THE AFRICAN AMERICAN MENTAL HEALTH DILEMMA:

A PHENOMENOLOGICAL CASE STUDY ON

HOW CHRISTIAN CLERGY ARE BRIDGING THE GAP

Penelopé Evans

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

The history of African Americans is composed of ongoing inhumane and normalized mistreatment that continues to generate widespread issues and challenges. African Americans' current higher likelihood of exposure to one or more traumatic life events increases the possibility their emotional and mental well-being will be negatively impacted. The ethnic group's development in historical trauma and abuse is being acknowledged as an underlying factor in the alarming increase in serious mental health conditions in African Americans. Continued racial and discriminative dynamics further increase African Americans' susceptibility and risk for severe psychological illnesses in the United States. African Americans' higher tendency not to seek mental health care from professional mental health care providers compounds the problem. Historically, their reluctance to seek professional mental health care is valid—based on mistreatment—as are African Americans' tendency to turn to faith leaders for help with psychological and emotional distress. African American churches, which developed as a support system for the race through their oppressive history, emerged as the largest informally established institution to obtain their confidence while offering spiritual guidance and countless other resources. Today, faith leaders, along with mental health professionals, are confronted with a growing African American mental health dilemma. Greater awareness and understanding of the complex issues African Americans who seek mental health care face is needed to address the current crisis effectively. The purpose of this case study is to glean insight from the lived experiences of sought-after Christian clergy serving in the gap and assisting African Americans with mental health challenges.

Keywords: African Americans, Blacks, church, clergy, help-seeking, mental health care, pastors

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Dedication

This study is dedicated to the clergy preaching hope from the pulpits while perplexed with feelings of inadequacy in addressing congregants in psychological distress. The research is dedicated to those with mental health conditions who sit in pews whispering prayers they cannot say aloud. This work is dedicated to scholars, mental health clinicians, and advocates of mental health care who will continue to explore and expand the understanding of the African American mental health dilemma and apply what is learned for the greater good of all.

Acknowledgments

All glory, honor, and praise to my Lord and Savior, Jesus Christ, who met me with new mercies every morning to encourage, strengthen, and revive me mentally, spiritually, and physically to keep going even while not able to see the destination. I trust that nothing I have learned will be wasted. May He be continually glorified, and The Church be edified as they maximize the opportunities to support African Americans in addressing mental health illness, conditions, and disorders.

I thank God for all the saints who supported me with faith-filled prayer and encouraging words. I thank God for my adopted mother in the faith, Acenter Graham, whose prayers and Holy Spirit inspired words were always timely. I thank God for the faith of Rev. Dr. Shirley Groce, who provided encouragement, guidance, prayer, and follow-up, which helped me stay the course when the process got difficult. I thank God for the wisdom and experience of Dr. Rhondra Willis-Brown and Dr. Wanda Corner, which they freely shared whenever asked. I thank God for my colleague Tawnya Fabian, who joined me on the dissertation journey just in time, with the inspiration and camaraderie I needed to finish the last mile. Last but definitely not least, I thank God for the beautiful, simplistic faith of my grandchildren, Anthony Molina and Lyric Evans, who helped me stay grounded and keep things in perspective.

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List of Abbreviations

African Methodist Episcopal Church (AMEC)

American Association of Christian Counselors (AACC)

Baptist Educational and Missionary Convention of South Carolina (BEMCSC)

Church of God in Christ (COGIC)

Department of Health and Human Services (DHHS)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

Institutional Review Board (IRB)

Interpretive Phenomenology Analysis (IPA)

Post-traumatic Slave Syndrome (PTSS)

Post-traumatic Stress Disorder (PTSD)

Progressive National Baptist Church (PNBC)

Severe Mental Illness (SMI)

Transformative Consciousness (TC)

Transformative Experience (TE)

Transformative Learning (TC)

Chapter One: Introduction

Overview

The state of mental health among African Americans is increasingly becoming an area of significant concern. The number of mental illness cases reported for Blacks has rapidly climbed in recent years. Current studies estimate that African Americans are at a 15–20% higher risk of having a severe mental health condition than other racial or ethnic groups (DHHS, 2019; Williams, 2018). Black youth suicide rates in America rose over 73% in the last two years (Mushunje & Graves, 2021). In that same period, numerous disturbing events, including the immobilization of the world during the COVID-19 pandemic, awakened the nation to an already existing African American mental health crisis while simultaneously heightening it (Snowden & Snowden, 2021). As lockdowns around the world created captive audiences in social and public media forums, multiple high-profile cases of horrific acts against African Americans were repeatedly replayed. Intermingled with the replay of the video clips were updates of staggering pandemic statistics revealing how the virus was disproportionately affecting multiple aspects of the lives of African Americans, including their mental health (Andrasfay & Goldman, 2021; Chapman, 2020). Invariably, many African Americans experienced an accumulative effect of processing the distressing events of an already existing history of collective racial trauma, navigating depression and anxiety of everyday racism, and an intensifying sense of uncertainty for African Americans as the social and political climate grew more volatile (Murry et al., 2018; Range et al., 2018; Snowden & Snowden, 2021).

The accumulative effect encompassed an inherent predisposition of being an African American demonstrative of why the higher levels of severity of mental health problems are creating a crisis rather than the higher quantities. To grasp and understand the many complicated

and intertwined issues involved in addressing African American mental health, deeper insight into their lives as well as their evolving story is necessary. Pastors and clergy, particularly of predominantly Black congregations, possess such valuable insight, and though not necessarily for that reason alone, they are commonly sought out by parishioners for help with psychological and emotional distress (Bolger & Prickett, 2021). Yet, there is minimal research revealing the perspective of clergy on the mental health crisis among African Americans, and fewer studies examine how clergy is effectively addressing the growing challenge. This study intends to gain insight, perspective, and experiential knowledge of how clergy perceive mental health as well as how they address African Americans seeking them for mental health conditions to further build existing literature seeking to address the growing dilemma.

Background

Many underlying factors contribute to the African American mental health dilemma, presenting complex challenges for professional clinicians as well as clerical and pastoral counselors. In addition to the failure to believe there is any need for help at all, a reluctance to an absolute refusal to seek professional mental health care is also a significant impediment to African Americans receiving care (Taylor & Kuo, 2019). Much of the disinclination to seek mental health care, like other misunderstood tendencies of African Americans, is tied to historical views passed down from an oppressive history. During that history, the African American or Black Church became, and remains, one of the most influential conglomerations of seven denominations operating as an informal institution led by and for Blacks (Plunkett, 2014). Consequently, Christian communities and faith leaders play a unique role in how Blacks see mental health and their decision-making process regarding it. The church’s influence is interwoven with social, cultural, and economic influences that factor into mental health and care

use (Cavalhieri & Wilcox, 2022). Like some other cultures, there exists much scrutiny and social stigma around what is or is not understood about mental illness among African Americans (Misra et al., 2021). Even when a more informed understanding exists, sharing such knowledge is taboo for some African American families. Mindfulness and insight into the source of these beliefs would benefit mental health professionals, churches, and their leaders.

The Impact of the African American Experience on Mental Health

Mental health clinicians are expected to have some knowledge of the history of Black slavery and discrimination in America. Understanding the long and far-reaching psychological impact of that history, as well as how it impacts African Americans' processing it today in conjunction with the continued reality of racism, is a difficult truth for some to fully grasp (Williams, 2018; Williams & Williams-Morris, 2000). In concept, having cultural awareness or cultural competence helps understand the impact of the African American experience on mental health. In reality, developing a personalized and effective treatment plan for African Americans warrants more than the standardized assessments, which are commonly not designed in consideration of many of the inherent stressors of just being born African American (Jones et al., 2018). Knowledge of the fact that African Americans have adapted as needed to survive (and even thrive) amid institutionally accepted, unaddressed, and denied discriminatory practices adds understanding of their reluctance or refusal to seek or trust clinical help or institutional help at all. When the resistance to seeking care is viewed from an informed perspective of such occurrences as the incorrigible 40-year governmentally approved experiment on 399 Black males to learn about the progression of syphilis falsely presented as an opportunity for treatment never provided, a different interpretation of assessed behaviors may occur (Gamble, 1997). Sadly, the infamous Tuskegee Syphilis Experiment occurred within the past 50 years. Though a presidential

apology was made 40 years later, many other discriminatory medical practices, exploitation, and experimentation involving African Americans preceded and followed it (Suite et al., 2007). Therapists would do well to be aware of how discriminatory practices and systemic racism in healthcare contribute to a distrust of medical professionals, which in turn creates Blacks' suspicion of clinical care for mental distress (Kennedy et al., 2007). The skepticism around the intent or reliability of professional care is intentionally and unintentionally reinforced by practitioners unaware or not cognizant of their own biases, often evident to the African Americans who seek their care (Alang, 2019). Many African Americans find themselves struggling with feeling confident they will get the help needed from a competent mental health care professional rather than being treated and viewed from a condescending or inferior perspective.

The Position of African American Clergy/Pastors and Religious Communities

On the other hand, the church and faith communities represent one of the largest singular sources to which African Americans widely connect and depend for help with many different issues in life. Mental health concerns are no exception, even if they were not referred to as such until recently. The prominent and expansive role pastors and churches play in the lives of Blacks is unique to the culture and unparalleled by most other ethnic groups' religious support (Pickard et al., 2019). As one of the first unofficial but widely recognized institutions led by Blacks for Blacks, the Black Church evolved into a one-stop resource for providing help to and advocating for African Americans, including promoting healthier communities (Brewer & Williams, 2019). Psychological and emotional health may not necessarily be recognized or treated as mental health from a clinical perspective in churches. Traditional understandings and connotations of mental health have been a hindrance to seeking help, particularly for Black men (Watkins et al.,

2020). It is challenging to assess the knowledge, skills, abilities, or even how clergy address mental illnesses directly or through church organizations and ministries (Hays, 2015). Still, of the African Americans who seek help for psychological difficulties, frequently churches and faith leaders are the first and primary sources sought. Even with new organizations emerging in response to the growing recognition of an African American mental health problem, faith leaders are in a prime position to both help change perceptions and overcome common barriers to accessing needed care (Coombs et al., 2022). Many pastors believe it is part of their responsibility to help those seeking competent help for mental illnesses (Campbell & Winchester, 2020; Williams & Cousin, 2021).

Mental Health Care System Structural Racism and Lack of Diversity

Mental health care professionals and organizations are also beginning to assume greater responsibility in making changes to better serve African Americans and other minorities. In 2021, a formal apology was issued by the American Psychiatry Association (APA), acknowledging its role in supporting structural racism and inequities in healthcare practices impacting Black, Indigenous, and People of Color [BIPOC] (APA, 2021a). The apology, followed by a promise of ongoing efforts to rectify the engrained racism in practices, recognized that not addressing or correcting the known issues has further contributed to a long-standing mistrust. Some of the ongoing efforts would do well to address the underrepresentation of people of African American descent in the mental health field by implementing plans to diversify as well as partner with clergy (APA, 2013).

Some professionals may not be knowledgeable or comfortable with the mental health implications that should be considered with African Americans (Dana, 2002; Proctor & Owens, 2019). African Americans seeking professional care often prefer a clinician of color or African

American to feel more comfortable and in hopes that they can better empathize (Goode-Cross & Grim, 2016). It is logical to assume African American mental health professionals would be more able to form a therapeutic alliance with those of the same ethnic group who seek their help. Many are likely to possess the ability to relate to some of the contextual backgrounds of clients of the same race and culture. On the other hand, they also risk the disadvantage of overidentification and mismanaging perceptions about reactions in therapy (Goode-Cross & Grim, 2016). Like their colleagues of other races, African American therapists are experiencing the realization that even their current education and experience in addressing some Black issues is wanting. Although they are 13.6% of the United States population, Blacks make up only 3–4% of the mental health workforce (APA, 2021b). In addition to being few in number, Black therapists and psychologists are suffering higher rates of burnout as utilization of services increases, particularly in the aftermath of COVID-19 (APA, 2013; Shell et al., 2022). The absence of more African Americans in the mental health profession further complicates addressing their increasing mental health need.

Overcoming Cultural and Social Stigma

In addition to historical and systemic factors, the African American mental health dilemma is further complicated by complex social, cultural, and economic dynamics. An awareness of the need to normalize mental health care to overcome the deep-rooted cultural stigma held by African Americans and other minorities is not new (Ward et al., 2013). During the pandemic and the highly publicized surrounding traumatic events, the cultural and social stigma of mental health was met with a level of distress and desperation that resulted in more Blacks seeking care (Armstrong et al., 2022). While efforts to reverse stigma as a deterrent to Blacks seeking professional mental health care increased along with new mental health programs

resulting from the enactment of the American Rescue Act of 2021, more clergy recognize a dire need to begin normalizing the subject within the church (Snowden & Snowden, 2021). Many African Americans have been documented to be particularly resistant to obtaining services that risk compounding stigmatism and embarrassment to their families or in their circles, preferring instead to rely on practices of their faith (Ward et al., 2013). Unfortunately, stigma also surfaces in church communities due to some religious beliefs that see a discrepancy in mental health conditions coexisting with faith or a proper application of it (Bryant et al., 2014; Peteet, 2019; Taylor & Kuo, 2019).

The resilience of the Black race with faith as a significant contributor has taken on an internal but unspoken mantra of the survival of the strong (Abrams et al., 2019; Alang, 2016). As a result, anything that exhibits vulnerability or lack of capacity to overcome is sometimes not looked upon as representative of African American people. Within the race, susceptibility is widely frowned upon as a weakness, consequently isolating those in most need of mental health care. It is not uncommon to be given simplistic advice when facing mental distress, such as “Pull yourself together,” “Pray about it,” or “You’ll be all right,” despite having experienced events that injured their mental functionality due to the normalcy of such events occurring in the culture. This perspective of needing to be strong is reflective of why mental illness is a complex subject to feel safe discussing outside of the family, even when it is evident help is needed (Dai & Morgan, 2021). In predominantly African American churches, where relationships are often equated to kinship, particularly if one grows up as a member of one congregation, there can be a safe place to share, hence the propensity to seek pastors for mental distress. The strength and history of the African American relationship with the church can hinder or facilitate the changes needed for better mental health care, mostly based on the perspective of leadership.

Changing African American Perspectives and Practices in Mental Health

Bringing about change in mental health care for African Americans requires a collaboration of various resources, all of which would benefit from the insight of others. To have a more significant overall impact on the growing dilemma, professional clinicians, health care organizations, churches, and their leadership must utilize a more informed understanding of mental health factors unique to meeting African American constituents' needs, thereby also reducing misdiagnosis of Blacks due to generalizing of symptom presentations (Ellison & Paradis, 2019; Saldana et al., 2021). Research reveals such gleaning of knowledge from the perspective of pastors is scarce despite their longevity in addressing the mental health issues of Blacks (Hays & Shepard Payne, 2020). The transformative framework of this study focuses on adding value to the existing research by obtaining, analyzing, and interpreting data gathered from clergies' experiences in the mental health care of African Americans. All stakeholders can benefit from the information collected in this case study's transformative framework (Creswell & Poth, 2018). The goal of learning embedded in a transformative concept is not to be judgmental but to think critically about current practices and views for guidance needed to change, create, and expand better outcomes.

Situation to Self

This research is inherently guided by an axiological assumption characterized by the researcher's own experiences, values, and beliefs, as well as those of the participants (Creswell & Poth, 2018). The researchers' values and beliefs were formed as an African American child raised in a household with strong religious practices. As an adult Christian, the researcher has formal training and experience in ministry and counseling, which prompted the need for further research on the mental health care of African Americans. Interaction with a racially diverse

group of colleagues, clients, and ministries also increased the desire of the researcher to explore intersections of pastoral and clinical mental health care. The researcher is transparent in ensuring integrity in presenting the results by recognizing her known biases and preconceptions within the report, believing they do not diminish the value of what was discovered (Creswell & Poth, 2018).

Problem Statement

Though African Americans are increasingly at a higher risk for chronic mental health conditions, they are less likely to acknowledge the need, tend to be more averse to seeking mental health care from professional providers, and face unique challenges in accessing the care needed. A disfavor of health services can legitimately be traced to a history of racial mistreatment, cultural and social stigma, and inhumane treatment in the health care of African Americans. Through a traumatic history, the role of the church or religion has been instrumental in providing coping skills and serving as an advocate in the interest of African Americans. Consequently, it is not uncommon for faith-based organizations and churches serving predominantly African American constituents to be referred to for help with psychological difficulties, irrespective of their knowledge level or skill capacity to assist (Avent & Cashwell, 2015).

Despite clergy and churches' history and ongoing services providing Blacks seeking help care, there are very few documented results captured through research to illuminate how they view and address the growing number of mental health issues African Americans are experiencing. Even an internet review of reputable and relatively large congregations of predominantly African American churches' websites reveals marginally identifiable information about their approach to mental health at best. When a distinctly identifiable approach fitting mental health care is apparent, it is usually embedded in programs or ministries that have a larger

focus, such as wholeness ministries, which address overall health. Though more clergy are faced with the growing challenge of addressing the African American mental health crisis, there is a need to see or implement more working models, guides, and reliable resources on how to best assist seekers of help in the church with their mental health conditions.

There are various positions on what makes clergy equipped since Christian leaders have different beliefs about the origin or contributors to mental illnesses, some of which are incongruent with those of mental health care professionals (Bilkins et al., 2016; Payne, 2014). More pastors acknowledge a need for formal training on mental health care (Hankerson et al., 2018; Karadzhov & White, 2020; Payne, 2014). Gaining the knowledge, skills, and abilities that help recognize mental health needs, and connect seekers with trustworthy care, could prove beneficial in ensuring proper care is received (Anthony et al., 2015; Bolger & Prickett, 2021).

Clergy who possess firsthand knowledge of some struggles that uniquely contribute to common mental health conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD) may still address help-seekers solely with spiritual solutions, not addressing psychological or biological components. Amongst African Americans, depression, anxiety, and PTSD may be slightly less prevalent than for Whites, but it is most often more chronic, warranting clinical intervention most clergies are not trained to provide (Garner & Kunkel, 2020; Hankerson et al., 2018). Clergies who are more informed on mental health care and mental illnesses may better serve those preferring faith-based assistance through integrative practices or partnerships with mental health clinicians (Hays & Shepard Payne, 2020). Forming a partnership has its challenges, particularly overcoming historical distrust and reconciling both views—secular and spiritual—however, some churches have successfully implemented partner programs (Dempsey et al., 2016; Vaidyanathan et al., 2021). Finally, African American clergy inherently

bring some of their own biases and presuppositions about mental health and health care systems, which, if not recognized and managed, add to the dilemma of African Americans obtaining needed mental health care.

Purpose Statement

The purpose of this phenomenological case study is to explore the lived experiences of Christian clergy who are sought for counsel or care by African American congregants and constituents with mental health issues or conditions. Many pastors and pastoral counselors within a church are acquainted with some of the common social, financial, and health problems that affect African Americans, as well as the associated emotional distress they bring. There is a need to learn how such problems connect and contribute to mental illness in Blacks and particularly ways clergy have learned to address the combinations of factors successfully. Gaining such knowledge would be in the interest of not only church leaders who desire to address the whole person but also those who seek their help, as well as clinicians in the mental health system.

The findings of this study will develop a deeper understanding of the relationship and the complexities of addressing African American constituents with mental health issues from the view of clergy (pastors, ministers) counseling or via church ministry. The research will provide another point of reference for improving practices and outcomes for the growing number of African Americans experiencing mental illness. By exploring the barely analyzed perspectives of the clergy, the existing gap in understanding how African American mental health care can be more culturally, clinically, and religiously informed may be reduced. Clergy may find it more informative and relatable to learn how other clergies and mental health care professionals are succeeding in engaging mental health issues in the current climate.

Significance of the Study

This study is significant in exploring a long-existing resource that has contributed to the perseverance of African Americans but has not been given much attention as an asset to the mental health field. Churches and their leadership have substantial experience and insight in working with African Americans facing mental health challenges through their regularity of being sought for help (Brewer & Williams, 2019). There is untapped value in gaining insight into how clergy and pastoral counselors view and engage the growing African American mental health crisis in their everyday lived experiences interacting with many who are affected. Research and statistics validate that the church is a respected institution naturally sought out by African Americans experiencing overwhelming challenges but do not provide an inside look at how that works when specifically addressing psychologically-distressing conditions (Hope et al., 2019; Mitchell et al., 2020). The African American historical context and cultural setting from which Blacks with mental health issues process life events is a relevant component for consideration in providing help, which may be a known factor within many churches (Ellison & Paradis, 2019; Taylor & Kuo, 2019). It is not information known to all therapists in professional mental health institutions, and race-related stressors are not always considered in all mental health assessments. Unfolding that understanding through exploration of pastors' and clergies' views is an additional outcome valuable to efforts in making progress toward better evaluations and treatment for African American mental health care and utilization (Summers & Lassiter, 2022).

Research Questions

1. How do Christian clergy describe their experiences in understanding and relating spiritual health to mental health when counseling African American congregants?

2. In what ways do clergy describe their experiences in normalizing and advocating for mental health care within the African American church and community they serve?
3. How do clergy serving African Americans describe their experiences and perceptions regarding their role or responsibility in the mental health care of those seeking assistance with psychological distress or conditions?
4. In what ways do clergy describe their experiences with specific measures or methods that have been successful in integrating ministry and clinical care for the mental health needs of African American members in their churches and community?
5. What practices or resources do clergy describe, based on their experiences, as necessary to prepare Christian leaders of African Americans more effectively in addressing mental or psychological problems?

Definitions

1. **African Americans or Blacks** – used interchangeably to describe an ethnic group of people of various darker colored skin pigments who are United States citizens but whose ancestry originated outside the United States and are generally descendants of enslaved Africans (Collier-Thomas & Turner, 1994).
2. **The Black Church** – The Black Church is defined as a Protestant "multitudinous community of churches, which are diversified by origin, denomination, doctrine, worshipping culture, spiritual expression, class, size, and other less obvious factors" (Douglas et al., 2021, p. 96). It is a historically invisible but powerful institution that has existed and evolved out of slavery in the United States to the largest influential and advocating entity commonly uniting African Americans (Hankerson et al., 2018). The reference to Black Church is sometimes misunderstood and criticized as indicating

separation of the church by race when its roots point to the religious practices and institutions shared by African Americans during slavery and segregation originally as the only option. It grew into a supportive community of many different denominations today that influence past and present quest for equal rights for all and with constituents of various races (Plunkett, 2014).

