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Mental Health Concerns in African American Churches: Pastoral Preparedness in Counseling

Melody Samuel

Mental Health Concerns in African American Churches: Pastoral Preparedness for Counseling

by

Melody Samuel

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Submitted by:	Approved by:
_____	_____
Melody Samuel	Anna S. Hamrick, DNP, FNP-C, ACHPN
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Date	Date

Abstract

African Americans rely heavily upon their pastors for more than spiritual guidance. Pastors are known as gatekeepers in the African American community serving as a resource to address a multitude of issues for their congregant from personal issues such as finances and marital issues, grief and bereavement, to physical and mental health issues. The aim of this study was to examine pastoral preparedness for counseling of mental health concerns in the African American church. To better understand the demand of mental health counseling for their congregants and assess the pastor's perception of educational and training needs, 35 pastors and/or associate pastors of predominately African Americans churches in the Upstate of South Carolina were surveyed.

Acknowledgements

I would like to express my gratitude to my husband Kendal for enduring this tedious journey along beside me and for the many pep talks saying, “You CAN do this” and “You CAN’T fail unless you QUIT”! And thanks to my children, Jada and Drew for reminding me of those words we instilled in you “If you start something, you finish it”. To my Mom, thanks for always reciting the scriptures Philippians 4:13 and Jeremiah 29:11 that carried me and lifted me when I doubted my ‘why’. I would also like to send up a heavenly shout out to my Aunt Reatha Ward who was the first black nurse to receive a Master’s in Nursing in 1969 at Medical College of Georgia. You were a woman of notable achievement despite the odds set against you. I am so regretful my journey of academic success was not complete before your transition last year but I’m sure you are singing praises and telling the angels how proud you are and that “She did it!” This one is for you! Thanks for being my professional motivation.

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CHAPTER I

Introduction

Mental illness is one of the most debilitating diseases. Major depression disorders are the leading cause of disability worldwide. Mental health disorders impacts more than 15 million adults in the United States (National Alliance on Mental Illness [NAMI], 2019). In 2017, there were an estimated 11.2 million adults aged 18 or older in the United Sates with Serious Mental Illness (SMI). According to National Institute of Mental Health [NIMH] (2017), there are two broad categories of mental illness: Any Mental Illness (AMI) and Serious Mental Illness (SMI). The signs and symptoms of each will vary depending on severity. AMI is defined as a mental, behavioral, or emotional disorder (NIMH, 2017, para 1). AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment. Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH, 2017, para 1). Statistically women have a higher incidence of mental illness than men. Young adults between ages of 18-15 years of age represent the highest prevalence in this population (Figure 1) (NIMH, 2017, p.1). By the age of 14, more than half of the signs and symptoms of mental illness will begin to manifest subtly and by the age of 24 the diagnosis will become apparent (NAMI, 2019, p. 1). Due to the stigma surrounding mental disease, only two-thirds will receive treatment for their illness. Those suffering from mental health issues may experience long term disabilities due to unmet mental health needs. Interventions are often delayed because these individuals may refrain from

seeking professional care due to stigma and lack of access to care (Kramer, Blevins, Phillips, Davis, & Burris, 2007, p. 123).

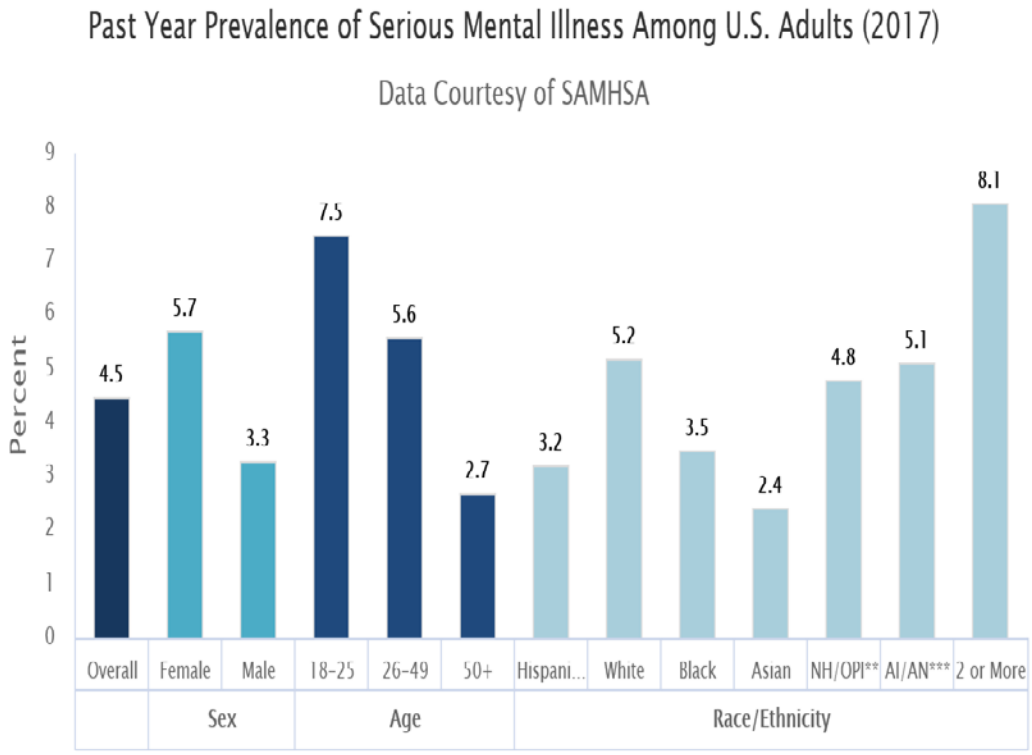

Figure 1. Past Prevalence of Serious Mental Illness Among U.S. Adults (NIMH, 2017)

Mental health is integral to overall health and should be treated with same sense of urgency as physical health. When someone is diagnosed with cancer, people are more likely to be sympathetic and supportive of the patient's journey. Whereas if an individual is diagnosed with a mental disorder, people may ostracize them. When an individual displays signs and symptoms of cancer, most people can direct them where to access proper resources for screening and treatment. Yet with mental illness, this is not typically the case. Unfortunately, there is a gap between what we know and how we

treat physical conditions or diseases compared to mental health conditions or illnesses (Rebecca Ulrich, personal communication, February 15, 2019).

Significance

The prevalence of mental illness has become a public health challenge throughout the entire nation. The challenges are identifying risks, increasing the awareness about the disorders and the effective treatment, removing the stigma, eliminating disparities, and improving access to mental health services (Centers for Disease Control [CDC], 2005, para 3). Mental illness does not discriminate against age, race, ethnicity or socioeconomic background. It affects all ages. Nearly 46.6 million people in the nation 'live with' some form of mental health condition. This equates to an estimated 20% of the adult population (Mental Health America [MHA], 2013, para. 1). The National Alliance of Mental Illness (NAMI) reports that mental illness affects approximately 1 in 5 youth between ages of 13 and 18 (National Alliance of Mental Illness [NAMI], 2019). Depression affects an estimated one in 15 adults (6.7%) in any given year (NAMI, 2019). And one in six people (16.6%) will experience depression at some time in their life (American Psychiatric Association [APA], 2017).

According to the 2015 report on "The State of Mental Health in America," it is estimated that 17.6%, 636,000, of adult residents of South Carolina, battling a mental illness (Mental Health America [MHA], 2015). The report also ranks South Carolina 37th in the nation in prevalence of adult and youth mental health illness (Mulliger, 2016, para. 2). Of the 45.7 million people (13.2 %) in the U.S. that identify as Black or African American (AA), about 16.8 % had some form of diagnosable mental illness (MHA, nd, para. 2).

Problem Statement

In the African American community, the church is, and has historically been, the stronghold of the family and the community. It is often seen as a "safe haven to take all of your burdens". Several studies have indicated that at least 30-40% of African American "churchgoers" use the church as their first source of emotional and psychological support (Young & McCreary, 2014, p. 3). As a part of their role, pastors may interact with congregants battling mental health issues on a regular basis. Pastors of color and pastors that serve in lower socioeconomic areas may have less access to pastoral counseling training opportunities. One study indicated that of the pastors surveyed, 70% had some form of pastoral counseling training while another study only 25% of those surveyed had formal training (Payne, 2013). However, the literature suggests that pastors do not have adequate educational training or experiences to support effective mental health counseling of their congregants.

Purpose

Given the growing concerns of mental health issues in the African American community, it is imperative that clergy be equipped with the necessary educational training, tools, and resources to make appropriate interventions and referrals. The purpose of this study was to explore pastoral preparedness in providing mental health counsel to African American congregants.

Theoretical or Conceptual Framework

Mental health is the foundation for emotions, thinking, communication, learning, resilience and self-esteem (American Psychiatric Association [APA], 2019). Mentally healthy people may maintain normalcy and have better opportunities to be active in

societal norms, engaging in daily activities such as work, school and a better chance at maintaining healthy relationships. Individuals with strong mental health may display effective coping skills which assists in adapting to change and adversity (APA, 2019). In the past decade, the impact of psychological well-being has been investigated in national studies using empirical indicators such as life satisfaction, purpose, personal growth, environmental mastery, self-acceptance, autonomy and positive relationships (Manderscheid et al., 2009, p. 2).

