A PHENOMENOLOGICAL STUDY OF AFRICAN-AMERICAN CLERGYS' EXPERIENCES WITH MENTAL HEALTH

by

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Abstract

The purpose of this hermeneutical phenomenological qualitative study was to describe African-American clergy's lived experiences with mental health and mental health's influence on the construction of their teachings, sermons, and church practice. The goal was to use interpretation to bring to light to an underlying coherence of actions of a group of people. This study reduced individual African-American clergy beliefs regarding mental health to a universal understanding. There were four philosophical assumptions in this study: 1) a search for wisdom to understand the phenomenon of African-American clergy's lived experiences with mental health influence their teachings, sermons, and church practice, 2) no judgments about reality of mental health to African-American clergy was formed until the data was analyzed, 3) African-American clergy bring both subjective and objective experiences as part of their lived experiences, and 4) the reality of African-American clergy was only perceived within the meaning of their individual experiences. The two research questions formulated that guided this study included (1) How do African-American clergy perceive their experiences with parishioners' mental health? (2) How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices? The theory guiding this study was social constructivism because culture and context is important in understanding what occurs in society yielding the ability to construct knowledge. Data collection consisted of six semi-structured interviews with senior pastors of African-American churches. Findings showed all the participants shared common experiences with four of the six particpants being recipient of professional MH services. All participants acknowledged a stigma existed in the African-American church regarding mental health and they felt it was important as pastors to help dispel this stigma. All participants reported they integrated mental health and life application into their sermons and bible teachings.

Keywords: African-American church, clergy, parishioners, mental health illness, mental health stigma, mental health professionals, contingency values, core values

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Dedication

I give all praise, honor, and glory unto God for the grace and favor he has shown me on this doctoral journey and completion. I thank God for blessing me with the insight, wisdom, and joy of learning. I am grateful for my family and friends for their support. I dedicate this doctoral work to all my "*Wings Babies*", nieces, nephews, and any young person who God has allowed me to impart on this journey. Know that with God all things are possible and there is no God given desire in your life that cannot be fulfilled.

I thank all the participants who shared their lived experiences with me and being a vessel of God on this earth to impact so many lives positively. Finally, I want to thank Dr. Kirk who began this journey with from Spring 2021-Fall 2022. Your unwavering commitment, passion, and support allowed me to get to this point. You held me accountable and without you I would have never made it to the dissertation proposal stage. Even after you were no longer on my committee you were hands-on ensuring the IRB transistion from you to Dr. Warren was accomplished.

Lastly, Romans 4:17 (b) "calleth those things which are not, as though they were", I dedicate this to those who called me Dr. Smith and believed in me years before I even fathom earning a doctoral degree. God is El Shaddai and I will forever be mindful of this scripture: "Give thanks unto the Lord, call upon his name, make known his deeds among the people. Sing unto him, sing psalms unto him, talk ye of all his wondrous works (I Chronicles 16:8-9).

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Institutional Review Board (IRB)

Mental Health (MH)

Research Question (RQ)

CHAPTER ONE: INTRODUCTION

Overview

There is a racial/ethnic disparity in utilization of help-seeking professionals in the United States (Taylor & Kuo, 2019). Mental illness affects everyone; however African-Americans use mental health services less than other racial ethnic groups (Cummings & Druss, 2011). Current data shows the disparity may be caused by psychological, cultural, socioeconomic, and other systematic factors (Cummings & Drus, 2011; Substance Abuse and Mental Health Services Administration, 2015). According to Conner et al. (2010) African-Americans are exposed to a "double stigma," a stigmatization which occurs when a person experiences prejudice and discrimination from having a mental illness as well as being a member of a racial or ethnic or minority group.

In addition to being a member of a racial or ethnic group, African-American's often suffer internalized stigma attributed to their culture. Traditionally, the Sunday morning African-American worship experience serves as cathartic and therapeutic, as the church environment is seen as a place of empowerment, healing, and rejoicing through dancing and singing. The pandemic of Covid-19 prohibited many African-American churches from face-to-face weekly corporate worship (DeSouza, et al., 2021) and reports of the higher death rate increased mental stress for the African-American population (DeSouza, et al.,2021). For the first time in many people lives there was no opportunity to meet with other believers to experience this cathartic experience and corporate empowerment. According to DeSouza, et al. (2020), many churches have re-opened; however, the daily operations of many churches have been permanently affected and could possibly negatively impact the mental health of African-Americans. Research on African-American clergy and their perspectives, beliefs, and practices regarding mental health is essential to decreasing the racial/ethnic disparity in mental health utilization between African-Americans and other racial groups. Additional research may lead to increased help-seeking behavior and increased treatment outcomes.

The focus of this phenomenological study was to describe the lived experiences of African-American clergy in the Southeast United States regarding their perceptions of mental health. The phenomenon of this study was understanding how African-American clergy's lived experiences with mental health influence their teachings, sermons, and church practices. This chapter consists of the overview, background, and the identification of the gap in literature. This chapter also describes the research topic, including historical, theoretical, and collective consciousness applications and situation to self. The study's problem statement, purpose statement, significance, research questions, and definitions complete the chapter. The following research questions guided this study:

RQ1: How do African-American clergy perceive their experiences with parishioner's mental health?

RQ2: How do African-American clergy interpret the lived experiences of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Historical Background

Historically and traditionally, the African-American church has functioned as the institution that provides African-Americans with a venue to meet their social, religious, spiritual, and communal needs. Samter, Morse and Whaley (2013) examined the religious beliefs of members of the four largest ethnic groups in the United States, Caucasians, African-Americans, Hispanic-Americans, and Asian- Americans. African-Americans were found to score highest on such items as ‘‘your religious faith is very important in your life’’ and ‘‘the single, most important purpose of your life is to love God with all your heart, mind, strength and soul.’’ (p. 175). Compared to the other three ethnic groups, African-Americans also emerged as the most likely to engage in each of five church-related activities during a typical week (attending church services, participating in a small group, attending a Sunday school class, praying, and reading the Bible), and to have made a personal commitment to Jesus Christ.

African-American churchgoers' experiences in the African-American church instill a wealth of values that are acquired and embraced, and these beliefs may have an impact on their decision to seek out mental health treatments and participate in counseling (Plunkett, 2014). African-American churches serve as the center of the Black community's religious life, giving African-Americans a safe place to practice their religion and find ways to deal with marginalization, stress in daily life, and social injustices. Although they are frequently untrained to offer mental health counseling, pastors and other clergy members may try to address mental health concerns from a pastoral, spiritual, or religious standpoint (Plunkett, 2014).

African American pastors should receive support for the social and psychological problems of their worshipers, regardless of their training, education, or previous experience with mental health problems (Avent et al., 2015). African Americans report that 50% of their mental health needs are met by pastors, who are the only source of support (Hankerson et al, 2013). Without understanding how the brain works or the psychology behind depression, pastors base their counsel on faith alone, using prayer, the Bible, and meditation. Only medical practices are important to God (Anthony et al., 2016). African American pastors who do not understand their own mental health and its impact on their congregations often mistakenly lead parishioners to believe that prayer is their only option (White, 2016).

Limited knowledge of mental health and inaccurate perceptions have led to African-American clergy referring parishioners to a general physician rather than a mental health professional (Stansbury & Schumacher, 2008). African-American college students report sermons from their pastors preached more on physical health issues than mental health issues (Avent-Harris & Wong, 2018). Spiritual coping resources were provided by clergy to parishioners in order to address any mention of mental health issues. Likewise, spiritual reasons were given as the cause of mental health issues. Avent-Harris and Wong's (2018) study also explored the stigma associated with African-Americans seeking mental health professionals. Throughout the study students shared that seeking help outside of the church could offend family

members. The students in the Avent-Harris and Wong (2018) study attributed the stigma to the historical oppression of African-Americans and the lack of access and resources. The findings of this study asserted that African-American undergraduate students prefer to utilize their church family or biological family for support rather than professional mental health professionals. This study reinforced previous studies that indicated that family pressure is a deterrent to treatment (Barksdale & Molock, 2009; Kane & Green, 2009).

Theoretical

There are two schools of thought regarding the place of mental health counseling in the African-American church. The first school of thought derives from the notion that the cure or mechanisms for dealing with mental health issues are a direct result of divine intervention from God (Plunkett, 2014). The notion that God (Jesus) directly heals is rooted in the biblical understanding that God intervenes in people's lives (Cook & Wiley, 2000). Biblical precepts highlight deific involvement when seeking relief from issues involving pain and suffering. For many, the religious practice of prayer, exhibition of faith, and God's mercy lead them to believe traditional counseling is unnecessary and that God will “fix it.” Other Black American churchgoers believe their religious beliefs and values would be unattended to if they engaged in traditional counseling; thus, they prefer to seek help from within the church (Cook & Wiley, 2000).

The second school of thought concerning pain and suffering is that God will provide those afflicted with mental illness with someone to work on his behalf in the form of a mental health professional . James 5:14-16 supports this school of thought, “Is any sick among you? let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord: And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he have committed sins, they shall be forgiven him. Confess your faults one to another, and pray one for another, that ye may be healed. The effectual fervent prayer of a righteous man

availeth much." (KJV, 1988). This implies that God will provide an indirect and intercessory means for the healing process to occur (Cook and Wiley, 2000).

Though there are two theoretical schools of thought regarding the place of mental health counseling in the African-American church, society, and the meaning of the African-American church still exert a powerful force on each individual in the culture. These shared norms, beliefs, and values become a shared way of understanding and behaving in the world, and together have been termed *the collective consciousness* of a culture, which is formed through social interactions (Durkeim, 2020).

Collective Consciousness

Not all African-Americans agree with one or either school of thought; however, all African-American church goers have core values that keep them in harmony with God and the contingent values that reflect their church's views (Cook and Wiley, 2000). Core values of love, inclusiveness, justice, and freedom help define African-Americans worldview expressed through songs, prayers, and testimonies. These values shape African-Americans views on healing and relief from mental illness (Douglas & Hopson, 2000/2001). Contingent values, on the other hand, differ among African-American churches due mostly to the message from the pulpit. One clergy may encourage professional mental health counseling while another one does not, which will affect how parishioners view mental health counseling (Plunkett, 2014).

Research continues to indicate that African-Americans are less likely to seek mental health professionals compared to Caucasians (Barksdale & Molock, 2009). Internalized stigma and public stigma of mental health illness and treatment have been identified as the primary deterrents to treatment (Barksdale & Molock, 2009). Previous research has focused on the barriers to African-Americans utilizing help seeking professionals. These barriers include the key function of the African-American church in African-American culture, and the leadership role of the clergy which impacts the social, cultural, financial, and health decisions of parishioners. This study will bring more awareness to the phenomena of African-American clergy's understanding

and approach to mental health. Implications of this study could influence the collaboration with, and value of, the need for mental health professional care among parishioners.

Situation to Self

As a licensed minister in the African-American Church my experience corroborates the assertions of Anthony et al. (2015), namely that African-Americans are taught to lean on God, and clergy are their source of support when disconnected and in need of a word from God concerning their problems in life. I know less than 5 professed Christians who have openly sought mental health services beyond marriage counseling which reinforced my belief that African-American Christians rarely seek outside mental health services.

The bias I had to be aware of was my belief that in addition to having a spiritual counselor, Christians also need professional mental health counseling to address certain issues. I am a member of a church in which the Senior Pastor champions the utilization of mental health professionals and often includes me in his Pastoral counseling with parishioners; therefore, I was mindful of that bias. I recognize my own background will shape my interpretation based upon my personal, cultural, and historical experiences.

Problem Statement

Lukachko et al. (2015) provided evidence that the importance of religion and the degree of religiosity is associated with decreased use of professional mental health counseling for African-Americans. African Americans who said religion was very important in their lives were less likely to use professional mental health services compared to African Americans who wre not stongly religious. Additionally, African-Americans with personal problems are more likely to seek help from ministers than from family doctors, psychiatrists, or other mental health professionals (Lukachko et al., 2015). This cultural group reports 50% of their mental health needs are met by their clergy as their only source of support (Hankerson et. al, 2013). African-American clergy are highly respected in the church and viewed as messengers of God's Word; thereby,

they are very influential in the community (Quinn & Dickson-Gomez, 2016). They are relied on for assistance with the social and psychological problems of their parishioners regardless of their educational background, knowledge of mental health issues, or previous experience (Avent et al., 2015). African-American clergy are exposed to the same types and severity of psychiatric disorders as mental health practitioners but less than half have clinical pastoral counseling training (Anthony et al.,2015).

Historically, in the African-American church, pastors have been regarded as having a direct and divine connection to God, thus making their pronouncements seem like divine revelation (Plunkett, 2014). Therefore, in many African-American churches, declarations from the pulpit are treated as the "gospel," meaning if the pastor proclaims it, then it must be God-inspired, important, true, and worthy of taking heed (Plunkett, 2014). When these proclamations are made in reference to mental health, they influence the development of contingent values pertaining to mental health. Contingent values represent the dogma of a church and vary by denomination. A church's views on singing or listening to secular music or the role of women in the ministry are examples of contingency values (Douglas & Hopson, 2001). Thus, pastors' core and contingent values have a heavy influence on the mental health help-seeking attitudes of Black American churchgoers. The problem is there is little research on how African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices (Plunkett, 2014). This study will address this gap in the literature.

Purpose Statement

The purpose of this hermeneutical phenomenological study was to describe how the lived experiences of African-American clergy's lived experiences with mental health influence their teachings, sermons, and church practices.. A hermeneutical phenomenological study describes the common meaning for a group of people based on their lived experiences and interpretation of the texts of life, leading to an underlying coherence of actions for this group of people (Creswell

and Poth, 2018). This current study reduces individual African-American clergy beliefs regarding mental health to a universal context to better understand how their perceptions, attitudes, and beliefs regarding mental health influence their practices as a clergyman or clergywoman. There are four philosophical assumptions in this study: 1) a search for wisdom in gaining insight into African-American clergy's understandings and perceptions of mental health, 2) there were no judgments about the reality of mental health to African-American clergy until the data was analyzed, 3) African-American clergy bring both subjective and objective experiences as part of their lived experiences, and 4) the reality of African-American clergy was only perceived within the meaning of their individual experiences (Creswell and Poth, 2018). The theory guiding this study was social constructivism, in that culture and context is important in understanding what occurs in society and constructing knowledge based on this understanding (Creswell and Poth, 2018). The African-American culture is rich with tradition, and social constructivism underpins African-American clergy's influence among their parishioners.

Significance of the Study

The intertwinement of religiosity, race, ethnicity, Christianity, and strong family ties can result in difficulties addressing the specific mental health needs of African-Americans (Millett et al., 2018). This study will expand the research which focuses on African-American Christians in context with other ethnic groups to better understand the phenomena of mental health practices in the African-American church. Specifically, this study will bring more awareness to the phenomena of African-American clergy's understanding and approach to mental health, which could influence the collaboration with, and value of, the need for mental health among parishioners.

Research Questions

The two research questions formulated for this qualitative study were:

RQ1: How do African-American clergy perceive their experiences with parishioners mental health?

RQ2: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Definitions of Terms

The following terms were used in this study:

1. *African-American Church:* the primordial institution that has taken on the responsibility of attending to the educational, social, economic, psychological, religious, and spiritual welfare of Black Americans (Boyd-Franklin, 2003; Cook & Wiley, 2000; Taylor, et al., 2000).
2. *Clergy*: pastors in the black church who are influential in forming the social, moral, and ethical values of the church (Plunkett, 2009).
3. *Contingency values*: values that are contextually dependent upon and derived from how the church deals with everyday problems and the tools or techniques used to survive and thrive as a church community (Douglas & Hopson, 2001).
4. *Core Values*: values that indicate what the church stands for and believes in. These values originated in the African-American church to challenge any ideas that God sanctioned slavery. They include "love, inclusiveness, justice, freedom, and equality (Douglas & Hopson, p. 101, 2000/2001).
5. *Mental health illness*: psychological and psychiatric problems (Taylor and Kuo, 2019)
6. *Mental Health Professional*: a person who has completed a degree in counseling, psychology, or social work and is licensed to provide mental health services (Plunkett, 2014).

7. *Parishioners*: Black American churchgoers (Plunkett, 2014). Their lives and worldview are influenced by the church community in which they belong (Lincoln & Mamiya, 1990; Taylor & Chatters, 2010).
8. *Mental Illness Stigma:* refers to a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn 1999).

Summary

The purpose of this hermeneutical phenomenological qualitative study was to describe African-American clergy's lived experiences with mental health and mental health's influence on the construction of their teachings, sermons, and church practice. There is a racial/ethnic disparity in utilization of help-seeking professionals in the United States (Taylor and Kuo, 2019). Core values of love, inclusiveness, justice, and freedom help define African-Americans worldview expressed through songs, prayers, and testimonies which shape African-Americans views on healing and relief from mental illness (Douglas & Hopson, 2001). Contingent values, on the other hand, differ among African-American churches due mostly to the message from the pulpit by clergy. There is a gap in research regarding how the beliefs and values of mental health held by African-American clergy are perceived in the church community, and how clergy's perceptions influence how mental health is communicated through sermons, teachings, and church practices of referring parishioners for professional mental health help (Plunkett, 2014).

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter includes a review of literature regarding mental health stigma in cultures, religious groups, and African-American Christians, as well as the theoretical framework that relates to the experiences of African-American clergy in the southeastern United States. Historically and traditionally, the African-American church has functioned as the institution that provides African-Americans with a venue to meet their social, religious, spiritual, and communal needs (Plunkett, 2014). African-American religious tradition is saturated with values that are learned and embraced because of experience in the African-American church, and these values may influence whether African-American churchgoers seek out mental health services and engage in the counseling process (Plunkett, 2014). The United States Department of Health and Human Services (2017) report only one third of diagnosed African-Americans seek professional mental health services.

In the African-American church, pastors are regarded as having a direct and divine connection to God, thus making their pronouncements divine revelation. Therefore, in many African-American churches, declarations from the pulpit are treated as the "gospel," meaning if the pastor proclaims it, then it must be God-inspired, important, true, and worthy of taking heed (Plunkett, 2014). When these proclamations are made in reference to mental health, they influence the development of contingent values pertaining to mental health. Thus, pastors' core and contingent values have a heavy influence on the mental health help-seeking attitudes of Black American churchgoers (Plunkett, 2014).

