 2005). A double stigma can become a barrier that negatively impacts help seeking behaviors and causes underutilization of mental health services. Anglin, Link, & Phelan (2006) found that African Americans were more likely than Caucasians to perceive individuals with a mental illness as dangerous or violent. African Americans also associated shame and embarrassment with mental illness (Thompson, Bazile, & Akbar, 2004). This perception may reaffirm the reasons why African Americans choose to not utilize mental health services. Terrell and Terrell (1981) first coined the term “cultural mistrust” to help explain the distrust that African Americans have developed of Caucasian clinicians. Researchers have conducted studies to better understand the concept of trust within the counseling relationship between African American clients and Caucasian counselors. Researchers have found that African American clients tend to refrain from sharing intimate information with

Caucasian counselors for fear of being misunderstood or being treated in a prejudicial fashion (Thompson, Worthington, & Atkinson, 1994).

Researchers continue to explore what factors may contribute to the low representation of African Americans seeking mental health support and have identified knowledge as one component. Briggs, Banks, & Briggs (2014) found that African Americans report a lack of knowledge and awareness as a reason for not seeking mental health support. Depending on factors such as availability, geographic location, stigma, etc. African Americans may not be aware of the specific services available or have an understanding the potential benefits. Briggs et. al also found that over 50 percent of African American participants in that particular study felt they were unaware of the different types of mental health disorders.

Religion and Spirituality as a Form of Coping

Spirituality can be understood as an individuals' lived experience (Kelly, 2004). Gallacher (2014) explains spirituality as a personal experience that incorporates one's values and belief system. Specifically, spirituality allows an individual to explore their purpose and meaning in life their own way (Gallacher). According to a survey by the U.S. Religious Landscape Survey, 87 percent of African Americans reported belonging to a religious group and 79 percent reported religion to be very important in their life ("A religious portrait of African Americans", 2009). Spirituality can include various forms of religion coping which include internal religious coping and external religious coping. Internal religious coping takes place within a person and is impacted by their thoughts, actions, and motivation. Internal religious coping can include activities such as journaling, studying scripture, prayer, and relationship with God (Moreno, Nelson, &

Caredmil, 2017). Having positive coping strategies in place has been linked to a higher wellbeing, increase in life satisfaction, improved health, and decreased stress (Chapman & Steger, 2010). Prayer is a common form of coping amongst African Americans (Ellison & Taylor, 1996). Researchers have found that individuals who engaged in prayer more have a higher satisfaction in personal relationships, a sense of purpose, and positive emotional wellbeing (Ellison, Bradshaw, Flannelly, & Galek, 2014).

External religious coping is the second most common form of religious coping along with internal coping. External religious coping involves an individual seeking resources other than those that exist internally. This form of coping requires the individual to display help seeking behaviors in that they are seeking more support from others to supplement what they are able to receive when using internal religious coping methods. External coping activities such as attending church services and increased involvement have been linked to increased psychosocial health outcomes (Szymanski & Obiri, 2011).

Adaptive coping is a form coping connected to religious coping strategies and its' foundations are in religious and spiritual beliefs that aim to help individuals cope with difficult situations by providing support and positivity (Lee & Chan, 2009; Pargament, Koenig, & Perez, 2000). Adaptive coping relies heavily on implementing positive strategies that will be beneficial to an individual and provides support through the situation. Jacinto (2010) found self-forgiveness to be an important concept in adaptive coping. Self-forgiveness is a process for an individual in that they work through a stage of unforgiveness to forgiveness for either themselves or other people (Jacinto). Maladaptive coping is a form of coping that integrates strategies that cause negative

outcomes for an individual. In maladaptive religious coping the relationship with God is seen as distant, non-existent, and less secure (Pargament, Smith, Koenig, & Perez, 1998). Researchers have found that individuals will chose maladaptive coping based on their thoughts, behaviors, and relationship with God and the severity of the stressful situation (Pargament et al.).

Role of the Black Church

The Black Church has played a critical role in the lives of many African Americans. Although there is no operational definition for The Black Church, it can be conceptualized as, “those independent, historic, and totally black controlled denominations, which were founded after the Free African Society of 1787 and which constituted the core of black Christians” (Lincoln & Mamiya, 1990, p.1). Specifically, the Black Church provides a safe space for African Americans to come together to receive and provide social support. Church involvement and activities provide a way for African Americans to feel a sense of inclusion and for members to interact with one another. Researchers have found that religious participation and social interactions results in positive mental and physical health benefits for African Americans. The structure of the Black Church can be conceptualized as a family unit. For example, the head of the household is represented by the Pastor and the congregation members represent family members.

Role of the Pastor

A Pastor serves as not only a spiritual guide but also provides support for members financially, emotionally, and psychologically. Pastors provide spiritual messages to their congregation members, and these messages can be practical and

applicable to one's everyday life. On the individual level, Pastors can serve as a spiritual guide during congregation members' journeys (Plunkett, 2014). While Pastors do provide support within the walls of the church, their responsibilities may also require them to visit church members in other locations. This allows members who are unable to attend service to still be connected with their Pastor. Pastors may also perform pastoral counseling in their leadership role. Pastoral counseling is a process in which Pastors, ministers, and etc. provide therapy which includes a spiritual components (Dayringer, 2012).

Pastors can be seen as the bridge that connects referrals of congregation members to mental health services in the community (Bilkins, Allen, Davey, & Davey, 2016). Although there is a scarcity in the research as it relates to African American Pastors' attitudes towards mental health, different factors such as the Pastors' personal experiences, cultural worldview, and understanding of mental health issues can either increase or decrease the likelihood of a community-based referral. Cultural beliefs may impact not only the interventions a Pastor utilizes, but also their conceptualization of the underlying causes of certain mental health issues (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013). Based on the Pastor's religious denomination, certain messages received from specific religious denominations can influence how a Pastor approaches mental health conditions in the church.

Pastors who have sought out mental health services and have personally experienced counseling are more likely to refer congregation members to mental health services in the community (Brown & McCreary, 2014). Pastor's will rely on their own personal experiences in order to provide support and also to provide information to assist

parishioners in making their own decisions. The training of Pastors can differ based on their background and/or denomination. In a study done by Farrell & Goebert (2008) it was found that 71 percent of Pastors felt incompetent in their training to recognize mental health conditions. Some Pastors reported acquiring their knowledge of mental health from their own research, self-study, personal and familial experiences (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013).

Purpose of the Study

The purpose of this study is to understand the role of African American Pastors in providing mental health support and ways in which the mental health field can help bridge the gap between the Black Church and mental health community. It is hoped that this study will highlight the role religious denominations may hold as it relates to counseling and what messages are being sent to congregation members about mental health. It is hoped that the results from the interviews will help to inspire collaborations and create partnerships between community counselors and African Americans Pastors.

This research seeks to better understand how African American Pastors conceptualize the mental health issues of their congregation and what aspects of their training, religious denomination or experience helps in providing counseling. This research also intends to contribute to the counseling profession by adding to the scarce literature available related to the intersection of African Americans, spirituality, religion, and mental health. Specifically, this study will provide the authentic experience of African Americans Pastors as it relates to mental health.

This research strives to provide a voice for the Black Church Community and African Americans as it relates to the barriers faced, experiences, and attitudes towards

the mental health profession. As previously mentioned, The ACA Code of Ethics Preamble calls for counselors to honor diversity, embrace diversity, and promote social justice. The research provides an understanding and ways the counseling profession can carry out their duty as described in the Preamble.

Statement of the Problem

For several decades there has been a gap in the literature as it relates to spirituality, mental health and The Black Church. Historically, African Americans have been underrepresented in utilizing mental health services (Avent, Cashwell, & Brown-Jeffy, 2015). Some of the barriers that may impact African Americans attitudes towards mental health services may include stigma, cultural norms, cultural mistrust, racial preference, and finances, to name a few (Awosan, Sandberg, & Hall, 2011). In the African American community, spirituality and religion have been identified as both a protective factor and a means to cope when faced with a difficult situation (Mitchell & Ronzio, 2011). There is a gap in the literature as it relates African Americans Pastors' experiences as responders when faced with the mental health concerns within their congregation. This research has investigated the individual experiences of African American Pastors in providing mental health support to their congregation members by listening to their stories and understanding their backgrounds.

Research Questions

The research questions were created with the intention of being mindful of the population of interest. This research will examine the relationship between the denomination of African American pastors and their experiences and role as responders

to the mental health needs of their congregation. The specific research questions of this qualitative study are:

1. What are African American Pastors' experiences of mental health issues in the Black church?
2. What are African American Pastors' beliefs in referring members to clinicians in the community?
3. What are African American Pastors' experiences with clinicians in the mental health community?
4. What approaches can the mental health community can take in building relationships with local Black churches?

Conclusion

African Americans tend to underutilize mental health services and instead choose to confide in their Pastors. Currently, there is a gap in the literature as it relates to African American Pastors' experiences as they provide support for mental health concerns of the Black Church. This study aims to further understand their experience and bring awareness to the issues unique to this population. The study also hopes to improve the relationship between the Black Church community and the mental health field by filling the gap in the literature.

Chapter 2: Literature Review

Introduction

Historically, African Americans are underrepresented in utilizing mental health services (Avent, Cashwell, & Brown-Jeffy, 2015). As discussed in Chapter 1, there are many components that may contribute to African Americans deciding to use mental health services. The first section of this chapter focuses on issues that are unique to African Americans. The challenges discussed are unique to this population as it relates to their historical background, specific issues identified in the family unit, and systemic barriers. After discussing issues unique to the African American population, this chapter will move into focusing on the barriers African Americans experience in seeking mental health support. This section highlights different external and internal barriers that African Americans experience. Spirituality and religion are later discussed in this section specifically discussing how African Americans use spirituality and/or religion as a coping mechanism. The chapter closes after closely examining the role and definition of The Black Church, the role of the Pastor, and the beliefs and attitudes Pastors may hold as it relates to mental health services.

Issues Unique to the African American Population

Familial Issues

The African American family unit provides a sense of support for both individuals and the community at large. Historically, the family unit has provided individuals a sense of security and connectedness, allowing individuals to be their authentic selves without perceived fear of judgment. There are different types of families within the African American culture: primary families (two-parent household), extended families (relatives),

and augmented families (nonrelated individuals) (Billingsley, 1968). Based on the structure of the family, the support can differ in its form and be on a continuum of harmful to helpful to an individual. Researchers have found that 71 percent of African American children were born outside of marriage, resulting in 54 percent of children living with only one parent (Parenting in America, 2015). Having a positive relationship with both parents is vital for individuals to create a positive healthy sense of self (Vereen, 2007). A poorly structured family can impact an individual physically, mentally, socially, and emotionally (Auslander, Haire-Joshu, Houston, Williams, & Krebill, H., 2000). African American families structured as a single-parent household are more susceptible to living in poverty than two-parent households (Durr & Hill, 2006). According to statistics provided by the United States Census Bureau, 8.2 percent of African American married couples were living in poverty as compared to 37 percent of African American single female households and 23.7 percent of African American single male households ("Poverty in Black America", n.d.).

African American families have often been stereotyped as unstructured, living in poverty, reliant on financial assistance, and families that are fatherless or husbandless (McAdoo, 1997). While these stereotypes are not present in every household there are some African American families that may experience one of more of those characteristics. Studies have shown that children who experience positive parental involvement from both parents are more likely to have a positive childhood (Causey, Livingston, & High, 2015). Children born to a single parent household experience a disadvantage in that they are less likely to have social support, pursue higher education, and experience positive overall wellbeing (Thomas, Krampe, & Newton, 2008). This

family structure can impact a child into their adulthood as these may replay itself and become a generational pattern.

Generational patterns can also have an effect on an African American family. Different factors such as education, criminal activity, drug use, and poverty can impact several generations in a family unit (Mandara, Rogers, & Zinbarg, 2011). An individual may receive certain messages from family members that may negatively impact their future. Friction amongst family members can cause increase conflict, decrease family cohesion and cause stress (Vereen, 2007). These issues can also take their toll on an individual's self-esteem as the family support may decrease. Historically, African American family units are related to strong kinship and strong bonds (Auslander, Haire-Joshu, Houston, Williams, & Krebill, H., (2000). Different situations may occur that can either strengthen or weaken the kinship which can positively or negatively impact future generations. Tension can occur between family members (i.e. grandparents and grandchildren) as the older generation may feel their experiences are not being validated or respected. In the African American family there is a sense of pride and tradition that has been carried from past experiences. The elders in the family pull on their resilience and wisdom in teaching the youth in the family (Causey, Livingston, & High, 2015). Those who are younger in the family may struggle to relate as their lived experiences are different than those experienced by the elders (Causey et. al).

Discrimination

Discrimination is a stressful event that unfortunately is experienced by African Americans daily. There are different forms of discrimination which can be related to gender, age, religious orientation, sexual orientation, race etc. Specifically, racial

discrimination is an intentional act that affects the self-esteem of racially identified people or those who have historically experienced oppression (Dulin-Keita, Hannon, Fernandez, & Cockerman, 2011; Sowell, 1986). Soto, Dawson-Andoh, & Belue (2010) found that there are two types of discrimination that one may experience, major discrimination and daily discrimination. Major discrimination can include situations such as being treated unfairly by law enforcement, being fired from a job, or being denied service due to the color of one's skin. Daily discrimination includes experiencing microaggressions defined as being treated with disrespect due to the color of one's skin. Although they differ in experience both forms of discrimination can have a lasting negative impact on the wellbeing of African Americans.

African Americans have dealt with a long history of experiencing discrimination during the slavery era and during the era of the Civil Rights Movement. The Jim Crow laws, which were in place from 1874 to 1975, operated under the idea of "separate but equal" treatment for African Americans (Hanson, 2011). Although these laws were put in place to establish equal treatment, there were still instances where African Americans were inferior to the dominant race. Examples of this discrimination include having to use separate restrooms, being forbidden from eating at certain restaurants and required to sit at the back of the bus. Historical figures, like Rosa Parks and Martin Luther King Jr., fought for true equal rights for African Americans and their efforts have an impact in modern day society, for example integrated schools, equal rights for African Americans, and the right to vote.

While much has changed, scholars still speak of a modern day Jim Crow due to the political climate present at this time (Murphy, 2016). In particular, African Americans

are often discriminated against due to the color of their skin and they also can experience treatment based on the shade of their skin (Monk, 2015). During slavery, African Americans with a lighter skin complexion were treated less harshly and often worked in the house due to direct kinship to Caucasians, while darker skinned African Americans were often required to work in the field (Russell, Wilson, and Hall 1992). While the comparison is not quite the same there is still preferential treatment and perceived stereotypes present based on the skin tone of African Americans (Monk, 2015). The use of the color labels has resulted in stereotypes that darker skinned African Americans are uneducated, unattractive, poor, and criminals while lighter skinned African Americans are perceived as educated, classy, attractive and career driven (Monk, 2015). The use of color labels not only creates discrimination amongst African Americans and members of the dominant race, but also amongst one another in the African American racial group. Researchers have found that African American males and females report a preference for lighter skinned men and women as opposed to darker skinned men and women (Esmail, 2006). The preference for one skin tone over another can create an element of exclusion and negatively impact one's social identity.

The experiences of discrimination can have both short term and long term effects that can impact African Americans health physically, mentally, and emotionally. Researchers have found a link between early experiences discrimination during childhood and increased substance use and mental health issues (Gibbons, Yeh, Gerrard, Cleveland, Cutrona, Simons, & Brody, 2007; Saleem, English, Busby, Lambert, Harrison, Stock, & Gibbons, 2016). As African Americans continue to mature and experience the world their racial identity is also evolving and pulling from passed experiences. Scholars have further

researched if there is a relationship between the racial identity of African Americans and overall wellbeing. Although wellbeing does not have a concrete definition researchers have conceptualized it as “being at ease with oneself, having meaning and fulfillment, experiencing positive emotions and canceling out negative emotions, positive and negative affect, and satisfaction with life” (Campion and Nurse 2007, p. 25).

The results from a study conducted by Hughes, Kiecolt, Keith, and Demo (2015) concluded that African Americans rated higher on overall wellbeing, higher self-esteem, and decreased depressive symptoms when they were able to racially identify with their group and feel socially accepted amongst other African Americans. Hughes et. al (2015) also found African Americans experienced confusion regarding their racial identity and lacked social acceptance, they scored higher on depressive symptoms and lower on self-esteem. Seaton, Neblett, Uptown, Hammond, and Sellers (2011) conducted a study on 260 African American students from middle and high schools. This study was a three year longitudinal study that focused on racial identity development and its psychological affect. It was concluded that the wellbeing of African Americans changed overtime due to experiences of discrimination that negatively impacted their psychological adjustment. Researchers are finding a link between the racial identity and discrimination experiences of African Americans and their wellbeing.

Unemployment

Unemployment is defined as, “people who are jobless, actively seeking work, and available to take a job” (How the Government Measures Unemployment, 2014, p. 3). The unemployment rate between individuals of an ethnic minority background and those from the dominant racial group has always been disproportionate (Avent, 2013). In 2016, the

overall employment rate stood at a 4.9 percent, with Hispanics slightly over the average at 5.8 percent, Caucasians 4.3 percent, and Asians 3.6 percent (Unemployment rate and employment-population (2017)). The unemployment rate for African Americans stands above the overall average and higher than any other ethnic group sitting at 8.4 percent.

Although more African Americans are pursuing a higher education they still experience a higher rate of unemployment than Caucasians (Kroll, 2012). Kroll calls for more programs to be created to help African Americans who possess the necessary qualifications but continue to struggle finding employment. Unemployment can take its' toll physically, mentally, and emotionally. Researchers have found empirical evidence that supports the claim that unemployment can increase depression, anxiety, substance abuse, and crime, which can be related to overall wellbeing (Rodriguez, Allen, Frongillo, & Chadra, 1999; Winefield, Winefield, Tiggemann, & Goldney, 1991). African Americans have a particularly harder time integrating coping skills once unemployed (Rodriguez et. al). As more research is conducted it is possible to find the link between African Americans and unemployment as it impacts the individual, their family, and overall wellbeing physically, mentally, and emotionally.

Poverty

Poverty is an epidemic that affects many individuals regardless of personal characteristics. Poverty can be understood as a situation where there is a lack of monetary income that is necessary to support basic needs ("Poverty", n.d.). Historically, African Americans are overrepresented among individuals living below the poverty line. According to data collected from the United States Census Bureau (2016) African Americans represent 13.3 percent of the overall population and 33 percent of those

individuals are living below the poverty line (Semega, Fontenot, & Kollar, 2017). The number African Americans living in poverty is nearly triple the number of African Americans represented in the general population. Because a large percentage of African Americans live in poverty as compared to other populations, the creation of more research, resources, and programs would aid in understanding the overrepresentation of this racial group and what can be done to decrease the rate.

While poverty can be a direct result from an individual being unemployed the two should not be understood as one and the same. Poverty can result from an individual becoming unemployed and lacking consistent income and financial stability. Poverty can also be experienced by those who have a job that provides consistent income but may be receiving minimum wage or part time hours (Stevens & Phil, 2016). These individuals have been categorized as the “working poor”. The working poor are people who work at least 27 weeks, either working or looking for work, whose income still falls below the poverty line (Semega, Fontenot, & Kollar, 2017). While poverty seems to greatly impact adults, children and those who are disabled experience similar difficulties.

