STIGMA AND THE ACCEPTABILITY OF DEPRESSION TREATMENTS AMONG

AFRICAN AMERICAN BAPTIST CLERGY

by

Connie Carter Gardner

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy

Liberty University

January, 2013

THE SIGNATURE PAGE

STIGMA AND THE ACCEPTABILITY OF DEPRESSION TREATMENTS AMONG
AFRICAN AMERICAN CLERGY

A Dissertation Proposal

Submitted to the
Faculty of Liberty University
in partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

by

Connie Carter Gardner

© January 2013

Liberty University, Lynchburg, Virginia

January 2013

Dissertation Committee Approval:

_____
Dr. John C. Thomas, PhD, PhD.   Date

_____
Dr. Lisa Sosin, PhD   Date

_____
Dr. Fernando Garzon, PhD   Date

ABSTRACT

STIGMA AND THE ACCEPTABILITY OF DEPRESSION TREATMENTS AMONG

AFRICAN AMERICAN CLERGY

Connie Carter Gardner

Center for Counseling and Family Studies

Liberty University, Lynchburg, Virginia

Doctor of Philosophy in Counseling

The purpose of this cross sectional study was to investigate stigma associated with

depression treatments and to approximate its association with treatment acceptability

among African American Clergy. There were 109 African American clergy who

completed three measures: treatment specific stigma instrument, treatment acceptability

instrument, and a demographic questionnaire, anonymously. Three hypotheses were

tested using descriptive statistics, Mantel-Haenszel common odds ratio estimate, Pearson

correlation coefficient, and ordinal logistic regression. Statistical analysis revealed

stigma did increase with the expansion of the social circle; Christian mental health

counseling had the highest acceptability rate among clergy not pastoral or lay counseling

and there was an association between treatment specific stigma and treatment

acceptability.

DEDICATION

To my husband, James P. Gardner, I dedicate this research to him for his love, patience,

understanding, and unyielding support and encouragement.

ACKNOWLEDGEMENTS

First and most importantly, I would like to thank Almighty God who spoke words into the lives of inspired men to write the bible. During this process, I relied heavily on the Word of God to inspire, comfort, guide, and bless me with knowledge to complete this task. "I can do all things through Christ who strengthens me."(Philippians 4:13). As mentioned in my dedication and second to no one on earth, I would like to acknowledge my husband, James, whose patience can be compared to Job. Honey, I thank you for being in the trenches with me on a day to day basis. Third, my parents who have encouraged and inspired me all of my life and continue to inspire me to achieve greatness, I love and thank you. Fourth, my two closest friends who are like sisters to me, Kristin Hicks and Iris Mathews, thank you for being supportive, sharing the Word of God with me when I got discouraged or delusional, and thank you for helping manage the other areas in my life so I could focus on this task. Fifth, I would like to thank my dissertation committee who provided great instruction with pleasantness and encouragement. To Dr. John C. Thomas, words cannot express the appreciation and gratitude I have for your knowledge, wisdom, guidance, and encouragement. Thank you for agreeing to be my Chair when your plate was already full. God Bless! Last but certainly not least, I would like to thank all the members of the clergy who participated in this study, especially my friends, Rev. Dr. Eddie Giles and First Lady Diane, for their encouragement and providing contact information for their friends and acquaintances in the clergy. I could not have completed this task with a sound mind without all of you. Thank you and may God continue to bless each one of you.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE: INTRODUCTION

In the United States, approximately 20.9 million people, or 9.5% of the

population, in a given year suffer from a mood disorder (Kessler, Chiu, Demler, &

Walters, 2005). Mood disorders include major depressive disorder, dysthymic disorder,

and bipolar disorders. Moreover, 14.8 million American adults, or about 6.7% of the

United States population, age 18 and older experience a major depressive disorder in a

given year (Kessler et al., 2005). Specifically, 10.4% of African Americans, 12.9% of

Caribbean Blacks, and 17.9% of non-Hispanic Whites have had major depressive

disorder at some point in life (Williams et al., 2007). Although African Americans have

lower percentage rates of depression than Whites or are less likely to have major

depression (National Institute of Mental Health [NIMH], 2007), the National Survey of

American Life (NSAL) in 2001 found that chronicity of major depressive disorder in

African Americans is 56.5% compared to 38.6% in Whites (Williams et al., 2007).

Despite the research confirming the chronicity and severity of depression among African

Americans, African Americans continue to have lower rates for utilizing mental health

services (Givens, Katz, Bellamy, & Holmes, 2007). Consequently, 55% of the African

Americans surveyed by the NSAL who had been diagnosed with clinical depression

received no treatment at all for depression during their lifetime (Payne, 2008).

There is limited research exploring reasons for lower utilization rates among

African Americans. However, previous research has investigated and confirmed that

stigma may have an impact on an individual's decision to seek, choose, or comply with mental health treatment, care, or services (Anglin, Link, & Phelan, 2006; Givens et al., 2007; Golberstein, Eisenberg, & Gollust, 2008). In the African American community, stigma was present centuries before mental health services were even a consideration. As a result of an extraordinarily horrific history, African Americans harbored feelings of fear and distrust of White Americans (Davis, Townsend, & Noel, 2005). With the passage of time, this fear and distrust gave birth to stigma which has been perpetuated from generation to generation among African Americans (Gamble, 1997; Lawson, 2008).

The immortality of stigma can be contributed to many sources (Trader-Leigh, 2008). However, this study's focus involves individuals who have been staples in the Black community since the slavery era in the United States, African American clergy. Clergy have been and continue to be vessels of communication and sources of information dissemination among African Americans. Despite Black clergy's prominence and influence in the Black community, virtually no research has been conducted that provides a glimpse of the stigma that may harbor in their minds regarding depression treatments. Therefore, this research will focus on stigma and the acceptability of depression treatments among African American clergy.

The unification of stigma and membership in a minority group can impede mental health treatment and well-being, creating morbidities and mortalities which could have been preventable and/or treatable (Gary, 2005). Goffman defines stigma as an "attribute that is deeply discrediting" and reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Stigma can restrict a person's ability to develop his or her potential (Goffman 1963). Corrigan and Kleinlein (2005) provided a

more intricate and updated definition of stigma: stigma refers to a cluster of negative

attitudes and beliefs that motivate the general public to fear, reject, avoid, and

discriminate against people with mental illness. The combination of these two definitions

will be utilized in order to provide a worldview perspective of stigma. The following

section will provide an explanation of the perpetuity of stigma in the Black community

and a description of the levels of stigma that will be investigated in this study.

Overview

In the African American community, several determinants of stigma have been

identified (Davis, Townsend, & Noel, 2005). However, this research will address the

most eminent factor influencing stigma, which is the inter-generational transmission of

attitudes and misinformation about mental illness (Matthews, Corrigan, Smith, & Aranda,

2006). Specifically, the beliefs of older African Americans are being passed to future

generations by directly communicating the significance of self-reliance in coping with

life struggles (Davis et al., 2005) rather than seeking help. Hence, it is not necessary to

seek outside assistance for mental health concerns. The dissemination of inaccurate

information pertaining to the causes of mental illness and the consequence of seeking

help (i.e. being labeled as crazy) has hindered Blacks from utilizing services (Payne,

2008). Consequently, in a study that included 42 Black churches and 19 White churches,

ministers reported their parishioners struggled with the stigma of being depressed and

fears of being labeled as crazy which interfered with care (Kramer et al., 2007). In

addition, in the African American culture the value of keeping and solving problems

within the family is highly recommended and emphasis is placed on prayer and faith for

life problems in lieu of counseling (Matthews et al., 2006). Previous research has confirmed the stigma attached to mental illness, and the existence of stigma among Blacks has been documented (Anglin, Link, & Phelan, 2006; Larson & Corrigan, 2008). Therefore, for an African American the effect of stigma is doubled.

In addition to stigma, the acceptability of depression treatments is a major focus of this study as well. Depression treatment acceptability among African American clergy has not been fully explored. However, the field of research has explored the acceptability of mental health counseling, prescription medication, spiritual counseling, and herbal remedies in relation to stigma among Black and White populations (Givens et al., 2007; Givens, Houston, Van Voorhees, Ford, & Cooper, 2006). Research revealed African Americans have lower acceptance of antidepressant medication (Cooper, Gonzales, & Gallo, 2003), greater preference for counseling (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000), and more interest in counseling from clergy (Blank, Mahmood, Fox, & Guterbock, 2002). Findings of Givens et al. (2007) were consistent with previous research; however, the lower acceptability of prescription medication could not be explained by concerns about stigma.

Background of the Problem

Depression has become the common cold of mental disorders. It significantly impacts an individual's functioning and quality of life (Harman, Edlund, & Fortney, 2004). Effective treatments for depression are available and national guidelines for major depression have been developed (American Psychiatric Association [APA], 1993). Yet, Alegria et al. (2008) report the odds of both having access to and receiving adequate care

for depression were significantly different for Asian and African Americans when compared to non-Latino Whites. The depression treatment rates for African Americans are between one-half and one-third of those for Whites (Young, Griffith, & Williams, 2003). Waldman et al. (2009) reported depression appeared to be under-treated especially in African Americans. Specifically, 35.5% of Whites with scores less than or equal to 10 on the Beck Depression Inventory (BDI) were treated with antidepressants, compared to only 17 % of Africans Americans. In 1999, the U.S. Surgeon General stated, "For our nation to reduce the burden of mental illness, to improve access to care . . . stigma must no longer be tolerated" (National Institute of Health, 1999, p. 19). Stigma can influence an individual's willingness to seek care, receive, or follow through with treatment. In addition to stigma associated with mental illness, Blacks may also experience the impact of race stigma.

Race is a stigma (Goffman, 1968). The American Heritage dictionary (1982) defines race as "a group of people united or classified together on the basis of common history, nationality, or geographical distribution" (p.1020). The American Heritage dictionary (1982) defines stigma as a mark "burned or cut into the skin of a criminal or slave as a sign of infamy, disgrace, or reproach" (p. 1197). Specifically, while race may inform social spaces, linguistic styles, and fashion, it is primarily linked to the body, or more particularly, the color of skin (Fanon, 1952).

Like stigmas of mental illness, HIV/AIDS, and disability, race is something that creates and perpetuates material inequalities and is secured in histories of prejudice, exclusion, and poverty (Howarth, 2006). Specifically, contemporary racist images remain tied to bloody histories of colonial relations, slavery which lasted for more than 200

years, and the denigration and economic exploitation of ethnic minorities (Miles, 1989). Although slavery was a horrific and crucial event in American history and the catalyst for mistrust and fear, the Tuskegee Syphilis experiment validated fear and mistrust of Whites and subsequently fears and mistrust of the health care system (Gamble, 1997; Lawson, 2008). As a result of fear and mistrust, African Americans prefer to receive help from someone of their race (Payne, 2008).

Consistent with social class, race is comprised of structural relations of power and oppression (Fanon, 1952). As a result of history, White Americans are viewed as possessing power and keeping minorities oppressed. Hence, Blacks are reluctant to seek services from those whose ancestors oppressed them for centuries. Consequently, in the mental health profession, African Americans represent approximately 2% of psychiatrists, 2% of psychologists, and 4% of social work professionals (National Alliance on Mental Illness [NAMI], 2004). The stigma of race may have an impact on the educational system in terms of degree acquisition as evidenced by Blacks and other ethnic minority students in Britain who experienced considerably lower levels of attainment in terms of qualifications and higher levels of school exclusion (Crozier, 2005; Office of Standards in Education [OFSTED], 2002). Similarly, the stigma of race can lead to higher levels of unemployment, increased vulnerability to health problems, increased involvement with the police and criminal justice systems, racial exclusion, and class stratification (Stambach & Becker, 2006). In conclusion, when the stigma of race and the stigma associated with mental illness are combined, they can impact an individual's decision to engage in or place trust in entities outside their race or community.

From the time of Nat Turner to the destruction of Hurricane Katrina, African American clergy have taken on the extraordinary task of not only being the shepherds of their congregations, but representatives who coordinate, manage, administer, and link individuals and families to community resources (Trader-Leigh, 2008). Therefore, it is imperative to have knowledge of the perspectives of individuals who influence so many others. African American clergy perform counseling duties more than 6 hours a week and often address serious problems similar to those seen by secular mental health professionals (Young et al., 2003). More than 50% of churchgoing African Americans agreed that "in a crisis situation, they would turn to their minister for advice" (Payne, 2008, p. 217). Pastors have been and continue to be a consequential resource for persons who lack sufficient access to needed mental health care (Young et al., 2003). In addition, research indicates patients of primary care physicians want their doctors to address concerns of faith and spirituality during their treatment (Cooper, Brown, Vu, Ford, & Powe, 2001); however, when primary care doctors refuse or express reluctance, patients seek their pastors rather than community mental health care.

Purpose of the Study

The purpose of this cross sectional study is to investigate stigma associated with depression treatments and to approximate its association with treatment acceptability among African American clergy. Specifically, the study investigates how stigma affects the acceptability of prescription medication prescribed by a psychiatrist, mental health counseling by a Christian counselor or secular counselor, and pastoral or lay counseling. Furthermore, data collected from the treatment stigma instrument and treatment

acceptability surveys will increase knowledge concerning the influence of negative attitudes, beliefs, thoughts, and behaviors on the selection of depression treatments among African American clergy and provide insight into treatment options clergy may recommend to their congregations.

Research Questions

In order to adequately investigate stigma associated with depression treatments and to approximate stigma associated with treatment acceptability, three questions were developed. The answers to these questions allowed the researcher to interpret the results in relation to the purpose and significance of this study. These questions are operationalized in Chapter Three and presented with hypotheses and statistical procedures. The following research questions were developed by the measures or instruments selected for this research.

1. Does stigma for depression treatments increase with the expansion of the social circle?

2. What are the acceptability rates for prescription, Christian and secular mental health counseling, and pastoral or lay counseling?

3. Is there an association between treatment-specific stigma and treatment acceptability?

Assumptions and Limitations

Limitations of this study are partially consistent with the limitations of the study conducted by Givens et al. (2007). Like Givens et al. (2007), this study used a vignette-

based questionnaire to evaluate intended rather than observed behavior. Responses to intended behavior may have the effect of raising the overall acceptability of treatments. This study, with the permission of Givens et al. (2007), used the treatment specific stigma instrument which was developed by Givens et al. (2007) for their target population to capture specific components of stigma associated with treatment. However, it may have captured stigma associated with depression which may have limited the ability to measure the full potency of the stigma associated with treatment. The capacity to capture the full scope and abstruseness of stigma concerns may have been limited by yes/no response selections. This research was purposefully restricted to African American clergy, so these findings cannot be generalized to other racial groups.

Several assumptions were made in developing and conducting this research. First, Ajzen's and Fishbein's (1980) Theory of Reasoned Action (TRA) when applied to this research would propose that African American clergy's volitional behavior is predicted by their attitude toward depression treatments and how they (clergy) think other people would view them if they accepted a given depression treatment.

Second, it is assumed that the instruments utilized in this research would be responded to honestly; hence, effectively capturing core concepts of the research. In an attempt to limit dishonest responses, informed consent was discussed and explained with emphasis on confidentiality of responses and data collection, voluntary participation regardless of phase of research, and the opportunity to learn about the results. Informed consent was discussed at the beginning of the study and reviewed at intervals or at participant request.

Third, results produced by this study are sufficient to support further exploration of the theory that various depression treatments are stigmatized by Black clergy.

Fourth, it is assumed that this study will provide valuable information for clergy, mental health professionals, and individuals considering mental health services. Specifically, this study will support previous research and/or provide the field with new or additional data by clarifying concepts and theories and strengthening the field of research by investigating and presenting a target population that has not been a focus of previous research.

Finally, it is assumed that this research will increase knowledge and understanding among clergy and mental health professionals thus re-establishing and establishing communication which will benefit society at large.

Definitions of Terms

The defining of terms is imperative for understanding the context of this study. For the purposes of this study depression, nutritionist, physician/medical doctor, prescription medication, psychiatrist, pastoral/ lay counseling, mental health counseling, and stigma will be defined as follows. In addition, references to clergy and African American will be clarified.

Depression is defined by the criterion as set forth in the Diagnostic and Statistical Manual IV-TR (DSM IV-TR, 2000):

> A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) Fatigue or loss of energy nearly every day

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized

by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (p. 356).

Christian Mental Health Counseling is conducted by professionals who approach their practices from a worldview formed by Christian principles (Barker, 2012). Secular and Christian mental health professionals have similar educational and training requirements for degree acquisition and licensure in mental health or counseling with the possible exception of biblical coursework and training acquired by Christian counselors (Barker, 2012).

Nutritionist is a professional who has completed academic degrees of BS, MS, EdD, or PhD in foods and nutrition and who uses the science of nutrition to help individuals improve their health (Mosby's Medical Dictionary, 2009).

Physician/medical doctor is a practitioner of medicine, as one graduated from a college of medicine, osteopathy, dentistry, chiropractic, optometry, podiatry, or veterinary medicine, and licensed to practice (Mosby's Medical Dictionary, 2009).

Prescription medications or prescription drugs are defined as those drugs considered safe for use only under medical supervision and may be dispensed only with a prescription from a licensed professional with governmental privileges to prescribe (for example, a physician, dentist, podiatrist, nurse practitioner, physician's assistant, or veterinarian) (Merck & Co. Inc., 2009).

Psychiatrist is a physician with additional medical training and experience in the diagnosis, prevention, and treatment of mental disorders (Mosby's Medical Dictionary, 2009).

Pastoral counseling is the establishment of a time-limited relationship that is structured to provide comfort for troubled persons by enhancing their awareness of God's grace and faithful presence and thereby increasing their ability to live their lives more fully (Brenner, 1992).

Lay counseling involves a caring relationship in which one person seeks to help another deal more effectively with the stresses of life (Tang, 1998). The keys to effective lay counseling ministry are spiritual gifts, training, and prayer (Tang, 1998).

Mental health counseling is the

> "provision of professional counseling services including the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families, and groups for the purposes of promoting optimal mental health, dealing with normal problems of living, and treating psychopathology. The practice of mental health counseling includes, but not is not limited to, diagnosis and treatment of mental disorders, psychoeducation designed to prevent emotional problems, consultation, and research into more effective psychotherapeutic treatment modalities" (American Mental Health Counselors Association [AMHCA], 1986, p. 2).

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Kleinlein, 2005).

Clergy, pastor, minister, preacher, and church leader will be used interchangeably.

African American, Black Americans, or Blacks will be expressed with equal meaning.

Significance of Study

Stigma and acceptability of depression treatments are not foreign topics in the field of research. Givens et al. (2006) and Givens et al. (2007) conducted studies closely related to this study. Both studies addressed stigma, preference or acceptability of depression treatments, and the participants included Blacks or African Americans and other minorities. The difference between previous research and this study is this study will focus exclusively on African Americans. Specifically, clergy are influential figures in the Black community. Previous research has found that Blacks are less likely to seek community mental health services but more likely to seek out the church or a church leader for counseling (Trader-Leigh, 2008). Therefore, information or knowledge gained through this study pertaining to stigmatization of clergy regarding depression treatments may provide a possible explanation for the underutilization of mental health services among the African American population. As a result of this study, mental health professionals may gain insight regarding clergy perspectives relating to mental health treatment and possibly, even if remotely, understand the position of their clients or parishioners. The ultimate outcome would be to gain a better understanding of barriers to treatment hence opening lines of communication between clergy and mental health professionals for effective, comprehensive services for individuals in need of mental health services.

