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THE EXPERIENCES OF AFRICAN AMERICAN PASTORS TREATING MENTAL

HEALTH ISSUES AMONG PARISHIONERS IN THE STATE OF TEXAS

A

DISSERTATION

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THE EXPERIENCES OF AFRICAN AMERICAN PASTORS TREATING MENTAL

HEALTH ISSUES AMONG PARISHIONERS IN THE STATE OF TEXAS

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TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

The purpose of this phenomenological study was to learn the practices, attitudes, and self-described competency of a sample of 12 African American pastors, with churches located in Texas, as they counsel their parishioners with mental health issues. Pastoral counseling formed the theoretical framework for the study. The researcher asked each pastor eight open-ended questions, inquiring about the pastor's experiences, practices, attitudes, and training in regard to dealing with their parishioners' mental health issues. The interviews were recorded and transcribed, and qualitative methods were used to analyze the responses to determine themes in the pastors' responses.

A total of 10 themes were identified in the pastors' responses. These were synthesized into three overall themes as follows. First, the pastors were aware of having limited competence for dealing with the mental health problems of their parishioners. As a result, they counsel and advise parishioners who approach them with relatively common mental health issues, but they refer parishioners with a serious mental health issue to mental health professionals. Second, the pastors show respect for the professional expertise of mental health professionals by referring parishioners to those professionals if they feel they cannot deal with a parishioner's mental health issue. Third, the pastors distinguish between cases where they believe they can help a parishioner with mental distress from those where a mental health professional is needed. When they judge they can help, they use various strategies to counsel parishioners. These strategies are generally based on the Bible and spiritual considerations, and they may reflect practical knowledge about how to engage people and encourage them to discuss their issues openly.

Several recommendations for further research were made. These included further study using more wide-ranging samples of African American pastors in different states and regions and

from different religious denominations. It was also recommended that research be conducted on ways to increase communication and cooperation between African American pastors and mental health professionals.

CHAPTER I

INTRODUCTION

There is evidence for higher diagnosed rates of mental illness in the African American community than in White community (U.S. Department of Health and Human Services, 1999). For example, Black Americans have been found to be over-diagnosed with schizophrenia (Williams, 1995). Yet many members of the African American community mistrust the mental health profession (Neighbors, Musick, & Williams, 1998). Consequently, African Americans with mental health issues often disdain and underuse regular outpatient treatments for mental health issues (Thompson, Bazile, & Akbar, 2004). As an alternative to the traditional counseling experience, Black Americans often opt to receive mental health support from the African American church (Allen, Davey, & Davey, 2010). As a result, African American pastors often constitute the first and only contact for their parishioners with mental health needs.

Black parishioners may present to their pastor with mental health issues ranging from sadness at the loss of a friend to serious undiagnosed mental illness. Especially in dealing with the latter sort of case, it is important for African American pastors to have the ability to competently assess and treat parishioners with serious mental health issues or to refer them to a qualified professional mental health practitioner. To date, research to determine the competencies and practices of African American pastors who counsel their parishioners on mental health issues is sparse. Research that has been done indicates that parishioners of African American churches may confide in pastors who have varying degrees of training and competency for dealing with mental health issues.

A study by Thompson et al. (2004) found that even educated pastors reported that they lacked adequate knowledge of the signs and symptoms of mental illness and had difficulty

discerning when a situation required professional services. African American pastors in another study reported feeling overwhelmed by the mental health issues that their congregation and community members brought to them for help (Aten et al., 2011). Some pastors may thus be unfamiliar with certain types of presentation of mental illness they may be confronted with due to a lack of training to identify psychopathology and symptoms of severe mental illness (Thompson et al., 2004).

Furthermore, their religious and spiritual perspective may sometimes affect the ability of Black pastors to effectively counsel parishioners with serious mental distress because the pastors can be expected to approach counseling of their parishioners with the unique perspective of pastoral care. Pastoral care, which forms the conceptual background of the proposed study, consists of the efforts of pastors to promote the spiritual well-being of their parishioners and of the community through fostering neighborly love and love of God. Promoting the psychological well-being of their parishioners can be seen as being a part of pastoral care. Yet, their religious and ministerial training may cause African American pastors to construe mental or emotional issues in religious terms or interpret clinical symptoms as sign of religious conflict (Kramer et al., 2007; Snowden, 2001; Stansbury & Schumacher, 2008).