The nursing theory that best guides or aligns with this research study is the Neuman's health care system model. Neuman's conceptual nursing framework considers the client as an open system because the elements are continuously exchanging information and energy (Alligood & Tomey, 2010). Neuman identifies five variables that are components to create this dynamic interaction. These variables include: physiological, psychological, sociocultural, developmental, and spiritual (Alligood & Tomey, 2010, p. 311). Neuman viewed health as a continuum of wellness to illness. The human body constantly encounters daily stressors that can result in imbalances that may lead to disease. Although biological processes, genetics, biochemical imbalances, and environment may be closely linked to MI, researchers strongly suggest that stress is the main culprit (Manderscheid et al., 2009). Neuman focuses on internal and external environmental stressors that can alter or disrupt the body's core balance. Stressors are tension-producing stimuli which may be intrapersonal, interpersonal, or extra personal in nature (Alligood & Tomey, 2010, p. 313). Mental illness involves stressors that change or impair the individual's ability to function and ultimately interfere with those normal daily activities (APA, 2017). According to Neuman, there are three factors that influence how

the body reacts and recovers from stressors. These factors are: (1) the number and strength of the stressor(s), (2) the length of exposure to the stressor(s), and (3) the meaningfulness of the stressor(s) (Hood, 2010, p. 134). When those stressors attack the psychological well-being of an individual, then disease will occur (Figure 2). Stressors that go unresolved can affect the body's normal line of defense (Alligood & Tomey, 2010).

The theoretical concept of Neuman's health care system is further delineated into lines of defense. Neuman incorporates the three levels of nursing intervention; primary, secondary, and tertiary prevention for retaining, attaining, or maintaining system stability (Hood, 2010). The first concept is the central core of the body's structure where homeostasis and harmony coexist. The goal is to prevent entry of the stressor into the body. This is the basis of health promotion which parallels to primary prevention. Neuman's also focuses on the flexible lines of defense and the normal line of defense. Consequently, both are closely aligned with the secondary prevention. At this point, the intent is to determine the most appropriate medical intervention in response to the invasion of the stressor. Finally, there is tertiary prevention on which the normal line of defense and the lines of resistance are designed to respond and react to the stressor. The objective here is to determine the most effective way to regain the body's homeostatic state or restore to optimal wellness (Hood, 2010). Mental health is the foundation for individual well-being and the effective functioning in the community.

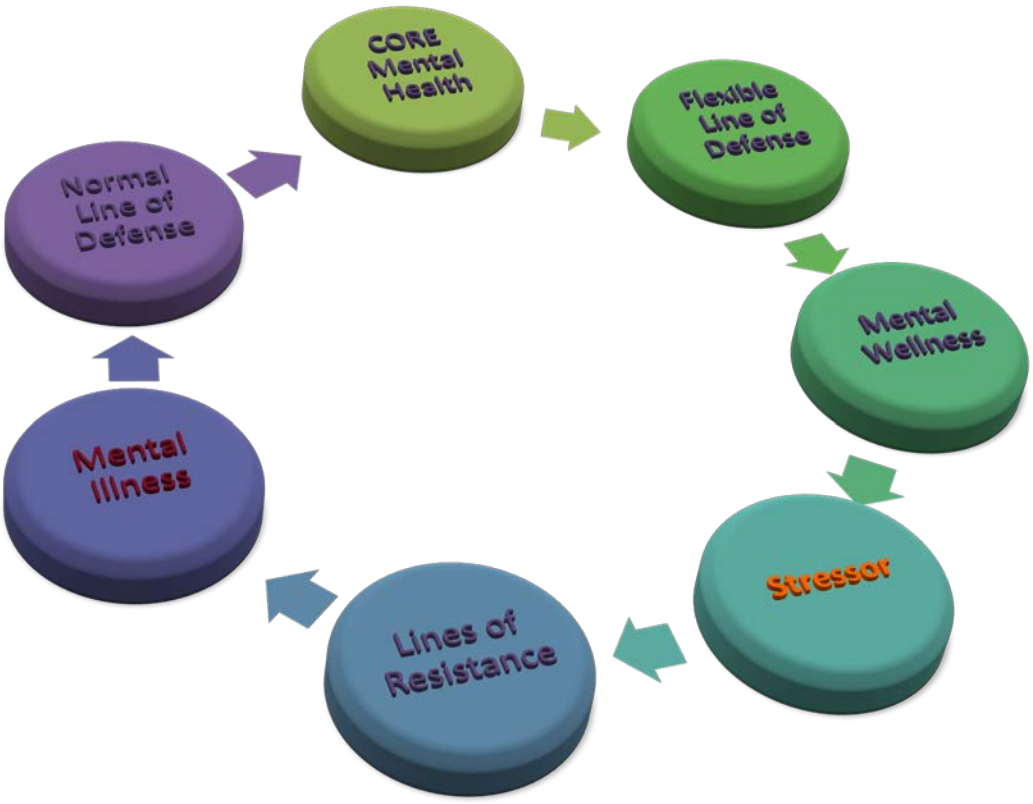

Figure 2. Conceptual/Theoretical (CTE) Diagram - Neuman's Lines of Defense Related to Mental Illness

Research Questions

The study was designed to answer the following questions: How frequently do pastors provide counseling for mental health concerns in the African-American church? Do pastors feel prepared to provide counsel on mental health concerns in African American churches?

CHAPTER II

Review of Literature

A thorough review of literature was conducted to explore pastoral preparedness to provide counsel on mental health issues in the African American congregation. The literature review was specifically aimed at gathering data to determine how frequently pastors provide counseling and if they feel prepared to provide counseling. The databases used in this collective search were ProQuest, Cumulative Index for Nursing Allied Health (CINHAL), CINHAL Plus, and Medline. The search was limited to include scholarly peer reviewed journals and the date of publications within the last 10 years. Key words used in the search were: “black church”, “spirituality”, “clergy perception”, “clergy attitudes”, “stigma”, “barriers to care”, “mental health literacy”, “mental illness”, and “culturally competent care”.

The Black Church

One of the most important institutions in the lives of most African Americans is the church. The Black Church is often synonymous with the African American church. African Americans value the deeply rooted connection and culture of the Black Church. The Black Church is a known prominent fixture in most African American communities. Historically and traditionally, the Black Church has functioned as the institution that provides Black Americans with a venue to meet their social, religious, spiritual and communal needs (Plunkett, 2014, p. 209). The Black Church offers a unique social experience for African Americans (Adkison-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005). It has served as a haven from relentless oppression for generations (Hardy, 2014, p. 4). In the African American family, religion and spiritualty

are the dimensions of culture and are considered the hallmarks of family values. African Americans take pride in their rich traditional religious and spiritual culture. Approximately 80% of African Americans identify religion as a vital part of their lives, with 59% of those reporting affiliations with a Black Church (Avent, Cashwell, & Brown-Jeffy, 2015). Current African American spiritual experiences are shaped from the indigenous rituals and practices of African culture. There is a deep sense of connectedness in the spiritual traditions which have been a part of their rich culture since slavery. There are connections that develop within the church that form family. Practices and rituals shape individuals, families, and communities (Plunkett, 2014).

The church provides a plethora of avenues to support African American congregants from counseling of personal and professional needs, assisting with psychosocial support, navigating through social injustices to even mental health needs. The Black Church has also traditionally provided means of socioeconomic support for members of the African American community (Blank, Mahmood, Fox, & Guterbock, 2002). The faith community is an environment of informal social support. It is not only serving as a place for worship, but also where individuals can manifest power regardless of socioeconomic status or educational achievement and feel that their issues will be addressed and kept safe and confidential (Armstrong, 2016). The Black Church serves a broader community. Additionally, the Black Church, as the hub of the Black community, offers Black Americans a haven for engaging in religious practices that provides a means of coping with the ills of society, managing life stressors, and dealing with marginalization (Plunkett, 2014).

In many rural communities, churches are the portals for addressing and providing education on physical health outcomes. Churches provide a wide–range of prevention and treatment-oriented programs that can reduce disparities in health (Hankerson, Watson Lukachko, Fulliove, & Weissman, 2013). However, unfortunately few churches focus on mental health education. Church-based health programs are designed to provide measurable benefits to individuals through education, screening and treatment. Such programs have effectively improved health outcomes for cancer screening, dietary change, weight loss, smoking cessation, and diabetes treatment. (Hankerson et al., 2013, p. 2).

African Americans may infrequently utilize or take advantage of mental health services. Hankerson et al, (2013) explored minister's views of depression and their perception of using church-based programs for depression counseling. This cross-analysis study gathered data from a predominately African American Mega-church in New York City. The study surveyed a ministerial focus group using semi-structured open-ended questions to guide their research interviews. The sample target size was 65 ministers. Of the 65, 32 had originally agreed to participate. Due to scheduling conflicts, 12 of the participants were unable to participate which decreased the final sample size to 21 participants. The demographics used were age, gender, ethnicity, marital status, and educational background. The study found that minsters were in favor of implementing church-based programs for depression care and collaborating with researchers and mental health providers (Hankerson et al., 2013).