Theoretical and Conceptual Framework

Like Givens et al. (2007), this study used the Theory of Reasoned Action (TRA). The Theory of Reasoned Action was developed by Martin Fishbein in the late 1960s and

later revised and expanded by Fishbein and Ajzen in 1980. TRA is a theory that focuses on a person's intention to behave a certain way. It proposes the following:

- An individual's volitional behavior is predicted by his/her attitude toward a given behavior and how he/she thinks other people would view him/her if he/she executes the behavior (Ajzen & Fishbein, 1980).

- An individual's attitude, combined with subjective norms, forms his/her behavioral intention (Miller et al., 2005).

- Behavioral intention is the likelihood that someone will behave in a particular way in specific situations, whether or not they actually do so (Ajzen & Fishbein, 1980).

Key concepts will be defined with brevity and simplicity to provide general knowledge and understanding of the TRA theory. Definitions of terms will assist in fully comprehending the propositions of TRA. According to Ajzen and Fishbein (1980), definitions are as follows:

Behavior (volitional): A specific behavior defined by four components: an action, a target, a context, and time.

Behavior intent: Perceived likelihood of performing the behavior or likelihood that someone will behave in a particular way in specific situations (as perceived by the person considering the behavior).

Attitude: A person's positive or negative feelings about performing a specific behavior.

Behavior belief: A belief that behavioral performance is associated with certain attributes or outcomes.

Evaluation: The value attached to a behavioral outcome or attribute.

Subjective norm: Beliefs about what others will think about the behavior.

Normative beliefs: Belief about whether key individuals and groups approve or disapprove of the behavior.

Motivation to comply: Whether or not the person's intentions and behavior will be affected by what others think.

Like Givens et al. (2007), the application of TRA for this research relates to the outcome which is the intention to accept a depression treatment. The instruments (treatment acceptability and treatment specific stigma) utilized in this research demonstrate the previously stated propositions of TRA. Specifically, the treatment acceptability instrument is used to investigate the intention to accept a depression treatment by providing the participant with the opportunity to accept or deny a depression treatment. Furthermore, the treatment stigma instrument explores the concepts of attitude and perceived subjective norms as factors that may influence the selection of a depression treatment.

The exploration of attitude is demonstrated by the participant having the opportunity to choose an attitude or feeling such as ashamed, comfortable, or okay in relation to a depression treatment. In addition, implications may be inferred regarding subjective norms from the treatment specific stigma instrument. For instance, attitudes or feelings are presented in relation to social strata: family, friends, and community. In other words, subjective norms demonstrated by social strata for the purpose of this study are the participant's beliefs about what others will think about the behavior or selection of a given depression treatment. In conclusion, TRA will help the researcher theorize

whether a behavior or intent (selection of depression treatment) is significantly

influenced by a person's attitude (stigmatizing beliefs) or perceived subjective norms

(what others will think about selection) or both.

Chapter Summary

Stigma and the acceptability of depression treatments among African American

clergy were investigated using a cross-sectional study design. Stigma will be evaluated

on four levels: self, family, public or community, and work. The influence of stigma was

assessed on depression treatments: prescription medication prescribed by a psychiatrist,

mental health counseling by a Christian counselor or secular counselor, and pastoral/lay

counseling.   African American clergy is the target population for this study because of

their prominence in the Black community. This investigation of the perceptions of Black

clergy regarding the impact of stigma on acceptability of depression treatments can make

inferences regarding utilization rates of mental health services and, depending on the

degree of stigmatization of a given treatment, may provide the answer to why utilization

is low for African Americans. For instance, if prescription medication is highly

stigmatized, then individuals may not choose prescription medications and they may not

choose to engage in mental health counseling where they may be referred to a psychiatrist

for medications.

Organization of Chapters

Information for this study will be organized and disseminated by chapters. For

instance, chapter one introduced the conditions and framework of the study by presenting

background information on the problem, purpose and significance of the study; the theoretical framework, assumptions and limitations of the research; and pertinent terms were defined to provide clarification. Chapter Two will present historical and current literature to establish a foundation for conducting this study.   Chapter Three will provide a detailed description of the research methods utilized in this cross-sectional study. Additionally, this chapter will review the purpose of the study, the hypotheses, and provide support for the suitability of the methods selected for this study based on sample population and instrumentation. Chapter Four will discuss the participants and procedures, address the hypotheses and research questions, and discuss results of the data analysis collected from the population surveyed. Chapter Five will restate the purpose of the study and provide conclusions, implications, and recommendations created by the research process and the findings from the study for future research.

CHAPTER TWO: LITERATURE REVIEW

Introduction

African Americans represent 13% or 38.9 million of the 308.7 million people in United States (Census, 2010). Of the 308.7 million Americans (Census, 2010), Blacks have a prevalence rate for depressive disorders of 7.5% (NIMH, 2007). The results from research conducted by Gonzalez et al. (2008) were consistent with previous research regarding Blacks having a lower depression rate than the general public (Brown et al., 1999); however, Gonzalez and colleagues reported the rate of chronic depression was highest in Black groups: 56.5% in African Americans and 56% in Caribbean Blacks, compared with 38.6% in Whites. The prevalence rate among African Americans is sufficient to support the purpose of this study, which is to measure stigma associated with depression treatments and to approximate its association with treatment acceptability among African American clergy.

This literature review will elaborate on research focusing on treatment options for treating depression, barriers to mental health services, African-American clergy, and mental health services. Specifically, antidepressant/ prescription medication, mental health counseling, and pastoral or lay counseling are treatment options that will be discussed in relation to clergy stigma and treatment acceptability. This will be followed by a discussion of factors related to barriers to mental health services: stigma, socioeconomic barriers, high need populations, sociocultural barriers, clinical bias, and spirituality. Information was provided on the formation of Baptist organizations because

they have the largest membership of African American clergy. The chapter concludes

with a description of African-American clergy and their views on mental disorders with

an emphasis on depression.

<div align="center">Treatment Options for Depression</div>

Individuals who seek help for depression have several options for treatment:

electroconvulsive shock therapy (ECT) (Lisanby, 2007), antidepressant medication,

acupuncture (Allen, Schnyer, Chambers, Hitt, Moreno, & Manber, 2006), mental health

counseling, and spiritual counseling (Glueckauf et al., 2009). This research focused on

prescription medication prescribed by a psychiatrist, mental health counseling by a

Christian counselor or secular counselor, and pastoral or lay counseling.

Mental health counseling and antidepressant/prescription medication have been

proven to be effective depression treatments (Dwight-Johnson et al., 2004). With the

increasing number of clergy performing counseling duties (Young et al., 2003) and the

increase in the production and use of herbal supplements, spiritual counseling and herbal

remedies have become alternative forms of mental health treatment and an interest in the

field of research as well (Givens et al., 2007; Givens et al., 2006). The following section

provides information on treatment options: antidepressant/prescription medication,

mental health counseling, and pastoral or lay counseling.

Antidepressant Medications

Depression is commonly treated with antidepressant medications (National

Institutes of Health [NIH], 2008). The function of an antidepressant is to restore the

chemical balance of naturally occurring neurotransmitters in the brain that have become

imbalanced (U. S. Food and Drug Administration [FDA], 2009). Neurotransmitters are needed for the brain to function normally and are involved in controlling mood and other responses such as sleeping, eating, pain, and thinking (NIH, 2008; FDA, 2009). Serotonin, norepinephrine, and dopamine are neurotransmitters thought to be associated with depression (NIH, 2008, FDA, 2009). By restoring the brain's chemical balance, antidepressants help relieve the symptoms of depression (NIH, 2008). The degree of symptom alleviation with antidepressant medication compared with a placebo increases with severity of depression symptoms and may be negligible or nonexistent, on average, in patients with mild or moderate symptoms (Fournier et al., 2010). For patients with very severe depression, antidepressant medication benefits compared to a placebo are significant (Fournier et al., 2010). The rate of antidepressant treatment increased from 5.84% in 1996 to 10.12% in 2005 or from 13.3 to 27.0 million persons (Olfson & Marcus, 2009). Significant increases in antidepressant use were evident across all sociodemographic groups examined except African Americans who had comparatively low rates of use in both years (1996, 3.61%; 2005, 4.51%)(Olfson & Marcus, 2009).

Other relevant studies conducted on the use of antidepressants among African Americans reveal the low prevalence of use in relation to other ethnic groups. Blazer et al. (2000) reported in 1986, 2.3% of Blacks and 4.6% of Whites used antidepressants in 1986 and in 1996. Blacks reported a slight increase in antidepressant use to 5%, although still considerably lower than Whites who reported 14.3%. Miranda and Cooper (2004) report the percentage of African American and Latino patients taking medications was significantly lower than White patients (i.e. 44.5% and 61% vs. 74%). Gonzalez and colleagues (2008) reported Black respondents (14.6%) had significantly lower rates of

antidepressant use than White respondents (32.4%). Waldman et al. (2009) reported the rate of antidepressant use was 21% for Whites but only 11.7% for Blacks.

Depression treatments or depression care preference was one of the primary interests of each study. Each study investigated antidepressant medication and/or counseling with the exception of Givens et al. (2006) and Givens et al. (2007) who added spirituality and herbal remedy for the treatment of depression. Although the percentages were varied, African American percentages for antidepressant use were consistently lower than Caucasian counterparts.

Mental Health Counseling

Mental health counseling is the preferred modality over prescribed or antidepressant medication among African Americans (Harman et al., 2004). However, Blacks continue to be underrepresented in outpatient treatment settings for the treatment of depression (Snowden & Cheung, 1990). For instance, 42% of Whites and 41% of Native Americans choose medications over counseling unlike the 54% of African Americans who prefer counseling to medications (Givens et al., 2007). Givens et al. (2006) revealed 48.2% of Blacks believe counseling is effective in treating depression whereas only 30.9% of Whites share this belief. African American's perceptions of medication may play a role in choosing counseling over medication. For instance, Cooper et al. (2003) reports 56% of African Americans believe medications are addictive while only 34% of Whites share this belief. Consequently, African Americans proved similar to Whites in response to depression treatment including counseling and

medication, except that African Americans had less improvement in their ability to function in the community (Brown et al., 1999).

Mental health counseling can be conducted using a variety of theoretical approaches and formats. Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Psychodynamic Therapy are renowned approaches in the field and have empirical data to support their efficacy. Depending on the theoretical orientation of the therapist or counselor, CBT, IPT, and Psychodynamic approaches can be conducted in marital, family, or group formats. The focus of this research involves depression treatments; therefore, the following paragraphs provide a description of these approaches, formats, and research data with emphasis on their efficacy in treating depression.

Cognitive Behavioral Therapy (CBT) for depression has its roots in the cognitive theory of depression (Beck, 1967). CBT is an active, structured, problem-focused, and time-limited approach to treatment which is based on the premise that depression is maintained by negatively biased information processing and dysfunctional beliefs toward the self, the environment, and the future which foster depressive affects and compromise functioning (Beck & Butler, 1995). While other approaches to therapy rely heavily on analyzing and exploring people's relationship with the world around them, the focus of CBT is on learning (Beck, 1995). The goal of CBT is to reduce depressive symptoms by challenging and reversing irrational beliefs and attitudes, and helping patients learn to think more adaptively and thereby experience improvements in affect, motivation, and behavior in real life (Beck & Butler, 1995).

In the 30 years since CBT's first evaluation as a treatment for major depressive disorder, CBT has been extensively studied in controlled trials (American Psychiatric

Association [APA], 2006). Meta-analyses have quantified the efficacy of CBT compared

with no treatment or minimal treatment; however, effect sizes have been fairly robust,

generally near or above one standard deviation in the outcome measures (Papakostas,

Fava, & Thase, 2008). According to a data synthesis of studies conducted by Hollon et

al. (2005) between 1980 and October 2004, CBT and IPT can be as effective as

medications in the acute treatment of depressed outpatients. Unlike medications, CBT

decreases the risk of relapse even after treatment is terminated (Hollon et al., 2005).

Interpersonal Therapy (IPT) for Depression

        In 1969, Interpersonal Psychotherapy of Depression (IPT) was developed in the

New Haven-Boston Collaborative Depression Research Project by Gerald Klerman, MD,

Myrna Weissman, PhD, and their colleagues for the treatment of ambulatory depressed,

non-psychotic, non-bipolar patients (Ravitz, 2004). IPT is a time-limited, manualized

psychotherapy based on the assumption that there is a relationship between the onset and

recurrence of a depressive episode and the patient's social and interpersonal relationships

at the time (Weissman, 2006). The specific focus involves current life changes, including

loss, role disputes and role transitions, social isolation, deficits in social skills, and other

interpersonal factors that may interact with the development of the depressive episode (Li

et al., 2005). The goal of IPT is to intervene by identifying the current trigger of the

depressive episode, facilitating mourning in the case of bereavement, promoting

recognition of related affects, resolving role disputes and role transitions, and building

social skills to improve relationships and to acquire needed social supports (Li et al.)

Interpersonal Therapy was developed to treat patients with major depressive disorder and has demonstrated efficacy in a series of randomized clinical trials (Robinson et al., 2007; Amsterdam, 2003). The Treatment of Depression Collaborative Research Program study in collaboration with the National Institute of Mental Health revealed IPT had greater efficacy than a pill placebo plus clinical management and was comparable to imipramine, an antidepressant medication, plus clinical management for patients with more severe major depressive disorder (APA, 2006). In addition, Cipriani et al. (2009) found IPT to be effective in treating pregnant and post-partum women with major depressive disorder.

Psychodynamic Therapy for Depression

The psychodynamic model was first developed by Freud and Karl Abraham, his student early in the 20th century (Comer, 2005). Psychodynamic psychotherapy is broader than most other psychotherapies in that it takes into account both current and past problems in interpersonal relationships, self-esteem, and developmental conflicts associated with anxiety, guilt, or shame (APA, 2006). Specific to this research, psychodynamic therapy is based on the assumption that a person is depressed because of unresolved, generally unconscious conflicts originating from early childhood and continuing through the life cycle of the individual (Freud, 1957; Blatt, 1998). Without resolution of conflicts, depression will develop (Comer, 2005). The goal of psychodynamic psychotherapy is to modify underlying psychological conflicts and deficits which increase the patient's vulnerability to depressive affect and the development of major depressive disorder (APA, 2006).

Clayton et al. (2004) conducted a meta-analysis which acknowledged that the quality of available studies on psychodynamic psychotherapy for treatment of depression was not optimal. In addition, the use of low-quality studies in meta-analysis of psychotherapy may lead to overestimation of effect sizes (Nurnberg, 2003). Therefore, some findings from meta-analysis of short-term and long-term psychodynamic psychotherapy suggest possible benefits in individuals with depressive symptoms and suggest that long-term psychodynamic psychotherapy may have beneficial effects in individuals with depressive and anxiety symptoms (APA, 2006). To confirm these results and extend them to individuals diagnosed with major depressive disorder, further research with more rigorous study designs will be needed (APA, 2006).

Marital and Family therapy

Marital and family problems are typical in the course of mood disorders including depressive disorders (APA, 2006). Marital and family problems may be the consequence of major depressive disorder but may also increase vulnerability to developing major depressive disorder or delay recovery from major depression (APA, 2006). Marital and family therapy may utilize a variety of psychotherapy approaches and techniques during the course of treatment; however, behavioral and strategic approaches are preferred (Ryan, Epstein, Keitner, Miller, & Bishop, 2005).

Reviews have concluded that marital therapy is effective for treating depressive symptoms and reducing risk for relapse (Segraves et al., 2007). Specifically, in a recent meta-analysis of eight marital therapy trials, marital therapy had comparable efficacy to individual psychotherapy for the treatment of depression (Segraves et al., 2007).

Consequently, marital therapy was superior in treating depressive symptoms compared with minimal or no treatment (APA, 2006). In addition, patients who received treatment that included a family therapy component were more likely to improve and had significant reductions in interviewer-rated depression and suicidal ideation compared with those whose treatment did not include family therapy (Miller et al., 2005).

Group therapy

The founders of group psychotherapy in the USA were Joseph H. Pratt, Trigant Burrow, and Paul Schilder. After World War II, group psychotherapy was further developed by Jacob L. Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Ormont. Yalom's approach to group therapy has been very influential, not only in the USA but across the world, through his classic text, *The Theory and Practice of Group Psychotherapy* (Blatner, 2007). Therapeutic principles or factors of group therapy include universality, altruism, instillation of hope, imparting information, corrective recapitulation of the primary family experience, development of socializing techniques, imitative behavior, cohesiveness, existential factors, catharsis, interpersonal learning, and self-understanding (Yalom & Leszcz, 2005).

Although group psychotherapy is widely practiced, the research on its application to major depressive disorder or depressive disorders is limited (APA, 2006). However; some research does exist on types of groups for individuals with mental disorders. Cognitive Behavioral group therapy and Interpersonal group therapy have data to support their efficacy (Ayen & Hautzinger, 2004; Bolton et al., 2003). Rossell et al. (2008) compared individual to group therapy formats using CBT and IPT for the treatment of

depression among Puerto Rican adolescents. Rossell et al. found that there were no

differences in treating depression between the individual and group conditions; however,

CBT did evidence more significant decreases than IPT in depressive symptoms and

improved self-concept. In addition, Jaurrieta et al. (2008) investigated the effectiveness

of using individual and group cognitive-behavioral interventions as compared to a wait-

listed group of individuals with obsessive compulsive disorder (OCD) and to identify

predictors of changes in OCD, anxiety, and depressive symptoms after treatment. The

results revealed that patients receiving group or individual treatment obtained better

results than wait-listed controls (Jaurrieta et al.). Both individual and group therapy were

effective in reducing anxiety, depressive, and obsessive-compulsive symptoms. While

individual treatment was more effective in reducing obsessive and compulsive symptoms,

patients treated individually were twice as likely to drop out of the study as those

receiving group therapy (Jaurrieta et al.).

Pastoral/Lay Counseling

The majority of people in our communities turn to a pastor or priest when they are

experiencing a crisis or are in need of counseling (Goodall, 2011). Pastoral counseling is

a function of pastoral care or a responsibility of the clergy or pastor (Tang, 1998).

Pastoral counseling involves the establishment of a time-limited relationship that is

structured to provide comfort for troubled persons by enhancing their awareness of God's

grace and faithful presence and, thereby, increasing their ability to live their lives more

fully (Benner, 1992).

The primary focus of pastoral counseling is on God and spiritual growth (Tang, 1998). According to Morgan (1997), there are several advantages to pastoral counseling: the relationship between pastor and parishioner is seen as a friendship instead of a professional relationship; the pastor usually has a prior relationship with the individual as a member of the congregation, therefore, the pastor has some knowledge of the family history, spiritual maturity, and past crisis experiences; the incorporation of biblical counseling from the pulpit via preaching, providing biblical advice; and pastors are much more accessible to their parishioners than a professional counselor. Pastoral counseling has its advantages, however, as congregations grow pastors are not always able to meet the counseling demands of the parishioners. Therefore, pastors will identify, select, support, and supervise individuals (lay persons) from their congregation to assist them in meeting the counseling needs of the congregation or to perform lay counseling services.