3. **Clergy/Pastors/Christian Leaders** – terms used interchangeably in this document which refer to those who, under their affiliated religion/denomination, are recognized by licensing or ordination, qualify distinctly from self-acclaimed evangelicals to those who meet the nine categories of Barna Group defining of an evangelical Christian minister (Barna Group, 2007)
4. **Collective Racial Trauma –** common group shared experiences of Racism occurring throughout history in acts of discrimination against individuals, families, and cultures impacting psychological and emotional stress warranting mental health care or therapeutic healing to reverse damage (Liu & Modir, 2020)
5. **Everyday Racism –** engrained social, economic, educational, and environmental restrictions and demands commonly placed upon individuals based on their race or appearance (Murry et al., 2018)
6. **Mental Health Condition, Disorder, or illness –** terms used interchangeably in this document that refers to a compromised state of one's emotional, psychological, or emotional well-being reflected in dysfunctional behavior or levels of internal distress that are manifested in unmanaged behavior, mood, or response to normal situations and some of which are identifiable as a disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013)

Summary

The rates of severe mental health issues and conditions among Blacks/African Americans are continually increasing, having reached a point of crisis in the United States. As illustrated in this chapter, there is difficulty in addressing the problems African Americans are facing in mental health for numerous reasons, including their reluctance to seek professional mental health care. The reluctance fostered initially by a history of racial discrimination and systemic mistreatment is also indicative of the reliance of the Black community on the church as a haven and resource to meet all needs without experiencing the associated social stigma. Pastors and church ministries have been and continue to provide counsel to Blacks seeking help with mental health problems. Meanwhile, due to shortages in professionals (particularly African Americans), lack of cultural competence, and not addressing long-existing discriminatory practices, mental health systems are challenged to address the recent fluctuation of those Blacks who are turning to professional care.

More is understood about the shortcomings of the mental health system than the advantages pastors/clergy are using to address the issue of serving those in need of mental health care as faith leaders. This study seeks to gain valuable knowledge and understanding around the shared goal of African American churches, their leadership, and the professional mental health community in addressing the growing numbers of Blacks in America needing effective mental health care. Through insight gathered from clergies' lived experiences assisting African Americans suffering from mental health problems, critical themes are expected to emerge to add value to existing literature and create more informed approaches to addressing the African American mental health dilemma.

Chapter Two: Literature Review

Overview

The context from which the African American mental health care dilemma emerged is covered deep and wide in past and present literature. As illustrated in Chapter One, a history of slavery, segregation, oppression, discrimination, and systemic racism are all well documented factors that continue to impact the health and health care of African Americans in the United States. Past inhumane practices on African Americans in medical research, such as the Tuskegee Experiment, the "Mississippi appendectomy" sterilization of black females, and racially-based mental diagnoses like "drapetomania," set an early precedence for distrust of clinicians and medical institutions (Alsan et al., 2020; Gamble, 1997; Suite et al., 2007). Current studies are inundated with findings about disparities in access, quality, and availability of culturally competent professional healthcare for African Americans who are dependent upon healthcare systems which are also still symptomatic of normalized structural racism (Yearby, 2018). Noonan et al.'s (2016) historical survey of the literature illustrates that despite two centuries of progress and countless political and social efforts, the health of African Americans today is comparatively worse than any other ethnic group in the United States.

Despite the wealth of current and historical information available on factors contributing to the mental health challenges affecting many African Americans today, a large gray area exists in the literature on how African American pastors, as one of the primary sources sought for help, are bridging the gap between the care needed and received. This examination of the literature validated the need for further research on the current predicament from the standpoint of pastors and church leaders who serve African Americans who seek help with mental or psychiatric conditions.

The African American Predicament

The distrust of health care systems by some African Americans amidst continued racially insensitive or discriminative practices of some medical institutions further complicates the mental health dilemma, particularly for Blacks already at risk for poor health due to being socially and economically disadvantaged. According to Snowden et al. (2022), African Americans with mental illnesses who are not treated are more likely to be disadvantaged economically, physically, and socially. The complex combination of these factors is commonly present and attributed to the growing higher rates of severe mental illnesses (SMI) in African Americans in the last 20 years (Maura & Weisman de Mamani, 2017; Odonkor et al., 2021). From 2008 to 2018, a steady increase occurred in the number of severe mental illnesses among African Americans in the United States (DHHS, 2019). The 2018 census reports indicate that one out of every five African Americans in the United States lives in poverty, which in and of itself doubles the risk for a serious mental illness (CDC, 2023.; U.S. Census Bureau, 2018). In 2020, the U.S. Office of Minority Health (OMH) estimated that the third leading cause of death of Blacks ages 15–24 was suicide, and the death by suicide rate was four times higher among males than females (DHHS, 2019). School-age Black girls were 60% more likely to attempt suicide in 2019 than White girls (DHHS, 2019). Along with the known data concerning increases in African American mental illness are statistics indicating that only a third of those needing care receive any kind of professional care (DHHS, 2019).

In Snowden et al.'s (2022) research on social economic disadvantages and other health risks, he refers to the compounding impact as "double jeopardy." Their critical 6-year review of the National Survey of Drug Use and Health (NSUDH) confirmed "double jeopardy" as more common in minorities who have unaddressed psychiatric conditions, with African Americans

most affected. The findings indicated that African Americans are almost three times more likely to experience the risk of combined external stress than their White counterparts. The study's findings are credibly established on a reasonably lengthy period of comparative reviews and the methodology implemented controls for distorting variables. An inherent limitation of generalization using survey review outcomes is that the magnitude of a problem can be diminished or exacerbated by the number, demographics, and depth of knowledge the participants responding possess. This research pointed out several groups of individuals (homeless, military, incarcerated) not included in the survey. African Americans make up a high percentage and are relatively overrepresented in the latter of the omitted groups' populations. Considering the absence of those figures alone, it is this author's position that the outcomes for African Americans with undiagnosed or clinically untreated mental illnesses are likely higher than illustrated in their sample. Notwithstanding, it is inherently difficult to get a response from participants fitting the criteria that would fully present the reality on such an elusive subject as African American mental illness.

Another Perspective on Addressing the Dilemma

The state of African American mental illness in the United States has proven to be difficult for those suffering from psychological disorders, their families, communities, and the providers and resources accessible to help them. African Americans' most common alternatives to clinical care— faith leaders and churches—have also awakened to the need to learn ways to effectively integrate mental health care into ministry and pastoral care (Snowden & Snowden, 2021; L. Williams et al., 2014). Despite the church having a long history as the preferred resource to which many African Americans turn for help with emotional, psychological, and many other types of health problems, only a small portion of the literature examines how clergy

understand and address mental health care seekers. This examination of the literature seeks to learn what historical and current positive and negative contributors are at work in the present African American mental health dilemma, focusing on understanding how churches and their leaders perceive and perform their role. The lived experiences of clergy and pastors who serve African American congregations will be the lens through which the study is focused to add value to existing research from the vantage point of their perspectives and practices.

The African American Mental Health Dilemma Brought to the Forefront

Despite public acknowledgments and recognition of institutional racism, the systemic changes needed to accommodate the mental health needs of African Americans have not been a priority, and short-lived have been the efforts made to regain their trust in the healthcare systems that have historically failed them (Castle et al., 2019; Hardeman et al., 2018; Noonan et al., 2016). It became very apparent as the recent acute state of mental health amongst Blacks was abruptly forced to the forefront of the American consciousness. As pandemic lockdowns occurred simultaneously with racist injustices towards African Americans being highly publicized, other reliable resources for coping, like the church, became inaccessible, and the escalation of stress on multiple levels began to manifest (K. Brewer et al., 2022; Chae et al., 2021). During this period, many African Americans found themselves not only more vulnerable to the biological impact of COVID-19 but also mentally overwhelmed as the pandemonium of responses to highly publicized crimes against Blacks unnerved the nation, giving rise to a collective vicarious trauma (Ashby et al., 2022; Chae et al., 2021; Wakeel & Njoku, 2021).

The disproportionate psychological and physiological impact African Americans incurred during the pandemic was further compounded and reflective of long existing social and economic inequalities in health care. A lack of access to COVID-19 testing kits due to the initial

disproportionate distribution, forgoing treatment due to uninsurance, and increased financial insecurity due to lockdowns were symptomatic of such inequalities (Reyes, 2020). Mays et al. (2021) posed that these inequalities, as well as the controversy surrounding African Americans obtaining the COVID-19 vaccination, were indicative of the structural racism that continues to interfere with Blacks receiving the care needed. Novacek et al. (2020) pointed out how the expansive scale of psychological needs of the Black community during COVID-19 more clearly revealed the mental health systems' deficiency in knowing how to assess mental issues from a culturally/contextually informed perspective as well as how to appropriately develop a treatment for Blacks suffering complex compounded mental distress.

The realization that African Americans were contracting and dying from the virus in higher numbers yet remaining more hesitant to receive the vaccination turned national attention back to the already existing health disparity dilemma (Andrasfay & Goldman, 2021; Mays et al., 2021). The resurgence of national concern acknowledged the higher contraction risks for Blacks were primarily due to pre-existing health conditions to which a history of disparities in care also contributed. The response was swift to educate and promote vaccination in African American communities (Bunch, 2021). While indecision, reluctance, optimism, and stress around whether immunization was trustworthy were a global concern, the higher prevalence of African Americans' resistance to vaccination has been tied to several other factors. Factors identified that caused some African American reluctancy about the virus included ongoing mistrust of health care systems due to discrimination, dissemination of misinformation in Black communities, and most of all, the catch-22, an inadequate number of Black participants in the vaccine's relatively quick development and testing (Jamison et al., 2019; Restrepo & Krouse, 2022; Zhang et al., 2022). Much of the African American community's reaction to the pandemic, the COVID-19

vaccine, and the uprise in publicized racism propelled attention back to the physical and emotional consequences of living out of a history of discrimination. It also brought attention to existing impediments to care because of the unaddressed need to address institutional racism and ignorance in America's health systems.

The Impact of Racism on African Americans' Mental Health

Though the experiences of African Americans in the United States today are widely more diverse than their earlier slave ancestors, there remains a connection through the shared cultural, historical, and social influences with which they identify (Pew Research Center et al., 2022). Intrinsically, some of the influences are byproducts of ongoing adaptations to adverse conditions related to discrimination, which is understood to be a contributor to more chronic levels of stress, anxiety, and depression (Mouzon & McLean, 2017). In his research, Williams (2018) identified common race-related stressors that elevate the risk for African Americans' mental health conditions. He demonstrated that discriminatory treatment is so influential on mental health that parental experiences with discrimination are documented to impact their children's mental health negatively (Williams, 2018). The number of encounters with discrimination, personally or otherwise, within a given time is positively correlated with the intensity of psychological distress caused (Nazroo et al., 2020). Despite the vast research and studies expounding on the particulars influencing African Americans' mental health, the gap in mental health care resources needed to adequately accommodate the growing demand persists. The existing gap in care is acutely problematic in light of the number of ill-equipped practicing clinicians as well as the growing number of African American patrons with a complex combination of coexisting stressors that blur the deeper psychological issues at work (Amuta-Jimenez et al., 2020).

The ramifications of racism and discrimination are evident as significant aspects of the critical state of African Americans' mental health in America, which still need to be further addressed (Jackson et al., 1996; Noonan et al., 2016). Its far-reaching impact is progressively being validated as its long-term effects result in increasing quantities of African Americans with severe mental health illnesses or SMI (Williams et al., 2019; Williams & Williams-Morris, 2000).

Living with Trauma

Historical, endemic, intergenerational, and vicarious racial trauma are all much more likely to be a part of an African American's life experience, though many mental health professional curriculums do not include training specifically for the ethnical context unique to their experience (Chae et al., 2021; Garrison et al., 2018; Isom et al., 2021; Medlock et al., 2017). Depression is a mental condition commonly found to be passed from one generation to the next because it tends to be the outcome of cumulative trauma experienced by African Americans (Hankerson et al., 2022). Understanding that trauma can be inherited is a concept not easily captured in an assessment or evaluation. Halloran's (2019) research specifically recognized the circular cause-and-effect pattern of racial discrimination against Blacks, causing their relatively poorer mental and social state, which creates a biased effect in some professional and institutional views, further undercutting the effectiveness of efforts to change. An example is how the psyche or social responses of African Americans are more likely to be misinterpreted or misdiagnosed by professional clinicians when the larger context is not understood or considered (Liu & Modir, 2020). Examining the reciprocal phenomenon through a terror trauma theory view showed that passing and validating cultural pride in the form of positive beliefs and traditions

acts as a protective factor against cultural or inherited trauma proliferated by ignorance (Halloran, 2019).

Posttraumatic Slave Syndrome (PTSS)

Halloran's (2019) terror management theory (TMT) analysis is based on a more recent but spreading concept of posttraumatic slave syndrome. PTSS is not an established DSM-5 mental illness, as is PTSD. It refers more specifically to a collective continuation or passing of trauma in a particular group, as intergenerational or multigenerational theories suggest. PTSS refers specifically to the mental health outcomes because of slavery and racism towards African Americans in the United States that are transferred or transmitted from generation to generation (DeGruy, 2017). DeGruy (2017) coined the PTSS condition after conducting 12 years of research to collectively identify the mental injury incurred by African American's behavioral and emotional adaption to survive slavery, oppression, and institutional racism. Some adaptations are transferred from generation to generation due to the absence of access to or proper means to heal. Like Halloran (2019), other therapies have begun to explore and develop trauma-informed treatments in consideration of the PTSS model as an effort to better help African American clients (B. Campbell, 2019; St. Vil et al., 2019).

Diverse Forms of Racism

Scientific Racism

In the medical and scientific research field, the largely debunked scientific racism theory, which was once fluent, posed that the poor mental health diagnosis in African Americans is characteristic of their inferior intellect (Bell et al., 2015; Chang et al., 2021). The theory does not recognize the racist social-economic and political culture in which Blacks suffer from mental illnesses. The literature supports remnants of the theory still exist, even in research today,

illuminating conscious and unconscious discrimination in medical andragogy or practice contributing to higher rates of inaccurate diagnosis of psychotic or schizophrenic disorders in African Americans). On the other hand, a less than the probable number of mood disorders are diagnosed in Blacks even when assessed with the same symptoms as Whites (Bell et al., 2015; Chang et al., 2021; Schwartz & Blankenship, 2014).

Coupled with the difficulty of addressing the historically scientific racial biases passed down through the health care profession is the unchallenged implicit bias of individual clinicians, which inevitably contributes to questionable or inappropriate treatment plans, particularly where there is a lack of accountability or practiced self-awareness (FitzGerald & Hurst, 2017). Williams (2018) provides numerous observation studies revealing unconscious provider-biased practices towards African Americans, with the most recent being a 2016 phone-based study with 326 licensed therapists showing Blacks were less likely to get an appointment than their counterparts based on racially distinctive names and class-based speech patterns. Whether acknowledged or not, there is a clear awareness and sense of its existence continuing to contribute to the African American distrust of existing systems and widening the gap in obtaining the mental health care needed. Chang et al. (2021) excellently paralleled the longevity of scientific racism to that of a deadly virus that spreads from human to human, normalizing its existence for those who could change it while subtly evolving into different forms as ownership is continually dodged.

Structural and Institutional Racism

Racism has been labeled with various terms to identify its many forms, though frequently they are used interchangeably. “Systemic” racism is commonly used to capture multiple types of discrimination associated with the method in which an organization, process, or society

functionally operates (Bonilla-Silva, 2021). Bonilla-Silva (2021) explained that discrimination exists within the structure or network of relational interactions beginning at the person's level, commonly without knowledge or intent. Discrimination experienced by African Americans based on race became institutionalized or established as a normal practice so profoundly embedded in society that it persists as a habit difficult to break even by those who participate and are not racist as commonly defined.

Desai et al.'s (2023) study of "atmospheric" racism revealed that though mental health is highly impacted by structural and institutional racism, it is the most minor type of healthcare studied in relationship to African Americans. Likewise, it has not been at the forefront of the assessment or consideration of changes to enhance African American well-being, such as physical care. Atmospheric racism is described as the contextual environment in which Blacks live from day to day as communities and individuals. The contextual environment encompasses interactions or experiences with uncontrollable external factors such as social, political, and economic forces and those encountered in immediate relationships with culture, family, and tradition that form individual beliefs and values (Desai et al., 2023). Similarly, systemic racism is identifiable in the formation of structures and institutions facilitating operations that perpetuate stereotypes and profiling. A well-researched example of such perpetuation is identified as police departments, which in simple existence in America are associated with stressors based on historical and ongoing African American experiences (Alang, 2020). Utilization of assessments, diagnosis, and treatment ignoring the discriminative context or atmosphere in which a mental illness presents diminishes the probability of African Americans receiving adequate care or mental health services at all.

Internalized Racism

Possibly the most harmful level of racism affecting African Americans' mental health, as well as the most elusive, is commonly referred to as "internalized" or, more recently, "appropriated racial oppression." A compilation study of the research done in 2019 found that African Americans were the focus of most clinical studies on addressing internalized racism (David et al., 2019). As the word "internalized" indicates, this type of racism is stated to be functioning from within the individual towards oneself. It is commonly concluded to result from an unconscious adoption of common stereotypical views (David et al., 2019). It sometimes manifests in the form of low self-esteem, lack of confidence, and feelings of inadequacy towards self and race, which at critical levels create depression, anxiety, and other mentally diagnosable conditions (David et al., 2019; Shellae Versey et al., 2019). Shellae Versey et al. (2019) refer to internalization as appropriated racial oppression whereby the majority group beliefs are inherently adopted by some in the social-cultural process. An integrated view of internal racism suggests association with the race, as well as being subjected to racism, contributes to internal racism (James, 2022).

David et al.'s (2019) systemic study on literature, which captured the intersection of internalized racism and mental health, revealed that internalization or adoption of negative beliefs can be doubly degrading or ennobling because it tends to work within individuals and through them, shaping beliefs and cultural practices. Though internalization of racism occurs on an individual level of processing information, its outworking can be said to create a common guardedness of many African Americans regarding seeking or receiving mental health, particularly when ongoing internal and external microaggressions may reinforce accepted negative beliefs. Internalized microaggressions occur within marginalized groups, most often

without awareness and with good intent rather than between groups, but also creating beliefs that may reduce the value of one's own identity (Nadal et al., 2021).

Religion, Churches, and African American Church Leaders

While U.S. healthcare systems have not adequately addressed the many complexities of the growing African American mental health crisis, churches and their leaders have and continue to serve as a resource to African Americans seeking help for emotional and mental distress (Alang, 2019; DHHS, 2019; Snowden & Snowden, 2021). Many churches, irrespective of racial or ethnic makeup, provide different supportive services, but according to an NIH survey of Black and White churches, historically Black churches have offered quantitatively more as well as a wider variety of support services acting as what is described as an "informal social service provider" (Blank et al., 2002, p. 1669). The most significant difference between the two groups found was links with formal mental health services until recently have only begun in recent years. Historically, not necessarily possessing the same language, terminology, or the same methods that mental health clinicians or definitions, ministers of African Americans have been a source of help to seekers in mental distress for centuries (Neighbors et al., 1998).

The application of clinical language and vocabulary by clerical helpers is not new or unique to African Americans, as demonstrated in Pruyser's classic work (1976). Pruyser prescribes an awareness of language use in his guidelines on interviewing to make a pastoral diagnosis, which he poses to mean the same as "discerning or discriminating in any field of knowledge" (p. 30). Pruyser, also a psychologist, makes a distinction between the ministers' basis for determining spiritual and psychological illness diagnoses that seems to be still a gray area today. He instructs from the premise that the Bible is the final authority for helping address human needs.

That premise is a shared belief behind the biblical counseling movement that began in the 1960s that, like Pruyser's (1976) instructions, emerged out of the question and disagreement on who and how one best qualified to address human conditions as well as the struggle over whether secular methodology should be integrated with religious practices (Powlison, 2010). The nouthetic view in the controversial *Competent to Counsel* by Jay Adams, founder of the biblical counseling movement, revealed that all pastors do not believe that psychological or therapeutic care opposes biblically based methods (Powlison, 2010).

Religion and African American Mental Health

The biblical counseling and Civil Rights movements began in the 1960s when churches were heavily segregated. There is little specific research on how one impacted or influenced the other. While there is documentation of various races and religious denominations participating in the Civil Rights movement, none indicates collaboration or involvement of African Americans in the origin of the Biblical counseling movement. Two prominent perspectives continue to prevail in the Black church on counseling (Plunkett, 2014). The first poses that all healing results from Divine intervention based on scriptural references, principles, and examples. Some who hold this perspective see counseling outside the church nullifying their faith practice. The second perspective adds that God also provides help through others, including secular therapists, to bring relief and healing based on biblical examples. Plunkett (2014) points out that neither view is entirely at odds with the other, but the first view is likely a contributor to the reluctance to see counseling.

Even with the variations in views on biblical counseling, religion, in general, has been widely studied to determine its influence on mental health and well-being. Though the majority of studies indicate religion as a benefit in providing positive coping tools, a substantial amount of

findings point out its potential detriment to constituents in acting as a hindrance to clinical care (Ellison et al., 2017; Garssen et al., 2021; Koenig et al., 2020; Weber & Pargament, 2014). For minorities, in particular, religion has been discovered to be a vital factor in their ability to maintain and thrive despite the disadvantages faced (Nguyen, 2020). Nguyen's (2020) compilation review of the research on religiosity and mental health focused specifically on outcomes of adult African Americans, Latino Americans, and Whites to make comparisons. The more prominent role of faith and religion has been indicated throughout the history and current values of the two minority groups. It was identified as prevalent in shaping culture, social systems, and racial identity. Another significant difference emerged when analyzing the relationship between mental health and church attendance factors noted to reduce depression and anxiety. African Americans demonstrated the strongest positive association between church attendance and better mental well-being. This is a finding consistent with the historical beginnings of the Black Church as a safe haven during slavery and early oppression (Assari & Moghani Lankarani, 2018). Among Latino Americans, the association was not as strong and varied among in-race groups, age, and stages of life. Among Whites, no significant association was determined to exist between church attendance and psychological well-being.