Role of the Clergy

Clergy play an invaluable role in mental health for their communities. Like primary care physicians, ministers are often front-line responders in mental health, serving as natural helpers within a community as well gatekeepers to formal treatment (Kramer et al., 2007, p. 124). Pastors are referred to as the "shepherd of the flock" and as the spiritual shepherd. They are held in high esteem and are typically some of the most well-respected persons in their communities (Allen, Davey, & Davey, 2010). Pastors are valued and are highly respected. The reverence of this position allows them to use their pulpit to advocate for social issues, injustices and inequality in their communities to impact change (Hardy, 2014). Pastors have an expanded role that reaches far beyond the Sunday and Wednesday night worship services, and Bible study. Counseling congregants with their personal needs is also an expectation and an assumed responsibility for clergy. Congregants are partial to utilizing clergy for a multitude of reasons such as financial issues, marital problems, grief counseling, and bereavement (Plunkett, 2014). Many African Americans prefer to seek counsel from their pastors for their personal issues because pastors offer a sense comfort through providing spiritual guidance and moral direction for their congregants. Many congregants have a rapport with their pastors because they have established longstanding relationships. This foundational relationship may put them at ease conversing with their pastors, health professional, regarding any personal issues, and particularly mental health issues. According to Kramer et al. (2007), approximately 24% of parishioners seek help only from members of the clergy but 40 % will seek assistance from clergy or mental health professionals. In the underserved communities, Black clergy are sometimes the only connection to advise congregants to

seek mental health services. They are considered the alternative to a mainstream health care provider. Due to the accessibility of clergy in the community, they often serve in the capacity somewhat like that of a 24-hour triage unit in a medical facility (Allen et al., 2010).

Hardy (2014) explores African American Christian's attitudes regarding their preferred source for counseling. The study surveyed 1,995 members of historically black churches that were identified from a pool of 35,356 members which was provided by the Pew Forum Religion and Public Life. The sample used a power analysis to ensure 5 % confidence interval for the external validity. The results showed that clergy play a pivotal role in providing physiological and psychological support. Although when congregants are in distress, they would rather confide in a faith leader in the community than seek formal or professional mental health assistance. However, there was a willingness on behalf of clergy to refer clients to licensed professionals. Faith leaders play an important role in healing. They not only serve as spiritual counselors but as a conduit to critical resources for their parishioners such as mental health counselors. (Kramer, et al., 2007).

Impact of Perception and Attitudes on Mental Illness

As research has established, clergy are extremely influential in the lives of African Americans thereby playing a significant role in guiding parishioner's access to mental health care. Pastors that are unfamiliar with the different diagnoses of mental illness may describe all congregants as depressed. The American Psychiatric Association defines depression as "a common and serious medical illness that negatively affects how you feel, the way you think and how you act (APA, 2017).

Regardless of educational background, African Americans share generational beliefs that not only impact their health seeking behavior from a physical standpoint, but particularly from a mental health care perspective. As a culture of people, African Americans may be expected to be strong and resilient. Many African Americans view mental illness as a sign of personal weakness. Displaying signs of mental weakness goes against cultural norms. Studies have shown that approximately 63% of African Americans believe that depression stems from lack of faith (Anthony & Johnson, 2015, p. 122). From a religious perspective, some feel that it is a punishment from God. Others believe that depression stems from internal turmoil resulting from sins and trials and tribulations. The belief that is instilled in the culture is that if you have a problem you go to God and if you seek outside help then your faith is questioned (Counseling@NYU Staff, 2018). Subsequently, this is seen as not trusting in God. Parishioners may encounter occult stigma surrounding the components of religious beliefs (Blank, 2002). Ministers believe that parishioners have more optimal outcomes if faith is integrated in the mental health treatment plans. The use of prayer as a coping mechanism instead of accessing professional mental health services is a normal method of help-seeking behavior for African Americans dealing with a diagnosis of mental illness. Although there are various coping mechanisms that are used within the church such as prayer, altar call, and music, by far the most culturally sanctioned strategy for coping is prayer (Conner et al., 2010, p. 13).

According to Payne (2009), it is vital to understand the impact beliefs can have as it can either facilitate of hinder treatment. In her study, Payne surveyed 204 Protestant pastors and ministers from 491 cities in the state of California. The aim of this

qualitative study was to determine the differences in pastor's perceptions of depression based on their race and religious affiliation. The study used a 45-question tool called Clergy Depressive Counseling Survey. The survey tool was emailed to participants. The demographics were 29 women and 175 men, ranging from 20 to 65 years of age. Approximately 65% were Caucasian and 25% were African American with varied levels of education. Eight-two percent had some level of secular education, 56% bachelor's degree and 9% had Ph. D's. Ninety- six % had some form of theological training. Chi-square analysis determined the relationship between race and religious affiliation as statistically significant (Payne, 2009, p. 8). One of the interesting conclusions highlighted in this study was that Caucasian pastors tend to believe that depression is a "biological" condition causing mood disorders whereas African American pastors define depression as more in line with a "spiritual" basis related to feelings of hopelessness (Payne 2009).

Conner et al. (2010) evaluated the impact that beliefs and attitudes of older African American's with depression had on their help-seeking behaviors. This was a descriptive qualitative study that used a cohort focus group. Coordinators for the study were stationed at a local community center for four to five days week in a low-income urban African American community. In effort to ensure a level of comfort for the participants, all the facilitators were African American. The sample size consisted of 42 participants with 84 % of them being women (Conner et al., 2010). The mean age of the participants was 65 years of age. The survey was a 90- minute open-ended questionnaire exploring feelings and general beliefs about depression. There were six emerging themes related to mental illness from "seeking treatment as a last resort", "stigma", "myths",

"perceptions of depression", and "culturally appropriate coping strategies to" the "unique experience of being African American" that contributes depression. Findings revealed that participants were reluctant to discuss their diagnosis because of the generational beliefs about MI. As well, the participants were often noncompliant with prescribed meds for" fear of getting hooked" and or being labeled as taking medications for "crazy" (Conner et al., 2010).

Stigma and Barriers to Care

Mental health conditions have a profound effect on the quality of life and productivity for individuals and families across the lifespan and around the globe (Pearson, Hines-Martin, Evans, Kane, & Yearwood, 2015 p. 14). Stigma surrounding those with mental illness leads to adverse consequences in the treatment of those with mental illness. Stigma is a universal barrier to mental health care. Negative attitudes and stereotypes are factors that contribute to adverse consequences toward those diagnosed with mental illness. Racism, religious beliefs, poverty, violence, and lack of provider cultural competency are also variables that may contribute to complex barriers in mental illness. Although African Americans may use family, community, and spiritual beliefs to help navigate through coping with daily stressors, these very entities can sometimes impede therapeutic interventions in the treatment of mental illness (Armstrong, 2016). Stigma may also exist as a religious component (Counseling@NYU Staff, 2018). Among many Blacks, mental health issues are often not considered medical issues. Mental illness is considered a character flaw, sign of weakness, and as a private matter. Along with these perceptions come a sense of embarrassment and shame and reflects the social stigma (Allen et al., 2010). There are many negative connotations used

to describe someone with mental illness. Offensive phrases like “she/he ain’t right, or not quite right”, “elevator don’t rise to the top” or words like “unstable”, “crazy”, “nuts”, “lunatic”, “deranged”, “psycho”, “mental case”, “insane”, and even “disturbed” are frequently used in general conversations in households, patient care environment and even on media outlets (Szeto, Luong, & Dobson, 2013). These stigmatizing words have shown to have a detrimental effect on individuals causing refusal of care to extreme social isolation. Unfortunately, derogatory words used to describe someone with mental illness are often key deterrents of help-seeking behaviors.

Besides these perceptual barriers of stigma and fear of misdiagnosis, there are key structural barriers that may significantly impact or hinder treatment. Barriers may include lack of services or access to services, transportation, no health insurance or lack of adequate coverage impeding quality care for this population (NIMHD, 2017). Approximately 27% of African Americans live below poverty level, compared to 10.8% of non-Hispanic whites (MHA, 2013). Another astounding statistic, reported by American Psychiatric Association [APA], is that approximately 11% of African Americans are not covered by health insurance compared with about 7% of non-Hispanic whites (MHA, 2013). For those without insurance, counseling is often not an option because it is unaffordable. Only one-in-three African Americans who need mental health intervention actually receive care (MHA, 2013).

Mental Health Literacy

Mental health literacy (MHL) is a derivative of health literacy. The World Health Organization (2018) defines mental health as the absence of illness and, more broadly and significantly, as “a state of well-being in which the individual realizes his or her own

abilities, can cope with normal stressors of life, can work productively, and is able to make a contribution to his or her community (World health organization [WHO], 2018). Mental Health Literacy (MHL) has been defined as:

> "understanding how to obtain and maintain positive mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; and enhancing help-seeking efficacy (know when and where to seek help and developing competencies designed to improve one's health care and self-management capabilities) (Kutcher, Wei, & Coniglio, 2016 p.155).