Collins (1980) defines lay counseling as an involvement in a caring relationship in which one person seeks to help another deal more effectively with the stresses of life. The keys to effective lay counseling ministry are spiritual gifts, training, and prayer (Tang, 1998). Tang emphasizes prayer as the foundation on which lay counseling is established. There are several models of lay counseling ministry that can be implemented, according to Tan (1995): informal spontaneous, informal organized, and formal organized. The informal spontaneous model involves people caring for one another naturally and simply in the existing church structure. The lay counselors in the informal spontaneous model do not have any special training, but are mature Christians who have the ability to give spiritual direction or directive counseling. The informal organized model of lay counseling involves counselors who are specially selected, trained, and supervised, but

who conduct counseling in homes, restaurants, and hospitals. In the formal organized model of lay counseling, counselors are specially selected, trained, and supervised, but the caring and counseling session is by appointment in a formal office setting or lay counseling center. The informal, spontaneous model has been the most utilized among Christians (Tang, 1998).

Givens et al. (2007) reports African Americans have higher levels of acceptability of spiritual counseling than Whites (69% vs. 53%). Givens et al. (2006) found that 67.9% of Blacks, in comparison to 40.3% of Whites, agreed that prayer can help heal depression. Research investigating the relationship between religious involvement and psychological well-being among African Americans indicates that prayer is an important means of coping with serious personal problems (Chatters, Taylor, Jackson, & Lincoln, 2008). African Americans rated having faith in God, being able to ask God for forgiveness, and prayer among the 10 most important aspects of depression care (Cooper et al., 2001).

Summary

In summary, antidepressant medication, mental health counseling, and pastoral/lay counseling appear to be viable options for the treatment of depressive disorders.   Antidepressant medication has been proven to be one of the most utilized modalities for the treatment of depression (Hollon, Thase, & Markowitz, 2002). However, it is the modality less utilized by African Americans. Although African Americans continue to underutilize mental health counseling, they prefer mental health counseling to antidepressant or prescription medication for the treatment of depression

(Givens et al., 2007). Consequently, African Americans stigmatized antidepressant medication more than mental health counseling. When utilized as a theoretical approach in individual or group formats, Cognitive Behavioral and Interpersonal therapies are supported by research to be efficacious in the treatment of depression. Counseling to include pastoral or lay counseling is preferred to medication. Spiritual counseling has been utilized by patients suffering from medical and mental disorders. For example, Gansler, Kaw, Smith, & Crammer (2008) reported 61.4% of cancer patients used prayer/spiritual counseling and 42.4% used faith/spiritual healing.

Barriers to Mental Health Services

Stigma has been identified as a barrier to mental health treatment. However, other barriers have been identified among African Americans that may impede the help seeking process. Other relevant barriers to consider include socioeconomic status and sociocultural factors. Socioeconomic information is expressed in terms of African Americans' economic position in relation to Whites in the United States. As a result of African Americans' socioeconomic status, they are considered a high need population. Socio cultural aspects are expressed by discussing fear and mistrust associated with mental health services and spirituality. Fear and mistrust are socio cultural factors identified in the African American community as having an impact on individuals who consider seeking help. In addition, spirituality is a sociocultural factor that can foster good mental health but has the potential to impede the help seeking process.

Stigma

Stigma is a significant barrier to the treatment of mental health disorders (Alvidrez, Snowden, Rao, & Boccellari, 2008). The fear or actual experience of stigmatization can lead individuals to postpone, avoid, or prematurely terminate mental health treatment (Bambauer & Prigerson, 2006). In this study, stigma is expressed and appraised on four levels: self, friends and family, community, and work environment. Self-stigma transpires when negative social stereotypes are internalized and a mental illness comes to be viewed as a personal failure (Stuart, 2004). Furthermore, self-stigma leads to automatic thoughts and negative emotional reactions such as shame, low self-esteem, and diminished self-efficacy (Corrigan, 2007). There are behavioral indications as the result of low self-efficacy and demoralization such as individuals failing to pursue work or independent living opportunities (Link, 1982, 1987). Stigma not only impinges upon an individual, it can affect families as well.

Family stigma is defined as the prejudice and discrimination experienced by individuals through associations with their relatives who are mentally ill (Corrigan & Miller, 2004). Blame, shame, and contamination are elements of family stigma. For instance, the public blames the parents for inadequate parenting skills that resulted in the family member's mental illness (Larson & Corrigan, 2008). As a result of the blame, family members may experience shame, which results in families isolating themselves from friends and neighbors (Larson & Corrigan, 2008). Ultimately, blame may result in members of the family unit or the entire family distancing them from the mentally ill person due to fear of being stigmatized like the mentally ill person (Corrigan & Miller, 2004).

Community and work are external entities that can exert a great influence on an individual's selection of treatment options. Community or public stigma is defined as the extent to which the general public negatively stereotypes and discriminates against a stigmatized group (Golberstein et al., 2008). For most individuals, work is a necessity and a normal activity of life. Work or the workplace has an influence on how and where one lives, it promotes social contact and support, and it confers title and social identity (Stuart, 2001). Since the work environment can assist in establishing individual and social identity, it may possibly have an impact on an individual's decision to engage mental health services. Work place stigma could result in unemployment and a hindrance to career goals resulting in economic hardship that may be a disadvantage to physical and emotional health, quality of life, community participation, and recovery from an emotional disorder (Wahl, 1999).

In addition to stigma, this study explores the referral rates for prescription medication prescribed by a psychiatrist, mental health counseling by a Christian or secular counselor, and pastoral/lay counseling. Psychotherapy or mental health counseling and prescription medications have been identified as primary treatments for depression (Dwight-Johnson, Shelbourne, Liao, & Wells, 2000; Givens et al., 2007). Although, spiritual counseling has been performed by pastors or church leaders and lay persons for many years, it has not been highly recognized as a preferred or recommended treatment modality (Mattis, Zapata, Grayman, & Taylor, 2007).

Relevant to this study, previous studies (Givens et al., 2006; Givens et al., 2007) have investigated the impact of stigma on four depression treatments: prescription medication, mental health counseling, herbal remedy, and spiritual counseling. Givens et

al. (2006) found that issues of stigma in depressed patients were salient when involving

employers, followed by friends and family for Whites and other ethnic groups who

participated in the study. Stigma is a primary factor in Givens' later research. Consistent

with Givens et al. (2006), Givens et al. (2007) found that stigma for prescription

medication, mental health counseling, spiritual counseling, and herbal remedy amplified

with the increase in the social circle. Given et al. (2007) found that herbal remedy was

less stigmatizing than prescription medication or mental health counseling and in an

adjusted analysis; stigma adversely affected the acceptability of mental health counseling

but not prescription medication. Interestingly, Givens et al. (2007) found that stigma was

higher in Whites for all treatments than African Americans. However, Blacks did report

lower acceptability of prescription medication but stigma could not account for the lower

acceptability.

Socioeconomic Barriers

        Barriers to mental health service utilization often result from socioeconomic status

(Davis & Ford, 2003). The average Black family median income was $33,916 in

comparison to $54,920 for non-Hispanic White families (Census Bureau Report, 2007).

According to the 2007 Census report, 24.5% of African Americans in comparison to

8.2% of Whites were living at the poverty level. Individuals of low socioeconomic status

usually reside in poor, inner city communities where the availability of mental health

services or professionals is scarce (McCarthy, 2001). Also, mental health providers are

virtually nonexistent in impoverished rural communities (McCarthy, 2001). Due to the

lack of mental health providers in these communities, individuals in poor communities

share the burden of transportation expenses to and from a mental health provider. Consequently, unemployment rates for Blacks were 8% while unemployment rates for Whites were 4%. Furthermore, 49% of Blacks in comparison to 66% of non-Hispanic Whites used employer-sponsored health insurance (Census Bureau Report, 2007). The working class and middle-class African Americans who had private health insurance continue to be underrepresented in outpatient treatment (Snowden, 1998). African Americans utilized public health insurance at a rate of 23.8% whereas Whites represented 9% (Snowden, 1998). Last, 10.4% of Whites and 19.5% of Blacks were uninsured (Surgeon General's Report, 2001). African Americans who were uninsured were more likely to utilize emergency services (Surgeon General's Report, 2001) and less likely to receive specialty mental health care (Algeria et al., 2002; Maynard, Ehreth, Cox, Peterson, & McGann, 1997). Despite private employer sponsored insurance or public insurance, Blacks continue to utilize mental health services at lower rates than Whites.

High Need Populations

As a result of African Americans' economic status, they are over-represented in high need populations that show increased risk for mental illness (Surgeon General Report, 1999). The mental health of African Americans cannot be fully assessed without considering the many African Americans found in high-need populations. Specifically, African Americans constitute 40% of the homeless, 50% of prisoners in state and federal systems, 40% of juveniles in legal custody, 45% of children in foster care and welfare systems, and 50% of children waiting to be adopted (Surgeon General Report, 1999). As a result of representation in high need populations, African Americans are more likely to

visit public hospitals, community health centers, and local health departments for both physical and mental health care (Surgeon General Report, 2001). This provides a safety net for mental health for those who would otherwise not seek help (Cooper-Patrick et al., 1997).

Sociocultural Barriers

Fear and mistrust of mental health treatment and its providers can be significant sociocultural barriers to mental health service utilization among African Americans (Davis & Ford, 2004).   Mistrust among African Americans may stem from their experiences of segregation, racism, and discrimination (Primm, Lima, & Rowe, 1996). The devaluation and mistreatment of Blacks by the United States health care system has fostered centuries of fear and mistrust (Davis & Ford, 2004). This fear and mistrust is the product of a history of exploitation of African Americans by the medical profession dating back to the antebellum period when slaves and free Black people were used as subjects for dissection and medical experimentation (Savitt, 1982). The historical event with overwhelming notoriety was The Tuskegee Syphilis Study, which was conducted under the supervision of the U. S. Public Health Service from 1932 to 1972 on 600 Black men who were the sons and grandsons of slaves. As a result of fear and mistrust, African Americans have a tradition of turning to and relying on their communities to include family, friends, neighbors, voluntary associations, and religious figures for assistance for psychological, physiological, and social survival (Hatchett & Jackson, 1993). Hence, African Americans seeking help prefer an African American provider (Blank, Mahmood, Fox, & Guterbock, 2002). Unfortunately, among clinically trained mental health

professionals, only 2% of psychiatrists, 2% of psychologists, and 4% of social workers are African American (Lawson, 2008).

Clinical Bias

Clinical bias has fostered fear and mistrust as well. In other words, African Americans are afraid they will be misdiagnosed or over diagnosed by mental health professionals. Diagnosis is primarily dependent on a client's behavioral presentation, the patient's report of the symptoms, and clinician judgment, rather than laboratory tests. Clinician bias is obvious in the over diagnosing and under diagnosing of African Americans with schizophrenia and depression. Several studies found that African Americans were more likely than Whites to be diagnosed with schizophrenia, yet less likely to be diagnosed with depression (Surgeon General Report, 2001; Hu et al., 1991; Snowden & Cheung, 1990).

Spirituality

Religion and/or spirituality have a significant role in the lives of African Americans (Payne, 2008). A study conducted by Taylor, Ellison, Chatters, Levin, and Lincoln (2000) found that 79 % of Black respondents indicated that religion was vital in their lives and 80 % of the National Survey of Black respondents described themselves as being either very or fairly religious. However, an individual's religiosity and/or spirituality can be barriers to seeking mental health care and continuing treatment (Davis & Ford, 2004). Individuals' spiritual beliefs can delay or impede the help seeking process in that individuals would most likely seek clergy rather than mental health

professionals. Fifty percent of churchgoing African Americans agreed that "in a crisis situation, they would turn to the Black preacher for advice" (Levin, 1986, p. 6). African Americans may terminate the therapy process prematurely because the therapist is reluctant or not equipped to handle concerns that are spiritual in nature (Frame & Williams, 1996).

Summary

In summary, stigma, socioeconomic status, membership in a high need population, sociocultural factors, clinical bias, and spirituality are identified as barriers to mental health services among the African American population. For the purpose of this study, stigma is expressed on four levels: self, friends/family, community, and workplace. Stigma for prescription medication, mental health counseling, spiritual counseling, and herbal remedy amplified with the increase in the social circle. In addition to the stigma barrier, 24.5 % of African Americans live at the poverty level. As a result of African Americans socioeconomic level, they are susceptible to high-risk circumstances such as homelessness, residing in poverty stricken neighborhoods, incarceration in a correctional facility, and being consumers of public health programs where mental health services are limited or not in close proximity to their home or neighborhood. Sociocultural factors and clinical bias encompass fear and mistrust of the healthcare system which lessens the likelihood that African Americans will seek mental health services. Spirituality and/or religion are positive aspects in the lives of African Americans; however, spirituality/religion can be a hindrance to seeking mental health services.

African American Baptist Clergy and Mental Health Services

According to the Yearbook of American and Canadian Churches (2005), the Baptist denomination is the second largest denomination in the United States with a large concentration in the southern part of the country. With such an impressive and growing membership, it is inevitable that clergy and/or members of their congregations will consider, need, seek, and/or engage in mental health treatment at some point in their lives. Hence, it is important for the purpose of this study to have knowledge of the formation of the Baptist denomination and the views of clergy regarding mental illness.

Baptists in Virginia

There are 17 million African American Baptists worldwide (National Council of Churches, 2008) as indicated by membership in the four largest Baptist organizations: the National Baptist Convention of America, the National Baptist Convention USA, Inc., the Progressive National Baptist Convention, Inc., and the National Missionary Baptist Convention of America. Specifically, the National Baptist Convention, USA, Inc., the mother church, is the largest African-American Christian denomination in the United States with more than eight million members (www.nationalbaptist.com/about-us/our-history).

On a smaller scale, the Baptist General Convention of Virginia (BGCVA) was founded in 1899 on the grounds of Virginia Union University. The Baptist General Convention of Virginia has a membership of more than 1,000 African American churches and thirty associations (www.bgcva.org/about/html). The BGCVA is an active supporter and affiliate of the National Baptist Convention, USA, Inc.

The National Convention of America and of the USA reported more than 40,000 African American clergy from 1987 to 1992 (Association of Religion Data Archives, 2000). Despite the rising number of Black clergy and growing congregations, there is limited research on the views of African American Baptist clergy regarding mental health and mental health treatment. Religious communities are a source of strength and support to many African Americans suffering from mental illness (National Alliance for Mental Illness [NAMI], 2004). Moreover, the African American minister often serves as a bridge between secular and spiritual care (Kramer et al., 2007). A quarter of those who ever sought treatment for mental disorders did so from a clergy member (Wang, Berglund, & Kessler, 2003). Clergy were contacted more often than psychiatrists or general medical doctors; psychiatrists and general practitioners were each contacted about one-sixth of the time (Wang et al. 2003). According to Milstein (2003), people choose these patterns of help-seeking because they are more familiar with clergy, clergy do not have a pay schedule nor do they charge co pay, and fewer stigmas are associated with discussing one's personal problems with clergy.

Black clergy perform counseling duties similar to community mental health professions. Black ministers conduct counseling and intervention for personal problems such as bereavement, marital issues, alcohol issues, depression, teenage pregnancy, unemployment, and legal problems (Chatters, Taylor, Jackson & Lincoln, 1999). Young, Griffith, and Williams (2003) report Black ministers conduct an average of 6.2 hours of counseling per week. In fact, Black clergy engage more in counseling work and make more referrals to secular counterparts than clergy in general (Gottlieb & Olfson, 1987). Like mental health professionals, clergy use therapeutic interventions. However, clergy

use more spiritually based interventions. African American clergy report a tendency to

pray, review scripture, and reference the significance of confession and faith healing

(Young et al., 2003).

Clergy and Mental Health Services

Clergy-provided services and mental health care are perceived as separate but

equal entities and clergy provide a wide range of services, including counseling, to

individuals in their congregation. There has been minimal research regarding the

collaboration between religious organizations and the mental health treatment delivery

systems (Taylor et al., 2000). McMinn, Runner, Fairchild, Lefler, and Suntay (2005)

investigated the factors affecting clergy-psychologist collaboration. McMinn's research

was conducted with a sample of clergy from the Southern Baptist convention. Although

only 5.3% of the clergy involved in McMinn's study were African American, the

research yielded essential results identifying the lack of collaboration between clergy and

psychologists. McMinn et al. (2005) found pastors prefer to collaborate with counselors

who were identified as either a Biblical counselor or a Christian psychologist who used

Scripture and prayer in counseling over counselors who were described as having

excellent interpersonal skills. Conversely, psychologists preferred to collaborate or make

referrals to Unitarian clergy rather than Baptist clergy and/or to clergy with doctorate

level degrees (McMinn et al., 2005). McMinn's research may provide insight for the

treatment acceptability component of this writer's research. Specifically, McMinn's

research may provide reasons for the selection of pastoral/lay counseling over traditional

mental health counseling.

Clergy Views on Mental Illness

A pastor's beliefs about the causes of depression in a spiritual context can both facilitate and impede treatment for parishioners or individuals in the community they serve. Pastors who are objective in their beliefs regarding biological and spiritual aspects of depression can serve as strong advocates for their counselees (Payne, 2008). Pastors who are able to utilize their spiritual expertise and refer when needed prove to be extremely effective service providers. Ministers who are not open to spiritual views can alienate those who come to them, and those who are not open to biological views can hinder those they serve from a referral they might need (Payne, 2008). Taylor et al. (2000) reports behaviors of parishioners may be defined differently by clergy than mental health professionals. In turn, these definitions shape beliefs about the best solutions to address the behaviors (Taylor et al., 2000). Thus, it is important to discover how clergy perceive the definition of and etiology of depression.

Payne (2008) conducted a study with Protestant and Pentecostal pastors in California regarding the variations in pastors' perceptions of the etiology of depression by race and religious affiliation. Payne found African American pastors were more open to the idea that depression can be defined on a spiritual basis—that is, it is hopelessness resulting from a lack of trust in God. African American pastors were much less likely to agree with the idea of depression being defined as a biological mood disorder than Caucasian pastors. Moreover, Payne found that race influenced how pastors defined depression.

Payne (2008) found that religious affiliation influenced responses regarding beliefs about etiology or cause of depression. Specifically, mainline Protestants were

committed to their view that depression is caused by medical or biological conditions rather than spiritual causes. This is a significantly different belief than that of Pentecostals, who were more likely to believe that depression was caused by spiritual problems or moral problems rather than biological reasons (Payne, 2008). Moreover, mainline Protestants view of depression is more consistent with mental health professionals' view in that they were more likely to see depression as having a biological component and more likely to see it as being separate from a religious issue. Pentecostals, in particular, were more likely to view depression as an issue that depends on a given situation and felt depression was strongly influenced by spiritual causes.

Kramer et al. (2007) conducted a qualitative study with 42 Black churches and 19 White churches that investigated ministers' perceptions of depression. Specifically, the purpose of the study was to produce a preliminary model of depression and depression care from the perspective of pastors of Southern Christian churches with predominantly African American or Caucasian membership.