Theoretical Framework

Interpretative frameworks in qualitative research are based on examining how individuals make meaning of their lived experiences (Pietkiewicz & Smith, 2017). The goal of interpretative frameworks is to seek an understanding of the world evidenced by the problem statement and the

research questions that are implemented to explore conditions which disadvantage or exclude cultures (Martin Heidegger, 1962). Another factor of interpretative frameworks is a researchers focus and receptiveness to multiple perspectives from participants which is guided by ethical practices to disclose bias and subjectivity related to the study (Creswell & Poth, 2018). Creswell and Poth (2018) acknowledged nine interpretive frameworks: 1) Postpositivism, 2) Disability theories, 3) Transformative frameworks, 4) Postmodern perspectives, 5) Pragmatism, 6) Feminist theories, 7) Critical theory and critical race theory, 8) Queer theory, and 9) Social Constructivism.

Social Constructivism

Social constructivism evolved from Vygotsky's sociohistorical approach to cognitive development (Hausfather, 1996). Vgotsky was a social scientist whose studies focused on how people learn in any given situation when influenced by psychology, gestaltism, linguistics and enculturation (Vgotsky, 1933; Vgotsky, 1978). Social constructivism was the interpretative framework guiding this study with the goal of interpreting how African-American clergy view mental health and how this view influences the construction of biblical teachings. Social constructivism will allow the use of open-ended questions to inductively generate a theory or pattern of meaning (Creswell & Poth, 2018). Social Constructivists believe that reality is constructed through human activity (Kukla, 2000). Knowledge is socially and culturally constructed through people interacting with each other in the environment in which they live (Ernest, 1999; Gredler, 1997; Prawat & Floden, 1994). By engaging in social activities people create meaning for their individual beliefs (McMahon, 1997).

As social constructivism asserts, the African-American church is heavily influenced by American's rejection of their slave master's version of Christianity (Douglas & Hopson, 2001). The culture of the African-American church in America was shaped by the slavery which reigned during the years of 1812-1861 known as the Antebellum period (Douglas & Hopson, 2001). The African-American church is the social center of African-American lives and serves

more functions than only meeting religious and spiritual needs of the parishioners (Douglas & Hopson, 2001). The African-American church has historically been the place where local and national black leaders developed their leadership skills (Douglas & Hopson 2001). Socially, during the time of slavery and racism oppression, the African-American church is attributed to the development of most forms of black music, drama, and literature as it allowed for the nurturing and displaying of these talents by its' parishioners (Douglas & Hopson, 2001). Likewise, Vygostky (1978) rejected the notion that learning is separate from social context, and the rich culture, beliefs, and values of the African-American church are inextricably linked to a broader social context.

Currently, the African-American church attends to the psychological, educational, social, economic, religious, and spiritual welfare of its parishioners (Boyd-Franklin, 2003; Cook & Wiley, 2000; Taylor et al., 2000). Therefore, culture is still one of the essential aspects of the African-American Church (Avent-Harris & Wong, 2018). Church members are often referred to as church family and play a vital role in biological families. They not only pray for each other but identities are often shaped by the African-American church family (Avent-Harris & Wong, 2018). According to Avent-Harris and Wong (2018), the actual worship style in an African-American church is viewed as a significant part of the foundation of the church. In addition, the church is considered the primary coping resource with specific ministries created within the church to address the needs of parishioners.

As social constructivism theory asserts, a culture group is an active participant in the creation of the knowledge and experiences (Vygotsky, 1978). Likewise in the African-American church, parishioners' knowledge regarding the worldview is created by their experiences within their church. The culture created by the African-American church provides a sociocultural environment which allows for the transference of attitudes and beliefs about issues. This aligns with the social constructivism assumption that individuals interact with one another in social settings to socially make meaning of their experiences (Vygotsky, 1978). Culture also affects the

interpretation and timing of symptoms of mental health as well as the onset of illness and how individuals and communities respond to mental health (Carpenter-Song et al., 2011). Thus, the African-American clergy have an important role in delivering information about mental health care and issues (Aaron et al. 2003; Author, 2008). The following sections outline the related literature supporting Vygotsky's framework of social constructivism in the African-American church. The overarching social influence, alongside the premise that the individuals in the church collectively make meaning of their experiences, are viewed on a larger scale.

Related Literature

Background of Christianity and Psychology

The church and applied psychology both purport to alleviate human suffering, address social problems, and promote the prospering of humanity (Hodge et al., 2020). Despite the commonalities of goals, the relationship between psychology and the church has historically been antagonistic. Before the 20th century, applied psychology operated with little consideration of religion and spirituality due to being heavily influenced by John Watson, B.F. Skinner, Albert Ellis, and Sigmund Freud. According to Watson, science could explain human affairs and people could move forward without being burdened with older generations views of moral or religious absolutes (Watson, 1925). B.F. Skinner asserted he became a behaviorist to resolve his early fear of theological ghosts (Skinner, 1967). According to Freud (1927) religious doctrine would fail to answer life's problems because religion contradicted reason. Ellis asserted that the less religious people are the more emotionally healthy they are (Ellis, 1980). These psychologists exhibited disdain for integrating religion or spirituality into either professional psychological research or clinical practice noting that integration weakened the scientific work (Plante, 2019). Heavily influenced by Freud, mentally ill individuals were looked upon harshly. Likewise, mental health professionals negatively viewed religion as pathological or old-fashioned (Papaleontiou-Louca, 2021).

In 1902 William James was one of the first psychologists to present a positive approach to reflecting on the religious experience through his understanding of the psychology of human behavior (Plante, 2019). This led to a shift in the mindset of psychologists due to research documenting religion and spirituality as positive components in physical and mental health. Furthermore, research provided evidence supporting the integration of religion and spirituality which produced greater outcomes in treatment. However, the same mindset shift has yet to be paralleled in the church as religious leaders identify barriers to integrating psychological science into ministry (Hodge, et al., 2020).

The church traditionally and currently is known for caring for the emotional, relational, and spiritual needs of congregants with clergy being placed in the Biblical role as the Shepherd of their congregation. This alliteration of the terminology of Shepherd and sheep for Christians emphasizes the relationship between God the Father, Jesus Christ the son of God and the Christian church. God the Father is the Great Shepherd leading and guiding those who have accepted Jesus Christ as their personal Savior. Symbolically, pastors are referred to as under shepherds tasked with leading and guiding their congregation with the use of the Bible which is the written Word of God. Therefore, religious leaders and clergy serve as the heartbeat of the church and act as gatekeepers to mental health (Heseltine-Carp & Hoskins, 2020). Positive acceptance towards psychological sciences is dependent on collaboration between clergy and psychologists (Hodge, et al., 2020).

Research indicates that 40% of Americans are more likely to seek support from clergy rather than psychiatrists and psychologist regarding their mental health (Heseltine-Carp & Hoskins, 2020). In this, clergy report 15% of their time is spent in pastoral counseling with less than a 10% referral rate to professional mental health practitioners. Suicidal ideation, delusions and substance use are behaviors identified as most likely to be referred out and behaviors that reflect depression, anxiety, and religious themed obsessive compulsive disorder are less likely to be referred by clergy to outside professionals (Heseltine-Carp & Hoskins,2020). Barriers to

clergy understanding the importance of congregants seeking outside psychological services include a lack of resources and funds to support mental health services, lack of training and psychoeducation of mental health, and concern that integration will produce a secular or humanistic influence that contradicts their spiritual and religious teaching (Hodge, et al., 2020). There are advantages of spiritually oriented well-being therapies that can provide meaning and purpose to life's adversities resulting in positive treatment outcomes (Hauck & Cloninger, 2021). Positive psychology can integrate psychology with religion and spirituality resulting in positive outcomes of mental health treatment.

Christian Theology and Positive Psychology

Positive psychology introduced by Martin Seligman in 1998, is an interconnection of virtue and science, shifting from a sole focus of repairing the worst things in life to include building on the strengths or best qualities in an individual's life such as hope, resilience, compassion, gratitude, coping, forgiveness, and humility (Hollman, 2018). Christians have identified spirituality as an important factor in determining their well-being, more so than those of the Jewish faith. Also, the practice of spirituality is more important for Christians than Muslims (Baker & Cruikshank, 2009; Cohen, 2002). The Christian faith is founded upon God's love for mankind; therefore, the love of God, others, and self are equally important for Christians as they live out their spirituality. The love of others incorporates psychology's positive constructs of altruism, kindness, and compassion. The love of self addresses the constructs of self-compassion, self-esteem, morality, and integrity.

Previous studies have shown that the love of others, seen in kindness interventions, can contribute to reduced anxiety and depression, a greater purpose in life, and greater life satisfaction (Carson et al., 2005; Fredrickson et al., 2008; Hofmann et al., 2011; Hutcherson et al., 2008; Otake et al., 2006). The study completed by Stodl and Jauncey (2017) confirmed previous findings which highlighted that the love of God, others, and self are associated with better psychological and physical well-being for Christians. Stodl and Jauncey (2017) further

supported the practice of integrating positive psychology with a focus on a client's spirituality in the psychotherapeutic treatment model. One limitation of this study was restricting the participants to predominately white Christian males (Stodl & Jauncey, 2017). There are existing treatment models integrating behavioral models with spirituality that address the mental health needs of those who identify spirituality as an important factor in their life.

Positive Psychology Models

Cognitive Behavioral Therapy (CBT) is a psychotherapeutic approach that integrates behavioral therapy, the cognitive principles of Aaron and Judy Beck, and the rational emotive therapy of Albert Ellis into one treatment (Pearce, et al., 2015). Religiously Integrated Cognitive Behavior (RCBT) is a treatment model that uses the traditions, beliefs, and behaviors of the client's religion to treat depression. The client's own religious beliefs are applied to identify and replace unhelpful thoughts and behaviors. The virtues of forgiveness, gratitude, generosity, and altruism are implemented when addressing client's behaviors. One of the greatest strengths of this treatment model is the reinforcement of the daily religious activities such as prayer, journaling, and scripture memorization to support the development of psychological skill agility. Currently, RCBT models have been developed for Christianity, Judaism, Islam, Buddhism, and Hinduism, allowing its application to spread to five of the world's religions while remaining sensitive to each specific religious tradition. A limitation of RCBT is the lack of empirical studies that have examined the effectiveness of religiously versus spiritually integrated psychotherapy (Pearce, et al., 2015).

Spiritually Informed Cognitive Processing Therapy (SIPCT) is an adaption of Cognitive Processing Therapy which utilizes scriptures, spiritual religious imagery, and references to religious theology to help dispute irrational thoughts based on the client's spiritual worldview. The clients spiritual worldview addresses their ultimate truth, purpose or meaning. Integrating their worldview requires interventions focusing on their concerns regarding ultimate meaning and purpose to recover from the mental aspect of trauma (Harris et al., 2011). Spiritually

Informed Cognitive Processing Therapy targets the spiritual crisis of those that are active in the military, veterans, and other people whose emotional disorder is rooted in shame and guilt as well as the psychological disorder of Posttraumatic Disorder which is rooted in fear. Those who suffer with PTSD may experience negative cognitions about themselves, others, and the world. Likewise, an individual suffering a spiritual crisis experiences negative cognition about self, God, or a higher power. Active-duty military and veterans on the battlefield can struggle with thoughts and questions regarding why God is letting this happen. If they experience a loss of faith or spiritual crisis, they usually have worse mental health outcomes requiring more mental health services than those who do not undergo a spiritual crisis and keep their faith. Research shows the inclusion of spiritual or religious practices such as prayer, scripture memorization, confession or meditation has increased positive outcomes in treatment (Wade, 2016). For Christians, the use of SIPCT can be beneficial in shaping a more holistic approach to suffering (Lloyd, 2021).

Suffering in Psychology

To better understand how clinicians can utilize religiosity and spirituality when working with Christian individuals who are suffering, a Christian-Meaning Model was developed mirroring Park's, meaning-making model (Park, 2010). The Global Meaning model (McMartin et al., 2020) includes core beliefs, goals, a subjective sense of purpose, schemas, and cognitive frameworks which individuals use to interpret life events in order to attribute a situational meaning to suffering. The Christian worldview is structured around the creation of man by God breathing into the nostrils of man, the fall of man with Adam's sin in the Garden of Eden, the redemption of man through Christ's death on the cross, and lastly the glorification of man through Christ's resurrection and the future coming of Christ to retrieve His bride - which is the church. God is the supreme being who is all-powerful, all-knowing, and omnipresent. God created humans in His image to reflect who is in the earth realm through love, kindness, gentleness, goodness, mercy, graciousness, faithfulness, and truthfulness (McMartin, et al, 2020).

God has created people as free moral agents with the ability to choose; therefore, suffering comes from different sources and has multiple meanings with the understanding that all suffering is allowed by God.

Schnicker et al. (2017) explored the relationship between Christian suffering and the development of patience. Suffering, as defined in their research, is any experience perceived by a person to be bad or burdensome. The results of the Schnicker et al., (2017) empirical study indicated that cognitive reappraisal is an emotional regulation strategy, when patience is viewed as a positive virtue in enduring suffering in a religious and spiritual context. The limitations of this study included the lack of socio-economic diversity among the participants, as most came from economically stable homes. Another limitation was the lack of age diversity. The focus in this study was on adolescents, which negated the possibility of the findings expanding to include other age groups. Further research should focus on independently measuring spiritual transcendence, religious meaning, and spiritual practices.

Another virtue researched in the psychology of religion and positive psychology is forgiveness. Everett Worthington targeted this virtue in his REACH Theory Forgiveness Model utilizing biblical forgiveness as the foundational construct. REACH is the acronym for the five steps of forgiveness: recall the hurt, empathize, altruistic gift of forgiveness, commit publicly to forgive, and hold on to forgiveness (Worthington, 2021). Forgiveness of others, self-forgiveness, and divine forgiveness studied by Chen et al. (2019) in relation to health and well-being supported previous research that found that forgiveness is a psychological asset that positively impacts measures of happiness, life satisfaction, and psychological well-being (VanderWeele, 2017). Chen et al. (2019) supported the notion that the forgiveness motivated by spirituality and religion is congruent with greater psychosocial well-being, lower risk of mental health, and fewer depressive or anxiety symptoms (Toussaint et al.,2001). Future studies should incorporate questions relevant to people who do not hold religious or spiritual beliefs, as well as consider personality factors, motivation of forgiveness, and severity of the offense.

Spiritual Interventions in Non-Spiritual Models

There is extensive research on spirituality and psychology, unlike the amount of research that connects suffering and patience with psychology. Of the addiction programs in the United States, 73% of them have a spiritual-based component. The 12-Step and Alcoholic Anonymous programs both emphasize a reliance on God or a Higher Power to stay sober. Religious beliefs, practices, and ministries have been deemed an essential component in substance abuse prevention and recovery, resulting in addicts healing faster when their faith is intertwined in treatment (Grim & Grim, 2019).

The 12-Step program fits the model of the trend of individuals seeking growth-enhancing approaches to deal with emotional distress through spiritual direction inclusive of regular meetings between a director and an individual focused on the individual's religious experience (Saadeh et al., 2018). A focus group of predominately professed Christians utilized in Saadeh, et al. (2018) explored the similarities and differences between the practice of spiritual direction model and psychotherapy. Findings suggested the differences resulted from the primary goals of each individual, the conceptualization of the problems addressed, and the resources utilized. For psychotherapists the primary goal of the practice of spiritual direction is growth in one's relationship with God while treating psychiatric conditions and repairing emotional distress.

Rosmarin et al. (2019) expanded upon the work of Saadeh et al. (2018) by focusing on a group-based treatment, (SPIRIT) spiritual psychotherapy for inpatient, residential, and intensive treatment. This treatment integrated spirituality and psychotherapy, targeting mood/anxiety disorders, acute or chronic psychotic disorders, substance use disorders, and posttraumatic and dissociate disorders. This model is based on a cognitive behavioral treatment framework, psychoeducation, and spiritual concepts or beliefs with the goal of helping patients explore and understand the relationship between their own spirituality or religion and their mental health. Rosmarin et al. (2019) confirmed that spirituality is relevant to mental health, both positively and negatively (Weber & Pargament, 2014). This study also confirmed that SPIRIT is an important

clinical innovation, and therapists have an ethical obligation to provide spiritually integrated psychotherapy to patients who desire it (Rose et al., 2001; Rosmarin et al, 2019). Limitations of SPIRIT include the lack of testing for outpatient use, it is not scripted or manualized, difficulty determining the success rate of recovery from psychiatric conditions due to participation in SPIRIT, and spirituality is only one-third of the treatment modality. Professional psychotherapeutic treatment of substance abuse additions, suicidal ideations, and delusions are more accepted in the church than depression or anxiety (Heseltine-Carp & Hoskins, 2020) creating a mental health illness stigma.

Overall Stigma of Receiving Mental Health Services

Stigma is a devaluing attribute based on traditional beliefs that degrade and diminish a person with a mental illness, linking them with undesirable characteristics (Del Rosa et al., 2020,). According to the World Health Organization, a mental health illness is often accompanied by a stigma, or negative attitudes and beliefs, resulting in the inappropriate labeling of people with mental illness and a deference to seeking proper treatment (Abuhammad & Al-Natour, 2021; WHO, 2016). In addition to stigma resulting in people avoiding professional help-seeking, other disadvantages include problems gaining or maintaining employment, reduced life-expectancy, self-judgment, reinforcement of negative stereotypes, or low self-esteem (Nugent et.al., 2021). Research shows 57.2% of adults with a mental illness do not receive mental health services.

The stigma of receiving mental health services can be targeted towards anyone receiving mental health services. According to Clement et al. (2015), stigmas are classified into six categories: 1) anticipated stigma, based on perceptions of being treated unfairly due to receiving mental health services; 2) experienced stigma of being treated unfairly due to receiving mental health services; 3) internalized stigma depicted by self-stigmatizing views about mental health; 4) perceived stigma centered on people’s views about the extent of which people with mental illness have been treated 5) stigma endorsement, characterized by a person's own stigmatizing

behaviors towards others with mental illness; and 6) treatment stigma based on being treating differently due to receiving treatment for mental health (Clement et al., 2015).

Public Stigma

Public stigma refers to a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). Public stigma has been correlated with negative treatment outcomes, lack of engagement in mental health care, housing and employment discrimination, and reduced autonomy (Parcesepe & Cabassa, 2013). A systematic literature review evaluating the methodology utilized in studying public stigma and summarizing the findings of public stigmatizing beliefs, actions, and attitudes toward mental health treatment in the United States support the belief that people with mental illness are prone to violent behaviors. A diagnosis of depression in children is associated with shame, blame, incompetency, punishment, and criminality. Likewise, adults diagnosed with a substance use dependency are associated with those same labels placed on children diagnosed with depression (Parcesepe & Cabassa, 2013).