To improve mental health knowledge, decrease the stigma, and enhance help seeking behaviors, it is crucial for pastors to understand mental health literacy. A qualitative study explored the level of knowledge and perception of attitudes of Korean American clergy regarding depression. The study surveyed 17 Korean born clergy using the Gateway Provider Model (GPM) framework to explore mental health literacy (Jang, Park, Yoon, Ko, & Jung, 2017). The GPM includes questions related to five main issues: (1) ability to identify the problem, (2) knowledge about causes and risks factors, (3) knowledge and beliefs about treatment, (4) knowledge about resources, and (5) contextual factors. The aim of this framework was to elicit responses to assess clergy's need for community mental health training and their use of mental health services (Jang et al., 2017). Approximately 52.9% of the participants reported having received some education or training on mental health and 41% of them reporting having had little to no education. The themes were divided into five categories highlighting the need for mental health education in minority communities. Mental health literacy is a crucial component in helping pastors with selecting the most appropriate and necessary interventions.

Culturally Competent Care

Mental Illness (MI) may be considered a taboo subject and is a topic often considered 'hush hush' and kept within the family or household. Many African Americans believe that it is a form of demons and should be taken to God in prayer (Armstrong, 2016). The engrained mindset of many members of the African American culture is that "family don't air their dirty laundry" and it's "my cross to bear" (Armstrong, 2016). The customary and generational beliefs surrounding mental illness and the fear of negative stereotype have greatly contributed to the inadequate treatment of the disease. Globally more than 70% of people with mental illness receive no treatment from health care staff (Henderson, Evans-Lacko, & Thornicroft, 2013, para. 1). The rationale is that people avoid seeking treatment primarily due to lack of knowledge to identify features of mental illness, ignorance about how to access treatment, and prejudice against people who have mental illness (Henderson et al., 2013, para. 1). African Americans fear being labeled as crazy or being deemed as crazy (Szeto et al., 2013). Because of the negative perceptions and labeling surrounding mental illness, treatment is often delayed. This labeling also places mistrust in health care professionals. Consequently, people are more likely to seek help from pastors which places a tremendous responsibility on clergy to address mental issues of their congregants (Payne & Hays, 2016). Customarily, religious leaders are the preferred social support service because they are less intimidating and stigmatizing than professional health care providers. Some congregants will seek clergy counsel over a professional counselor because they may simply be uncomfortable with sharing or seeking help with certain issues. Many African Americans have a grave fear they will be misunderstood or

misdiagnosed by mental health specialists that are unfamiliar with their plight or simply insensitive to their unique circumstances. Clients may be apprehensive about using formal healthcare providers in general for fear of mistrust. Some believe that white health providers are unable to adequately provide therapeutic services to African Americans because of their lack of understanding of culture and history and experiences (Payne & Hays, 2016).

Blacks prefer black therapists and are less likely to trust white therapists or seek their services (APA, 2019). The typical characteristics of mental health providers are primarily white males. Only 3.7% of American Psychiatric Association and 1.5% of American Psychological Association members are African American (APA, 2019). Studies have shown that African Americans feel that white males can be insensitive to their social and economic realities (Plunkett, 2014). As well, white therapists may be dismissive and even display discomfort in treating African Americans. According to a study by Payne (2009), for mental health professionals to develop therapeutic relationships with African Americans they must acknowledge the impact that religion plays in the lives of African Americans.

Bilkins, Allen, Davey, and Davey (2016) surveyed black church leader's attitudes about seeking help outside the church. They surveyed 112 church leaders in a Black Mega-Church which consisted of over 2,000 members. The aim of this study was to evaluate black church leader's willingness to collaborate with community partners. They used 225 Likert-scaled items selected from a National Survey of American Life (NSAL) database. They added four questions to help delineate the hierarchy process in the mega-church. The convenience-sampling frame used surveyed 112 leaders which consisted of

associate pastors, deacons and deaconesses, deacon aids and congregational care givers. The overall results suggested that black church leaders feel that mental healthcare providers and researchers should more be more cognizant of their past experiences of racial discrimination play a part in their willingness to refer clients or utilized their services (Blevins et al., 2016).

Jackson (2015) conducted a study on Licensed Professional Counselors' (LPC) perception of pastoral counseling. This study evaluated 441 LPC's in a face- to-face interview to determine their views of pastor's preparedness for counseling. The evidence revealed insightful emerging themes. Both parties, the LPC's and Pastors, agreed that there were areas they desired exploring in order to close the gap and provide ways of improving communication, establishing mutual respect of roles, respecting boundaries of each profession, enhancing counseling methods, engaging and collaborating with community (Jackson, 2015).

Another important entity in cultural competence is the understanding what value and significance spirituality plays in the lives of African American. It is distinct component to developing trust in the African American client. Thus, it is essential that mental health clinicians be cognizant as to how they interpret the importance of religion to their clients. Many mental health professionals do not share core values of the Black church or do not exercise these values in caring for Black American churchgoers (Plunkett, 2014, p. 215). Counselors don't often value the spiritual aspect. Counselors that are in tuned with their own personal feelings toward religion and spirituality are better able to integrate into therapy hence developing therapeutic relationships with clients. They must be intentional to show acceptance of one's religious beliefs and

incorporate religion and spirituality in the care of the client. Most importantly, mental health specialists must be sensitive to culture and cautiously refrain from being judgmental or sending negative cues. Although recent studies have shown there is a growing willingness on behalf of African Americans to seek assistance of nonreligious healthcare providers, a crucial component to therapeutic care is having counselors that are culturally competent (Hardy, 2014). Failure to develop culturally appropriate strategies and timely care can result in significant public health crisis. Interaction between race and attitudes affects an individual's decision to seek health care.

Clergy Referral Practices Related to Training

Approximately 23% of people use religious leaders to provide an array of different services (Jang et al., 2017, p. 385). To improve outcomes of mental health needs of congregants, clergy may need more training and resources to assist with interventions. Pastors that are better prepared and well informed have a higher tendency of making referral practices (Allen et al., 2010 p.123). Consequently, evidence has shown that ministers who are ill-equipped in recognizing and managing signs and symptoms of depression will make fewer referrals. Anthony (2015) examined clergy's preparedness in recognizing signs and symptoms of depression and what they felt they needed to effectively care for their congregants. This descriptive quantitative study used a Mental Health Counseling Survey (MHCS) which consisted of 11 questions designed to determine the clergy's competency level and what type of training and resources were needed to assist in caring for congregants. Of the 65 participants, 62 were African American clergy with varying levels of educational preparation. The overall findings revealed that higher levels of education weighted rather significantly with regards to

confidently and effectively managing care. Further literature suggests that most clergy who have a secular background are more apt to make referrals and collaborate with a HCP professional. They typically have a broader understanding about depression and can recognize symptoms before they become severe (Anthony, 2015). Clergy with a broader theological training are less likely to refer congregants to professionals. Mattis et al. (2007) found that pastors who have acquired counseling coursework through seminary education often correlates with their willingness to engage in dialogue with professionals and thereby make the necessary referrals (Mattis et al., 2007).

Pickard and Inoue (2013) conducted a study to determine the likelihood of clergy to make referrals for older adults. A cross sectional study examined the likelihood of referral to formal mental providers. Four hundred ninety-three participants took part in this survey. They were mailed a two-page questionnaire survey called Attitudes towards Older Adults and Mental Illness (AOAMI). The results found that clergy with positive attitudes and more education were more likely to make referrals (Pickard & Inoue, 2013). Clergy play an integral role in addressing and identifying mental health needs of their congregants. Therefore, it is essential that they are aware of all available community resources and mental health resources (Taylor, Ellison, Levin, Lincoln, & Chatters, 2000). Research suggests that clergy who are more knowledgeable and familiar with professional services and with public agencies are more confident in making the necessary referrals and understand which issues require prompt intervention (Mattis et al., 2007). It is important that faith-based communities provide education about symptoms of mental illness symptoms, significance of social inequities, identify social support systems, and access to community-based settings. Religious institutions can

reduce stigma of mental illness by offering programs and being open to ideas that will help their members (Counseling@NYU Staff, 2018, p.2). Outreach efforts can be instrumental in providing access to timely treatment (Hardy 2014, p. 13).

CHAPTER III

Methodology

Introduction

The purpose of this study was to explore pastoral preparedness in providing mental health counsel to African American congregants. Additionally, the study evaluated the frequency pastors provided mental health counseling to their congregants.

Study Design

A descriptive, quantitative study was conducted to assess the pastor's preparedness to provide counsel on the mental health needs of their congregants.

Setting and Sample

The study was conducted in the upstate region of South Carolina. The sample included 28 pastors and 7 associate pastors from a database of 28 predominately African American churches. The Mental Health Counseling Survey Tool, used for data collection, was originally developed by W. E. Wylie (Appendix A) and was adapted in 2015 by Jeanne Spann Anthony. The researcher was granted permission to use the tool by Anthony and given additional permission to adapt tool according to needs of intended research (Appendix B). The modified Mental Health Counseling Survey Tool (Appendix C) included demographic questions regarding the pastors or associate pastors of predominately African American churches highest level of education completed, age range, and any formal training in depression counseling skills as well as demographics of the congregant's age and characteristics. The modifications were designed to explore the pastor's perception of their own ability to identify behavioral issues that warrant professional counseling and identify the appropriate resources for referrals.