The relationship between religion and mental health is a principal factor in the complex issues surrounding African Americans obtaining needed care. As discussed in Chapter One, church and church leaders have been a common informal alternative source to clinical care for many African Americans seeking help with emotional and psychological distress. Without regard to other demographics, Hays and Lincoln's (2017) analysis indicated that African Americans who are less involved in religious activities are less likely to seek help from a religious leader or organization; likewise, those more involved are more likely to seek churches or faith leaders.

Weber and Pargament (2014) indicate that higher "religiosity," meaning the rate of involvement in organized religious assemblies, could also have an adverse mental outcome— "spiritual" or "religious struggle." Anger with God or other Christians, as well as shame, guilt, and doubt, are cited as religious struggles that create negative coping with mental illness, which may intensify mental health conditions such as depression, anxiety, and suicidal ideation.

The three conditions noted to be intensified by negative coping (depression, anxiety, and suicidal ideation) have increased among African Americans at alarming rates in the past 3 years (SAMHSA, 2023). In 2020, among African Americans 10–24 years old and males 25–34 years old, suicide was the third highest cause of death, according to the SAMSHA 2023 report. While the prevalence of mental illness among African Americans was reported to be 2.9% less than Whites, only 39% of African Americans reported receiving mental health services compared to 52% of Whites (SAMHSA, 2023). Considering that the majority of known African Americans with mental health issues are likely not having their conditions addressed professionally, one of the grave questions that this study seeks to explore is the ability and potential of churches and their leaders to do so.

Churches and Leaders' Mental Health Care Capacity

African American churches and their leadership's competency to address emerging mental health conditions are viewed across a broad spectrum of differing perspectives; nonetheless, the Black Church acting as a one-stop resource by necessity precedes much of the mental health care practices accessible to them today (Dempsey et al., 2016). In Hays's (2015) research exploring the capability of Black churches to administer structured psychological care through education, counseling, and therapeutic services, it was identified that many of the methods used by professionals were already in practice. In addition, faith and religion are

essential components of the African American culture, which provides a more receptive client in many cases (Hays & Aranda, 2016). The reliance on the power of faith is one of the reasons behind Blacks' tendency to seek clergy for psychological help (Payne & Hays, 2016). Many churches are often already operating as a buffer against feared discrimination while simultaneously providing an element of support in a community, which is rarely a role for clinicians (Williams, 2018).

Positive mental health outcomes are associated with church attendance and participation in general, described in the Religion and African Americans portion as religiosity. The social context of the church also acts in favor of promoting better mental health outcomes. However, Codjoe et al.'s (2021) study review on mental health among Christian congregants revealed that it is difficult to measure just how well attendance and participation in predominantly African American assemblies contribute to mental well-being or decrease the stigma due to the lack of quality research done. Studies conclude that faith practices and involvement in religious activities provide a positive coping mechanism and may also be part of integrative care regardless of patients' race or ethnic background (Captari et al., 2018; Koenig et al., 2020).

African American Church Leaders

African American church leaders, especially those of color, are more likely to possess an understanding of how the cultural milieu and socioeconomic circumstances influence the resistance of Blacks in seeking licensed mental health assistance. In addition to understanding the contextual factors, many African American pastors have their own lived experiences informing the administration of personal treatment plans or counseling for Blacks seeking them for care, which some professional healthcare providers lack (Argyriadis et al., 2022). Professional clinicians are less likely to assess African Americans' mental health concerns with

the level of cultural awareness their pastors possess. They are more likely to be uncomfortable with recognizing race as a factor when other associated contributors can be identified (McMaster et al., 2021). McMaster et al. (2021) thematic review of self-reported reactions during interviews with mental health clinicians revealed passive racism, a belief that race-matching clients is more beneficial, belief disparities result from socioeconomic differences, and discomfort discussing race. This discomfort or reluctance to recognize that being of a particular race, ethnic group, or culture increases one's mental health risk further contributes to inadequate care. In addition, ethnic matching clients can be disadvantageous to African Americans since they are underrepresented in mental health professions. Race as a factor in receiving care has long been a fact for African Americans that clergy knowledge factors in when providing care for those who seek assistance as well as in their own lives (Powell, 2018).

Though pastors and church leaders of African Americans are often advantaged in understanding the surrounding cultural context contributing to seekers' concerns, they may lack a clinical perspective or knowledge on addressing the severity of some seekers' psychological problems. Pastoral counselors and faith leaders encounter some of the same mental health issues as mental health professionals; however, no state or federal regulation or standardized training exists among clergy. Some clergy may have no formal training in counseling or distinguishing behavioral health conditions, according to Dempsey et al. (2016). The outcome of their analysis of interviews with 41 Black churches' pastors revealed a mostly favorable interest from pastors regarding teaming up with formal mental health agencies to help reduce the gap in needed care for African Americans. Little demographic information is included in Dempsey et al.'s research, which is purposed to explore collaboration possibilities between churches and mental health professionals. This would help highlight associated factors that may need to be considered. Since

African Americans are predisposed to a higher risk of serious mental health conditions and more susceptible to vicarious trauma from environmental stress, the ideal mental health care for Blacks would include the benefit of clinical and pastoral knowledge (Bor et al., 2018; Williams, 2018). In the last 10 years, numerous collaborations and partnerships have been implemented in response to the increasing mental health needs (Hankerson et al., 2018; Hays & Aranda, 2016; Scribner et al., 2020). One of the ongoing challenges is pairing the clinical and spiritual to obtain the best possible outcomes; however, many church leaders have successfully collaborated to provide the best care (Dempsey et al., 2016; Hankerson et al., 2018; L. Williams et al., 2014).

Ethnic Identity and Church Leaders' Influence

While Christian leaders being personally informed on the history as well as the cultural context from which seekers are mentally challenged is helpful, they also embody a role that can hinder or facilitate followers to pursue needed professional mental health care by the mindset they display (Harmon et al., 2018). Harmon et al. (2018) research identified an individual's authoritative role as a pastor inherently influencing three sources: a positional history, contextual, and reciprocity in relationships (pp. 3–7). In African American churches, the role of the pastor has always been multifold, and their leadership role expands beyond the church. As a race, there is a general distrust of health care systems by African Americans, which perpetuates itself in a collective sense, which Monk (2020) refers to as a "linked fate" view. Linked fate suggests that an individual expects the things that commonly have occurred to those of their same ethnicity or racial background (Monk terms it "ethnoracial identity") to be likely to happen to them as well. As a result, those pastors who identify positively with aspects of their "ethnoracial identity" share a sense of group belonging and views, which for African Americans can perpetuate poor mental health conditions, according to Monk.

Other studies indicate racial or ethnic identity as a valid predictor of mental health, particularly among races suffering from discrimination exhibiting poorer mental health (Loyd et al., 2022; McClain et al., 2016). Unlike Monk, Loyd et al. found that racial or ethnic identity, in some instances, functioned as a protective factor with coping mechanisms, subduing the psychological impact. For the 199 Black adolescent girls and Black women who experienced microaggressions in their 1-year longitudinal study, symptoms of mental distress did occur in response to microaggression. The girls' adverse behavior more noticeably externalized them. Similarly, McClain et al. (2016) found ethnic identity to be a positive predictor in their study sample of 218 African American college students when race-related stress (discrimination) was identifiable. In addition to the ability to generalize due to sample size, the limitations of both studies were a few other influencing factors surrounding the context of discriminatory experiences that were not considered in this research.

Church leaders act as models to shape ethnic identity. They can be a proponent or a deterrent to seeking professional care. Like other leaders, the followers' expectations and accountability to denominational leadership, traditions, and ordinances are accompanied by the pressure to maintain views that may no longer be beneficial (Campbell & Winchester, 2020). Hays and Shepard Payne (2020) found that African American pastors who personally experienced mental illness demonstrated attributes and an understanding needed to positively influence and help seekers get the mental health care needed.

Model Studies of Clergy on Mental Health

Payne and Hays's (2016) analysis of clergy perspectives on mental health, which also serves as the model guiding the framework of this study, found a wide range of different perspectives among clergy concerning what causes mental illness. Their grounded theory

approach research was conducted in 2012 on a social media online group where clergy networked spontaneously rather than as participants for research. As a result of the format, the clergy studied were less inhibited and free to express themselves amongst peers and colleagues. The 35 participants in the two-week-long conversations analyzed spanned three countries, providing valuable insight into understanding the relationship of faith leaders to mental health and help-seekers.

The clerics' beliefs on the origin of mental illness included demons, spiritual warfare, responses to life trauma, and oppression. Some of these beliefs are explained from a biblical premise. The perspective that an adequate exercise of faith is sufficient in addressing the illness without clinical care was present. Those who hold firmly to this view believe the use of mental health services discounts the power of faith or Christians who seek help elsewhere have not developed a strong enough faith yet. Naturally, the understanding that such a view as being authoritative presents an internal conflict for seekers considering clinical care. This model adds value to the work of this study in presenting existing diverse views of clergy comparable to outcomes in the current research findings.

Even within the gamut of clergy views on causes of depression and PTSD alone, there were varying views from biological, psychological, sin, or some combination (Payne & Hays, 2016). The views of the clergy markedly impacted how they addressed the subject of mental health with congregants and how they counseled those who sought them for help. A deficiency of trust in God was found to be a notable number of Christian leaders' explanations for depression in Ayvaci's (2016) compilation study of surveys of church leaders. His study highlights the necessity of addressing religious background in assessment and improving clinical knowledge of faith-based services with coordination when possible (Ayvaci, 2016). This

research endeavors to look a decade later from a case study approach at clergies' perspectives on African American mental illness as risk rises, creating a higher demand for their services.

African American preferences for help from Christian leaders are not necessarily based upon an established demonstration of their capacity to effectively assist (Hays, 2015). There is a deep and long connection between Blacks and religion as an institution serving the interest of the race and providing spiritual care as well as other needed social services. (Garner & Kunkel, 2020). Care provided in faith-based organizations that serve African Americans emanates from leaders with differing beliefs or practices, some of which do not align with those of the mental health care professional, particularly concerning some diagnosable conditions (Bilkins et al., 2016). In addition, Payne and Hays (2016) noted that leaders' views are dynamic and change over time and experience, which is part of the premise of this researcher's work to analyze current views and perspectives.

Despite the limited evidence Payne and Hays (2016) provided for the shift in perspectives, it is significant that via the grounded theory process, observations of some participants in the views shift over time, particularly to one more favorable to mental health integration. A notable example was shared during a 2015 exploration on the same social page. One participant previously opposed psychiatric treatment, obtained counseling certification, and pursued a psychology degree (Payne & Hays, 2016). It speaks to the possibility of change and re-evaluation that can occur from experiences or rein an effort to change outcomes as needed in the current African American mental health dilemma.

African Americans Help-Seeking Tendencies

The prevalence of African Americans preferring help from spiritual leaders over seeking institutional care for mental health, in particular, is significant (Allen et al., 2010; Avent &

Cashwell, 2015). Although limited in sample and demographics, one study of 243 participants in Philadelphia determined that primary care physicians ranked higher in preference for seeking help for mental health issues amongst older African Americans than mental health professionals due to associated stigma (Lee et al., 2021).

Blacks' negative or suspect perception of clinicians, coupled with the time-honored place churches have had in African Americans' lives, naturally places spiritual leaders and faith organizations in a role of providing care in many different forms (Avent et al., 2015; Avent Harris & Wong, 2018; Hays & Lincoln, 2017). Fellowship, music and song, ministry, small groups, and spiritual practices such as scripture meditation and prayer have, in many ways, functioned as forms of help, healing, hope, and coping with stress under the auspices of the Black Church. Professional mental health care widely recognizes the therapeutic value of many religious practices; however, the opposite is not always true of the churches or help-seekers (Koenig et al., 2020; Weber & Pargament, 2014).

Harris et al. (2020) study discovered a pattern of common attitudes from a diverse group of 632 self-identified African American respondents to their electronic survey seeking insight into help-seeking preferences and their perspective on the cultural views of mental health care. In addition to stigma, which is prominent in most studies, views of those with a mental illness as dangerous, limited intellectually, diminishing or denying of a mental health issue, or diminishing of a person with a mental illness value emerged. Most of these views could be tied back to a fear of how others would think or treat them (Harris et al., 2020). Apart from stigma, there were some distinct variations in age groups, with older African American women being more likely to seek treatment despite concerns noted. As Black females are generally believed to be more religious and active in faith organizations, an additional explorative question that could have been

included in this study would be respondents' religion and religious practices (VanderWeele et al., 2017).

Religion Help or Hindrance

Behaviors are often defined or identified as acceptable (or not) based on the religious belief system in which one is raised. Some religious practices and beliefs remain rigid and do not change or evolve with the current context of surrounding circumstances. The Black Church has been accused of being somewhat ununified and rigid to vacillating in its response to biblically and socially controversial subjects like homosexuality, despite rising numbers of associated mental health-related issues (Douglas & Hopson, 2000). For some individuals, incongruency between what they experience and what their religious upbringing taught about God's love, life, and salvation creates spiritual struggles that can negatively impact one's mental well-being (Wilt et al., 2017). In this respect, religion and sometimes churches indirectly compound or intensify mental distress, particularly when there is an explicit or implied shortcoming on the part of those who have a mental illness (Bockrath et al., 2022). Bockrath et al.'s examination of 32 studies on spiritual struggles found recovering from, or treatment of, mental illnesses can be hindered by religious struggles. It raises an interesting question for African Americans who prefer to go to faith leaders for help with psychological issues if moral or religious struggles exist, which may need to be addressed to effectively treat other issues.

In Upenieks et al.'s (2023) study, the possible explanations of why quantitatively African Americans suffer from mental illness at relatively equal rates as Whites by looking at religion and spirituality are explored. The basis for the research was that the rates do not align with the higher risk for mental health illness of African Americans and to determine the extent to which religion may play a role. One of the outcomes from the data analysis of 1,381 American adults'

responses indicated Blacks had fewer spiritual struggles than Whites (Upenieks et al., 2023). Thompson et al. (2020) posed that African Americans also exhibit a unique expression of faith that extends beyond attendance in church or involvement in religious activities (commonly used to determine religiosity). It could be that Upenieks et al. did not capture all contributors since African Americans have a higher severity of mental illnesses when diagnosed (Williams et al., 2019; Williams & Williams-Morris, 2000). Possibly overlooked is that when some Blacks experience moral or spiritual struggles, an existing mental health condition may be exacerbated. As part of a study of older African Americans' religiousness, it was determined that religion was not considered church participation or attendance but a frequency of private or personal religious activities such as scripture study, personal prayer, and sharing through everyday interactions (Thompson et al., 2020). Because the Black Church was born out of the African American experience, it could be said that for centuries, Blacks' association with church was equivalent to their association with lifestyle. As such, the depth of spiritual formation for many African Americans is the grounds for moral principles and spiritual beliefs that are viewed as standards of acceptability in culture or race. They can be more restrictive than liberating for some Blacks navigating emotional distress.

Discrimination and Ignorance

Still, as many African Americans' response to an overtly discriminative health system was distrust and reluctance to seek professional mental health care, faith communities were serving as a refuge and safe place for those emotionally distressed and mentally challenged (Taylor et al., 2014). Strong faith and church-nurtured spiritual practices accompanied by the trusted relationships developed in religious assemblies served as coping sources for many African American congregants managing mental health difficulties when discrimination ruled

out the possibility of seeking or receiving professional mental health care (Balkin et al., 2022; Turner et al., 2019).

Discrimination has been linked to a higher risk of psychiatric conditions that occur in African Americans, such as post-traumatic stress disorder (PTSD), anxiety, and depression (Sibrava et al., 2019; Williams, 2018). Sibrava et al.'s (2019) 5-year analysis of 152 African Americans' clinical course of PTSD indicated that ongoing discrimination contributes to its progression as well as outcomes after treatment. The higher severity of these mental conditions, when identified in African Americans, can be tied to a continued reinforcement of distorted thinking caused by multiple sources and structures, as well as the challenges of recognizing how they contribute to the compounding cycle that has created a growing crisis.

Together with a complex history of trauma from slavery and ongoing racism in formal and informal systems, many existing agencies were created with marginalized ideologies about African Americans, which perpetuate multigenerational trauma and its impact on the well-being of African Americans (Barlow, 2018; Williams-Washington & Mills, 2018). Neely-Fairbanks et al. (2018) pointed out critical connections in how a history of systemic racism contributed to Blacks' cultural stigma and reluctance to seek mental health care from professional healthcare systems. Understanding the history of Blacks is a critical and essential part of grasping the spectrum of complexities involved in responding to their mental health care needs (Paul et al., 2020; Shim, 2022). Likewise, an awareness of structural and process racial bias is equally as important as knowledge about a client's culture and ethnicity when treating emotional distress and anguish (Mathur et al., 2014; Shim, 2022). Public health institutions operate from a racial structure implicitly biased toward African Americans (APHA, 2020).

Unfortunately, many clinicians who provide psychological care to African American

clients are not acquainted with how collective trauma is another factor that may be present in individuals of color, creating more chance for error and a less informed diagnosis, thereby, a less effective treatment (Watson et al., 2020; Wilcox, 2022). Collective trauma should be understood as more prevalent in African American subgroups like males, single moms, and homosexuals, who are doubly susceptible to encounters that impact their mental health negatively (Bauer et al., 2020). Schizophrenia should be established as an established diagnosis highly misapplied to African Americans in the absence of racial or cultural considerations (Barnes, 2013). Omission, intentionally or otherwise, of possible racial or cultural contributing factors is detrimental and inhibits receiving the mental health care needed by African Americans.

Transformative Theoretical Framework

The conceptual framework for this research is purposefully transformative, examining the unique issues Christian church leaders face in assisting Blacks with mental health problems amid overwhelmed mental health care systems to obtain an understanding that fosters awareness and improvement for all involved (Creswell & Poth, 2018). The framework is also intentionally implemented with a less rigidly defined structure to avoid constraining the process in a way that simply produces the underlying existing notions of the researcher (Grant & Osanloo, 2014). The transformative lens supports the processes, particularly in the data collection, which requires translation or valid interpretation of open, candid responses for critical reflection over boxed answers by restrictive formats. There are multiple types of transformative theories, but this application applies to the benefit of the participants' shared experiences (clergy), mental health professionals, and students or researchers during the study, as well as the application of additional insight added to the literature findings.

Transformative learning prompts the participants' and consumers' attention to critically

examining existing beliefs and truths, particularly in systems and social or cultural issues (Romm, 2015). Analyzing the relationship between systems and practices or behaviors is foundational to the transformative theory, which posits that critical processing is crucial to making progressive change, particularly in societal structures.

Transformative Consciousness

Another significant aspect of the transformative framework is that it does not seek to create a separation between the mental, physical, social, or physical factors involved in exploring the African American mental health dilemma. The transformative paradigm recognizes and engages all factors as contributors to ascertain conceptions of various cultures to produce impartiality for objective outcomes (Mertens, 2010). Its intention is multifold in this research to explore the interconnection of complex human issues from the perspective of those involved to further thought, which promotes transformation to any degree from the knowledge and understanding gained.

Jemal (2018) expanded on the intention of transformative theory with a concept fitting to the lens of this study on transformative consciousness (TC) of health inequities. His examination of oppression further informs the prevalent view that it is not just a physical subjection to harsh treatment but also consists of mental oppression like the undermining of African Americans psychologically, which is internalized, usurped by the larger group, creating “appropriated racial oppression” (Shellae Versey et al., 2019, p. 294). TC primarily focuses on learning through raising awareness where some of the underlying health issues stem from social issues on an individual and group level, requiring a more informed perspective to be addressed in a way that results in true progress (Jemal, 2018).

Transformative Experience

Transformative experience (TE) theory is, more specifically, the foundational structure guiding the interview process where clergy share lived experiences of addressing Blacks' requests for mental health care. This interactive component of the research TE establishes as the scaffolding to "motivate use, expand perception, and add experiential value (Pugh et al., 2020, pp. 546–547). Though modified for various applications, TE theory was initially applied in a school setting to utilize life interactions to create change based on John Dewey's philosophical view of the value of experiences in effective education (Chew, 2015). An axiological assumption characterized by the researcher's experiences, values, and beliefs will guide the research (Creswell & Poth, 2018). The assumption is grounded in a knowledge of the context and an increased understanding of the numerous perspectives and influences around the dilemma of the African American mental health dilemma. This provides a sensitive and open approach to engaging the subject with integrity (Azzari & Baker, 2020). At the most basic level, the assumed shared interest among the clergy to effectively help Blacks suffering from mental health issues contributes to the dynamics inherent to this TE research framework, which adds valuable perspective necessary for beneficial change.

Transformative Learning

Transformative learning (TL) will occur as a byproduct of the interviews and questionnaires, which inherently create an introspective look at the existing views of each church leader. Participants will be provided with a summary of outcomes from which they provide feedback. Their responses and feedback will likewise confirm that expected TL occurs and adds value to the research process as it has done similarly in the healthcare field, where it has become a developing theory of education (Van Schalkwyk et al., 2019). Exposing health professionals to

new experiential information expands their views of care (Whitaker et al., 2021). The TL conceptual framework in this study produced useful information in an enlightening process that identifies a need for more exploration of services Blacks receive for mental health care from churches and pastors. The transformative conceptual guided process unraveled nuances of information in numerous studies evidencing participatory reflective learning at different stages observed in the process (Nye & Clark, 2016). This study's strategy of learning clergy perspectives on responding to Blacks seeking help for mental health concerns is designed to have a similar impact.

Halloran's (2019) terror management theory (TMT) analysis is based on a more recent but spreading concept of post-traumatic slave syndrome. PTSS is not an established DSM-5 mental illness, as is PTSD. It refers more specifically to a collective continuation or passing of trauma in a particular group, as intergenerational or multigenerational theories suggest. PTSS refers specifically to the mental health outcomes because of slavery and racism towards African Americans in the United States that are transferred or transmitted from generation to generation (DeGruy, 2017). DeGruy (2017) coined the PTSS condition after conducting 12 years of research to collectively identify the mental injury incurred by African Americans' behavioral and emotional adaption to survive slavery, oppression, and institutional racism. Some adaptations are transferred from generation to generation due to the absence of access to or proper means to heal. Like Halloran (2019), other therapies have begun to explore and develop trauma-informed treatments in consideration of the PTSS model as an effort to better help African American clients (B. Campbell, 2019; St. Vil et al., 2019).