According to Dockery et al. (2015) 83.2% of their research participants feared that being treated for mental health would lead to possible harm when applying for jobs, thereby deterring them from seeking mental health treatment. In terms of gender, females in the military are more likely to report stigma-related treatment barriers, while males in the military report longer periods of delayed treatment seeking due to stigmas. Clients diagnosed with schizophrenia are more likely to report stigma-related barriers than those diagnosed with bipolar disorder due to the more positive perception of bipolar disorder (Dockery, et al, 2015). Stigma-related barriers regarding negative labeling by peers and fear of discriminatory reactions if confidentiality was comprised caused secondary school students, ranging from 12-17 years of age to decline school based mental health interventions (Gronholm, Nye & Michelson, 2018).

Stigma towards Christians seeking mental health has caused them to fear being judged as deviant and hindered them from seeking professional mental health services (Adams et al.,

2018). Research by Adams et al. (2018) confirmed earlier statistics that revealed 30% of Christians participating in mental health services experienced a negative interaction with the church having been told they did not have a mental illness, or the cause of their problem was a result of their sin or a demonic attack (Stanford, 2007). Adams et al. (2018) was conducted on predominately Caucasian females attending a Christian college in southeastern United States, and focused exclusively on schizophrenia. Future research could expand the participants gender, location, and include more common or less severe mental illness.

Internalized Stigma

Internalized stigma is how people feel about themselves when they are diagnosed with a mental illness or receive mental health treatment. Del Rosa et al. (2020) completed a review of literature published between 2010-2020 on internalized stigma. The purpose of the study was to understand how to support the people affected by internalized stigma. A loss of positive beliefs about oneself, psychological distress, reduced self-esteem, and poor self-concept resulted from internalized stigma (Del Rosa et al., 2020). The higher the level of internalized stigma the lower the recovery from mental illness marked by depressive symptoms, and lower levels of self-esteem, hopefulness, and empowerment (Del Rosa et al., 2020). The variables of ethnicity, socioeconomic status, social support system and medication compliance were not considered in this study. In addition, inclusion of only research studies that were relevant to achieve their research purpose were considered.

Stigma in Religious Communities

According to Peteet (2019) tribalism is often found in religious communities. Strong social bonds form through a sharing of faith encouraging a sense of security and identity. This sense of tribalism is often a barrier to mental health treatment for most religious communities. The disclosure that Muslim high school students in the Middle East had a mental illness by was considered shameful (Abuhammad & Al-Natour, 2021). This concept supported previous

research (Al-Natour et al, 2021) which indicated that individuals with mental disorders should be segregated from society into psychiatric facilities. The greater religious background in United States correlated with increased public stigma. In addition, religious clients in this study questioned the help-seeking professionals' ability to help them and the evidence-based treatment that was being implemented. A prevalent highlight, as well as a gap in literature, aligned with Peteet (2019) showed religious clients believe secular help-seeking professionals have an inability to comprehend how religion and religious beliefs shape their perspective on life experiences (Nakash, et al., 2018).

Religious reinforcement of mental health has been an obstacle to effective treatment of mental health due to some faith communities attributing addiction, depression, and or psychosis to a lack of faith, sinful choices, or possession of evil spirits. Some clients have reported therapeutic sessions with secular clinicians have left them feeling like their Christian worldview is faulty and should be rejected (Peteet, 2019).

Stigma in Christianity

Evangelical Christians believe in personal conversions, the Bible is authoritative, and that Jesus Christ's birth, death, and resurrection are fundamental. They also believe that the Holy Spirit is a gift from Christ and spreading of the Gospel by all Christians is imperative (Lloyd & Waller, 2020). The Lloyd & Hutchinson (2022) qualitative study on evangelical Christians revealed that Christians suffer internalized stigma as evidenced by increased guilt, sadness, and shame, associating mental distress as symptomatic of deeper spiritual issues. In addition, some Christians are unable to reconcile suffering psychological distress with their Christian faith, self-reporting that they felt misunderstood and isolated. Evangelical Christians have higher levels of self-stigma regarding depression than non-evangelical Christians, and non-Christians and are less likely to seek treatment for depression (McGuire & Pace, 2018). Limitations of the study by McGuire and Pace (2018) are the exclusion of the religious beliefs and attitudes causing the self-stigma about

depression. Further research could address focusing on sub-denominations as the beliefs and practices of evangelical groups are not homogenous.

Stigma in Cultures

Stigma is not only significant in religious communities but also for racial and ethnic minority groups in the United States. Misra et al. (2021) explored the effect of stigma on Latinx Americans, Asian Americans, and African-Americans in the United States with a focus on service barriers, family experiences, knowledge, beliefs, and attitudes. This review focused on cultural aspects of stigma manifested in structural stigma, affiliative stigma, public stigma, and self-stigma. The results of public and internalized stigma was examined as all three groups experienced both.

Latinx Americans experience public stigma as family members prefer that mental illness is handled within the family (Martinez, 2017). Latinix Americans experience internalized stigma when they attribute mental illness and treatment to a fault of their own (Sadule-Rios et al., 2014) and fear being labeled as crazy (Withers et al., 2015). Asian Americans experience public stigma due to a lack of knowledge regarding mental illness. Asian Americans believe people with mental illness are contagious, dangerous, or out of control (Han et al., 2017). Public stigma leads to internalized stigma as Asian Americans feel they are failures and should get better on their own, thereby psychotic disorders are often concealed (Chung et all. 2015).

Black Americans experience public stigma based upon a belief that taking psychiatric medications are unsafe (Kranke et al. 2012). Moreover, a black woman with mental illness defies the cultural role of being a strong black woman (Jones et al., 2015), and religious beliefs that mental illness equate to being in sin (Johnson et al., 2009). For Black Americans the internalized stigma is fear of being seen as weak, crazy, or dangerous sometimes leads to denial of a mental illness (Haynes et al., 2017).

In addition to the lack of knowledge about mental illness, public stigma exists due to cultural stereotypes relating to the effects of antidepressants on Latinx Americans, the work ethic

for Asian Americans, and the strength and independence of Black Americans. Internalized stigma for all three cultures was evidenced by shame and feelings of failure manifested through denial and isolation. Future research could include expansion on this systematic review increasing the sample sizes and altering the community settings with a specific focus on each stigma (Misra et al., 2021).

Stigma of Cultural Beliefs on African-Americans

African-Americans are taught to lean on God, and clergy are their source of support when they feel disconnected from God and need to hear from God concerning their problems in life (Anthony et al., 2015). African-Americans understanding of the role of clergy along with their beliefs regarding prayer reinforces their belief that God alone can cure all their problems. Due to the history of African-Americans relative to slavery, there is a distrust of people outside of their race, especially Caucasians. According to Millet et al., (2018) African-Americans are disproportionately affected by discrimination, financial strain, poverty, early mortality, and health disparities dating back to slavery when the church was a haven from White supremacy. Now, the church is the one place where African-Americans can hold positions of power and are not discriminated on based on educational level, financial status, or race (Armstrong, 2016). As a result, church and Christianity helped restore enslaved African-Americans and became a coping mechanism (Millett et al., 2018).

African-Americans attend more religious services than other races. Caucasians who attended religious services were reported to have fewer anxiety and depressive symptoms and were less likely to have mood disruptive disorders than any other race (Sternthal, et al., 2012). Additionally, children raised in religious households who have been told all their life to endure hardship may develop a jaded view of life and see it as unfair and become disengaged and disillusioned with and by any religion (Henderson, 2016). The intertwine of religiosity, race, ethnicity, Christianity, and strong family ties makes it difficult to address the specific mental health needs of African-Americans (Millett et al., 2018).

Stigma of Misdiagnosis in African-American Culture

Depression in African-Americans is often undiagnosed due to historical mistrust of the medical profession, as well as their cultural reliance on the support of their family and church during distress. Factors not attributed to other races that contribute to depression in African-Americans are racial oppression, injustice, discrimination, and high crime levels. Yet, even with these additional factors present, only 29% reported contact with a mental health professional and only 39% followed through with completing the appointment (Anthony et. al., 2015). African-Americans believe depression is sign of weakness and utilizing prayer and faith can heal them from depression (Anthony et. al., 2015).

The mistrust of mental health professionals is augmented by African-Americans being misdiagnosed with schizophrenia and other psychosis disorders instead of the appropriate diagnosis of mood disorders, resulting in prescriptions for antipsychotic medications instead of antidepressants. This misdiagnosis has been attributed to clinicians' racial bias and cultural differences regarding how symptoms are expressed by African-Americans (Bilkins et al., 2016). Due to African-Americans avoiding professional mental health professionals and public stigma they often deny their symptoms of mental health illness. This results in the inability to have accurate data to complete comparison data of mental health treatment by race (Avent et al., 2015).

Spirituality and Religion for African-Americans

African-Americans view religion as important in their lives with 79% identifying as Christian (Pew Research Center, 2015) and Protestant (Nguyen et al., 2019). African-American religious communities provide love, encouragement, and hope as coping strategies for problems and challenges which enhance self-perception and self-preservation (Henderson, 2016). African-Americans families tend to have multigenerational and/or extended families living in the same home. As a result, Christian beliefs, practices, and the faith community can serve as multi-faceted (psychological, emotional, spiritual, financial, and social) sources of strength that fortify

Black Christian families in the face of profound stress (Millett et al., 2018). Having a personal relationship with God and prayer are associated with increased self-esteem and self-efficacy in African-Americans (Holt et al., 2014). African-American Christians who belief that God is actively involved in their lives reportedly have positive marriage and family relationships, commitment, and cohesion (Millett et al., 2018).

Those who indicate that religion is highly important in their lives are less likely to use professional mental health services compared to those who indicate a lower level of religious importance (Lukachko et al., 2015). Davenport and McClintock (2021) corroborated these findings, suggesting that African-Americans who identify religion being significant in their lives are less likely to endorse positive attitudes toward mental health treatment. They used religious coping mechanisms such as prayer to manager their psychological issues. A limitation of Davenport and McClintock's (2021) study was the population sample was taken from church attendees in four churches in northeastern United States with depressive symptoms as the only mental health illness explored.

Effect of African-American Pastors/Clergy on Mental Illness

Pastoral counseling is the first preference for African-Americans with issues associated with marriage and bereavement. Physical abuse, emotional abuse, abortion, and general loneliness were other issues in which pastoral counseling were preferred over other mental health professionals (Hardy, 2014). This confirmed a previous study by Chatters et al. (2011) reporting how African-Americans were more likely to seek help from ministers rather than family doctors, psychiatrists, or other professional mental health services.

African-American clergy are relied on for social and psychological problems of their parishioners regardless of their educational background, knowledge of mental health issues, and previous experiences (Avent et al., 2015). African-Americans report 50% of their mental health needs are met by their clergy as their only source of support (Hankerson et. al, 2013). Clergy without knowledge of how the brain works, psychoeducation, or depression, usually base their

counseling only on theology, using prayer, scriptures, and implicit focus on God as their only treatment interventions (Anthony et al., 2016). African-American clergy who are unaware of their own perceptions of mental health and their impact on their congregation often lead parishioners unintentionally to believe that prayer is their only option (White, 2016).

Research has shown the use of religiosity by African-Americans as a coping mechanism has positively affected their ability to cope with major depressive disorders, chronic illness, and the death of loved ones (Burke et al., 2011). When African-American clergy are taught the signs and symptoms of depression and refer parishioners out to mental health professionals, the stigma is removed and parishioners readily seek outside services (Hankerson et al., 2013).

African-American clergy's attitude about mental health professionals can be influential in tearing down the stigma of mental health illness as well as motivating parishioners to accept outside referrals (Brown & McCreary, 2014). Social workers are encouraged to provide in-service trainings to clergy and co-facilitate counseling sessions so that the guidance the congregants seek is infused with both spiritual and clinical content (Hardy, 2014). If African-American clergy promote community-based health care programs it alleviates some of African-Americans distrust of the medical profession; however, in order for the programs to be successful, the programs must build relationships with church members. Allowing church members to volunteer in their program is one way to build relationships (Collins, 2015).

Hodge et al. (2020) provided insight into ways to increase collaboration between religious leaders and mental health professionals based on a sample size of 394 predominantly Caucasian, male church leaders. Key findings were : (1) Greater communication and relationship ties between clergy and mental health professionals will increase collaboration positively impacting the referrals to professionals outside the church setting; (2) Mental health professionals presenting psychological findings to clergy in a way that is aligned with the Bible will lessen the defensiveness of clergy; (3) Mental health professionals providing clergy with the psychoeducation on specific scientific basis for interventions may assist clergy in deciding when

referrals should be made. The limitations of this study do not consider the perception of African-American church leaders who tend to have lower percentages of their parishioners receiving mental health services than Caucasians.

Matching an African-American client with an African-American mental health professional can assuage some of the distrust of mental health professionals; however dependent on geographical location there may not be an African-American mental health professional available (Bilkins et al., 2016). To increase trust in mental health professionals, African-Americans need a therapist who is culturally sensitive to the plight of African-Americans while not viewing every experience presented by African-Americans from a racism lens. There must be a balance of understanding which creates a therapeutic atmosphere of trust (Hall & Sandberg, 2012).

Clinicians and therapists can better assist African-Americans by being aware of different types of microaggressions which affect African-Americans while providing psychoeducation. This approach provides opportunities for clients to recall past experiences of microaggressions to cope with any unresolved feelings that may lead to internalized racism, self-doubt, or other negative mental health outcomes, or that may affect any other aspect of their social or identity development. (Nadal et. al., 2014).

Summary

Gaps in the underutilization of mental health services by African-American Christians has been comprehensively documented over the years. African-American Christians are less likely than their Caucasian counterparts to voluntarily seek professional mental health services. The African-American church historically has been the place where parishioners sought religious and spiritual direction as well as support for mental health needs. Clergy of African-American churches are usually the most inflectional persons in church leadership.

More research is needed on how Pastors differentiate between a mental illness and a spiritual issue (McCain, 2016). Understanding the referral practices of African-American clergy

to professional mental health services could possibly reduce the disparity of mental health utilization that exists between African-Americans and their Caucasian counterparts. In addition, understanding the phenomena of African-American clergy's understanding and approach to mental health can be valuable to professional mental health therapists and social workers when soliciting collaboration. African-American clergy's attitude about mental health professionals can be influential in tearing down the stigma of mental health illness as well as motivating parishioners to accept outside referrals (Brown & McCreary, 2014).

CHAPTER THREE: METHODS

Overview

This chapter provides a brief background of the proposed study and a summary of the qualitative methodology that will used in this study. I describe the terms phenomenology and hermeneutic phenomenology as the research methodology. I specify the participants, the setting, and the procedures for this research in this chapter. The final section includes the data collection methods that ensure trustworthiness and the ethical considerations involved in this proposed study.

The purpose of this hermeneutical phenomenological qualitative study was to describe the lived experiences of African-American clergy in the Southeast United States regarding the practices and perceptions of mental health among their parishioners. This research will provide a voice to the lived experiences of African-American clergy with respect to understanding how their belief and attitudes regarding mental health influence their teachings, sermons, and church practice. Lived experiences are defined as any experiences which shaped their understanding of mental illness and mental health as well as their practices of referring their parishioners to professional help-seeking agencies.

Qualitative Overview

Qualitative research makes sense of, or interprets phenomena and the meanings people bring to the phenomena (Denzin & Lincoln, 2011). Qualitative research is used to explore a problem or issue in which detailed understanding is needed and can only be established by talking directly with people and allowing them to tell their stories without regard to the researcher expectations or what has been read in literature (Creswell & Poth, 2018). With qualitative research, researchers seek to understand the complexity of people's lives using the perspectives of individuals in context (Heppner et al., 2016).

According to Denzin and Lincoln (2011) there are five phases of qualitative research applied to all qualitative research designs. Phase one is the concept that the researcher is a

multicultural subject, which means the researcher's worldview affects all aspects of the study (Denzin & Lincoln, 1998; Yeh & Inman, 2007). One aspect affected is the use of open-ended questions which are designed by the researcher. This makes the researcher the key instrument in the study as opposed to relying on questionnaires or instruments developed and others. According to Wolcott (2010) reflexivity in qualitative research is necessary to allow readers to understand the influence the researcher has on the people or topic being studied. This will provide the reader with information regarding what prompted the researcher's interest in the phenomenon, the researcher's cultural experiences, background, and how those elements inform the interpretation of the information. Qualitative research is shaped by the researcher's personal history, social class, race, and ethnicity and researchers should acknowledge those elements through bracketing (Denzin & Lincoln, 2010). Bracketing in this study was accomplished through field notes and a reflexive journal. My biases was documented in this study under the Situation of Self in Chapter One and the Researcher's Role section in this chapter.

The second phase is the identification of theoretical or interpretative perspectives that guide the making of meaning in the study. The standards of evaluation of the research are determined by the theoretical or interpretative paradigm and are selected at the beginning of a study to ensure solid qualitative research (Morrow, 2007). This study's interpretative paradigm is ontological. Ontological issues are concerned with the existence of, and relationship between different aspects of society, such as cultural norms and social structures addressed in this proposed research. With an ontological paradigm the researcher can address the assumptions made about the kind and nature of reality and what exists for African-American clergy (Creswell &Poth, 2018). The researcher values perceptions as the reality of each participant's lived experiences with respect to understanding how their belief and attitudes regarding mental health influence their teachings, sermons, and church practice.

The third phase is identification of strategies of inquiry and interpretive paradigms (Heppner et al., 2016). Social constructivism is the interpretative framework that will guide this

study with the goal of understanding African-American clergy's view of mental health in the world in which they worship and serve Christ. Social constructivism will allow for the use of open-ended questions to inductively generate a theory or pattern of meaning (Creswell & Poth, 2018).

The fourth phase of qualitative research is the identification of the methods for data collection and analysis. Data collection is usually obtained through observations, interviews, and existing materials. This study will utilize interviews for data gathering. Data coding was used to identify patterns, themes, or categories in the study and analysis begun as an inductive process (Creswell & Poth, 2018). Complex reasoning through inductive and deductive logic will result from building patterns, categories, and themes. While organizing the data in to themes the researcher will focus on learning the meaning of the phenomenon for the participants.

Qualitative research is context-dependent, and the researcher must seek to understand how contextual features influence the participant's experiences. Understanding the cultural, historical, and social contexts of the participants in this study will allow the researcher to "understand how events, actions, and meanings are shaped by the unique circumstances in which these occur" (Maxwell, 2013, p.30). The final phase of qualitative research is data interpretation - the synthetization of information into a bigger picture - and data presentation and evaluation. In qualitative research, thick description is the most basic way to present qualitative data. Thick description is the use of excerpts from the interviews, field notes, and direct quotes in the presentation (Geertz, 1973). Evaluation of a study evaluates rigor, reliability, validity, credibility, trustworthiness, fairness, authenticity, attentiveness, engagement, awareness, and carefulness (Davies & Dodd, 2002; Morrow, 2005).