Protection of Human Subjects

The study was analyzed and approved by the University Institutional Review Board (IRB) and found no more than minimal risk to participants. The participants were provided with informed consent and informed that study participation was strictly voluntary and anonymous. There were no incentives for participating or penalties for not participating.

Procedure

Following the IRB approval, the participants were recruited by sending emails to pastors of African American churches in the Upstate region of South Carolina. The email addresses were obtained via public domain on the internet. The participants received an email describing the study, providing informed consent, and a link to the electronic survey. Consent was implied if the participant clicked on the link and completed the survey. The anonymity of the participants was protected utilizing the privacy options provided via Survey Monkey®. No personal information was collected. The researcher provided detailed instructions via Survey Monkey® and informed participants that no personal information such as participant's names, addresses, emails addresses or IP addresses, or any other data that could have potentially identified subjects would be collected. Participants were informed that the anticipated length of time involved in completing survey was approximately 10 minutes. Participants were asked to complete the survey within two-weeks of receiving the email. A specific date for deadline was communicated in the email. A reminder email was sent after seven days of the initial email. Based on the low participation at the end of the two-week period, a second email was sent reminding them of the survey availability with a two-day extension.

Data Analysis

Data was collected utilizing Survey Monkey®. Upon completion of the study, data was analyzed with Survey Monkey's® internal software. Statistical analysis was entered into a Microsoft Excel spreadsheet by the nurse researcher/investigator. Descriptive statistics were computed for the sample characteristics using standard deviations frequency, percentages of the mean, and median as appropriate to the level of measurement.

CHAPTER IV

Results

Introduction

The purpose of this study was to explore pastoral preparedness in providing mental health counsel to African American congregants. Additionally, the study evaluated the frequency pastors provided mental health counseling to their congregants.

Sample Characteristics

Thirty-five emails were sent out to clergy of predominately African American churches. Twenty-eight emails were sent to the Pastor's emails and seven were sent to Associate Pastors. The modified Mental Health Counseling Survey Tool was used for data collection via Survey Monkey®. The email included detailed instructions informing participants that clicking the link to complete the attached survey indicated implied consent. Of the 35 surveys sent out, 13 (37 %) participated in the actual survey. Twelve of the surveys were completed in its entirety. One responder skipped multiple questions and those were primarily the open-ended questions that were left unanswered. The survey collected demographic information regarding the pastors or associate pastors' highest level of education completed, age range, and any formal training in depression counseling skills. Other pertinent demographic information collected was specific to the congregant's age range and characteristics. These modifications on the original tool elicited responses regarding the pastor's perception of their own ability to identify behavioral issues that warrant professional counseling and identify the appropriate resources for referrals.

Major Findings

The demographic criteria for this study are separated into two sections (Table 1). One for the pastor's personal demographics and the other was to describe the demographics of their congregants. The first question confirmed the position/role of the participant in the church and asked the participant to select "Yes or No" if they were the Pastor or Associate Pastor of a predominately African American church. Twelve of the respondents answered 'Yes' (92.31 %) and one answered 'No' (7.69 %). Since a select few of the surveys were emailed to a generic church email address, the assumption for this outlier was the possibility that the Administrative Assistant had access to the email and answered the survey for the pastor, although this cannot be confirmed nor denied.

The second demographic question collected data about the pastor's age. The age range was from 18 years of age to greater than 70 years of age. Approximately half (48.15%) of the clergy were between the ages of 51 and 60. Three of the participants were between the ages of 61-70. Only one clergy member was between the ages of 18 to 30 and no participants were older than 70.

Educational preparation of the participants was collected to explore correlations and patterns. All participants had at least "some college experience". Four out of the 13 participants indicated they had "some form of college education". 'Some college' and '4/year bachelor's degree' both resulted with the same percentage, 15.38 %, which may suggest some clarification was needed to accurately assess this response. More than half of the clergy held a Master's degree (53.85%) and one (7.69%) participant had some post-graduate education. However, none of them had Doctoral Degrees.

Demographic data on the congregations served was also collected. Participants were asked to select all the age ranges represented in their congregations. Data revealed that a wide range of age groups were represented in their congregations from less than 18 years of age to greater than 69 years of age. Many of the clergy serve congregations who include individuals in the 19-59 years of age range.

The final demographic question was regarding the type of the congregants that clergy counsel with survey options being “individual”, “couples”, “family”, “parent/child” or “other”. The characteristics of the “type of congregants being counseled” revealed all participants provide counsel to individuals (100%), 30.7% (N=4) provide counsel to couples, 30.7% (N=4) provide counsel to families, and 30.7 % (N=4) provide counsel to parent/child.

Table 1

Clergy Demographics Frequency

Clergy Personal & Congregant Demographics			N=13
Church Pastor			
	Yes	92.31%	12
	No	7.69%	1
Education			
	Some High School	0.00%	0
	High School/GED	0.00%	0
	Some College	15.38%	2
	2 year/ Associate Degree	7.69%	1
	4 year /Bachelors' s Degree	15.38%	2
	Some Post Graduate Degree	7.69%	1
	Master's Degree	53.85%	7
	Doctoral Degree	0.00%	0
Age Range			
	18-30	7.69%	1
	31-40	0.00%	0
	41-50	23.08%	3
	51-60	48.15%	6
	61-70	23.06%	3
	>70	0.00%	0
Age range of Congregants			
	<18 years of age	15.38%	2
	19-29 years of age	38.46%	5
	30-39 years of age	76.92%	10
	40-49 years of age	46.15%	6
	50-59 years of age	53.85%	7
	60-69 years of age	30.77%	4
	> 69 years of age	15.38%	2
Characteristics of Congregants			
	Individuals	100.00%	13
	Couples	30.77%	4
	Family	30.77%	4
	Parent/Child	30.77%	4
	Other	0.00%	0

In order to determine pastoral preparedness for counseling, this survey asked three specific questions to assess clergy's existing counseling practices. Item 1 asked participants "Do any of your congregants seek your help when dealing with anxiety, depression, suicidal ideation, and/or bereavement?" As demonstrated in Figure 3, anxiety and bereavement/grief are the primary reasons people seek help from survey respondents. Eleven out of the 13 respondents answered the question for anxiety and bereavement/grief related issues yielding a response of 84.62%. The third highest response of reasons for help seeking was for depression. There were 10 out of 13 respondents who answered yielding 76.92 %. Surprisingly, the most uncommon reason people seek help was for suicidal ideation. Five of the 13 respondents answered this question yielding a frequency of 38.46%.

Item 1: Do any of your congregants seek your help when dealing with the following issues?
N=13

Answer Choices	%	Freq
Anxiety	84.62%	11
Depression	76.92%	10
Suicidal Ideation	38.46%	5
Bereavement/Grief	84.62%	11

Figure 3. Survey Question #1: Do any of your congregants seek your help when dealing with anxiety, depression, suicidal ideation, and/or bereavement?

Item 2, asked participants, "In the past 6-months, estimate the number of people whom you have counseled for any reason". Five out of 13 participants report they counsel an average of 5–10 congregants within a 6-month time frame. Three of 13 responded that they counsel less than five, two out of 13 say between 11-15, two responded 16-20 and only one clergy member counseled greater than 20 congregants in the 6-month time frame. (See Figure 4).

Item 2: In the past 6 months, estimate the number of people whom you have counseled for any reason.
N=13

Answer Choices	%	Freq
Less than 5	23.80%	3
Between 5-10	34.46%	5
Between 11-15	15.36%	2
Between 16-20	15.36%	2
Greater than 20	7.69%	1

Figure 4. Survey Question #2: In the past 6-months, estimate the number of people whom you have counseled for any reason.

Figure 5 shows survey item 3 asked respondents "In the past 6-months, estimate the number of people whom you have counseled for the following: depression, anxiety, and/or suicidal ideation". Thirteen participants reported they had counseled less than five people in a 6-month time frame for depression 36.36 % of the time, 27.27% for anxiety, and 36.36% for suicidal ideation. Others reported that they counseled anywhere from 5-10 congregants in 6-months for depression 71.43% of the time, and anxiety 26.57% of the time. One of those participants stated that of the 16-20 congregants they have counseled in 6-months, all of them were for depression. Only one participant stated that they had counseled more than 20 congregants for anxiety in this 6-month period.

Item 3: In the past 6 months, estimate the number of people whom you have counseled for the following Depression Anxiety Suicidal Ideation.
N=13

	Depression		Anxiety		Suicidal Ideation		
Answer Choices	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**Total**
Less than 5	36.36%	4	27.27%	3	36.36%	4	11
Between 5-10	71.43%	5	26.57%	2	0.00%	0	7
Between 11-15	50.00%	1	50.00%	1	0.00%	0	2
Between 16-20	100.00%	1	0.00%	0	0.00%	0	1
Greater than 20	0.00%	0	100.00%	2	0.00%	0	2

Figure 5. Survey Question #3: In the past 6-months, estimate the number of people whom you have counseled for the following: depression, anxiety, and/or suicidal ideation

Item 4 asked "Why do you think most people come to you instead of going to mental health professionals for help with depression? Of the twelve of the participants, more than half (56.56%) of them believe the reason congregants seek their help instead of mental health professionals may be primarily due to health insurance not covering visits to a mental professional. And approximately 40% of the participants believe that congregants are deterred from seeking health care professionals because of not having their spiritual values respected. (See Figure 6).