Payne (2009) conducted a study on the variations in pastors' perception of the etiology of depression by race and religious association. In the study, Protestant pastors in California were queried about their knowledge of depression. The results revealed that racial and religious affiliation influenced how pastors perceive and arbitrate in the area of depression. It was noted that Black pastors in the research were often open to the idea that depression is defined as a spiritual factor. Moreover, Black pastors were more likely to agree that depression is an episode plagued with trials and tribulations. In short, the participants believed that depression resulted

from a limited trust in God. Thus, African American pastors were less likely to agree with the idea of the causal factor to depression as a biological mood disorder than their counterparts.

Variations and possible deficiencies in the practices and competencies of African American pastors can be problematic for both church and pastor because the pastor may be called upon to deal with parishioners with serious undiagnosed mental illnesses. As a result, while some parishioners requiring counseling may feel they are receiving adequate care from their church and do not need other services, others may continue to experience symptoms that interfere with their daily living. This problem suggests the importance of understanding better the counseling practices and competencies of African American pastors and whether there is a need for mental health training for these pastors. Yet to date there is limited research on how African American pastors approach their counseling function and their competencies in doing so. Due to this paucity of research, literature on how and how well Black pastors deal with the mental health needs of their parishioners relies more on assumption and belief than on valid documentation of current practices and competencies (Stansbury & Schumacher, 2008).

Statement of the Problem

The problem this study addressed is that Black pastors may have varying amounts of competence to assess and treat the mental health needs their parishioners may have or even to refer parishioners to competent mental health practitioners. To address this problem, it is important to understand, as well as possible, Black pastors' practices and degree of competence in dealing with parishioners' mental health needs. Yet at present, these pastors' practices and degree of competence in this respect are not well understood.

To help provide greater understanding in this problematic area, an obvious source of cogent information about their competency and practices in dealing with parishioners' mental

health needs would be the pastors themselves. Becoming cognizant of the experiences, practices, attitudes, and self-perceived competency of African American pastors could help shed much needed light on the issues of how and how well these pastors are performing when called on by parishioners to offer counseling to assuage psychological distress.

Accordingly, the researcher conducted a phenomenological study to explore the experiences, practices, attitudes, and self-described competence of African American pastors in regard to their counseling of parishioners for mental health issues. The purpose of the study was to better understand the actual practices and competencies of African American pastors as they deal with the mental health issues of their parishioners. One practical result of the study is that it provides needed information on the actual practices of African American pastors in dealing with their parishioners' mental health issues and on principles and considerations underpinning and guiding those practices. Another practical result is that the study may provide information on whether or not African American pastors need additional training in assessing and treating parishioners with mental health needs. Overall, the results of the study will be a more informed understanding of how African American pastors deal with their parishioners' mental health issues, their competency in doing so, and their attitudes toward mental health treatment.

Purpose of the Study

The purpose of the study was to learn the practices and competency of African American pastors in dealing with their parishioners' mental health issues by interviewing a sample of African American pastors. The study was phenomenological in nature. According to Creswell (2014), the key focus of phenomenological research is to formulate an overall description of the experiences of informants in regard to some phenomenon based upon their descriptions of the phenomenon. In the proposed study, the main phenomena in question were the practices and

competence of African American pastors. To determine these, the researcher interviewed 12 African American pastors to ask about their experiences and practices in dealing with parishioners who come to them with mental health issues and about their self-described competence in counseling parishioners.

To provide even greater understanding of the practices and competence of the pastors, the pastors were also asked to describe their training and their attitudes toward mental health treatment. The responses of the pastors were analyzed by qualitative methods to determine patterns and themes in their responses and to construct an overall description of the practices and competence of the pastors based on these identified patterns and themes.

The central concepts to be investigated in the study were the practices and competency of African American pastors in dealing with their parishioners' mental health needs. To explore these concepts, the researcher asked the pastors to describe their experiences, their practices, and their self-reported competence in dealing with parishioners' mental health needs. Other concepts related to the central concepts that were explored included the pastors' attitudes toward mental health and their training in mental health issues. The conceptual background that informed the study was the concept of pastoral care.