Qualitative methodology was best suited for conducting this study because I will collect data by talking directly and observing the participants within their natural context (Creswell & Poth, 2018). The research process for qualitative design is emergent meaning the purpose of qualitative research is to learn about the problem from the perspective of participants and use the

best practices to obtain information (Creswell& Poth, 2018). This study will have 10 semi-structured interview questions; however, follow-up questions may arise based upon the response of the participants. Lastly, qualitative research is not bound by cause-and-effect relationships; instead, it provides a holistic account reporting on multiple perspectives, identifies the factors involved in an experience or phenomenon, and presents the larger picture that emerges from the inquiry.

Phenomenological Research

Phenomenological research purposes to produce an exhaustive description of the phenomena of everyday experiences emphasizing that the world or reality is not separate from the person (McLeod, 2001; van Manen, 1997). Phenomenological research is descriptive and focuses on the structure of the experience and the principles that give meaning to the life (Kvale, 1996; Osborne, 1994; Polkinghorne, 1983). Edmund Husserl is known as the father of phenomenology whose earliest work focused on mathematics (Cohen, 1987; Koch, 1996; Polkinghorne, 1983; Scruton, 1995). Husserl's work shifted to the social sciences when he exerted that psychology as a science erred in applying methods of natural sciences to human issues (Jones, 1975). Husserl believed conscious awareness builds one's knowledge of reality and this intentionality was the essence of understanding phenomenology. A second key concept for Husserl is bracketing. Bracketing requires a person to restrain from their individual biases and suspend their beliefs about the phenomena to see it clearly (Edie, 1987). Martin Heidegger began his work with Husserl but later disassociated himself from Husserl and his work due to differences in phenomenology concepts.

Hermeneutic Phenomenology

Unlike Husserl, Heidegger viewed consciousness as a part of a person's lived experiences, specifically known as "Dasein", meaning the mode of being human or situated meaning of a human in the world (Annells, 1996; Jones, 1975). He believed a person's world

view is intertwined in their cultural, social, and historical contexts (Munhall, 1989; Polkinghorne, 1983). The interpretive process according to Heidegger (1962) is achieved through a hermeneutic circle which moves from the parts of experience to the whole of the experience and back and forth again and again to increase the depth of engagement and the understanding of texts. Hermeneutic phenomenology differs from phenomenology due to the focus on illuminating details and seemingly trivial aspects within lived experiences that may be taken for granted in our lives thereby creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991). Hermeneutic research is interpretive rather than descriptive, focusing on historical meanings of experience and the effects of cultural and social contexts (Barclay, 1992).

Hans-Georg Gadamer extended the work of Heidegger into a practical application believing hermeneutics involved moving from just a process of understanding people to clarifying the circumstances in which the understanding occurs (Gadamer, 1976; Polkinghorne, 1983). Understanding and interpretation from Gadamer's belief were bound together and interpretation is always evolving and never definitive. His beliefs regarding bracketing were aligned with Heidegger both believing it is impossible for a researcher to use bracketing in hermeneutic phenomenology research (Gadamer, 1998).

Hermeneutical Phenomenological Design

A hermeneutical phenomenological design is used to identify the problem requiring further study and exploration. A hermeneutical phenomenological study describes the common meaning for a group of people based on their lived experiences and interpretation of the texts of life. Vygotsky's Social Constructivism Theoretical Framework (1979) guides the researcher's goal in interpretating an underlying coherence of actions of a group of people (Creswell & Poth, 2018). This study will reduce individual African-American clergy's beliefs regarding mental health to a universal understanding. There are four philosophical assumptions in this study: 1) a search for wisdom to understand the phenomenon of African-American clergy's lived

experiences with mental health influence their teachings, sermons, and church practice, 2) no judgments about reality of mental health to African-American clergy was not formed until the data was analyzed, 3) African-American clergy bring both subjective and objective experiences as part of their lived experiences, and 4) the reality of African-American clergy was only perceived within the meaning of their individual experiences (Creswell and Poth, 2018). A semi structured interview was utilized to provide some consistency across the interviews. The interview questions was comprised of background, opinion or belief, knowledge, and experiential questions (Heppner et al., 2015). This approach focuses on understanding life as it is lived and achieving an understanding of how to act well in concrete, particular circumstances (Moules et al., 2014).

This design has been chosen because it addresses an abiding concern which interests me. The concern of interest for me is does the spirituality of African-Americans along with the limited clinical knowledge of Senior Pastors aid in the stigma of African-American Christians not seeking professional mental health services. This research design will enable me to reflect on essential themes and interpret the lived experiences of the participants.

Research Questions

Research Question One: How do African-American clergy perceive their experiences with parishioners' mental health?

Research Question Two: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Methodology

Setting

The sites for my study was six African-American churches located in the southeastern part of the United States. According to Pew Research Center (2021), African-American

southerners are more likely to be an active part of a church than other African-Americans living in other parts of the United States, with two-thirds reporting religion is very important to them. In the southeast, 65% of African-Americans report worshipping at a predominantly African-American congregation than African-Americans in other regions. Likewise African-American southerners are more likely to view Bible as the literal Word of God. Seventy-two percent of African-Americans report being of the Protestant faith (Pew Research, 2021). This study focused on two denominations of the Protestant faith: Baptist, and Non-Denominational that have a congregation comprised of at least 65% African-Americans. This criterion aligns with Pew Research (2021), in that 65% of African-Americans report worshipping at a predominantly African-American congregation.

Participant Selection/Identification

Participants for this study were selected using purposive sampling based upon the best population that can inform the research problem (Creswell & Poth, 2018). According to Rubin and Rubin (2012), participant selection should be based on the certainty that participants have real experiences and intimate knowledge about the phenomenon that was studied. For the study to produce authentic data from the essence of the meaning that emerges from the study the participants should each have their own distinct experiences and perspectives (Rubin & Rubin, 2012). The follow criteria was used in participant selection:

- Senior Pastor of an African-American church
- Served as a senior Pastor for a minimum of three years
- Be at least 20 years of age that begins adulthood and ethical and spiritual values are adapted (Colarusso & Nemiroff, 1981).
- No specified minimum or maximum size of church membership.

Procedures

Prior to the recruitment of participants, the researcher sought and received approval from the Liberty University's Institutional Review Board (IRB). The IRB approval process included the submission of a complete proposal detailing the procedures that were taken to secure the safety, privacy and rights of clergy and security of the data. The Privacy and confidentiality of clergy was kept by using pseudonyms that were provided for each church. Upon receiving IRB approval to collect data, an email was sent to potential participants by emailing the church's website. The researcher had at least visited the churches once before March 2020 when Covid-19 caused many churches to cease in-person worship. The email outlined the above criteria with exclusion of the criteria if the Senior Pastor had only provided pastoral counseling to fewer than 20 parishioners (Robinson, 2014). Once I received the pastor's preferred method of contact, I sent them a formal written invitation to participate in the study via email. The written invitations included the details and procedures of this study as well the expectations and responsibilities of the participants (see Appendix A). Once the participants agreed to the parameters, they were sent a copy of the consent form (see Appendix B). The participants chose to voluntarily engage in the study after reading the consent form.

Sampling Strategy

The sampling strategy that I selected for this study was maximum variation sampling to recruit 12 participants out of 20 possible participants. According to Creswell and Poth (2018), utilizing this approach will allow me to determine in advance some criteria that differentiate the participants and differentiating sites. Maximum variation in this study was used to document shared patterns across regions and denominations as well as diverse variations that have emerged as African-American clergy adapt to different denominations (Patton, 2002). The criteria differentiated was the denomination of churches chosen as well as the location. Two African-American denominations was represented in this study: The National Baptist Convention, USA

Church, or Non-Denominational Church. The location of the churches chosen was Southeast United States. This approach increased the likelihood that different perspectives were revealed regarding the phenomena which is ideal in qualitative research (Creswell, 2018). To fulfill the requirements of purposive sampling the participants must have knowledge along with the ability to articulate their past experiences providing pastoral counseling to their parishioners in a reflective manner (Bernard, 2002; Spradley, 1979).

The Researcher's Role

My role as the researcher was to collect and record all data with integrity and no personal bias. I do not have a personal relationship with any of the participants nor do I have daily direct contact with any of them . I am a licensed minster of the Gospel in a non-denominational church as well as a licensed clinician. In my experience as a licensed minister in the African-American Church, I know less than five professed Christians who have openly sought mental health services beyond marriage counseling. This information reinforced my belief that African-American Christians rarely seek outside mental health services. The bias that I have to be aware of is my belief that in addition to having a spiritual counselor, Christians also need professional mental health counseling to address certain issues. I am a member of a church in which the Senior Pastor champions the utilization of mental health professionals and often includes me in his pastoral counseling with parishioners; therefore, I was mindful of that bias.

Data Collection

The purpose of a phenomenology study was to focus on the insider perspective of the lived experiences of the participants who are integrally involved in the phenomenon (Edie, 1987). Miles et al., 2014). Interviews, observations, documents, and audiovisual materials are the four major types of data collection in qualitative research as identified by Creswell and Poth (2018). In-depth interviews with as many as 10 participants are typically the main data collection for phenomenological research (McCraken, 1988). In addition, multiple interviews with each

participant are also a common data collection method in phenomenological research (Creswell & Poth, 2018). The participants in this study attended individual semi-structured interviews and were able to review their transcipts.

Interviews

Interviews allow for interaction with participants on their own terms and non-participant observation (Creswell, 2012) which are key elements of a phenomenological study. Participants articulated their experiences in an uninhibited manner without tainting or embellishing the meaning (Merriam, 2009). Semi-Structured interviews were held with participants individually using the Microsoft Teams video conferencing platform. Each interview was recorded and automatically transcribed as a means of data collection. Ten open-ended questions were used to provide flexibility during the 1.5 to two-hour time slot. Semi-structured interviews provide the researcher with latitude to explore the responses of participants and adapt questions for participants (Creswell & Poth, 2018). Of the ten questions, questions one and two were designed to establish background (Heppner et al., 2016). Question 3 was designed to provide participants beliefs about their lived experiences (Heppner et al., 2016). Questions four and five were designed to provide information regarding behavior and knowledge regarding the phenomena (Heppner et al., 2016). Questions six through eight provided participant feelings about the phenomena and question nine provided sensory and experiential information about the phenomenon. The final question allowed for the participant to provide their final insight (Heppner et al., 2016).

During the process, observations was recorded in memos, journal entries, logs, field notes and anecdotal records. Questionnaires with open and closed ended questions served to corroborate data. Methods such as these enhance the validation, and triangulation of data, as well as improve the breadth and depth of the research so that a rich, detailed account may be formulated. After the interview, participants provided any additional information that was pertinent to the study that may not have been addressed during the interview. Field notes were

taken by the researcher during the interview. Notes were taken during and immediately after each interview about observations, thoughts, and ideas about the interview (Heppner et al., 2016).

Data Analysis

Data in a phenomenological study are comprised of observations, interviews, and documents of participants. Participants who have lived the experience are the only legitimate source of data (Jasper, 1994). It was important to preserve the spontaneity of participants experiences while collecting data (Baker et al., 1992). Data analysis in qualitative research includes the researcher familiarizing themselves with data, making connections with the data, creating a master list of themes, representing the data in figures, tables, or a discussion, and writing the final report (Smith et al., 1999). Data must be evaluated from all angles to provide an "exhaustive description" (Heppner et al., 2016, p. 391) extracted from significant statements from the data, the meanings formulated, and clustered themes from the data.

Memoing and Familiarizing Data

My first step is this hermeneutical phenomenological study was to intensively engage with the data by listening to the audio-taped interviews, and reading and re-reading verbatim Microsoft Team transcripts. I took notes while reading the transcripts using reflective thinking in an attempt to synthesize the transcripts into higher analytical meanings (Creswell & Poth, 2018). This will lead to summarizing my field notes into a digital audit trail that can be reviewed and examined (Silver & Lewins, 2014). The final step in this process was to complete the code development. (Creswell & Poth, 2018). This process was repeated for each participant's interview.

Classifying Codes and Connections within Interviews

After completing the code development, I will reduce the code to themes. According to Creswell and Poth (2018), the final code list may be 25-30 categories that should be broken

down into five or six themes. I will then review the interview data to ensure that the connections I made were correct (Smith et al., 1999). From this I can develop a finalized codebook, inclusive of code categories and descriptions. The codebook will describe personal experiences through epoche as well as the essence of the phenomenon (Creswell & Poth, 2018).

Developing Theme Table

The next step was interpreting the themes and developing significant statements which are grouped into meaningful units. For each interview, data was placed into relating categories and themes. Next, I will create a master list of themes, grouping statements into meaningful units ensuring significant themes are representative of the data and not reflective of researcher bias (Smith et al., 1999). This process was repeated several times allowing for the emergence of higher level themes. I will then repeat this process of creating a master list for all participant interviews consolidating all the interviews into one master list (Smith et al., 1999). The follow-up interviews with participants will provide feedback on my interpretation of the data through member checking. This will allow me to identify alternate understandings which challenge my own interpretations (Creswell & Poth, 2018).

Visualizing Data

After creating a master list of themes for each participant's interview I will consolidate all the interviews into a table. I will then identify the themes that are consistent through all the interviews based on the occurrences, and richness of passages relevant to the themes (Smith et al., 1999).

Writing Report

The final step in data analysis is reproducing data in a tabular, figure, or hierarchal form. I developed a textural description denoting what happened, a structural description of how the phenomenon was experienced, and the essence of the phenomenon using a composite description (Creswell & Poth, 2018). The report should provide the reader with information regarding why

the data and interpretation are important distinguishing between what was said versus the interpretation of what was said (Smith et al.,1999)

Trustworthiness

Shenton (2004) established protocols using Guba's constructs to ensure trustworthiness to satisfy criterions of credibility of internal validity, transferability of external validity, dependability in terms of reliability, and confirmability in regard to objectivity. I will ensure adequacy of the data by deliberately seeking out the unexpected in my findings. In addition, multiple points of evidence and data triangulation was utilized from interviews, field notes, and member checking in which participants were able to review themes for accuracy and resonance with their experiences (Birt, et al.,2016; Heppner, et al.,2016). Adequacy of interpretation was ensured by using participants words and being aware of my own bias (Heppner et al.,2016) through reflexive journaling.

Credibility

Credibility is the truth of the research findings and establishes whether the interpretation is an accurate depiction of the participants original views (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). This study will utilize research methods that are well established for data collection in qualitative research. The type of interview questions used to gather information are aligned with a qualitative question format to gather information regarding background, the lived experience, behavior, feelings and sensory, and experiential information about the phenomenon (Shenton, 2004).

The researcher was a part of the culture being studied so familiarity of the culture was already established. One hour and half was dedicated to each interview to ensure deep engagement. It is important in qualitative research to understand the position, perspective, beliefs, and bias of the researcher. "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this

purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, (2001), p. 483-484). I developed a reflexive journal making regular entries during the research process documenting my methodological decisions, reasons for them, and reflecting on what was happening from the perspective of my own values and interests (Lincoln &Guba, 1985).

Member checks were utilized to reduce the systematic bias and cross-examine the integrity of the participants' responses (Heppner, et al., 2016). Member checks will provide an opportunity for participants to correct errors and challenge any incorrect interpretations during data analysis. In addition, member checks allow participants to assess adequacy of data and preliminary results (Lincoln & Guba, 1985). This process also ensures narrative truth in the authenticity of the participants' reflections, comments, stories, and perspectives.

Triangulation is the use of different methods for data collection (Guba, 1985). Supporting data may be obtained from documents to help explain the attitudes and behaviors of participants. I attempted to collect sermon notes from the participants of those who report integrating mental health in their teachings and sermons. I was unable to receive any sermon documents. Negative case analysis is another method to establish credibility. I searched for and discussed elements of emerging data from inquiry which contradicted my prior expectations (Bistch, 2005).

Reflective commentary was used to record my initial impressions after each interview to note patterns as they emerge. (Lincoln and Guba, 1985). This allowed the researcher to clearly state the lens through which the social world is interpreted and discuss how the researcher's background influences data collection and analysis (Lincoln & Guba, 1985). This progressive subjectivity was implemented in the results and discussion portion of the study (Lincoln & Guba, 1985).

Lastly, thick description of the phenomenon was used to present the findings. Thick description is the untouched and thorough presentation of data through direct quotes from the participants (Geertz, 1973). This study will include lengthy excerpts from the interviews. This

allows the reader to have direct insight from the participants and determine to what extent the findings are true (Shenton, 2004).

Dependability and Confirmability

Confirmability is established in qualitative research through an audit trail providing a description of the research design, data collection decisions and the process of managing, analyzing, and reporting the data of the study (Lincoln & Guba, 1985). The audit trail consists of six categories: 1) raw data, 2) data reduction and analysis products, 4) process notes, 5) material relating to intentions and dispositions, and 6) instrument development information (Halpern, 1983). My study will include raw data of interview notes and field notes (Guba & Lincoln, 1982). Data reduction and analysis was evident in my study by the inclusion of summaries of condensed notes. According to Lincoln and Guba (1985), the final report was comprised of data reconstruction and synthesis through structuring of themes, definitions, and relationships found in the study and connecting it to existing literature integrating concepts, relationships, and interpretations. Process notes will include my procedures, designs, strategies, and trustworthiness notes relating to credibility, dependability. My reflexive notes were included in this study to provide insight into my predictions and intentions.

Dependability was established as participants will evaluate the findings of this study and all recommendations was supported by the data received from the participants (Cohen et al., 2011: Tobin & Begley, 2004). I will utilize the code-recode strategy in which I will code the same data twice within a one-week period to see if my results are the same or different (Chilisia & Preece, 2005). I will record and retain copies of all electronic records and field notes to reflect on while writing the final report for this study (Wallendorf & Belk, 1989). The problem statement, research questions, methodology, and research design are clear and aligned. Peer debriefing, which includes consulting with mentors or experienced qualitative researchers, offers important feedback on the design and analysis of the study.

Transferability

Transferability is the degree to which the results of my qualitative research can be transferred to other contexts or settings with other respondents ((Bitsch, 2005; Tobin & Begley, 2004). I will employ thick description to achieve external validity (Lincoln and Guba, 1985). I will provide a detailed description of my study allowing it to be replicated due to using purposive sampling, with a focus on African-American clergy in the southeast United States who are knowledgeable about the issues in my study. The methods of my study are sufficiently detailed so that other researchers will be able to address any transference issues (Creswell, 2012; Lincoln & Guba, 1998). Data saturation occurs when enough information is collected from the study so that it can be replicated, there is no new information that can be attained, and there is no longer an ability to code (Guest et al., 2006; O'Reilly & Parker, 2012: Walker, 2012). The use of semi-constructed interviews (Bernard, 2012) is one method this study will use to achieve data saturation, as well as ensuring the interpretation of the phenomena represents the participants viewpoints and not those of the researcher (Dibley, 2011; Fields & Kafai, 2009).