Item 4: Why do you think most people come to you instead of going to mental health professionals for help with depression? N=12

	1		2		3		4		
Answer Choices	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**Total**
Their spiritual values and beliefs may not be respected by health care professionals	40.00%	4	30.00%	3	10.00%	1	20.00%	2	10
Health insurance does not cover visits to a mental health professional	0.00%	0	56.56%	5	44.44%	4	0.00%	0	9

Figure 6. Survey Question #4: Why do you think most people come to you instead of going to mental health professions for help with depression?

Item 5 asked the participants "What cues make you suspect a congregant might be depressed?" This item was included to explore signs and symptoms that may alert clergy that a congregant may be depressed. Participants answered the open-ended question with varied responses: Lack of engagement, lack of enthusiasm, intermittent distance, increased weeping, family problems and lack of information, always crying, unable to forgive, can't move forward, attending church less, disengaged, extreme in reaction, mood and body language, low attendance, anxious, negative outlook on life, missing church, change in attitude, just not themselves, and change in mood, and absenteeism. (See Figure 7).

Item 5: What cues make you suspect a congregant might be depressed?
N= 11
Answer Choices
Lack of engagement, lack of enthusiasm, intermittent distance, increased weeping
Family Problems and lack of information
Always crying, Unable to forgive, Can't move forward
Attending less, Disengaged, Extreme in reaction
Their mood and body language
Low attendance
Anxious
Negative outlook on life
Missing Church service
Change in attitude, not themselves
A change in mood, absenteeism etc.

Figure 7. Survey Question #5: What cues make you suspect a congregant might be depressed?

Item 6 surveyed the participants on "How does depression counseling compare to your spiritual counseling experience?" Based on the data collected, there are distinct variations in beliefs with regards to depression counseling and spiritual counseling. Of the 12 participants that completed item number 6, 25% believe that issues brought up in

depression counseling almost never overlap with spiritual counseling. However, approximately 16% believe that the issues addressed are identical to those in spiritual counseling. As far as the methods used for counseling, 33.33% of the participants believe that their methods used for depression counseling are distinctly different than those used in their spiritual counseling practices. And 16.67% of the participants believe that the two methods are actually no different. As far as similarities in depression counseling and spiritual counseling, approximately 42% of the participants believe that depression counseling is very similar to spiritual counseling, and only 8.3% of the participants believe that the two are very dissimilar. (See Figure 8).

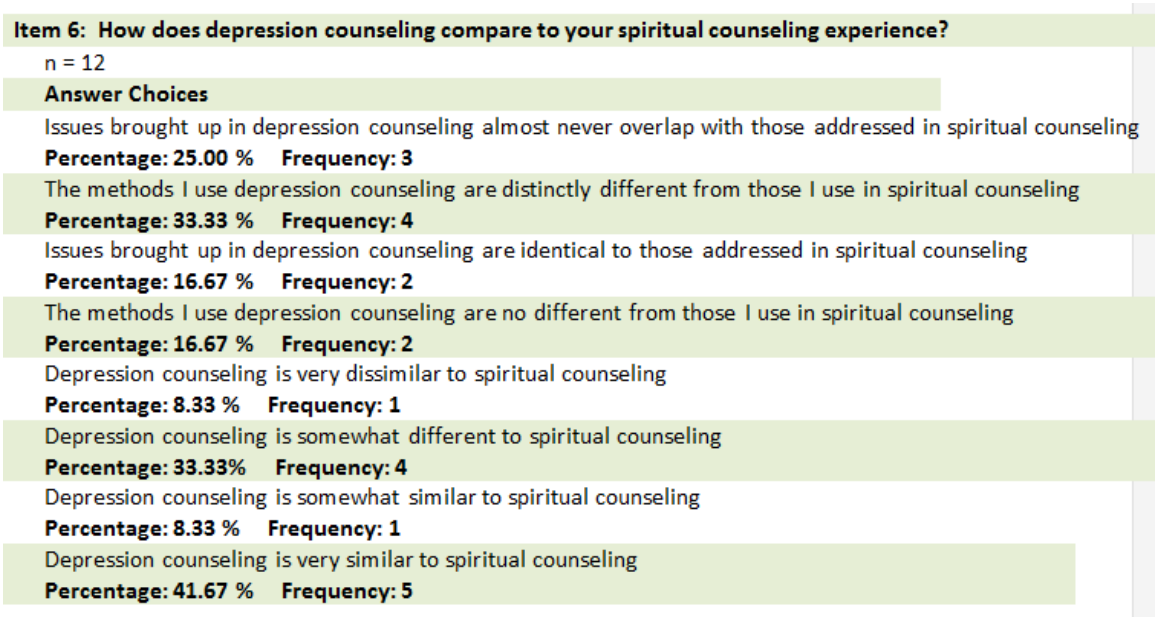

Figure 8. Survey Question #6: How does depression counseling compare to your spiritual counseling experience?

The final section of the survey was focused on the referral practices of clergy. This section of the survey contained five questions that were asked of the participants. Item 7 asked participants "Do you refer depressed congregants to any of the following?" Answer choices were the following: Mental health specialists (MHS), Hospital

Emergency Room, Primary Care Provider (PCP), Psychiatric hospital, or other. Only one of the 13 participants omitted responding to this question. Mental Health Specialists (66.67%) was overwhelmingly the preferred group that clergy referred congregants to for depression. Eight of the 12 selected MHS. Five out of 12 indicated they would refer congregant to the Primary Care provider (41.67%). Four out of 12 would refer them to other sources such as licensed therapist. Additional comments on this item included "I recognize that my area of training is not in Depression, so I would refer them to their pastor". One participant also responded, "I would refer but depends on the situation". (See Figure 9).

Item 7: Do you refer depressed congregants to any of the following?
N=12

Answer Choices	Percentages	Frequencies
Mental health specialists	66.67%	8
Hospital Emergency room	0.00%	0
Primary Care Provider	41.67%	5
Psychiatric hospital	0.00%	0
Other (please specify)	33.33%	4
Licensed therapists		
I recognize that my area of training is not in Depression or Mental Health		
Refer them to their Pastor		
it depends on situation		

Figure 9. Survey Question #7: Do you refer depressed congregants to any of the following?

Item 8 asked respondents "what factors influence your decision to make a referral?" Answer Choices were the following: congregant's signs and symptoms, your comfort level, individual's request, or other. Again, one participant omitted the question. Therefore, nine out of 12 (75%) say that a congregant's signs and symptoms would dictate their decision for referral. As well, nine out 12 (75%) would base the decision on

their own comfort level, and two out 12 indicate that the individual's request and other factors would determine referral. Comments were as follows: "In some instances, members are not as comfortable sharing intimate details about their situation with pastor". "My training is in Theology. So, when in doubt I know to make a referral. I had CPE training". (See Figure 10).

Item 8: What factors influence your decision to make a referral? N=12		
Answer Choices	**Percentages**	**Frequencies**
Congregant's signs and symptoms	75.00%	9
Your level of comfort	75.00%	9
Individual's request	16.67%	2
Other (please specify)	16.67%	2
-In some instances, members are not as comfortable sharing intimate details about their situation with a pastor.		
-My training is in Theology. So, when in doubt I know when to referral. CPE training.		

Figure 10. Survey Question #8: What factors influence your decision to make a referral?

Item 9 asked participants to provide open-ended responses to "As you think about your experience in counseling individuals suffering with depression, is there anything that would help you do a better job?" Responses included: (1) annual and biannual training for pastors to help separate clinical depression from other forms of depression, (2) remove self and focus solely on the imminent need of the individual, (3) seminar training and classes, (4) collaboration with mental health providers in the community. (See Figure 11)

Item 9: As you think about your experience in counseling individuals suffering with depression, is there anything that would help you do a better job?
Responses
-Maybe updated or annual or bi-annual training for pastors and learning to separate clinical depression from other forms of depression.
-Continue to read new material and be in touch with local Agencies.
-In the time we are living in, we need more training in how to look for signs of someone suffering with depression.
Because pastors can't reach all, each Ministry head/ leader need to be trained in this area. As a minister we need to be honest with ourselves, we help others and yet we choose to deal and be silent about our own demon depression.
-Trainings
-More training
-Training
-Seminar training
-More collaboration with Mental health providers and community Awareness programs
-Classes
-More Classes
-Remove self and focus solely on the imminent need of the individual

Figure 11. Survey Question #9: As you think about your experience in counseling individuals suffering with depression, is there anything that would help you do a better job?

Item 10 asked participants to share "in your opinion, is formal training in depression counseling skills appropriate for clergy?" The answer choices were 'Yes' or "No" as it was a closed-ended question. All the participants (n=12) answered 'Yes". They all agreed that this was appropriate for clergy. (see Figure 12).

Item 10: In your opinion, is formal training in depression counseling skills appropriate for clergy? N=12

Answer Choices	Percentages	Frequencies
Yes	100.00%	12
No	0.00%	0

Figure 12. Survey Question #10: In your opinion, is formal training in depression counseling skills appropriate for clergy?