Incarceration

There seems to be a racial disparity in the incarceration rate of African Americans and other racial groups. As of 2016, African Americans represent the majority of minority inmates making up 34 percent of the prison population and more than half in certain states (Criminal justice fact sheet, n.d.). Researchers have found that African Americans are five to ten times more likely to be incarcerated than Caucasians (Nellis, 2016). Alexander (2011) specifically points out mass incarceration as a component of modern day Jim Crow laws. It has been found that more African Americans are in prison

or jail than African Americans enslaved in the 1850s (Alexander). Alexander suggests that a racial caste system exists which may contribute to the large number of African Americans currently incarcerated. Doherty, Cwick, Green, & Ensminger (2016) found that life events and transitions for African Americans can contribute to likelihood of becoming incarcerated. Doherty et. al drew from sociological and cultural constructs to better understand how a life event can result in a high incarceration rate. The researchers found that a large number of African Americans were not equipped with the right tools to successfully move through different events and transitions in life. They further found that after incarceration African Americans were still likely to become habitual offenders and struggle with substance use (Doherty et. al).

Western and Wildeman (2009) have found that the mass incarceration of African American males are having a profound impact on the family by resulting in single parents and children experiencing a difficult childhood. When one parent is incarcerated, it shifts not only the financial responsibility onto the other parent but also the responsibility to take care of the household and children. Families of those incarcerated are typically young, African American, and lack an education which can lead to poor life skills, low self-esteem, or criminal behaviors (Western & Beckett, 1999; Solomon & Zweig, 2006). Researchers have examined the link between incarcerated parents and children and have found that children are at a greater risk of developing a conduct disorder or being incarcerated. Incarceration not only results in the loss of a parent or individual in a family but increases the likelihood of African American children experiencing a difficult childhood.

Education

As the United States continues evolving socially and economically the need for an individual having an education is becoming increasingly important. In 2015, 33 percent of adults in the United States reported earning a bachelor's degree or higher. The average number of African Americans who have earned any level of education higher than a high school diploma is 10.3 percent compared to Caucasians who average 56.1 percent (Ryan & Bauman, 2016). African Americans have been historically disadvantaged when it comes to education. For example, until schools desegregated in 1954 by the Supreme Court, African American children received little attention, care, or financial support. Education provides a chance to improve overall quality of life through better employment and opportunities. As of 2015, the national unemployment rate was 5.3 percent with 16.6 percent of African Americans who had no high school diploma classified as unemployed (Wilson, 2015). Obtaining higher education not only provides African Americans an opportunity to improve their lives but also be a positive example for others in their community.

Although there is a slight increase in the number of African Americans attending college there still remains a financial barrier that prevents some from attending. The cost of college continues to steadily increase which impacts an individual's decision whether or not to obtain a degree. Reid & Mark (2013) found that many African American students are high-achieving but come from a low socioeconomic background. They found that the financial barrier not only eliminated the possibility of college but also resulted in individuals experiencing a decrease in overall wellbeing. While there are scholarships available to help cover a portion of the total cost to attend college, only 28 percent of

African Americans are awarded scholarships compared to 72 percent of Caucasian students (Martin, 2011). Even when African Americans may receive a scholarship there is still the need to perform well academically in order to prove that they are deserving.

African Americans who attend a predominantly White institution (PWI) often experience alienation, disconnection, and a racially hostile campus climate (Baber, 2012). Researchers have found themes that relate to African Americans experience at PWIs. African American students struggle with identifying their racial identity as there is often a struggle to fit in with Caucasian peers and identify similarities but also remain “African American” when around African American peers (Baber). Students discussed the struggle in wanting to appear intellectual when talking with Caucasian peers but feeling “too Caucasian” when around African American peers (Baber). This can create an identity crisis as students move into adulthood feeling they have not been accepted by any group. Baber also found that students felt the external structure around them can also cause feelings of alienation and sense of disconnect. Specifically, students spoke of the lack of diversity present on the college campus and the lack of a sense of belonging and isolation.

Anxiety

The DSM-5 defines anxiety as when one experiences fear as an emotional response to a real or perceived immediate threat and anxiety is the anticipation of a perceivable threat (American Psychiatric Association, 2013). There are two major components of anxiety, which are worry and somatic symptoms within hyper-arousal (Huppert & Sanderson, 2005). People tend to excessively worry about minor situations and eventually develop a sense of pathological worry. Dugas and Koerner (2005) found

that individuals that exhibited pathological worry often thought the excessive worry helped to prevent negative situations and solve problems. Huppert and Sanderson also found that individuals may experience muscle tension, restlessness, difficulty sleeping, and worry. With anxiety there may be an excessive amount of worry that is often uncontrollable and includes the tendency to fixate the worry on a specific event or situations (Dugas & Koerner). In most instances a person experiencing anxiety will attempt to avoid the stimuli or situation that produces the anxiety.

Anxiety affects 6.8 million adults, or 3.1 percent of the United States population and women are twice as likely to be affected as men (“Understand the facts”, n.d.). According to the National Alliance on Mental Health (NAMI), African Americans are 20 percent more likely to experience mental health issues (“African American Mental Health”, n.d.). Although anxiety can be treated using psychotherapy or medications only one third of those diagnosed will seek treatment. Out of the one third of individuals who aware they are experiencing anxiety symptoms, only one quarter of African Americans will seek treatment for their symptoms (Neal-Barnett, n.d.). It is important to further research and understand the causes of anxiety for African Americans and the way the symptoms may present.

Although strides are being taken to better understand how anxiety manifests with in the African American population the literature seems to be divided. Some researchers have found that African Americans have a higher prevalence for anxiety disorders such as simple phobia, social phobia, and agoraphobia (Carter, Sbrocco, & Carter, 1996) while other researchers have found that African Americans have a lower prevalence rate of anxiety (Hunter & Schmidt, 2010; Salami & Walker, 2014). Researchers are beginning to

examine the lived experiences of African Americans and how this may contribute to experiencing anxiety symptoms (Carter et. al, 1996). In further researching the lived experiences of African Americans and their mental health, racial discrimination continues to be a prominent issue negatively impacting their wellbeing (Soto, Dawson-Andoh, & BeLue, 2011). It has been found that experiencing racial discrimination can increase the psychological symptoms African Americans experience (Jackson, Brown, Williams, Torres, Sellers, & Brown, 1996). Not only do the etiologies of anxiety disorder differ but also the way that symptoms present themselves (Soto et. al). Smith, Allen, and Danley (2007) founded the term racial battle fatigue which is a psychological response that presents as stress or emotional withdrawal when experiencing a microaggression. These symptoms can often mirror the symptoms present in an anxiety disorder such as muscle tension, restlessness, difficulty sleeping, and excessive worrying (Huppert & Sanderson, 2005; Soto et. al).

Researchers are beginning to conceptualize anxiety psychopathology in African Americans as one with a sociocultural influence (Hunter & Schmidt, 2010). Using a sociocultural lens includes the cultural history and present influences. These are considered when looking at the etiology, expression, and prevalence of anxiety disorders in African Americans (Hunter & Schmidt). Salami and Walker (2014) found that hopelessness was a recurring component in African Americans experience of anxiety. Hopelessness can be defined as, “the perception that one had no control over what was going to happen and by absolute certainty that an important bad outcome was going to occur or that a highly desired good outcome was not going to occur” (Carson, Butcher, & Mineka, 2000, p. 239). Hopelessness draws on this sense of not having control and

feeling that a negative outcome will happen regardless (Salami & Walker). Salami and Walker conducted a study that specifically examined if there was a link between hopelessness, anxiety, and socioeconomic status (SES). Socioeconomic status was an important component of this study as African Americans are overrepresented in the unemployment rate and compromise a large number of individuals living below the poverty line (“A Profile of the Working Poor 2015”, 2017). From the study it was found that, with African Americans, there is a direct link between hopelessness and anxiety symptoms. As hopelessness increased the severity of anxiety also increased (Salami & Walker). Researchers also found that hopelessness and symptoms of anxiety increased for African Americans with a low and high SES.

Depression

Depression is a mental disorder that can greatly impact an individual’s mood. The DSM-5 identifies sadness, feeling empty, or irritable mood paired with somatic and cognitive changes that can severely impact a person’s ability to function as the major characteristics of depression (American Psychiatric Association, 2013). According to the National Institute of Mental Health, 16.2 million adults have experienced at least one major depressive episode with 5 percent of African Americans having experienced a major depressive episode (Major Depression, 2017). After Asian Americans, African Americans represent a smaller number of the those who have experienced depression.

Similar to anxiety, researchers have found that the etiology of depression for African Americans may be experiences of racism or unequal treatment (Williams, Chapman, Wong, & Turkheimer, 2012). William et. al noted the role ethnic identity has as it relates to development of the self for African Americans. Ethnic identity is defined

as a subset of identity categories in which eligibility for membership is determined by attributes associated with descent (Chandra, 2006, p.398). It is connected to one's self-esteem, ability to cope, and ability to remain positive (Roberts, Phinney, Masse, Chen, Roberts, & Romero, 1999). Researchers have found that if an individual is not able to successfully connect to their ethnic identity, symptoms of loneliness and depression can manifest (Williams et. al). The symptoms of depression may look different for African Americans. Specifically, when African Americans are experiencing depressive symptoms they are more than likely to identify somatic symptoms which can mirror a medical cause (Scott, Matsuyama, & Mezuk, 2011).

In addition to depression, other health concerns may be a concern for African Americans. Medical doctors have found that African Americans have a greater risk of developing health issues such as diabetes, high blood pressure, heart disease, and certain cancers (Scott et. al, 2011). It is important that both mental health professionals and medical providers continue researching depressive symptoms in African Americans in order to understand possible connections. Not only will this create more accurate diagnosing and treatment plans but decrease the chance of African Americans being mistreated for a physical or medical illness.

Summary

The previously mentioned challenges of familial issues, discrimination, unemployment, poverty, incarceration, education, anxiety, and depression are issues that can impact anyone but are unique to the experience of African Americans. Additional research can increase a better understanding of how these challenges can impact African Americans physically, mentally, and emotionally. Some research supports the notion that

African Americans are seeking help but not necessarily from mental health professionals. The question arises from whom and where are African Americans seeking support and professional help.

Barriers to Seeking Mental Health

Historically, African Americans have been underrepresented in utilizing mental health services as compared to other ethnic minority and majority groups (Avent, Cashwell, & Brown-Jeffy, 2015). Recently, research has been conducted to better understand some of the barriers African Americans may experience that impacts their attitudes towards mental health services. These barriers may include availability of counseling, accessibility issues, cost, personal and cultural attitudes, stigma, and lack of knowledge or awareness about the mental health resources available (Copeland & Synder, 2011). For African Americans who live in rural areas these barriers may be even more prevalent. Resiliency may also impact the help seeking behaviors in the African American community. Historically, African Americans have experienced several forms of oppression throughout history. These important experiences have instilled a level of resiliency in African Americans throughout which they learned to cope with difficulties intrinsically. The identified barriers must be further dissected to understand how African Americans may perceive them, and to learn more about how they are interacting with these barriers.

Availability

The counseling field continues to grow and expand as more people are becoming more invested in their mental health along with more counselors being trained. The mental health needs of an individual may warrant support from professionals such as a

medical doctor, psychiatrist, psychologist, counselor, or social worker. Counselors may be trained in different specialties which include: addiction counseling, career counseling, clinical mental health or community agency counseling, marriage, couple and family counseling, school counseling, student affairs and college counseling, gerontological counseling, or rehabilitation counseling (American Counseling Association, n.d.). Based on the needs of the individual they may specifically seek a counselor who specializes in a certain issue. The problem occurs when certain specialties are not available in certain areas. This may require an individual to travel an extensive distance or choose to not receive services (Turpin, Bartlett, Kavanagh, & Gallois, 2007). This issue is especially prevalent in rural communities where services may not be provided. Approximately 60 million Americans live in rural communities with 12 percent of those residents identifying as African American (Probst, Samuels, Jespersen, Willert, Swann, & McDuffie, 2002).

African Americans may also have a preference to receive support from counselors of a similar cultural or racial background (Cabral & Smith, 2011). Although research does not directly support the claim that matching African American clients based on cultural or racial background will lead to a better treatment outcome it has been found that it positively relates to the duration of the treatment (Takeuchi, Sue, & Yeh, 1995). With only 2 percent of psychiatrists, 2 percent of psychologist, and 4 percent of social workers identifying as African American, it may be difficult for those specifically seeking a mental health profession of that racial background (Holzer, Goldsmith, & Ciarlo, 1998). The lack of availability of services paired with difficulty identifying a

specific clinician may contribute to African Americans reluctance in seeking mental health services.

Accessibility/Cost

Medicaid provides insurance for over 72 million Americans and is the largest source of health insurance coverage provided (“Eligibility”, n.d.). Particularly, Medicaid provides insurance for those considered low income, individuals living in poverty, children, and disabled people (Rowan, McAlpine, & Blewett, 2013). Rowan et. al also found that 33 percent of those receiving Medicaid met the criteria for having a mental illness. Even though Medicaid may cover a portion of the expenses related to receiving mental health services there still may be some out of pocket costs. Rowan et. al found that three out of five individuals with a recent mental health diagnosis will not seek treatment due to out of pocket cost or lack of health insurance coverage. The burden of the out of pocket expenses falls heavy on African Americans as they comprise the largest percentage of individuals living below the poverty line (United States Census Bureau, 2016).

Attitudes

Over the past few years’ researchers have conducted studies to better understand African Americans’ perceptions of mental health services. Researchers are also curious about which factors may impact African Americans help seeking behaviors. Evidence has shown that positive attitudes towards receiving mental health services results in positive treatment outcomes (Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016). Attitudes can be affected by both intrinsic and extrinsic barriers. Intrinsic barriers are those that exist inside an individual, such as knowledge, awareness, cultural mistrust while extrinsic

barriers are those that exist outside of an individual such as geographic location, access to resources, or financial availability (Pepin, Segal, & Coolidge, 2009).

Mental health stigma can be defined as, “a collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders” (Gary, 2005, p. 980). Typically, individuals deemed mentally ill are labeled as “unpredictable” or “hopeless” (Corrigan, 2004; Masuda & Latzman, 2011). These labels can cause African Americans to refuse seeking mental health treatment for fear of experiencing a double stigma (Gary). Gary explains a double stigma as those of a minority group with a mental illness who are subjected to being stigmatized due to minority status and mental illness. This can create significant barriers that negatively impact help seeking behaviors and causes underutilization of mental health services. Anglin, Link, Phelan (2006) conducted a study that examined the differences between African Americans and Caucasians as it relates to stigmatizing attitudes. Their findings showed that African Americans were more likely than Caucasians to perceive individuals with a mental illness as dangerous or violent. More research needs to be done to examine if there is a link between the stigmas African Americans may hold and how this impacts their utilization of mental health services or creates self-stigmas (Cheng, Wang, McDermott, Kridel, & Rislin, 2018).

In a focus group conducted to learn more about African Americans’ perceptions on mental health, researchers found that African Americans associated shame and embarrassment with mental illness (Thompson, Bazile, & Akbar, 2004). The feelings of shame and embarrassment can prevent African Americans from also sharing mental health concerns with family or friends for fear of being rejected (Thompson et. al).

Participants also spoke of cultural beliefs in relation to family concerns and expectations. Thompson et. al identified themes that emerged during the groups. Participants discussed the need to appear “strong” and “prideful” in their family. An unspoken rule emerged that issues that happen in the family or with an individual should not be discussed with others outside of the family. This is seen a sign of disrespect due to potentially sharing information about members of the family to an “outsider”. Family members may also view the individual seeking mental health services as weak and disregarding the things they were taught to help cope with difficulty (Thompson et. al).

Stigma seems to play a role in African Americans perceptions of mental health services and potentially influences their help seeking behaviors. More research needs to be conducted that specifically looks at the effect of stigma and ways to decrease the barriers and negative thoughts African Americans experience.

Cultural mistrust. Terrell and Terrell (1981) first coined the term “cultural mistrust” to help explain the mistrust that African Americans have developed of Caucasians. Through this mistrust African Americans already hold preconceived notions regarding the relationship with a Caucasian counselor and often do not anticipate any changes due to therapy (Watkins Jr., Terrell, Miller, & Terrell, 1989). Trust is an important aspect of any relationship and without it no growth can occur. Over the past four decades’ researchers have conducted studies to better understand the concept of trust within the counseling relationship between African American clients and Caucasian counselors. Researchers have found that African American clients tend to refrain from sharing intimate information with Caucasian counselors for fear of being misunderstood or being treated in a prejudicial fashion (Thompson, Worthington, & Atkinson, 1994).

Thompson et al. (1994) found that African American clients felt most comfortable with African American counselors due to racial similarities and expectations that African American counselors will understand them due to a shared cultural perspective.

Empirical evidence supports the claim that African Americans are being over diagnosed for mental disorders such as schizophrenia, depression, and anxiety (Whaley, 2001). While some diagnoses may have substantial evidence to support these diagnoses some may be based on a Caucasian clinician's first interaction with an African American client. Due to cultural mistrust an African American client may display "healthy cultural paranoia" which explains African Americans manner of response due to a history of being oppressed (Whaley, 2001). The avoidance or suspicion that African American clients may be projecting can be easily confused with symptoms of certain mental health disorders. Terrell & Terrell (1981) created the Cultural Mistrust Inventory (CMI) which is a 48-item inventory that measures the degree that African Americans distrust Caucasians by indicating their level using a 7-point Likert scale. The CMI is made up of four subscales to assess the level distrust in the domains of business, interpersonal relationships, education, politics and law. Whaley conducted a study using the CMI with African American and African Caribbean participants. The results from administering the CMI were not statistically significant and did not support the notion that cultural mistrust must be conceptualized on a broader level. More research needs to be conducted in this area to better understand cultural mistrust and how it may or may not influence the therapeutic relationship between an African American client and Caucasian clinician.

Knowledge/Awareness

Researchers continue to explore what factors may contribute to the low representation of African Americans seeking mental health support and have identified knowledge as one component. Briggs, Bank, & Briggs found that African Americans report a lack of knowledge and awareness as a reason for not seeking mental health support (2014). Depending on factors such as availability, geographic location, stigma, etc. African Americans may not be aware of the specific services available or have an understanding of its potential benefits. Briggs et. al also found that over 50 percent of African American participants in that particular study felt they were unaware of the different types of mental health disorders. With an absence of the knowledge of the types of disorders it may prove difficult for African Americans to pinpoint the symptoms being experienced and what resources would be most appropriate. Snowden (2001) stressed the need for community involvement to help provide workshops or psychoeducational programs for African Americans that helps provide the knowledge of services available and what to expect. Researchers have found that once African Americans were provided the information mental health clinics saw an increase from 6 percent to 30 percent in African American clients. Culture specific engagement is important for both the specific community and African Americans as it helps foster relationships and provide African Americans with the knowledge and resources available.

Religion and Spirituality as a Form of Coping

The definition of spirituality can differ based on different perceptions and interpretations. Spirituality can be understood as an individuals lived experience (Kelly, 2004). Gallacher (2014) explains spirituality as a personal experience that incorporates one's values and

belief system. Specifically, spirituality allows an individual to explore their purpose and meaning in their life in their own way (Gallacher). In the African American community, spirituality and religion have been identified as both a protective factor and a means to cope when faced with a difficult situation (Mitchell & Ronzio, 2011). According to a survey by the United States Religious Landscape Survey, 87 percent of African Americans reported belonging to a religious group and 79 percent reporting religion to be very important in their life (A religious portrait of African Americans, 2009). Religion as a form of coping can serve several purposes for individuals which include spirituality, self-development, resolve, sharing, and restraint (Pargament, 1997). Religion allows people to see their struggles through a specific lens and incorporate a different perspective to help guide them through their situation (Avent, 2013).