Ethical Considerations

The three basic Belmont Principles guiding this study are ensuring respect for persons, beneficence, and justice. Respect for persons was ensured by recognizing each participant in the study voluntarily consented to be a part of the study and are entitled to their own opinion (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978). The participants provided with an informed consent as well as information about the research project so they can make an informed decision about participation. (Heppner, et al., 2016). It is my responsibility to acknowledge the original contributions of other writers and clearly distinguish my original scholarly insights from the works of others (Heppner, et al., 2016).

Beneficence was ensured by making sure the participants are not harmed and maximizing possible benefits while minimizing possible harm (National Commission for the Protection of

Human Subjects of Biomedical and Behavioral Research, 1978). The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher[s] will have access to the records. Data collected may be shared for use in future research studies or with other researchers. If data is shared, any information that could identify them, if applicable, were removed before the data is shared. Participant responses are anonymous. The responses were grouped by denomination. Participant responses were kept confidential through the use of pseudonyms. Interviews were conducted in a location where others will not easily overhear the conversations. Data is stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Interviews were recorded and transcribed. Recordings are stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Justice was achieved by ensuring the fair treatment of all participants and fair distribution of the risks and benefits of the research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978). This research study offers new insight for the African-American church in the Southeast United States by providing an understanding of African-American clergy's perspective of mental health. The participants was provided copies of the reports (Creswell & Poth, 2018). Data collection and analysis will meet standards of the International Review Board (IRB) regarding Behavioral Sciences. The researcher will report multiple perspectives and contrary findings (Creswell & Poth, 2018).

Summary

Chapter Three offers the specifications of the methodology of this hermeneutical phenomenological study. I will seek to explore the experiences of African-American clergy in the Southeast United States to better understand their perceptions and practice s regarding mental health. The research provides a voice to the lived experiences of African-American clergy with respect to understanding how their belief and attitudes regarding mental health influence their

teachings, sermons, and church practice. The proposed research addresses the gap in literature regarding the difficulties that occur in addressing mental health in the African-American community due to the intertwinement of religiosity, race, ethnicity, Christianity, and strong family ties. This study brings more awareness to the phenomena of African-American clergy's understanding and approach to mental health, which possibly could be valuable to professional mental health therapists and social workers when soliciting collaboration with African-American clergy.

CHAPTER FOUR: FINDINGS

~~Overview~~

The purpose of this hermeneutical phenomenological qualitative study was to describe African-American clergy's lived experiences with mental health and mental health's influence on the construction of their teachings, sermons, and church practice. The goal was to use interpretation to bring to light an underlying coherence of the actions of a group of people. This chapter discusses the results of the data collected from interviewing six African-American Senior Pastors, who are named by pseudonyms throughout this study to protect their identities. These interviews were completed virtually, recorded, and transcribed through Microsoft Teams over the course of six weeks. The interview transcripts were coded through MAXDA software which serves as a flexible tool to assist in coding, organizing, and analyzing transcribed interviews. The following research questions (RQs) guided this study:

- RQ1: How do African-American clergy perceive their experiences with parishioners' mental health?
- RQ2: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Finally, a summary concludes this chapter by highlighting key themes and findings.

Modification of Participant Quotes

Qualitative research consists of contextual details and phenomenological studies utilize direct participant quotes to communicate research results (Bhattacharya, 2017). Quotes were modified by removing filler ("uhm", "so", "you know") or repeating words. Attention was given to make sure that all modifications honor the participants' original statements and maintain the intended meaning. The results are communicated in a manner that identifies varying aspects of

the experience. Quotations illustrate the findings while simultaneously highlighting features of the data (Daly, 2009).

Participants

According to Rubin and Rubin (2012), participant selection should be based on the certainty that participants have real experiences and intimate knowledge about the phenomenon that was studied. The initial sampling strategy that was selected for this study was maximum variation sampling to recruit 12 final participants out of 20 possible participants. After sending out the recruitment email and follow-up emails to 20 possible participants over a period of 12 weeks, only six agreed to participate in this study. All participants were African-American senior pastors located in the Southeast United States between the ages of 42–53. Each participant served in various roles in the church for at least 8 years before becoming a senior pastor. All participants had served as the senior pastor of their current church for at least 5 years.

A senior pastor is referred to as an undershepherd because they are the leaders of their parishioners, watching overr them and guiding them in their spiritual life. This role is compared to a shepherd who herds, tends, and guards sheep in the field. Senior pastors are tasked with leading and guiding their congregation with the use of the Bible which is the written Word of God (Heseltine-Carp & Hoskins, 2020). As the spiritual leader, senior pastors are responsible for proclaiming the gospel of Jesus Christ through weekly sermons, Bible Study, and Sunday School. Senior pastors are responsible for training and teaching ordained and licensed ministers as well as other church leaders. In addition, senior pastors appoint parishioners to provide administrative leadership over the various ministries or programs in the church. Lastly, senior pastors engage in pastoral counseling with their parishioners.

The participants in this study were drawn from the Protestant faith, pastoring from the denomination of either The National Baptist Convention, USA, or a non-denominational Church.

A non-denominational church is one that does not have a connection with recognized denominations such as Catholic, Baptist, Lutheran, or Methodist. The latter denominations have a broader organization that provides set guidelines on membership, structure, and operations. In non-denominational churches, each church leader makes decisions about how their church operates. In non-denominational Christian churches, though different in structure, the belief is that the Bible is the authority that governs the teaching, preaching, worshipping, and daily living of its members. The cornerstone of this belief is Jesus Christ is the Son of God, born of the virgin Mary, who was crucified on the cross for man's sins. Jesus was resurrected or brought up from the dead by God and will return one day to gather people to go to heaven (Turley, 2023).

Table 1 describes the demographic characteristics of each participant including gender, age, race, denomination, and education. Interviews with the pastors occurred between August and October 2022. Pseudonyms were chosen based on the participant's preference for their favorite designer. Pseudonyms were used to ensure beneficence was achieved and that participants were not harmed (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978).

Table 1

Participant Demographics

Pseudonym	Age	Gender	Educational level	Current denomination	Years in ministry leadership	Years as senior pastor	Years at current church	Number of members
Gucci	49	Male	Bachelors Theology	The National Baptist Convention, USA Church	24	16	9	50–100
Fendi	54	Male	Earned Doctorate in Theology	The National Baptist Convention, USA Church	13	23	23	150–200
Polo	46	Male	Earned Doctorate in Business Administration/ Earned Doctorate in Ministry	Nondenominational Christianity	26	15	9	Less than 50
Nike	53	Female	Associate in leadership studies from Seminary	Nondenominational Christianity	16	11	11	Less than 50
Louie	49	Male	Earned Doctorate in Theology	Nondenominational Christianity	33	24	23	200–250
Coach	42	Male	Earned Doctorate Biblical Studies	Nondenominational Christianity	18	8	10	100–150

Individual Profile Portraits

Individual portraits according to Oether (2020), are used to combine the details of a study to enable comparisons. The participants profiles contain each participant's personal history surrounding the phenomena of being an African-American senior pastor. In the African-American church, the process of becoming a pastor begins with a person publicly announcing their call to ministry. This means a person shares with their pastor and the church congregation that they are being led by God to be a proclaimer of the Gospel of Christ in a ministerial leadership capacity. The individual portraits give a synopsis of which participants have received counseling from a MH professional. The portraits include the demographic makeup of each participant's congregation as well as the highest level of education obtained by each participant.

Gucci

Gucci is a 49-year-old African-American male whose foundational years were spent under the Baptist doctrine in Franklin, Georgia. He currently pastors a Baptist church. He served as a deacon, licensed minister, and ordained minister for eight years before becoming a senior pastor. He has been a senior pastor for a total of 16 years in two different Baptist churches in Georgia. The age demographics for Gucci's current church population are as follows: 20% are between the ages of 0–17, 5% are between 18–30 years of age, 40% are between 31–50 years of age, 20% are between 51–70 years of age, 10% are 70 years of age or older.

Gucci's highest level of education obtained is a Bachelor's degree in Theology. He shared, "In my personal life I have a somewhat of a strong psychological background as well. I well, I'm not degreed psychologically, but I did have a strong interest in psychology" He stated that one of his strengths is observing humans naturally to better understand them psychologically as well as spiritually. Additionally, Gucci desires to be able to understand where people are in their thought processes.

Gucci admitted he has never received counseling from a MH professional. Due to the Covid pandemic, Gucci shared that, "In the last three I would say I've focused more on MH in my pastoring; even in my messages I reference it a lot more in my sermons and messages now than I ever have before" His church has partnered with their local hospital to provide seminars and workshops on MH awareness and MH wellness.

Fendi

Fendi is a 54-year-old African-American male whose parents raised him under the Baptist doctrine in Atlanta, Georgia and he currently pastors a Baptist Church. He described his journey to becoming a senior pastor at his current church:

> I think maybe about three years in the ministry [I] received a call that a church had a vacancy. I didn't want it, to be honest with you. I just wanted to preach, you know. So I went and preached and from that they invited me back. They asked me would I be

> interested in being one of the candidates and [I] prayed about it, said yes. And in 23 years later, I'm still the pastor

Before becoming the senior pastor, he served as a deacon, licensed minister, and ordained minister in the church he had attended since childhood. The age demographics for Fendi's current church population are as follows: 30% are between 0-30 years of age, 30% are between 31–50, and 40% are 65 years of age or older.

Fendi's highest level of education obtained is an earned Doctorate in Theology. A PhD in Theology presents an academic perspective to explore the nature of the divine, religious beliefs and practices, and the role of religion in society. He shared that from a biblical standpoint, his doctorate has prepared him to counsel parishioners; however, from a MH standpoint, he feels he does not have the tools to address the MH needs of his parishioners. Fendi is one of the two participants in this study who never received counseling from a MH professional.

Polo

Polo is a 46-year-old African-American male who pastors a non-denominational church in Douglasville, Georgia. His foundational years were spent under the Pentecostal Holiness church doctrine in Baltimore, Maryland. He announced his call to ministry during his teenage years. His entry into ministry began through serving in different leadership roles in the church until he delivered his initial sermon and became a licensed minister. Polo then became an ordained elder and a senior pastor. Later he was consecrated as a bishop in Atlanta, GA. Polo has served a total of 15 years as a senior pastor with the first three years pastoring a non-denominational church, then three years pastoring a Baptist Church. Polo currently pastors at a non-denominational church. The age demographics for Polo's current church population are as follows: 10% are between the ages of 0–19, 80% are between 20–49, and 10% are 50 years old or older.

Polo's highest level of education obtained are earned Doctorates in Business and Ministry. A Doctor of Ministry is a professional doctoral degree meant to enrich religious leaders

in traditional and non-traditional settings, and to deepen their understanding of and commitment to ministry and to refine its practice. Polo shared that because of his formal training, he knows pastoral counseling sessions should be 45–55 minutes long and if more than 5 sessions are needed, he refers parishioners out to MH professionals. He stated, the "molding of much of my ethos and thought perspective regarding pastoral counseling and mental health" are a direct result of his Doctorate in Ministry.

Polo has received counseling from a mental health professional and found it beneficial. He believes that anyone who serves in the role of a pastor, ordained elder, or any higher episcopal office should engage in mental health counseling. He believes that MH counseling will give leaders the opportunity to address any unresolved areas in their own life thereby deterring the plausibility of giving unvetted advice. He shared that this would ensure that the pastoral counseling is provided with integrity and is clinically applicable. Polo added that pastors are public figures and guiding someone improperly could lead to litigation. Polo provided an example of a situation in which he would not provide marital counseling:

> If someone hypothetically is going through a marital challenge and they come out and need help. [I ask] What are you looking to accomplish? [If the response is] I'm looking to save my marriage. I'm not the person you need to talk to. Although I have marital training and I have marital experience, if you come to me under the guise of wanting to save your marriage, I can't help you because my fundamental belief is although I believe marriage is a sacrament, marriage is a union, honorable, by God, as well as a covenant and a contract in the land. I don't wanna talk to you about saving your marriage, which typically leads to what the other party is doing wrong. I think the individuals should seek individuals counseling and then two people on a healing path could then form a healing union.

He pointed out most pastoral counselors focus on the union and not the individuals in the union.

Nike

Nike is a 53-year-old African-American female who pastors a non-denominational church in Carrollton, Georgia. Her foundational years were spent under the Baptist doctrine in rural Whitesburg, Georgia. She announced her call to minister in the Baptist Church where she was licensed and ordained. After serving 5 years in that role, she founded her own non-nenominational church where she is serving in her 11th year. The population demographics of Nike's current church were not obtained.

Nike's highest level of education is an associate's in leadership studies from seminary school. She pursued this specific degree after she realized God had called her to the ministry. Nike has received counseling from a mental health professional and currently is employed with an organization that delivers mental health services to troubled teens. She admits her views on MH evolved since working in the field and she now understands the importance of it, self-love, and taking care of your mental well-being. She attributes her ability to understand her parishioner's stigma regarding the existence of MH issues because, "I have said to them myself that I used to think the same way." Nike desires to now educate not only her parishioners but the African-American community about the importance of MH wellness.

Louie

Louie is a 49-year-old African-American male who pastors a non-denominational church in Decatur, Georgia. His foundational years were spent under the Pentecostal Holiness Church doctrine in Detroit, Michigan. He announced his call to ministry during his teen years. His progression into ministry began through serving in different leadership roles in the church until he delivered his initial sermon and became a licensed minister. When Louie started college, he became the leader of the Morehouse College choir. During this time, he became an ordained elder and the college choir transformed into a church founded by him. Later he was consecrated as a Bishop and has been set aside to be consecrated as an Apostle in 2023. He has served a total of 24 years as a senior pastor of the church he founded in college.

Louie shared his academic journey from high school was to pursue a law degree:

> I was salutatorian, graduated salutatorian from high school in River Rouge, MI. And came to Morehouse College on partial scholarship. And it was in my sophomore year at Morehouse that I realized that my plans to go to law school would not be pursued as the Lord began to deal with me about ministry. So I continued and finished Morehouse.

Louie's highest level of education obtained is an earned PhD in Theology. He shared that he focuses a lot on the mind, feelings, and behavior of his parishioners. During the interview he used a few cognitive behavioral therapy terms when he discussed how he targets the minds of his parishioners in his sermons and teachings. When asked about it, he shared he was a certified life coach. Louis has received counseling from a mental health professional and is married to a licensed clinical social worker. Louie and his wife often counsel parishioners together with his focus on the spiritual and hers on MH.

Coach

Coach is a 42-year-old African-American male who pastors a non-denominational church in Pelham, Alabama. His foundational years were spent under the Baptist doctrine in Anniston, Alabama. Once he enrolled in the North Carolina College of Theology, he began attending a non-denominational church. He became a licensed minister, ordained elder, and consecrated as a bishop. Coach was in ministry leadership for 10 years before founding his church where he has served for the last eight years. The age demographics for Coach's current church population are as follows: 20% are between the ages of 0–25, 40% are between 25–39, and 40% are between 40–65 or older.

Coach's highest level of education obtained is an earned Doctorate in Biblical Studies. A PhD in Biblical Studies is designed for pastors and teachers who intend to teach biblical studies in liberal arts colleges, universities, or churches. He pursued this degree because it was "his heart's desire to teach people all he knows and to have them fall in love with the scriptures in the Bible." He wants people to enjoy and love the Word of God. Coach shared that around 2005

when he was 23, he became connected to an Apostle who preached on counseling and therapy, and that "shaped and molded" his views on incorporating it into his church. He admitted that he provides limited pastoral counseling though he holds a certification in pastoral counseling. He prefers to be a resource and a reference providing referrals to a professional MH counselor.

Coach has received and is currently receiving counseling from a MH professional. He first began in 2020 due to a life-threatening illness he endured. He was in the hospital from February until July, endured five major surgeries, and 4 minor surgeries. He almost died three times. His sessions started as weekly and now are bi-weekly. Coach believes every pastor and leader should have a therapist due to the demands of the church inclusive of bearing the weight of parishioner's burdens. Bearing the weight of burdens is the fulfillment of one of the roles of a senior pastor. The expectation is to pray for parishioners and be available to them as they experience hardships in their lives. He shared:

> I compel any leader, pastor to get a therapist-to get someone that you can talk to, someone that you can cry to. And I will say, when it comes to pastoring, is making sure you get someone who at least understands just that role of what it [is]that that that because it's a different place. You know, the hurt is so much different. The struggle is so much different. The pain is different.

Researcher's Journal

As the researcher, I kept a journal to write my thoughts about the data collected during the interviews. My first thoughts came after completing the initial interviews. My second thoughts came after re-watching the interviews while reviewing the transcriptions. One interesting thing I noted was that two of the six participants had never been to a professional MH professional as a client. I also noted that all the participants shared that their parents raised them in the church from birth. Additionally, four of the six participants hold a Doctorate in Theology, Biblical Studies, or Ministry. However, even though this group of participants displayed diversity, I felt that for an further research I would want to use a more diverse population of

participants. I reflected that I wished I had found some participants whose formative foundation did not begin in church. I also wished I had found participants who's age ranged between 30–40 years old.

The group had diverse experiences and shared memorable moments that occurred in their pastoral counseling. Two of the six participants were adamant they would never refer their parishioners to a non-Christian MH professional. These two pastors were both non-denominational Pentecostal pastors, raised in the Pentecostal faith, and had been in leadership positions in ministry for over 20 years.

All participants reported they integrated MH into their sermons, sharing that since the Covid-19 Pandemic they have increased teaching about MH concepts in their sermons. One pastor shared that their church partners with a local hospital that provides regular educational forums on MH. The participant who has the associate's degree shared she currently works in the MH field at an inpatient hospital facility serving ages five years old to 18 years old. She was more reflective of her counseling approach with her parishioners than the other participants.

I added additional notes in my journal regarding the African-American senior pastor's perspectives on pastoral counseling and professional MH counseling. I found it interesting to hear how they feel stigma impacts their congregation. As I interviewed the pastors, I found such inspiration in how they view their calling from God, as well as their purpose, when assisting their parishioners with sensitive life matters.

Overall, I filled my journal notes with comments regarding the experiences of African-American clergy and their experiences with their parishioners in pastoral counseling. Common themes emerged from my notes, the interviews, and subcoding using Maxqda Software. One themes related to RQ1; a sense of responsibility and satisfaction. Themes related to RQ2 include: (a) sense of vulnerability, (b) providing hope through life, and (c) application and promoting change.