In order to develop such a model, the etiology of depression was explored. Kramer et al. (2007) found that preachers held a plethora of biological, psychological, spiritual and cultural/social beliefs about the causes of depression. For instance, depression was thought of as an illness like other physical concerns that require medical attention. Despite the admission of the biological factor in depression, the ministers discussed the impact of society and its emphasis on material wealth, the discord and termination of family units, elevated professional and personal expectations, longer work hours, and less attention to self-care as significant determinants of depression. A number

of Black Christians have the belief that depression is a spiritual stronghold as well and seeking a medical doctor only addresses part of the problem (Payne, 2008).

Chapter Summary

It is evident African Americans do experience, are diagnosed with, and continue to be susceptible to depression. Therefore, areas of concern such as depression treatment options, barriers to mental health care, and African American clergy are of interest to the field of research. Previous research regarding depression treatment options revealed when Blacks seek treatment, they prefer mental health counseling to medication. Moreover, African Americans prefer pastoral /lay counseling to mental health counseling. The knowledge of preferences for antidepressant medication, mental health counseling or spiritual counseling may provide some insight into the underutilization of self or clergy referrals.

Although stigma is one of the primary factors of investigation, socioeconomic and sociocultural factors, members of high need populations, clinical bias, and spirituality can be barriers to mental health care and influence the choice of depression treatment as well. As aforementioned, African American clergy are prominent and influential figures in the Black community; therefore, having knowledge of their perspectives on depression treatment acceptability and if stigma is a factor in their selection of treatments would be valuable knowledge in the mental health field for the purposes of treating African Americans and would provide insight for collaboration between mental health professionals and the clergy. This research confirms and increases the knowledge regarding the African-American population in relation to stigma and depression treatment

options by the treatment stigma and treatment acceptability instruments that are described

in Chapter Three.

CHAPTER THREE: METHODS

The purpose of this cross sectional study is to measure stigma for depression treatments and to approximate its association with treatment acceptability among African American clergy. This chapter provides a description of the sample population, selection criteria, and pertinent demographic information. A description of each measure or instrument to be administered is provided with validity and reliability information. Procedures for engaging the sample population and administration of the instruments are explained. Ethical considerations are reviewed. This chapter concludes with a review of the research questions, data processing, and analysis.

Research Design

The primary objective of this cross-sectional study is to investigate the role of stigma on depression treatments and estimate the association of stigma on treatment acceptability among African American clergy. A cross-sectional design was utilized in order to obtain a snapshot of a given population at a single point in time (Marshall, 1998). A cross-sectional design is appropriate for this study because cross-sectional designs can be conducted in a short period of time and large groups can be studied at little or no cost (Simon, 2002).

Participants

Initially, the number of participants registered on the survey website was 119. However, the final number used for data analysis was 109 because two individuals

reported ethnic backgrounds of multiracial and Caucasian, one individual completed only the first page after consenting to the survey, and seven individuals consented but did not complete the survey. The participants were male and female members of the clergy. The participants represented different age groups, educational levels, and marital status. Based on points of contact made by the researcher, the participant pool included students and faculty of seminary schools, members of national and local Baptist associations who were African American, and members of the clergy in localities throughout the United States. Participants were eligible if they were African American, 18 years or older, male or female, and members of the clergy. Participants of other ethnic backgrounds other than African American were excluded.

Instrumentation

Treatment specific stigma (Givens et al., 2007) and treatment acceptability (Garzon & Gardner, 2011) were the two instruments selected for this study. In addition, demographics or participant characteristics were collected. Demographic variables were independent variables that were controlled and entered into data analysis appropriately. Participants were given the option of completing the instruments by paper and pencil or by utilizing the online survey website via Survey Monkey (www.surveymonkey.com /s/Gardner6370).   The instruments were entered on the secure website using the appropriate formats established by survey monkey online security policies. The following paragraphs discuss the measures in great detail.

Treatment Stigma Instrument

     Givens and associates (2007) developed the treatment stigma instrument because of the lack of any instrument to assess depression stigma. In addition, extant instruments used to assess mental illness stigma do not assess the stigma associated with accepting treatment (Givens et al., 2007). The treatment stigma instrument focuses on feelings of personal shame and fear of disclosure, two facets of stigma that may cause apprehension in a person contemplating depression treatment (Givens et al., 2006). As indicated in the sample below, each statement requires a *Yes* or *No* response. A Yes response indicates agreement with the statement and a No response indicates disagreement with the statement.

    If I were seeing a psychiatrist and taking medication for depression,

1.   Yes   or   NO   I would feel ashamed

2.   Yes   or   NO   I would feel comfortable telling my friends
        or family

3.   Yes   or   NO   I would feel okay if people in my
        community (church, school, etc.) knew

4.   Yes   or   NO   I would not want to tell people at my job

     The responses remained the same for each statement; however, the text of each statement changed to indicate treatment modality (Givens, 2007). Givens assessed the internal consistency of the stigma items for each treatment modality to determine if items could be combined. Cronbach's alphas were too low to combine items and, as a result, simple frequencies were utilized to describe treatment stigma items for each modality as well as treatment acceptability (Givens, 2007). The researcher for this study obtained

permission to use and distribute the survey from Jane Givens (Appendix F). Several

revisions were made to the treatment specific stigma instrument at the request of the

committee (Appendix C).

Treatment Acceptability Instrument

The original treatment acceptability instrument was developed by Givens and

colleagues in 2007. This instrument was revised with the guidance and direction of the

dissertation committee (Appendix D). This instrument has not been tested for reliability

or validity. This instrument assessed. Each participant was given four vignettes

describing an individual with variances in gender and age who report symptoms

consistent with criteria for a depressive disorder as defined by the Diagnostic and

Statistical Manual (DSM-IV-TR) of the American Psychiatric Association. For example:

> Ms. Elizabeth, 80 year old widowed woman who has been a member of the
> congregation for the past 30 years has requested to speak with you after church
> service. After greetings, Ms. Elizabeth tells you she has lost 20 pounds in the past
> 2 months because she does not feel like eating and she sleeps most of the day and
> into the evening. She tells you she has nothing to wake up for any more since her
> husband died and her children do not visit regularly. She tells you she feels sad all
> the time and she has considered ending her life. She tells you her medical doctor
> did not find anything physically wrong with her. She wants your advice on what
> she should do.

After each vignette was presented, participants were asked to rate eight referral or

treatment options to suggest to the congregational member and each participant was

given the opportunity to write in a preference that was not included in the list of options

provided by the researcher. Each participant rated options 1 through 8 using a Likert

Scale:

On a scale of 1-5, with 5 being Highly Likely and 1 being Highly Unlikely, please rate the likelihood that you would refer this congregation member for one of the following services. You may use the same rating for more than one item. For example, you can rate 5 (Highly likely) for item 1 and item 2 if that is your preference.

1	2	3	4	5
Highly Unlikely	Unlikely	Neutral	Likely	Highly Likely

What is the likelihood that you would refer this congregational member for,

1. Counseling by another congregation member
   who dealt with a similar problem   1   2   3   4   5

2. Consultation with a licensed nutritionist   1   2   3   4   5

3. Counseling with a Christian mental health
   professional (psychologist, licensed professional   1   2   3   4   5
   counselor, marriage & family therapist, social
   worker, etc.)

4. Counseling with a secular mental health
   professional (psychologist, licensed professional   1   2   3   4   5
   counselor, marriage & family therapist, social
   worker, etc.)

5. Medication evaluation by a psychiatrist   1   2   3   4   5

6. Consultation with a physician   1   2   3   4   5

7. Participation/increased attendance in a church   1   2   3   4   5
   Bible study

8. Participation/increased attendance in   1   2   3   4   5
   prayer & praise services

9. Other (write in other suggestion): _____

Demographics Questionnaire

The sociodemographic variables included on the Demographic Questionnaire

were age, gender, race, marital status, education, and years in the ministry (Appendix E).

These variables were included in order to assess participants' association with treatment-specific stigma and treatment acceptability. Givens (2007) reported age, sex, education, religious service attendance, prior depression treatment, and family history of depression were not associated with acceptability.

Specifically, age was assessed using the following categories: 18-25, 26-29, 30-39, 40-49, 50-59, and >60 years. Gender was assessed by F for female and M for male. Race classification was assessed using the following: Black/African American, White/Caucasian, Hispanic, Latino, Arab, Asian/Pacific Islander, Multiracial, and Other. Marital status was expressed using the following descriptors: Single, Married, Separated, Divorced, and Widowed. Education was assessed using the following descriptors: High School Diploma or Equivalent (9-12), Vocation/Technical School, Some College, Associates degree (any field of study), Bachelor's degree (4 year degree, any field of study), Master's level degree (any field of study), Doctoral degree (any field of study), or other. Number of years in the ministry was assessed using the following categories: less than 12 months, 1-5 years, 5-10 years, 10-15 years, 15-20 years and over 20 years. Analysis excluded participants with less than 12 months in the ministry.

Participants were asked to describe the type of region where they currently reside and the type of region where their church is located by indicating rural, urban or suburban. The questionnaire included inquiries regarding the number of referrals made by participants in the past 2 years for mental health counseling, pastoral/lay counseling, and recommendations for prescription medication. For example: How often do you refer parishioners, members of your congregation, or others to mental health counseling? Each question was assessed using the following categories: None in the past 2 year, 1 time

past 2 years, 5-10 times past 2 years, 10-15 times past 2 years, over 15 past 2 years, Never, and Other.   Last, participants were asked if they have ever received mental health counseling, pastor/lay counseling, and if they have ever taken prescription medication by indicating Yes or No to each question.

Assumptions

Several assumptions were made in developing and conducting this research. First, Ajzen and Fishbein's (1980) Theory of Reasoned Action (TRA) will propose that African American clergy's volitional behavior is predicted by their attitude toward depression treatments and how they (clergy) think other people would view them if they accepted a given a depression of treatments. Second, it is assumed that the instruments utilized in this research were responded to honestly, hence, effectively capturing core concepts of the research. In an attempt to limit dishonest responses, informed consent was discussed and explained with emphasis on confidentiality of responses and data collection, voluntary participation regardless of phase of research, and the opportunity to learn about the results. Informed consent occurred at the beginning of the study and reviewed at intervals or at participant request. Third, results produced by this study are sufficient to support further exploration of the theory that various depression treatments are stigmatized by Black clergy. Fourth, it was assumed that this study would provide valuable information for clergy, mental health professionals, and individuals considering mental health services. Specifically, this study supports previous research and provides the field with new or additional data by clarifying concepts and theories and strengthening the field of research by investigating and presenting a target population that

has not been a focus of previous research. Finally, it is assumed that this research will increase knowledge and understanding amongst clergy and mental health professionals hence re-establishing and establishing communication which will benefit society at large.

Limitations of this study are partially consistent with the limitations of the study conducted by Givens et al., (2007). Like Givens et al. (2007), a vignette –based questionnaire was to evaluate intended rather than observed behavior. Responses to intended behavior may have the effect of raising the overall acceptability of treatments. This study with the permission of Givens (2007) used the treatment specific stigma instrument which was developed by Givens et al. (2007) for their target population to capture specific components of stigma associated with treatment. However it may have captured stigma associated with depression which may have limited ability to measure the full potency of the stigma associated with treatment. The capacity to capture the full scope and abstruseness of stigma concerns may have been limited by yes/no response selections. This research was purposefully restricted to African American clergy so these findings cannot be generalized to other racial groups.

Research Procedures

This study was approved by the Institutional Review Board (IRB) on February 4, 2012. This researcher arranged with the Samuel DeWitt Proctor School of Theology's Dean to address students during a regularly scheduled community formation meeting on the grounds of Virginia Union University, a historically Black university. Students were informed that the study is voluntary and anonymous, but demographic information would be collected for statistical purposes only and not for identification. Each packet included

a cover letter (Appendix A) , an anonymous survey information form or consent form

(Appendix B) which included the purpose of the study, procedures, risk and benefits,

confidentiality and contact information and paper copies of measures/instruments.   The

packet also included a stamped self-addressed envelope for those who elected to use a

paper and pencil method for completing the instruments. Sixty five students requested

and were given packets with paper copies of the survey and the website address, if they

elected to complete the survey online. Thirty responses were received; 17 by United

States Postal Service and 13 completed on survey monkey.

Due to lack of responses, researcher requested and was approved on March 14,

2012 for a change in protocol by the IRB to expand research beyond seminary students.

Researcher mailed approximately 250 survey packets to churches in Virginia, Maryland,

North Carolina and Atlanta from local newspaper listings and internet searches. Emails

were sent to faculty of seminary schools and local and national Baptist

associations/conventions. In final efforts to acquire the numbers needed for data analysis,

snowballing was implemented by using personal relationships of her parents, family,

family and friends in the clergy, her pastors' connections, and coworkers who were

members of the clergy and who were affiliated with or had personal knowledge of clergy

who were potential participants.

Research Questions

This study replicated core concepts of Given's (2007) study regarding stigma and

the acceptability of depression treatments among African Americans and Whites.

Therefore, the following questions were adapted to this phenomenon of stigma and the acceptability of depression treatments among African American clergy.

Does stigma for depression treatments increase with expansion of social circle?

H_1: Stigma for depression treatments does increase with the expansion of social circle.

H_0: The expansion of the social circle does not affect stigma for depression treatments.

Descriptive statistics, frequency analysis, chi-square test, and Mantel-Haenszel common odds ratio estimate were used to test the association between stigma, depression treatment options, and demographic variables.

What are the acceptability rates for prescription medication, Christian and secular mental health counseling, and pastoral/lay counseling?

H_1: The acceptability rates for pastoral/lay counseling are higher than rates for prescription medication or mental health counseling.

H_0: There are no significant differences in the acceptability rates for prescription medication and mental health counseling.

Descriptive statistics, frequency analysis, chi-square test, and Pearson product- moment correlation were used to obtain rates and observe relationships with demographic variables.

Is there an association between treatment-specific stigma and treatment acceptability?

H_1: There is an association between treatment specific stigma and treatment acceptability.

H_0: Treatment specific stigma and treatment acceptability have no association.

Pearson's correlation was used to test an association between the two variables.

Data Processing and Analysis

The focus of this cross-sectional study involved the element of stigma and the acceptability of depression treatments among African American clergy. Specifically, does stigma influence the acceptability of prescription medication, mental health counseling, and pastoral/lay counseling? Unlike the study conducted by Givens et al., (2007), each analysis was executed using IBM's Statistical Package for the Social Sciences (SPSS) software.

Ethical Considerations

This researcher made great effort to protect the rights of the participants of this study. Individuals were provided with a legible typed copy of the informed consent (see Appendix A). Additionally, participants were informed of the purpose and significance of the study, risk and benefits, and disclosure of findings from the research in order to protect the participants' autonomy and beneficence. Confidentiality was guarded by protecting the anonymity of the participants when collecting, storing, and reporting information. In addition, participants were informed verbally and in writing that they could refuse to participate without consequence.

The following ethical considerations for data protection were consistent with the mandatory requirements of the Data Protection Act of 1998 checklist. The checklist can

be located at www.recordsmangagement.ed.ac.uk/InfoStaff/DP_Research/Research

AndDPA.htm

1. The data will be used exclusively for research purposes.

2. The information will not be used to support measures or decisions relating to *any* identifiable living individual.

3. The data will not be used in a way that will cause, or is likely to cause, substantial damage or substantial distress to any data subject.

4. The results of this research, or any resulting statistics, will not be available in a format that will identify the data subject.

5. Proper consents have been obtained.

6. Security procedures (collecting and storage) for protecting data relevant to internet surveys utilized for this study have been identified and implemented by researcher. Data stored on researcher's computer will be password protected.

7. Data will be stored and securely locked in a file cabinet in the researcher's home (Data Protection Act, 1998, pp. 1-3).

Chapter Summary

The primary objective of this cross-sectional study was to investigate the role of stigma on depression treatments and to explore the influence of stigma on treatment acceptability among African American Baptist Clergy. The participants were asked to complete the treatment specific stigma instrument, treatment acceptability instrument, and an anonymous demographic questionnaire. Participants had the option of completing the surveys by paper and pencil method and returning by mail or going online and

completing surveys with the provided website address. The three research questions

were tested by using descriptive statistics, frequency analysis, chi-square test, and

Mantel-Haenszel common odds ratio estimate, and Pearson product-moment correlation.

The researcher protected the data and data results by following the principles set forth in

the Data Protection Act of 1998.

CHAPTER FOUR: RESULTS

The purpose of this study was to investigate stigma associated with depression treatments and to approximate its association with treatment acceptability among African American clergy. This chapter presents the results of the analyses. First, an overview of the research design and statistical procedures used for this study is discussed. Second, descriptive and ordinal logistic regression statistics were performed using demographic variables as independent variables. Next, research questions and hypotheses are presented with data analysis results. This chapter concludes with a summary of the results and an introduction to Chapter Five.

In this study, a cross-sectional design was utilized in order to obtain a snapshot of a given population at a single point in time (Marshall, 1998). The major purpose of a cross-sectional design is to describe the frequency of a phenomenon within an identified group in an effective manner (Portney & Watkins, 2000). For the purpose of this study, stigma was the phenomenon and African American clergy was the identified group. A cross-sectional design was appropriate for this study because cross-sectional designs can be conducted in a short period of time and large groups can be studied at little or no cost (Simon, 2002). The researcher was interested in investigating the frequency, association between variables, and predicting outcomes of variables. Therefore, descriptive statistics, ordinal logistic regression, chi-square test, Mantel-Haenszel common odds ratio estimate, and Pearson product-moment correlation were used to analyze the data.

Descriptive Statistics of Demographic Variables

Demographic variables entered into the analysis included gender, age, marital status, education, years in the ministry, geographic locations of primary residence and church affiliation, referral histories for mental health and/or pastoral counseling and medication, and history of treatment for mental health and/or pastoral counseling and medication. These variables were used as control and independent variables. Missing data represented 7% of the demographic information. The following paragraph presents participant characteristics by majority representation.

One hundred and nineteen (119) questionnaires were returned; however, due to insufficient or missing data, 109 questionnaires were usable for analysis. Fifty-three percent (53%) of the participants were male and 40% were female. The majority of the participants (32%) reported being between the ages of 50-59. Sixty-six percent (66%) of the participants reported being married. In terms of level of education, the majority of participants (40%) reported having a Master's degree. With regard to years in the ministry, the majority of participants (26%) reported more than 20 years in the ministry. Participants were asked to describe their region of primary residence and church affiliation by indicating urban, suburban, or rural. The majority of participants (34%) reported residing in suburban areas and the majority of participants (37%) reported church affiliation in urban areas. Table 4.1 displays a detailed description of each participant characteristic by count and percentage.

.