Internal Religious Coping Styles

Internal religious coping takes place within a person and is impacted by their thoughts, actions, and motivation. Internal religious coping can include activities such as journaling, studying scripture, prayer, and relationship with God (Moreno, Nelson, & Caredmil, 2017). Internal coping can be understood as religious activities that are practiced alone. Individuals may choose to practice in solitary to have uninterrupted time with God but also have a chance to be with their own thoughts and self. Having positive coping strategies in place has been linked to a higher well-being, increase in life satisfaction, better health, and decreased stress (Chapman & Steger, 2010). Researchers have found that those who identify as religious prefer to rely on religious coping strategies rather than other sources of support. Particularly, researchers have found that

internal coping styles can differ based on characteristics such as race, age, level of education or marital status.

In the African American community it has been found that internal coping styles differ based on age. During the Civil Rights Movement African Americans relied heavily on internal religious coping activities due to fear of being harassed or violence when practicing externally in the community or at church. Some of the messages learned during those times have been passed down and still exist today. Ellison & Taylor (1996) found that older African Americans rely heavily on prayer during difficult times. They attributed the heavy emphasis on prayer to wisdom gained through life experiences and the ability to be reflective. Ellison & Taylor also found that over the course of life African Americans felt they have strengthened spiritually and have experienced the positive outcomes of integrating prayer. In a study conducted by Chatters, Taylor, Jackson, and Lincoln on African Americans and Caribbean Blacks, it was found that 80 percent of the 1,299 respondents reported prayer as an important resource (2008).

Prayer. Prayer is a common form of coping amongst African Americans (Ellison & Taylor, 1996). Formulating a definition for prayer is difficult as its meaning is personal and dependent on the individual and their belief. Baker (2008) conceptualized prayer as, “a belief and ritual that occur simultaneously and represents an individual’s attempt to communicate with the supernatural” (Baker, 2008, p. 169,). Researchers have found that individuals who engaged in prayer more have a higher satisfaction in personal relationships, a sense of purpose, and positive emotional wellbeing (Ellison, Bradshaw, Flannelly, & Galek, 2014). Ellison et. al conducted a study that examined the relationship between prayer, attachment to God, and level of anxiety symptoms. Their findings

confirmed that individuals who prayed and had a secure attachment to God experienced a decrease in anxiety symptoms while adversely those that prayed and had a distant attachment experienced elevated symptoms of anxiety. Prayer can be an act that yields results based on a person's belief and motivation.

External Religious Coping Styles

External religious coping is the second most common form of religious coping along with internal coping. External religious coping can also be seen as extrinsic way of coping. External religious coping involves an individual seeking resources other than those that exist internally. Some of these resources include seeking religious counsel with the Pastor or Pastoral counsel, religious support groups, attending religious services (i.e. Sunday service, Sunday school, bible study, etc.), and receiving support from congregation members (Moreno, Nelson, & Cardemil, 2017). This form of coping requires the individual to display help seeking behaviors in that they are seeking more support from others to supplement what they are not able to receive when using internal religious coping methods. Unlike internal religious coping methods, external coping methods provides a sense of connectedness and social support by interacting with other members, the Pastor, and becoming involved in church activities (Sanchez, Dillon, Ruffin, & Rose, 2012). External coping activities such as attending church services and increased involvement have been linked to increased psychosocial health outcomes (Szymanski & Obiri, 2011).

Pargament, Olsen, Reilly, Falgout, Ensing, & Haitsma (1992) argue that external coping can be seen as a desperate form of coping that is implemented when an individual feels they may be in danger and are limited in resources. On the flip side Paragment et al.

(1992) also mention that external religious coping can be seen as a way to maintain and learn more skills to implement when faced with a crisis. In a study done by Holt, Clark, Debnam, & Roth it was found that African Americans reported a decrease in negative coping methods such as binge drinking and smoking once implementing external coping strategies (2014). It seems more research is being conducted to specifically understand the relationship between religious coping, African Americans, and overall wellbeing. While there have been advances made it is still unclear whether internal or external religious coping prove to be more efficacious than the other.

Adaptive Coping

Adaptive coping is a form coping connected to religious coping strategies whose foundations are in religious and spiritual beliefs that aim to help individuals cope with difficult situations by providing support and positivity (Lee & Chan, 2009; Pargament, Koenig, & Perez, 2000). Adaptive can at times cross over with internal and external religious coping methods as these are seen as positive coping religious skills. Adaptive coping relies heavily on implementing positive strategies that will be beneficial to an individual helping to provide support through the situation. Adaptive religious coping also focuses on strategies that integrate cognitive and emotional processing (Jacinto, 2010). Jacinto found self-forgiveness to be an important concept in adaptive coping. Self-forgiveness can be understood as, “fostering compassion, generosity, and love toward oneself” (Enright, 1996, p. 116). Self-forgiveness is a process for an individual in that they work through a stage of un-forgiveness to forgiveness for either themselves or other people (Jacinto, 2010). Researchers have found that there is a relationship between adaptive coping and self-forgiveness. When individuals are able to experience self-

forgiveness self-condemning attitudes decrease while acceptance of one's actions increases (Fisher & Exline, 2006).

In general, researchers have found that religious individuals implement adaptive coping strategies more often than maladaptive strategies (Bjork & Thurman, 2007). Along with individuals thinking more cognitively and abstractly, the concept of a secure attachment with God or a High Power is very important (Ellison et. al, 2014). Adaptive coping allows for one to understand a difficult situation as part of a greater plan and have the tools and guidance provided from God to navigate through a situation (Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011). Through adaptive coping an individual is able to seek God's love and support through the difficult situation and have a collaborative relationship with him to receive his support to solve problems (Thuné-Boyle et al.). Paragament et. al identified five concepts related to religious adaptive coping. They are as follows:

“(1) religious coping to give meaning to an event; (2) to provide a frame- work to achieve a sense of control over a difficult situation; (3) to provide comfort during times of difficulty; (4) to provide intimacy with other like- minded people and (5) to assist people in making major life transformations” (Thuné-Boyle et al., p.772).

These five concepts act as a guide in understanding a stressful situation but also reframing the situation as a chance to grow spiritually (Thuné-Boyle et al.).

Maladaptive Coping

When difficult situations arise an individual may attempt to integrate adaptive coping strategies but may also result to maladaptive coping. Maladaptive coping is a form of coping that integrates strategies that cause negative outcomes for an individual. While

research has mostly focused on the positive benefits of religion during a stressful situation there is also a negative aspect of religion as a coping mechanism (Bjork & Thurman, 2007). In maladaptive religious coping the relationship with God is seen as distant, non-existent, and less secure (Pargament, Koenig, & Perez, 2000). A person may also feel like the world is against them and struggle to find their purpose. In maladaptive coping a person may feel they deserve to be punished and struggle through difficulty, experience spiritual discontent, and interpersonal spiritual discontent (Pargament et al., 2000; Pargament, Zinnbauer, Scott, Butter, Zerowin, and Stanik 1998). Researchers have found that individuals will chose maladaptive coping when based on their thoughts, behaviors, and relationship with God and the severity of the stressful situation (Pargament et al., 1998). While negative religious coping methods can disrupt one's spiritual wellbeing it can also take its toll on one's physical and mental health. McConnell, Paragament, Ellison, & Flannelly (2006) conducted a study that specifically looked at how spiritual struggles and maladaptive coping impact mental and physical illness. McConnell et al. found that individuals experienced increased anxiety, depression, and physical illness when practicing negative religious coping strategies.

Spiritual Bypass. *Spiritual bypass* was first introduced by John Welwood with the intention of explaining an individual using their spirituality or beliefs to avoid dealing with unresolved psychological issues in an unhealthy way (Cashwell, Glossoff, & Hammond, 2010; Picciotto & Fox, 2018). Spiritual bypass seems to be a forgotten concept in the growing body of research related to spirituality and religion. Although there is no literature that empirically examines spiritual bypass the main idea is that a person intentionally represses things that may have happened previously while

simultaneously neglecting their spiritual development (Cashwell et al., 2010; Fox, Cashwell, & Picciotto, 2017). During spiritual bypass, spirituality is used as a maladaptive coping skill to provide a basis or understanding for the unhealthy coping through avoiding (Fox et. al).

Role of the Black Church

History

The Black Church has played a critical role in the lives of many African Americans. The idea of the Black Church dates back to the slavery era when only Caucasians were able to hold formal church services and African Americans were not allowed to attend (Avent & Cashwell, 2015). Before the 1960s the Black Church was referred to as the “Negro Church” (Lincoln & Mamiya, 1990). Although there is no operational definition for The Black Church it can be conceptualized as, “those independent, historic, and black controlled denominations, which were founded after the Free African Society of 1787 and which constituted the core of black Christians” (Lincoln & Mamiya, p.1). A major component of the foundation of the Black church is being free (Lincoln & Mamiya). This sense of freedom has allowed African Americans to not only practice Christianity in their own unique way but also integrate aspects of their culture and values. The Black Church is comprised of seven black denominations, which include: The African Methodist Episcopal Church (A.M.E.), the African Methodist Episcopal Zion Church (A.M.E.Z), the Christian Methodist Episcopal Church (C.M.E.), the National Baptist Convention, U.S.A., Incorporated (NBC), the National Baptist Convention of American, Unincorporated (NBCA), the Progressive National Baptist Convention (PNBC), and the Church of God in Christ (COGIC). When referring to the

Black Church in this document, the term may incorporate any or all the previously mentioned denominations, unless otherwise specified.

During the late 1890s and early 1990s, around 90 percent of the African Americans in the United States resided in the South with more than 80 percent living what became known as the Bible Belt. The Bible Belt refers to denominations that practice under a rigid belief of the Bible (Brunn, Webster, & Archer, 2011). During the twentieth century, The Black Church began to spread across different areas of the United States with much of its influence rooted in the South. From the creation of The Black Church many organizations for African Americans were birthed such as: The National Association for the Advancement of Colored People (NAACP), the National Urban League, Historically Black Colleges and Universities (HBCU), and African American college sororities and fraternities. This movement not only allowed the chance for more opportunities for African Americans to advance but also a sense of identity and inclusion. The Black Church influenced these movements by providing support, leadership, and founding some of the organizations (Lincoln & Mamiya, p.9).

Church Support

The Black Church provides a safe space for African Americans to come together to receive and provide social support. The social structure can almost be seen as a family system (Taylor, Chatters, Lincoln, & Woodward, 2017). For example, the head of the household is represented by the Pastor and the congregation members represent family members. Church involvement and activities provide a way for African Americans to feel a sense of inclusion. This allows members to interact with one another but also with those in the community. Researchers have found that religious participation and social

interactions results in positive mental and physical health benefits for African Americans. Taylor et. al also found that support can come in many different forms within the Black Church. This support can include spiritual guidance, emotional support, financial assistance, employment, transportation, food and housing. The Black Church is a community inside of a larger community (Roberts, 1980). It can provide an opportunity for members to receive the support and assistance that may be unavailable in the larger community.

Mentorship. Mentorship has played a vital role in the lives of African Americans. Mentorship can provide the chance for personal relationships and for young African Americans to learn how to navigate life (Owens, 2017). Spiritual mentorship provides an opportunity for the elderly in the church to provide spiritual guidance to the younger members in order to aid in their spiritual growth (Williamson & Hood, Jr., 2013; Taylor, Chatters, Lincoln, & Woodward, 2017). This relationship allows mentees to glean on the wisdom of the elderly and learn how to consciously deal with everyday situations. Mentees learn from the personal experiences of their mentors as they experience how to integrate spirituality into their daily lives.

Role of the Pastor

A Pastor's role is pivotal in the structure of the church. A Pastor serves as not only a spiritual guide but also provides support for members financially, emotionally, and mentally. While the church is the actual meeting place, the Pastor provides a sense of guidance and spiritual direction. Pastors provide spiritual messages to their congregation members, and these messages are practical and applicable to one's everyday life. Historically, Black Pastors have served as an immense support during difficult times such

as slavery and the Civil Rights movement. African Americans relied heavily on their spiritually as a means to cope and looked to their Pastors to help make better sense of the struggles they were experiencing. A Pastor is often seen as an individual chosen by God to spread God's love and the gospel here on earth. In this role, Pastors can have a direct impact on the individual level, the church congregation as a whole, and also within their community (Baruth, Wilcox, & Saunders, 2013).

Because Pastors are able to meet with members one-on-one to provide support for an array of different issues, turning to their Pastor as a first source of support when dealing with difficulties is often a choice made by many members. While Pastors do provide support within the walls of the church their responsibilities may also require them to visit church members in other locations. As with any individual, things can happen such as an illness or physical accident which may prevent one from attending church services or other activities. Pastors are able to still visit their members and provide support, prayer and spiritual guidance. As a result, Pastors and members are still able to maintain a relationship but also members can still feel a sense of connectedness even though not physically present.

The spiritual needs of an individual can be addressed directly with the Pastor. Members spiritual needs will differ based on who the individual is and where they are in their spiritual journey. The Pastor is able to be a sounding board and provide specialized attention to the person and their issues being presented. In this way the Pastor is assuming the role of a spiritual guide offering their expertise. Based on the needs of the individual, the Pastor may decide to discuss the issues in a Biblical perspective by providing scripture. The Pastor also may also choose to incorporate prayer with the individual about

their concerns. The Pastor also may choose a Pastoral counseling approach to better assess the needs of that person.

Pastoral counseling is a process in which Pastors, ministers, and etc. provide therapy which includes a spiritual integration (Dayringer, 2012). In this role, Pastors are able to address the immediate needs of their congregation members. As mentioned previously there are several barriers to African Americans seeking mental health counseling. Pastors can provide an element of familiarity and comfort in that members may already have a relationship with their Pastor in which a level of trust has been established. This trust allows members to share certain issues that they might typically share with a counselor outside of the church. These issues could include issues related to one's spirituality, challenges of everyday life, and mental health concerns. An individual presenting to their Pastor with issues of everyday concerns may also appreciate the integration of scripture or prayer.

Related to specific mental health issues, Pastors may differ in their approaches to providing support. Pastors may view the issues of the individual purely spiritually in nature, requiring prayer, scripture, and spiritual guidance. Other Pastors may take an approach that incorporates different elements of counseling while still integrating spirituality. This approach can vary and is likely based on the Pastor's education and training (Farris, 2007).

Church Congregation

The congregation represents the body of the church which forms one union. This union is led by the Pastor who provides leadership and direction for the church. In this role, the Pastor acts as the leader of those who attend and often assumes the role of an

educator. The Pastor is the person the congregation looks up to and provides leadership spiritual guidance. As part of the Pastor's leadership he or she assumes the role of being the head of the administration. The administration's primary responsibility is overseeing the daily functions and operations of the church. These duties may include the finances, budget, updating the church's bylaws, scheduling of church activities and etc.

Part of the leadership role requires that the Pastor provide foundation and structure for the church (Ingram, 1981). In the structural role the Pastor is able to evaluate different aspects of the church and to provide leadership where needed. This leadership can include assigning different tasks to church members, being involved in church activities, and educating church members. In the leadership role Pastors may find themselves integrating a certain level of ambiguity in their role (Ingram, 1981). Ambiguity involves allowing flexibility to switch between different roles as needed. As different needs and issues arise in the church a Pastor may need to adjust his or her role in that moment to respond appropriately.

Pastors Attitudes towards Mental Health Services

In the African American community, The Black Church and its leaders seem to be first responders to the mental health needs of African Americans. Pastors hold the important task of providing a safe space for congregation members to receive support related to multiple issues (Bilkins, Allen, Davey, & Davey, 2016). This is especially important as African Americans have been historically oppressed making it difficult to trust those outside of the walls of the church (Allen, Davey, & Davey, 2009). Pastors can be seen as the bridge that connects referrals of congregation members to mental health services in the community (Bilkins et al.). Bilkins et al. conducted a study that

specifically examined Black Pastors attitudes toward mental health professionals. From this study they concluded that more research needed to be done to accurately grasp Black Pastors attitudes. They also found that different factors such as Pastors' personal experiences, cultural worldview, and understanding of mental health issues can either increase or decrease the likelihood of a community based referral.

Cultural Influences

The cultural beliefs of a Pastor not only influence the way one may provide spiritual guidance to their congregation, but also their approach to addressing mental issues. Cultural beliefs may impact not only the interventions a Pastor utilizes but also their conceptualization of the underlying causes of certain mental health issues (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013). Payne (2009) focused specifically on the impact of the race of the clergy and their views on the etiology of mental health conditions. She found that African American Pastors tended to conceptualize the etiology of mental health conditions as purely spiritual in nature. Due to this stance, African American Pastors typically approached mental health concerns from a religious viewpoint. Interventions used included prayer, scriptures, participating in church activities and etc. (Payne).

Another cultural influence that impacts a Pastor's attitudes towards mental health services is religious denominations. Messages received from specific religious denominations can influence how a Pastor approaches mental health conditions in the church. Payne (2009) found that Mainline Protestant Pastors viewed mental health conditions as those caused by biological or medical conditions, while Pentecostal Pastors felt mental health conditions were caused by spiritual or moral reasons. The views

Pastors hold regarding mental health services may impact a Pastors willingness to refer to clinicians in the community. Pastors are protective of their congregation and want to be sure that they will be taken care of if referred to an outside resource. Sharing the values held by the church, leaders, and members is an important component in creating a relationship between The Black Church and the mental health community (McMinn, Runner, Fairchild, Lefler, & Suntay, 2005). The mental health community would better serve African Americans if it recognized how spirituality impacts these clients' coping mechanisms and resilience.

Personal Experiences

Personal experiences throughout one's life can help form one's worldview and impact how people make everyday decisions. Discrimination has plagued African Americans for decades and continues to impact this population psychologically to this day. Discrimination can be present in the health care agencies as some professionals may not be delivering culturally competent services (Rowland & Isaac-Savage, 2014). Culture competence can be defined as, "systems, agencies and practitioners with the capacity to respond to the unique needs of populations whose cultures are different from that which might be called dominant or mainstream" (Cowan, 2009, p.29). Delivering culturally sensitive services requires mental health professionals to be knowledgeable and appropriately trained. Cultural competence can aid can counselors who will be working with African Americans who rely heavily on their religion or spirituality.

Pastors who have sought out mental health services and have personally experienced counseling are more likely to refer congregation members to mental health services in the community (Brown & McCreary, 2014). Brown & McCreary also

concluded that Pastors who are unwilling to receive their own counseling and hold a negative stigma towards mental health services are highly unlikely to refer congregation members. Pastors may rely on their own personal experiences in order to provide support but also to provide information to assist parishioners in making their own decisions. Trust is also an important characteristic needed to foster a therapeutic relationship. Historically, African Americans are less likely to trust Caucasian clinicians versus African American clinicians (Thompson, Worthington, & Atkinson, 1994). This distrust can cloud the judgment of Pastors in creating relationships with clinicians within the community (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013).