Results

Theme Development

Theme development was assisted by MAXQDA 2022 (VERBI Software, 2021), a computer software for qualitative research. The transcribed participant interviews were imported into MAXQDA as data files, coded by highlighting statements from the participants' transcript and then organized into potential themes. Exploration of the data files and codes involved running word frequencies, various queries, and creating visuals to identify demographics and detail results. Bracketing was achieved by acknowledging my understanding is shaped by my personal knowledge and experience while still maintaining an attitude of openness (Gadamer, 1989). My experience as a MH therapist provided me with ability to apply active listening to respond. In addition, since I am a licensed minister on my journey to ordination, I was able to allow new knowledge to challenge my old knowledge regarding the role of African-American clergy as gatekeepers to MH acceptance in their congregation.

I addressed two RQs in this study using African-American pastor's participant interviews and my researcher journal.

- RQ1: How do African-American clergy perceive their experiences with parishioners' mental health?
- RQ2: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Table 2 illustrates the themes and subthemes that emerged from the data.

Table 2

Themes and Subthemes

Theme	Research question	Definition	Subthemes	Exemplary Quote
Sense of responsibility	RQ1	An awareness of one's obligations	Pastoral counseling perspective; Parishioner issues requiring more training; Parishioner satisfaction; referral process	"if we reach a place to whereas I cannot deal with such as you know alcohol addiction..."
Sense of vulnerability	RQ2	A state of emotional exposure that comes with a degree of uncertainty	Benefits of receiving counseling from mental health professionals; challenges of being a recipient of mental health	"avoiding the pitfall of self-treatment and self-diagnosis and avoiding ontological arrogance"
Providing hope through life application	RQ2	A feeling of trust and faith in God	Perspective of mental health integrated into sermons	"I know that most of my sermons are birthed from my life experiences.
Promoting change	RQ2	Doing something different that leads to beneficial outcomes	Overcoming stigma	"Black folks don't do stuff like that because we've been taught to, we've been conditioned to have a mindset to tolerate certain levels of pain and just accept things as normal..."

Themes Related to Research Question One

The first major theme that emerged relative to RQ1 was a sense of responsibility which includes subthemes of pastoral counseling perspective, parishioner issues requiring more training, referral process, and parishioner satisfaction. The following section presents the results relative to the first research question. It was evident that the participants felt a sense of duty and responsibility to their parishioners and how they impacted their parishioner's lives. It was evident all participants felt that a sense of responsibility and a high of understanding were requirement for effective pastoral counseling; however, only three of the six participants were able to articulate a structured intake process.

Major Theme One: Sense of Responsibility

All six participants agreed that the pastor and under shephard experiences times when they are not able to help their parishioners through certain life issues. They all expressed the importance of pastoral counseling as one of the duties of a senior pastor. Subthemes generated from this theme include, Pastoral Counseling Perspective, Parishioner Issues Requiring More Training, and the Referral Process. Discussion of the subthemes below include comments from each participant.

Subtheme One: Pastoral Counseling Perspective

All six participants agreed they were able to effectively counsel with the support of God and the Holy Spirit. The Holy Spirit for Christian denominations is the third person of a triune God. Christians believe God is manifested as God the Father, God the Son, and God the Holy Spirit. God the Father is the one who created the world. God then sent his Son, Jesus, to earth to save the world from sin. Jesus died for the sins of the world and those who choose to believe in Him and accept Him as their savior then receive the Holy Spirit. The purpose of the Holy Spirit is to lead and guide believers in everyday life according to what God has spoken through the Bible. Fendi shared how he approaches pastoral counseling from this perspective:

> I love to hear what they have to say. I want them to be open and not hold back. So my stand is always to be available to hear from the parishioners to know what what's going on in their life.

Louie shared:

> I'm not counseling just out of my own personal wisdom and knowledge, but I depend on the Holy Spirit to help me help you. I think that's an edge of that we have even in Christian counseling. We have the Holy Spirit that reveals to us truth. That's his job and He shows us sometimes what the exact matter is to be able to help people.

Similarly, Gucci stated:

> I do know that the Word of God and biblical principles are as strong foundation in the life of all believers. There're several instances where I've been able to provide them with biblical foundation and assistance and it helped them with their issue.

Coach added, "I have had quite a few marriages that have been sustained through biblical counseling. I have seen great success with biblical scriptures and biblical principles being used." Nike summed it up in this manner:

> I believe that a lot of times symptoms are the enemy's way of getting us to accept certain things that that is put on us, you know. And by faith we have the right to speak those things that are not as though they were already are so it's a constant battle of what you said and what you say you believe. So that's what I do. I constantly remind them this is what we this is this is a part of the benefit package that we have.

Polo, emphasizing the need to ensure that the pastoral counseling relationship is ethical said:

> I'm not looking-I have no desire to be someone's rescuers, someone's hero. I don't need to be the sunshine in anyone's life. And sometimes when you deal with someone from that perspective, it can create a sense of dependency or codependency if you will. And if I see that - if I see that brewing, I step away, my job is to help, not enable.

Subtheme Two: Parishioner Issues Requiring More Training

Five of the six participants were able to recall instances in which they felt they were not able to provide the counseling their parishioner needed at that time. These experiences demonstrated the need for more training. Polo shared:

> I do not have any training in adolescent psychology or early childhood development or even childhood education. So in that, I would say, let's pray. Let's seek out someone and let them do their work, and I will speak to them as they go through the process. I would go with them to a session. But I don't have specialization with children, so something like that I can't do.

Fendi and Louie both shared instances when a parishioner was thinking about suicide, so they knew the person needed help beyond pastoral counseling. Fendi shared:

> There was a time when I had a situation where [a] young kid was really thinking about suicide. And the parent you know, reached out to me. I knew the parent knew the child, prayed with the parent, but I felt like it was at that point where they needed more professional help than just a spiritual level of guidance.

Louie provided an example where he referred one of his parishioners to a professional MH counselor and the role he took upon after the referral:

> Someone who's been triggered in their present about a matter in their history that was never resolved. So, I've talked with them and they're really heavy in that matter, so I've recommended them to sit with somebody, but I still send them scriptures. I still send them encouraging words to assist in that.

Coach added:

> I had a young lady that came up to me with an issue. She was molested, raped and she came to me and my heart broke because, of course, as a pastor, you wanna have all the answers and the help. At that moment, you know, all I could do is just be an ear for her.

Gucci did not provide specific examples like the other participants, but he did recall a time when he felt he did not provide adequate pastoral counseling and his subsequent response in his pastoral counseling techniques:

> There was a time where I was counseling or talking with a parishioner and they didn't share all the information that I believe would have helped me to guide them and the system better. So now whenever I'm counseling someone or speaking with someone, I ask specific questions so that I can try and gain all of the necessary information. Because typically when you're dealing with people and they're dealing with a stressful or traumatic or serious situation, you want to be sensitive to them, to not act like you're prodding or just demanding information from them.

Nike had a similar experience in which she felt she did not provide effective pastoral counseling and the parishioner, who did not accept her referral later committed suicide:

> There was a time that there was a there was a situation and I wished I had done more. I wish I had done more as far as maybe advocating for somebody who was really in need of help therapy. I still struggle with that sometimes still to this day, you know, because the person was crying out and I just felt as he probably needed more of expert advice. More of a what he needed [was] counseling, and I did suggest it several times, but I didn't push it. You know what I'm saying? And I just wish, that's the one thing that I still regret to this day, cause he's no longer with us.

Subtheme Three: Referral Process

There were opposing thoughts about referring parishioners to a non-Christian MH professional. Three of the six participants were unopposed to it, two were opposed, and one had mixed feelings. Fendi was unopposed and shared, "From a medical standpoint a person can still receive the medical attention that they need." Gucci agreed, sharing, "I think that it is acceptable for them to do so, umm because I believe that mental health, while it is vital and critical, it can be received outside of religious background or foundation." Coach stated his thoughts this way:

> If they're getting help from a counselor that does not know Christ, I mean, I you know, I I my whole objective is just the same way you might get. You might get a cast put on your arm by somebody who doesn't know Jesus. So you know, as long as you're getting the help that you need, that is, you know, pointing you in the direct, direct right direction of help. I'm OK with it.

Polo was opposed, sharing:

> Believe that although when you deal with mental health, the understanding of of psychology, psychiatry, sociology and all those other ologies or studies of. I still believe that in all of that there has to be a fundamental understanding of the core of the individual. I think that it's difficult to understand that which is the core of the individual,

> even their history or their current position, without understanding the importance of prayer. Now, if you are an agnostic, which which you are, you believe knowledge is essential or you are in atheist where you denied the existence of a God, than to whom are we praying? So if we remove prayer as the focal point, then I, I think it's kind of difficult to fully assess.

Louie shared:

> No, because the roadbook for life is the Bible. Christians seeking out non-Christian therapists - is that if you don't understand my culture and what it is I subscribe to and what it is I believe, then can be damage done there.

Nike has a preference for a Christian MH professional but is not completely opposed to a non-Christian MH professional sharing:

> When a person feels that there's a crisis that's going on in their lives, umm they need, they need help. You know what I'm saying? And of course, of course, I would suggest a Christian counselor, but if that person is not ,if it means that that person wouldn't seek help at all if they had to go to a Christian counselor - I certainly wouldn't want them to just not get the help that they need.

Subtheme Four: Parishioner Satisfaction

During the interview process each participant was asked*, "Can you think about one of your most challenging issues you've had to counsel a parishioner through? If I were to speak to that person, how do you think they would rate their level of comfort and satisfaction with the services you provided?"* Gucci responded, "they would have a high rating for the services that I provided. I typically try to be very thorough in helping parishioners when they are in need." Fendi provided an example of pastoral counseling with a parishioner and their child regarding a school matter. He stated, "I felt like that was successful. I felt like they would say it was helpful because it prevented it going or spreading out and causing problems with other people." Nike shared an example of a couple that was having marital issues. They began the pastoral

counseling process not even speaking to each other but after the counseling process and heated sessions they were able to sustain their marriage. Louie also recalled a time when he felt good about that the services that he was able to provide. One of his parishioners was depressed due not having attended her mother's funeral. She had been grieving her mother's death for years. He drove her to the cemetery and allowed her to grieve. He shared; "I think they would say that we went well beyond what was required in order to try to bring some resolve." Coach replied:

> I do try to make it my mission again to follow the wisdom of God, you know. And so when I'm counseling someone and I'm talking to someone again, I praise God that I've had the I've had the blessed opportunity to see umm success in many people's lives, only due to the fact of the Holy Spirit. I've had people to come back and say thank you. You saved my life, or you saved my marriage.

Polo's response to this question was differend from all of the other partiipants. He said, "I really don't know. I am not seeking to provide comfort but just trying to provide them with a service."

Themes Related to Research Question Two

Research question two sought to understand how African-American clergy interpret the lived experience of using their lived experiences with MH in constructing teachings, sermons, and church practices? Three major themes emerged relative to this question. The first theme, sense of vulnerability, includes the subthemes of benefits of receiving MH counseling and challenges of receiving MH counseling. The second major theme relative to RQ2 is providing hope through life application. the third theme is promoting change.

Major Theme Two: Sense Vulnerability

Four of the six participants have received counseling from MH professionals. The two that have never received counseling shared they never had any issues in life which caused them to seek MH professional counseling. The four who had received counseling from a MH professional all expressed challenges with being on the receiving end of counseling. The benefits

and challenges of receiving counseling were subthemes generated from this theme. The subthemes include comments from each participant.

Subtheme One: Benefits of Receiving Mental Health Counseling

Polo asserts all ministers, elders, and pastors should go through counseling to resolve their own personal issues before giving advice to others. He believes that without resolution of personal issues; pastors may unintentionally give unvetted advice based on their personal opinions or experiences instead of presenting a "multidisciplinary or multifaceted approach." Coach shared:

> It has been extremely beneficial to me when I started going to therapy back in 2020 due to my sickness and death going through major surgeries which shook his faith. It has been extremely beneficial and helpful for me in my mental health as a pastor.

He emphasized the importance of MH for pastors who carry the weight of their members' pain. He added that he slacked off in 2021 but now still attends counseling bi-weekly and weekly if needed.

Nike shared that experiencing counseling as a client has been instrumental in helping her understand how to mold parishioners' perspective on MH, "I have said to myself that I used to think the same way." She emphasized that this realization allows her to be more strategic when she is engaging in open discussions with her parishioners. Louie shared his experience with receiving MH counseling challenged his prior perspective on MH professional counselors:

> I've always been concerned that therapists were more interested in making money than getting you where you need to be, but that was not my experience. So when I actually went after number of sessions, he told me you have your answers and there's nothing else I can do. You can keep paying to come talk to me, but you have what you need. And so it was refreshing to know that I wasn't being milked.

Subtheme Two: Challenges of Receiving Mental Health Counseling

Four participants shared their challenges with receiving MH counseling. Polo shared, "I had to avoid the snares of pride and being honest although my honesty maybe at points contradictory to what people think my title says who I am are or what I should experience." Nike recalled feeling like "the counselor was being very judgmental and little bit overly opinionated." Similarly, Louie shared that he struggled when the therapist told him he "had the answers and there was nothing else they could do"; however, it alleviated his initial thoughts that therapists continued sessions to make money. Coach shared that his challenge with a MH professional occurred when he began to think his issue was resolved:

> I kind of slacked off with going to therapy because you know, I'm like, OK, I'm cool. I'm good now. However, I quickly realized no, I need to keep going, you know? And so since 2021, I have been going, like I said, I started weekly. Now I just go bi-weekly.

Major Theme Three: Providing Hope Through Life Application

All six participants expressed the importance of integrating MH into their sermons and teachings. Gucci indicated:

> Everything starts in the mind. So when the mind is sound and strong and healthy, then obviously they can receive and perceive things in life better as it deals with anything pertaining to religious or biblical nature.

Nike shared:

> I feel a theologian, so to speak, you know. I know that most of my sermons are birthed from life experiences. I always find myself in the starting blocks of something, or I mean a coming out of something that somebody else may be in the starting blocks.

Fendi added:

> I use light application through all of my sermons because I want my members to

> understand from a spiritual standpoint with the Bible, we have that. But that's everyday life that we live and they need to be able to apply the principles of the Bible to their personal life."

Coach explained how he believes pastors "do a wonderful job of delivering but a horrible job on development." His sermon series on "Life After Deliverance" led to 10–12 members going to a MH therapist for further deliverance. Louie shared he is also a certified life coach and believes when you preach you must study and use outside resources to support the point you are making. He believes in incorporating philosophy, psychology, numbers, and other things to strengthen biblical points to make sure the focus is on the Word of God. Polo discussed the importance of applying biblical teachings to real-life situations. He noted that without application of the Bible, the Bible becomes nothing more than a fictional or historical book. By exploring the characters' minds and experiences, we can understand that they faced real issues and emotions, such as grief and depression. He further explained that the key is to seek God as the true healer in these situations, and sometimes this may involve seeking both prayer and professional help.

Major Theme Four: Promoting Change

All six participants agreed there is still a stigma in the African-American Christian community regarding receiving counseling from a MH professional. They believe they can promote a change of mindset in supporting parishioner's overcome the stigma of seeking MH professionals.

Subtheme One: Overcoming Stigma

Louie believes the stigma of seeking MH counseling has lessened but still exists. He feels it is very necessary to pay attention to MH and people should seek insight into whatever they are battling with or wrestling with in life. Gucci shared:

> I definitely have put a lot more emphasis on dealing with mental health. I hope that other pastors will begin to do the same, especially African-American pastors, so that the

> African-American community can remove the stigma on mental health concerns and begin to get the help that that they need or may need.

Fendi shared:

> I would add that mental health is a serious illness and we, as pastors have to be aware of it and not just wanna treat it as a spiritual issue of Satan just attacking the mind. I mean, there are some Christians that are saved and still having mental issues and so I would say it is a serious issue that a lot of times we have swept it under the rug and don't wanna deal with it.

Fendi believs that pastors need to address everyday issues that parishioners face outside the church. Pastors should be transparent and honest in their teachings and preach the complete whole person addressing the body, soul, and mind.

Nike shared:

> I think that anything to do with self-help, self-love [in] the African-American community is always-has always been an issue. It's now being made a priority but in times past it wasn't, and I think a lot of that stuff is just generational stuff that's passed down. We've been taught to tolerate pain and we've been taught to accept certain things that are definitely not normal at all. We have seen it being made ok or as if it is something that our cultural does. Even when you hear about suicide. Oh, it must have been a white woman, or it must have been a white man. Black folks don't do stuff like that because we've been conditioned to, a mindset to tolerate certain levels of pain and just accept things as normal. And you can become addicted to a chaotic environment and not even know it not even be aware of it.

Along with others she shared there must be open discussions about mental health and the importance of self-love and taking care of your mental well-being. Polo referenced an example he saw growing up as a child to illustrate a step the church can implement to help lessen stigma.

> My forefathers in ministry did not have that formal training. Their belief was in the text, which says, my little children I will labor with you, till Christ be formed in you. So my pastor would literally have meeting or what we call now sessions with people for an hour before Bible study instead of sending them to a counselor who could really address their issues.

Polo believes pastors following ethical practices regarding pastoral counseling and utilizing referrals to professional MH counselors can help lessen the stigma. Coach was the only participant who addressed MH stigma regarding pastors only and not the entire African-American community. He said:

> My therapist that I have now, he was a life changer. I don't know who sees this or watches this man, but I compel any leader, pastor to get a therapist - to get someone that you can talk to, someone that you can cry to. And I will say, when it comes to pastoring make sure you get someone who at least understands just that role of what it is because it's different. It's a different place. You know, the hurt is so much different. The struggle is so much different. The pain is different.

Research Question Results

The purpose of this hermeneutical phenomenological study was to describe how the lived experiences of African-American clergy's lived experiences with mental health influence their teachings, sermons, and church practices. A hermeneutical phenomenological study describes the common meaning for a group of people based on their lived experiences and interpretation of the texts of their lives, leading to an underlying coherence of actions for this group of people (Creswell & Poth, 2018). This current study reduces individual African-American clergy beliefs regarding MH to a universal context to better understand how their perceptions, attitudes, and beliefs regarding MH influence their practices as clergymen or clergywomen. There were four philosophical assumptions in this study: 1) a search for wisdom in gaining insight into African-American clergy's understandings and perceptions of mental health, 2) there were no judgments

about the reality of MH in African-American clergy until the data was analyzed, 3) African-American clergy bring both subjective and objective experiences as part of their lived experiences, and 4) the reality of African-American clergy was only perceived within the meaning of their individual experiences.

RQ1: How do African-American clergy perceive their experiences with parishioners' mental health?

Pastoral Counseling Intake

All six participants were able to articulate their initial interactions with their parishioners while providing pastoral counseling. Their intake method most closely identifies with Carl Rogers, person-centered approach. All participants expressed a desire to understand the needs of their parishioners who seek counseling. Emphatic understanding is one of the key concepts of person-centered counseling in which the counselor attempts to understand the client's point of view (Rogers, 1946). Fendi remarked:

> I have an open-door policy so I allow my parishioners to come in and you know, voice what's going on. I love to hear what they have to say. I want them to be open and not hold back. So my stand is always to be available to hear from the parishioners to know what what's going on in their life.