Related Literature

COVID-19 and African American Mental Health

Many have credited the COVID-19 pandemic for bringing to the forefront the long-existing mental health disparities Blacks face daily. The disproportionate impact of the virus reflected in statistical data dauntingly supports their view. Novacek et al. (2020) posited that the context in which Blacks experienced the pandemic compounded the impact mentally due to preexisting stressors and a higher risk for trauma. With fewer resources and more reluctance to trust health care systems, which have historically demonstrated an inequity in service, added to the sudden physical shutdown of the church, which is a cornerstone resource for every sought of help, Blacks' mental health detriment was likely far worse than could be measured (DeSouza et al., 2021). Despite the strain and disconnection all entities experienced during the pandemic, faith communities all over strategized to find methods to do what the churches and Christian leaders that serve predominantly Black congregations have been doing for centuries—be a supportive resource in providing help with mental and emotional distress (Jacobi et al., 2022). Many Blacks continue to prefer seeking mental health help, as has been historically done through their faith leaders, over mental health care professionals (Dempsey et al., 2016).

Complementary and Integrative Health Care

In a 2017 study of the use of complementary and integrative health care (CIH) by minority adults with mental illnesses, only 31% of African Americans with mental illnesses were determined to be utilizing such services (NIHM, 2021; Ong et al., 2021). Ong et al. (2021) posed that the need for more integrative treatment for minorities is crucial, considering the likelihood of more severe outcomes in its absence. Disability, depression, PTSD, alcoholism, and suicide are more prevalent outcomes in undiagnosed or untreated mental illness in African Americans

than in their Caucasian counterparts (APA, 2013). CIH treatment is not defined literally by the National Center for Complementary and Integrative Health (2021) to include “faith” practices or church as one of the different provider resources for coordinating care. The goal of addressing the whole person for many African Americans hinges upon its inclusion.

The Influential Role of the Black Church

The Black Church is arguably one of the oldest, most influential, and culturally significant forces in the lives of African Americans as a race (Brewer & Williams, 2019). The ascription of the Black Church developed in the early assembling of Black slaves to identify the place of communal worship, which, sometime after slavery, was also referred to as the Negro church (Bennett, 2018). Refusing to accept the interpretation of scripture that implies Christianity endorsed slavery, captives from Africa surviving the Middle Passage believed that freedom and equality were God’s design for all mankind. The belief in freedom and equality was one of the primary tenets from which the values of unity, healthy relationships with man, and a personal relationship with God wrought the Black Church. Though initially the slaves began secretly meeting due to restrictions on gathering, their faith assemblies essentially formed the first social support group therapy or mental retreat (Avent & Cashwell, 2015; Douglas & Hopson, 2000). The gatherings began as a faith community sourcing hope for a future of freedom from the dehumanization to which they were subjected. Over the decades, that unifying belief evolved into many descriptions or titles attempting to capture the expansive and diverse role of the pseudo-institution of the Black Church. It evolved into a platform with numerous inter and intra-religion governing bodies advocating financial, political, and educational advancement while expanding in influence as African Americans moved into different social, educational, and political circles. While some religious beliefs, traditions, and worldviews originating in Africa

impacted the formation of the Black Church, Christianity was adopted in the United States. The first formal Christian congregations of freed slaves were Baptist, Presbyterian, and Episcopal denominations with various sub-religions; however, today, it continues to diversify into various denominations and religions as well as integrate with people of different colors and origins in the United States (Avent & Cashwell, 2015; Plunkett, 2014). The Black Church is a "multitudinous communities of churches, which are diversified by origin, denomination, doctrine, worshipping culture, spiritual expression, class, size, and other less obvious factors" (Douglas & Hopson, 2000, p. 96).

Having evolved and developed into a catalyst for change in and for Blacks in America while serving as a solid source of relief, strength, and hope, the Black Church remains the founding landmark of the resilience behind African Americans' progress (Croft, 2020). Today, the more visible witness to its existence is a growing number of megachurches with African American leadership that reflect and shape the cultural identity. The relationship between Blacks and religion or church and their leaders informs their identity as Christians and their expectancy as members of the race socially, spiritually, and politically (Allen et al., 2010). Weathering shortcomings, criticism, change, and progression, the Black Church remains a hallmark of unity and solidarity in the African American pursuit of justice and equal rights, as well as an advocate and founder of higher educational institutions. African American faith leaders are positioned to foster healthier views of mental health care and overall healthier life practices (Baruth et al., 2013; Gross et al., 2018).

African American Attitudes about Church

It is not surprising that the African American culture boasts a history that was built on and thrived from a faith that provides practices that have long been used as survival or

overcoming mechanisms for navigating through mental and emotional anguish (Avent et al., 2015; Hamilton et al., 2013). Pastors and ministers are widely regarded as appointed by God and sources of great authority from the perception of many congregants (Plunkett, 2014). By mere virtue of position, Christian leaders automatically assume responsibility for roles that expand far beyond the pulpit and spiritual care to counselors providing mental health care and as models from which clinical care is perceived (Harris & Ulmer, 2017).

The attitude Black Church leaders have had regarding the mental health profession is changing with the times and generations, as is that of many African Americans. The literature indicates that older African American pastors and leaders with closer ties to the historical Black Church values or tenants are personally less inclined to use or advocate for clinical mental health care (Bilkins et al., 2016). This is even more likely if they have personally experienced discrimination or racism (Okunrounmu et al., 2016). It is also reflective of prior generations evolving out of trauma before there were names or words to describe mental distress, much less freedom to articulate its impact if possible. While the leader's age appeared to be a significant factor in how they perceive or utilize professional mental health care, commitment to the church via attendance, application of spiritual practices, higher incomes, and health care insurance correlated positively to their wellness. The earlier stated orientation of some that healing results solely from divine intervention, the struggle to reconcile faith and mental illness combined, and an other-worldly theology that relief from suffering comes after the earthly life of the Christian are all becoming less prevalent views in this generation (Avent & Cashwell, 2015).

Advantages of Church Care for Blacks

Many African American church leaders today have acknowledged or recognized the growing need to understand and appropriately assist those they serve suffering from mental

illnesses or conditions (Avent et al., 2015). The congregations embracing this view from leadership are playing a critical role in helping remove the stigma and reduce the scrutiny and shame formerly associated with the church's view of mental illness. As a result, more opportunities are developing in and through the church for African Americans to receive help who might not otherwise. In addition, many pastors and ministers who have become more informed via education or personal experience are using their position of influence to change the cultural narrative about therapy and clinical help as contrary to Christianity or demonic.

Author and educator Dr. Rosalyn Denise Campbell centers on mental illness in underprivileged populations. Her exploration of Blacks' experiences and disposition to trauma recognized the church as significantly positioned to provide culturally informed mental health intervention (Campbell & Littleton, 2018; Campbell & Winchester, 2020). In seeking to understand the Black help-seeking tendency for faith leaders, it was clear to some extent that the church was and is actively involved in filling the void left by the professional health care system. In addition to having an inherited degree of understanding of the cultures and communities they serve, churches are often more accessible logistically and economically to many Blacks. Also notable is that seeking help from religious leaders in the Black culture does not have the shame and stigma associated, which mental health advocates are continually working to remove.

Dr. Krystal Hays' work as an advocate of Black health seeks to determine how the inner workings of the church and those pastors who personally respond to requests for help vie in providing mental health services (Hays, 2015). The capacity to meet the need involves complex interactions and sometimes competing factors. Clergies' knowledge, skills, and abilities to recognize or distinguish (if they believe there is a distinction) a mental illness varies greatly. It is often not included in formal ministry or pastoral care curricula. Christian leaders struggle with

identifying the intersection and separating spiritual care and mental care, particularly with a diagnosed mental health disorder (Taylor & Kuo, 2019). This gap is the foundation on which Hays' work inspires this study, and there is a need to explore how churches can take advantage of their position and build capacity through awareness, education, and promotion of Black mental health care (Hays & Lincoln, 2017).

Churches and Clergy Mental Health Care Challenges

Churches and Christian leaders inevitably play a role in diminishing or improving African Americans' views as well as the possibility of them receiving professional mental health care. Changing the current view comes with many challenges, even for faith leaders. Consider the different denominational and personal perspectives. Differing beliefs about the source of mental health issues and ignoring the reality of symptoms are other barriers common to Blacks, which may or may not be intentionally reinforced by churches (Avent et al., 2015). Williams and Cousin (2021) unveiled common "misperceptions" and "misconceptions" pastors see amongst their congregations about mental health, which continue to hinder Blacks from taking advantage of opportunities for mental health care. One more prevalent example is older Blacks who have strong ties and beliefs in the religious tenets of the traditional African American churches and have a less confident or optimistic view of professional mental health care (Davenport & McClintock, 2021; Thompson et al., 2020).

Like professional caregivers, clergy' perspectives inescapably orchestrate how they approach and respond to requests for mental health care. Depression, one of the most common mental conditions, which can range in degrees from mild to clinically severe disorder, was described by clergy of a megachurch through the lens of a distressing response to external conditions such as finances or social oppression impacting the individual (Hankerson et al.,

2013). From this perspective, partnering with professional health care for a church-based care program was welcomed. These partnerships are most needed and an excellent tool for helping Blacks with mental health issues caused by the described source; however, there are other varying views of depression by clergy ingrained in the culture that must be overcome. The denial of depression based on the belief that it is an indication of vulnerability or "weakness" in the African American culture is likely a contributor to the higher severity of cases when it manifests in unhealthy expressions (Alang, 2016; Anthony et al., 2015).

Burse et al.'s (2021) study of 246 Black Christian ministers indicated that most can identify when a seeker's mental issues exceed their ability to address with common pastoral care faith practices. Referrals to professional mental health care occur most often when the surrounding situation has reached a critical state per the minister's assessment. The issue with relying on the minister's assessment is that there is no standardized format for doing one, and mental conditions may be interpreted as a product of spiritual or other issues that can be addressed. The concept of what is mental illness, as well as the definition of holistic health, has been found to vary among the clergy of Blacks (Campbell, 2021). Participants in Campbell's (2021) research evidenced that the extent of their exposure to mental illness through help-seekers and other sources developed their definitions and understanding over time. Other pastors conceptually saw mental health care as an indication of a need for help with an extreme psychological condition affecting normal daily functions.

African Americans have been found to have a higher risk for PTSD (post-traumatic stress syndrome) and are more likely to be underdiagnosed. Currently, post-traumatic slave syndrome (PTSS), which is a collective nonclinical theory explained in a previous section, has been gaining attention in explaining as well as offering solutions to addressing the behaviors adopted by

African Americans to survive the abusive pain of slavery and oppression hundreds of years ago that is still not healed today (DeGruy, 2017). Like religious struggles, mental health clinicians may need to be knowledgeable about attending to PTSS first to treat the presenting mental illness effectively. Unfortunately, some past adaptive behaviors passed down, like depression that would be diagnosed as a mental illness, are not always viewed in the Black Church as needing counseling, thereby lengthening suffering even in silence, which ultimately impacts overall health (McMaster et al., 2021). Some of the language or code words many Blacks utilize to refer to someone experiencing mental illness can be degrading and loaded with stigma. Despite being in an opportune position to reduce the disparity in care Blacks receive, many ministers understandably express hesitancy in addressing mental illness due to not having enough information to distinguish and a preference to stay in the role of spiritual counseling (Karadzhov & White, 2020).

Church and Mental Health Collaborations

Collaborations and partnerships between African American churches and mental health professionals occur frequently in the aftermath of disasters, demonstrating the increased effectiveness of their union in their efforts in crisis. When Blacks were disproportionately impacted by losses during Hurricane Katrina, pastors and leaders of predominantly Black churches aligned efforts with counselors, which were notably effective. Aten et al. (2010) uncovered five primary partnership functions that the victims found most helpful: “(a) educational and outreach opportunities, (b) assessment procedures, (c) consultation activities, (d) clinically-focused services, and (e) spiritual resources and support” (pp. 169 – 172). It was not only evidenced that clergy could benefit from an increased understanding of mental health professionals but that the opposite turned out to be true. Professional care helpers witnessed the

therapeutic alliance quickly formed between those in distress and clergy who provided a sense of continuity and comfort. Such partnership applications and functions are examples of possibilities churches and mental health professionals can implement to benefit Blacks in culturally sensitive but with professional and clinical guidance.

Leveraging the Position of the Church for Better Care

Blacks who seek clergy for mental health care are likely more trusting of the faith leader than the healthcare system; however, that does not ensure or guarantee the quality of care or credibility of treatment from a possibly otherwise great leader. Four significant traits emerged from Hays and Shepard Payne's (2020) examination of the rarely explored views of the clergy who, to some degree, assist with a request for help with a known mental health concern. "Personal experiences with mental and emotional problems, transparency in sharing their stories, personal help-seeking, and humility" were the dominant influential factors present in the clergy who support and administer mental health care intentionally to meet the needs (Hays & Shepard Payne, 2020, pp. 7–8). The responses of the pastors with these traits did not indicate a need to separate or diminish the spiritual aspects of the foundation of their faith but rather detailed how biblical mental health care is supported. The transparency in sharing their own stories immensely supports the efforts of destigmatizing mental health care in the Black community.

Christian leaders of Blacks who are open to, or advocates of, mental health care are learning ways to be inclusive in their ministry to the whole person from a faith-based tenet (Williams & Cousin, 2021). Some view their role as including a demonstration and communication of health through the pulpit platform and other formats compatible with their faith (Lumpkins et al., 2013). As a result of such efforts, many churches are bringing mental health to a community level by normalizing mental health care practices in Church-Based Health

Promotion (CBHP) programs, which align the importance of religion to Blacks in their approach. The CBHP model was initially developed to encompass the social and historical aspects of religious institutions and constituents' cultural and economic backgrounds to develop the best support for healthier lives (Daniels & Archibald, 2011). Hays (2018) advocates for an expanded effect of CBHP at the community level, particularly for Blacks, from a Social Action Theory (SAT) framework to better target the racial disparity in mental health outcomes experienced. By capitalizing on the connection socially developed in the church relationships with those of shared backgrounds and faith beliefs, a new norm is developed for Blacks culturally and as a race.

The Challenge of Reconciling Mental and Spiritual Health

One of the many challenges professional and clerical counselors face is identifying and reconciling the intersection between mental and spiritual health care. Alone, there are limitations for both caregivers; knowing where one begins and the other ends or how they work together is a difficult determination. Integrated care has evidenced that care for the spirit has often improved mental health, and many pastoral counselors support this view in their practice (Skinner et al., 2022). Military chaplains have integrated faith and religion as a part of supporting service members and their family's mental health as a regular practice. However, they coordinate with an office of behavioral health to address client needs assessed with clinical mental health conditions. Civilian church leaders would benefit from such an established network that extends the connection between Blacks and their spiritual leaders to community resources they coordinate with and develop an educational or consultant relationship. Rudolfsson and Milstein's (2019) study of the collaboration of clergy and mental health clinicians found that knowledge development and team effort were needed to bring the desired results.

Mental health professionals initially struggled with exploring and qualifying faith as a measurable therapy component for validity, having less knowledge of what faith meant to clients. Likewise, pastors acknowledge that their depth of understanding of trauma was lacking what was needed to know how to help some who sought their help as the only option. Skinner et al. (2022) described the development of the collaboration as "pastoral caregivers engaging confidants' lives; psychologists treat psychiatric symptoms" (p. 810). This partnership model is still without challenge but presents another example of spiritual and mental care, church, and mental health care professionals meeting.

Two barriers to collaboration were the clergies' promise of total confidentiality and the lack of resources (professionals) to allocate or commit to the efforts in the Swedish pilot collaboration (Rudolfsson & Milstein, 2019). Focus group discussion determined workarounds for the confidentiality vow in the interest of the more significant benefit of providing the best help and possible outcomes. Nakash et al.'s (2019) study of secular and religious mental health clients found that the latter identified more impediments to receiving care. In addition to past bad encounters with clinical care, religious clients were more skeptical about the profession and weary of the stigma associated with mental illness. The skepticism is higher if the clinician is not religious or does not identify, as the client perceived this as limiting their ability to relate. While this study did not make race distinctions, all of the mentioned concerns and financial barriers are consistent with the African American struggle, which supports seeking help from clergy first (Ayvaci, 2016).

Summary

The disparity in mental health care for Blacks has yet to see a decrease despite advances in the mental health care system. Likewise, the long-time use of the church and faith-based

leaders as Blacks' preferred choice for help with mental health care continues to be a practice that has many advantages and challenges. The Black Church has historically served and guided the culture of Blacks, making it ideally positioned to be a channel of hope in addressing the increasing development of mental health issues experienced by its constituents and communities. The issues with taking advantage of that position are multifaceted and require resources outside of the church for the service needed.

Scholars are discovering that African Americans who do seek clinical services for mental health are more likely to receive a psychiatric diagnosis or be hospitalized but less likely to experience improvement after treatment than Whites (Maura & Weisman de Mamani, 2017; Schwartz & Blankenship, 2014). Numerous studies demonstrate that the higher level of poorer health and severity of mental health conditions among Blacks is one of the consequences of the historically racist context from which the African American story developed in the United States (Gómez, 2015; Noonan et al., 2016). In the pages of the horrific story, Blacks adapted physically and mentally to survive; however, some protective measures adopted prove to negatively impact mental health as well as their view of it today. Likewise, the discriminative practices and disparity in systems formed and structures developed in the historically racist context in which Blacks strive are far from reaching the transformative change needed to accommodate mental health care via current clinical practices. A collaboration between the church/church leaders and the mental health systems would provide a more comprehensive network for addressing the dilemma.

Despite these facts, there is only a paucity of information investigating how Christian leaders and churches meet the increasing challenges in Blacks' mental health issues, and even less insight is available from clergy' lived experiences to further inform the work of mental

health care. As their story continues to unfold, African Americans find themselves in a conundrum facing existing psychiatric and health care challenges, including maneuvering everyday life issues as a person of color, which in and of itself contributes to higher rates of stress and trauma (Alang, 2019). Churches and their leaders, somewhat by default, possess the influence and position in the lives of African Americans to reduce the gap in mental health care as the need continues to increase.

Gaining insight into how pastors, ministers, and churches respond to the call to serve in a mental health care capacity has implications for Christian leaders, professional mental health care systems, providers, and those seeking mental health care (Brown & McCreary, 2014). Providing a format where others can benefit from their lived experiences will ultimately increase awareness that promotes change.

Chapter Three: Methods

Overview

The purpose of this case study was to develop a deeper understanding of the issues involved in addressing African Americans' mental health care challenges from the lived experiences of clergy and church leaders who provide them care. This research was conducted from the conjecture that exploring the phenomena of the African American tendency to seek church leaders' help with mental and emotional distress from a less studied vantage point of pastors/pastoral counselors can provide valuable insight in addressing the larger issue of disparity in care. The qualitative research design provides the flexibility to capture cognitive value using a data collection method that produces meaningful interpretations that can be validated with comprehensible analysis procedures (Cardano, 2020). The phenomenological approach suits this case study investigation of an ongoing human occurrence where experiential knowledge is indispensable, particularly from a less studied perspective (Creswell & Poth, 2018).

The increasing disparity in health care, particularly mental health care of African Americans, along with their increasing rates of severely diagnosed disorders, is a growing concern (Liu & Modir, 2020; Noonan et al., 2016). An overview of the background behind the unique contributors to the existing disparities and, paradoxically, African Americans being at a higher risk for psychological disorders is provided in Chapter One. Chapter Two presented the research findings from multiple perspectives throughout the literature, revealing the complexity of addressing the interaction of numerous dynamic variables. It illustrated how these variables created and continue to influence the mental health dilemma and its efforts to address it. Most of those variables involve health care systems, social economics, and the African American

experience in America. Though the Black Church and faith or church leaders play a significant role in that experience, little scholarly exploration of their role as an alternative or preference to professional mental health care has been made. This research explored that role to gain an understanding of affected Christian leaders' outlooks on mental health while simultaneously obtaining a spectrum of the different rationales behind their views on clinical care. Extracting the underlying beliefs that guide how and why Christian leaders address the psychological issues they encounter and their position on other possibilities is another expected outcome.

Research Design

The methodology presented in this chapter provides a concise but detailed synopsis of the research design by specifying procedures followed, including data collection and analysis, participants' criteria, and the selection process. Interview questions, ethical considerations, trustworthiness, and the researcher's role illuminate and provide transparency to demonstrate the integrity of evidence-based results. The methodology intentionally aims for objectivity in unfolding knowledge on past, present, and probable future influences that could better inform African Americans' mental health care practices, clinical or pastoral. The integrity and objectivity characterize its procedures deemed approvable by the IRB.

Learning from others' experiences is a valuable tool used in research to promote improvement, especially in education and health (Neubauer et al., 2019). This study's phenomenological approach provides a structure complementary to an intricate exploration of the human experience of religious leaders and churches that have personally provided care for African Americans suffering from mental distress. From a hermeneutic or interpretive philosophy beyond mere observational facts, meaning will be gained that attributes to useful findings and the resulting later review for further critical consideration. The nature of the

information the research attempted to understand, like values, belief systems, and mindsets around mental health care, could easily evade a quantitative or surface view of facts (Hill, 2012).

For this reason, an instrumental case study was the research format. By executing an instrumental case study, participants were considered carefully as perspectives of the larger community phenomena of interest by meeting the necessary criteria and being accessible (Kekeya, 2021). The primary focus of an instrumental case study is not the specific individual cases explored but rather the larger issue to which they collectively provide insight (Creswell & Poth, 2018; Tight, 2017). The exploration of each clergy's life experience in serving African Americans seeking help with mental health issues is secondary to the analysis of what their collective experiences convey to expand the understanding of the current dilemma of receiving adequate treatment.

The format allowed for the analysis of multiple viewpoints to identify any recurrent or shared positions among them in a particular phenomenon. Tight (2017) describes how the goal of education can be accomplished by exchanging information from others' life experiences in the case study process. Educating aligns with the transformative framework described in Chapter One to non-judgmentally seek information to change, create, and expand better outcomes for receipt of mental health care to African Americans. Due to the inherent biases in the axiological assumption of the researcher, bracketing for the sake of identifying how guiding values inform the interpretation of data will be incorporated (Anderson et al., 2014). Bracketing is the intentional and literal effort the researcher makes to divide her lived experience implications from the factual analysis of those being researched to obtain the most objective results (Creswell & Poth, 2018).