Understanding of Mental Health Issues

The training of Pastors can differ based on their background and/or denomination. These differences can have an impact on the knowledge and understanding of Black Pastors. In a study done by Farrell & Goebert (2008) it was found that 71 percent of Pastors felt incompetent in their training to recognize mental health conditions. Some Pastors have reported that they simply are uninterested in the role that mental health professionals serve (McRay, McMinn, Wrightsman, Burnett, & Ho, 2001). These two factors are important in trying to understand Black Pastors attitudes towards mental health issues. According to Allen, Davey, & Davey (2010) 85 percent of Pastors who have a college degree report referrals to mental health services in the community. Consequently, there may be a link in a Pastor's level of education and willingness to make community referrals. Some Pastors reported acquiring their knowledge of mental health from their own research, self-study, or personal and familial experiences (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013).

Researchers are acknowledging the gap between education and training of some clergy. Although very limited, there are some programs that exist which provide mental health trainings for Pastors. This type of training would allow Pastors a chance to better understand the causes, diagnoses, and treatments of mental health conditions from the perspective of a mental health professional. Age may also play an important role in how Black Pastors understand mental health issues. Stanford and Philpott (2011) found that senior Baptist Pastors who considered themselves to be modern and mainstream were more knowledgeable and willing to refer its members out to the community. In Stanford and Philpott's study senior Pastors were defined as middle-aged, highly educated, and predominantly Caucasian. Caucasian Pastors comprised 89.9 percent of the participants while African American Pastors comprised 3 percent of the participants in this study.

Other Support Services

Authors have acknowledged that there is a gap between the Black Church community and the mental health field (Avent, Cashwell, & Brown-Jeffy, 2015). Although steps have been taken to create a trusting relationship for collaboration, the progress is slow. There are several other organizations that exist to support Pastors in addressing the mental health concerns in their congregation.

Clergy Outreach and Professional Engagement (C.O.P.E.). C.O.P.E. was created in 1998 to serve the mental health needs of an urban African American community (Milstein, Manierre, Susman, & Bruce, 2008). Glen Milstein, a clinical psychologist, and Amy Manierre, an ordained minister, decided to collaborate to address both the mental and spiritual needs of individuals on a larger scale. The goal of C.O.P.E. is to facilitate a trusting collaboration between mental health professionals and clergy in

the community regardless of their religious denomination. C.O.P.E. operates through the lens that an interprofessional collaborative approach is more helpful than one individual working alone.

Mental Health Service Act (MHSA). MHSA is a program that was created in California. MHSA is a full service partnership program that, “addresses social welfare and other human service needs of seriously mentally ill adults and children who are especially socially and economically vulnerable or who are untreated or insufficiently treated” (Cordell & Snowden, 2017). MHSA appropriates its funds to the state of California who then makes it available to county level mental health systems. Between 2004 and 2012, MHSA raised over 8.3 billion dollars specifically for the mental health treatment of those from a vulnerable background. MHSA works from a holistic prospective in that it partners with community officials such as clergy members.

Substance Abuse and Mental Health Service Administration (SAMHSA). SAMHSA is a federal agency housed under the United States Department of Health and Human Services (HHS). It was created in 1992 to provide recovery support services at a low cost to individuals struggling with a substance use and mental disorder (SAMHSA, 2016). SAMHSA has partnered with faith-based and community organizations to provide support for individuals, families, and communities. Different types of assistance provided through faith-based organizations are: youth violence prevention, HIV/AIDS resources, homelessness, and crisis support.

Chapter 3: Research Methodology

Chapter Overview

The purpose of this chapter is to explain and describe the research methodology that was used in the qualitative research study. The following areas will be addressed: The purpose of the study, research question, protocol related to participants, data collection procedures, data analysis, and trustworthiness.

The researcher conducted a qualitative research study by incorporating a phenomenological research approach. A phenomenology study focuses on the meaning and perceptions of individuals' lived experiences (Merriam & Tisdale, 2016). In a phenomenological research study there is no influence of objective interpretations but only the subjective experience and interpretation of the participants. Within a phenomenological approach exists a social interactionism approach, which focuses on one's experience, interpretation of experiences, and how people may create or share meaning through interactions (Merriam & Tisdale). The phenomenological/social interactionism approach aligns with this research study as a heavy emphasis is placed on the participants' experiences as well as meaning making via interactions between members and mental health professionals.

Aspects of the postmodern perspective are relevant to this research study. A postmodern approach supports the notion that there is no single truth or single reality (Merriam & Tisdale, 2016). Instead it contends that there are multiple worldviews which acknowledge differences in diversity, cultures, systems, and subjective realities of individuals (Merriam & Tisdale, 2016). In line with this approach, this research not only

focuses on the subjective experience of its participants but also how race, culture, spirituality and religion may influence their experience (Merriam & Tisdale, 2016).

Problem Statement

As previously discussed in chapters 1 and 2, there is a weak relationship that exists between the Black Church community and mental health referrals. The research study sought to clarify how spirituality, religion, and culture are associated with the Black Church and can impact African American pastors' experiences with mental health issues and services.

For several decades there has been a gap in the literature as it relates to spirituality, mental health and The Black Church. Historically, African Americans have been underrepresented in utilizing mental health services (Avent, Cashwell, & Brown-Jeffy, 2015). Some of the barriers that may impact African Americans' attitudes towards mental health services may include stigma, cultural norms, cultural mistrust, racial preference, and finances to name a few (Awosan, Sandberg, & Hall, 2011). In the African American community, spirituality and religion have been identified as both a protective factor and a means to cope when faced with a difficult situation (Mitchell & Ronzio, 2011). There is a gap in the literature as it relates to African American Pastors' experiences as responders when faced with the mental health concerns within their congregation. The research will investigate the individual experiences of African American Pastors in providing counseling services to their congregation members by listening to their stories, learning about their training, and hearing about their experiences.

As counselors, educators, and supervisors, The American Counseling Association (ACA) Code of Ethics Preamble specifically calls for those in the counseling profession to, “honor diversity and embrace a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts and promote social justice” (ACA Code of Ethics, 2014, p. 3). This standard calls for those in the counseling profession to bridge the gap between the mental health community and communities that represent individuals from a vulnerable population.

Purpose of the Study

The purpose of the study was to understand the role of African Americans Pastors in providing mental health support and ways the mental health field can help bridge the gap between the Black Church and mental health community. The researcher sought to learn more about the impact religious denominations may have on counseling services as well as messages that have been relayed to members concerning mental health. It was hoped that the results from the interviews will help to build collaboration and create partnerships between community counselors and African Americans Pastors.

The research sought to better understand how African American Pastors conceptualize the mental health issues of their congregation and what aspects of their training, religious denomination or experience helped them in providing counseling or referring to outside services. The research contributed to the counseling profession by adding to the scarce literature available related to the intersection of African Americans, spirituality, religion, and mental health. Specifically, the study provided an opportunity to explore the authentic experience of African American pastors as it related to mental health.

The research provided a voice for the Black Church community and African Americans overall experiences and barriers faced by the community, and attitudes towards the mental health profession. As previously mentioned, The ACA Code of Ethics Preamble calls for counselors to honor diversity, embrace diversity, and promote social justice. The research provided an understanding of the ways the counseling profession can carry out its duty as described in the Preamble.

Research Questions

The research questions were created with the intention of being mindful of the population of interest. The research examined the relationship between the denomination of African Americans Pastors and their experiences and role as responders to the mental health needs of their congregation. The specific research questions of the qualitative study were:

1. What are African Americans Pastors' experiences of mental health issues in the Black church?
2. What are African Americans Pastors' beliefs in referring members to clinicians in the community?
3. What are African Americans Pastors' experiences with clinicians in the mental health community?
4. What approaches can the mental health community can take in building relationships with local churches?

Sample

The research study included participants who identified as African American Pastors of a predominantly African American church (n=8). Participants were located in

the Eastern Region of the United States. Three participants were interviewed from each of the following religious denominations: Baptist, Non-denominational, and Pentecostal. Participants were conveniently sampled by using the researcher's personal connections within the Black Church community with the incorporation of snowball sampling, as needed. Snowball sampling was used during the recruitment process. The researcher discussed the criteria needed to be a participant in the study and gave permission to interested individuals to share the study with others.

The researcher contacted participants via email and by phone for recruitment for the study. The research included pertinent information such as the rationale for the study, time frame of interviews, protecting participants' identity and confidentiality during the initial contact. To ensure confidentiality, the information related participants was stored on a password protected computer. The researcher had participants sign an informed consent to detail all relevant information related to the research study.

Methods

Participants were invited to participate in a semi-structured interview ranging between 45 to 60 minutes. The interviews took place via Skype or by phone. Each interview was audio recorded and transcribed using a transcription service. All recordings were stored on an encrypted and password protected hard drive. The interviewer used a transcription service that ensured the protection of information and confidentiality. Once the transcripts were transcribed they were sent to the researcher, electronically, by the transcription service. The transcripts were stored on an encrypted and password protected hard drive and secured in a locked file until completion of the study.

Interview Protocol

The interviews were semi-structured due to the nature of the study relying heavily on the participants' experiences. A semi-structured interview allowed for flexibility in the interview protocol and an opportunity for spontaneity as new themes emerged during the discussion. The semi-structured interview protocol was as follows:

Semi-Structured Interview Questions

1. What is your role in supporting the mental health needs of your congregation members?
 - a. How has your role changed across time and/or location?
2. What is your experience in providing counseling to congregating members?
3. How do you believe your denomination may differ in training Pastors from other denominations?
4. What role do you find yourself in when supporting your congregation member during a mental health crisis?
 - a. What issues or challenges have you encountered for yourself when providing this support?
5. How well prepared do you feel in providing mental health support as it relates to the mental health needs of the church?
 - a. What experiences or parts of your training make you feel prepared?
 - b. What experiences or types of training do you wish you had?
6. What is your experience in working with mental health professionals in the community?

- a. What is your experience in referring members to mental health professionals in the community?
7. What do you feel is important to help co-create a relationship with mental health professionals in the community?
8. What else would you like me to know about your experiences with the mental health needs in your church?

Data Analysis

The research worked from the framework of the phenomenological analysis which is used to analyze the experiences of participants (Merriam & Tisdale, 2016). Epoche, bracketing, phenomenological reduction, imaginative variation, and heuristic inquiry are all characteristics of phenomenological analysis (Merriam & Tisdale, 2016). Epoche is, “the process through which the researcher brackets or isolates biases in order to be open to the experience” (Merriam & Tisdale, 2016, p. 227). Merriam & Tisdale report that a phenomenological reduction allows the researcher to put aside any biases and reflect on the data to better understand the lives experiences of the participants (2016). Imaginative variation allows the researcher to view the experiences from several different perspectives and Heuristic inquiry includes the personal experience of the research and interactions with the data (Merriam & Tisdale, 2016, p. 227).

Each interview was transcribed and coded. Coding involves a method used to retrieve, organize, and analyze collected data. The coding process included open coding, which allowed for the retrieval of pertinent data relative to the study, axial coding placed the data into categories and selective coding which formulated the core themes. For the purpose of the study, a theme is defined as a main idea or reemerging pattern.

Trustworthiness

Trustworthiness relates to the credibility of the qualitative research and trustworthiness of the researcher who collects and analyzes the data (Merriam & Tisdale, 2016). Trustworthiness also seeks to understand the impact of the researcher's biases, assumptions and beliefs. The researcher engaged in active consultation with counselor educators. As form of bracketing, the researcher recorded, in writing, her own biases in relation to worldview, assumptions or cultural beliefs to avoid influencing the participants.

Chapter 4: Data Collection and Analysis

Overview of the Study

The purpose of the study was to understand the role of African American Pastors in providing mental health support as well as ways the mental health field can help bridge the gap between the Black Church and mental health community. The researcher used the phenomenological approach to help understand the experiences of African American Pastors as it related to providing mental health support to their congregation members. The researcher aimed to provide the participants the opportunity to discuss their role and experiences. The researcher strived to give meaning to the participants' experiences in an effort to better understand the relationship between the mental health field and African Americans. The data for the study was collected by conducting one-on-one semi-structured interviews. The following research questions were used to guide the study:

1. What are African American Pastors' experiences of mental health issues in the Black church?
2. What are African American Pastors' beliefs in referring members to clinicians in the community?
3. What are African American Pastors' experiences with clinicians in the mental health community?
4. What approaches can the mental health community can take in building relationships with local churches?

The primary purpose of this chapter is to present the findings of the research study. The findings were organized into themes and subthemes, which were discovered through the consensual qualitative research data analysis process. As previously

mentioned in chapter 3, a theme is defined as a main idea or reemerging pattern. The themes were derived from the descriptions given by the African American pastors and their perceptions regarding mental health and their role in providing mental health support. Attitudes and beliefs related to referring to clinicians in the community were broached during the initial clinical interviews. The semi- structured interviews, demographic questionnaires, and fields notes were also analyzed to discover emerging themes and patterns. Chapter 4 is organized into the following: data collection, description of participants, data analysis, and summary.

Data Collection

The researcher followed an interview protocol when collecting data for the research study. The researcher conducted eight semi-structured recorded interviews via telephone with eight participants. The interviews were conducted via telephone due to location restraints and the request of some of the participants. The interviews were conducted in the home office of the researcher to ensure privacy and confidentiality. The interviews ranged from 13 minutes to 45 minutes with an average time being 25 minutes. The researcher recorded all interviews using a password protected Apple MacBook Air recording software and Dictopro Digital Voice Activated Recorder. The researcher used a transcription service called Azur Captions which ensured confidentiality. Once the interviews were transcribed, the researcher reviewed the transcripts by listening to the audio recording of the interviews while reviewing the transcripts to correct any content or grammatical errors. The researcher created folders for each participant on an encrypted and password protected hard drive. The laptop, audio recording device, and encrypted and password protected hard drive were stored and locked in filing cabinet.

Participants were first recruited by using convenience sampling by utilizing the researchers personal connections within the Black Church community. The researcher conducted the first round of recruiting participants by using the recruitment email outlined in Appendix B. The researcher conducted a second round of recruitment, which included snowball sampling in which the researcher recruited participants by allowing participants and personal contacts to share the request for participants with their acquaintances. The third round of recruitment involved the researcher locating African American pastors from different denominations and contacting them via email by following interview recruitment protocol. Once potential participants expressed interest in participating in the research study, the researcher contacted them either via phone or through email to collect pertinent information such as name, contact information, and scheduling information. The researcher also ensured that the participants met the criteria necessary to participate in the study. The researcher informed all participants that they would receive two documents which were required to participate in the research study. The researcher emailed the Consent to Participate in Research (Appendix C) and Demographic Questionnaire (Appendix E) to participants. The researcher explained the purpose of each document to the participants, reviewed confidentiality, and explained to participants their right to discontinue their participation at any time.

During the initial contact, participants were made aware that the researcher would be using a digital recording device to record the interview and that a transcription service would be transcribing the interviews. Each participant confirmed their understanding and consented to participate in the research study. At the end of each interview the researcher provided the participants an opportunity to address any issues or share additional

thoughts that they felt were important for the researcher to know. The following interview questions were used to conduct the one on one semi-structured interviews:

1. What is your role in supporting the mental health needs of your congregation members?
 - a. How has your role changed across time and/or location?
2. What is your experience in providing counseling to congregating members?
3. How do you believe your denomination may differ in training Pastors from other denominations?
4. What role do you find yourself in when supporting your congregation member during a mental health crisis?
 - a. What issues or challenges have you encountered for yourself when providing this support?
5. How well prepared do you feel in providing mental health support as it relates to the mental health needs of the church?
 - a. What experiences or parts of your training make you feel prepared?
 - b. What experiences or types of training do you wish you had?
6. What is your experience in working with mental health professionals in the community?
 - a. What is your experience in referring members to mental health professionals in the community?
7. What do you feel is important to help co-create a relationship with mental health professionals in the community?
8. What else would you like me to know about your experiences with the mental health

needs in your church?

Description of Participants

The sample of the research study consisted of eight African American Pastors who lived primarily in the Southern Region of the East Coast. There were four African American men and four African American women who participated in the research study. The researcher gathered demographic information such as age, gender, denomination, size of church, highest level of education, and years served as Pastor. The following are detailed descriptions of each participant. For the purpose of the study and to protect the identity of each participant, a pseudonym will be used and each participant will be referred to as such for the study.

Participant 1

Karen is a 61 year old African American female who identified the denomination of the church she currently is Pastor of as Non-Denominational. Karen reported her church is located in a small rural community in which the population is less than 20,000 residents. Her church has an estimate of 300 members. Karen has been the pastor of this church for one year and reported she earned her Doctorate Degree in Christian Counseling. Karen reported she has had personal experience with mental health by receiving mental health services from a licensed mental health professional.

Participant 2

Sean is 57 year old African American male who identified as a Pentecostal Pastor. He reported his church is located in a small rural community with a population of 20,000 residents or less. He stated he has approximately 50 members who attend his church. He

has 17 years as a pastor of a church. Sean reported he has a High School diploma. Sean has never sought services from a licensed mental health professional.

Participant 3

Paul is a 57 year old African American male who identified the denomination of the church he currently is Pastor of as Baptist. Paul reported his church is located in a small urban community in which the population is less than 20,000 residents. His church has an estimate of 150-175 members. Paul reported he has 17 years of experience as a Pastor and reported he earned his Doctorate Degree in Theology. Paul reported he has had personal experience with mental health by receiving mental health services from a licensed mental health professional.

Participant 4

Jessica is a 40 year old African American female who identified the denomination of the church she currently is Pastor of as Non-Denominational. She reported her church is located in a large urban community in which the population is over 75,000 residents. Her church has an estimate of 150 members. Jessica reported she has 15 years of experience serving as a Pastor and received her Bachelor's degree in Marketing. Jessica has never sought services from a licensed mental health professional.

Participant 5

Frank identified as an African American male and reported the denomination of the church he currently is pastoring as Non-denominational. Frank's church is located in a small suburban area in which the population is less than 20,000 residents. Frank reported his church has an estimate of 1,000 members. He reported he has six years of experience

pastoring a church. He currently is working on his Doctor of Ministry. Frank has sought mental health support from a licensed mental health professional.

Participant 6

Anna is a 65 year old African American female who identified her denomination as Pentecostal/Apostolic. Her church is located in a small rural community which has a population of less than 20,000 residents. She reported her church as 15 members. She has been a Pastor for three years and a Minister for 28 years. She received her Doctor of Philosophy in Ministry. Anna has never sought services from a licensed mental health professional.

Participant 7

Rick is a 66 year old African American male who identified his denomination as Baptist. His church is located in a small suburban community in which the population is less than 20,000. He reported his church has 250 members. He has his Doctorate degree in Counseling Psychology. Rick reported he has received mental health services from a licensed mental health professional.

Participant 8

Diane is a 43 year old African American female who identified her denomination as Non-Denominational. She reported her church is located in a urban community which as over 75,000 residents. She has seven years of experience as a Pastor and her church currently has an estimated of 30 members. She reported she has a Bachelor's degree in Communication. Diane has never sought counseling services from a licensed mental health professional.