The second key concept that was shared among the pastors was an "unconditional positive regard, the counselor being non-judgmental.

> I tried to establish a basic exchange, you know, and then at some point, I'll ask them how can I serve you? And I'll listen to what their issue is, what the challenge is, what their matter is and understanding that I'm not a licensed counselor. I try to never tell people what to do. My job is to listen to you. To seek the Holy Spirit for some guidance, some scripture to help you along in your way to pray with you, but never to tell people what to do.

The third concept that I derived from the participants pastoral intake process is they embrace

Roger's approach of the counselor being a genuine person (Rogers, 1946). Polo shared:

> I would ask them, what is the desired outcome? Then from the desired outcome then I will let them know that I am not a licensed therapist. I've been trained in pastoral counseling, I have certain clinical trainings, if you will or developments, but I am not licensed by any board certified by no state. So, I am extremely limited.

Nike shared:

> I let them know instantly that I am not a counselor, but I can advise you on some things or talk to you about some things. But at the same time, I have to make that clear to them. And sometimes I've had people saying, well, I want you to counsel me.

Pastoral Counseling Interventions

Five of the six participants shared experiences of success when only using the Bible and prayer as interventions in their pastoral counseling. Nike shared there have been several times when a parishioner has come to her seeking counseling due to a sickness or negative report and she has only used the Bible and prayer as interventions. Fendi provided an example of an elderly parishioner who was depressed due to feeling she was at the onset of memory loss:

> I had prayer with her and gave her some good guidance from the scripture standpoint and just tried to encourage her to realize that it will get better. You know, some from a spiritual standpoint, some good references, scriptures and trusting and Lord and not allow Satan to attack her she was being attacked. Few hours later receive a text saying they made at home. She was feeling great. She was in the kitchen cooking that she hadn't did in a in a for the last past week, so I felt like it was successful.

Gucci added:

> I do know that the Word of God and and biblical principles are as strong foundation in the life of all believers. So I could - there's several instances where I've been able to provide them with biblical foundation and assistance and it helped them with their issue.

Nike works in the mental health field and was able to articulate different coping strategies as deep breathing and relaxation techniques; however, she shared this when asked what process she used to determine whether to use spiritual interventions or coping skills. She explained:

> I believe everything you know starts with prayer, you know, regardless of what it is or what that we're dealing with. I believe that because of my faith, anything outside of my faith should be an extension to it, you know? So my faith comes first, especially when I'm dealing with parishioners. I've always going to look at things from a spiritual perspective.

Polo was the only participant who shared he has never counseled a parishioner only using the Biblical scriptures and prayer. He believes the divine must be mixed with science to holistically address a parishioner's needs in pastoral counseling. He declared:

> I don't believe science and theology are distinct disciplines, although they are taught distinctly. I think science underscores the existence of God. And I think God himself underscores the importance as God himself expresses himself through science.

Pastoral Counseling Referral Process

All participants shared they have referred parishioners to a professional mental health counselor and have contacts for specific therapists; however, they are open to parishioners finding their own therapist. As noted above, there were differing perspectives on whether the parishioners should receive counseling from a Christian MH counselor. Of the six participants, only two had a structured referral process. The other four participants recalled previous instances and issues which caused them to refer a parishioner to a professional MH counselor such as suicide, child psychological issues, a fire starter, deep generational issues, addictions, and depression.

Polo shared that in his seminary training he was taught to limit pastoral counseling to three to five sessions and if there is no result he should hand them off to a professional MH

counselor. Coach shared that he has a certification in pastoral counseling and therapy which has provided him with the boundaries he uses for referrals. Coach noted:

> I'm that pastor that says, look, if you need some help, man, we gonna get you some help. So I'm not gonna sit there and try to answer or solve all of their problems. I will be that brother that showed up for them to lean on that ear for them to talk to the shoulder to cry own. But if there's some deeper issues and some deeper-rooted issues there, hey, I'm going to lead them to therapy and the counselor.

Parishioners Reaction to Referrals

Five of the six participants described instances when they attempted to refer a parishioner to a professional mental health counselor and their referral was rejected. All of the participants agreed that they did not take the rejection of the referral personally, and understood that it takes time for some people to admit they need help. All participants shared they have never tried to force a parishioner to accept a referral after it had been rejected it.

Gucci's response to the question of "How do you feel when you refer parishioners to outside mental health services and they refuse to accept your recommendation?" garnered this response:

> Hmm disappointed, not personally, but disappointed that they didn't go forth to get the additional help they could have received and somewhat obviously concerned and somewhat saddened because when you see that their situation or their condition didn't improve and you know it's because they didn't take the advice that you provided, then it obviously causes you to feel saddened because you want to help them and they refuse the help. So yeah, it's disappointing.

Polo shared that he understands it is a process to admit you need counseling, so he considers that when parishioners refuse to accept a referral to a professional MH counselor.

> I think people progress according to their own level of honesty within themselves. Therapy, mental health assistance, whatever nomenclature you want to attach to it, all of

> it in my opinion, revolve-involves a sense of vulnerability. It will require someone to face what they may not want to face, or they may not be positioned to face at the moment. So I feel like no, they don't wanna do it right now, but just know that you are now the orchestrator or the author or contributor to your own chaos. So if you're not ready, we go at the pace you wanna go. But don't think things gonna be miraculous when you're not a participant in the making of the miracle.

Coach discussed how he tries to explain to his parishioners why he is referring them to a professional MH counselor. He said:

> I don't take it personal, so it doesn't bother me . I will say, what does bother me though is that when I do send you to get help and you come back to me with the same problem, thinking I'm gonna be able to help you, I'm gonna send you right back to the same person that I refer to you. I do let everyone know, hey, I don't think you're crazy. I don't think you're psycho. You're dealing with something that I know that I can't help you know. It's not to you know again push you away. It's just I can't help you with it. If you don't take it that's that's on you.

Louie was aligned with Polo's perspective of realizing some things take time to accept and process. He noted:

> I do not take responsibility for that. I have learned that helping requires acceptance. And you cannot carry the burden for people who don't receive help. So, there was a time I'll be like, well, I'm just trying to help you and you get it frustrated because you're really invested. And I've learned that uh you share from your heart you give from your heart from the Word of God, uh rom everything you have. But when it's rejected. Only thing you can do is pray for them. And pray that they're led into the answer for their lives.

RQ2: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Although only four of the six participants have received professional MH counseling from a licensed therapist, all participants were able to provide adequate information of how their pastoral counseling has been shaped by their perspective on mental health. Interestingly, the two participants who had never received MH counseling were both pastors with a Baptist foundation, and both currently pastor in a Baptist church.

Personal Experience of Receiving Counseling

The benefits and challenges of receiving counseling were one of the themes derived from data analysis. Polo believes all ministers, elders, and pastors should go through counseling to resolve their issues before advising others. He believes without the resolution of personal issues; pastors may unintentionally give unvetted advice based on their personal opinions or experiences instead of presenting a "multidisciplinary or multifaceted approach. Coach emphasized the need for pastors to have a pastor to ensure their own MH and wellness because they consistently deal with the weight of walking parishioners through life issues. The four participants shared that being on the receiving end of MH counseling gave them a perspective of how their parishioners may feel about receiving pastoral counseling.

Educational Background Effect on Mental Health Perspective

The participant's educational levels include an Associate's in Leadership Studies, a Bachelor's in Theology, earned PhD in Biblical Studies, earned PhD in Ministry, and two earned PhD's in Theology. The participant who obtained the Associate's in Leadership Studies at the seminary shared that her educational level did not shape her views on MH. The participant with a Bachelor's in Theology shared that his psychology classes prepared him to use observations to better understand his parishioners psychologically as well as spirituality when he is providing pastoral counseling. The participant with a PhD in Biblical Studies attributes his understanding of the importance of MH to his Apostle preaching on counseling and therapy that also "shaped and molded" his views on incorporating it into his church. He earned a certification in pastoral

counseling to become better equipped for pastoral counseling. He along with one other participant was very adamant regarding referring parishioners out to professional MH counselor after a couple of pastoral counseling sessions. The one participant with a PhD in Ministry attributes his ethos and perspective regarding pastoral counseling and MH directly to his education. He is the only participant who shared he never provides pastoral counseling using only the Bible and prayer, but integrates a multidisciplinary approach to holistically address his parishioner's issues. He was the second participant who was adamant that after three to five sessions he would refer parishioners to a professional MH counselor if the issue is not resolved. The participants with earned PhDs in Theology shared that their education has prepared them to counsel parishioners spiritually; however, from a MH standpoint, they were not given the tools to address the MH needs of their parishioners. One of the participants with a PhD in Theology attributes his understanding of the mind and teaching parishioners to reframe his thinking as a result of being a certified life coach.

Approach to Addressing Mental Health with Parishioners

All six participants expressed the importance of integrating MH into their sermons and teachings. Gucci shared:

> I believe that everything is dealing with the mind. Everything starts in the mind. So when the mind is sound and strong and healthy, then obviously they can receive and perceive things in life better as it deals with anything pertaining to religious or biblical nature.

Fendi added:

> I use life application through all of my sermons because I want my members to understand from a spiritual standpoint with the Bible. But there's everyday life that we live and they need to be able to apply the principles of the Bible to their personal life. So yes, I'm firmly believe in life applications principles that parishioners can apply to their life to make them better after they leave there on Sundays.

Polo provided an example of how he has used the story of Job to teach on depression and grief. He stated:

> Job got knowledge that his children were dead, Bible says he fell to the ground, he rent his clothes and then he worshipped the falling to the ground, the renting of the clothes. Some clinicians would say he was actually going through stages of grief if not bordering on depression. But sometimes we skip over that and go straight to worship. And it causes a mindset that if you have mental health challenges that you're not spiritual. No beloved it, you could be spiritual and depressed, you could be saved and depressed. So but the key is do we remove God in our depression or do we seek him as the as the true healer? Because sometimes you know people say sometimes you need prayer. You need a pastor and a therapist. I say sometimes you need prayer and the prescription.

Louie shared that as a certified life coach he believes when you preach you must study and use outside resources to support the point you are making. He incorporates philosophy and psychology, numbers, and other things to strengthen biblical points ensuring the Bible is the foundation and no discipline incorporated undermines or conflicts with the Bible. He likens his sermons to a therapy session. Simarly, Louise shared that there are times when her sermon incorporates something that is psychiatric in nature:

> Oftentimes the sermon can be likened unto a therapy session. Because you're hearing what you need to hear, you're getting answers. You're getting insight. You're getting clarity about matters and it's really designed to help you in progressing in life.

Coach shared he incorporates a lot of MH and dealing with self-care in his sermons and teachings. He provided a specific example, quoting the Bible to teach the principle of self-love and self-care:

> Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind. This is the first and great commandment. And the second is like unto it, Thou shalt

> love thy neighbour as thyself.

Coach added:

> But you can you do a disservice to that scripture if you love your neighbor, but you never love yourself, you know. And so it is important, and it is vital to take time to yourself, whether it's vacationing, whether it's just a break, you know.

Addressing the Stigma Associated with Mental Health

All six participants agreed there is still a stigma in the African-American Christian community regarding receiving counseling from a MH professional. The participants believe that African-Americans know how to sing, dance, and praise God well but when it comes down to living a life outside of the church where they live in authentic peace, joy, and love there is room for improvement. They concurred that pastors can decrease the stigma attached MH by being transparent and honest in their teachings and preaching about the complete whole person, addressing the body, soul, and mind. They further declared that there must be open discussions about MH and the importance of self-love and taking care of your mental well-being. All believed that pastors should be aware of MH and treat it as a serious illness and not as an attack from Satan and normalize seeking help from professional MH counselors.

Summary

In this chapter, the results from the inquiry into the lived experiences of six African-American senior pastors were reported. The six participants were pastors in African-American churches located in the southeastern part of the United States. According to Pew Research Center (2021), African-American southerners are more likely to be an active part of a church than African-Americans living in other parts of the United States, with two-thirds reporting religion is very important to them. In the southeast, 65% of African-Americans reported worshipping in a predominantly African-American congregation, more than African-Americans in other regions (Pew Research, 2012). Likewise, African-American southerners are more likely to view the

Bible as the literal Word of God. Seventy-two percent of African-Americans reported being of the Protestant faith (Pew Research, 2021).

This study focused on two denominations of the Protestant faith: Baptist, and non-denominational whose congregations are at least 65% African-Americans. This criterion aligns with Pew Research (2021), in that 65% of African-Americans report worshipping at a predominantly African-American congregation. Participants' background information along with information from the researcher's journal was included in this chapter.

The following research questions (RQ) guided this study:

- RQ1: How do African-American clergy perceive their experiences with parishioners' mental health?
- RQ2: How do African-American clergy interpret the lived experience of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Participants shared experiences with the phenomenon through virtual interviews on the Microsoft Teams platform. Data received from the participants was discussed in individual portraits of the participant. Data analysis through MAXQDA software and the researcher's journal allowed the research questions to be answered fully. One theme that emerged for RQ1 was a sense of responsibility. Four subthemes were discovered; pastoral counseling perspective, parishioners' issues requiring more training, referral process, and parishioner satisfaction. The three themes that emerged relative to RQ2 were a sense of vulnerability with subthemes of benefits of receiving MH counseling and challenges of receiving MH counseling. The remaining themes are providing hope, and promoting change with the subtheme of overcoming stigma.

All six participants expressed the importance of pastoral counseling, as counseling is one of the duties of a senior pastor. Furthermore, they shared how they can effectively counsel their parishioners with the help of the Holy Spirit. The purpose of the Holy Spirit is to lead and guide

believers in everyday life according to what God has spoken through the Bible. Each participant was able to recall examples in which they felt their parishioners were satisfied with the pastoral counseling the participants were able to provide. Five of six participants were able to recall instances in which they felt they were not able to provide the counseling their parishioner needed at the time. Molestation, rape, suicide, fire starting, generational issues, and child development were specific issues the participants cited which required a professional MH counselor. The discussion about whether to refer parishioers to a non-Christian MH professional, yielded varying responses. Three of the six participants were unopposed to the idea, two were opposed, and one had mixed feelings. Those that were unopposed to non-Christian counselor stated they just wanted their parishioners to get help regardless of the religious beliefs of the therapist. Those opposed to a non-Christian counselor expressed concerns of a therapist providing interventions or guidance which would be in direct opposition to the foundational beliefs of Christianity. Regardless of the choice of the referral source, all participants experienced rejection of a referral to a MH proforessional by a parishioner. This led to feelings of disappointment for some participants, however, they all stated that this rejection was not personal and they understood the importance of not forcing any referral upon their parishioners.

The majority of the participants had received or are currently receiving counseling from MH professionals. The two that have never received counseling felt that they had no experiences in life that caused them to seek MH counseling. The recipients of professional MH counseling recognized some benefits of counseling, such as being able to resolve their issues before providing pastoral counseling, and being able to share with a professional who can confirm they are healthily handling their life issues. They noted challenges such as opening up to another person and not allowing their title as senior pastor to hinder them from honesty.

All of the participants expressed the importance of integrating mental health into their sermons and teachings. They all provided examples of how they use life application to teach and

preach in order for parishioner's to easily apply Biblical scriptures to their own lives. In addition, all participants believe pastors can decrease the stigma attached to MH being transparent and honest in their teachings and preaching about the whole person, addressing the body, soul, and mind. There must be open discussions about MH and the importance of self-love and taking care of your mental well-being. Furthermore, all participants believe that pastors should be aware of mental health and treat it as a serious illness and not as an attack from satan. It is vital that pastors normalize seeking help from professional MH counselors.

CHAPTER FIVE: CONCLUSIONS

The purpose of this hermeneutical phenomenological qualitative study was to describe African-American clergy's lived experiences with mental health and mental health's influence on the construction of their teachings, sermons, and church practice. This chapter discusses the conclusions drawn from the study with a discussion of the empirical and theoretical implications of the study. Contributions to the fields of research regarding African-American clergy and mental health perspectives are also discussed. This chapter also includes limitations, delimitations, and recommendations for future research.

Summary of Findings

The focus of this phenomenological study was to describe the lived experiences of African-American clergy in the Southeast United States regarding their perceptions of mental health. The phenomenon of this study was understanding how African-American clergy's lived experiences with MH influence their teachings, sermons, and church practices.

The following research questions (RQs) guided this study:

- RQ1: How do African-American clergy perceive their experiences with parishioner's mental health?
- RQ2: How do African-American clergy interpret the lived experiences of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

Four major themes and eight subthemes related to the phenome of African-American clergy's lived experiences with MH and MHs influence on the construction of their teachings, sermons, and church practice were revealed through the data analysis. The first major theme was the participant's sense of responsibility. The participants felt a sense of duty and responsibility to their parishioners and impact they had on their parishioner's lives. This theme produced four subthemes which were (a) pastoral counseling perspective, (b) parishioner issues requiring more

training, (c) referral process, and (d) parishioner satisfaction. The second major theme was a sense of vulnerability. Here participants expressed challenges and benefits related to their experiences of receiving professional MH counseling. This theme produced two subthemes: (a) the benefits of receiving MH counseling, and (b) the challenges of receiving MH counseling. The third major theme was providing hope through life application. Participants felt it was imperative that they presented scriptural passages from the Bible in a format and cadence during preaching and teaching so that the parishioners could apply the scripture to their everyday lives. The fourth major theme was promoting change. The participants saw themselves as agents in the church to promote MH wellness. This theme produced one subtheme which was overcoming stigma.

Research Question One: How do African-American clergy perceive their experiences with parishioner's mental health?

The first RQ was answered by the major theme: participant's sense of responsibility and its accompanying subthemes. Participants expressed the perception of their role and interaction with parishioners regarding their MH and counseling. All participants expressed themselves as wanting to understand the needs of their parishioners who were seeking counseling. Emphatic understanding, unconditional positive regard, and viewing the counselor as a genuine person were three concepts identified as common approaches to pastoral counseling by the participants. The pastoral counseling intake method that was discussed most closely identified with Carl Rogers' person-centered approach.

Five of the six participants shared success using Biblical scriptures and prayer as their only interventions during pastoral counseling. Only one participant noted that he always uses Biblical scriptures and prayer along with scientific data when providing pastoral counseling. All participants stated that they have referred parishioners to a professional MH counselor and have contacts for specific therapists. There was a consensus among the participants that

rejection of a referral is not something that they take personally, and they all understand that it takes time for some people to admit they need help. All participants shared they have never tried to force a parishioner to accept a referral after they have rejected it.