Research Questions

1. How do Christian clergy describe their experiences in understanding and relating spiritual health to mental health when counseling African American congregants?
2. In what ways do clergy describe their experiences in normalizing and advocating for mental health care within the African American church/community they serve?
3. How do clergy serving African Americans describe their experiences and perceptions regarding their role or responsibility in the mental health care of those seeking assistance with psychological distress or conditions?
4. In what ways do clergy describe their experiences with specific measures or methods that have been successful in integrating ministry and clinical care for the mental health needs of African American members in their churches and community?
5. What practices or resources do clergy describe, based on their experiences, as necessary to prepare Christian leaders of African Americans more effectively in addressing mental or psychological problems?

Setting

The need to exhibit that the participants' time and contribution to the research are valued was considered in determining options for the setting. While telephone interviews have been widely used effectively in research, there are some limitations on the format's ability to capture non-verbal communication and establish rapport, which may be particularly significant in value with qualitative content analysis (Magnusson & Marecek, 2015). Subsequently, telephone interviews were considered the last option to be used in the event as all other possibilities were exhausted to ensure participants met the criteria. Considering their current growing practices for

meetings and diverse types of interviews, two face-to-face options will be used—in-person and virtual meetings, with the second being preferred.

Richland Library Main was the preferred in-person interview site in Columbia, South Carolina, based on its central location and conference rooms. Reservations of available rooms to accommodate privacy within a public setting could be made a month in advance. The location removed clergy and researchers from possible distractions of meeting in church settings. The rooms support technology for recording and transcription. Each room was well-lit and comfortable for the hour-maximum session yet set up to provide an atmosphere of professionalism. The level of privacy without interruption was difficult to guarantee at any of the pastors' local churches. Privacy and confidentiality were also considered when selecting the online means to which participants received a link via email to submit their completed pre-interview questionnaire.

Virtual interviews, which were for a long time before the COVID-19 pandemic considered a secondary or a compromise for in-person face-to-face interviews, are now commonly used for various purposes. Recently, remote video streaming has become recognized as more than an alternative but a format possessing its benefits as a qualitative research option (Keen et al., 2022). For this research, the opportunities presented in the advancing innovative technology provided in virtual interviews, such as video and audio recording, auto-transcription, and captioning that can be replayed, in addition to the flexibility afforded overtime or location restraints, made it a substantially viable option.

Data collection via virtual technology was efficient and useful for this study. Keen et al. (2022) determined that the common concerns around virtual and face-to-face interviews are similar, but appropriate workarounds exist to overcome most. Confidentiality and obtaining

appropriate consent to participate in and record interviews properly were the areas the researcher addressed regarding face-to-face and virtual interviews. Considering and identifying possible limitations such as participants' virtual access, technical skills, or comfort level; a less clear view of body language and facial expressions; and uncontrollable distractions or interruptions made virtual a good but not perfectly ideal option.

Participants

Defining the target population for reasonable levels of generalization in this case study helped establish the boundaries and requirements for possible participants (Heppner et al., 2015). Replicating the sampling methods in the study by Avent et al. (2015), a purposive and snowball sampling technique was used to narrow down participants who met the criteria and to acquire other participants from their networks. The primary criteria were predominantly African American church heads and senior pastors or pastoral counselors with a tenure that included experience in addressing mental health issues. A degree of valid inference was made to support generalization in selecting participants recruited from the pool or associated with other participants who volunteered.

Recruitment steps involved an initial telephone introduction call as a precursor to the emailed invitation. The invitation correspondence provided detailed study information and purpose. It also indicated that a contact call would follow to answer questions, provide additional information, and set up an interview upon consent. Details of the interview and pre-interview questionnaire process and a commitment to share all findings with undisclosed research participants for validation before publishing were given. Participants were assigned pseudonyms for the study write-up. Five to 10 clergy members of either, but preferably both, genders and various generations were sought to capture a wider perspective. The number of participants

needed varies widely among scholars; however, interpretative researchers agree that the quantity of participants is not as significant as the wealth of the content, which can be very rich in smaller numbers for some research (Magnusson & Marecek, 2015). Saturation can occur quickly, depending upon the focus of the study.

As described in Chapter Two, the Black Church is an informal institution consisting of many different religions, denominations, and congregations, predominantly African American, united by a history where faith communities were formed within the culture by necessity to meet multiple needs that otherwise would not have been. In this study, the recruited participants are intentionally from long-standing Protestant denominations founded by African Americans who adopted Christianity and are widely active today. The African Methodist Episcopal Church (AMEC) was founded in 1816, the Baptist Educational and Missionary Convention of South Carolina (BEMCSC) was founded in 1877, the Church of God in Christ (COGIC) founded in 1897, and the Progressive National Baptist Church (PNBC) founded in 1961, are the denominations making up the pool of participants recruited (Pew Research Center et al., 2021). All pastors were encouraged in recruitment to consider inviting or referring affiliate pastors through personal communication. Although a minimum of 150 congregants or members was the church size preferred to increase the probability of obtaining mental health care, sought leaders serving in the capacities described in pre-interview responses were also considered. Official association under the wider indicated denominational covering in combination with pre-interview screening survey responses was superseded by congregation size.

Procedures

As required under the guidance provided in the approval of the IRB, ensuring appropriate and non-harmful activity in using human subjects in conducting this study was the priority. The

participants' occupation and high-profile community position required not only attention to ethical guidelines but also to the appearance of any self-promotion and perhaps even advocacy by supporting the research, which is inevitably at risk of wrong interpretation. One of the researcher's goals in gaining volunteer participation was to ensure efforts to reduce such risk through protective measures included in the process. Protection of identity and data collected was a primary measure applied at different stages for all, except the online survey, which, by format, allowed total anonymity.

The Researcher's Role

From the profound interest of a Christian African American advocate of mental health care with limited lived experience in the phenomena of Blacks seeking religious leaders for help with psychologically distressing issues, this researcher sought to better understand and create a catalyst for further learning. The motivation behind the researcher's goal for the study consisted of lived experience with a family member with mental illness and a ministerial observation of a gap between need and knowledge. The goal was to understand the broader scope and depth of the phenomena from Christian leaders, particularly as the pandemic and its aftereffects highlighted a rise in mental health issues in African Americans. The researcher was committed to approaching the research objectively, including bracketing, to mitigate existing presumptions that could distort the study process or outcome. Setting aside the researcher's preconceptions to extract valid meaning, themes, and patterns from data were practiced and rechecked.

On various occasions or at Christian events, the researcher may have engaged in a conversation or shared a table for dinner with a possible participant; however, the association level was at most affiliative or in attending Christian events at a common venue. The researcher indeed has a disposition that perceives a lack of effort to intentionally address mental health as a

normal part of church functions or as connected to spiritual health. To some extent, the researcher is internal to the research by background context knowledge; however, an external perspective of the phenomena was taken to ensure basic questions were included for comprehensive data analysis and maintaining the highest ethical interpretation (Floyd & Arthur, 2012).

Data Collection

Interviews

The participant data collected from the church leaders interviewed via virtual streaming utilizing the questions approved by the IRB did not identify by name, nor was any identifying information of the church affiliation specifically included in the outcome product when referencing their responses. As explained concisely in an agreement and consent form completed before participation, interview responses were transcribed and recorded but were to be destroyed per IRB guidance after all participants provided feedback on interpretations for additional rigor in objectivity.

This research scope was compatible with streaming technology that supports virtual interviews, providing the capacity to capture and store audio and video with live captions and written transcription. As Keen et al. (2022) described, virtual and face-to-face interviews share similar concerns from the user perspective; however, appropriate measures can be implemented to reduce possible issues. The researcher made transparency of those issues and risks explicit in participant consent agreements. Confidentiality of identity from initial invitation responses, analysis, publication, and deletion of recordings will be specified.

Accommodation was extended to the degree possible to support the participants' virtual access and technical needs. Microsoft Teams allowed the researcher to visually record and

automatically transcribe the interviews, which were saved securely for analysis.

For effectiveness in capturing the true essence of how participants understand what they are sharing when articulating responses, the construction of the interview questions was designed to promote a conversational, safe, and inquisitive interaction that invited natural, un-canned, non-edited, and unrestricted responses, referred to as "rich talk." (Magnusson & Marecek, 2015) In such interactions, the facilitator or researcher must carefully watch for queues that indicate opportunities for further expounding on inquiry. The research questions served as guides to allow sharing from lived experiences on the defined topics at the center of the inquiry to balance the need for open-ended responses with the extent of structure needed. The purpose of the research questions was to guide but not limit, which differed from the pre-interview screening survey questions, to create boundaries for homogeneity in the participant group.

The following interview questions were designed to allow a wide range of possible responses that can be probed further for additional individual responses to include in collective analysis for patterns, themes, and outliers to inform this study.

1. How do you see the growing issue of mental health surfacing among African Americans from the viewpoint of a faith leader?
2. What are some of the factors you see attributed to the tendency of many African Americans to consult with faith leaders first or solely when experiencing relatively serious psychological, mental, and or emotional distress?
3. What is your view on church/pastors' addressing/responding to requests for help from congregants experiencing mental health issues and known mental health conditions?
4. How do you see mental health care fitting or not fitting within the schema of spiritual health care, ministry, and/or pastoral counseling?

5. What are the barriers for church leadership in assisting members seeking help with psychological distress or mental disorders?

From their responses to the above interview questions purposely broad enough to solicit open answers but defined enough to stay within the scope of purpose, themes emerged in the data analysis that assisted with answering the research questions.

Pre-Interview Screening Survey

To establish the level of uniformity among pastors selected for an interview, a short pre-interview online questionnaire was utilized as part of the data collection. It began with some demographic questions, including age range, gender, education level, denomination, church affiliation, church position or office, and demographics to assist with identifying associations and establishing homogeneity in the sample of participants to be interviewed. Participants then indicated the frequency to which the statement descriptions occur using a 5-point Likert scale with the options Never, Rarely, Sometimes, Often, and Frequently; as well as providing an area for comments.

1. I receive requests for assistance from congregants identifiably suffering psychological and/or emotional distress.
2. Our ministry promotes and encourages congregants to practice a holistic lifestyle that includes spiritual, mental, and physical health.
3. Mental health care awareness is a part of church leadership development and church ministry functions.
4. Collaboration and/or partnership with professional mental health clinicians occurs with leadership/pastoral counselors.
5. Mental health care is referred to be addressed exclusively by mental health professionals.

Data Analysis

The data analysis process included creating and saving a data file of interview and questionnaire responses via analytical software and applications to determine the format that best accommodated the responses after the initial analysis for further interpretive evaluation. Three main steps were executed in the data analysis indicative of an interpretive phenomenology analysis (IPA) process (Creswell & Poth, 2018).

Reading and Memoing

After the thorough review for input errors, manual annotations and highlights of individual transcriptions and responses were made to pinpoint 1) significant statements made by each interview participant, 2) frequently used words, phrases, and expressions, and 3) omitted or illogical survey responses. A cross-examination of the data extracted from reviews noting emerging themes regarding mental health care and the church leaders was conducted. Likewise, significantly contrasting responses regarding mental health care were noted with the affiliated church or denomination when appropriate. Lastly, unique views or perspectives regarding mental health care and the church were highlighted.

Coding

Data were organized into groups based on identifications made during the initial review. Emerging themes from participants' shared experiences were assigned codes—short-word descriptions (Creswell & Poth, 2018). Dedoose provided an automated process to assign related codes to appropriate data extracted from transcripts that were utilized for this process and to prepare tabled or graphic descriptive displays of outcomes for the final presentation. The data was constructed in a composite detailed description to support the interpretation of findings extracted from the research.

Trustworthiness

The researcher exercised reflexivity by clearly and honestly stating her background, experience, and position, which, despite bracketing, could influence interpretation. Participant checks were conducted as needed for clarification, to avoid inaccurate representation, to ensure trustworthiness, and to maintain integrity in findings. To further increase reliability and transferability, the two collection approaches of pre-interview surveys, interview findings, and previous similar studies were conducted to provide a stable context. A comparison of the three constitutes a degree of rigor which strengthens the results' credibility (Abdalla et al., 2018).

Credibility

The worth of the results to a useful expansion of existing research relies upon the methods carefully selected to minimize subjectivity and increase accuracy in the process, ultimately producing correct results (Creswell & Poth, 2018). Credibility was built into the methodology design for this research, which considered limitations and possibilities based on previous research. Building upon the past along with recent heightened awareness of mental health care needs of the African American community caused by multiple renowned events, including COVID-19, the credibility was displayed in the truth verifiable from the results.

Dependability and Confirmability

Verifiable results and replicable study methods translate into dependability and confirmability for future researchers that may expand the topic of study (Merriam & Grenier, 2019). This study considered and implemented documented means to attribute to the assurance of both. It also built on incorporating similar previous study methods to determine changes expected in qualitative study topics under various times and circumstances.

Transferability

Qualitative studies' view of transferability varies in comparison to quantitative due to the ability to apply assumptions in the same manner to statistics and concepts (Merriam & Grenier, 2019). However, consistent internal and external validation is the depth of what Merriam and Grenier (2019) referred to as the application of obtaining shareable "rich, thick description" extracted from findings. This study sought to present a quality description that other researchers will find appreciably satiated with useful information for progress despite the limited span of generalization to the entire issue of the African American mental health dilemma.

Ethical Considerations

Protection of participants was exercised in full disclosure of the purpose of the study, guarantee of non-disclosure of their identity in all written results, destruction of recordings and transcriptions after the final presentation, and the opportunity to review all materials prior if desired. Objectivity in facilitating the interview was another ethical consideration the researcher prepared for in practicing self-awareness and remaining neutral, avoiding agreeing or disagreeing that could appear as criticism or placating—also, reiterating all necessary information in consent agreements that may not have been read, particularly the non-disclosure of certain information shared before ensuring awareness (Douglas et al., 2021). All proper names of institutions or individuals included in the transcription or survey were removed or replaced with pseudonyms.

Summary

The procedures outlined in this chapter ensured that the findings of exploring the lived experiences of pastors and churches endeavoring to help African Americans with mental health care demonstrate in detail the validity of the resulting interpretations. The researcher's efforts to act trustworthy regarding human participants and presentation provided further reliability in the

integrity of additional knowledge for informing mental health care and future studies. The insight gained will contribute to the field and reveal specific areas for further study into African Americans seeking religious leaders for mental health care and how the church is standing in the gap.

Chapter Four: Findings

Overview

The objective of this study was to explore and examine the current views of Christian clergy who serve African Americans who seek - help with mental health-related issues and conditions. In the previous chapters, the value of clergy insight was established as a significant resource minimally investigated in understanding the growing African American mental health care dilemma of receiving mental health care. Chapter One outlined several historical and continually growing complex factors that have significantly contributed to trauma, anxiety, and depression in addition to other mental health challenges for African Americans (Williams-Washington & Mills, 2018). Research findings cited in Chapter Two illustrated how mental health conditions amongst African Americans have reached unprecedented rates in the past 10 years. The care needed is difficult to obtain as human resources, appropriate training and skills, access to mental health systems, and culturally informed care are often limited (DHHS, 2019; Williams, 2018; Snowden & Snowden, 2021). Coupled with the African American tendency or preference to seek faith leaders for helping with mental health related issues is a historical reluctance to seek clinical mental health care due to stigma and distrust, which further complicates addressing mental health care needs (Ward et al., 2013).

Obtaining mental health care is a quandary intertwined with a wide array of other types of disparities facing African Americans. While the literature is saturated with findings on the contributing factors, there is a dearth of research on how the clergy whom African Americans seek are experiencing the growing increase in mental health illnesses and conditions. Chapter Three provided a research design and transformative framework guiding this instrumental case study that captured the experiences of five African American clergy via interviews, which

informed the findings of this phenomenological investigation. From those findings, coding via recognition of patterns and meaning-making was done to extract developed themes that address five pre-established research questions.

Research Questions

1. How do Christian clergy describe their experiences in understanding and relating spiritual health to mental health when counseling African American congregants?
2. In what ways do clergy describe their experiences in normalizing and advocating for mental health care within the African American church/community they serve?
3. How do clergy serving African Americans describe their experiences and perceptions regarding their role or responsibility in the mental health care of those seeking assistance with psychological distress or conditions?
4. Can clergy describe their experiences with specific measures or methods that have been successful in integrating ministry and clinical care for the mental health needs of African American members in their churches and communities?
5. What practices or resources do clergy describe, based on their experiences, as necessary to prepare Christian leaders of African Americans more effectively in addressing mental or psychological problems?

Participants

Clergy were required to be 18 years of age or older, hold an official leadership position or office as a pastor or clergy serving a community or congregation of predominantly African American constituents in the African Methodist Episcopal Church (AMEC), Church of God in Christ (COGIC), the Baptist Educational and Missionary Convention of South Carolina (BEMCSC), or the Progressive National Baptist Church (PNBC) in South Carolina to participate.

The denominations and churches were selected to support the validity and verifiability of this research process (Creswell & Poth, 2018). The feasibility of a sole investigator to conduct qualitative research on the expansive African American mental health problem existing in the United States necessitated narrowing the sample pool to specific denominations and affiliations within one state for homogeneity (Robinson, 2014). Robinson (2014) posited that the need for homogeneity requires critical consideration of 'theoretical and practical factors" (p. 27). Doing so creates congruent value when conducting interpretative phenomenological analysis (IPA).

To help ensure rigor and reliability in the IPA process, denominations and affiliations selected shared a historical alignment with the Black Church by a direct organizational affiliation, being founded during the same period, and having a continuity in serving African Americans across the United States today. As described in Chapter One, the Black Church is the oldest and largest informal institution serving African Americans. It was one of the first organizations formed by Blacks advocating for equal rights of Blacks from slavery to the present. A condensed overview of the role of the Black Church and background details of its historical relationship with African Americans is provided in Chapter Two, and an abundance of literature exists on the facts and misnomers around its history (Blank et al., 2002; Plunkett, 2014; Thompson et al., 2020). In addition, establishing a sample population of denominations affiliated with the Black Church helped fulfill the significant research need to obtain clergy serving within South Carolina who met the specific criteria and possessed sufficient experience to contribute to the study.

Recruitment

To ensure participants met the criteria and simultaneously collected preliminary data that would potentially add context to the perspectives analyzed, each potential participant completed

a pre-interview screening survey. Out of the recruitment pool of approximately 275 possible churches, 135 possible Christian clergies were invited. The recruitment was conducted via clergy's personal and church emails, letters, flyers, phone calls, social media, and clergy referrals, with follow-ups on most except those returned due to physical or digital address issues. After 7 weeks of active recruiting, 12 respondents completed and returned pre-interview screening surveys. Only seven of those met the established criteria and possessed a suitable degree of experience with serving African Americans seeking help with mental health-related issues or conditions. The depth of knowledge, insight, and perspective shared in the interviews from the lived experience of the five Christian clergy who were able to schedule an interview provided some shared and unique views on the current African American mental health dilemma.

All the interviewees were of African American ethnicity. Three of the five clergy were senior pastors serving in a pastoral office for 7 to 45 years. The other two clergy were associate ministers serving officially as licensed or ordained reverends from 4 to more than 30 years in various leadership positions. Two of the clergy had prior service as Christians in the military chaplaincy, including the clergy in an official leadership position, which included counseling. The participants did not represent all denominations but were from four of the five in the sample pool: African Methodist Episcopal Church (AMEC), Baptist Educational and Missionary Convention of South Carolina (BEMCSC), and Progressive National Baptist Church (PNBC). Table 1 provides basic demographic information from the pre-interview screening and responses on their present mental health care (MHC) interaction. It includes age range, gender, education level, and responses to the following survey questions.

1. I respond to requests for assistance from congregants/constituents requesting help who are suffering psychological and/or emotional distress.

Never Rarely Sometimes Often Frequently

2. Our ministry promotes and encourages congregants to practice a holistic lifestyle that includes spiritual, mental, and physical health.

   Never Rarely Sometimes Often Frequently

3. Mental health care awareness is a part of church leadership development and church ministry functions.

   Never Rarely Sometimes Often Frequently

4. Collaboration and/or partnership with professional mental health clinicians occurs with leadership/pastoral counselors.

   Never Rarely Sometimes Often Frequently

5. Mental health care is referred to be addressed exclusively by mental health professionals.

   Never Rarely Sometimes Often Frequently

Table 1

Participant Demographics and Survey Question Responses

Pseudonym	Ava	Brent	Claire	Doug	Elle
Age Range	66+	46–55	46–55	66+	56–65
Gender	Female	Male	Female	Male	Female
Education	Doctorate	Bachelors	Masters	Doctorate	Masters
SQ1	Sometimes	Often	Sometimes	Often	Sometimes
SQ2	Rarely	Frequently	Often	Often	Frequently
SQ3	Rarely	Often	Sometimes	Sometimes	Often
SQ4	Rarely	Sometimes	Sometimes	Rarely	Often
SQ5	Sometimes	Often	Sometimes	Rarely	Frequently

Interviews

Interviewees completed the required consent form before the interview. Reiterated at the start of the interview was the agreement that it would be recorded and transcribed, but their responses and identities would be kept confidential by replacing names with pseudonyms. Accordingly, all the names identifying clergy in this document are pseudonyms. In addition, the personal names of persons, organizations, or formal positions mentioned in interview excerpts have been changed to eliminate revealing identities. Excerpt modifications were minimal and carefully determined so as not to take away from transparency or validity in providing the views of the clergy (Creswell & Poth, 2018).

All five interviews were conducted via the Microsoft Teams conferencing application, allowing transcription and recording, which was downloaded for further review and analysis. Of the one hour allotted for each interview, an average length of 49 minutes was taken, with only one lasting 60 minutes. The interviews were intentionally conversational and less formal, using five open-ended questions to encourage natural and uninhibited responses from which points were expounded upon to collect further clarification or understanding (Magnusson & Marecek, 2015). To ensure accuracy in understanding the clergy responses, the researcher practiced mindful, active listening, which allowed for the representation of statements when needed and the formation of questions to encourage expounding.

Each interview opened with a review of confidentiality, and participants were reminded that the interview was being recorded. Interviewees were provided a brief background of the study purpose, as shared in the consent form and invited to ask any questions. All declined. The interview process began with a brief review of their responses to the pre-interview screening to ensure responses indicated what was intended. Each was offered an opportunity to share

anything else about their background. None of the senior pastors desired to share additional information; however, much of their clerical background is published publicly on their church websites. The two other clergy, though not affiliated with one another, both shared their experience working with specifically women and families impacted by mental health conditions within and without the church.