Data Analysis

The purpose of the study was to better understand the experiences of African American Pastors as it relates to providing mental health support to congregation members. The researcher was also interested in learning if there was a connection between religious denomination and attitudes regarding community mental health services. The researcher used the phenomenological method by interviewing participants to get a better understanding of their experience and to provide meaning to their shared stories (Merriam & Tisdale, 2016). Below are the results from the interview which are organized by interview question. The researcher explained the purpose of each interview question and what she hoped to learn. If a theme emerged it was listed under the interview question from which it emerged from. A small description is provided for each theme along with the responses from the participants. There were five overarching themes that were most common which were: Role of Pastor, Impact of Denomination, Training, Community Involvement, and Initiative. There were 15 themes that were less common yet worth noting due to the emphasis placed on them by participants. The 15 themes were: Pastoral Counseling, Spiritual Interventions, Awareness, Beliefs, Background, Differences, Individualized, Prayer, Therapy, Knowledgeable, Experience, Education, Referrals, Respect, and Dialogue.

Interview Question 1

The first question of the interview was, *What is your role in supporting the mental health needs of your congregation members?*. The question served as one of the main questions as it related to research questions that guided the study. The purpose of the question was to learn more about the role that the pastors feel they are in when it comes

to providing mental health support. All of the participants discussed their role as one that provided pastoral counseling or Christian counseling. The participants discussed their role as one that is based in Biblical influences and seen through a spiritual lens. The first theme that emerged from this interview question was the role of Pastor. There were also three additional themes that emerged which were pastoral counseling, spiritual interventions and awareness.

Theme 1: Role of Pastor

The first theme identified in the research study was the role of the pastor. The researcher identified this as theme through the discussion with the participants regarding their responses to the mental health issues of their congregation members and how they provide mental health support.

Pastoral Counseling. All of the participants discussed their role in providing mental health support as one that was based in pastoral or Christian counseling. It seemed clear that the participants were clear in their identity. For example, Karen stated:

Well, I'm actually a Christian counselor. With any position in the church basically it's some form of counseling; it's just that I'm a professional Christian counselor that's qualified to do so.

Sean elaborated on his role and how he provided support through a spiritual lens. He stated:

Pretty much when it comes to the Pentecostal church with a mental health issue, we deal on a spiritual basis, mostly the fact that we have psychiatrists and mental health professionals -- we, in a sense of spirituality -- we deal with it on a spiritual basis.

Frank provided a detailed response in which he discussed how his role is one that is based in the “Biblical truth” and shared the importance of his role as one that views his congregation through a holistic lens which includes looking at an individual “mentally, physically, emotionally and spiritually”. He said:

Supporting their mental health needs. My role as a pastor, one, is to share truth, Biblical truth that is relevant and ensure the relevancy of the Biblical truth to pair in context. And so, one thing I recognize with mental health is that there’s not new concepts just because it now has a diagnosis or you’ve made a diagnosis, but there are people that have mental health issues in the Bible and also, too, that Jesus addressed many of those things or somewhere in the Bible those things were addressed. Now, the way they’re addressed in the Bible -- this might come up a little bit later -- some things are seen more as a spirit issue than just a mental issue. And so, one, I believe when there is clear truth it would give people a decent place to start asking more questions or to seek more answers with the issues that they find. So, one, in general as a pastor, I believe one of my duties is to help people identify a human problem that we have and that human problem affects us mentally, physically, emotionally and spiritually. Specifically with mental health, if they identify it, some things can be handled in pastoral counseling.

Rick and Diane expressed a similar view in which their role is one that provides congregation members with a chance talk about their issues and to be a “point of contact”. Diane also mentioned how her personal experience influences her role. She said:

I guess that it would be through counseling and talking to them, simply because my approach to mental health is different because I deal with it with my mom.

She has bipolar.

Spiritual Interventions. Spiritual interventions encompass a variety of different interventions that pastors may include when providing mental health support. During the interviews the participants discussed how they would use prayer or scriptures as a way to provide support for congregation members. Sean discussed how he used prayer and the word of God. He stated:

The person who has a mental problem, we counsel them, talk to them -- pray for them and counsel them, you know, and then try to direct them in the right way in whatever issue they may be dealing with. We try to deal with it with the word of God, you know. We'll bring scriptures in to deal with depression or whatever the mental.

Jessica discussed how she used prayer and conversation as spiritual interventions stating, "I'm able to pray with them and I'm able to have conversations with them". She shared how she viewed her role as one that is also an "advocate". She used the title "coach" and "advocate" to explain how she moreover provides "resources" to her congregation members. She stated:

I like to think of myself as a resource. I don't -- what I do -- let me say it like this. One thing that I do is I coach. I am a coach but there are a lot of times when I'm assessing their needs and meeting with them that I realize what they need. So, I see myself as a liaison and an advocate but not clinical in my role. I don't do the deep stuff. I know how to pray.

Karen was similar in stating that prayer is also a spiritual intervention that she uses. She said:

I know God's word. I understand it and it's what I want to preach, and I feel like prayer and things like that are going to change a person's mental status.

Anna shared how she was intentional with the support she provided stating her roles includes, "Prayerfully offering verbal interaction to aid the wounded parishioner to overcome and correct obstacles which effect proper Christian personality and behavior."

The first sub-question was, *How has your role changed across time and/or location?* The participants discussed a variety of different changes that have influence how they view their role. The participants discussed how the difference in the location can heavily influence the way they view their role in providing mental health support. Some participants mentioned how their role changed through awareness and a few participants felt their role has not changed at all.

Awareness. Awareness was a theme that emerged as participants discussed whether they felt their role had changes across time and/or location. Karen discussed how she felt it change due to society changing and become more aware. She stated:

I think it's changed because people now realize that they need to have some kind of background to do any type of counseling other than just saying that God has called me to do so. We're in a society where people kind of respect you being qualified educationally to things. When I was coming up, just someone saying, "God called me to be a preacher. God called me to be a counselor," it was acceptable, but now you almost have to have something more.

Diane was similar in feeling that there has been more awareness regarding mental health. She said:

I do. I really do believe it has changed because you know, when I was growing up more with my -- well, let me say this. It probably has not changed; it's just more out in the forefront, so it's something that has to be dealt with. Because I can remember going to church with my grandmother, you know, and everything was demons, you know? I don't think they talked about mental health issues like that. They didn't want to believe that it could be depression or, you know, any kind of mental health illness. So, I really believe that it's just more out in the forefront. So, we're forced to deal with it.

Paul discussed how he felt the role has changed over time and location. He shared the following:

The role definitely changed as far as location and churches. I would say in the city I would say it's probably a bit more advanced with assistance and aids that met mental healthcare. I would say in a rural area it's more defined in the church.

Anna differed in which she felt her role has changed as it related to time. She mentioned "maturity, experience, and education" as factors that have contributed to her role evolving. She stated:

I have learned that not one person has it all together. No matter how gifted and educated we may be, we need each other. God has a way of knitting us together in love, as his children. If we all have the same goal of "putting Him first" he works things out for our good.

Interview Question 2

The second question of the interview was, *What is your experience in providing counseling to congregating members?* The purpose of this question was to serve as an extension from the first interview question. This question was used to find out the participants experience in providing counseling to their congregation members versus how they view their role. It was hoped to learn how participants experience counseling and how they view their experiences with congregation members. Many of the participants explained their experience as one that included pastoral counseling as a main form of support. The previously identified theme of pastoral counseling re-emerged as the pastors discussed their experiences with counseling.

Pastoral counseling. Pastoral counseling repeated as a subtheme and reemerged when participants discussed their answer for interview question 2. Karen was very clear in articulating her experience but also what the next step is when she feels her congregation members may need more. She explained:

I'm currently our church's Christian counselor and my experience has been basically people coming in for spiritual guidance, which sometimes is some type of mental issue but not to the point where I need to say that maybe meds are needed or whatever; I don't do that type of referral. I tend to the spiritual aspect, but if I identify that a person needs more I'll let them know.

Paul was similar in his experience stating, "It's been mostly pastoral counseling". Paul and Jessica were both similar in that they felt their experience had progressed over time. Paul stated:

As time progresses I see now that it's also progressing into mental health as well; not as much, but I could tell you once again I'm going to research and if I can't provide help to the person then I try to point them in the right direction.

Jessica provided a more detailed answer in which she linked her experience as a graduate counseling student to her experience providing counseling to her congregation members. She explained how a project she was completing related to psychological assessments and inventories and through doing research it was confirmed that the things she was learning were things she currently was doing through providing support for her congregation members. She stated:

I was actually working on a project last night and I was doing a psychological assessment for a patient, a client or whatever, and one of the things that I had to do was come up with some different inventories or scales that would help them to see if this person was good enough to go and one of the inventories that I was looking at was testing a person's anxiety scale. If they'd been through any major life events in the few years, it showed how they may be at a higher risk of being burned out or depressed in the future. So, I was really -- I didn't know that then, but I was letting them know that at any time you could make it back to this place if you're not willing to do the work. So, sometimes it doesn't make it to that but sometimes I do have to intervene, and I'll tell you -- I'll just share real quick.

What I typically do is, of course, I ask them to tell me what's going on and how they're feeling, and then what I do is if they can't seem to grasp what's making them depressed, then I usually give them homework. I really encourage them and I say, "I want you to go home and think of the worst three things that have

happened in your life. I want you to write about them, talk them out,” because a lot of times these people have not had any -- they have not been able to get these things out.

She went on to explain that her experience is not just solely providing counseling but also providing psychoeducation as it relates to mental health. She stated:

So, they've held onto it and it becomes toxic, and if you don't deal with it as a child you're going to have to grow up and deal with it one day. So, that sort of counselor. That's usually what I do. I just ask open-ended questions. I use very few close-ended questions, but something to get them talking. And then, I clarify: “So, this is what I'm hearing you say.” And I pray with them if that's something they're open to, because even though I'm a spiritual leader, people aren't as open to those things so I sort of gauge where they are and that helps me determine when is the right time to pray and when isn't.

Anna was very reflective when answering this question and came from a place where she is both caring but also likes to challenge her congregation members when providing counseling. She discussed a quote that one of her congregation members referred to her as which reads, “using cream instead of lemon”. She explained how this member stated she used cream instead of lemon to help him through a crisis. She discussed how in her experience of providing counseling she always likes to provide ‘caring, empathic, and supportive’ counseling for congregation members instead of being “sour” like a lemon. She said:

A pastor has to have a heart for the people of God. Listening is a sacrificial gift of love. As I listen, empathize, support (prayer, food, finance, education, etc.) to

help heal the hurt, parishioners are receptive. My experience has been that of gratitude, a solid understanding of God's promises to us and that we have a Christian family who will uplift us through the process. Clear direction and correction is offered and received with the parishioner following the process to healing, peace and love for God and others. One of my parishioners has referred to me as "using cream instead of lemon" to help him through his crises.

Rick discussed his experience as one that comes naturally due to his identity as a licensed psychologist and regularly providing counseling. He shared:

Because I do it on the regular, I feel like it's a function of my role to the degree that I'm involved with people at such a significant level and what I do is -- for my members, I try to keep it short-term. If I see that it's something that requires more time that I'm able to give, I probably facilitate a referral.

Diane differed in her response in that she spoke more about her personal experience with mental health issues as it related to her family and how that has made her more sensitive to mental health issues when providing counseling. She stated:

I think it's more both, but one thing about me is that I'm very sensitive to mental health issues because I know it's something that can be in you for years before it even surfaces, you know? Again, I deal with it -- when my mom suffered that, we didn't even have a clue that she had until we found her checked into one of the mental hospitals. So, I know that it's a different way than it appears to be. So, I just try to really approach my members on a real basis, you know, and share with them the mental health issues that I've seen and that I deal with on the regular.

And I always encourage them, “Look, if you need to talk to somebody, you don’t have to talk to me.”

Interview Question 3

The third interview question was, *How do you believe your denomination may differ in training Pastors from other denominations?* This question was included to better understand the training of the participants as it related to their religious denominations. The researcher interviewed participants from three different denominations. Participants shared how their denominations may or may not differ from others. They also discussed how their denomination impacts their views of mental health. The themes that emerged were impact of religious denomination, beliefs, background, and differences.

Theme 2: Impact of Religious Denomination

The researcher identified the impact of religious denomination as a theme due to the importance of spirituality and/or religion to both congregation members and the pastor. The research study included three different religious denominations who were similar and different in some of their ideologies and trainings. Participants shared how the beliefs and messages they receive from their respective denominations regarding mental health and how it has influenced them.

Beliefs. Some of the participants discussed how their denomination influences their beliefs as it relates to mental health. Karen shared how she thinks the beliefs should be the same if God is who the denomination believes in. She stated:

If it’s a denomination that worships God, we should all be pretty much using the word of God as our guidance. No matter what your denomination if they’re all

serving one God. Now for, the many that don't believe in God, they may operate in a different manner because our belief would be different.

Sean shared how coming from a Pentecostal denomination has influenced his beliefs and how he approaches mental health issues. He shared that mental health is not necessarily a primary focus of the Pentecostal denomination, but moreover stated, "They've been taught and they believe God can deliver, set you free, you know". He went on to say:

Yeah, so that's what we've pretty much been taught, trained. By the same token, I don't discourage or try and keep anybody -- any of my members from going to a mental health professional or a psychiatrist, you know what I'm saying? If they want to go, they're free to go. I don't try to stop a member from going to the doctor if they're sick or anything like that. Get a doctor, you know? But people have been taught that, so you know what I'm saying? What they're taught, that's what they go through, you know what I'm saying?

Frank discussed how his denomination is new but also an extension from an existing denomination. He also discussed their beliefs. He explained:

Yes. So, it's a relatively new denomination in the sense that it's about twenty five years old. In most circles, people would just say they're non-denominational, and it's more of a network of churches. But we have a set of doctrinal beliefs and we operate like a denomination overall in the sense of how we formulate how the churches resemble one another, things like that. And so, spiritual formation would probably be one of the lynchpins or what I would say is one of the bedrock foundational things that helped me understand me and helped other people come

to a place of discerning God's voice or discerning what they're going through. So, that level of discernment kind of came through spiritual formation.

Anna identifies as Pentecostal and shared the following regarding her beliefs:

I don't know that there are vast differences in the basics (purpose, mode) of counseling. We do believe that God is all knowledgeable, a healer, a deliverer, a provider, he keeps his promises and his word is truth and our solid foundation for whatever life offers. We believe that God uses doctors, counselors, medicine and miraculous divine healing. We have witnessed all and have full faith in the power of God.

Background. A few of the participants connected the influence of their denomination to their background as it relates to their upbringing or as Sean state "where I come from". Sean explained how he is not necessarily aware of how other denominations may feel or believe about mental health but spoke about his stance as it relates to being a Pentecostal pastor. He shared:

I don't know what the other churches, Baptist or Methodist or Episcopalian, because I haven't really studied what their belief in that field was but I'm speaking on where I come from, Pentecostal. I know we believe in God for deliverance and people can be delivered through prayer and fasting and all that, and through counseling from the word.

Jessica moreover discussed her background as is related to how she was raised. She specifically differentiated the impact of the denomination she practiced when she was younger versus the denomination she currently is a part of. She shared how growing up she learned that things were to be kept private and "you didn't go tell them your

business”. She repeatedly said mental health was “taboo” and something you “don’t do it”. She shared:

So, I think I definitely differ from a lot of my counterparts from other denominations because not all, because I think some are very open to that.

Frank had a similar experience to Jessica’s in which he discussed his background and being raised in a Baptist denomination. He shared how his training is varied in that it is a combination of several different backgrounds and the messages he received. He stated:

And so, my training in regards to ministry and people actually comes from a few different backgrounds. I was raised Baptist and so -- traditional African American, not Southern Baptist, just Baptist -- and we never talked about counseling. I grew up in a very African American setting that was -- you know, people didn’t talk about counseling. You know, the solution was either ignore it, get drunk, get high, or act like it never happened. You know what I’m saying? That’s the cultural background and my personal formation that I came up in.

Differences. The last theme that emerged from the third interview question was differences. When speaking about differences participants shared their thoughts on other denominations how they may differ from one another in their beliefs. Paul was very open in sharing how he felt the Pentecostal denomination differed from others and even shared his experience as a Baptist pastor. He shared his perception of other denominations and how he learned that prayer is not the only form of healing. He stated he felt other denominations were more spiritual in their approach. Jessica was similar in her answer in that she felt most denominations are not trained to be receptive to mental health support. Jessica stated how some may “feel like the pastor is the end all, be all and whatever you

need your pastor can help you”. She also shared how she personally differs in feeling that not only do congregation members need counseling but that pastors need counseling too.

She shared a powerful statement during the interview. She said:

So, if you’ve never had counseling, how are you going to be able to really help someone who’s in need of it if you’ve never experienced it?

Diane also was open in her answer and shared that she also felt denominations differed in training. When answering the question she spoke about the beliefs held as a Non-Denominational pastor and stated, “ I feel like it’s very different because there are denominations that do not suggest that you are as open as I am with it”. She went on to say that she feels some pastors from other denominations may refrain from discussing the “reality of mental health issues” because they just do not want to deal with it or have received messages that tell them not to. She made a statement that stuck out. She said, “They’re just not that open and I think it’s because sometimes when you’re in certain organizations, the tradition shuts you down”.

Interview Question 4

The fourth question of the interview was, *What role do you find yourself in when supporting your congregation member during a mental health crisis?* The question seemed to provoke a response from pastors that required them to examine their role as it relates to providing mental health support. This question was helpful in moving pastors away from discussing their duties through a spiritual lens but also how they may use themselves as a tool to provide support in a mental health crisis. The themes that emerged from this question were: individualized, prayer, therapy, and knowledgeable.

Individualized. Quite a few pastors discussed how supporting a mental health crisis needed to be individualized and personalized to each person. They were in agreeance that no mental health issue is the same and therefore cannot be treated the same. Sean, Paul, and Frank all mentioned that providing support is individual. Sean stated he felt support was more “individual” when it “came to mental health issues”. He went on to explain how he is not the one who provides the initial mental health support but instead a senior staff member. Paul also stated that he feels the type of support that is given “depends on the individual”. Frank was similar in his response to Sean in that he also has a pastoral team who assist him in addressing and providing support related to mental health issues. He stated:

What we have set up in our church is we have what we call a “life pastor”, and the life pastor -- his main duty is when there’s somebody that’s going through a grieving situation or a major life event that happened -- marriage, funerals, babies being born, a hospitalization, car accident, things like that. Those things are his first point of contact. And so, we work with him and we’re going to give him all the resources and he has a team around him that will be able to help people out, get to the right people, to the right resources

Prayer. As Sean has mentioned previously he is not the point of initial contact when it comes to congregation members experiencing a mental health crisis. He did mention that he does provide support by incorporating spiritual interventions. He stated, “we’re praying for him and ministering to him through word, counseling the word”. Anna stated that she provides support through, “prayer, listening, refers them to their doctor or hospital if the situation warrants”. Diane also agreed that prayer was an intervention that

she used to provide crisis support but also discussed how she felt prayer alone is not enough. She stated:

Of course, you know, praying with them, but it's just there's a lot of mental health issues that need to be treated that, you know, it takes more than prayer.

Therapy. Therapy was another theme that emerged when participants answered question three for the interview. When the term therapy came up it referred to mental health support provided by the pastor and counseling from professionals outside of the church. Paul discussed how he has experienced congregation members who want immediate counseling from him but also recognizes when he needs to refer a member to a professional to receive crisis counseling. He mentioned, "I have seen sometimes individuals that want counseling, but then again they use whatever the situation is as weakness and excuses. So, trying to get them to see the importance of getting the proper help and assistance and not to use it as an excuse".