Item 11 collected responses on "in your opinion, is formal training in counseling skills necessary for clergy?" This question was also closed ended with, a 'Yes' or 'No'

response being solicited. 83.3% (n=10) said 'Yes'. Only 2 participants said 'No' or disagreed that it is necessary. (See Figure 13).

Item 11: In your opinion, is formal training in depression counseling skills necessary for clergy?
N=12

Answer Choices	Percentages	Frequencies
Yes	83.33%	10
No	16.67%	2

Figure 13. Survey Question #11: In your opinion, is formal training in depression counseling skills necessary for clergy?

Item 12 asked respondents "have you had any formal training in depression counseling skills?" The answer choices were either 'Yes' or 'No'. Five out 12 responded "Yes" (41.67 %) and 7 out of 12 responded "No" (58.33 %). (See Figure 14).

Item 12: Have you had any formal training in depression counseling skills?
N=12

Answer Choices	Percentages	Frequencies
Yes	41.67%	5
No	58.33%	7

Figure 14. Survey Question #12: Have you had any formal training in depression counseling skills?

Summary

In data analysis, it was determined that most of the participants in this study were middle-age African American pastors with a minimum college education of a bachelor's degree. Pastors characterized the type of mental illnesses observed in this population was more related to anxiety and depression as opposed to suicidal ideations. If a congregant's symptoms warranted intervention, these pastors are comfortable with making the

necessary referral and were more inclined to utilize professional mental health services. Although almost half of them believed that spiritual counseling was very similar to depression counseling, they acknowledged that further education and training as well as collaboration was needed to help them to be more effective in their perspective roles. (See Tables 2 and 3).

Table 2.

Counseling Practices

Clergy Survey Questions 1-6 Results

Item 1: Do any of your congregants seek your help when dealing with the following issues?
N=13

Answer Choices	%	Freq
Anxiety	84.62%	11
Depression	76.92%	10
Suicidal Ideation	38.46%	5
Bereavement/Grief	84.62%	11

Item 2: In the past 6 months, estimate the number of people whom you have counseled for any reason.
N=13

Answer Choices	%	Freq
Less than 5	23.80%	3
Between 5-10	34.46%	5
Between 11-15	15.36%	2
Between 16-20	15.36%	2
Greater than 20	7.69%	1

Item 3: In the past 6 months, estimate the number of people whom you have counseled for the following Depression Anxiety Suicidal Ideation.
N=13

	Depression		Anxiety		Suicidal Ideation		
Answer Choices	%	Freq	%	Freq	%	Freq	Total
Less than 5	36.36%	4	27.27%	3	36.36%	4	11
Between 5-10	71.43%	5	26.57%	2	0.00%	0	7
Between 11-15	50.00%	1	50.00%	1	0.00%	0	2
Between 16-20	100.00%	1	0.00%	0	0.00%	0	1
Greater than 20	0.00%	0	100.00%	2	0.00%	0	2

Item 4: Why do you think most people come to you instead of going to mental health professionals for help with depression?
N=12

Answer Choices	1 %	Freq	2 %	Freq	3 %	Freq	4 %	Freq	Total
Their spiritual values and beliefs may not be respected by health care professionals	40.00%	4	30.00%	3	10.00%	1	20.00%	2	10
Health insurance does not cover visits to a mental health professional	0.00%	0	56.56%	5	44.44%	4	0.00%	0	9
Clergy more likely to integrate spiritual values and beliefs into the counseling	0.00%	0	0.00%	0	25.00%	3	75.00%	9	12
Other	75.00%	6	12.50%	1	0.00%	0	12.50%	1	8

Item 5: What cues make you suspect a congregant might be depressed?
N= 11

Answer Choices
-Lack of engagement, lack of enthusiasm, intermittent distance, increased weeping

-Family Problems and lack of information

-Always crying, Unable to forgive, can’t move forward

-Attending less, Disengaged, Extreme in reaction

-Their mood and body language

-Low attendance

-Anxious

-Negative outlook on life

-Missing Church service

-Change in attitude, not themselves

-A change in mood, absenteeism etc.

Item 6: How does depression counseling compare to your spiritual counseling experience?
N=12

Answer Choices	%	Freq
Issues brought up in depression counseling almost never overlap with those addressed in spiritual counseling	25.00%	3
The methods I use depression counseling are distinctly different from those I use in spiritual counseling	33.33%	4
Issues brought up in depression counseling are identical to those addressed in spiritual counseling	16.67%	2
The methods I use depression counseling are no different from those I use in spiritual counseling	16.67%	2
Depression counseling is very dissimilar to spiritual counseling	8.33%	1
Depression counseling is somewhat different to spiritual counseling	33.33%	4
Depression counseling is somewhat similar to spiritual counseling	8.33%	1

Depression counseling is very similar to spiritual counseling	41.67%	5

Table 3.

Referral Practices and Training

Clergy Survey Questions 7-12 Results

Item 7: Do you refer depressed congregants to any of the following?
N=12

Answer Choices	Percentages	Frequencies
Mental health specialists	66.67%	8
Hospital Emergency room	0.00%	0
Primary Care Provider	41.67%	5
Psychiatric hospital	0.00%	0
Other (please specify)	33.33%	4

-Licensed therapists
-I recognize that my area of training is not in Depression or Mental Health
-Refer them to their Pastor
-It depends on situation

Item 8: What factors influence your decision to make a referral?
N=12

Answer Choices	Percentages	Frequencies
Congregant's signs and symptoms	75.00%	9
Your level of comfort	75.00%	9
Individual's request	16.67%	2
Other (please specify)	16.67%	2

-In some instances, members are not as comfortable sharing intimate details about their situation with a pastor.
-My training is in Theology. So, when in doubt I know when to referral. CPE training.

Item 9: As you think about your experience in counseling individuals suffering with depression, is there anything that would help you do a better job?

Responses
-Maybe updated or annual or bi-annual training for pastors and learning to separate clinical depression from other forms of depression.

-Continue to read new material and be in touch with local Agencies.

-In the time we are living in, we need more training in how to look for signs of someone suffering with depression.
Because pastors can't reach all, each Ministry head/ leader need to be trained in this area.
As a minister we need to be honest with ourselves, we help others and yet we choose to deal and be silent about our own demon depression.

-Trainings

-More training

-Training

-Seminar training

-More collaboration with Mental health providers and community Awareness programs

-Classes

-More Classes

-Remove self and focus solely on the imminent need of the individual

Item 10: In your opinion, is formal training in depression counseling skills appropriate for clergy?
N=12

Answer Choices	Percentages	Frequencies
Yes	100.00%	12
No	0.00%	0

Item 11: In your opinion, is formal training in depression counseling skills necessary for clergy?
N=12

Answer Choices	Percentages	Frequencies
Yes	83.33%	10
No	16.67%	2

Item 12: Have you had any formal training in depression counseling skills?
N=12

Answer Choices	Percentages	Frequencies
Yes	41.67%	5
No	58.33%	7

CHAPTER V

Discussion

Implications of Findings

Although the sample size for this study was small, findings are meaningful and serve as a foundation for further study and action. Results suggest there are opportunities for improvement in the approach to mental health counseling in African American churches. Apparent differences in background and training among clergy members may have important consequences for detecting mental illness and emotional distress and in making the appropriate client referrals (Taylor et al., 2000, p. 76). The comments of the participants speak to the fact that pastors realize their professional limitations with mental health interventions. It is a positive finding that African American pastors are notably aware of the need for more advanced education and enhanced collaboration for mental health issues in their communities. There is added value in pastors acquiring the necessary education to gain insightful knowledge on mental issues.

Application to Theoretical/Conceptual Framework

Neuman's theory focused on the adaptability of the body to respond and react to stressors. This concept correlates with the state of mental wellness possibly evolving into mental illness when a life crisis or situation is not properly addressed in a timely manner (Manderscheid et al., 2009). Based on the results of this study, pastors have expressed a desire to become more knowledgeable about the mental health needs of their congregants. If they are better equipped, they are more likely to intervene timelier and more effectively thereby ultimately improving mental health outcomes of their congregants.

Limitations

There were several limitations to this study. At the foundational level, this topic is not often discussed in the faith community. It was recognized that the lack of comfort with the topic may impact the response rate. The overall response rate was lower than anticipated with only 13 of a potential 35 individuals completing the survey. Data collection timeframe was shortened due to a number of factors. Extending the timeline and reminding individuals to respond may have increased responses. The final sample size was too small to accurately reflect true representation of pastoral preparedness. In future studies, consideration of a qualitative study design should be considered. Face to face interactions with individuals may have increased response rate as well as data collection in this selected population. The role of a pastor demands their time far beyond the 8-hour work day. Their role requires them to manage multiple responsibilities from preparing for weekly sermons, preaching and conducting worship services to pastoral care, and community outreach. Therefore, some pastors utilize support services such as administrative assistants to assist in the management of incoming mail, emails, and scheduling meetings. Also, different sampling pattern is suggested for future studies. Due to the required anonymity of this research study protocol, the researcher was unable to determine which pastors on the email list had responded. Collection of pastor's specific email address rather than generic email addresses for the church may improve response rate.