Individual Clergy Profiles

Additional context for richer analysis was drawn from the collection and examination of the individual backgrounds of each participant. Some of the details of their background were offered, and others were collected before and during the interview in preparation via public information searches from valid sources, which required participant knowledge and were verifiable. Despite the similarity in the denominational structures and alignment with the Black Church, the group's diversity provided a substantial and in-depth perspective. Comparatively, as might be expected based on the phenomena being explored, all participants were in their latter 40s or older, with bachelor's degrees or higher. In addition to leadership in their congregation, they have been involved in Christian or people care for most of their adult lives. Below are brief highlights of their backgrounds that are significant to the context of this study.

Ava

Ava is an African American female in her late 60s. She is currently serving as an associate minister with her congregation. In addition to completing seminary, Ava has a PhD in Educational Leadership and Administration. She has served in ministry as a licensed and ordained clergy in numerous leadership positions, including pastor and pastoral mentor. She serves full-time in the ministry and provides a consulting service. Ava is very reflective and transparent in sharing her experience with mental health issues from many years of service in

various predominantly African American churches. In her relatively long tenure, she has experienced requests from Blacks requesting help with mental health issues, but she is very clear that she does not see herself as equipped. “I’m not even equipped. I don’t feel like it unless I sense that it’s something spiritual going on, and if it’s something spiritual occurring, then I do feel equipped.”

She has observed some misconceptions as well as misunderstandings from both leadership teaching and help-seekers’ understanding of faith and mental health. Two notable misconceptions are that they cannot coexist or that sources outside the church (often avoided) cannot be helpful. “Proper teaching and how the message is translated can sometimes be a disconnect.” “God can use absolutely everything . . . it may be that God wants to use outside sources.” Ava shared her experience working in a Christian organization that served clients of all backgrounds experiencing mental health conditions that impacted entire families. She noted that they networked with professional clinicians who were able to address the needs they could not.

Ava does not see a lot of networking currently in the church or denomination, though she believes it is needed to address the current mental health crisis among African Americans. She describes the continued detrimental mental impact of COVID-19 on many African American family members still today walking around, not being able to grieve lost loved ones who died alone and never had a funeral. Identifying the pandemic as a veritable realization of extensive mental health needs, she explains how some Blacks who commonly had their primary relationships or connections at church coping mechanism resulted in other “They were searching all over the internet for a community to join in order to be accepted, but the problem was not all the communities and the other distractions on social media helped but some contributed to more issues.” These were two examples of the many Ava expressed that she believes collaboration to

address both the spiritual and mental aspects of African Americans' mental health is needed between the church and professional mental health care providers.

Brent

Brent is an African American male in his early 50s. He has served as the senior pastor of a growing predominantly African American church for over 20 years. He is considered the community pastor. He is also employed full-time and provides technological assistance through his consulting firm. Before pastoring, he served in numerous leadership positions in the church, and he currently serves in leadership roles under his denomination and his community. Brent has a bachelor's degree and is certified in pastoral care. Brent provides both a macro and micro view of African American mental health from the perspective of a faith leader in his responses. He particularly points out that the African American male mental health issue often runs parallel or is similar to what some see as their low numbers comparatively to women active in the church: "And if there's not a space for men to be vulnerable and in a trusted environment, then they'll never really open up. And then that's when you see it being bottled up, and eventually, the wrong thing happens."

Brent sees the mental health needs of African Americans seeking clergy not being met as they could be due to several factors at work. "I think that, you know, the resources is a big deal, and also the question of role where the roles cross and where they actually intersect, where they can be working together." He describes resources such as the church's finances, help-seekers' finances, and accessible quality services. In response to the preponderance of needs during the pandemic, he capitalized on his technological background to help his church. They implemented an initiative using resources and professional skills identified within the congregation and

networked with external sources to provide virtual support. This initiative developed into a community mental health outreach, which thrives.

Brent expressed that more knowledge and education on mental health and honest talk about African American issues is a primary need of pastors, congregants, and many clinicians. He describes a situation of a youth who was receiving periodic professional care and was recently seen by a different clinician. It was clear that the new clinician omitted to review or understand the history by the "seemingly fixed and scripted" conclusions drawn from observations on the one visit. The conclusion could have been damaging had his parents not been informed enough to be an advocate on his behalf:

> How many other people don't know what they knew to be able to communicate that, and so this is part of the problem that we have is that when people do go for help, then they get labels that can stick with them for a long time.

Claire

Claire is an African American female senior pastor of a long-standing traditional Black church founded in the early 1900s. She has a master of divinity, and although she does not disclose her age, her pre-screening interview survey indicates she is between 46 and 55. Based on her responses during the interview, a good portion of the congregation is a much older generation that is not as receptive to the concept of mental health care as relating to or fitting in church ministry. Clair shares her observation that some of the issues a faith leader faces with integrating mental health into ministry are "generational and lack of exposure." "Grandma never talked to a therapist. Mama never talked to a therapist, so I'm not familiar with that. You know, you're just told to pray about whatever it is that you're dealing with. You are told to go to the altar, and you leave it there." However, Claire does not entirely share this view. As one who has

experienced mental health challenges, she is intentionally transparent about having her own therapist as well as in her teaching, preaching, and practices of "self-care," which she sees as necessary to serve well as a pastor. "When I went to this church that I'm at now, I was very frank the very first time I met with my officers. I told them that my mental health matters to me. And there will be Sundays when I will not preach."

In addition to being a pastor, Claire works a full-time job and is very active in a women's sisterhood organization. She also participates in peer pastor group check-ins where they see how each other is "really" doing. They have conversations on various subjects that raise concerns. "It's amazing because, you know, there are different things conveyed by different age pastors." During the interview, she noted how the questions about mental health sparked an idea to design "member check-ins" as another intentional effort to integrate mental health care conversations into the church community and remove some taboos. "Mental Health Mondays" is one such initiative to bring awareness and educate the congregation on what is meant by mental health as well as what might indicate a need for additional resources to help maintain it. She also referred to the increased incentives implemented under her denomination in speaking about it in public virtual forums, including a leadership panel with different expertise. "I think people are beginning to talk about it more in the church community, the Black Church community and I can definitely speak for (our denomination), about a month or two ago, there was a segment about mental health held in a Facebook leadership connection forum."

Claire thinks mental health care should be a part of ministry, from the pulpit to pastoral counseling. "It certainly fits. I mean, even when you look at scripture, you find, you know, you can find some text that would relate to our mental and emotional health that where you can pull in information that's beneficial to your congregation." She explains how she exercises that

practice in counseling and during mental health awareness months, during which sermons include biblical inferences or directives about the mind, thoughts, or emotions. She explains how she does not see ministering as a substitute for clinical therapy when needed. “Sometimes it’s finding someone who has the specialty for whatever that person is dealing with. So, helping them find the right connection based on the issue that they’re having.”

Doug

During the interview, Doug, an African American male, shared that he was in his early 70s. He shares this in conjunction with the fact that he suspects he may be a more progressive thinker than many of his peer clergy because of the interaction his experience has afforded him. Doug has been the senior pastor for over 20 years. He is also a retired military chaplain with counseling training and leadership experience serving over military chapels, of which some parishioners attending were predominantly African American. Most of his leadership experience, in and out of the military, involved counseling. He explained that he served as an installation Family Life Chaplain, earning the required “master’s degree in family life, education, and consultation, which had a heavy emphasis on counseling.” However, the level of clinical mental health training included was minimal because, unlike many churches, other resources were accessible for that type of care. Doug also has a doctorate in ministry and adjunct educator experience.

Doug has a very interrelated view of mental, physical, and spiritual health. He was expressively concerned about the current toll he sees mental health taking on African Americans, particularly the youth, and the need to find ways to intervene. He shared a more recent example of the loss of a youth to suicide as he explained how suicidal ideation was a prominent part of his counseling. “It’s a tragedy. It’s a growing issue.” Doug reflected on the issues he sees that bring

mental distress that he states are inherently part of being born African American. He pointed out circumstances from when he grew up in segregation compared to the more subtle and unknown influences that affect youth. He sees bullying, exploitation, pornography, and rejection occurring through electronic platforms like phones, the internet, and games where interaction is easily hidden as particularly detrimental to the psychological well-being of youth today.

Doug's views align with the historical literature regarding the African American church and mental health. He believes African Americans seek pastors and clergy for several reasons, including confidentiality, trust, and cost. He also strongly emphasized that one of the reasons many do not seek clinicians other than stigma is a lack of knowledge and understanding or belief there are no African American counselors:

> So, there's some misnomers I think about mental health professionals and what they can do. And so we go to the church, we go to the pastor that because we believe the pastor would keep our confidences and that kind of thing won't get out.

Doug recognized that some African Americans may believe an African American clinician would be more relatable and more accepting of trying mental health care. However, he is an advocate for referrals to qualified clinicians without regard to race.

Elle

Though recognized as an African American female, Elle is a native of Trinidad; her island accent quickly became apparent. Elle shared that she has spent most of her adult life in the United States and was raised "on the island in an 'orthodox' Christian family." She did not share her age during the interview but indicated she is between 56 and 65 years old on the pre-screening interview survey. She serves in a leadership position at her church as a licensed and ordained associate minister and leads the youth ministry. Elle is a retired military religious

affairs specialist, a youth mentor, and a doctoral student. She is very active in volunteering in the community and participating in or coordinating events promoting the well-being of others like the Red Cross, a women's fitness movement, and helping with the needs of youth in the South Carolina Department of Social Services.

Elle has been active in church ministry for a while and was licensed while serving in a military chapel. Elle explained how being ordained in her current "civilian" church brought about some unexpected difficulties in helping African Americans with mental health issues.

> I don't know if I'm learning to adapt, accept, or if I'm learning to build for myself the idea that a lot of the older African American clergy that I'm now coming in contact with continually say let's pray about it.

Elle agrees with the need to pray but states there is also a need to involve other resources, which, as a practice, are not sought, even if some might be available. She expressed how getting approval to address mental health a bit differently through senior leadership, particularly older clergy, is a factor she sees in the Black Church that slow change needed to help. As a "younger Black clergy member," she feels the need to be careful when approaching the subject. "I feel like I'm treading lightly, and I have to tread on pins and needles." Elle gives examples of other obstacles she has run into assisting families impacted by mental health who came to her, unlike her experience in the military, where resources are designed and accessible on the military installation:

> I'm on the civilian side, even if even if you have services out there that are there to serve the people, it comes down to what type of insurance do you have, or your parents have or what type of medical benefits do you have?"

Elle finds her counseling experience growing more challenging as more psychological and emotional issues are presented. She explains that she finds herself becoming a bridge to fill gaps between parents and kids and resources. “I think we as clergy have to come to the mindset that this whole idea of telling us that let’s consult the Bible and let’s call on Jesus. There’s more to it than that right now.”

Results

Theme Development

Interpretive Phenomenological Analysis (IPA)

This qualitative research involved the investigator extracting meaning from what the clergy shared based on an intentional survey of all interview transcripts to discover recurring ideas, expressions, and thought patterns throughout the group, demonstrating running themes or shared views. This process follows the interpretative phenomenological analysis (IPA) guidelines, from which the investigator started by reading and memoing (annotating) transcripts. The memoing allowed excerpts to be color-coded and grouped under related topics, illuminating themes. The themes that emerged from IPA allowed the researcher to systemically capture a depth of meaning below mere surface implications (Magnusson & Marecek, 2015).

Recognizing that the inherent and unconscious biases of the researcher might influence what is or is not detected in the analysis process, the researcher utilized Dedoose, a web-based software application able to perform the IPA more objectively and thoroughly. Transcripts cleaned of identifying information were uploaded as media in text format under the researcher’s password-secured login to perform analysis. The software application allowed the researcher to run jobs and queries on word and phrase frequencies as well as color code, group, and create tables. Recognizing that bracketing was necessary as the implementor of the queries, an

intentional openness to the findings was maintained in the cross-examination of outcomes, understanding the importance of not allowing presuppositions and assumptions to cloud the validity of the findings (Creswell & Poth, 2018).

A summary of the thematic findings emerging from the analysis corresponding to the five research questions this study sought to answer is provided in Table 2. More details on the responses informing the findings follow in the table. While other themes emerged, there was a reasonable degree of overlap in the statements coded that informed them to condense it to the five themes for conciseness of the main point.

Research Questions' Corresponding Themes

Table 2

Thematic Findings

Research Questions	Theme	Description	Indicative Excerpt
RQ1	Spiritual Mental Coexistence & Counseling Boundaries	Clergy understand spiritual element as present even when "mental" issues are presented and should recognize what they are equipped to address.	". . . we can do something for the spiritual, whereas we have these trained professionals who could do something for the mental . . . they all have a place . . . ."
RQ2	Need for Intentional/ Continued Integration	Clergy observe a need for long-term planning to make progress integrating mental health in ministry.	"I'm very intentional as a pastor to make sure that in my congregation they are aware that it's okay to not be okay, . . . that it's okay to seek that clinical help that they need."
RQ3	Inherent Responsibility/	Clergy experience helping with all	". . . there's a sense of trust in the pastor, a

Research Questions	Theme	Description	Indicative Excerpt
	Trust	types of care as intrinsic to their role.	lack of trust within the community and fear of losing children, or job, confiding elsewhere."
RQ4	Efficiency in Collaborated/ Combined Efforts	Clergy experience more receptiveness in integrating mental health awareness via collaborative efforts and via multiple platforms	". . . we took all the counselors that we have, and we're blessed to have several people that work in that in clinical counseling and different resources we had, and we started our online curriculum."
RQ5	Education/ Professional Mental Health Resources	Clergy recognize a gap in knowledge around the subject of mental health among leaders in general.	". . . many pastors in the African American community aren't theologically trained and if they are theologically trained, they may have gone to seminary, but they don't have any type of training in the practical ministry of counseling."

Research Question Responses

Research Question 1: Theme – Spiritual Mental Coexistence and Counseling Boundaries

Spiritual mental coexistence and counseling boundaries emerged as the theme corresponding to the experiences clergy described in understanding and relating spiritual and mental health as RQ1 inquires. It became a clear significance as the need to clarify two points related to spiritual and mental health in the context of counseling reoccurred throughout the

transcripts as clergy shared different experiences. Spiritual mental coexistence and counseling boundaries are presented as one of the participants expressed in such a way that they hinged upon one another or required the other to make their point. First, making a distinction related to whether an issue was spiritual or mental was not focal. Instead, they understand that they coexist or interact when issues exist. Doug was very clear in stating that he believes the issues presenting are spiritual and mental:

> Even though it's also a physical matter, it's still a spiritual battle, as I view it from high places. I think that there is a merger that is a connection, rightly so, of being able to not only emerge but match the spiritual. By match, I mean provide appropriate biblical guidance.

Claire shared a similar perspective. She indicated she actively considers this when counseling those who seek her that may be seeking spiritual advice but require additional help:

> I found when people come to you, parishioners, friends, family, whomever, they don't even understand that their issue is a mental health issue. And so they're coming for spiritual insight. So I approach it so they can understand that there's a connection to our spiritual health, and our emotional health, and our mental health. They intersect, they really do intersect.

Brent explained that sometimes, within the church, wrong mindsets take root that spiritualize mental health issues that show up in counseling that must be unraveled:

> I think there are misconceptions on mental and spiritual health, of where there might be even the need for more teaching. We equate, you know, being sound mentally with total faith and that's just not the reality of how life goes. I've seen people demonized because

> they're going through something. Whatever happens in your mind, your spirit, your body, they all interact.

Ava and Elle expressed similar understandings of coexistence or interconnection of spiritual and mental issues but add a biological element. Ava mentioned three other factors :

> Other than like a chemical or substance or something or something that's in the family the mental and spiritual health issues are the condition of the mind and spirit can be found interacting even through scripture.

Elle also included reference to biological elements when considering counseling:

> This is all I think it's supposed spiritual and mental. Because we understand it is a deception of the enemy to get you isolated. But we understand there are drugs, and medications that distort and deceive the mind. We understand genetics may have some influence.

Influence, connection, and interaction regarding mental and spiritual health issues were mentioned. The theme's term "coexistence" is understood not as the indicator of what clergy addresses but rather as the need to acknowledge the boundaries of their training and that of professional mental health clinicians. This way of thinking commonly accompanied responses around the mental and spiritual health conversation. In explaining the subject of mental health in counseling, Doug concluded his thoughts by stating, "We can do something for the spiritual, whereas we have these trained professionals who could do something for the mental . . . they all have a place." Characteristic of this theme was Claire's statements regarding counseling those presenting mental issues:

> They recognize that there's a problem, but the other piece of that is to recognize also that they need help from someone who is trained and licensed and mental health to assist

> them. And so, staying in your lane as a leader, to understand your training is not clinically based, I think that's another problem pastors may run into because you try to take on more than your qualified to do.

Brent gave the following example of demonstrating a recognition of his boundaries counseling:

> When I started noticing that, he started, you know, demonstrating some, some somewhat paranoia kind of things that would come up in different response. Like the world's against him, that kind of thing. I consulted with the family and got him other resources to assist in ways I was not trained to do.

Ava shared her general boundary practice for counseling:

> My experience with dealing with people who have come to me about clearly mental health issues have centered around acknowledging I'm not even equipped. I don't feel like it needs to be considered or attempted unless I sense that it's something spiritual going on, and if it's something spiritual, then I do feel equipped to address that aspect.

Elle sees a difference in how generations perceive counseling boundaries concerning clinicians' and clergy counselors' roles:

> And a lot of senior elder clergy do not want to acknowledge that areas like mental health and wellness, and so forth, require people that are in those fields to come in and help. We have had a lot of setbacks in stigmas and held back and so forth, but I feel when it comes to helping individuals, we take the best resources that are out there for us.

The findings on RQ1 seemed to indicate that all the clergy did not interpret the inquiry the same, and the answers comingled two responses: 1) an explanation of the relationship between the spiritual and mental, and 2) the clergy's ability to relate to one or the other in

counseling. The theme that surfaced captures both, indicating a relationship across all, meaning understanding mental and spiritual coexistence better informed their understanding of their counseling boundaries.

Research Question 2: Theme – Need for Intentional/Continued Integration

Within the responses of the clergy participants surfaced a shared perception of a need for more intentional and continued integration efforts to normalize and better advocate for mental health care within their African American churches and communities. The running theme informs question two from the view of the participants. While four of the five participants recognized COVID-19 and the pandemic as a catalyst for response, which resulted in some significant initiatives to remove stigma and bring awareness to African Americans, all indicated the long history of misconceptions and lack of knowledge must be faced with deliberate and ongoing efforts to incorporate mental health care. Some participants made particularly relevant reflections on other African American health challenges advocated through ministry, like heart disease and diabetes. In the following two excerpts, participants indicate how other health issues have become initiatives that continue to inform and support the congregants, such as pastoral and community efforts on mental health, that would be beneficial to continue.

Doug shared his experiences involving two initiatives:

> We have had a health and wellness ministry for many years. They'll give a little brief on various issues of life, you know, diabetes and hypertension, and we have even addressed mental health to some degree. Several months ago, we [community clergy] had about a four hour presentation with a psychologist who came in to talk about mental health. And you know, we got really some knowledge and some understanding out of that. Now that was that was a direct, you know, attack at addressing mental health stuff. I'll tell you that

> after that presentation, there were a whole lot of folks here agreeing we need to do this again. But it doesn't happen regularly.

Claire was very clear that she is continually finding ways to normalize mental health care, including using her personal experience as a model. Her conviction in doing so is expressed in the following statement.

> I think that's a message that must be being shared again and again. I'm very intentional as a pastor to make sure that in my congregation, they are aware that it's OK to not be OK, that they are aware that it's okay to seek that clinical help that they need.
>
> And so I also let them know that as the pastor, I have a therapist because I listen to people's issues all the time. I say it even from the pulpit on Sunday mornings, if it fits somewhere in a sermon.

It appears that some clergy members were more intentional personally as models and others as advocates or initiators of incentives. However, all acknowledged the need for consistency in practice for mental health care to become realized as not uncommon. It was also clear that preferences for a Christian or African American existed, but more so for a helpful, creditable clinician or therapist.

Research Question Three: Theme – Inherent Responsibility and Trust

The most prevalent and developed theme resulting from the data analysis was the inherent responsibility and trust perceived as part of the role of clergy in the mental health care of those who seek them with psychological distress or conditions. This theme informed the third research question. Each participant's transcript contained multiple references to the confidence in clergy those who seek them possess. Clergy believes that helping those seeking them is an intrinsic part of their role. Participants relate the desire to help not just to a position or office but

also to a calling and ties to African Americans' history with the church. The data revealed that pastors, in particular, feel an innate duty to provide guidance, as they are revered and trusted figures in most African American churches and communities. Some participants indicated that the seeker's expectation could provide pressure to be leveraged within counseling boundaries, as pointed out in RQ1's corresponding theme. In the two supporting excerpts selected below, participants indicate how they see their roles and how they are perceived by mental health care-seeking congregants or constituents.

Brent shared a very comprehensive understanding of the clergy's role in mental health care viewed by seekers and from pastors' experiences with some of the surrounding circumstances:

> Most importantly, there is a sense of trust in the pastor, a lack of trust within the community, and fear of losing children or jobs or confiding elsewhere. Many times there a long term relationship that they've developed over time and so they look at their pastor as being educated as being someone that's understanding that preaches the gospel of deliverance. And so you talking about what Jesus did and how he came to set me free. And so I'm hearing this message of liberty from you that I'm automatically assuming that you know how to get me there.

The inherent responsibility to help seekers in some way was a clear desire conveyed by each of the five clergy members during the interview process. It was noted that none of them took the trust of others lightly but recognized they did not always know how best to help with some issues.

Research Question 4: Theme – Efficiency in Collaborated/Combined Efforts

When sharing specific successful measures or methods clergy have taken integrating ministry and clinical care, efficiency in collaborated/combined efforts was a common characteristic discovered. This discovery developed as a theme that informs RQ4. All participants acknowledged that integrating clinical care within the ministry requires resources and knowledge beyond what the church currently possesses to be successful. Participants also expressed a need for more collaboration and combined efforts between and within churches (denominations) and outside sources. The excerpt from Ava below most concisely expressed this need.

> But even partnering and collaborating with each other is not something that takes place as it should sometimes because there appears to be more of a competitive spirit, you know? So when we're talking about partnering with outside agencies, you know in order to assist is really needed, you know? Yes, I don't see much collaboration and partnering within the church. It is an area I think the church has got to begin to, especially the African American Church. It has got to begin to partner. If you don't want to partner with the secular mental health facilities, there are some Caucasian churches that have got mental health staff salaried.