Jessica recounted a situation in which she had a phone call with a member who was experiencing suicidal thoughts and in the midst of a crisis. She shared how she felt in that moment she needed to "diffuse the situation" and "encouraged him to her help". She mentioned how she has received several calls in which members were experiencing suicidal thoughts. She made it clear that she felt the support she could provide in the moment would be listening, providing encouragement, and trying to get members in a place where they could receive the additional help needed.

Frank explained that he may see "roughly 1,000 people a week" due to the large size of his church. He stated that he would love to interact with all of his members if he could but it is nearly impossible due to the large volume. He discussed how he does not

serve as the initial point of contact for congregation members in a crisis but provides support for his staff and volunteers when they may need mental health support. He made it clear that if a volunteer or staff member is experiencing suicidal thoughts or threatening harm he refers that person to a professional. He stated:

And so, a lot of the folks that I would have most access to or would have most access to me are probably leaders or volunteers at my church, so these are people that are already serving. They most likely have a Christian journey already, somewhere on the spectrum. And so, if they need time from me, I'm going to give them time, sit down with them at least more than once. The only time that I would not sit down with them more than once is if they are suicidal or if they are threatening to harm themselves or somebody else. At that point, we need a medical professional.

Rick is both a pastor and a licensed psychologist. When answering this question he discussed the different types of counseling that he provides and explained that he is still a pastor so his support may look different in that it is short term counseling. Similar to Jessica and Frank he will refer members to other professionals when necessary. He shared the following:

But as far as counseling, it's not unusual for me to see a member of the church for several months before I decide that something needs to be done, because usually in pastoral counseling of any sort -- we're just crisis-oriented. Usually, things are resolved within a time of four to six months. It's rare to see someone that needs long-term counseling. Usually individuals who present to that degree -- they often are referred right out.

Diane relied on her experience to answer the question. She discussed how she had a family member who was diagnosed with a mental health illness and stated, “So, I know mental health. I know what it looks like versus you know, a demon, so they say. It takes more than just talking once or twice. It obviously takes a lot of therapy to help you with those issues, so yeah”. She shared how her personal experience in dealing with hospitals who were unhelpful in relation to crisis support has shaped how she responds to a member who may be experiencing a mental health crisis. She stated:

So, I do try to just keep numbers on hand, the 24-hour -- they can call and talk to someone that may get them through the night until they can get to see someone. but just constantly reminding them that you have to go see someone. You know, God is okay with you going to talk to someone about the issues that you’re dealing with. I promise you he’s not going to keep you out of the Kingdom. But I think a lot of times as Christians we just believe that we’re doing God a disservice by going to see a mental health counselor or something, and that’s not the case.

The second sub-question was, *What issues or challenges have you encountered for yourself when providing this support?* This sub-question was included to gain more information on any challenges that participants may have experienced in providing crisis related support.

Knowledgeable. This theme emerged from the second sub-question related to any challenges that participants may have experienced when providing mental health support related to a crisis. Paul explained that the biggest challenge he experienced was when he was pastoring a relatively large church in Richmond. He shared how he was helping one member who was diagnosed with Bipolar Disorder and how he was not knowledgeable

about the disorder. He shared, “ I really had to do research on a person being bipolar. Mental healthcare is not something that they really teach or you even hear about in seminary. So, it’s an ongoing process but at the same time me as a pastor, the only courses I have taken is counseling and now I’m getting more involved in understanding the mental healthcare part of counseling as well.” Paul discussed how dealing with members with a mental health disorder not only challenged him and pushed him outside of his comfort zone but also helped him to take the initiative to become more knowledgeable about mental health issues and care.

Anna discussed how she had a member who decided not to take their medication and was to receive assistance from local resources. She explained how he was unable to keep his job and eventually became homeless. She stressed how she had to step into the role of an advocate by reaching out to her contact in the community. She stated:

After reaching out to these programs, one of the parishioners was unable to receive any help, due to budget constraints and not being mentally deficient enough for their criteria. He became homeless. When I became aware of this, I provided him with housing, helped him with the job hunting process, provided finance, education, clothing, and prayer. I am happy to say he now has a job and rents his own home.

Rick shared that help felt his challenged dealt with time and not being able to “commit” to

providing the type of care and time that a member may want and need. He shared:

I think that the greatest challenge I’ve found is when I am unable to commit to the kind of care that a person needs and they’re unable to understand that boundary.

And what I mean by that is when people really do need long-term kind of help, it's not easily practical for me to be the person that would engage in that, and I will often recommend or refer them.

Interview Question 5

How well prepared do you feel in providing mental health support as it relates to the mental health needs of the church, was the fifth question asked during the interview. The purpose of this question was to learn more about the areas in which pastors felt they needed more support in to feel prepared. The theme that emerged from this question was training along with the two subthemes which were experience and education. Majority of the answers that the participants provided were related to trainings they have received and recounted different experiences that they feel have helped them to feel prepared.

Theme Three: Training

The third sub-question of the interview was, *What experiences or parts of your training make you feel prepared?* This question was included as an extension from the fifth interview question. Along with knowing whether or not they felt prepared to provide mental health support the researcher wanted to know specifically what has helped the participants.

Experience. The theme that emerged was experience. Several pastors discussed how they felt their experiences during their tenure as a pastor helped them feel prepared to provide mental health support. Sean discussed how he felt prepared because he relies on God and relies on his experience of seeing people delivered. He shared:

Well, I can say I feel prepared because I've got God in my life. I know He knows what's best for us and I know He can help us and I have seen people that were

totally out of their mind -- I mean, totally out of their mind -- get back through prayer. You know, people praying for them. Without -- without any mental health professional help, a caregiver or anything. They don't have to take a medicine at all. I've seen people totally -- you know, some people are out of touch with reality, I mean, mentally they don't know nothing. They just walk around like a zombie, you know? I've seen that, you know what I'm saying, and I've seen God bring them back. I mean, and actually come back to their mind and have a testimony of what God did for them, you know?

Paul opened up by sharing that he felt "okay" when it came to feeling prepared to provide mental health support. He stated that he still did not feel "comfortable in some areas" and those areas were dealing with mental health issues that he was not knowledgeable about. He stated that he felt that counseling takes a lot of time and that he did not have enough time to dedicate to every issue that may present itself. He stated:

I feel very confident in meeting with individuals, whatever the situation may be. I feel confident in that -- I feel confident in being supportive to them and I feel very confident in the advice that I give to them. Just when you hit the gray areas of, like I said, with the bipolar person -- I knew how a bipolar person reacts and responds but I didn't know exactly how the sickness really affects the person. So, it really taught me a lot but also it made me to research so that I would give them the right advice to guide them in the right direction.

Jessica felt that she has become more comfortable and used this question to reflect on how prepared she felt a year ago versus today. Jessica talked about how she may have been doing certain things in the past but just did not know the exact "terms" for what it

was she was doing. She shared that she never knew exactly what she was “supposed” to be doing but always relied on using herself as a tool and pulling from different experiences to help her. Anna shared that much of her preparation came from working as a Human Resources Administrator for over 10 years. She shared how dealing with people and their emotions has contributed to her overall preparedness. She stated:

Having worked in a hospital for twelve years as a human resources administrator of 365 employees, I am knowledgeable of many aspects of both physical and mental health. Knowledgeable of the resources in our area, the network of professionals available and an in-depth understanding of the insurance process. As a pastor, understanding the mechanics both in and outside of the church is a bonus many pastors don't possess.

Education. Education seemed to be a theme that reemerged several times during the interview. As discussed in the description of the sample, six of the participants either hold a Doctorate degree, are pursuing one, or are in graduate program. This representation is 80 percent of the participants, which is a strong indication of how strong of an influence education has on the participants. Jessica is currently enrolled in a graduate program in counseling. She discussed how she felt more comfortable and “competent” due to the skills that she is learning in her current program. It seemed that she was learning more about herself and how to provide mental health support to her members through the courses she was in. She shared the following:

But I think I feel more competent today because I'm in a program that teaches you a lot about what to expect in a counseling session, you know, assessing their needs, knowing when you need to make a referral, that kind of thing. Like, I'm

learning, but I really don't see myself as an expert in that. I really see myself as an advocate because some people need counseling but others need -- they need medicine. Like, they actually need assistance and it's not something that we can just counsel out.

Frank was similar to Jessica in that he also took educational courses which helped him to feel more comfortable in providing mental health support. He discussed how he took pastoral counseling classes and currently is taking courses now. Anna received her Ph.D. in Christian Counseling and shared how she has experience providing counseling to both congregation members and employees. She explained how her Ph.D. provided her "insight" and helped her to be more "effective". Rick shared that help felt his "academic training has certainly been helpful".

Interview Question 6

Theme Four: Community Involvement

The researcher identified community involvement as the fourth theme as it related to the participants experience with either creating relationships with counselors in the community or referring members to professionals in the community

The sixth question of the interview was, *What is your experience in working with mental health professionals in the community?* This question helped to answer the second research question of the study which was, *What are African American Pastors' experiences with clinicians in the mental health community?* The question allowed the researcher to dive deeper into exploring the relationship between African American pastors and mental health professionals in the community. This question seemed to get a variety of different responses in which some of the participants had experience with

professionals outside of their church and some participants discussed experiences with professionals who were members of their church. The theme of referrals emerged during discussion of their experiences.

Sean explained that his experiences with mental health professionals in the community is limited. He stated, “Yeah, I think because there have been some -- I may say a mistrust exists between the mental health professionals and clergies, you know. Feeling a dislike or I guess probably for the approach that maybe they’re using, and probably the mental health professional doesn’t trust us, either, some of the things we do.” Sean discussed how feels there is not a mutual understanding between mental health professionals and clergy members. He stated:

I’ll be honest with you, the Pentecostal church doesn’t have a whole lot of confidence in the mental health professional. I think there’s an issue between the clergy and mental health professionals in that I really don’t think sometimes we understand each other, understand what each other is trying to do, but we understand that each one, what we’re trying, what our aim is, the purpose, the goal is to get people better.

Paul shared how he did not have any experiences with professionals in the community due to having a counselor who attends the church. He discussed how people are “very private when it comes to mental health” and therefore has not really needed to reach out to professionals in the community. Jessica was very similar in that she also has members in her church who were licensed and credentialed in the mental health field. She reported she offers inhouse referrals for support related to mental health concerns of congregation members.

Rick and Frank both shared a similar experience in which they both have had experiences with professionals in the community. Rick shared the clinicians he has had experiences with are ones that he has a professional relationship with and has worked with to some degree in the mental health field. Frank stated, "I've had pretty good experiences". He shared how he worked closely with the church members and the counselor with whom they were seeing to ensure everyone was on the same page. Diane mentioned how she had a colleague who owned a private practice and was not connected to her church. She shared that she had a professional relationship with her and identified her as a resource in the community. Anna did not identify any experiences with mental health professionals in the community other than encouraging people to see their doctor or psychiatrist when needed.

Referrals. Referrals came up during discussion when participants answered the sub-question, *What is your experience in referring members to mental health professionals in the community?* When participants discussed their experience in referring their members to a professional in the community, several participants mentioned referring their members specifically to a medical doctor but not a counselor. Like previously mentioned Anna reported, "Well, I have had to send people back to their doctors and sometimes their psychiatrist, sometimes their regular clinical MDs". Karen also stated that "I just let them know to go back to their medical doctor, because if I tell them to go to a counselor I'm giving them medical advice that I don't want to give, even though it's counseling". She explained how she refrains from "telling" her members what to do to avoid giving medical advice. She discussed how she likes to stay in the realm of Christian counseling. Paul also made a statement that he does not typically provide

referrals but encourages members to keep all of their medical appointments and regularly see their doctor.

Sean stated that he likes to only provide spiritual support to his members as it relates to prayer and scripture. As it related to referrals in the community he stated, “They pretty much find their own -- like the issue I’ve got now with one of my members, they pretty much just found somebody”. Jessica differed in that that she is cautious when referring members to professionals in the community because of the stigma and negative perceptions that African Americans may hold regarding counseling. She discussed how she prefers to do inhouse referrals in which she refers to other professionals who are members of the church. She elaborated below:

Also, our Pastor Bill, of course. He’s got a mental health background so a lot of times people hear different things from that perspective and his experience and that helps. Then I have some others that are sort of friends or associates that I may talk to. The majority of these friends that I have will be people that are connected to the church. I always offer that first because I know in the African American community -- which is the majority demographic of the congregation right now -- I know in African American communities that counseling is somewhat taboo. So, I know that getting them to go to a local counseling center may be too much for them but maybe let them know that there is someone within the church that isn’t certified but is able to get them going if they want that. So, sort of going at it from that perspective.

Frank was the only participant who stated that he refers his congregation members to professionals in the community. He provided a quote from a member who stated, “I don’t

want to walk in the market and see the person that knows all my business.” He explained how he tries to always refer into the community or even outside of the community so his members feel more comfortable and have privacy. He stated:

So, if a congregation member asked me for a recommendation either I would refer to somebody I already know or I’d talk with another pastor and then they’d give me a recommendation -- whether that’s in Every Nation or I also know some local pastors here. Also, what I found that has comforted some people is that they’d rather do counseling with somebody that’s outside of this community.

Interview Question 7

What do you feel is important to help co-create a relationship with mental health professionals in the community, is the seventh interview question. The discussion surrounding this question related back to the fourth research question of the research study which was, *What approaches can the mental health community can take in building relationships with local churches?* This question was eye opening to both the researcher and the participants. The discussion was authentic as it related to what both the Black Church and mental health community can do to bridge the gap. The themes that emerged through discussion was initiative, understanding, and dialogue.

Theme Five: Initiative

Initiative was identified as a theme as participants discussed what they felt was needed from both the Black Church community and mental health community in efforts to have a mutual understanding and support as it related to mental health issues experienced by congregation members.

Understanding. Karen mentioned how she felt an important component in a relationship between “Christian” and “secular” counselors is “respecting” one another’s disciplines. Karen felt that there is a lack of understanding, which contributes to the huge gap between the two communities. She stated:

I think the most important thing is going to be that secular counselors respect the fact that we’re Christian counselors and Christian counselors respect the fact that they are mental health counselors, because there is a difference.

Sean also mentioned understanding one another as an important component in a mutualistic relationship. He shared the following:

Again, I think -- like I said, we pretty much need to just learn from each other what -- sometimes people learn from their leaders and then they pretty much practice what their leaders teach them, you know what I mean? And I think we’ve got to better understand things. I think sometimes they’re taught these things from their leaders and they carry on this.

Dialogue. Dialogue was mentioned several times as an important factor in creating a relationship between the Black Church and mental health community. Paul shared that he felt mental health professionals need to take the initiative and create dialogue with church clergies. He shared by having these conversations clergies can become more knowledgeable about mental health and share this information with their congregation members.

So, I would say having some of the institutes come in with the clergies first before we open it up to the clergies, the clinic and the congregation. Let’s let the clinics

educate us first so that we would be familiar with what we need to do and what we shouldn't do, and how involved we should become when we see that mental health needs need to be handle in that realm or in that direction. You know, hopefully start having some sessions and some classes for this because this is like a domino effect. It's not just one church is very good at it and other church is poor at it. I think it's kind of like a leveling field. Some churches may be more supported with their mental health situation, and then some other churches, I mean, it's like a foreign language.

Jessica also discussed how important it would be to have dialogue between both communities. She stated:

I think there needs to be dialogue on both sides. It's on both sides where people need to come together, but I do think that the door needs to be opened by the pastors. The pastors are shepherds, which means that everything in that field they're responsible for. If they're going to let someone else in, they've got to open the door to these people.

She went on to explain how professionals in the mental health field could provide psychoeducation in the form of workshops or trainings to bring the communities together and make those professionals who are local more visible to local churches. She stated:

I think that I would like as far as the relationships between the mental health community and the church -- I think there needs to be mental health workshops. One of the things that I'm So, I think every time I get an opportunity to bring people that have expertise in to sit with my leaders, because if I have those people with my leaders then my leaders always have an advocate for their own life.

Frank discussed how “exposure” and “education” related to mental health awareness and issues would be beneficial in bringing the two communities together. Diane was similar in that she stated the mental health community needs to be more visible and engage with the leaders and clergy in the Black Church communities. She stated:

I think the mental health community needs to get out more and not just go to outside organizations but come into -- knock on the door of the church and have your services be used. Let the pastors know that you're in the community to help. But I find that a lot of people who are in the mental health community -- when you mention church, it's almost like they're scared. It's a figure that they don't want to touch.

Diane also suggested that local churches and professionals from the community can join together to have open forums about mental health issues. She explained that each forum could include a counselor providing education and a church member providing their testimony of how they overcame a particular mental health issue.

Interview Question 8

The final question of the interview was, *What else would you like me to know about your experiences with the mental health needs in your church?* The purpose of this question was to allow participants to share any additional information that they would like as it pertained to the topic of the research study. Karen shared how she recently did a workshop on the topic of Christian counseling. She discussed how important it is to recognize your level of competency as it relates to certain mental health issues. Specifically, she shared how sometimes you need to know when to “hold them and fold them”. She shared the following:

There are going to be people that walk into your office that you have to say, “I am not the qualified person to assist you,” and you have to know that it’s okay to say that. It doesn’t mean that you are not doing what you’re supposed to do. It’s that you’re making a better decision for that person. And whether it’s secular counseling or whether it’s Christian counseling, all of them have a similar ultimate goal to help people be self-sufficient, to make sound decisions, and to live a quality life.

Paul and Jessica both used the opportunity to reflect on the changes they looked forward to implementing moving forward. Paul shared how conducting this interview helped him to become more “aware” and highlighted things that his church and clergy need to change as it relates to mental health. Jessica discussed how currently in her church she requires each leader to have a relationship with one official in their city. She stated how moving forward she is going to require each leader to also have a relationship with someone from the mental health community.

Rick discussed the influence of the cultural background of African Americans and how this may impact how African Americans view mental health. He stated:

I think that particularly as an African American, because most ministries do not really give a lot of attention to the systemic issues and kinds of things that most African Americans have experienced or even the things that have been transmitted through a multi-generational transmission system. They need to be sensitive to a history of pain and brokenness creates a greater link for caring, and when clinicians have an appreciation for this area people may not like them but it certainly makes it a more welcoming presence and creates a greater pathway for

them to be able to help. But if you approach people who have an experience that is not like your own with the sense that everybody is the same, when you start caring about African American people you're going to miss it.

Summary

In conclusion, there were 20 themes that emerged which were: Role of Pastor, Impact of Denomination, Training, Community Involvement, Initiative, Pastoral Counseling, Spiritual Interventions, Awareness, Beliefs, Background, Differences, Individualized, Prayer, Therapy, Knowledgeable, Experience, Education, Referrals, Respect, and Dialogue. These themes helped guide these research answer the research questions that were put in place for the study:

1. What are African American Pastors' experiences of mental health issues in the Black church?
2. What are African American Pastors' beliefs in referring members to clinicians in the community?
3. What are African American Pastors' experiences with clinicians in the mental health community?
4. What approaches can the mental health community can take in building relationships with local churches?

The participants were similar and different in the responses they provided but all shared valuable insight about their experiences and used the interviews as an opportunity to share their experiences as it related to providing mental health support. They spoke about their beliefs and experiences about mental health and also how they believed their denomination may or may not influence their attitudes and beliefs regarding mental

health. The participants offered different ways that they believed the mental health community and Black Church community could work together to bridge the gap between the two communities. Chapter 5 discusses the findings of the study and connects the themes to the research questions that guided this study.