Research Questions

The grand tour question for this study was the following: What experiences, practices, attitudes, training, and competence do African American pastors report in regard to counseling their parishioners on mental health issues? This Grand Tour Question was divided into five more specific research questions.

Research Question 1: What are the experiences of African American pastors in counseling parishioners with mental health issues?

Research Question 2: What are the practices of African American pastors in counseling parishioners with mental health issues?

Research Question 3: What are the attitudes of African American pastors toward mental health treatment?

Research Question 4: What training do African American pastors have for dealing with mental health and illness issues among their parishioners?

Research Question 5**:** How competent do African American pastors feel they are for dealing with mental health and illness issues among their parishioners?

To answer the research questions, the investigator interviewed a sample of 12 African American pastors with a series of open-ended interview questions. One or more interview questions were focused on providing answers to each of the research questions.

Justification for the Study

This study was needed because African Americans with mental health issues frequently avoid traditional mental health services and instead go to their pastor for counseling. Yet to date, there has been little research on the practices and competencies of African American pastors who are called on to deal with the mental health needs of their parishioners. Of studies that have been done, several suggest that some Black pastors may have inadequate training or competence to assess serious mental illness or may be hesitant to refer individuals to professional mental health practitioners. It was thus important to better understand the mental health practices, competencies, attitudes, and training of Black pastors.

The study adds to the research by providing firsthand accounts of how African American pastors identify and address mental health concerns within their congregations. Due to the paucity of literature examining the counseling competence of Black pastors, this area warranted

further investigation. The findings from the study not only contribute to the knowledge base but may also increase discussion in an area often considered sensitive. In addition, pastors' exploration of their own counseling competence regarding mental health may serve as a helpful tool they may use to educate their congregation as well as other members of the African American community about mental health services, which may help lower the barriers preventing Black people from seeking outside counseling as well as increase their knowledge of mental health.

Limitations of the Study

The study sample was limited to a geographical area in the State of Texas. Pastors living in a different geographical area might have a different experiences, practices, and competencies. Having a sample size of 12 individuals in the study was considered sufficient; however, the study might have been strengthened by having a larger sample size.

Lack of generalizability was another limitation of the study. As with most qualitative studies, generalizability of the findings is limited to the group that is being studied. The larger the sample population, the more one can generalize the results (Krathwohl, 2009). However, it is important to note that generalization was not the goal of this study, rather its goal was to understand the counseling practices, attitudes, and self-described competence of a group of African American pastors from the state of Texas.

Another limitation was its focus on the practices and competencies of member of one specific group, i.e., African American pastors. Including other pastors from other ethnic-racial populations might have allowed for a broader understanding of pastors' counseling competence as it relates to addressing mental health within their congregation; however, the focus on African

American pastors was due to the widespread avoidance of traditional mental health services by African Americans and their turning to their pastor as a counseling substitute.

Definition of Terms

*African American/Black***:** These terms were used interchangeably in the study. The terms refer to an American with African, especially Black African, ancestors. The spiritual and social identity of the African American population can be considered as going beyond racial or physiological characteristics. The pan-Negro outlook of W. E. B. Dubois (1990) in the early 19th century called for solidarity of all Blacks in America as a singular and unique population. On this theme, the talented American Black poet Langston Hughes wrote,

> We are related – you and I
> You from the West Indies
> I from Kentucky
> We are related – you and I
> You from Africa
> I from these States
> We are Brothers – you and I

Black Church: Also known as the African American church, the Black church is mostly composed of African Americans, who, with an African American pastor, worship God together in the same location, forming an organized group or institution. Douglas (2001) described the Black Church as a multitudinous community of churches diversified by origin, denomination, doctrine, worshipping culture, spiritual expression, class, size, and other less-obvious factors. He explained that although Black churches may seem to be disparate, they actually share a special history, culture, and role in Black life, attesting to their collective identity as the Black church.

Competence: Sufficient knowledge, psychomotor, communication, and decision-making skills and attitudes to enable the performance of actions and specific tasks to a defined level of proficiency (WHO, 2011).

Counselor, Therapist, Psychologist, Psychiatrist or any mental health practitioner: These terms were used interchangeably for persons trained to give guidance on personal, social, or psychological problems. Counseling is a systematic approach to problem solving that focuses on helping clients deal with their presenting problems.