Table 4.1

Characteristics of Participants as Frequencies and Percentages

Characteristic	(N)	(%)
MALES	(63)	52.9
FEMALES	(48)	40.3
AGE		
18-25	(1)	.8
26-29	(3)	2.5
30-39	(13)	10.9
40-49	(34)	28.6
50-59	(38)	31.9
60 Plus	(22)	18.5
MARITAL STATUS		
Married	(79)	66.4
Single	(18)	15.1
Divorced	(10)	8.4
Separated	(1)	.8
Widowed	(2)	1.7
EDUCATION		
High School	(11)	9.2
Some College /Vocational /Technical School	(11)	9.2
Associate Degree	(2)	1.7
Bachelor's Degree	(19)	16.0
Master's Degree	(47)	39.5
Doctoral Degree	(21)	17.6
YEARS IN THE MINISTRY		
Less than 12 months	(3)	2.5
1 to 5	(25)	21.0
5 to 10	(16)	13.4
10 to 15	(18)	15.1
15 to 20	(18)	15.1
Over 20	(31)	26.1
REGION 1 – LOCATION OF RESIDENCE		
Urban	(35)	29.4
Suburban	(40)	33.6
Rural	(33)	27.7
REGION 2 – CHURCH AFFILIATION		
Urban	(44)	37.0
Suburban	(26)	21.8
Rural	(41)	34.5

Ordinal logistic regression was performed to test predictability between independent variables (characteristics) and dependent variables (Christian and secular mental health counseling, pastoral or lay counseling, and prescription medication). Variables with multiple levels were recoded into dichotomous variables. Independent variables such as age and education and the dependent variables previously reported consisted of five or more levels; therefore, they were recoded into dichotomous variables for more efficient data entry and less complications when interpreting the data. For example, age was transformed into two groups: age group 1(60 and under) and group 2 (60 and older). Age was the only variable found to be a significant predictor for pastoral or lay counseling and prescription medication. Participants 60 and under ($B = 1.191, p <$ .01) compared to 60 and older were more likely to accept pastoral or lay counseling. In terms of prescription medication, the cohort 60 and under ($B = 1.106, p < .01$) compared to 60 and older was more likely to accept prescription medication as a treatment option.

In terms of participant referral history, 38% of participants reported making referrals for pastoral or lay counseling 1 to 5 times in the past 2 years; 35% reported making referrals for mental health counseling 1 to 5 times in the past 2 years; and 17% reported making referrals for medication treatment 1 to 5 times in the past 2 years, as displayed in Table 4.2.

Table 4.2

Participant Referral Rates

	Types of Referrals		
	Referrals to Pastoral/ Lay Counseling (*N*, %)	Referrals to Mental Counseling (*N*, %)	Referrals to Psychiatrist for Medication (*N*, %)
None in the past 2 years	(32) 26.9	(30) 25.2	(37) 31.1
1-5 times in past 2 years	(45) 37.8	(41) 34.5	(20) 6.8
6-10 times in past 2 years	(10) 8.4	(5) 4.2	(4) 3.4
11-15 times in past 2 years	(4) 3.4	(1) .8	(1) .8
Over 15 times in past 2 years	(4) 3.4	(5) 4.2	(4) 3.4
Never	(14) 11.8	(27) 22.7	(44) 37.0

In regard to participants' history of treatment, 67% reported receiving pastoral/lay counseling, 33% reported receiving mental health counseling, and 11% reported medication treatment for depression, as displayed in Table 4.3.

Table 4.3

Treatment Received by Participants by Gender as Frequencies and Percentages

Type of Treatment Received	(*N*, %)
Mental Health Counseling	(39) 32.8
(male /female)	(20 / 19)
Pastoral/Lay Counseling	(80) 67.2
(male /female)	(47 / 33)
Medication for Depression	(13) 10.9
(male /female)	(6 / 7)

While conducting analysis for treatment history and referral history, Pearson correlation yielded significant and positive associations between participants' treatment history and referral rates. The significance level of .05 was used to evaluate the overall association between variables. There was a positive association between previous mental health treatment and mental health referrals (r (109) = .31, $p < .001$). This suggests approximately 10% of the variance in making mental health referrals can be attributed to having received previous mental health treatment. The frequency analysis supports this association as evidenced by 61% of the participants who indicated they would make referrals for mental health counseling.

There was also a positive and significant association between previous pastoral or lay treatment and mental health referrals (r (109) = .30, $p < .001$). This suggests individuals who received pastoral or lay counseling are more likely to make referrals for mental health counseling as well. In addition, there was a positive and significant association between previous pastoral or lay treatment and referrals for pastoral or lay counseling (r (109) = .30, $p < .001$). This suggests individuals who have been counseled by a pastor or lay person are more likely to make referrals for pastoral or lay counseling. The Pearson coefficient between previous pastoral or lay counseling and mental health referrals is slightly stronger than the association between previous pastoral or lay treatment and for pastoral or lay counseling.

There were three hypotheses explored in this present study. To examine these hypotheses, descriptive and correlation analysis were employed.

Hypothesis 1:

H$_1$: Stigma for depression treatments does increase with the expansion of the

social circle.

The null hypothesis is rejected based on the results of descriptive statistics.

Feeling ashamed of self was endorsed the least on all four treatments. Stigma item

endorsement doubled on the friends and family level. There was a 20% to 30% increase

on the community level. The workplace level had the highest rate of stigma endorsement

for all treatment options. Specifically, 67% endorsed stigma items for secular mental

health counseling, 65% endorsed stigma for medication prescribed by a psychiatrist, 64%

endorsed stigma for Christian counseling and 61% endorsed stigma for pastoral or lay

counseling on the workplace level. Table 4.4 displays treatment stigma item endorsement

for each of the four treatment options.

Table 4.4

Stigma Item Endorsement for Depression Treatment Options

	Depression Treatment Options			
Stigma Item	Psychiatrist/ Medication (*N*, %)	Pastoral/ Lay Counseling (*N*, %)	Christian Counseling (*N*, %)	Secular Counseling (*N*, %)
Ashamed of Self	(23) 19.3	(7) 5.9	(12) 10.1	(22) 18.5
Family/Friends	(49) 41.2	(45) 37.8	(41) 34.5	(50) 42.0
Community	(64) 53.8	(67) 56.3	(62) 52.1	(68) 57.1
Work	(77) 64.7	(73) 61.3	(76) 63.9	(80) 67.2

The Mantel-Haenszel odds ratio estimate found a positive and significant

relationship between friends and family stigma and previous mental health treatment

[*OR* (109) = 2.15, *p* < .001, 95% *CI* (1.42, 3.25)]. This suggests individuals with

previous mental health treatment are twice as likely to have stigma related to friends and

family than individuals with no history of mental health treatment. There was a negative

and significant association between previous mental health treatment and self-stigma [*OR*

(109) = -1.111, *p* < .001, 95% *CI* (.17, .654)]. This suggests participants with previous

mental health treatment are more likely to have less self-stigma than those with no

previous mental health treatment.

Hypothesis 2:

      H$_2$: The acceptability rates for pastoral or lay counseling are higher than rates for

           medication consultation by a psychiatrist and mental health counseling by a

           Christian or secular counselor.

      Hypothesis 2 includes four treatment options for depression (pastoral or lay

counseling, medication consultation by psychiatrist, and mental health counseling by a

Christian and secular counselor) and is discussed in detail in this research. However,

participants had the opportunity to select physician consultation, nutritional consultation,

bible study, and prayer and praise service as referrals for the congregational member

experiencing symptoms described in the scenarios. Descriptive statistics were used to

analyze the data collected for this hypothesis. In the following paragraph, a brief

summary of the results is discussed. Please review Table 4.5 for results for all treatment

options.

      For Hypothesis 2, results showed that the highest frequency (73, 57, 33, 66,

respective to the order of scenario presentations) overall was for Christian mental health

counseling not pastoral or lay counseling for all four scenarios (A, B, C, D). Thus, Hypothesis 1 was not supported. Specifically, respondents elected to refer congregational members for Christian mental health counseling by selecting Highly Likely for the depressive symptoms described in each scenario. Surprisingly, secular mental health counseling was the secondary selection, followed by pastoral or lay counseling, and medication consultation by a psychiatrist, as evidenced by selections of Highly Likely. However, frequencies for the Likely selection were close in comparison across the four scenarios. Medication consultation by a psychiatrist had the highest frequencies among the four treatment options for the Highly Unlikely referral. Physician consultation in comparison to medication consultation by a psychiatrist had higher frequencies for Highly Likely. This comparison is noteworthy considering psychiatrists and physicians have degrees in medicine. Nutritional consultation had the lowest frequencies (15, 20, 7, 11) for Highly Likely and Likely (30, 32, 16, 20) among all the treatment options. Bible study and prayer and praise services had the highest selection rates in the Likely category of all the treatment options. Table 4.5 displays the results of the analysis of research question two.

Table 4.5.

Percentages of Acceptability Rates for Depression Treatment Options

	Highly Likely (%, n)	High Unlikely (%, n)	Likely (%, n)	Neutral (%, n)	Unlikely (%, n)
Christian Mental Health Counseling					
ScenarioA	61.3(73)	1.7(2)	25.2(30)	3.4 (4)	2.5 (3)
ScenarioB	47.9(57)	1.7(2)	34.5(41)	6.7(8)	2.5 (3)
ScenarioC	27.7(33)	15.1(18)	23.5(28)	15.1(18)	11.8(14)
ScenarioD	55.5(66)	.8(1)	29.4(35)	5.9(7)	1.7 (2)
Secular Mental Health Counseling					
ScenarioA	34.5(41)	6.7 (8)	24.4(29)	11.8(14)	16.8(20)
ScenarioB	30.3(36)	7.6 (9)	26.9(32)	14.3(17)	12.6(15)
ScenarioC	32.8(39)	9.2(11)	22.7(27)	13.4(16)	14.3(17)
ScenarioD	33.6(40)	10.1(12)	21.8(26)	12.6(15)	15.1(18)
Pastoral / Lay Counseling					
ScenarioA	30.3(36)	10.9(13)	30.3(36)	14.3(17)	8.4(10)
ScenarioB	25.2(30)	12.6(15)	35.3(42)	9.2 (11)	10.9(13)
ScenarioC	27.7(33)	15.1(18)	23.5(28)	15.1(18)	11.8(14)
ScenarioD	29.4(35)	17.6(21)	29.4(35)	5.0 (6)	11.8(14)
Psychiatrist for Medication Consultation					
ScenarioA	16.8(20)	16.0(19)	24.4(29)	17.6(21)	19.3(23)
ScenarioB	12.6(15)	17.6(21)	21.0(25)	21.8(26)	17.6(21)
ScenarioC	17.6(21)	12.6(15)	21.0(25)	23.5(28)	16.8(20)
ScenarioD	18.5(22)	15.1(18)	25.2(30)	21.0(25)	11.8(14)
Physician / Medical Doctor					
ScenarioA	27.7(33)	8.4(10)	31.1(37)	10.1(12)	14.3(17)
ScenarioB	25.2(30)	8.4(10)	33.6(40)	14.3(17)	11.8(14)
ScenarioC	16.8(20)	12.6(15)	25.2(30)	20.2(24)	17.6(21)
ScenarioD	26.1(31)	6.7 (8)	31.9(38)	15.1(18)	12.6(15)
Bible Study					
ScenarioA	22.7(27)	9.2(11)	32.8(39)	19.3(23)	10.1(12)
ScenarioB	18.8(22)	7.6 (9)	39.5(47)	21.0(25)	6.7 (8)
ScenarioC	21.8(26)	5.9 (7)	41.2(49)	18.5(22)	5.9 (7)
ScenarioD	24.4(29)	4.2 (5)	37.8(45)	20.2(24)	6.7 (8)
Prayer / Praise Services					
ScenarioA	22.7(27)	7.6 (9)	33.6(40)	24.4(29)	5.9(7)
ScenarioB	18.5(22)	5.9 (7)	42.0(50)	18.5(22)	6.7(8)
ScenarioC	23.5(28)	4.2 (5)	41.2(49)	16.8(20)	7.6(9)
ScenarioD	28.6(34)	3.4 (4)	37.8(45)	16.0(19)	7.6(9)
Nutritionist Consultation					
ScenarioA	12.6(15)	14.3(17)	25.2(30)	16.8(20)	25.2(30)
ScenarioB	16.8(20)	11.8(14)	26.9(32)	21.0(25)	16.8(20)
ScenarioC	7.6 (9)	21.0(25)	13.4(16)	24.4(29)	26.9(32)
ScenarioD	9.2(11)	21.8(26)	16.8(20)	21.8(26)	22.7(27)

Note: Scenario A equals 80 y/o widowed woman with depressive symptoms
Scenario B equals 16 y/o single male with depressive symptoms
Scenario C equals 40 y/o single male with depressive symptoms
Scenario D equals 40 y/o married woman with depressive symptoms

Hypothesis 3:

    H_3: There is an association between treatment stigma and treatment acceptability.

Pearson correlation was used to examine the association between treatment stigma (self, friends/family, community, and work) and treatment acceptability (Christian and secular mental health counseling, pastoral/lay counseling, and prescription medication). The correlation between secular mental health counseling and friends and family stigma were found to be positive and significant (r (109) =.26, $p < .001$). This would suggest the acceptability of mental health counseling (secular) is associated with higher levels of friends and family stigma. Secular mental health counseling and self-stigma were found to be negative and significant (r (109) = -.28, $p < .001$). These findings suggest feelings of shame are indirectly associated with the acceptability of secular mental health counseling.

Chapter Summary

In summary, 109 questionnaires were used for analysis. Demographic or participant characteristics were analyzed using descriptive statistics. They were used as independent variables in ordinal logistic regression statistics and controlled when appropriate. Through correlation analysis, an association was found between mental health and pastoral or lay counseling referral histories and previous mental health and pastoral or lay treatment received. Hypothesis 1 was supported by the analysis in that stigma for depression treatments do increase with the expansion of the social circle. Hypothesis 2 was not supported. Mental health counseling had higher rates than pastoral or lay counseling. Hypothesis 3 was partially supported as evidenced by secular mental

health counseling having a positive association with friends and family stigma and a negative association with self-stigma.

Chapter Five discusses the results of this study in relation to existing literature relative to this topic. Implications for the counseling profession are discussed. Last, based on the findings of this research, recommendations for the future are discussed.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this cross sectional study was to investigate stigma associated with depression treatments and to approximate its association with treatment acceptability among African American Clergy. This chapter summarizes the methods, which include the research questions and hypotheses, measures and procedures, characteristics of the participants, and research findings. The chapter concludes with a discussion of the limitations of the study, implications for counselors, and recommendations for future research.

Research Questions

Three research questions framed this investigation. These questions were derived from the measurements used in the study. The research questions were as follows:

1. Does stigma for depression treatments increase with expansion of social circle?

2. What are the acceptability rates for prescription medication, Christian and secular mental health counseling, and pastoral/lay counseling?

3. Is there an association between treatment-specific stigma and treatment acceptability?

Summary of Study Measures and Procedures

The treatment specific stigma instrument (Givens et al., 2007) and the treatment acceptability instrument (Garzon & Gardner, 2011), along with a demographic

questionnaire were selected for this study. Participants were given the option of

completing the instruments by paper and pencil or by utilizing the online survey website

via Survey Monkey (www.surveymonkey.com/s/Gardner6370). Responses were

collected anonymously during a period of 6 months from February 2012 to July 2012.

This was a longer time period than originally anticipated; however, due to slow and low

response rates, the deadline for completion was extended three times.

In terms of procedures, the researcher initially hand delivered surveys to a

Southern seminary with the permission of the Dean. Sixty-five students requested

packets which included a hard copy of the survey, a return stamped envelope, and the

website address for online completion; however, only 30 surveys were received from

mail-ins and online. Surveys were mailed to local churches from a listing obtained from

the local newspaper office. Due to a low response rate, an internet search was conducted

to acquire mailing, email addresses, and phone numbers of churches identified as having

African American clergy. As a result of this search, the researcher mailed more than 100

packets to churches in Virginia, North Carolina, Georgia, Washington, D.C.,

Pennsylvania, and Maryland. More than 300 emails were sent to seminary school

faculty, national and local Baptist associations, and churches with websites that listed

email addresses. The emails included the study title, a brief summary of the study,

deadline date, and a statement stating the survey had to be completed by individuals of

African American descent.

The sample for this study consisted of 109 African American clergy (male and female) to include students and faculty of seminary schools, members of national and local Baptist associations, and members of the clergy in localities throughout the United States. The participants represent different age groups, educational levels, and marital status. Participants were eligible if they were African American, 18 years or older, male or female, and members of the clergy. Participants of other ethnic backgrounds other than African American were excluded.

Summary of Findings

Stigma is one of the primary variables in this research; therefore, the focus of this investigation was to identify the context in which stigma exists. Hence, research question one: Does stigma for depression treatments increase with the expansion of the social circle? Descriptive statistics, frequency analysis, chi-square test, and Mantel-Haenszel common odds ratio estimate were used to test the association between stigma, depression treatment options, and demographic variables. This research found that stigma related to treatment options (pastoral or lay counseling, medication consultation by psychiatrist, Christian mental health counseling, and secular mental health counseling) increased as the social context (i.e., self, family and friends, community; church; school, and work) expanded.

The acceptability of depression treatments was the other variable under analysis. This research focused on investigating the depression treatments that clergy found acceptable for referring congregational members. Therefore, research question two: What are the acceptability rates for mental health counseling (Christian or secular),

pastoral/lay counseling, and prescription medication by a psychiatrist? The acceptability rates for pastor or lay counseling were hypothesized to be higher than rates for prescription medication or Christian or secular mental health counseling. Descriptive statistics, frequency analysis, chi-square test, and Pearson product-moment correlation were used to obtain rates and observe relationships with demographic variables. This study found Christian mental health counseling had the highest rates among the four depression treatment options.

Research question three investigated two variables: stigma and treatment acceptability. Question 3: Is there an association between treatment specific stigma and treatment acceptability? It was hypothesized that there would be an association between the two variables. Pearson's correlation analysis found a positive and significant association between secular mental health counseling and friends and family stigma, and a negative and significant association between secular mental health counseling and self-stigma.

Discussion

This research found stigma related to depression treatment options (pastoral or lay counseling, medication consultation by a psychiatrist, Christian mental health counseling, and secular mental health counseling) increased as the social context (i.e., self, family and friends, community, church, school, and work) expanded. More than half the participants reported experiencing fear of their community and workplace becoming aware of their involvement in any of the treatment options. These findings are consistent with Givens' and colleagues' (2007) research where stigma increased as the social

context widened despite the fact that Given's depression treatment options included prescription medication, mental health counseling, herbal remedies, and spiritual counseling.

In an earlier study, Givens et al. (2006) found that issues of stigma in depressed patients were salient when involving employers, followed by friends and family for Whites and other ethnic groups who participated in the study. Like Givens' study, prescription medication and secular mental health counseling had the highest endorsements of stigma in community and work environments. These findings are also consistent with Roeloffs, Sherbourne, Unutzer, Fink, Tang, and Wells (2003) who found 24% of depressed patients reported an anticipated depression-related stigma to have a negative impact on friends, and 67% reported an anticipated negative impact on employment. This research, like Givens and unlike Roeloeffs and associates (2003), used vignette-based or scenarios which asked participants to imagine themselves in a depressed state. Despite the use of scenarios, the results were consistent in that stigma increased with the expansion of the social circle.

Consistent with the findings of Thompson-Sanders, Bazile, and Akbar (2004) and USDHHS (2001), this present research supports the existence of stigma among African Americans. In previous research, stigma has been identified as a barrier to mental health treatment (Alvidrez, Snowden, Rao & Boccellari, 2008) and it contributes to the underutilization of mental health services and early termination of mental health treatment(Corrigan, 2004). This study reflects the underutilization of mental health services within this population as evidenced by 33% of respondents reporting receiving mental health counseling and 67% reporting receiving pastoral or lay counseling.