Brent shared his experience and success with partnering and collaborating within and without the church to integrate clinical care. He also shared how they collaborated during the pandemic:

> So, in, in my particular church, I have partnerships with other ministries that have counseling departments and have the counseling ministries. I have a list of counselors that I can refer people to if I need to do so. If we can get past our own differences and work together and have teams that that we can actually put our resources together and

> train, then it would be seen as OK, well this is then normal. During COVID, we took all the counselors that we have, and we're blessed to have several people that work in clinical counseling and used different resources we had, and we started what is now our online mental health care curriculum.

Doug's excerpt indicated he sees it as an error to think an individual church or clergy can alone or on their own find successful ways to address mental health issues that arise:

> I can't speak comprehensively, but I think I've been doing this for about 40+ years. I think that many of us try to do it on our own. And there is a fallacy in that. It's like that phrase but in fact, 'You don't know, what you don't know.'

The running theme of efficiency in collaborated or combined efforts in the responses of the five clergy was consistent despite their varying levels of experience or involvement with partnership or referrals to clinical care professionals. Each expressed a belief that African American help-seekers, churches, clinicians, and communities would benefit from a more integrative approach to successfully addressing the growing rates of mental health issues and conditions.

Research Question Five: Theme – Education/Professional Mental Health Resources

While collaboration and combined efforts of professional mental health providers and churches were viewed as significant to successfully helping churches and communities, education and professional mental health resources were expressed as needed to prepare Christian leaders of African American leaders to more effectively assist seekers of mental health care. Education and professional mental health resources were the emerging components of the theme that corresponded closely to RQ5. Lack of knowledge, training, and dedicated or assessable professional mental health resources to provide mental health-specific guidance to

referrals is primarily mentioned as a hindrance to better assisting or referring seekers with mental health care even when there is collaboration and combined efforts, as noted as needed in the previous theme. Brent, from his shared experience, which included "moderating over 18 churches," stated:

> Many pastors in the African American community aren't theologically trained, and if they are theologically trained, they may have gone to seminary, but they don't have any type of training in the practical ministry of counseling, much less exposure to mental health issue indicators.

Elle explained in the following excerpt the need for more practical knowledge on hand to assist with addressing or referring to better help mental health care seekers when describing a situation a family sought her after their preteen was impacted physically, mentally, and spiritually by the actions of an adult:

> So now we have to come up with a solution. So it's just, it's as though you want to help from a clerical perspective. But if you do not know the resources that are out there and you do not reach out for the right type of resource, then you end up not guiding your people the right way. Mental wellness, and so forth, requires people that are in those field to come in and help us.

Education, in the form of formal instruction, denominational curriculum, or a standard guidance handbook, is a tool clergy indicated as necessary to assist. It is almost absent regarding mental health care issues and conditions that they observe in counseling and their communities. One participant suggested that the possibility of recognizing and knowing what not to do might even be increased if more knowledge was shared about mental health with leaders regularly.

Summary

The continued rise in the rates of African American severe mental health conditions and illnesses has exceeded the crisis level, presenting a complex dilemma for Blacks to receive needed care (Mushunje & Graves, 2021). Obtaining needed care comes with many unique obstacles and factors beyond meeting the volume of increased rates for African Americans. The factors include a historical distrust for, avoidance of, and perceived stigma with receiving professional mental health care that continues to persist (Dempsey et al., 2016; Neely-Fairbanks et al., 2018). Another persisting historical factor is the African American tendency to seek out faith leaders for assistance for numerous things, including emotional and psychological issues that may be mental health-related. Considering the current problem, this research sought insight from the lived experiences of clergy who respond to African Americans seeking their help, as only a scarcity of literature provides a view from the faith leaders' perspective.

The findings in this chapter were the result of interviews with five Christian clergy who shared their lived experience in responding to African Americans seeking care for psychological, emotional, and mental health-related issues. The interview questions they were asked also captured their views on the current mental health predicament Blacks are encountering. Each clergy member met the pre-screening criteria for the interview and consented to the transcribing and recording for further analysis, understanding that their identity would not be disclosed. Accordingly, all clergy names used in this chapter are pseudonyms.

An analysis of the transcriptions and interview observations produced five themes presented in this chapter, which informed the research questions and were designed to give structure and guidance in the researchers' goal of exploring the phenomenon from the Christian clergy viewpoint. To increase validity and objectivity in the findings extracted from the clergy

responses to intentionally open-ended questions designed for further exploration and more comprehensive feedback, interview transcripts were analyzed by Dedoose, a qualitative data analysis software application which was queried for repeated phrases, words, and patterns, then grouped in excerpts for further meaning-making. After a manual cross-examination, five themes emerged that satisfied the research questions. In summarizing the themes associated with the corresponding research question they satisfied, this case study provides the following findings.

First, the interviewees all indicated that they understand spiritual and mental health as interconnected, having a degree of impact on each other. Behavior or issues presented in counseling may relate to a spiritual or mental health problem. In connection with this concept, clergy expressed the importance of recognizing or discerning the limits or boundaries of their equipping to address specific matters. They do not all see this as something that is necessarily done due to pressure and some misconceptions that one should be able to address everything through prayer and scripture.

Second, the clergy see normalizing particularly and advocating as well for mental healthcare in their church, the Black Church, and the African American community as possible only as a byproduct of intentionally continued efforts to integrate mental health in multiple ways. The multiple ways include various platforms like pulpit, Bible studies, and social media. Clergy see normalizing mental health care so it is no longer seen as taboo as a needed process that must include leadership role models. Clergy see the associated stigma developed through history as something that will need to be directly addressed for a period to maximize normalizing on a broader scale. Mental health stigma has long been one barrier to African Americans seeking professional care but appears more prevalent in the older generations (Pederson et al., 2022).

Third, part of normalizing and advocating for mental health care is included in their role. However, clergy see assisting those who seek them for assistance with any type of distress or condition, including mental health, as intrinsic to their calling and position, as well as a natural desire to care for people. In alignment with the literature, they recognize their leadership office as respected and seen as held by one who is trustworthy, especially with things that people want to share in confidence (Allen et al., 2010). Clergy also recognize that sometimes helping means getting seekers the assistance and resources they need.

Fourth, clergy's experience with specific successful measures or methods of integrating clinical care and ministry varied; however, the most beneficial experiences involved collaboration with mental health professionals and a combined effort of more than one church or a mental health agency. Several clergy members suggested that the integrative effort is relatively new and challenging for some churches to grasp for various reasons. Other clergy have more time vested and seen continued success in partnering with clinicians as beneficial for the church and the surrounding community. This finding is similar to the challenges and benefits Dempsey et al. (2016) described Black churches having experience successfully collaborating to improve physical wellness, which is still lacking in mental health efforts.

Lastly, the clergy described more education and professional health resources as needed to prepare Christian leaders of African Americans to address mental and psychological problems more effectively. Clergy explained that though it's not uncommon that they encounter mental health problems in counseling, ministry training and pastoral care curriculum provide little if any guidance on addressing such issues. This observation of the clergy is supported in the literature, inferring more counselor education for Black church leaders is needed (Anthony et al., 2015; Karadzhov & White, 2020; Plunkett, 2014; Stansbury & Schumacher, 2008; Vermaas et al.,

2017). Clergy also expressed a need for a network of professional health resources including literature, programs, and counselors. Except for one of the clergies, it was shared that they are often unsure what to do or who to ask.

A collective review of the findings demonstrated some overlap and some interdependency; however, they distinctively surfaced in the analysis. Their interrelationship could be a topic considered for future research. Each clergy participant contributing to the finding gave some unique insight, demonstrating an ongoing effort and desire, and described actions to stand in the gap in their respective responsibilities to help African Americans who seek them for care with mental health related issues.

Chapter Five: Conclusion

Overview

This phenomenological research intended to explore the lived experiences of Christian clergy who are sought for counsel or care by African American congregants and constituents who have mental health-related issues or conditions. This exploration aimed to gain insight and current perspectives from the Christian clergy of African Americans. Historically, African Americans possess a reluctance to seek professional mental health care and reveal a higher tendency to seek help from faith leaders when experiencing emotional and psychological distress (Avent & Cashwell, 2015; Neely-Fairbanks et al., 2018). As a result, Christian clergy are a valuable resource from which to gain perspective on the dilemma of meeting the growing need for care as the rate of serious mental health conditions and disorders continues rising among African Americans, though research from their viewpoint is scarce.

Chapters Two and Three detailed the growing gap between African Americans needing mental health care and accessing it and the multiple factors contributing to the dilemma (Ayvaci, 2016; Powell, 2018; Yearby, 2018). Chapter Three described the research design and its rationale for guiding this study. The findings of the data collected from interviews of five clergy were presented in Chapter Four. Chapter Five summarizes the findings, discusses their implications in consideration of current literature, reviews delimitations and limitations of the study, and provides recommendations for future research.

Summary of Findings

This instrumental case study was designed to capture an understanding of Christian clergies' experience and perspective as counselors/care providers to African Americans seeking help with mental health-related issues. Using the data collection tool of virtual one-on-one

interview recording and transcripts, the interpretative phenomenological analysis (IPA) yielded the five themes that informed the five pre-determined research questions. Together, these five themes depict a comprehensive view of the clergy's shared perspective on the phenomenon despite differences in their backgrounds and experiences. The five themes that developed were: 1) spiritual mental coexistence and counseling boundaries, 2) need for intentional/continued integration, 3) inherent responsibility/trust, 4) efficiency in collaborated/combined efforts, and 5) education/professional mental health resources.

The first theme, "spiritual, mental coexistence and counseling boundaries," was derived from numerous occurrences where participants conveyed that what distressed seekers experience has a spiritual and a mental aspect; therefore, clergy must be clear on their skill limitations when assisting. The second theme, "need for intentional/continued integration," emerged from the participants recognizing that advocating and normalizing mental health care in the African American churches and community would only occur as a byproduct of Christian leaders' intentionality in doing so through a continued effort rather than periodic emphasis or response. Out of the participants' view of Christian leaders surfaced the third theme, "inherent responsibility/trust," which they view as an expectation in their role of assisting when seekers present mental health issues. The fourth theme, "efficiency in collaborated/combined efforts," emerged from the participants' unanimous indications that their successful experiences integrating clinical care in ministry have been with multiple agencies, churches, and resources working together. The fifth theme, "education/professional mental health resources," resulted from the common identification of additional instruction, knowledge, and training, as well as a need for resourceful connections to professional mental health institutions that would enable the

participants to better help those who seek them with mental health issues. The following section further describes the five themes in association with the research question they satisfied.

Research Questions and Corresponding Themes

Research Question 1, "How do Christian clergy describe their experiences in understanding and relating spiritual health to mental health when counseling African American congregants?" was satisfied by the theme "spiritual mental coexistence and counseling boundaries." The participants conveyed a belief that both spiritual and mental aspects co-exist in the distress seekers are experiencing. They believe that whether issues present as one or the other, seekers are experiencing an impact on both. One participant believed that something "spiritual" is almost always at the root of the issues. For these reasons, the participants feel there is a biblical or spiritual application in counseling that may be rendered by clergy even when there may be a need for clinical or professional therapy. Participants indicated that this requires acknowledgment and humility of clergy in realizing where the end of their qualification is, and professional counseling is required. The more experienced clergy participant expressed that drawing such boundaries is challenging for some pastors.

Research Question 2, "In what ways do clergy describe their experiences in normalizing and advocating for mental health care within the African American church/community they serve?" was informed by the theme "the need for intentional/continued integration." There was a consistent sense that participants see advocating and normalizing mental health care as a long-term goal reached only by continued, consistent, and intentional efforts, particularly from Christian leadership in the African American churches. Some integrative programs they have participated in or implemented in response to the pandemic were shared. They witnessed

progress toward normalizing, and they felt there was a need for more to reach the African American community.

Research Question 3, “How do clergy serving African Americans describe their experiences and perceptions regarding their role or responsibility in the mental health care of those seeking assistance with psychological distress or conditions?” was addressed by the theme “inherent responsibility/trust.” This finding was the most prevailing theme emerging from the transcripts in participants’ responses to questions and strongly connected to the other themes. The innate sense of responsibility to seekers depicted in the interviews of the participants was not entirely predicated on the high level of trust they perceive African Americans have in their Christian leaders. It was also described as an essential characteristic of those who serve as clergy. Mental health assistance was understood not necessarily as something clergy had to render to assist personally. The participants think that as clergy, they have to be conscious that it is a fallacy to think that God does not provide sources of help outside the church or the faith community.

Research Question 4, “Can clergy describe their experiences with specific measures or methods that have been successful in integrating ministry and clinical care for the mental health needs of African American members in their churches and communities?” was satisfied with the theme “efficiency in collaborated/combined effort.” Despite the range of exposure and involvement with partnerships or integrative efforts involving mental health clinicians, the clergy pointed out that being effective requires a joint effort across churches and various agencies to obtain the needed resources. Clergy shared recently implemented mental health events, programs, and ministries they participated in that could not have been as successful without the

collaboration between different churches and state agencies in presenting mental health care awareness in a user-friendly manner to the leaders and community.

Research Question 5, "What practices or resources do clergy describe, based on their experiences, as necessary to prepare Christian leaders of African Americans more effectively in addressing mental or psychological problems?" was addressed by the theme "education/professional mental health resources." For Christian leaders of African Americans, there exists a substantial knowledge gap in the desire to assist best those who seek them with mental health issues and the ability to do so. Clerical and pastoral care training traditionally has been from a biblical counseling perspective, and not much consideration of what is now understood as mental health disorders and conditions is included. Participants believe this is even more so historically for African Americans in general, as the mere survival of so many injustices precluded space for consideration of mental health care. Participants shared that no developed guidance is designed for clergy or established professional resource connections they may consult. The participants described what they have learned thus far, resulting from counseling experience and recent initiatives on mental health. A need for practical knowledge and professional mental health resources for consultation or referrals would help them better help seekers.

Discussion

A discussion of how the perspectives informed this study's findings are similar or different from findings in the existing literature is presented in this section. Before the pandemic lockdowns in 2020 that occurred after this research study was designed, little literature existed in the last decade explicitly examining the state of African American mental health directly from the view of Christian clergy who provide them care. A review of the relative literature examined

in Chapter Two, alongside the findings of this study, indicates some ongoing, consistent findings and deviating views in the research from which the implications in the next section will be drawn.

Comparable to Existing Literature

Stigma and Lack of Knowledge

The findings of Taylor and Kuo's (2019) literature survey identified several contributors to the challenges African Americans have had with seeking professional mental health care. Those contributors include stigma and a general lack of mental health knowledge. This study validated those findings as still contributors today. Participants quickly identified that there is a stigma that has and continues to persist for generations amongst African Americans regarding mental health. The participants believe it is based on a combination of facts, fears, and being less informed about mental health. Misra et al.'s (2021) systemic study examining the contributors of stigma among minority cultures residing in the United States, including African Americans, supports this view. Their major findings reflected four types of stigma – structural, affiliative, public, and self (Misra et al., 2021). The latter three types of stigmas identified are fear-based and often a result of misconceptions. This study participants describe what Misra identifies as "affiliative, public, and self-stigma" as not wanting others to know to avoid embarrassment to the family and self because of a sense of shame and fear of losing a position, reputation, and status. As a culture, the Church has also been perceived as demonstrating views that may contribute to a "religious" stigma based upon a fear of being seen as lacking in faith (Bryant et al., 2014; Peteet, 2019). On the other hand, structural stigma is a result of some facts like systemic racism and discrimination, as well as not being adequately informed (Saldana et al., 2021; Suite et al., 2007).

African Americans have suffered a long history of racial mistreatment that contributes to

the historical fear/distrust of professional clinicians; lack of knowledge about mental health care is a natural byproduct of that history. The findings of this study agree with the literature's recognition of educational intervention as a need to reduce the African American mental health services utilization gap (Pederson et al., 2023). Participants in this finding suggested that educating African Americans on mental health, as well as pastors, is a growing need, particularly with the increasing rates. They also recognize the viewpoint on this need is not as quickly accepted by older generations in the Black Church as was the need for education to reduce heart disease and diabetes, which involves physicians. Older African Americans, in general, tend to have a higher confidence or degree of comfort with medical doctors than mental health clinicians (Lee et al., 2021; Thompson et al., 2020). Pederson et al. (2023) found the lack of knowledge not only a deterrent to African Americans seeking care but also a factor in making them more susceptible to severe mental illness.

The Position of Church/Clergy

Overcoming the stigma and the lack of knowledge concerning mental health has been a goal of many agencies advocating for the normalization of mental health care. Christian clergy of African Americans are in a unique and influential role to be instrumental in the efforts to normalize mental health care and obtain care from professionals as we do for physical care. Coombs et al.'s (2022) qualitative study indicates that churches are ideally positioned to be change agents for mental health care. Their study demonstrates how they offer a platform for "psychoeducation, destigmatization, and connection to mental health services" compatible with many needs inimitable to African Americans. The Christian clergy participants in this study identified trust and confidentiality as needs that make them sought out rather than clinicians by many African Americans. In addition to the reverence of the spiritual call of clergy, seekers, their

families, and their friends have often been raised in their churches through kinship-like relationships for generations. As a result, the Black Church and its leaders are a safe place to bring concerns that may be uncomfortable to share elsewhere.

As a safe place, the church can be a bridge that overcomes many of the existing barriers (Coombs et al., 2022). Clergy see the need for intentional and continued integration, which includes leader education and professional mental health resources to better assist African Americans in the current mental health dilemma. Christian clergy serving African Americans with mental health-related issues or conditions validate existing research implications that clergy do not normally possess a working knowledge and understanding or training of mental health practices (Karadzhov & White, 2020; Payne, 2014). Vermaas et al. (2017) found this to be true irrespective of denomination, demographics, education, or race. Clergy of African Americans also face unique educational barriers, and there is a lack of Black representation in the professional mental health field to use as a resource (APA, 2021b). Currently, the participants see themselves as supportive of mental health normalization and personally advocating in several ways in their ministries, including transparency in sharing their own experiences with mental health challenges, but do not see much collaboration amongst churches. In agreement with existing literature, clergy acknowledged a difference in views between younger and older clergy and African Americans on mental health that sometimes acts as an obstacle to progress (Harris et al., 2020; VanderWeele et al., 2017).

In Contrast to Existing Literature

Unlike the findings of Payne and Hays's (2016) grounded theory analysis of a clergy network, which found a varied spectrum of beliefs on how clergy should respond to or counsel mental health issues presented by seekers, this study's participants shared similar beliefs. There

were no opposing views about whether mental health issues should be exclusively addressed from a spiritual or a medical approach. The participants demonstrated a personal and demonstrative awareness of the African Americans' mental health predicament. When describing their own experiences counseling individuals, they articulated specific observations in terms of possible mental health "disorders" or "conditions" requiring clinical help. Severe depression, anxiety, and suicidal ideation were mentioned, with a mutual concern about not knowing how best to respond. An understanding that either of these three conditions could be at or rise to a level of intensity requiring a mental health professional was apparent. Grief, however, is becoming a gray error distinguishing when both mental and spiritual care is needed based on participants experiencing seekers grieving with depression longer and greater intensity since COVID-19. Participants did not see addressing spiritual issues as negating the need or minimizing the value of professional mental health care in any case.

In considering professional mental health care, one participant in the study said that by virtue of "being in this skin" (colored), there is always a question of whether you would get a good clinician or the best care. Bonilla-Silva (2021) poses that racism is interlaced in the structures of our society, organizations, and governments operate in a way that may not be an action of an individual but could be a process or practice without intent that excludes African Americans from receiving the mental health care needed. Another participant felt that the notion of some that an African American therapist would be better is not accurate and should not be the first consideration. While the view is not refuted by current literature, which suggests the advantages and disadvantages of having an African American therapist, it does document that many feel more comfortable with a therapist of their own race or culture (Goode-Cross & Grim, 2016).

In this study, participant inferences around racism and discrimination regarding mental health care varied and were not a central concern or factor as in some existing literature (Bilkins et al., 2016; Bonilla-Silva, 2021; Mouzon & McLean, 2017). It was unclear whether participants saw mistrust, discrimination, or racism as a significant factor in any of the seekers not seeking professional care or seeking it. The researcher recognized this as a possible research implication based on the state of South Carolina's history as a Confederate state whose economy was supported through slavery and a history of institutionalized racism in the participant pools' geographic limits.

A Progressive Perspective of Mental Health

This study's findings further inform the topic of the African American mental health dilemma by providing a more current view from the perspective of these Christian clergy participants who now see supporting mental health care as part of their role as faith community leaders and counselors. This was not a view highlighted in the previous literature. The interviews of the five Christian clergy in this study painted a unified view that they are open, receptive, and desire to have mental health care beneficial to seekers received by those who need it and are acting to support that happening through normalizing mental health care in the church and African American community.

COVID-19's impact seems to be one of the significant influences on the participants' views of the need for normalization and integration of mental health in the church and community. COVID-19 was described as an opportunity or wake-up call for African American church leaders by participants. The devastation of the virus and the lockdowns forced them and clergy colleagues to acknowledge that African Americans' mental health needs, like depression, may be better addressed by connecting with secular resources (Assari & Moghani Lankarani,

2018). Participants described examples of the detriment to families' mental health they witnessed during and are still witnessing after the pandemic. COVID-19's impact also further demonstrated the clergy/church's capacity to act as a bridge between African Americans and obtaining mental health care they may not feel comfortable seeking by other means. One of the senior pastor participants spearheaded a mental health initiative during the pandemic by finding and connecting resources within and without the church community to provide virtual mental health care. Clergy from the county of Doug, who has the most counseling and pastoral experience, hosted a meeting with mental health professionals to learn what more they could do due to what help-seekers were experiencing. The progressive view the clergy demonstrated in this study was not so focused on the disparities, barriers, and complex factors involved as much as changing the misconceptions of mental health in their circles to help African Americans get the care needed through resources that can provide it.

The clergy in this study acknowledged a personal need to obtain more knowledge and guidance on mental health to better serve constituents. As one participant framed it, "It's hard to help when you really don't know what it is you don't know." Unlike previous studies, the participants did not view helping from the perspective of a dichotomy between addressing mental health or addressing spiritual health, or between the role of a pastoral counselor and the role of a clinician, or of being spiritual or worldly. From their life experience, clerical experience, and perhaps formal education, they see the dilemma similarly as interconnected with physical or spiritual health issues. They expressed that components (mental, spiritual, and physical) that impact each other may need to be addressed by different sources to best help.