Mental health, mental illness, and mental problems: According to the U.S. Surgeon General's supplement report (United States Department of Health and Human Services [USDHHS], 2001),

> mental health [is] the successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental illness is all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and /or impaired functioning. Mental problems are signs and symptoms of insufficient intensity or duration to meet the criteria for mental disorder. (p. 7)

Pastor: The leader of a church congregation. A pastor is defined as a person having the spiritual care of a number of people. The pastor is an ordained minister serving the body of Christ either locally or at large. It will be assumed by the author that pastors are those who received ordination by a church or the denomination.

Pastoral Care: The efforts of pastors to promote the spiritual well-being of parishioners and the community.

Organization of Remaining Chapters

This dissertation contains four additional chapters. The next chapter provides a review of literature pertinent to the study's purpose. The third chapter explains the methodology used in this qualitative phenomenological study. The fourth chapter reports the results of the study. The fifth chapter consists of a discussion of the results, including a summary of the study, implications, limitations, and recommendations.

CHAPTER II

REVIEW OF THE LITERATURE

This review of literature focuses on literature that is relevant to the study. The purpose of this phenomenological study was to interview African American pastors in order to investigate their experiences, practices, and competence as they counsel parishioners who come to them with mental health issues. Given this purpose, in order to understand the issues pertinent to the study, it was necessary to review literature related to the history and nature of the Black church; the role the Black church and Black pastors play in the lives of African American communities; the attitudes of African Americans toward professional mental health practitioners, their usage of such services, and barriers to usage; how mental and spiritual health issues are often blended among African Americans; research on the mental health benefits of religion and spirituality; and research related to the competence of Black pastors in dealing with mental health issues among their parishioners.

The chapter is divided into six main sections. The first section of the chapter focuses on the Black church in America, providing a brief history of the Black Church and what it has meant in the lives of African Americans, as well as information on the contemporary Black church and the role it plays in African American culture. The second main section of the chapter reviews literature related to the use by African Americans of professional mental health services. This section includes literature about reasons African Americans often avoid professional mental health services in favor of counseling by Black pastors.

The third section focuses on the African Americans' choice of Black pastors for counseling as an alternative to mental health professionals. The fourth section reviews literature concerned with the mental health benefits of religion and spirituality. The fifth section reviews

literature related to the issue of Black pastors' competence for treating mental health issues.

Finally, the sixth main section of the review provides a summary and conclusion for the chapter.

History and Contemporary Role of the Black Church

In what follows, I use the term "Black church" to comprise seven historically African American church denominations in the United States. These denominations are the African Methodist Episcopal Church; African Methodist Episcopal Zion Church; Christian Methodist Episcopal Church; National Baptist Convention, USA, Incorporated; National Baptist Convention of America, Unincorporated; Progressive National Baptist Convention; and the Church of God in Christ. These are all Christian Protestant churches.

Brief history of the Black Church

Historically, the Black church in the United States has provided help to its people for over 400 years, starting with slavery. During what has been called the Middle Passage, Africans were transported from their homeland of Africa to America and placed into slavery, with slave owners attempting to strip away their cultural heritage. During the slavery era, African American men were denied basic human rights, such as marrying their partners, parenting their children, or earning wages for their families. Often, they were ripped away from their families, sold to other families like cattle, emasculated, and disempowered by White slave owners (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005).

In 1794, in response to the maltreatment of African Americans and in opposition to the Christianization of African slaves by White evangelical preachers, freed slaves organized to create what would become known as the "Black Church" (Allen, A. J., Davey, M. P., & Davey, A. 2010). The Black church became a safe haven for freed African Americans, where they had permission to express their authentic cultural and spiritual heritage and could feel entitled to the

simple dignities offered to human beings such as teaching their children the virtues of life through the word of God (Allen et al., 2010). These cultural expressions within the context of the Black church became ways in which African Americans demonstrated a sense of loyalty to their culture.

Further, the Black church became a safe place to develop a community in which African Americans could internally organize themselves (Adksion-Bradley et al., 2005). During the many years African Americans were treated unjustly and were not recognized as United States citizens with the most basic civil rights, the Black church created a dependable place where individuals and their families could vote for and elect church officers and leaders within the context of their spiritual environment (Allen et al., 2010).