In terms of treatment acceptability, the results of this study are consistent with the findings of VanderWaal, Sandman, Hernandez, and Ippel (2011) that Christian counseling had the highest ratings and referrals were made on the basis of scenarios describing depressive symptoms. VanderWaal and associates reported clergy (60%) believed it was important to make referrals to Christian counselors for general life problems, and that clergy were likely to make referrals for mental health services for issues that they view as more serious such as depression, domestic violence, sexual abuse, and substance dependence. McMinn and associates (2005) reported that pastors preferred to collaborate with either Biblical counselors or Christian psychologists who used Scripture and prayer in counseling over counselors who were described as having excellent interpersonal skills.

Although, this present study did not address how clergy view depression, the findings of Shellman, Mokel, and Wright (2007) and VanderWaal and associates (2011) are similar in respect to Bible study and prayer as viable and desired treatment options. Shellman and associates and VanderWaal and associates both reported that African Americans often view depression as a personal weakness that is best addressed by faith and prayer rather than counseling and pharmacology. The practices of faith and prayer, which are viewed as more private methods for dealing with problems over other methods of treatment, may be explained by Matthews, Corrigan, Smith, and Aranda (2006) who reported that the African American culture values keeping and solving problems within the family; therefore, emphasis is placed on prayer and faith over life problems in lieu of counseling. Furthermore, this study supports previous research which revealed African

Americans have a lower acceptance of antidepressant medication (Cooper, Gonzales, & Gallo, 2003) and greater preference for counseling (Dwight-Johnson et al., 2000).

With regard to associations between treatment stigma and treatment acceptability, this study was consistent with Givens (2007) in that friends and family stigma was positively associated with secular mental health counseling. Unlike Givens, secular mental health counseling and self-stigma were found to have a negative association; therefore, the acceptability of secular mental health counseling was not influenced by self-stigma. These differences may be accounted for by the different types of statistical analysis used. The referrals for Christian mental health counseling may have been increased due to clerics being overwhelmed by the demands of their congregation. Therefore, they make more referrals due to not having adequate time to address all the needs of their congregation. Several participants verbalized their concerns about having time to complete this survey due to responsibilities for their church. In addition, this researcher surmises that providing the participants with knowledge of the type of degree (Professional Counseling) she was seeking may have influenced the referral rates for Christian mental health counseling.

Despite the variations in results between the two studies, significance was found among the same three variables (mental health counseling, self-stigma, and friends and family). This study was consistent with Givens in that there was no significant relationship found between treatment stigma and treatment acceptability for prescription medication for depression. This study did not observe any significance for Christian mental health or pastoral or lay counseling in relation to stigma. This could be the result of modifications or revisions to the treatment acceptability measurement.

In addition to the results of this study, valuable ancillary data was revealed during the investigation of stigma and treatment acceptability in relation to demographic information. These findings will increase the demographic data regarding African American clergy.

There is literature addressing the roles of African American clergy in relation to mental health care (Farris, 2007; NAMI, 2006; Young, 2003), clergy perceptions of mental health (Blalock, 2012; Watson, 2006; Vassol, 2005), and educating and training clergy for mental health care (Payne & Dyer, 2006; NAMI, 2006). However, this researcher did not find past or present empirical data in the literature regarding African American clergy and their treatment history, pastoral or mental health counseling, or medication. Studies were available regarding referral rates and patterns of referrals which are referenced in this chapter; but, literature regarding diagnosis and treatment of mental health concerns for this population are less than scarce. Therefore, the following findings are novel to the field in that clergy actually sought and engaged in mental health and pastoral counseling by their own reports.

This study found a positive relationship between secular mental health treatment received and referral history. Specifically, previous reported secular mental health treatment was positively associated with mental health counseling referrals. This implies that the secular mental health treatment/counseling was a positive experience so participants made referrals for mental health counseling. Also, previous pastoral or lay treatment received was associated with pastoral or lay counseling and previous mental health counseling referrals.

In terms of treatment acceptability or referrals, studies dating back to the 1960s document interest in the education of clergy and their ability to address the various needs, including mental health needs, of their congregation members effectively. Bentz (1967) found that less educated ministers were more willing to cope with a greater variety of problems and tackle the more serious problems of mental illness more often than a minister who had attained a relatively high educational level. The results of this study supports Bentz's findings that the better-educated minister is more knowledgeable as to the existence of and functions performed by other community health resources and is more likely to refer a person who exhibits symptoms of a serious mental illness to another community health agency.

In this study, individuals with high school diplomas, vocational trades, some college, and associate degrees reported making referrals for mental health counseling and pastoral or lay counseling 1 to 5 times in the past 2 years at a rate of 16%, whereas bachelor's, master's, and doctoral degree participants made referrals for mental health counseling and pastoral or lay counseling in the past 2 years at a rate of 62%.

Individuals with higher education levels tend to make more referrals than those with less education, but do they have higher rates of receiving treatment? Broman (2012) reports higher education in Blacks was associated with lower receipt of mental health services than Whites (non-Hispanic) and Latinos. The findings of this study revealed that individuals with bachelor degrees or higher (33%) reported previous mental health treatment whereas only 3% of participants with high school to associate degree education reported previous mental health treatment. Furthermore, this study revealed 67% of the participants of all levels of education, from high school diplomas to doctoral degrees,

reported receiving pastor or lay counseling. However, these individuals reported they would make more referrals for Christian mental health counseling for congregational members over pastoral/lay counseling. Consequently, 82% percent of the participants in this study reported never being treated with medication for depression and 68 percent reported "None in the Past Two Years" and "Never" for making medication referrals to congregational members. Interestingly, 11 percent did report receiving medication for depression.

Gender is highly significant; men of all researched ethnicities are significantly less likely than women to receive mental health services, and women are found in almost all research to be greater users of mental health services (Broman, 2012). Broman reports that it is not gender per se among young Black adults, but rather it is the need for mental health that drives services use. This study is consistent with Broman's findings in that there were no salient differences in the reported history of mental health treatment among African American men (16.8%) and women (16%). In addition, there were major differences in referral rates for mental health counseling among African American men (21%) and women (13.4%). In this study, the higher rates of referrals for men than women may be related to the years in the ministry. Thirty-six percent (36%) of the males had 15 to more than 20 years in the ministry, whereas only 12% of the females had 15 to more than 20 years in the ministry. Therefore, these men may have more experience recognizing mental illness and may be more aware of community resources and the referral process so they make more referrals.

The surveys in this study served as awareness tools for clergy who participated. The treatment specific stigma instrument provided clergy with the opportunity to reflect

on their own attitudes and beliefs about treatments for depression and professionals who treat mental disorders. In addition, clergy were provided with the symptoms of depression for future reference and available treatment options outside of church.

<div align="center">Implications for Counselors</div>

The findings from this research have several implications for counselors in relation to African Americans and African American clergy. First, mental health professionals need to be more visible and accessible to clergy. This researcher found that when she introduced herself in person, by telephone or through the clergy's church clerk, the rate of responses increased. This researcher's introduction included ethnicity, which also might have had an impact on response rates. VanderWaal and associates (2011) reported a few of the Caucasian clergy participants considered the need to consult with a counselor of the same ethnic background. Additionally, about half of all Hispanic/Latino and African American clergy prefer to consult with a counselor of the same ethnic background. Furthermore, this researcher is a Licensed Professional Counselor in private practice in a rural area. In the practice, referrals have been made from pastors, which provided access to counseling church members. The referrals may have been the result of the clergy's familiarity and confidence in the counselor.

Second, as a result of the stigma observed in this study, mental health professionals may need to acknowledge and address the stigmas some clients perceive about therapy at the onset of treatment in order to increase service utilization and decrease premature termination. Vogel et al. (2007) reports mental health professionals should address how stigma affects African Americans after they enter treatment.

Therefore, the practitioner would need to address the concerns of Black clients in a culturally sensitive and appropriate manner Broman (2012).

Third, mental health professionals can assist in improving public awareness of effective treatment. Community service boards are established to service rural, urban, and suburban areas. Professionals associated with these agencies could develop and implement quarterly or annual outreach programs to provide communities, including African American communities, with information on mental disorders and available treatments.   The effectiveness of the outreach could increase if mental health professionals were educated on various denominational beliefs, values, and practices. In addition, counselors or mental health professions should have knowledge of spiritual interventions, and possess the ability to recognize when clients need referrals to a cleric or when collaboration is needed. Mental health professionals should also possess a resource list of Christian mental health counselors and a list of area churches and their pastors. The church could be a point of contact and a meeting place for community outreach. All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence (Surgeon General, 1999).

Last, increased funding for African American psychologists and other mental health providers would help increase the number of African Americans in treatment as minority clinicians are more likely to see minority patients with more effective outcomes (Ronzio, Guagliardo, & Persaud, 2006).

Recommendations for Future Research

Based on the findings of this study, African American clergy are performing counseling duties as evidenced by participants' reports of receiving counseling from a member of the clergy and reports of making referrals to their congregational members for pastoral/lay counseling. Therefore, it is recommended that future research investigate the types of concerns addressed by clergy and identify the type and quality of the counseling being provided. In addition, investigate the level of mental health education or training acquired by clerics who provide counseling to assess the level of care being received. In this study, clergy are making referrals based on the depressive symptoms presented in the scenarios which may be an indication that helping these individuals is outside their scope of knowledge. This could be an educational opportunity. It would be recommended that clergy have training on recognizing symptoms of mental disorders in general, not just depression. The scenarios in this research described the symptoms of depression and participants were told the treatment options were for depression; therefore, it is unclear if participants would recognize the symptoms outside of this context. Also, the focus of future research should be to find out if clergy are aware of the mental health services available in their communities and the process for making referrals.

In this study, stigma was observed on the community and workplace levels. Future research should focus on reasons why stigma is more prominent on community and workplace levels for African Americans. Initially, the design should include personal interviews with clergy in order to get more detailed responses and better understanding. This research may provide information on how to engage African Americans in general

and clergy in a manner that is perceived as less stigmatizing. In addition, personal interviews can open the lines of communication between clergy and mental health professionals.

This study revealed African American clergy are willing to make referrals to Christian and secular mental health counselors. Future research should focus on the attitudes, beliefs, and perceptions of mental health professionals regarding African American clergy and referrals made by clergy. The attitudes, beliefs and perceptions of mental health counselors could impede the collaboration and referral process. Therefore, mental health professionals must consider their own biases and attitudes regarding religion and religious institutions, and their willingness to work in a unified effort to support the Black church (Taylor & Ellison, 2000). Collaboration can be enhanced by addressing several barriers. Farrell and Goebert (2008) reported some clergy members have expressed concern that mental health specialists may undermine or show contempt for the faith of individuals who are referred, and poor collegiality between professions was cited.

As a result of participants' comments in reference to length of the survey and not having enough time to complete the survey, future research designs should be conservative in the amount of time it takes to complete the survey. This researcher would reduce the number of vignettes or the survey length in order to decrease the time for completion. If the research is extensive with numerous surveys/questionnaires that require lengthy periods of time to complete, consider administering the surveys over several months. If this is a chosen method, the researcher will have to follow up with the participants at intervals to encourage and maintain participation.

Limitations

This study should be interpreted irrespective of certain methodological limitations. Like, Givens et al. (2007), a vignette–based questionnaire was used to evaluate intended rather than observed behavior. Responses to intended behavior may have the effect of raising the overall acceptability of treatments. This study, with the permission of the developer, used the treatment specific stigma instrument for the target population to capture specific components of stigma associated with treatment. However, it may have captured stigma associated with depression which may have limited ability to measure the full potency of treatment stigma. The capacity to capture the full scope and abstruseness of stigma concerns may have been limited by Yes/No response selections.

Additionally, this study chose to limit the scope of its investigation. Specifically, this research purposefully confined its participants to African American clergy, so these findings are limited in generalization to other racial or ethnic groups.

In the conducting this study, problems were encountered in the data collection process which may have been related to the design of the research. The first problem was the low response rate. In efforts to increase the response rate, the researcher extended the sampling area, extended the deadline three times, conducted follow up calls to churches who were mailed surveys, and emailed clergy two additional times in 30 day increments. A small fraction of the emails were returned unread or replies were sent to the researcher stating, "Please do not send again."

Last, the measurements used, with emphasis on the scenarios, received some criticism. Pastors who knew this researcher personally or who were acquainted with the

researcher's pastor and/or parents reported the scenarios were redundant and took up too much time despite the fact the individuals in the scenarios had different characteristics. This may account for missing data.

Chapter Summary

There is an association between stigma and the acceptability of depression treatments as hypothesized. However, stigma was associated with secular mental health counseling only, not other treatment options. In addition, stigma relating to self and friends and family was lower for all treatments and stigma relating to community and work was higher for all treatments. Stigma continues to exist as evidenced by the findings of this research; therefore, the problem of underutilization of mental health services among African Americans will continue. This research revealed the importance of African American clergy. Sixty-seven percent of the clergy in this study reported previous counseling with a member of the clergy. For members of the clergy who are experiencing difficulties in life and may not be comfortable seeking help from a mental health professional, they can rely on other clerics for help. However, this may account for the low utilization rates of mental health services among African Americans. If clergy prefer other clergy for help with problems, is it likely that they would refer their congregation members to mental health professions over pastoral or lay counseling? According to the findings of this study, 38% made referrals to clergy in the past 2 years and 35% made referrals for mental health counseling. However, referrals for Christian and secular mental health counseling had higher acceptability rates than pastoral or lay counseling. As discussed earlier, this could be the result of clergy not feeling comfortable

treating someone with depression. Therefore, indications for future research would be to find out more about the types of concerns pastors encounter and what type of treatment/counseling they are providing. As with all social science studies, this research had a number of limitations; however, the findings provide a starting place for further investigation.

Study Summary

Depression affects all people regardless of age, ethnicity, education level, socioeconomic status, or geographic location. Prescription medication and mental health counseling have been found to be the most effective forms of treatment for depressive disorders (Dwight-Johnson et al., 2004). Alternative forms of treatment have emerged such as herbal remedies and spiritual counseling (Givens, 2007). Despite evidence of the efficacy of treatments and the availability of various treatments, African Americans continue to underutilize mental health services. As aforementioned in previous research, stigma is a barrier to mental health treatment for African Americans. The roots of stigma are embedded in years of oppression from slavery and other horrific events such as the Tuskegee experiments. Stigma has been perpetuated through the years and it has resulted in African Americans not receiving the adequate and quality treatment needed. African American clergy have been and continue to be staples in the Black community. Therefore, this researcher was hoping African American clergy would be able to shed some light on stigma from the view of clerics and how it impacts their decision to accept various depression treatments and make referrals for treatment. This study supports other research in that stigma exists among African Americans and, in this case, clergy. Based

on the findings of this study, it appears the participants would be more willing to engage in treatment if the knowledge of their treatment was private or if only friends and family had knowledge; however, there was fear associated with community and work having knowledge of their treatment. Therefore, if clergy have a fear of community and work knowing about their treatment, would they refer their members? According to their reports, they would make most of their referrals to Christian mental health counselors. This finding is encouraging because it suggests African American clergy are open to communication with mental health professionals.

Communication is a start to pulling down the barrier of stigma. Ultimately, communication can ignite collaboration between the two professions and possibly increase the rate of mental health service utilization in the Black communities or assist clergy in more effective ways to counsel individuals who refuse to seek help outside their community. African American clergy can be essential contacts for successful community outreach sponsored by mental health agencies and instrumental in bringing mental health awareness to African Americans communities.

REFERENCES

Alegria, M., Chatterji, P., Wells, K., Cao, Z., Chen, C., Takeuchi, D., . . . Meng, X. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11)*,* 1264-1272. Retrieved from http://www.psychservices.psychiatryonline.org

Alegria, M., Canino, G., Rios, R. Vera, M., Calderon, J., Rusch, D., & Ortega, A. N. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services, 53*(12), 1547-1555. Retrieved from http://www.psychservices.psychiatryonline.org

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior.* Englewood Cliffs, N.J.: Prentice-Hall.

Alvidrez, J., Snowden, L. R., Rao, S. M., & Boccellari, A. (2009). Psychoeducation to address stigma in Black adults referred for mental health treatment: A randomized pilot study. *Community Mental Health Journal, 45*, 127-136. doi: 10.1007/s10597-008-9169-0

American Mental Health Counselors Association. (1979-2011). (pp. 2). Retrieved from http://www.amhca.org/assets/content/AMHCA_Standards_1-26-2012.pdf

American Psychiatric Association. (1993). Practice guideline for major depressive disorder in adults. *American Journal of Psychiatry, 150* (Suppl), 1-26.

American Psychiatric Association (4th ed.). (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR).* Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2006). *Practice guidelines for the treatment of psychiatric disorders: Compendium.* Retrieved from http://psychiatryonline.org/ guidelines.aspx

American Psychiatric Association, Office of Minority and National Affairs. (2010). *Mental health disparities: African American, APA Fact Sheet.* Retrieved from http://www.psychiatry.org/home/searchresults?k=Mental%20health%20 disparities:%20African%20Americans

Amsterdam, J. D. (2003). A double-blind, placebo-controlled trial of the safety and efficacy of selegiline transdermal system without dietary restrictions in patients with major depressive disorder. *Journal of Clinical Psychiatry, 64*(2), 208–214. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12633131

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services, 57*(6), 857-862. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16754764

Bambauer, K. Z., & Prigerson, H. G. (2006). The stigma receptivity scale and its association with mental health service use among bereaved older adults. *The Journal of Nervous and Mental Disease*, *194*, 139–141. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16477195

Barker, L. (2012). *How to become a certified Christian counselor.* Demand Media, Inc.

Beck, A. T. (1967). *Depression: Causes and treatments*. Philadelphia: University of Pennsylvania Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.

Bentz, W. K. (1967). The clergyman's role in community mental health. *Journal of Religion Health, 9*, 7-14.

Butler, A. C., & Beck, A. T. (1995). Cognitive therapy for depression. *The Clinical Psychologist, 48*(3), 3-5. Retrieved from http://www.apa.org/ divisions/ div12/rev_est/cog_depr.html

Benner, D. (1992). *Strategic pastoral counseling*. Grand Rapids: Baker Books.