Implications for Nursing

The potential impact from this study to nursing is important. Nurses have a unique opportunity to impact healthcare in the community by raising awareness of health needs to a variety of stakeholders. The opportunity to partner with faith communities to increase awareness of mental illness and resources for care is an appropriate role for a nurse. By partnering with faith communities and their clergy, nurses could increase awareness, increase access to care, and have a positive impact on individuals with mental illness. This study could add value from a clinical perspective. Nurses can be advocates for those with mental health issues by implementing community initiatives such as mental health community screenings. Nurses also have an opportunity to bridge the gaps between mental health specialists and pastors by fostering relationships with churches and providing training on diagnoses and even culturally competent healthcare. Interventions such as these could help reduce the stigma related to the mistrust some African Americans have for mental health providers.

Recommendations

To reduce stigma, we must be conduits of change and take the necessary steps to educate the general public by offering community programs. Enhancing professional education of community leaders and health care providers can improve health care for all. As a result of this study, it is recommended that pastors be encouraged to achieve baseline competency in dealing with mental health issues. Educational opportunities could come from attending mental health seminars, online education, and collaborating with mental health specialists to discuss ways to collaborate and meet the needs of the community.

Conclusions

Research has shown that pastors are influential amongst constituents in their communities as a whole. As well, they represent an important link to social services for their congregants. There is opportunity for growth among pastors and churches to expand their capacity to serve those with mental health issues. One of the most effective approaches to improving the mental health outcomes in faith-based communities is to ensure members of clergy are well-equipped and competent in assessing and addressing the mental health needs of their congregants (Anthony, 2015). Although there is little systematic information on the nature and quality of mental health counseling and referral practices of clergy, there is some indication that ministers with advanced education are more likely to make referrals to mental health service agencies (Taylor et al., 2000, p. 81). Pastors that have had some form of structured training or additional education related to mental health are better prepared to readily identify the signs and symptoms and understand the ramifications of delaying treatment. In effort to better serve their congregants, pastors must stay abreast of current literature on mental illness by maintaining competency through educational opportunities, developing and establishing professional working relationships with mental health providers, and collaborating with appropriate community partners in mental health services. Ultimately, pastors can help decrease the stigma and change the mindsets in the African American community by one simple concept: starting the conversation.

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Appendix A

Original Mental Health Counseling Survey Tool Developed by Jean Anthony

Mental Health Counseling Survey

Adapted from: Wylie, W.E. (1984) Health counseling competencies needed by ministers.Journal of Religion and Health. 23: 237-49

1. **Describe the characteristics of congregants who seek counseling from you.**

   Age range: _____ Income range: _____ Educational Level_____

   Gender: ____ Male _____Female _____both

   Do they come in as: ____Individuals _____Couples_____Family ____Parent/child

2. **Do any of your congregants seek your help when dealing with the following issues?**

   (Check all that apply).

   __Anxiety

   __Depression

   __Suicidal Ideation

   __Bereavement/Grief

   __Other (please specify) _____

3. **In the past 4 weeks, estimate the number of people whom you have counseled for any reason:**

   Total number: _____

4. **In the past 4 weeks estimate the number of people whom you have counseled for each of the following mental health problems:**

   Depression_____ Anxiety_____

   Suicidal ideation_____

5. **Why do you think most people come to you instead of going to mental health professionals for help with depression? Rank in order of importance below (1= lowest, 4 = highest).**

   ____Their spiritual values and beliefs may not be respected by health care professionals

   ____Health insurance does not cover visits to a mental health professional

   ____Clergy integrate their spiritual values and beliefs into the counseling

   ____Other (Explain) _____

6. **What cues make you suspect that a congregant might be depressed?**

   _____

   _____

7. **How does your depression counseling compare to your spiritual counseling experiences? (Check all the answers below that are true for you)**

   ___Issues brought up in depression counseling **almost never overlap with those addressed in spiritual counseling.**

___ The methods I use in depression counseling are **distinctly different from those I use in spiritual counseling.**

___ Depression counseling is **very dissimilar** to spiritual counseling.

___ Depression counseling is **somewhat different** from spiritual counseling.

___ Depression counseling is **somewhat similar** to spiritual counseling.

___ Depression counseling is **very similar** to spiritual counseling.

___ Issues brought up in depression counseling are identical to those addressed in spiritual counseling.

___ The methods I use in depression counseling are no different from those I use in spiritual counseling.

8. **Do you refer depressed congregants to any of the following?**

Check all those that you refer to):

__Mental health specialist ___Primary care provider

__Hospital emergency room ___Psychiatric hospital

__Other (describe) _____

9. **What factors influence your decision to make a referral?**

___Congregant's signs & symptoms ___Individual request

___Your level of comfort ___Other (Explain) _____

10. **As you think about your experiences in counseling individuals suffering with depression, is there anything that would help you do a better job?**

_____

_____

11. **In your opinion, is formal training in depression counseling skills appropriate for clergy?**

___Yes ____No

If no, why not? _____

Is formal training in depression necessary for clergy? ___Yes ___No

If not, why not? _____

Appendix B

Permission to Use Research Tool

From: Anthony, Jean (anthonje) [mailto:ANTHONJE@UCMAIL.UC.EDU]
Sent: Wednesday, February 27, 2019 4:45 PM
To: Samuel, Melody
Subject: #ExtMail# RE: Request for use of Survey Tool

Hi Melody,
I believe Dr. Wylie used the questionnaire in his dissertation years ago. I believe at that time it was reviewed for face validity.
Hope this is helpful.
Let me know how things progress.
Take good care.
J. Anthony

From: Anthony, Jean (anthonje) [mailto:ANTHONJE@UCMAIL.UC.EDU]
Sent: Tuesday, February 12, 2019 3:15 PM
To: Samuel, Melody
Cc: Anthony, Jean (anthonje)
Subject: #ExtMail# RE: Request for use of Survey Tool

Dear Ms. Samuel,
It was a pleasure talking with you today. Your research sounds quite interesting.
You have my permission to revise the *Mental Health Counseling Survey (2015)* in any way that facilitates your research needs for this project.
Please contact me if you have further questions.
I wish you great success with your research study.
Regards,
Jean Anthony, PhD, RN
Associate Professor
University of Cincinnati College of Nursing
3110 Vine St., Procter Hall
Cincinnati, Ohio 45221-0038
(O) 513-558-5239
Jean.Anthony@uc.edu

Appendix C

Modified Mental Health Counseling Survey Tool

1. Are you a pastor/associate pastor of a predominately African American Church?

   Options: Yes/No

2. What is the highest level of education you have completed?

   Options: Some High School/High School or GED/Some College/Associates Degree/ Bachelors Degree/Some post graduate/Masters Degree

3. What is your age range?

   Options: 18-30/31-40/41-50/51-60/61-70/>70 y/o

4. Describe the age range of your congregants who seek counseling from you.

   Options: <18 /19-29/30-39/40-39/40-49/50-59/60-69/>69

5. Describe the characteristics of the congregants who seek counseling from you.

   Options: Individuals/Couples/Family/Parent or Child

6. Do any of your congregants seek your help when dealing with the following issues?

   Options: *Check all that apply*: Anxiety/ Depression/Suicidal Ideation/ Bereavement and or Grief

7. In the past 6 months, estimate the number of people whom you have counseled for any reason.

   Options: Less than 5/Between 5 -10/ Between 11-16/Between 16-20/Greater than 20

8. In the past 6 months, estimate the number of people whom you have counseled for the following: Depression /Anxiety/Depression

Options: Less than 5/Between 5 -10/ Between 11-16/Between 16-20/Greater than 20

9. Why do you think most people come to you instead of going to the mental health professionals for help with depression?

Options: Their spiritual values and beliefs may not be respected by healthcare professional/Health insurance does not cover visits to a mental health professional/Clergy more likely to integrate spiritual values and beliefs into the counseling

10. What cues make you suspect a congregant might be depressed?

Options: Open-ended

11. How does depression your counseling compare to your spiritual counseling experience?

Options: Check all answers that are true to you:

1. Issues brought up in depression counseling almost never overlap with those addressed in spiritual counseling

2. The methods I use in depression counseling are distinctly different from those I use in spiritual counseling

3. Issues brought up in depression counseling are identical to those addressed in spiritual counseling

4. The methods I use in depression counseling are no different from those I use in spiritual counseling

5. Depression counseling is very dissimilar to spiritual counseling

6 Depression counseling is somewhat different to spiritual counseling

7. Depression counseling is somewhat similar to spiritual counseling

8. Depression counseling is very similar to spiritual counseling

12. Do you refer depressed congregants to any of the following?

Options: Check all that you refer to: Mental Health Specialists/Hospital Emergency Room/Primary Care Provider/Psychiatric Hospital/Other (specify)

13. What factors influence your decision to make a referral?

Options: Check all that apply: Congregants signs and symptoms/Your level of comfort/Individuals' request/Other (specify)

14. As you think about your experience in counseling individuals suffering from depression, is there anything that would help you do a better job?

Options: Open ended

15. In your opinion, is formal training in depression counseling skills appropriate for clergy?

Options: Yes or No If not why?

16. In your opinion, is formal training in depression counseling skills necessary for clergy?

Options: Yes or No If not why?

17. Have you had formal training in depression counseling skills?

Options: Yes or No