Chapter 5: Discussion

Chapter Overview

The purpose of Chapter 5 is to provide a brief overall summary of the results from the research study. The research study was a qualitative study that consisted of eight African American pastors who discussed their experiences in the role of providing mental health support to congregation members. Specifically, the study was a phenomenological study as that allowed the researcher to conduct interviews to learn about participants experiences and explore their narratives as it related to the research questions that guided the study. The chapter is organized into the following: Summary of the results, discussion of the conclusions, limitations, implications, recommendations for future research, and conclusion.

Summary of the Results

The purpose of the qualitative study was to better understand the role of African American pastors as related to providing mental health support to their congregation members. The researcher wanted to understand whether there was a relationship between the religious denominations of the pastors and their attitudes and/or perceptions regarding mental health.

As a result of the research study, there were 20 themes that emerged. The researcher reviewed previous and current research as it related to responses provided by the participants. The researcher found that some of the themes that emerged were consistent with the research presented in the literature review. Specifically, similar themes were: the lack of knowledge and/or awareness regarding mental health, the impact of spirituality and religion on wellbeing, and the role of the Pastor. Themes that

appeared to be new or different included: the impact of religious denomination, training/background, and community involvement. Themes that emerged with at least four participants during the data analysis process in this study will be highlighted.

In analyzing the results, there were themes which were related to the original research questions guiding the study. The majority of the responses from the participants were consistent with the research discussed in the literature review. Specifically, the participants discussed the importance of spirituality and religion as related to their identity and role in providing mental health support. The participants' responses included discussions related the support and comfort that spirituality and religion provides their congregation members during difficult times in their lives. Participants also shared the importance of implementing spiritual interventions such as prayer and scripture when congregation members are dealing with a mental health crisis. . These findings were consistent with studies by Ellison, Bradshaw, Flannelly, and Galek (2014) and Gillum and Griffith (2010) which also found over 50 percent of African Americans engaged in prayer and individuals who implemented spiritual interventions such as scripture and prayers reported higher life satisfaction and positive emotional wellbeing.

Many participants described their role as including acting as providers of pastoral counseling or general counseling. Many of these responses were based on the background of the participants, as well as training some of the participants had experienced related to the mental health field. Five out of eight of the participants who described themselves as mental health providers or supporters had some formal training related to mental health. This training included taking courses related to clinical counseling, pursuing a graduate degree in counseling, or earning a doctorate degree in counseling or psychology. These

responses highlighted the importance of the pastors' training as related to mental health. There were varied responses as some of the participants discussed how their training consisted of taking courses related to mental health or receiving a graduate degree in counseling or psychology. There seemed to be a relationship between pastors who stated they lacked training related to mental health and their perceptions regarding referring members to a counselor in the community. Specifically, participants who stated they lacked training preferred to avoid referring members to clinicians in the community who referred members to their medical doctors. The participants discussed lack of awareness, lack of knowledge, and mistrust as reasons for avoiding referring members or referring them to their medical doctors.

The influence of the participants' religious denomination was also an important discussion point during the interviews. The participants came from three different religious denominations which all differed significantly. For example, one of the participants discussed his experience in the Pentecostal denomination and how the belief is relying as God, scripture, and prayers in efforts to provide someone support. He stated that in the Pentecostal denomination seeking support from a mental health professional is not encouraged. Two other participants who identified as Non – Denominational shared how their denomination differs in that it is more open as it relates to mental health and encourage members and other Pastors to seek counseling from mental health professionals. In their responses, participants shared how their religious denomination influenced their beliefs regarding mental health and how they see their role. For example, four out of eight of the participants shared how their denomination influenced their beliefs as it related to their training to become a Pastor and messages they have learned

regarding mental health. Participants also discussed the learned messages they received from their denominations when growing up. Three out of eight of the participants who identified as Non – Denomination shared how they grew up as Baptist and learned that seeking counseling was discouraged and were taught to keep their problems to themselves. They both specifically shared how those messages negatively impacted their attitudes towards mental health which lead to changing their religious denomination. This proved to be a powerful part of the interview as the researcher was able to learn how strong of an influence the participants’ religious denominations had on their perception towards mental health services as well as their role in providing mental health support. The previous examples given support the researchers statement as the participants shared how their denomination either encourages or discourages seeking counseling from mental health professionals.

The topic of creating a relationship between the Black Church community and local mental health professionals was discussed by all of the participants. The responses consisted of recommendations from the participants as to what mental health professionals could do to help foster working relationships between pastors and counselors. Specifically, participants shared how they would like mental health professionals to be more visible and to create dialogue as related to mental health issues. Some participants even shared what leaders in the Black Church community could do to be more open and vulnerable as it related to connecting with mental health professionals, such as inviting mental health professionals into their church to have provide workshops or participate in forums related to mental health issues. Participants ended by sharing their thoughts related to spirituality, religion, and mental health. Some of the participants

shared how this interview opened their eyes to issues present in their church and how they would dedicate more time to bringing awareness to mental health within their churches.

In summary, the overarching themes from the interviews included lack of knowledge and/or awareness regarding mental health, the impact of spirituality and religion on wellbeing, the role of the Pastor, the impact of religious denomination, the training and background of the Pastor, and community involvement. The most surprising result of this study is the importance of the involvement from mental health professionals that was not found in previous literature. Spirituality and/or religion are important in the lives of African Americans as they view their Pastor as a leader and source of support during a crisis. This study is important as it provides practicing counselors and counselor educators an opportunity to learn about the role of African American Pastors in providing mental health support but also how Pastors view mental health and some of the factors that may be preventing African Americans from seeking support from mental health professionals in the community. The study adds to the gap in the literature as it relates to African Americans, spirituality and/or religion, and mental health. Practicing counselors and counselor educators can use the information learned from the results to provide support through a multiculturally sensitive lens but also addressing the importance of spirituality and/or religion as it relates to African Americans and their mental health.

Discussion of the Conclusions

Both the results of this study, as well as previous literature from Bilkins, Allen, Davey, and Davey (2016) and Dayringer (2012) which discuss the importance of the role

of Pastors and their attitudes towards mental health services, suggest that there are several themes that still need to be addressed regarding the role of the Pastor with mental health concerns in African American church communities. These themes include lack of awareness and/or knowledge regarding mental health, how African Americans value spirituality and religion, and the importance of the role of the Pastor in assisting with mental health concerns of their church members..

Awareness/Knowledge

The lack of awareness regarding mental health that African American Pastors and/or congregation members may be attributed to a variety of different factors. Previous research identified in the literature review supports the claim that lack of awareness and/or knowledge can negatively impact African Americans perceptions regarding mental health. Briggs, Bank, & Briggs found that African Americans report a lack of knowledge and awareness as a reason for not seeking mental health support (2014). Briggs et. al also found that over 50 percent of African American participants in that particular study felt they were unaware of the different types of mental health disorders. Lack of awareness and knowledge could be due to the geographic location. For example, for African Americans who reside a rural areas, mental health services may not exist in their communities and therefore they are unable to access counseling resources. Mental health may also be a topic that is considered taboo in the African American culture. Terrell and Terrell (1981) originally defined the term *cultural mistrust* in which they examined the relationship between any biases or suspicions that African American clients may hold towards Caucasian counselors. Townes, Chavez-Korell, and Cunningham (2009) conducted a study related to cultural mistrust in which they found that African

American participants held a high level of cultural mistrust as it related to Caucasian counselors. This mistrust may contribute to African Americans seeking mental health support from their Pastors as there is a level of trust already established.

Spirituality/Religion

For African Americans, spirituality and religion are often identified as an important part of ones' life. This is consistent with research presented by the United States Religious Landscape Survey, which found that 87 percent of African Americans reported belonging to a religious group and 79 percent reported religion to be very important in their life. Historically, African Americans have utilized different spiritual coping skills such as prayer, scriptures, or attending church to help them deal with different issues. Specifically, African Americans use internal or external religious coping skills to assist them in coping with issues that may be related to mental health. Both of these styles can be helpful for African Americans as having positive coping strategies in place has been linked to a higher well-being, increase in life satisfaction, better health, and decreased stress (Chapman & Steger, 2010). This relates to research conducted by Szymanski and Obiri (2011) in which they found that African Americans have an increase in psychosocial health outcomes when they participant in activities such as attending church or being involvement which was similar to the research findings.

Role of Pastor

Similar to the results of this research study, Baruth, Wilcox, and Saunders (2013) found that Pastors are often able to positively impact an individual. The Pastor serves at the leader of the church and often will fulfil different roles such as a spiritual leader, mentor, or counselor. Pastoral counseling can be an important component Pastor's role.

Pastoral counseling involves pastors providing therapy that includes a spiritual integration (Dayringer, 2012). Through pastor counseling pastors are able to provide the support needed for a congregation member who is experiencing a crisis.

Limitations

As with any research study, there certain limitations that can prevent a study from being generalized. As this research study was a qualitative study, the results cannot be generalized across the entire population of African American pastors. The first limitation of this research study was the sample size of the study. The study consisted of eight participants, four of whom were men and four of were women . This small sample size cannot adequately capture the entire population of Pastors of African American churches. Additionally, the participants were also recruited using purposeful and snowball sampling which did not create a randomized sampling population. The second limitation of the study was the geographic location of the sample. The participants were generally all located in the geographic location which was the Southeastern region of the United States. The third limitation of the study was the limited number of religious denominations represented by the participants. The researcher was able to recruit participants from only three different religious denominations. The fourth limitation of the study was utilizing snowball sampling to recruit participants. By using snowball samplings participants came from some form of common experience (i.e. referral source, religious denomination, church community, location etc.). The final limitation was the method of the interviews. The researcher conducted all of the interviews via phone. The researcher feels important observations such as nonverbal cues were missed which could have added value to the study as it related to the topics of the interview questions.

Implications

The results from the research study prove to be important as it relates to practicing clinicians in the counseling field and counselor educators. The findings from the study suggest that mental health professionals can be more visible to the Black Church community. In order to build trust, mental health professionals can take the initiative be informing clergy and congregation members in the Black Church community about issues related to mental health and their role. Specifically, workshops and/or seminars can be conducted to teach Pastors and members about mental health issues and the resources available to help assist those with coping with symptoms of a mental health issue. This not only creates visibility but provides Pastors support.

Findings from the study also are important for counselor educators and counseling students. There are steps programs can take now to uphold the competencies set in place by the Association for Multicultural Counseling and Development (AMCD) and Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC). Specifically, competency I.C.1 of the AMCD competencies states that, “Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations” (Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996). The fifth ASERVIC competency specifically states, “The professional counselor can identify the limits of his or her understanding of the client’s spiritual and/or religious perspective and is acquainted with religious and spiritual resources and leaders who can be avenues for consultation and to whom the counselor can refer” (2009). These competencies are especially important for counseling programs as the field continues to highlight the

importance of providing culturally sensitive services. Programs can provide opportunities for students to provide culturally sensitive services by having practicum and internship places at churches in the local community. Educators can also be intentional by including the importance of spirituality and religion within the curriculum.

Recommendations for Future Research

While the results of the research study provided important information related to African Americans, mental health, and spirituality and/or religion more research needs to be conducted to help contribute to a limited body of existing research. There are two recommendations to help advance the mental health field. The first recommendation is to conduct a study that includes a larger sample size, participants from various geographic locations, and additional religious denominations. In addition, it is recommended that research be focused on congregation members to learn about their experiences receiving mental health support from their pastors versus a mental health professional in the community. From this research it is possible to learn information that could be helpful for practicing counselors who may work with African American clients who identify spirituality, religion, and/or their pastor as an important coping mechanism or resource.

The second recommendation is to conduct more research focusing on African American pastors' personal experiences with a mental health crisis. This study could focus on how African American pastors coped and if they utilized community resources such as a mental health counselor. This study could include a focus group to provide pastors a chance to discuss the topic of mental health issues and their personal experience, or lack thereof, with mental health professionals. This research study would

not only contribute to an existing body of research but contribute a line of research that has not been explored.

Conclusion

The mental health field continues to become more multiculturally competent and sensitive while committing to recognizing and embracing the diversity of the client's that are served. As highlighted in the mission statement of American Counseling Association (ACA) Code of Ethics, "The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity" (American Counseling Association, 2014, p. 2). Specifically both the Association for Multicultural Counseling and Development (AMCD) and Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) call for counselors to recognize diversity and all of its cultural components while being multiculturally sensitive in efforts to best serve its clients. This study sought to explore the role of African American pastors as it related to providing mental health support to their congregation members. This study also highlighted the cultural component of religious denominations of the participants and how this may influence their attitudes and beliefs regarding mental health. Currently, there is a scarcity of existing research as it relates to African Americans, mental health, and spirituality and/or religion. This present study contributes to the mental health field by providing valuable knowledge as it relates to the importance of spirituality and/or religion in the lives of African Americans, the role of African American pastors in providing mental

health support, the impact of one's religious denomination, and African American pastors attitudes, beliefs, and experiences as it related to mental health services.

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APPENDIX A

James Madison University
Human Research Review Request

FOR IRB USE ONLY:

Exempt:	<input type="checkbox"/>	Protocol Number:	1st Review:	Reviewer:
Expedited:	<input checked="" type="checkbox"/>	IRB: <u>19-0034</u>	2nd Review:	Reviewer:
Full Board:	<input type="checkbox"/>	Received: <u>06/08/18</u>	3rd Review:	

Project Title:	<u>Let the Church Say Amen! Experiences of African – American Pastors of Different Religious Denominations in Providing Mental Health Support to Congregation Members</u>
Project Dates: (Not to exceed 1 year minus 1 day)	From: <u>7/01/18</u> To: <u>6/30/19</u> MM/DD/YY MM/DD/YY

Responsible Researcher(s):	<u>Tiffanie Sutherlin</u>	
E-mail Address:	<u>SUTHERTD@DUKES.JMU.EDU</u>	
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Department:	<u>Graduate Psychology</u>	
Address (MSC):	<u>MSC 7401</u>	
Please Select:	<input type="checkbox"/> Faculty	<input type="checkbox"/> Undergraduate Student
	<input type="checkbox"/> Administrator/Staff Member	<input checked="" type="checkbox"/> Graduate Student

(if Applicable):

Research Advisor:	<u>Michele Kielty</u>
E-mail Address:	<u>kieltyml@jmu.edu</u>
Telephone:	<u>540-568-2553</u>
Department:	<u>Graduate Psychology</u>

Address (MSC):	<u>MSC 7401</u>
Minimum # of Participants:	<u>8</u>
Maximum # of Participants:	<u>12</u>
Funding:	<p>External Funding: Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/> If yes, Sponsor: _____</p> <p>Internal Funding: Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/> If yes, Sponsor: _____</p> <p>Independently: Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/> _____</p>
Incentives:	<p>Will monetary incentives be offered? Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/></p> <p>If yes: How much per recipient? _____ In what form? _____</p>
Must follow JMU Financial Policy:	<p>HTTP://WWW.JMU.EDU/FINANCEMANUAL/PROCEDURES/4205.SHTML#.394IRBAPPROVEDRESEARCHSUBJECTS</p>
Institutional Biosafety Committee Review/Approval:	<p>Use of recombinant DNA and synthetic nucleic acid molecule research:</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If "Yes," approval received: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending</p> <p>IBC Protocol Number(s):</p> <p>Biosafety Level(s):</p>
Will research be conducted outside of the United States?	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If "Yes," please complete and submit the International Research Form along with this review application:</p> <p>HTTP://WWW.JMU.EDU/RESEARCHINTEGRITY/IRB/FORMS/IRBINTERNATIONALRESEARCH.DOCX.</p>

Certain vulnerable populations are afforded additional protections under the federal regulations. Do human participants who are involved in the proposed study include any of the following special populations?

- Minors
 Pregnant women (*Do not check unless you are specifically recruiting*)
 Prisoners
 Fetuses
 My research does not involve any of these populations

Some populations may be vulnerable to coercion or undue influence. Does your research involve any of the following populations?

- Elderly
 Diminished capacity/Impaired decision-making ability
 Economically disadvantaged
 Other protected or potentially vulnerable population (*e.g. homeless, HIV-positive participants, terminally or seriously ill, etc.*)
 My research does not involve any of these populations

Investigator: Please respond to the questions below. The IRB will utilize your responses to evaluate your protocol submission.

1. **YES** **NO** Does the James Madison University Institutional Review Board define the project as **research**?

The James Madison University IRB defines "research" as a "systematic investigation designed to develop or contribute to *generalizable knowledge*." All research involving human participants conducted by James Madison University faculty and staff and students is subject to IRB review.

2. **YES** **NO** Are the human participants in your study **living** individuals?

“Individuals whose physiologic or behavioral characteristics and responses are the object of study in a research project. Under the federal regulations, human subjects are defined as: living individual(s) about whom an investigator conducting research obtains:

(1) data through intervention or interaction with the individual; or (2) identifiable private information.”

3. YES NO Will you obtain data through *intervention* or *interaction* with these individuals?

“Intervention” includes both physical procedures by which data are gathered (*e.g.*, measurement of heart rate or venipuncture) and manipulations of the participant or the participant's environment that are performed for research purposes. “Interaction” includes communication or interpersonal contact between the investigator and participant (*e.g.*, surveying or interviewing).

4. YES NO Will you obtain *identifiable private information* about these individuals?

"Private information" includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, or information provided for specific purposes which the individual can reasonably expect will not be made public (*e.g.*, a medical record or student record). "Identifiable" means that the identity of the participant may be ascertained by the investigator or associated with the information (*e.g.*, by name, code number, pattern of answers, etc.).

5. YES NO Does the study present *more than minimal risk* to the participants?

"Minimal risk" means that the risks of harm or discomfort anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during performance of routine physical or psychological examinations or tests. Note that the concept of risk goes beyond physical risk and includes psychological, emotional, or behavioral risk as well as risks to employability, economic well being, social standing, and risks of civil and criminal liability.

CERTIFICATIONS:

For James Madison University to obtain a Federal Wide Assurance (FWA) with the Office of Human Research Protection (OHRP), U.S. Department of Health & Human Services, **all** research staff working with human participants must sign this form and receive training in ethical guidelines and regulations. "Research staff" is defined as persons who have direct and substantive involvement in proposing, performing, reviewing, or reporting research and includes students fulfilling these roles as well as their faculty advisors. The Office of Research Integrity maintains a roster of all researchers who have completed training within the past three years.

Test module at ORI website

[HTTP://WWW.JMU.EDU/RESEARCHINTEGRITY/IRB/IRBTRAINING.SHTML](http://www.jmu.edu/researchintegrity/irb/irbtraining.shtml)

Name of Researcher(s) and Research Advisor	Training Completion Date
Tiffanie Sutherlin	09/11/16

Michele Kielty	08/21/17

For additional training interests, or to access a Spanish version, visit the National Institutes of Health Protecting Human Research Participants (PHRP) Course at:
[HTTP://PHRP.NIHTRAINING.COM/USERS/LOGIN.PHP](http://PHRP.NIHTRAINING.COM/USERS/LOGIN.PHP).

By signing below, the Responsible Researcher(s), and the Faculty Advisor (if applicable), certifies that he/she is familiar with the ethical guidelines and regulations regarding the protection of human research participants from research risks. In addition, he/she agrees to abide by all sponsor and university policies and procedures in conducting the research. He/she further certifies that he/she has completed training regarding human participant research ethics within the last three years.