Black churches, therefore, provided a salubrious way for members to hold onto their dignity and spiritual pride. They gave African Americans helpful ways to cope, which were needed to survive the many years of turmoil brought about by inhumane forms of injustice during slavery and racism in this country. For many African Americans, the Black church became a primary location for social life and a place where they could encounter a source of spiritual strength as well as achieve distinction and status. The church's role, according to Adksion-Bradley et al. (2005), was especially important for African American men, who often were otherwise unable to assert themselves and assume male roles, especially in family relations as defined in American culture.

Contemporary Role of the Black Church in African American Culture

The important historical role the Black church played has endured to the present time, with religion continuing to be important in the lives of Black people (Frazier, Mintz, & Mobley, 2005). Research has shown that in the United States, rates of religious affiliation among

ethnicities are highest among African Americans (Graham & Roemer, 2012). The Black church today offers a haven and a home-like atmosphere for Blacks, an environment in which they are comfortable (Eyerman, 2002). According to Allen et al. (2010), no other institution in the United States can claim the level of loyalty and attention to African Americans as the institution of the Black church. The Black church continues to be a primary and salient resource that has met many of the needs of African Americans and their families in our communities. A study conducted by Bullock (2006) found that nearly 9 out of 10 African Americans viewed the Black church as having a positive influence on their lives.

African Americans perceive their churches to provide sustenance, strength, assistance, and moral guidelines for conduct as well as serving as a source of unity, a community gathering place, and a help in attaining social, economic, and educational goals, making the Black church a powerful force for many African Americans (Frazier et al., 2005). Functions of the Black church include the promotion of health and social well-being, education, and community development (Martin, Younge, & Smith, 2003). There are numerous community outreach efforts by the Black church in the form of formal church-based social support.

A survey of Black churches in the northern United States found more than 1,700 church-sponsored outreach programs (Graham & Roemer, 2012). These outreach programs included financial services, counseling for community members, basic assistance (including food, clothing, and shelter), parenting classes, youth programs, and health awareness. Black churches also provide informal church-based social support, which is social support that is exchanged among church members as opposed to more formal outreach efforts and events (Taylor, Chatters, & Levin, 2004). Such informal social support is considered valuable by the Black community (Graham & Roemer, 2012).

Today's Black church has a significant focus on addressing life conditions and the difficult circumstances that plague the African American community, being concerned with issues such as disenfranchisement, the multifaceted aspects of racial discrimination, and economic issues (Taylor & Chatters, 2010). A study by Graham and Roemer (2012) investigated whether church-based social support moderated the relation between experiences of racism and two types of anxiety symptoms: general anxiety and anxious arousal among a sample of 50 Black adults (52% identifying as females) who attended Black churches in the Boston, Massachusetts, area. Participants completed four scales, measuring: (a) general anxiety (stress) and anxious arousal, (b) perceptions of racist events over the past year and the lifetime, (c) general social support, and (d) church-based social support.

Analysis of Graham and Roemer's (2012) results by hierarchical regression showed that social support moderated the relationship between experienced racism and general anxiety symptoms. In particular, at low levels of church-based social support, there was a significant positive relationship between experienced racism and stress, but not at high levels of church-based social support. This relationship continued even when the researchers controlled for general social support. Graham and Roemer (2012) concluded that their results are in agreement with other research that has found that church-based social support is an important coping strategy that African Americans use to buffer the experience of racism and lessen its negative effects on mental health.

Given the many social support advantages provided by the Black church, African American pastors play a crucial spiritual, political, economic, and social role in the lives of their members and surrounding communities (Mattis et al., 2007; Young, Griffith & Williams, 2003).

Indeed, according to Battle (2006), there is often little distinction between the life of the Black church and the life of the Black community.

Mental Health Services and the African American Community

The Surgeon General (USDHHS, 2001) reported that the availability of mental health services for African Americans is generally through hospitals, community mental health centers, and local health departments. The numbers of African American professionals providing mental health services are exceedingly low. Black mental health professionals comprise 2% of psychiatrists and psychologists, and 4% of social workers.

Reduced Use of Mental Health Services by African Americans

People of color are less likely to seek formal mental health services for the following reasons: the cost of care, societal stigma, and a disjointed offering of available services and lack of trust (Parham, 2002; USDHHS, 2001). When they do seek care, they are not likely to find health care offered by professionals that look like them. Additionally, most White mental health professionals lack training and sensitivity to the issues faced by their clients. The African American community shares a great deal of mistrust of the mental health profession, based primarily on past misuse and abuse of People of Color in treatment and research endeavors (Neighbors, Musick, & Williams, 1998; Turner, Wieling, & Allen, 2004).