Blank, M. B., Mahmood, M., Fox, J. C., & Guterback, T. (2002). Alternative mental health services: The role of the Black in the South. *American Journal of Public Health, 92*(10), 1668-1672. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/ articles/PMC1447305PMC

Blalock, L., & Dew, R. E. (2012). A pilot survey of clergy regarding mental health care for children. (Article ID. 742410) *Research Article*. doi:10.1155/2012/742410

Blatner, A. (1988). Spontaneity. In *Foundations of psychodrama: History, theory & practice*. New York: Springer. Retrieved from http://www.blatner.com/ adam/pdntbk/hxgrprx.htm

Blatt, S. J. (1998). Contributions of psychoanalysis to the understanding and treatment of depression. *Journal of American Psychoanalytic Association, 46,* 722-752. doi: 10.1177/00030651980460030301

Blazer, D. G., Hybels, C. F., Simonsick, E. M., & Hanlon, J. T. (2000). Marked differences in antidepressant use by race in an elderly community sample: 1986-1996. *American Journal of Psychiatry, 157*(7), 1089–1094. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10873916

Bledsoe, S., Setterlund, K., Connolly, M., Adams, C. (2011, October). *Promoting emotional well-being among southern California parishioners through clergy/mental health practitioner collaboration.* Paper presented at the meeting of NACSW Convention, Pittsburgh, PA.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P.,…Weissman, M., (2003). Group interpersonal psychotherapy for depression in rural Uganda. *The Journal of the American Medical Association, 289*, 3117-3124. doi:10.1001/ jama.289.23.3117

Broman, C. L. (2012). Race differences in the receipt of mental health services among young adults. *Psychological Services, 9*(1), 1541-1559. doi:10.1037/a0027089

Brown, C., Schulberg, H. C., Sacco, D., Perel, J. M., & Houck, P. R. (1999). Effectiveness of treatments for major depression in primary medical care practice: A post hoc analysis of outcomes for African American and white patients. *Journal of Affective Disorders, 53*(2), 185–192. Retrieved from: http://www.ncbi.nlm. nih.gov/pubmed/10360414

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2005). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17– 31. doi:10.1016/j.cpr.2005.07.003

Chatters, L. M., Taylor, R. J., Jackson, J. S. & Lincoln, K. D. (2008). Religious coping among African Americans, Caribbean Blacks and non-Hispanic Whites. *Journal of Community Psychology, 36*, 371–386. doi: 10.1002/jcop.20202

Cipriani, A., Furukawa, T. A., Salanti, G., Geddes, J. R., Higgins, J. P., Churchill, R.,…Barbui, C. (2009). Comparative efficacy and acceptability of 12 new-generation antidepressants: A multiple-treatments meta-analysis. *Lancet, 373*, 746–758. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19185342

Clayton, A. H., Warnock, J. K., Kornstein, S. G., Pinkerton, R., Sheldon-Keller, A., McGarvey, E. L. (2004). A placebo-controlled trial of bupropion SR as an antidote for selective serotonin reuptake inhibitor-induced sexual dysfunction. *Journal of Clinical Psychiatry, 65*(1), 62–67. Retrieved from http://www.ncbi. nlm.nih.gov/pubmed/14744170

Collins, G. R. (1980). Lay counseling within the local church. *Leadership 1*(4), 78-86. Retrieved from http://www.christianitytoday.com/le/1980/fall/80l4064.html

Comer, R. J. (4th ed.). (2005). *Fundamentals of abnormal psychology,* New York, New York: Worth Publishers.

Cooper, L. A., Brown, C., Vu, H., Ford, D. E., & Powe, N. R. (2001). How important is intrinsic spirituality in depression care? A comparison of White and African-

American primary care patients. *Journal of General Internal Medicine, 16*, 634-638. doi: 10.1046/j.1525-1497.2001.016009634.x

Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., … Ford, D. E. (2003). The acceptability of treatment for depression among African American, Hispanic, and White primary care patients. *Medical Care, 41*(4), 479-489. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12665712

Cooper-Patrick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (1997). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine, 12*, 431-438. doi: 10.1046/j.1525-1497.1997.00075.x

Corrigan, P. W., & Miller, F. E., (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13*, 537-548. doi: 10.1080/09638230400017004

Corrigan, P. W., & Kleinlein, P. (2005). The impact of mental illness stigma. In P. W. Corrigan, (Ed.), *On the stigma of mental illness: Implications for research and social change (pp. 6-25).* Washington: The American Psychological Association.

Crozier, G. (2005). There's a war against our children: Black educational underachievement revisited. *British Journal of Sociology of Education*, *26*, 585-598. doi**:**10.1080/01425690500293520

Davis, S. D., & Ford, M. (2004). A conceptual model of barriers to mental health services among African Americans. *African American Research Perspectives,10*, 44-54. Retrieved from http://www.rcgd.isr.umich.edu/prba/perspectives/springsummer2004/ford-davis.pdf

Davis, K., Townsend, W., & Noel, M. B. (2005, May). *Decreasing discrimination and stigma associated with mental illness in the African American community.* Rockville, Maryland: SAMHSA ADS Center. Retrieved from http://www.esi-bethesda.com/ADSmediafiles/TeleconferencePresentations/AfricanAmericanCommPres05052005.pdf

Dwight-Johnson, M., Sherbourne, C. D., Liao, D., & Wells, K. B., (2000). Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine, 15*, 527-534. doi: 10.1046/j.1525-1497.2000.08035.x

Eck, B. E. (2002). An exploration of the therapeutic use of spiritual disciplines in clinical practice. *Journal of Psychology and Christianity, 21*(3), 266-280. Retrieved from http://connection.ebscohost.com/c/articles/7902527/exploration-therapeutic-use-spiritual-disciplines-clinical-practice

Fanon, F. (1952). *Black skin, White masks*. London: Pluto Press.

Farrell, J. L., & Goebert, D. A. (2008). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Journal of Psychiatry Online, 59*(4), 437-440. Retrieved from *ps.psychiatryonline.org*

Farris, K. D. (2005). *Innovative ways to address mental health needs of African Americans: An exploratory study examining the importance of understanding how African American clergy conceptualize and attribute causation of mental illness* (Doctoral dissertation). Retrieved from http://repositories.lib.utexas. edu/bitstream/handle/2152/1908/farrisk65814.pdf?sequence=2

Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *Journal of American Medical Association, 303*, 47-53. doi:10.1001/jama.2009.1943

Frame, M. W., & Williams, C. B. (1996). Counseling African Americans: Integrating spirituality in therapy. *Counseling and Values*, *41*, 16-25. doi:10.1002/j.2161-007X.1996.tb00859.x

Freud, S. (1954). *The complete introductory lectures on psychoanalysis.* In J. Strachey (Ed. & Trans.). New York: Norton

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing*, *26*, 979-999. doi: 10.1080/01612840500280638

Gamble, V. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health, 87*(11), 1773-1778. Retrieved from http://acs.etxahec.org/LinkClick.aspx?fileticket=gPGORiIYh0c%3D&tabid=79&mid=410

Gansler, T., Kaw, C., Crammer, C., & Smith, T. (2008). A population-based study of prevalence of complementary methods use by cancer survivors. *Cancer, 113*, 1048–1057. doi:10.1002/cncr.23659

Garzon, F. & Gardner, C. C. (2012). *Treatment Acceptability Instrument.* (Doctoral Dissertation) [Hard paper copy]. Unpublished instrument. Lynburg, VA: Liberty University, Integrated Learning Resource Center

Givens, J. L., Houston, T. K., Van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2006). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry*, *29*, 254-263. doi:10.1016/j.genhosppsych.2006.11.002

Givens, J. L., Katz, I. R., Bellamy, S., & Holmes, W. C. (2007). Stigma and the acceptability of depression treatments among African Americans and Whites. *Society of General Internal Medicine, 22*, 1292-1297. doi: 10.1007/S11606-007-0276-3

Glueckauf, R. L., Davis, W. S., Allen, K., Chipi, P., Schettini, G., Tegen, L., . . . Ramirez, C. (2009). Integrative cognitive-behavioral and spiritual counseling for rural dementia caregivers with depression. *Rehabilitation Psychology, 54,* 449-461. doi:10.1037/a0017855

Goffman, E. (1963): *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, N. J.: Prentice Hall

Goffman, E. (1968). *Stigma: notes on the management of spoiled identity*. Harmondsworth: Penguin.

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2008). Perceived stigma and mental health care seeking. *Psychiatric Services, 59,* 392-399. doi:10.1176/appi.ps.59.4.392

Gonzalez, H. M., Croghan, T., West, B., Williams, D., Nesse, R., Tarraf, W., …Jackson, J. (2008). Antidepressant use in Black and White populations in the United States. *Psychiatric Services, 59*, 1131-1138. doi:10.1176/appi.ps.59.10.1131

Goodall, W. I. (2011). Pastoral counseling: 10 key principles. *Enrichment Journal*. Retrieved from http://enrichmentjournal.ag.org/199803/096_key_principles.cfm

Gottlieb, J. F., & Olfson, M. (1987). Current referral practices of mental health care providers. *Hospital and Community Psychiatry, 38*(11)*,* 1171-1181. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/3311961

Harman, J. S., Edlund, M. J., & Fortney, J. C. (2004). Disparities in the adequacy of depression treatment in the United States. *Psychiatric Services, 55*, 1379-1385. doi:10.1176/appi.ps.55.12.1379

Hatchett, S. J., & Jackson, J. S. (1993). In H. P. McAdoo (Ed.), *Family ethnicity: Strength in diversity* (pp xx-xx)*.* Newbury Park, CA: Sage.

Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D., Salomon, R. M., & O'Reardon, J. P. (2005). Prevention of relapse following cognitive therapy vs.

medications in moderate to severe depression. *Archives of General Psychiatry, 62*(4), 417–422. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15809409

Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of

depression. *Psychological Science in the Public Interest, 3*, 39-77. doi:10.1111/1529-1006.00008

Holmes, P., & River, L. P. (1998). Individual strategies for coping with the stigma of severe mental illness. *Cognitive and Behavioral Practice, 5*, 231–239. http://dx.doi.org/10.1016/S1077-7229(98)80008-4

Holzer, C. E., Goldsmith, H .F., & Ciarlo, J. A. (1998). In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental Health, United States* (pp. xx-xx). Rockville, MD: Center for Mental Health Services.

Howarth, Caroline. (2006). Race as stigma: Positioning the stigmatized as agents, not objects. *Journal of Community and Applied Social Psychology*, *16,* 442-451. doi:10.1002/casp.898

Hoyt, D. R., Conger, R. D., Valde, J. G., & Weihs, K. (1997). Psychological distress and help seeking in rural America. *American Journal of Community Psychology, 25,* 449-470.

Hu, T. W., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health, 81*(11), 1429-1434.   Retrieved from: http://www.ncbi.nlm. nih.gov/pmc/articles/PMC1405672

Jaurrieta, N., Jimenez-Murcia, S., Menchón, J. M., Alonso, M. D. P., Segalas, C., ÁLvarez-Moya, E. M., Labad, J., . . .Vallejo, J. (2008). Individual versus group cognitive-behavioral treatment for obsessive-compulsive disorder: A controlled pilot study, *Psychotherapy Research*, *18,* 604-614. doi: 10.1080/10503300802192141

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R*). Archives of General Psychiatry, 62*(6), 617-627. Retrieved from http://archpsyc.jamanetwork.com/article.aspx?articleid=208671

Kramer, T. L., Blevins, D., Miller, T. L., Phillips, M. M., Davis, V., & Burris, B. (2007). Ministers' perceptions of depression: A model to understand and improve care. *Journal of Religion and Health, 46*, 123-139. doi:10.1007/s10943-006-9090-1

Larson, J. E., & Corrigan, P. (2008). The stigma of families with mental illness. *Academic Psychiatry*, *32*(2), 87-91. Retrieved from http://www.ncbi.nlm.nih.gov/ pubmed/18349326

Lawson, W. B. (2008, April). *Depression and ethnic health disparities.* Paper presented at National Black Caucus Foundation, Inc., Washington, D. C. Retrieved from http://www.nmqf.org/08summitpresentations.aspx

Lawson, W. B., Hepler, N., Holladay, J., & Cuffel, B. (1994). Race as a factor in inpatient and outpatient admissions and diagnosis. *Hospital and Community Psychiatry, 45*, 72–74. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8125467

Levin, J. S. (1986). Roles for the Black pastor in preventive medicine. *Pastoral Psychology, 35*(2), 94–103. Retrieved from http://cretscmhd.psych.ucla.edu/nola/video/Clergy/Articles/Roles%20for%20the%20Black%20pastor%20in%20preventive%20medicine.pdf

Li. Z., Maglione, M., Tu, W., Mojica, W., Arterburn, D., Shugarman, L. R., … Morton, S.C. (2005). Meta-analysis: Pharmacologic treatment of obesity. *Annals Internal Medicine, 142*, 532–546. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15809465

Liber, J. M., Van Widenfelt, B. M., Utens, E. M.W. J., Ferdinand, R. F., Van der Leeden, A. J. M., Gastel, W. V., & Treffers, P. D. A. (2008). No differences between group versus individual treatment of childhood anxiety disorders in a randomised clinical trial. *Journal of Child Psychology and Psychiatry, 49*, 886–893. doi: 10.1111/j.1469-7610.2008.01877.x

Lisanby, S. H. (2007). Electroconvulsive therapy for depression. *The New England Journal of Medicine, 357*(19), 1939–1945. Retrieved from http://img2.tapuz.co.il/CommunaFiles/24518833.pdf

Matthews, A. K., Corrigan, P. W., Smith, B. M., & Aranda, F. (2006). A qualitative exploration of African-Americans' attitudes toward mental illness and mental illness treatment seeking. *Rehabilitation Education, 20*(4), 253-268. Retrieved from http://ps.psychiatryonline.org/article.aspx?articleid=116508

Mattis, J. S., Mitchell, N., Zapata, A., Grayman, N. A., Taylor, R. J., Chatters, L. M., & Neighbors, H. W. (2007). Uses of ministerial support by African Americans: A focus group study. *American Journal of Orthopsychiatry, 77,* 249-258. doi: 10.1037/0002-9432.77.2.249

Maynard, C., Ehreth, J., Cox, G. B., Peterson, P. D., & McGann, M. E. (1997). Racial differences in the utilization of public mental health in Washington state. *Administration and Policy in Mental Health, 24*(5), 411-424. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9239945

McCarthy, M. (2001). U.S. mental-health system fails to serve minorities, says U.S.

Surgeon General. *Science and Medicine, 358,* 733. doi: 10.1016/S0140-6736(01)05940-2

McMinn, M. R., Runner, S. J., Fairchild, J. A., Lefler, J. D., & Suntay, R. P. (2005). Factors affecting clergy-psychologist referral patterns. *Journal of Psychology and Theology, 33*(4), 299-309. Retrieved from http://psycnet.apa.org/psycinfo/2006-02038-006

Miller, K. (2005). Communications theories: Perspectives, processes, and contexts. New York: McGraw-Hill.

Merck Sharp & Dohme Corp., a subsidiary of Merck & Co. Inc. (2009). *Merck manuals: Drug overview.* Retrieved from http://www.merckmanuals.com/ home/ drugs/overview_of_drugs/overview_of_drugs.html

Miller, I. W., Keitner, G. I. , Ryan, C. E., Solomon, D. A., Cardemil, E.V., & Beevers, C.G. (2005). Treatment matching in the post hospital care of depressed patients. *American Journal of Psychiatry, 162*, 2131–2138. doi: 1010.1176/appi.ajp. 10.162.11.2131

Milstein, G. (2003). Clergy and psychiatrists: Opportunities for expert dialogue. *Psychiatric Times, 20*(3), 36-39. Retrieved from http://www1.ccny.cuny.edu/ prospective /socialsci/psychology/upload/Milstein_2003_Psychiatric-Times_Expert-Dialogue-4.pdf

Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine, 19*, 120-126. doi:10.1111/j.1525-1497.2004.30272.x

Morgan, R. J. (1997, Spring). Why pastors make great counselors. *Leadership Journal.* (pp. 29-31). Retrieved from http://www.christianitytoday.com/le/ 1997/spring/7l2029.html?start=1

Nutritionists. (2009). *Mosby's Medical Dictionary* (8th ed.). Elsevier. Retrieved from: http://medical-dictionary.thefree dictionary.com/nutritionists

National Alliance on Mental Illness (NAMI). (2004). *African American community mental health.* Retrieved from: http://www.nami.org/Content/ContentGroups/ MIO/Fact_Sheets1/AA_MH_Disparities_04.pdf

National Council of Churches USA. (2007). *Yearbook of American and Canadian Churches, Annual.* Retrieved from http://www.ncccusa.org

National Institute of Mental Health (NIMH), Depression Research at the National Institute of Mental Health. (2006). *The numbers count: Mental disorders in*

America. Retrieved from: http://www.nimh.nih.gov/health/publications/ the-numbers-count-mental-disorders-in-america/index.shtml

Nurnberg, H. G., Hensley, P. L., Gelenberg, A. J., Fava. M., Lauriello, J., & Paine, S. (2003). Treatment of antidepressant associated sexual dysfunction with sildenafil: A randomized controlled trial. *Journal of American Medical Association, 289*, 56–64. doi:10.1001/jama.289.1.56

Office of Standards of Education (OFSTED). (2002). *Achievement of Black Caribbean pupils: Good practice in secondary schools.* (Reference No. HMI 448). Retrieved from http://www.ligali.org/pdf/achievement_of_ caribbean_ pupils_good_practice_in_secondary_schools.pdf

Olfson, M., & Marcus, S. C. (2009). National patterns in antidepressant medication treatment. *Archives of General Psychiatry, 66,* 848-856. doi: 10.1001/ archgenpsychiatry.2009.81

Papakostas, G. I., Fava, M., & Thase, M. E. (2008). Treatment of SSRI-resistant depression: A meta-analysis comparing within-versus across-class switches. *Biological Psychiatry, 63*, 699–704. Retrieved from http://www.ncbi.nlm. nih.gov/pubmed/17919460

Payne, J. S. (2008). Saints don't cry: Exploring messages surrounding depression and mental health treatment as expressed by African American Pentecostal preachers. *Journal of African American Studies, 12,* 215-228. doi:10.1007/s12111-008-9044-7

Physician. (2009). *Mosby's Medical Dictionary* (8th ed.). Elsevier. Retrieved from http://medical-dictionary.thefreedictionary.com/physician

Primm, A. B., Lima, B. R., & Rowe, C. L. (1996). Cultural and ethnic sensitivity. In W. R. Breakey (Ed.), *Integrated mental health services: Modern community psychiatry* (pp. 146–159). New York: Oxford University Press.

Ravitz, P. (2004). The interpersonal fulcrum-interpersonal therapy for treatment of depression. *Canadian Psychiatric Association Bulletin, 36* (1), 15-19. Retrieved from: http://ww1.cpaapc.org:8080/publications/archives/ bulletin/ 2004/february/ravitz.asp

Robinson, D. S., Gilmor, M. L., Yang, Y., Moonsammy, G., Azzaro, A. J., Oren, D. A., & Campbell, B. J. (2007). Treatment effects of selegiline transdermal system on symptoms of major depressive disorder: A meta-analysis of short-term, placebo-controlled, efficacy trials. *Psychopharmacology Bulletin, 40*, 15–28. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18007565

Ronzio, C. R., Guagliardo, M. F., & Persaud, N. N. (2006). Disparity in location of urban mental service providers. *American Journal of Orthopsychiatry, 76*(1), 37-43. doi:10.1037/0002-9432.76.1.37

Rosselló, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 234-245. doi: 10.1037/1099-9809.14.3.234

Ryan, C. E., Epstein, B. E., Keitner, G., Miller, I. W., & Bishop, D. S. (2005). *Evaluating and treating families: The McMaster approach.* New York: Routledge Taylor Francis Group.