Research Question Two: How do African-American clergy interpret the lived experiences of using their lived experiences with mental health in constructing teachings, sermons, and church practices?

The second RQ was correlated with the following major themes: parishioner issues requiring more training, referral process, and parishioner satisfaction. Accompanying subthemes also addressed this question. The second RQ was designed to understand the nature of each participant's reality within a lived experience. Although only four of the six participants received professional MH counseling from a licensed therapist, all participants were able to provide adequate information relative to how their pastoral counseling has been shaped by their perspective on MH. Interestingly, the two who had never received counseling from a MH professional had a Baptist church foundation and both currently pastor in a Baptist church. The participant's educational levels include an Associate's in Leadership Studies, a Bachelor's in Theology, an earned PhD in Biblical Studies, an earned PhD in Ministry, and two earned PhD's in Theology. Of the three participants with a doctoral degree only one of the participants with a PhD in Theology felt the educational training he received while pursuing his degree molded his pastoral counseling ideology.

Discussion

Theoretical Discussion and Findings

Interpretative frameworks in qualitative research are based on examining how individuals make meaning of their lived experiences (Pietkiewicz & Smith, 2017). The goal of an interpretative framework is to seek an understanding of the world evidenced by the problem statement and the RQs that are implemented to explore conditions that disadvantage or exclude

cultures (Heidegger, 1962). Another factor of interpretative frameworks is a researcher's focus and receptiveness to multiple perspectives from participants which is guided by ethical practices to disclose bias and subjectivity related to the study (Creswell & Poth, 2018).

Social Constructivism

Social constructivism was the interpretative framework that guided this study with the goal of interpreting how African-American clergy view MH and how this view influences the construction of biblical teachings. Social constructivism allowed the use of open-ended questions to inductively generate a theory or pattern of meaning (Creswell & Poth, 2018). Knowledge is socially and culturally constructed through people interacting with each other in the environment in which they live (Ernest, 1999; Gredler, 1997; Prawat & Floden, 1994). By engaging in social activities people create meaning for their individual beliefs (McMahon, 1997).

The culture created by the African-American church provides a sociocultural environment that allows for the transference of attitudes and beliefs about issues. This aligns with the social constructivism assumption that individuals interact with one another in social settings to socially make meaning of their experiences (Vygotsky, 1978). The discussion below provides information regarding the empirical and theoretical findings. I include the four themes (a) sense of responsibility, (b) sense of vulnerability (c) providing hope through life application, and (d) promoting change derived from the analysis of interviews and my research journal.

Educational Background Effects

The theoretical implications in this study showed that the African-American church attends to the psychological, educational, social, economic, religious, and spiritual welfare of its parishioners (Boyd-Franklin, 2003; Cook & Wiley, 2000; Taylor et al., 2000). The participants reported their desire to thorough and provide spiritual guidance in conjunction with professional MH services when helping their parishioners. All participants were able to report on the type of issues they felt should be referred out to MH professionals.

Three of the six participants with earned Doctorates in Ministry or Theology reported that their educational training provided information that enhanced their roles as a pastoral counselor and what matters are beyond pastoral counseling.

Cultural Effects

Social constructivists believe that reality is constructed through human activity (Kukla, 2000). Likewise in the African-American church, parishioners' knowledge regarding the worldview is created by their experiences within their church. The culture created by the African-American church provides a sociocultural environment that allows for the transference of attitudes and beliefs about issues (Vygotsky, 1978). All participants reported using life applications as well as MH in their sermons.

Culture also affects the interpretation and timing of symptoms of MH as well as the onset of illness and how individuals and communities respond to MH (Carpenter-Song et al., 2011). Thus, African-American clergy have an important role in delivering information about mental health care and issues (Aaron et al. 2003; Author, 2008). Participants reported there is a stigma that exists within the African-American community regarding MH. Each participant was able to share something they are currently doing in their church to dispel that stigma.

This study did not corroborate historically, that the African-American church does not differentiate between religious or church concerns and civil or social concerns (Douglas & Hopson, 2001). All participants acknowledged issues that parishioners have presented that they were unable to address. To address this, all participants have instituted a referral process, and four participants have specific MH professionals they frequently use as a referral source.

Empirical Discussions and Findings

Empirical research is based on observation and experiments. Understanding the existing empirical research of both qualitative and quantitative studies helped lay the foundation for this study to comprehend what research on this topic currently tells us along with what should be

further explored.

Role of African-American Pastors

Symbolically, pastors are referred to as under-shepherds tasked with leading and guiding their congregation with the use of the Bible which is the written Word of God. Therefore, religious leaders and clergy serve as the heartbeat of the church and act as gatekeepers to MH (Heseltine-Carp & Hoskins, 2020). Suicidal ideation, delusions, and substance use are behaviors identified as most likely to be referred out. Behaviors that reflect depression, anxiety, and religious-themed obsessive-compulsive disorder are less likely to be referred to outside professionals by clergy (Heseltine-Carp & Hoskins,2020). Participants reported that they have referred parishioners to MH professionals if they were suicidal, suffering depression, or a victim of sexual assault or molestation.

Benefits of Pastors Receiving Mental Health Counseling

Barriers to clergy understanding the importance of congregants seeking outside psychological services include a lack of resources and funds to support MH services, lack of training and psychoeducation of MH, and concern that integration will produce a secular or humanistic influence that contradicts spiritual and religious teaching (Hodge et al., 2020). The participants in this study did not express a lack of understanding of the importance of MH services. All six participants reported that they encourage and support their parishioners to seek MH services. Four of the six participants recalled firsthand their own experiences of engaging in professional MH services. The benefits expressed included understanding how it feels to need counseling, and the ability to share their personal experiences to encourage parishioners to seek professional MH counseling.

Challenges of the Referral Process

Peteet (2019) found that some clients experienced therapeutic sessions with secular clinicians that left them feeling like their Christian worldview was faulty and should be rejected.

The point of view of two of the six participants in this study aligned with Peteet. Strongly against referring their parishioners to non-Christian MH professionals, two participants reported that without a Christian perspective therapists can not understand the culture of Christianity and the core of parishioners. Therefore, they can not properly integrate Christian beliefs in their counseling techniques. One participant who had previously shared this belief, changed her perspective after working in the MH field and seeing the need for professional counselors to be utilized in the African-American community. Now, it doesn't matter to her if her parishioners receive services from a Christian or non-Christian MH professional, as long as they are getting the help they need. The other three participant's views were aligned with the same notion that as long as their parishioners were getting help it didn't matter if the professional MH therapist was a Christian or not.

Educational Background

Parishioners generally rely on their African-American clergy for support with social and psychological problems regardless of the educational background, knowledge of MH issues, and previous experiences of the clery member (Avent et al., 2015). The educational level of the participants in this study ranged from an associate's degree to an earned PhD. Four participants reported their academic background has prepared them to effectively provide pastoral counseling but not to address MH concerns. To address the gap in training, one participant became certified in Biblical counseling, and another one obtained certification as a life coach. The one participant with a PhD in Ministry attributes his ethos and perspective regarding pastoral counseling and MH directly to his education. He was the only participant who shared he never provides pastoral counseling using only the Bible and prayer but integrates a multidisciplinary approach to holistically address his parishioner's issues. The one participant who holds an Associate's in Leadership Studies is currently employed in a facility providing MH services to teenagers. She admited her teaching and pastoral counseling perspective on mental health shifted after she

began working in the field and realized the importance of MH wellness.

Decreasing Stigma of Mental Health

African-American clergy's attitude towards MH professionals can be influential in tearing down the stigma of MH illness as well as motivating parishioners to accept outside referrals (Brown & McCreary, 2014). All participants acknowledged that they influence their parishioners and shared how they integrate MH into their sermons in the hopes of decreasing any stigma related to MH illness. One participant shared his success in doing so, noting that one of his preaching series resulted in 10 of his parishioners seeking professional MH services. Overall, the participants supported the notion that the church should be an advocate for MH and help people understand the importance of taking care of their MH. Mental health should be prioritized and MH professionals should be invited into churches to share their insights on.

Implications

This section discusses the implications of the findings from this research. The study included African-American clergy who have been senior pastors for at least three years. Research was conducted on the role of African-American clergy in the church. In addition, research was conducted on the stigma of MH in the African-American community. Gaps in the underutilization of MH services by African-American Christians has been comprehensively documented over the years. African-American Christians are less likely than their Caucasian counterparts to voluntarily seek professional MH services. Clergy of African-American churches are usually the most inflectional persons in church leadership. This research focused on African-American clergy's lived experiences with MH and MHs influence on the construction of their teachings, sermons, and church practice**.**

Understanding the referral practices of African-American clergy to professional MH services could reduce the disparity of MH utilization that exists between African-Americans and their Caucasian counterparts. In addition, understanding the phenomena of African-American

clergy's understanding and approach to MH may be valuable to professional MH therapists and social workers when soliciting collaboration. African-American clergy's attitude towards MH professionals may be influential in tearing down the stigma of MH illness as well as motivating parishioners to accept outside referrals (Brown & McCreary, 2014).

Delimitations

Delimitations are purposeful decisions that the researcher makes to limit or define the boundaries of the study (CITE). I only included participants who were African-American senior pastors of a predominantly African-American church with at least 15 years of serving as a senior pastor, which is a delimitation. This decision was made to ensure the participant had experienced the phenomenon being studied. An additionaly delimitation was the choice to implement a phenomenological study to provide a voice to the lived experiences of African-American clergy concerning how their beliefs and attitudes regarding MH influence their teachings, sermons, and church practice. The use of hermeneutic phenomenology was chosen due to its dedication to focus on understanding the meaning of the experiences shared by each participant through entering their world.

Limitations

Limitations are the potential weaknesses of the study that cannot be controlled (CITE). The limitations that may have impacted this qualitative study are identified as the researchers' skills, accurate descriptions of the phenomenon, the researcher as the human instrument, and any potential biases in geographic location or participant selection. The interviews were conducted using qualitative interviewing strategies to overcome limitations during the interviewing process.

For this study, my skills in collecting and analyzing the data weigh upon its validity. Hermeneutic phenomenology understands the researcher as a human instrument within the research being studied. Recognizing any biases regarding the data is consistent with hermeneutic

phenomenology's roots, and I openly explored my perceptions during the analysis process. As a human instrument of data analysis, the themes that emerged were based on my perception and understanding of the stories that were being told during the interviews. To transmit the findings accurately during the analysis phase, I used MAXQDA software to facilitate the process.

Limitations on the reliability and transferability of the findings of this research study include the geographic location and participant selection process. Although the sample size of six was sufficient for this qualitative study because the point of data saturation had been reached, it may not be generalized to the population of African-American senior pastors throughout the United States. The participants of this study all resided in Georgia or Alabama which only encompassed two states of the southeastern region of United States. There was also a lack of diversity in gender, as there was only one female participant.

Recommendations for Future Research

To truly describe African-American clergy's lived experiences with MH and MHs influence on the construction of their teachings, sermons, and church practice a qualitative research design was the optimal choice. Qualitative research is used to explore a problem or issue in which detailed understanding is needed and can only be established by talking directly with people and allowing them to tell their stories without regard to the researcher's expectations or what has been read in literature (Creswell & Poth, 2018). With qualitative research, researchers seek to understand the complexity of people's lives using the perspectives of individuals in context (Heppner et al., 2016). A discussion of the recommendations is presented in this section.

In this study, six African-American clergy living in Georgia or Alabama volunteered to participate based on their experiences with MH. The empirical implications suggest there has been a shift in African-American clergy's perspectives on professional MH services. A larger study including more participants may be developed to ensure a better representation of the

general population. Quantitative data could be collected from African-American clergy across the other 14 states which comprise the southeastern states of the United States. This number may provide better evidence that a shift has taken place regarding African-American's perspective in support of professional MH services for their parishioners.

Although included, the educational background and the effects it has on African-American clergy was not a major focus of this study. Further research on how educational background impacts African-American's clergy worldview and its approach to MH may support the researcher's view that those with a higher educational level were more assertive in their stance on the importance of MH education and support for their parishioners. Another recommendation for future research is to explore the attitudes and perceptions of African-American parishioners on the use of professional MH services. This measure may help to determine if there has been a shift in perspective on professional MH services for the African-American church in totality.

Finally, it would be interesting to gain a baseline understanding of African-American clergy's ability to recognize when professional MH services are needed beyond when suicidal ideations or depression are present. This information could inform the type of training that is needed for African-American clergy in recognizing signs of symptoms of mental distress that are not exhibited in extreme forms or behaviors. In addition, this could help African-American clergy to have a standardized referral process. Though all participants reported referring their parishioners out for MH services, only one participant had a structured referral process.

Summary

Chapter Five offers the conclusions drawn from the study. This research focused on African-American clergy's lived experiences with MH and MHa influence on the construction of their teachings, sermons, and church practice**.** There were four philosophical assumptions in this

study: 1) a search for wisdom to understand the phenomenon of African-American clergy's lived experiences with MH and that influence their teachings, sermons, and church practice, 2) no judgments about the reality of mental health to African-American clergy was formed until the data was analyzed, 3) African-American clergy bring both subjective and objective experiences as part of their lived experiences, and 4) the reality of African-American clergy was only perceived within the meaning of their individual experiences. This chapter began with a discussion on the empirical and theoretical implications of the study regarding African-American clergy and mental health perspectives. This chapter concluded with limitations and recommendations for future research.

The findings of this study showed all the participants shared common experiences, and four of the six participants were recipients of professional MH services. All participants acknowledged that stigma exists in the African-American church regarding MH and they felt it was important as pastors to help dispel this stigma. All participants confirmed that they integrated MH and life applications into their sermons and bible teachings, as well as refer their parishioners to a professional MH counselor when they feel they can't meet the parishioner's needs. The empirical implications suggest there has been a shift in African-American clergy's perspectives on professional MH services. Therefore, it is imperative that more research is conducted to understand this shift and what can be done to bridge the gap that exists in the use of MH services by African-American as compared to their Caucasian counterparts.

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Appendix A: IRB Approval

Consent Form

Title of the Project: A phenomenological study of African American clergy's experiences with mental health
Principal Investigator: Rosalind R. Smith, LAPC, NCC, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must self-identify as an African American having served as a Pastor for a minimum of 15 years and must currently serve as a Senior Pastor. The church's membership should be comprised of at least 65% of parishioners who identify as African American. Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to understand how African American clergy beliefs, perceptions, and attitudes regarding mental health influence their practices as a clergyman or clergywoman.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in one videotaped virtual semi-structured interview via the Zoom Platform for 90 minutes.
2. Provide copies of written sermons, teachings, or recorded teaching and sermons in which you have addressed mental health to your parishioners if applicable. It will take the participants up to one hour to gather these documents and provide to the researcher.
3. Participate in one thirty-minute follow-up interview to review the themes and interpretations based upon the researcher's data analysis.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

This research will benefit society by bringing more awareness to the phenomena of African American clergy's understanding and approach to mental health, which could influence the collaboration with, and value of, the need for mental health among parishioners.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential using pseudonyms. Interviews will be conducted through Zoom platform. The researcher will conduct the interview in a private location and will encourage the participant to abide by the same conduct.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Documents collected from participants will be stored in a locked file cabinet that only the researcher has access to and will be shredded once the study is completed and accepted by the dissertation committee.
- Interviews will be recorded via Zoom platform and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free not to answer any questions and withdraw from the study at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

You have the right to withdraw from participating in the study at any time. If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study Rosalind R. Smith. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] You may also contact the researcher's faculty sponsor, [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio and video record me as part of my participation in this study.

_____ _____

Printed Subject Name Signature & Date

Appendix B: Participant Recruitment Email

August 15, 2022

Pastor ABCD
Church Name
Email Address

Dear Pastor ABCD:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. Three weeks ago an email was sent to you inviting you to participate in a research study. This follow-up email is being sent to remind you to respond if you would like to participate and have not already done so. The deadline for participation is August 31, 2022.

Participants must currently serve as the Senior Pastor of an African-American church in the southeast United States comprised of a congregation that is at least 65% African-American. The participant must have served as a Senior Pastor for a minimum of fifteen years and self-identify as African-American. There is no specified minimum or maximum size of church membership. Participants, if willing, will be asked to participate in a semi-structured virtual interview that should take approximately 90 minutes to complete and a follow-up interview to review the themes and interpretations of the researcher that will take approximately 30 minutes. If applicable, participants will be asked to submit copies of sermon notes and or audio sermons they have preacher to their entire congregation with references to mental health wellness. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please contact me at (email) for more information or to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me via email prior to the time of the interview.

Sincerely,

Signature
Title

Appendix C: Consent Form

Title of the Project: African-American Pastors Referral Practices to Professional Mental Health Services
Principal Investigator:

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be an African-American Senior Pastor of either an AME, CME, National Baptist Convention, or Non-Denominational church. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to understand African-American pastors' referral practices when referring parishioners to professional mental health counseling in Southeast United States.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Participate in one videotaped semi-structured interview for 1-1.5 hour
2. Provide copies of written sermons or recorded sermons in which you have addressed mental health to your parishioners.
3. Participate in one to two focus groups with the other 11 participants in order to provide feedback on themes interpreted by researcher.
4.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include an understanding the stigma attached to African-American Christians seeking professional mental health services.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher[s] will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be anonymous. The responses will be grouped by denomination. Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

- Interviews/focus groups will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.
- Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.
-

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you apart from focus group data, will be destroyed immediately and will not be included in this study. Focus group data will not be destroyed, but your contributions to the focus group will not be included in the study if you choose to withdraw.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study Rosalind R. Smith. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 404 957-2624 You may also contact the researcher's faculty sponsor, [name], at [email].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____ _____

Printed Subject Name Signature & Date

Appendix D: Interview Questions/Guide

1. Tell me about your background and procession into your role as a Senior Pastor.
2. Have you ever received professional mental health counseling? What was your experience?
3. What is your belief about Christians seeking mental health services from a therapist who does not believe in Jesus Christ?
4. Describe your typical initial encounter (intake) with your parishioner when they provide the reason(s) they are seeking your guidance. What process would you use to determine whether to provide spiritual coping skills versus common mental health coping skills such as deep breathing or reframing?
5. Some preachers use life application incorporating mental health awareness as they deliver their Sunday sermons, is this a practice you use? Explain why or why not.
6. Describe a time when you have felt you were ill-equipped to address the need of your parishioner seeking counseling.
7. Describe a time when you have felt successful in meeting a parishioner's need by providing counseling using only scriptures and Biblical principles.
8. How do you feel when you refer your parishioners to outside mental health services and they refuse to accept your recommendation?
9. Think about one of your most challenging issues you had to counsel a parishioner through; if I were to speak to that person, how do you think they would rate their level of comfort and satisfaction with the services you provided?
10. Is there anything you would like to add related to your experiences with mental health?