While there remains some skepticism about the roles/benefits of the church and the clinician in the older generations of African Americans, the younger clergy see the combination

of both efforts as an opportunity to better serve. The Christian clergy participants also see a need for some level of mental health awareness and practical knowledge in what has historically been biblical/spiritual clerical training. Karadzhov and White (2020) describe a "tension" between clergy and clinician methods of care based on their incongruent views, which these participants did not deny. They agree that some clinical practices may be questionable, but they do not see that as a barrier to attempting to get the beneficial care needed. As they are learning more about working with seekers, the clergy participants in this study are of the position that God provides various resources in various people, places, and agencies within and without the church.

Unexpected Finding Outcomes

What was not expected in the finding outcomes was the strong congruence in the clergy's position on the African American state of mental health considering their generational, gender, educational, counseling, and clerical experience. Upon comparing the participants' demographical backgrounds and experience, Doug, the eldest participant with the longest clerical experience and the most diverse counseling training resume in a civilian and military capacity, was expected to have a vastly different perspective on addressing the issues of mental health African American face than Claire, the youngest pastor both in age and tenure. Despite their differences, they both indicated that part of the change needed to better assist the clergy was more intentionality and continued integration efforts as well as education and professional mental health resources. These were two of the prevalent themes that emerged from the responses of all clergy.

Another unexpected finding was the clergy's rationale behind the theme "spiritual mental coexistence and counseling boundaries." Clergy consistently indicated that spiritual and biblical guidance remains applicable in some form, even when there is a mental health issue. The

explanation posited was that because of the connection of the spirit and mind, an issue can impact either of them or the body. One participant expressed that "in his opinion," there is always a spiritual element behind mental health issues. However, even in the clergy's indication understanding of an interconnection of the mental and spiritual, they did not see themselves, or clergy in general, as equipped to address mental health issues. Doug indicated that some clergy struggle with acknowledging the limits of their training but believes it is essential that clergy recognize the boundaries of how they can be helpful. As mentioned in the previous section, the acknowledgment of clergy limits was one of the results of the fallout of COVID-19 shared by participants.

Reflection on Similar Research

In reflecting on the previous research where clergy were participants to gain more insight into mental health, observations on three studies were notable. First, the "model study" for this research, referenced in the Literature Review, was Payne and Hays's (2016) ground theory approach analysis conducted in 2012 involving 35 clergy participants in two week-long conversations in an online social media group. The researcher identified this as a model study because of its similar goal of gaining knowledge on how clergy were handling mental health issues, which was closely aligned with the goal of this study. The diversity in participant demographics and the number of participants was higher, and the online format afforded more data from which to draw findings. Comparatively, the beliefs around the source of mental health issues were an outcome that varied the most from that of the input of the five clergy from South Carolina in this study. A broad spectrum of beliefs emerged, including demonic, trauma, and lack of faith. This study's participants saw mental health as either a biological issue, a result of a life event(s), or possibly a result of a personal spiritual struggle. A noted similarity identified in

the outcomes was the recognition of a shift in perspectives discovered during a 2015 exploration of the same page where some clergy previously opposed to mental health had experiences that changed their view. This shift is what the researcher identifies as “a progressive view” also recognized in the study participants as their experiences increased, particularly after the impact of COVID-19. The variations in the outcomes may be due to time but the shifting of view the researcher identifies with transformative experience (TC), which was part of the framework guiding this research (Azzari & Baker, 2020).

A second observation was noted when reflecting on Avent et al.’s (2015) consensual qualitative research (CQR) exploration of the perspectives of 8 protestant pastors in North Carolina. One of the eight pastors was a female, and they ranged in age from 28–69 years old. All of them were identified as regularly addressing parishioners’ requests for help with mental health conditions. Similar to this study, five research questions were posed but with a sub-focus on coping skills for anxiety and depression. The distinct difference from this study was that the data analysis for CQR requires a team and a minimum of 8 participants. This study involved a sole researcher. Despite the difference in methodology, there were two similar views shared—spiritual and social causes behind mental health issues (though spiritual explicitly included demonic influences) and the belief in the benefits of an integrative approach with mental health professionals. A notable finding of Avent et al. is the identifier “Christian counselor,” which was recognized as a credible and trustworthy source by pastors as it implies additional counseling training beyond clerical, which this study identified as a need by its participants.

Thirdly, Brown and McCreary’s (2014) research sought to learn more about pastors’ views of mental health services, particularly within their churches. Through the online survey responses of pastors, the findings identified that the favorableness of each participant’s views

toward mental health services corresponded positively with the frequency in which they counseled congregants and the expanse of counseling issues they encountered. There were 48 pastor participants, 18 of whom were female. The average age of the participants was 50, and it was noted that the sample was "highly educated . . . with 95% having at least a bachelor's degree" (Brown & McCreary, 2014, p. 7). The level of education for a sample of respondents of this size to a survey is interesting, particularly in comparison to all the clergy in this case study who had a higher education, two of which were doctorate degrees. Other similarities include the participants' viewing the church as an opportune place to bring mental health care help to the African American community and the recognition of limitations in the skills pastors possess to address mental health issues in their role as counselors. A final interesting similarity was that the majority of the participants had never referred a congregant to a mental health source. Referrals came up among the five clergy only as indicating they needed resources.

Reflection on the three studies was noted because they shared a similar goal and research design as presented in this study (Avent et al., 2015; Brown &McCreary, 2014; Payne &Hays, 2016). Due to the scarcity of research from the clergy's viewpoint, it was difficult to find more comparable research. Still, the identified similarity in outcomes with this study increases the credibility of the findings. They also add value to the literature on mental health, particularly concerning African Americans. Likewise, though some of the outcome differences may be attributed to methodology, participant demographics, and possibly the time frame in which the research was conducted, others are implications for further consideration and research.

Implications

This section considers the findings of this phenomenological research during a time of increasingly alarming growth rates of African American mental health conditions in conjunction

with existing literature. The researcher recognized three substantial implications from the views of Christian clergy. The theoretical implication of ongoing transformative change, the empirical implications for future improvement, and the practical changes needed for clergy, churches, and mental health professionals follow.

Transformative Theory Implications

The transformative framework in which this research was designed to add value to the research on mental health as it has in the healthcare field yielded valuable implications for all stakeholders while preventing the researchers' presuppositions from impacting the informative findings (Creswell & Poth, 2018; Mertens, 2010). Romm's (2015) view of transformative theory accurately supports the benefit of learning by investigating the current views and understanding from the unique perspective of the Christian clergy. The study purpose was fulfilled, and participants were compelled to interrogate their beliefs based on their experiences over time. Transformative learning (TL), transformative consciousness (TC), and especially transformative experience (TE) were evident in the expansion of perspectives over time for the participants and in comparison to the previous literature that captured clergy views (Azzari & Baker, 2020).

A review of the collective responses of clergy in this study led to three significant conclusions about the transformative concept of change. First, these clergy participants are not only becoming more aware of the urgency of finding ways to assist African Americans as the mental health issues climb, but they also have a developing understanding of how mental health literacy and professional mental health partnerships with the church may be a very efficient means to do so given the unique circumstances. Second, the clergy in this study understand the success of efforts to integrate and normalize mental health care in the African American community as well as through the church and Christian leaders as possible over a period of

consistent, intentional efforts with collaboration between professional mental health agencies and across churches due to different capacities. Third, the clergy in this study see appropriate education on mental health care as an equipping, proactive, and destigmatizing tool needed by clergy, African Americans, and mental health professionals. Based upon the continued evolving views of clergy such as those in this study, there are expected actions to follow that will affect the African American mental health dilemma both empirically and practically.

Empirical Implications

Change is slow but occurring as conceptions are being transformed by the demand to revisit beliefs in the face of a mental health care dilemma with a complexity of unique factors that contribute to increasing numbers of African Americans with severe mental health illnesses. Capturing a measure for the absence of those African Americans receiving the care needed in specific measurements is a challenge, yet it reveals a problem of crisis level statistically. It is a widely documented fact that many of the coping strategies in the absence of professional mental health care are negative, with suicide being the most detrimental, while religiosity is found to be both positive and negative (Ellison et al., 2017; Garssen et al., 2021; Koenig et al., 2020; Weber & Pargament, 2014). The expectation for change in these findings will be evidenced, too, as changes are implemented successfully over time through the collaborative efforts of educating all the stakeholders while investing in making the resources accessible to those who need them. The empirically or observably needed change may be measured differently, but the outcome is dependent on the practical application of what is being learned and its solutions.

Practical Implications

The findings in this study identified several needs that can be fulfilled by establishing interprofessional forums, resource networks, and structured collaboration plans between

Christian clergy leaders, churches, and mental health agencies or professionals to better serve the African American community, congregants, and Black mental health clients. This study's findings and current literature indicate a lack of knowledge or capacity to some degree by all involved that the others possess or have access to. There were a number of programs, incentives, symposiums, and forums emerging in response to the mental health impact on African Americans during the pandemic; however, none of them possess the existing position of trust and confidence, as well as the logistical access as the Black Church (Snowden et al., 2022; Snowden & Snowden, 2021). In addition, in the interest of the African Americans who are suffering from mental illnesses, an interchurch collaboration of resources to include other denominations or races is needed.

Delimitations and Limitations

Delimitations

Three intentional decisions were made in defining the boundaries of this study regarding Christian clergy participants' geographic residency, affiliations and denominations, and experience with African Americans seeking assistance with mental health-related problems. In general, the boundaries were to establish homogeneity and feasibility in conducting valid research in a case study by one investigator (Robinson, 2014). In addition to homogeneity, participants it was determined that clergy residing within the state of South Carolina could still be interviewed in a reasonable period in person if a virtual (automatically transcribed and recorded) interview was not possible. The affiliations and denominations were selected based on the common characteristic of longevity as originally being established as predominantly African American denominations similar to, or a part of, those associated with the Black Church (Hankerson et al., 2018). The Black Church developed and grew out of necessity from the time

of slavery and has remained a shared catalyst for African Americans' advocacy in every area of life. The decision to ensure participants had some level of experience in counseling African Americans seeking them with psychiatric or emotional distress that may be related to mental health was critical to obtaining informed insight from lived experience.

Limitations

The size of the sample size precludes broad generalizations about the African American mental health dilemma. Though saturation was observable in analyzing this convenience sample's participant responses, a broader or more universal application of the findings would require a larger sample and a pool that captures more of the U.S. population (Saunders et al., 2018). The findings of the sample validate and present new considerations on some of the existing literature through the insight provided.

Geographic limitations also preclude generalization. In addition to the location limits of the participant pool, South Carolina is historically considered a deep south Confederate state housing the most extensive transatlantic slave port slavery. Although it was not explicitly referred to by any of the participants, South Carolina's history of racism and segregation could have influenced the effectiveness of the recruiting, why certain participants responded, and possibly the research findings. The outcomes may be very different from those of clergy in northern states. It is also significant to note that though not a requirement, all the participants who responded possessed college degrees, with two having doctorates.

An unexpected limitation encountered was the ability to acquire more participant responses through the multiple methods of communication determined in the research design (clergy personal and church emails, letters, flyers, phone calls, social media, and clergy referrals with follow-ups). Of the eight percent that responded to the invitations, only five went through

the process of returning pre-screening, completing a consent, and finding a time to schedule an interview. Their central focus of sharing to provide their perspective on mental health care seekers contributed to a wealth of insight despite the small sample.

Recommendations for Future Research

From this study's findings, limitations, and delimitations, several recommendations might benefit expansion and future research. Finding a forum or shared network within which the study may be addressed to obtain a greater response would be the first and most ideal recommendation for expansion. An example would be requesting permission to share questions in an anonymous electronic survey format at a regularly scheduled clergy conventional meeting. One of the participants shared this suggestion with me, and informed me that several of the denominations were in conference with clergy from all over the United States during this study's recruiting period. A survey, in general, may capture more responses. Still, as part of an understood approved process in a clergy forum, it may bring more attention or interest than an email or letter from an unknown sender.

A second recommendation would be to consider expanding beyond the denominations in this study to cover a broader spectrum of views. Clergy may have a comparatively different view by clergy of non-denominational or other denominations not historically affiliated with the Black Church. This can add valuable insight to further developing an understanding of how clergy who serve African Americans are responding.

Lastly, another significant area of exploration evoked by this study as clergy progressively move towards gaining knowledge, resources, and collaborations to normalize mental health is to explore where professional mental health institutions and clinicians' positions. In recognizing the valuable and opportune resource the church and faith leaders are in

helping address the African American mental health dilemma, the question of how mental health systems can take advantage of collaborations with faith communities as a means to better address the issues arises.

Summary

A summary of the findings of this instrumental case study involving five Christian clergy who shared their lived experience and perspectives on responding to requests from African Americans with mental health-related issues is shared in this chapter, as well as implications and recommendations for future research. The findings, which resulted from an IPA of the collective transcripts from the virtual interviews with each clergy, identified five emerging themes. Those themes informed the research questions established in the research design: 1) spiritual mental coexistence and counseling boundaries, 2) need for intentional/continued integration, 3) inherent responsibility/trust, 4) efficiency in collaborated/combined efforts, and 5) education/professional mental health resources. The research questions were aligned with the interview questions to determine how Christian clergy are navigating the current mental health dilemma African Americans are facing.

The emergence of African Americans' mental health conditions and challenges at the rates currently being experienced is alarming. African Americans have been documented as being at a higher risk for serious mental illnesses, with depression and anxiety being two of the more common conditions often linked to poor physical health conditions Blacks (Maura & Weisman de Mamani, 2017; Odonkor et al., 2021). It is not uncommon for Blacks to be reluctant to receive mental health care from professionals due to stigma, concerns about discrimination, and fear of negative repercussions against themselves or family (Desai et al., 2023; Misra et al., 2021).

Simultaneously, there is a historical and continuing tendency for many African Americans to seek faith leaders by virtue of their trust in clergy, long relationship with the church, religious beliefs, and understood confidentiality. The African American history in the United States is uniquely intertwined with the development of the Black Church as a predominant informal yet highly influencing institution advocating for the rights and equality of Black people through spiritual, educational, and social leadership. While all African American churches today are not recognized under the reference of the Black Church nor all African American congregants in associated denominations, the roots of African Americans and faith began in the United States from its development. As a result, clergy are heavily relied upon for help in matters beyond spiritual and biblical help. This phenomenological case study was developed to gain insight from the intersection of African Americans' reliance on and tendency to seek clergy for mental health issues and their reluctance to seek professional mental health care despite increasing African American mental health rates.

The theoretical, empirical, and practical implications drawn from the findings suggest that views on mental health care are evolving in a more receptive direction amongst African American clergy through generations as more awareness, knowledge, and understanding, as well as mechanisms for addressing, is made available to faith leaders and churches. There is an increasing expectation and desire for resources to help churches bridge the current gap between the African American need and availability of professional mental health care. Clergy recognizes some constituents present mental health issues they are not personally able to address in the entirety of what is needed to better help seekers of care. Clergy believes the best help that can be provided to many African Americans suffering from mental health issues would come from

collaborated efforts on the parts of leaders of churches and professional mental health agencies and providers on an intentional basis.

One of the most significant implications of the research findings is the recognition of the unique position of clergy and the church in filling the gap in care. Understanding this position as an opportunity to gain ground in resolving the African American mental health dilemma from both a mental health care provider or agency position and a faith leader position is elemental in the motive for partnering. In considering all the various historical and present complex factors contributing to the mental health problems of African Americans and also factors dissuading the desire to seek professional care, the clergy and church are uniquely positioned as a safe place and a change agent for normalizing as well as destigmatizing mental health care (Baruth et al., 2013; Gross et al., 2018). Studies have shown that clergy who are openly transparent in sharing their mental health issues and that seeking care does not diminish but support it are influential in others seeking care (Hays & Shepard Payne, 2020). Even so, there is unmistakable evidence that in exploring how clergy are filling the gap in care, the old saying “we’re better together” applies. As mental health professionals/agencies and faith leaders/churches come together to share and learn from each other’s strengths, areas of opportunity to reduce the gap in the care of African Americans suffering from mental health issues can be maximized.

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Appendix A: Interview Questions/Guide

The following interview questions are designed to allow a wide range of possible responses that can be probed further for additional individual responses to include in collective analysis for patterns, themes, and outliers to inform this study.

1. How do you see the growing issue of mental health surfacing among African Americans from the viewpoint of a faith leader?
2. What are some of the factors you see attributed to the tendency of many African Americans to consult with faith leaders first or solely when experiencing relatively serious psychological, mental, and or emotional distress?
3. What is your view on church/pastors' addressing/responding to requests for help from congregants experiencing mental health issues and known mental health conditions?
4. How do you see mental health care fitting or not fitting within the schema of spiritual health care, ministry, and/or pastoral counseling?
5. What are the barriers for church leadership in assisting members seeking their help with psychological distress or mental disorders?

Appendix B: Pre-Interview Screening Survey

1. Please indicate your full name, title, official position, and church/denominational affiliation:
2. Please indicate your state of residence:
3. Please indicate your age range:

   a. 17 or younger b. 18–25 c. 26–35 d. 36–45 e. 46–55 f. 56–65 g. 66 or older
4. Please specify your ethnicity/race:

   a. African American b. Asian c. White d. Hispanic e. Other
5. Please indicate the highest level of education completed:

   a. Some High School b. High School c. Bachelor's Degree. d. Master's Degree

   e. Doctorate Degree f. Prefer not to say.

Please Circle One

1. I respond to requests for assistance from congregants/constituents requesting help who are suffering psychological and/or emotional distress.

   Never Rarely Sometimes Often Frequently
2. Our ministry promotes and encourages congregants to practice a holistic lifestyle that includes spiritual, mental, and physical health.

   Never Rarely Sometimes Often Frequently
3. Mental health care awareness is a part of church leadership development and church ministry functions.

   Never Rarely Sometimes Often Frequently
4. Collaboration and/or partnership with professional mental health clinicians occurs with leadership/pastoral counselors.

   Never Rarely Sometimes Often Frequently

5. Mental health care is referred to be addressed exclusively by mental health professionals.

Never Rarely Sometimes Often Frequently

Appendix C: Research Questions

1. How do Christian clergy describe their experiences in understanding and relating spiritual health to mental health when counseling African American congregants?
2. In what ways do clergy describe their experiences in normalizing and advocating for mental health care within the African American church or community they serve?
3. How do clergy serving African Americans describe their experiences and perceptions regarding their role or responsibility in the mental health care of those seeking assistance with psychological distress or conditions?
4. Can clergy describe their experiences with specific measures or methods that have been successful in integrating ministry and clinical care for the mental health needs of African American members in their churches and communities?
5. What practices or resources do clergy describe, based on their experiences, as necessary to prepare Christian leaders of African Americans more effectively in addressing mental or psychological problems?

Appendix D: Recruitment Flyer

Research Participants Needed

The African American Mental Health Dilemma:
A Phenomenological Case Study on How Clergy are Bridging the Gap

- **Are you a pastor/clergy serving in the**
African Methodist Episcopal Church (AMEC), the Church of God in Christ (COGIC),
the Baptist Educational and Missionary Convention of South Carolina (BEMCSC),
***or* the Progressive National Baptist Church (PNBC)?**
- **Are you 18 years of age or older?**
- **Do you live in South Carolina?**

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.

The purpose of this study is to explore the lived experiences and views on African American mental health from Christian church clergy who provide care to Black/African American congregants who seek them for help with psychological and emotional distress which may be, and/or, are related to mental health issues. The perspectives of Christian clergy, a longstanding resource for African Americans, will provide additional insight and information scarcely found presently in the research.

Participants will be asked to participate in a video recorded interview, in-person or virtual, that will take no more than 1 hour total. Names and other identifying information will be requested as part of this study, but participant identities will not be disclosed.

After completing the interview, participants will receive a $20.00 Amazon e-gift card via e-mail.

If you would like to participate, please contact the researcher at the phone number or email address provided below to receive a screening questionnaire.

A consent document will be e-mailed to you prior to your interview.

Penelope Evans, a doctoral candidate in the School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact Penelope Evans at (803) 673-6357 or pevans25@liberty.edu for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

Appendix E: Consent Form

Title of the Project: The African American Mental Health Dilemma: A Phenomenological Case Study on How Clergy are Bridging the Gap

Principal Investigator: Penelopé Evans, Student/Doctoral Candidate, School of Behavioral Sciences, Liberty University.

Invitation to be part of a research study

You are invited to participate in a research study. To participate, you must be 18 years of age or older, hold an official leadership position or office as a pastor serving a community and/or congregation of pre-dominantly African American constituents in affiliation with the African Methodist Episcopal Church (AMEC), Church of God in Christ (COGIC), the Baptist Educational and Missionary Convention of South Carolina (BEMCSC), or the Progressive National Baptist Church (PNBC). 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.

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

The purpose of this study is to explore the lived experiences and views on African American mental health from Christian church clergy who provide care to Black/African American congregants who seek them for help with psychological and emotional distress which may be related to mental health issues. The perspectives of Christian clergy, a longstanding resource for African Americans, will provide additional insight and information scarcely found presently in the research.

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:

1. Participate in a video recorded interview, in-person or virtual, that will take no more than 1 hour.

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:

1. Additional insight and awareness in the research on ways African American mental health is being addressed.
2. Enlightening and useful perspective to inform mental health professionals, advocates, educators, Christian clergy, and society as a whole on African American mental health.

What risks might you experience from being in this study?

The expected risks from participating 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. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with 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. After 3 years, all electronic records will be deleted and/or all hardcopy records will be shredded.

- Recordings will be stored on a password locked computer for 3 years and then deleted.

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

At the conclusion of the interview, participants will receive a $20.00 Amazon e-gift card via email.

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 that relationship.

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 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 is Penelopé Evans. 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, D. Kristen Small, PhD, at [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 IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is 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-record/video-record/photograph me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix F: IRB Approval

IRB #: IRB-FY23-24-1058

Title: The African American Mental Health Dilemma: A Phenomenological Case Study on How Clergy are Bridging the Gap

Creation Date: 12-13-2023

End Date:

Status: Approved

Principal Investigator: Penelope Evans

Review Board: Research Ethics Office

Study History

Submission Type Initial **Review Type** Expedited **Decision** Approved

Key Study Contacts

Member Don Small Role: Co-Principal Investigator Contact: [redacted]

Member Penelope Evans Role: Principal Investigator Contact: [redacted]