Principal Investigator Signature

Date

Principal Investigator Signature

Date

Principal Investigator Signature

Date

Faculty Advisor Signature

Date

Submit an electronic version (in a Word document) of your **ENTIRE** protocol to

RESEARCHINTEGRITY@JMU.EDU.

Provide a **SIGNED** hard copy of the Research Review Request Form to:

Office of Research Integrity, MSC 5738, 820 Madison Drive, Burruss Hall, First Floor, Room
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Purpose and Objectives

Please provide a lay summary of the study. Include the purpose, research questions, and hypotheses to be evaluated. (Limit to one page)

Historically, African – Americans have been underrepresented in utilizing mental health services (Avent, Cashwell, & Brown-Jeffy, 2015). Some of the barriers that may impact African – Americans attitudes towards mental health services may include stigma, cultural norms, cultural mistrust, racial preference, and finances just to name a few (Awosan, Sandberg, & Hall, 2011). In the African – American community spirituality and religion have been identified as both a protective factor and a means to cope when faced with a difficult situation (Mitchell & Ronzio, 2011). The definition of spirituality can differ based different perceptions and interpretations. Spirituality can be understood as an individuals lived experience (Kelly, 2004). In the African – American community spirituality and religion have been identified as both a protective factor and a means to cope when faced with a difficult situation (Mitchell & Ronzio, 2011). According to a survey by the United States Religious Landscape Survey, 87 percent of African – Americans reported belonging to a religious group and 79 percent reporting religion to be very important in their life (Pew Research Center, 2009). Religion as a form of coping can serve several purposes for individuals which include spiritual, self-development, resolve, sharing, and restraint (Pargament, 1997).

Much is unknown about African – American pastors’ experience providing mental health support when faced with the mental health concerns within their congregation. For the purpose of this study mental health support will be defined as providing emotional support or practical assistance for individuals dealing with a mental health issue or emotional distress. The purpose of this study is to understand the role of African – Americans Pastors in providing mental health support but also ways the mental health field can help bridge the gap between the Black Church and mental health community. It is also hoped to learn more about the role religious denominations may hold in delivering counseling services and any messages that have been learned related as it relates to mental health. This research intends to contribute to the counseling profession by adding to the scarce literature available related to the intersection of African – Americans, spirituality, religion, and mental health. Specifically, this study will provide the authentic experience of African – Americans pastors as it relates to mental health. It is hoped that the results from the interviews will help to build collaboration and create a partnership between community counselors and African – Americans Pastors. Results from the interview will help to build collaboration and create a partnership between community counselors and pastors.

The research questions were created with intention of being mindful of population of interest. This research will examine the relationship between the denomination of African – Americans pastors and their experiences and role as responders to the mental health needs of their congregation. The specific research questions of this qualitative study are:

5. What are African – Americans Pastors’ experiences of mental health issues in the Black church?
6. What are African – Americans Pastors’ beliefs in referring members to clinicians in the community?

7. What are African – Americans Pastors’ experiences with clinicians in the mental health community?
8. What approaches can the mental health community can take in building relationships with local churches?

Procedures/Research Design/Methodology/Timeframe

Describe your participants. From where and how will potential participants be identified (e.g. class list, JMU bulk email request, etc.)?

Participants will be African – Americans pastors of predominantly African-American churches. Participants will be located in the Eastern United States. A minimum of two or maximum of four participants will be interviewed from each of the following religious denominations: Baptist, African Methodist Episcopal (AME), Non-denomination, and Pentecostal. Participants will be purposefully sampled by using the researcher’s personal connections (her father and a colleague who both identify as an African – American Pastor within the Black Church community) and snowball sampling if needed to recruit participants.

How will subjects be recruited once they are identified (e.g., mail, phone, classroom presentation)? Include copies of recruitment letters, flyers, or advertisements.

The researcher will contact participants via email and by phone for recruitment for the study. The researcher will include pertinent information such as the rationale for the study, time frame of interviews, and protecting the participant’s identity and confidentiality. To ensure confidentiality the information will be stored on two encrypted and password protected hard drives. The researcher will provide an informed consent to detail all relevant information related to the research study.

Describe the design and methodology, including all statistics, IN DETAIL. What exactly will be done to the subjects? If applicable, please describe what will happen if a subject declines to be audio or video-recorded.

Participants will be invited to participate in a semi-structured interview ranging between 45 to 60 minutes. The interviews will take place in person in a secure office located at the participant’s church or via Skype, FaceTime, or phone. Before the interview participants will be provided with the same informed consent given via email and asked to complete the demographic questionnaire. The interview will be audio recorded and transcribed. At any time, a participant has the right to decline being audio taped without any penalties or repercussions and their information will be omitted from the study. Participants will be given pseudonyms and they will be used to name files to help ensure confidentiality. Pseudonyms will only be connected to participants’ identifying information (i.e. name, age, race, year in school and university affiliation) in a single document and the principal investigator will have sole access to this document, which will also be stored as an encrypted file on a password protected computer. All recordings will be stored on multiple secure locations which includes two encrypted and password protected hard drives. The interviewer will be using a transcription service that ensures the protection of information and confidentiality. Transcripts will be stored electronically on the researcher’s encrypted and password protected hard drives. After transcription of the

recordings, the recording will be erased and deleted from the two encrypted and password protected hard drives.

This research will work from the framework of the phenomenological analysis which used to analyze the experience (Merriam & Tisdale, 2016, p.227). Epoche, bracketing, phenomenological reduction, imaginative variation, and heuristic inquiry are all characteristics of phenomenological analysis. Epoche is, “the process through which the researcher brackets or isolates biases in order to be open to the experience”. Phenomenological reduction allows the researcher to put aside any biases and reflect on the data to better understand the lived experiences of the participants. Imaginative variation allows the researcher to view the experiences from several different perspectives. Heuristic inquiry includes the personal experience of the research and interactions with the data. Each interview will be transcribed and coded. Participants will have the opportunity to review the transcripts via email once the data has been collected, transcribed, and coded. Participants will be able to alter or redact anything shared in the interviews. The researcher will follow up with participants after 2 weeks for feedback and/or corrections. Participants will also have access to the completed dissertation to expand their knowledge and understanding. Coding involves a method used to retrieve, organize, and analyze collected data. The coding process will include open coding, which allows for the retrieval of pertinent data relative to the study, axial coding which places the data into categories and selective coding which formulates the core themes.

Emphasize possible risks and protection of subjects.

There are no expected risks for taking part in the study, beyond the risks associated with everyday life. Participants do not have to answer every interview question. They will not lose any benefits if they skip questions. They do not have to answer any questions that make them feel uncomfortable.

What are the potential benefits to participation and the research as a whole?

Participants have the opportunity to share their story and experience with mental health issues of congregation members. Participants involvement will also contribute to the scarce availability of research related to the intersection of spirituality, religion, and mental health. The participation of participants will help inform the field of counseling and educate counselors about the experiences of pastors with mental health needs and ways mental health professionals in the community can provide support.

Where will research be conducted? (Be specific; if research is being conducted off of JMU's campus a site letter of permission will be needed)

Interviews conducted in person will be conducted at the location of the participant's church. If done via Skype/FaceTime or by phone the interviews will be conducted in the researcher's office located in her home.

Will deception be used? If yes, provide the rationale for the deception. Also, please provide an explanation of how you plan to debrief the subjects regarding the deception at the end of the study.

No deception will be used in the study.

What is the time frame of the study? (List the dates you plan on collecting data. This cannot be more than a year, and you cannot start conducting research until you get IRB approval)

July – October: Gather data by conducting interviews upon receiving IRB approval.

October – January: Data analysis

January – February: Dissertation manuscript preparation

March: Dissertation defense

Data Analysis

For more information on data security, please see:

[HTTP://WWW.JMU.EDU/RESEARCHINTEGRITY/IRB/IRBDATASECURITY.SHTML](http://www.jmu.edu/researchintegrity/irb/irbdatasecurity.shtml).

How will data be analyzed?

Each interview will be transcribed and coded. Coding involves a method used to retrieve, organize, and analyze collected data. The coding process will include open coding, which allows for the retrieval of pertinent data relative to the study, axial coding which places the data into categories and selective coding which formulates the core themes.

How will you capture or create data? Physical (ex: paper or recording)? Electronic (ex: computer, mobile device, digital recording)?

Interviews will be audio recorded by using a password protected computer. Cloud services will be turned off to ensure interviews are not upload to any off-site server locations.

Do you anticipate transferring your data from a physical/analog format to a digital format? If so, how? (e.g. paper that is scanned, data inputted into the computer from paper, digital photos of physical/analog data, digitizing audio or video recording?)

No.

How and where will data be secured/stored? (e.g. a single computer or laptop; across multiple computers; or computing devices of JMU faculty, staff or students; across multiple computers both at JMU and outside of JMU?) If subjects are being audio and/or video-recorded, file encryption is highly recommended. If signed consent forms will be obtained, please describe how these forms will be stored separately and securely from study data.

Data will be stored on two encrypted and password protected hard drives which will be stored in a locked file cabinet located in the researcher's office in her home. Informed consents will also be stored in a locked file cabinet separate from the data in a separate file cabinet located in the principal research investigator's office in her home.

Who will have access to data? (e.g. just me; me and other JMU researchers (faculty, staff, or students); or me and other non-JMU researchers?)

Myself and the transcription service will have access to the data.

If others will have access to data, how will data be securely shared?

Others will not have access to the data

Will you keep data after the project ends? (i.e. yes, all data; yes, but only de-identified data; or no) If data is being destroyed, when will it be destroyed, and how? Who will destroy the data?

Only de-identified data will be kept after the project ends on the password-protected computer of the primary investigator. The data will be kept for 2 years and then deleted and erased by the primary investigator.

Reporting Procedures

Who is the audience to be reached in the report of the study?

The audience is mental health professionals who provide counseling services to those in the community and African – American Pastors who provide mental health support to parishioners. The results of this study will explore the need for collaboration between the Black Church and mental health community to provide culturally competent counseling to an underserved population.

How will you present the results of the research? (If submitting as exempt, research cannot be published or publicly presented outside of the classroom. Also, the researcher cannot collect any identifiable information from the subjects to qualify as exempt.)

The results of the research will be publicly presented at local, state, and/or national symposiums and/or conferences. Presentations may be in the form of posters and/or oral presentations. In addition, the findings will be submitted for publication as a dissertation manuscript. Additional manuscripts may be published from the results of the research.

How will feedback be provided to subjects?

Participants will be informed that they can request a copy of the final study from either the researcher or faculty advisor and will be provided with contact information.

Experience of the Researcher (and advisor, *if student*):

Please provide a paragraph describing the prior relevant experience of the researcher, advisor (if applicable), and/or consultants. If you are a student researcher, please state if this is your first study. Also, please confirm that your research advisor will be guiding you through this study.

Tiffanie Sutherland is a PhD student in Counseling and Supervision program in the department of Graduate Psychology. Tiffanie has both professional and personal

knowledge of the content literature as it relates to this study. This is Tiffanie's first study and will be guided by her dissertation chair/research advisor Dr. Michele Kielty.

Dr. Michele Kielty is a Professor in the Department of Graduate Psychology. Dr. Kielty is actively engaged in teaching, research, and service endeavors related to children and adolescents and child/adolescent well-being as a part of her professional commitment as an educator and scholar. Dr. Kielty directs the school counseling program at JMU. She has completed research projects during her tenure at JMU on topics of spirituality, mindfulness, well-being in schools, and girls' leadership. She has published in national journals such as *Counselor Education and Supervision*, *The Professional School Counselor*, *Counseling and Values* and the *Journal of School Counseling*. She is the co-author of several book chapters on the topic of spirituality and counseling

APPENDIX B
Recruitment Email

Dear _____,

I am writing to let you know about an opportunity to participate in a research study about the experiences of African – American Pastors in providing mental health support to their congregation members. My name is Tiffanie Sutherlin and I am a doctoral student at James Madison University conducting research to complete my dissertation titled, “*Let the Church Say Amen! Experiences of African – American Pastors of Different Religious Denominations in Providing Mental Health Support to Congregation Members*”. I am interested in learning more about experience and role in providing mental health support to congregation members who present with a mental health issues.

If you choose to participate in this study you will be asked to participate in a 60-minute interview. The interview will either be conducted over the phone, via Skype/FaceTime or in person. The interview will include questions about your experience and role in providing mental health support, your training, and experiences with mental health professionals in the community. Interviews will be audiotaped, however all of your information will remain anonymous and confidential. Before the start of the interview, you will be asked to complete a demographic questionnaire that will collect basic information.

If you are interested in participating in this research study please contact me by email at suthertd@dukes.jmu.edu or by phone at 540-209-6365 for additional forms and additional information regarding the research study. If you have any additional questions or would like more information, please feel free to contact me.

Warm Regards!

Tiffanie Sutherlin, MA, NCC
Ph.D. Candidate | Counseling & Supervision
Department of Graduate Psychology
James Madison University

Pronouns: she/her/hers

APPENDIX C

Participant Informed Consent

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by *Tiffanie Sutherlin* from James Madison University. The purpose of this study is to understand experience of African – Americans Pastors in providing mental health support to parishioners as well as ways the mental health field can help bridge the gap between the Black Church and mental health community. For the purpose of this study mental health support will be defined as providing emotional support or practical assistance for individuals dealing with a mental health issue or emotional distress. This study will contribute to the researcher's completion of her dissertation.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of an interview that will be administered to individual participants located on the East Coast. You will be asked to provide answers to a series of questions related to the experience of African – Americans Pastors in providing mental health support to parishioners. Participants will be audio recorded. The principal investigator, Tiffanie Sutherlin, and a transcription service will be the only entities to have access to the interviews.

Time Required

Participation in this study will require 60 minutes of your time.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).

Benefits

Participants have the opportunity to share their story and experience with mental health issues of congregation members. Participants involvement will also contribute to the scarce availability of research related to the intersection of spirituality, religion, and mental health. The participation of participants will help inform the field of counseling and educate counselors about the experiences of pastors with mental health needs and ways for mental health professionals in the community can provide support.

Confidentiality

The results of the research will be publicly presented at local, state, and/or national symposiums and/or conferences. Presentations may be in the form of posters and/or oral presentations. In addition, the findings will be submitted for publication as a dissertation manuscript. Additional manuscripts may be published from the results of the research. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and

publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, only de-identified data will be kept after the project ends on the password-protected computer of the primary investigator. The data will be kept for 2 years and then destroyed by the primary investigator.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Tiffanie Sutherlin
Department of Graduate Psychology
James Madison University
540-209-6365
suthertd@dukes.jmu.edu

Michele Kielty, PhD
Department of Graduate Psychology
James Madison University
540-568-2553
kieltyml@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley
Chair, Institutional Review Board
James Madison University
(540) 568-2834
cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

I give consent to be audio recorded during my interview. _____ (initials)

Name of Participant (Printed)

Date

Name of Participant (Signed)

Date

Name of Researcher (Signed)

Date

APPENDIX D

VERBAL CONSENT DOCUMENTATION FOR PARTICIPATION.

SUBJECT: Let the Church Say Amen! Experiences of African – American Pastors of Different Religious Denominations in Providing Mental Health Support to Congregation Members

Oral consent serves as an assurance that the required elements of informed consent have been presented orally to the participant or the participant's legally authorized representative.

Verbal consent to participate in this telephone survey has been obtained by the participant's willingness to continue with the telephone survey by providing answers to a series of questions related to what the participant has heard about the dissertation study titled, "Let the Church Say Amen! Experiences of African – American Pastors of Different Religious Denominations in Providing Mental Health Support to Congregation Members"

*Phone Script: Hello. My name is Tiffanie Sutherlin and I am a doctoral candidate from James Madison University. I am calling you to discuss your participation in the research study titled, "Let the Church Say Amen! Experiences of African – American Pastors of Different Religious Denominations in Providing Mental Health Support to Congregation Members". Recently I sent you an email that providing information about participating. If you are still interested in participating, I'd like to review the consent form in agreeing to participate which will provide more information. The purpose of my study is to better understand the experiences of African – Americans Pastors in providing mental health support to congregation members. I hope through this study I can identify ways the mental health field can help bridge the gap between the Black Church and mental health community. For the purpose of this study mental health support will be defined as providing emotional support or practical assistance for individuals dealing with a mental health issue or emotional distress. The interview will be no more than 60 minutes. Based on your preference we can conducted the interviews FaceTime, Skype, or the phone. With your consent I will be audio recording our interview which will be transcribed by a transcription service that upholds confidentiality. At this time, I'd like to confirm that you agree to be audio taped for the interview. A benefit that I appreciate with this study is that is gives an opportunity to share your story and experience with mental health issues you've seen in your church. It also will contribute to the scarce availability of research related to the intersection of spirituality, religion, and mental health. Through your experience I hope to inform the field of counseling and educate counselors about the experiences of pastors with mental health needs and ways for mental health professionals in the community can provide support. I'd like to also review confidentiality with you. If you participate, you will be given a pseudonym instead of using your real name. This is done to protect your confidentiality. I do want you to know that the results of this study may be presented a conferences or submitted for publication. Please know that you have the right to withdraw your participation at any time. Do you have any questions about

participating in this study? At this time, I'd like formally ask if you agree or decline to participate in my study. If you agree I will no document that you have agreed to participate in this study.

I attest that the aforementioned written consent has been orally presented to the human subject and the human subject provided me with an oral assurance of their willingness to participate in the research.

Surveyor's Name (Printed)

Surveyor

Federal requirements mandate that informed consent shall be documented by the use of a written consent form and in the case of oral presentation must also be witnessed in circumstances where human subjects are blind or illiterate.

APPENDIX E

Demographic Questionnaire

Age: _____

Gender: _____

Relationship status: _____

Denomination of church you currently Pastor:

Number of church members: _____

City in which church is located: _____

Experience (years served as Pastor of a church):

Highest Level of Education Completed (Please choose from one of the following):

- high school diploma some college associate degree
 bachelor's degree master's degree doctorate degree
 other (please explain):

Please specify in which field(s) degree was earned:

In what year did you receive your highest educational degree: _____

Have you ever sought out counseling from a licensed mental health professional for personal or emotional concerns? Yes No

If yes, please rate your experience using the scale below:

Very Poorly	1	2	3	4	5	6	7	Very
				Well				
				Somewhat				
				Effective				

Have you ever sought out pastoral counseling from another Pastor or spiritual mentor for personal or emotional concerns? Yes No

If yes, please rate your experience using the scale below:

Very Poorly	1	2	3	4	5	6	7	Very
			Well					
			Somewhat					
			Effective					

APPENDIX F

Interview Questions

Semi-Interview Questions

1. What is your role in supporting the mental health needs of your congregation members?
 - a. How has your role changed across time and/or location?
2. What is your experience in providing counseling to congregating members?
3. How do you believe your denomination may differ in training Pastors from other denominations?
4. What role do you find yourself in when supporting your congregation member during a mental health crisis?
 - a. What issues or challenges have you encountered for yourself when providing this support?
5. How well prepared do you feel in providing mental health support as it relates to the mental health needs of the church?
 - a. What experiences or parts of your training make you feel prepared?
 - b. What experiences or types of training do you wish you had?
6. What is your experience in working with mental health professionals in the community?
 - a. What is your experience in referring members to mental health professionals in the community?
7. What do you feel is important to help co-create a relationship with mental health professionals in the community?
8. What else would you like me to know about your experiences with the mental health

needs in your church?