Savitt, T. L. (1982). The use of Blacks for medical experimentation and demonstration in the old South. *Journal of Southern History, 48*(3), 331-348. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11632403

Segraves, R. T., Lee, J., Stevenson, R., Walker, D. J., Wang, W. C., & Dickson, R. A. (2007). Tadalafil for treatment of erectile dysfunction in men on antidepressants. *Journal of Clinical Psychopharmacology, 27*, 62–66. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17224715

Snowden, L., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347-355. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2310083

Stuart, H. (2003). Violence and mental illness: An overview. *World Psychiatry, 2*(2), 121-124. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525086/

Stambach, A., & Becker, N. C. (2006). Finding the old in the new: On race and class in U.S. charter school debates. *Race, Ethnicity and Education, 9*, 159-182. doi: 10.1080/13613320600696730

Stuart, H. (2004). Stigma and work. *Healthcare Papers, 5*(2),100–111. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15829771

Tan, S. (1995). Starting lay counseling ministry. *Christian Counseling Today, 3*(1)*,* 56-57. Retrieved from http://enrichmentjournal.ag.org/199804/092_counseling.cfm

Tan, S. (1994). Lay Counseling: A Christian approach. *Journal of Psychology and Christianity 13*(3), 264-269. Retrieved from http://enrichmentjournal.ag.org/199804/092_counseling.cfm

Tang, A. (1998). The case for lay counseling in the local church. Retrieved from http://www.kairos2.com/case_for_lay_counseling_in_the_l.htm

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work, 45*(1), 73–87. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10634088

Taylor, R. J., Mattis, J., & Chatters, L. M. (1999). Subjective religiosity among African Americans: A synthesis of findings from five national samples. *Journal of Black Psychology, 25,* 524-543. doi: 10.1177/0095798499025004004

Trader-Leigh, K. (2008). Understanding the role of African American churches and clergy in community crisis response. *Joint Center for Political and Economic Studies, Health Policy Institute.* Retrieved from http://www.jointcenter.org/hpi/sites/all/files/UnderstandingRoleofChurches.pdf

U.S. Department of Commerce, U. S. Census Bureau (2010). *State and county quick facts.* Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

U.S. Department of Health and Human Services, National Institutes of Health. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Author. Retrieved from: http://profiles.nlm.nih.gov/ps/access/NNBBJR.ocr

U. S. Department of Health and Human Services, National Institutes of Mental Health. (2001). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44243/

U.S. Department of Health and Human Services, National Institutes of Health. (2008). *Introduction: Mental health medications* (NIH Publication No. 08-3929) Retrieved from: http://nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml

Vassol, E. L. (2005). *African American pastors' perceptions of their congregant's mental health needs* (Doctoral dissertation). Retrieved from DocumBase.com at http://krex.kstate.edu/dspace/bitstream/handle/2097/114/ElvertaVassol2005.pdf?sequence=1

Waldman, S. V., Blumenthal, J. A., Babyak, M. A., Sherwood, A., Sketch, M., Davidson, J., & Watkins, L.L. (2009). Ethnic differences in the treatment of depression in patients with ischemic heart disease. *American Heart Journal, 157*(1), 77-83. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19081400

Wahl, O. F. (1999). Mental health consumer's experience of stigma. *Schizophrenia Bulletin, 25*(3), 467-478. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10478782

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research, 38*(2), 647–673. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12785566

Weissman, M. M. (2006). A brief history of interpersonal psychotherapy. *Psychiatric Annals, 36*(8), 553-557. Retrieved from http://www.psychiatry.wisc.edu/mridepressionstudy/briefhistoryIPT.pdf

Williams, D. R., González, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and non-Hispanic Whites: Results from the National Survey of American Life. *Archives of General Psychiatry, 64*(3), 305-315. Retrieved from: http://archpsyc.jamanetwork.com/article.aspx?articleid=482214

Yalom, I., & Leszcz, M. (5th ed.). (2005). *The theory and practice of group psychotherapy*. New York: Basic Books.

Young, J. L., Griffith, E. H., & Williams, D. R. (2003). The integral role of pastoral counseling by African American clergy in community mental health. *Psychiatric Services, 54*(5), 688-692. Retrieved from http://psychservices.psychiatryonline.org

APPENDIX A: Cover Letter to Participants

Greetings:

My name is Connie C. Gardner and I am a doctoral student at Liberty University, Center for Counseling and Family Studies, located in Lynchburg, VA. I am currently conducting a study for my dissertation about views and attitudes of African American clergy and seminary students regarding depression treatments. Detailed information regarding the study can be found on the Anonymous Survey Information Form found in your packet. This survey is anonymous.

I would greatly appreciate your participation in completing the survey. I am sensitive and respectful to the fact that pastors and other clerics are busy with doing God's work in their church and community. I believe my research can provide insight into the views of African American clergy regarding depression treatments. Therefore, I ask just 25 to 30 minutes of your time. **Pastors, if you are unable to complete the survey, would you please ask another member of the clergy on your staff to complete the survey. I have enclosed 5 surveys for churches blessed by God to have several members of clergy.   I would like to be blessed with their responses as well.** Surveys must be completed by a member of the clergy for results to have validity. Your response is very important because it will increase the value of my study and research in the field of counseling.

This survey packet includes the survey, a self-addressed return envelope, and also a web address in case you prefer to complete the survey online. Before entering the survey website, you will be asked to give your consent to participate in the study. **The web address for access to the online version of the survey is:** http://www.surveymonkey.com/s/gardner6370**.** The survey will take approximately 30 minutes to complete. **PLEASE COMPLETE ONLINE OR RETURN SURVEYS ON OR BEFORE <u>APRIL 9, 2012.</u>**

If you have any questions or concerns about the study, please do not hesitate to contact me, Connie Gardner, at (804) 445-8020 or clcarter2@liberty.edu. If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Institutional Review Board, Dr. Fernando Garzon, Chair, 1971 University Blvd, Suite 1582, Lynchburg, VA 24502 or email at fgarzon@liberty.edu.

Thank you for your consideration, attention, and time.

Respectfully,

Connie C. Gardner, MS, LPC, LSATP

Stigma and the Acceptability of Depression Treatments among

African American Clergy

You are invited to participate in a research study conducted by Connie C.
Gardner, who is a doctoral student from the Center for Counseling and Family Studies at
Liberty University. Mrs. Gardner is conducting this study for her doctoral dissertation.
Your participation in this study is entirely voluntary. You should read the information
below and ask questions about anything you do not understand, before agreeing to
participate. You are being asked to participate in this study because you are a member of
the clergy or are currently or have been enrolled as a seminary student.

Background Information

The purpose of this study is to investigate how attitudes and beliefs can influence
the selection of mental health counseling, pastoral/lay counseling, and prescription
medication when referring members of their congregation for treatment of depression.
This study's goal is to answer the following questions:

1. Is there a connection between attitudes and beliefs and the selection of a
depression treatments (mental health counseling, prescription medication,
pastoral/lay counseling)?

2. What are the selection or acceptability rates or percentages for prescription
medication, mental health counseling, and pastoral/lay counseling?

3. Do attitudes change if family, friends, employers or community are aware of an individual's choice or selection of a specific depression treatment (mental health counseling, pastoral/spiritual counseling and prescription medication).

Procedures

This anonymous survey takes approximately 30 minutes to complete. You will not be asked to give your name. Your participation will involve:

- Completing one brief questionnaire designed to measure attitudes and beliefs regarding medication, mental health counseling and pastoral/lay counseling.

- Completing four brief questionnaires designed to measure the acceptance of medication, mental health counseling and pastoral/lay counseling when making a referral to a member of the congregation.

- Completing a questionnaire asking general questions regarding age, gender, race, marital status, education, household income, state of residence, and years in the ministry.

- Questionnaires may be completed on receipt of questionnaire packet or questionnaires can be returned by mail with the stamped self-addressed envelope provided in the packet within 5 days.

- Participants will not be asked to complete follow up questionnaires at a later date.

Risks and Benefits

The risks in this study are no more than you would encounter in everyday life. However, participation in this research may lead to increased self- awareness or a general awareness of depression or related topics that may result in some minor discomfort. If

you begin to feel uncomfortable, you may withdraw from this study at any time. A list of mental health agencies is provided.

Participation in this study may not benefit you directly. However, the knowledge that we obtain from your participation, and the participation of other volunteers, may help us understand more clearly the attitudes, beliefs, and thoughts African American clergy and seminary students have regarding a variety of treatment options for depression.

Confidentiality

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. This means that I will not record your name, address, phone number, date of birth, etc.

Contacts and Questions

If you have questions, contact Dr. Gardner at clcarter2@liberty.edu. You may contact the Institutional Review Board, Dr. Fernando Garzon, Chair, 1971 University Blvd, Suite 1582, Lynchburg, VA 24502 or email at fgarzon@liberty.edu.

Read Scenario and Respond to Items A through D.

Treatment Specific Stigma

For the past 2 months, you have been feeling down and have lost interest in many of your normal activities. You no longer want to go out with to visit the sick in the hospitals or in their homes and attending weekly bible study and other church activities have become difficult because you feel a loss of energy. Lately you have had difficulty sleeping and have been worried about a change in your weight. Your doctor has examined and tested you thoroughly and has made a diagnosis of depression(Givens et al).

Complete EACH Section (A through D) by responding YES or NO to each item.

A) If I were seeing a psychiatrist and taking medication for depression,

	YES	NO
I would feel ashamed	◯	◯
I would feel comfortable telling friends and family	◯	◯
I would feel okay if people in the community (church, school, etc) knew about my treatment	◯	◯
I would want people at work to know about my depression treatment	◯	◯

B) If I were receiving counseling from another Pastor or clergy who had experience dealing with depression issues,

	YES	NO
I would feel ashamed	◯	◯
I would feel comfortable telling friends and family	◯	◯
I would feel okay if people in the community (church, school, etc) knew about my treatment	◯	◯
I would want people at work to know about my depression treatment	◯	◯

C) If I were seeing a Christian mental health professional (psychologist, licensed professional counselor, marriage & family therapist, social worker)

	YES	NO
I would feel ashamed	◯	◯
I would feel comfortable telling friends and family	◯	◯
I would feel okay if people in the community (church, school, etc) knew about my treatment	◯	◯
I would want people at work to know about my depression treatment	◯	◯

D) If I were seeing a secular (i.e., not identified as Christian) mental health professional (e.g., psychologist, licensed professional counselor, marriage & family therapist, social worker)

	YES	NO
I would feel ashamed	◯	◯
I would feel comfortable telling friends and family	◯	◯
I would feel okay if people in the community (church, school, etc) knew about my treatment	◯	◯
I would want people at work to know about my depression treatment	◯	◯

Derived from Givens et al.(2007)

[   ]

SCENARIO A

Ms. Elizabeth, 80 year old widowed woman who has been a member of the congregation for the past 30 years has requested to speak with you after church service. After greetings, Ms Elizabeth tells you she has lost 20 pounds in the past 2 months because she does not feel like eating and she sleeps most of the day and into the evening. She tells you she has nothing to wake up for any more since her husband died and her children do not visit regularly. She tells you she feels sad all the time and she has considered ending her life. She tells you her medical doctor did not find anything physically wrong with her. She wants your advice on what she should do.

On a scale of 1-5, with 5 being "Highly Likely" and 1 being "Highly Unlikely", please rate the likelihood that you would refer this congregation member for one of the following services. You may use the same rating for more than one item. For example, you can rate 5 (Highly Likely) for item 1 and item 2 if that is your preference.

What is the likelihood that you would refer this congregational member for...

	Highly Unlikely	Unlikely	Neutral	Likely	Highly Likely
1. Pastoral counseling or counseling by another congregation member who dealt with a similar problem	◯	◯	◯	◯	◯
2. Consultation with a licensed nutritionist	◯	◯	◯	◯	◯
3. Counseling with Christian mental health professional(psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	◯	◯	◯	◯	◯
4. Counseling with a secular mental health professional (psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	◯	◯	◯	◯	◯
5. Medication evaluation by a psychiatrist	◯	◯	◯	◯	◯
6. Consultation with a physician	◯	◯	◯	◯	◯
7. Participation/increased attendance in a church Bible study	◯	◯	◯	◯	◯
8. Participation/increased attendance in prayer & praise services	◯	◯	◯	◯	◯

Other (please specify)

SCENARIO B

Chris, 16 year old single male comes to the Altar during the call for discipleship. Chris requests prayer and a meeting with you after service. Chris tells you he used to play sports everyday and teach children at the youth center to play basketball after school but for the past 2 months he stays in the house after work because he has no energy and no interest in playing or teaching sports. He tells you he is unable to concentrate at school. Chris tells you he has gained 30 pounds in the past 2 months because he is unable to sleep so he eats most of the night. He tells you he had a physical 1 month ago for after school sports requirement and medically he is healthy. He thinks he is depressed and would like to know what you think he should do.

On a scale of 1-5, with 5 being "Highly Likely" and 1 being "Highly Unlikely", please rate the likelihood that you would refer this congregation member for the following. You may use the same rating for more than one item. For example, you can rate 5 (Highly Likely) for item 1 and item 2 if that is your preference.

What is the likelihood that you would refer this congregational member for...

	Highly Unlikely	Unlikely	Neutral	Likely	Highly Likely
1. Pastoral counseling or counseling by another congregation member who dealt with a similar problem	◯	◯	◯	◯	◯
2. Consultation with a licensed nutritionist	◯	◯	◯	◯	◯
3. Counseling with Christian mental health professional(psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	◯	◯	◯	◯	◯
4. Counseling with a secular mental health professional (psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	◯	◯	◯	◯	◯
5. Medication evaluation by a psychiatrist	◯	◯	◯	◯	◯
6. Consultation with a physician	◯	◯	◯	◯	◯
7. Participation/increased attendance in a church Bible study	◯	◯	◯	◯	◯
8. Participation/increased attendance in prayer & praise services	◯	◯	◯	◯	◯

Other (please specify)

[   ]

SCENARIO C

John, 40 year old single man who has been a member of your congregation for 10 years comes to your office after service and asks to speak with you. John tells you for the past 2 months, he has been feeling down and has lost interest in many of his normal activities. He no longer wants to participate in single ministry or usual family and friend activities. John tells you his energy is low and he is having difficulty sleeping. John tells you his doctor completed a physical and blood work which was normal but his doctor has given him a diagnosis of depression. John wants to know what you think he should do.

On a scale of 1-5, with 5 being "Highly Likely" and 1 being "Highly Unlikely", please rate the likelihood that you would refer this congregation member for the following. You may use the same rating for more than one item. For example, you can rate 5 (Highly Likely) for item 1 and item 2 if that is your preference.

What is the likelihood that you would refer this congregational member for...

	Highly Unlikely	Unlikely	Neutral	Likely	Highly Likely
1. Pastoral counseling or counseling by another congregation member who dealt with a similar problem	○	○	○	○	○
2. Consultation with a licensed nutritionist	○	○	○	○	○
3. Counseling with Christian mental health professional(psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	○	○	○	○	○
4. Counseling with a secular mental health professional (psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	○	○	○	○	○
5. Medication evaluation by a psychiatrist	○	○	○	○	○
6. Consultation with a physician	○	○	○	○	○
7. Participation/increased attendance in a church Bible study	○	○	○	○	○
8. Participation/increased attendance in prayer & praise services	○	○	○	○	○

Other (please specify)

[   ]

SCENARIO D

Sarah, 40 year old married woman who has been a member of your congregation for 10 years comes to your office after service. Sarah tells you she is feeling depressed and she reports lately she is becoming more irritable with her husband and children. She tells you she cannot concentrate at work, her energy is low, and her spiritual life is very dry. She feels worthless and guilty because she is not caring for her children and husband like she once did. Sarah thinks she may be suffering from depression and would like your advice on what she should do.

On a scale of 1-5, with 5 being "Highly Likely" and 1 being "Highly Unlikely", please rate the likelihood that you would refer this congregation member for the following. You may use the same rating for more than one item. For example, you can rate 5 (Highly Likely) for item 1 and item 2 if that is your preference.

What is the likelihood that you would refer this congregational member for...

	Highly Unlikely	Unlikely	Neutral	Likely	Highly Likely
1. Pastoral counseling or counseling by another congregation member who dealt with a similar problem	○	○	○	○	○
2. Consultation with a licensed nutritionist	○	○	○	○	○
3. Counseling with Christian mental health professional(psychologist, licensed professional counselor, marriage & family therapist, socialworker, etc)	○	○	○	○	○
4. Counseling with a secular mental health professional (psychologist, licensed professional counselor, marriage & family therapist, social worker, etc)	○	○	○	○	○
5. Medication evaluation by a psychiatrist	○	○	○	○	○
6. Consultation with a physician	○	○	○	○	○
7. Participation/increased attendance in a church Bible study	○	○	○	○	○
8. Participation/increased attendance in prayer & praise services	○	○	○	○	○

Other (please specify)

[   ]

Demographic Information / Participant Characteristics

What is your age?

☐ 18-25   ☐ 26-29   ☐ 30-39   ☐ 40-49   ☐ 50-59   ☐ 60 or Older

What is your gender?

◯ Male

◯ Female

How do you classify yourself?

☐ Black/African American

☐ White/ Caucasian

☐ Hispanic/Latino

☐ Arab/Middle Eastern

☐ Asian/ Pacific Islander

☐ Multiracial

Other (please specify)

[   ]

What is your current marital status?

☐ Married

☐ Single

☐ Divorced

☐ Separated

☐ Widowed

☐ Living with Partner

112

What is the highest level of education you have completed?

☐ Grammar School

☐ High School or Equivalent

☐ Vocation/ Technical School

☐ Some College

☐ Associate Degree

☐ Bachelor's Degree

☐ Masters Degree

☐ Doctoral Degree

Other (please specify)

[   ]

Which of the following best describes the area you live in?

☐ Urban (city population over 90,000)

☐ Suburban (city/town population between 6,000-89,000)

☐ Rural (town population below 6,000)

Which of the following best describes the area you attend church?

☐ Urban (city population over 90,000)

☐ Suburban (city/town population between 6,000-89,000)

☐ Rural (town population below 6,000)

How often do you refer parishioners, members of your congregation, or others for mental health counseling?

☐ None in the past 2 years

☐ 1-5 times past 2 years

☐ 6-10 times past 2 years,

☐ 11-15 times past 2 years

☐ over 15 times past 2 years

☐ Never

Other (please specify)

[   ]

113

How often do you refer parishioners, members of your congregation, or others for pastoral or counseling by another church member (lay counseling)?

- [ ] None in the past 2 years
- [ ] 1-5 times past 2 years
- [ ] 6-10 times past 2 years
- [ ] 11-15 times past 2 years
- [ ] over 15 times past 2 years
- [ ] Never

How often do you recommend parishioners, members of your congregation, or others to seek medication for treatment of depression?

- [ ] None in the past 2 years
- [ ] 1-5 times past 2 years
- [ ] 6-10 times past 2 years
- [ ] 11-15 times past 2 years
- [ ] over 15 times past 2 years
- [ ] Never

Have you ever received mental health counseling?

- [ ] YES
- [ ] NO

Have you ever received counseling from another member of the clergy?

- [ ] YES
- [ ] NO

Have you ever been prescribed medication for depression?

- [ ] YES
- [ ] NO

Number of years in the ministry:

- [ ] less than 12 months
- [ ] 1-5 years
- [ ] 5-10 years
- [ ] 10-15 years
- [ ] 15-20 years
- [ ] over 20 years.

114