Definitions of mental health are often precise and on their face generally do not stigmatize any individual based upon gender, race, ethnicity, or creed; however, who defines the concept of mental health can be and has been problematic for People of Color. The presenting mental health concern may involve circumstances related to any of a number of life situations, such as poverty, illness or disease, homelessness, drug and alcohol addictions, or marital

conflicts. The definitions of mental health, illness, and problems, according to the Surgeon

General's report (USDHHS, 2001) are:

> [Mental health is] the successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental illness is all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and /or impaired functioning. Mental problems are signs and symptoms of insufficient intensity or duration to meet the criteria for mental disorder. (p. 7)

> According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*

([DSMIV], 1994), a mental disorder is defined as

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (p. xxxi)

> There tend to be higher diagnosed rates of mental illness in the African American

community than in the White community (USDHHS, 1999). Furthermore, Conner, K. O.,

Copeland, V. C., Grote, N. K., Rosen, D., Albert, S., McMurray, M. L., & Koeske, G. (2010)

reported that elderly African Americans experience more psychological distress than their White

counterparts "due to their exposure to and experiences with racism, discrimination, prejudice,

poverty, and violence" (p. 971). Indications also suggest that in comparison to their White

counterparts, there may be greater percentages for some particular mental disorders among

African Americans. For example, African Americans were found to be over-diagnosed with

schizophrenia (Williams, 1995). Conner et al. (2010) reported that while research suggests that

African American elders experience depression at about the same rate or possibly slightly less or

slightly more than White elders, the African American elders are not as likely as White elders to

seek mental health treatment for their depression. African American elders also have a greater

probability of not receiving an appropriate diagnosis, and they are less likely to receive evidence-based treatments for their depression.

One result of the reduced use by African Americans of counseling for mental health is evidenced by research showing that older African American adults are less likely than Whites to be prescribed antidepressants (Blazer et al., 2000). Wittink, M. N., Jin Hui, J., Lewis, L. M., & Barg, F. K. (2009), suggested that this population may doubt the biological nature of depression and may in fact be fearful of the possibility of becoming addicted to the medications used to treat depression.

Barriers to African Americans' Use of Professional Mental Health Services

There exist several kinds of barriers that may prevent Black people from seeking outside counseling. One such barrier is the financial cost of treatment and the lack of mental health insurance. Research shows that the use of various church leaders for mental/emotional health counseling is, in part, because fees are not associated with their services (Hill & Pargament, 2008). African Americans in one study believed the hourly rate for psychotherapy was excessive and viewed psychotherapy as a luxury rather than a necessity (Thompson et al., 2004). Due to lack of funds to pay for professional mental health treatment, their pastor tends to be the first support many African American people seek out for help (Allen et al., 2010). In many cases, the church may be the only free professional support system available (Allen et al., 2010).

Another barrier is the stigma associated with mental illness. This perceived negative stigma, along with feelings of shame and embarrassment associated with psychological problems, causes considerable reluctance to seek professional psychological help among African Americans (Snowden, 2001). Many Black people avoid formal mental health resources for fear of being considered mentally ill (Wallace et al., 2005) or a moral failure (Allen et al., 2010).

In a study by Williams and Justice (2010), 212 male African American undergraduate students were surveyed to determine their attitudes toward mental health counseling. Some of the students attended one of two historically Black colleges or universities, and others attended one of two predominantly White universities. All institutions of higher education were located in the state of Texas. The students were administered the Attitudes toward Seeking Professional Psychological Help Scale and a demographic questionnaire. The results of the study indicated that male African American college students at both historically Black colleges/universities and at predominantly White universities had a negative overall attitude toward seeking professional counseling. There was no significant difference in attitude between the Black students related to the type of institution they attended. The researchers reported that based on their answers to survey items, the students' negative attitudes toward professional counseling included concerns about the negative stigma associated with professional counseling and about counseling being a sign of weakness and a cause of embarrassment (Williams & Justice, 2010).

A third type of barrier may be reluctance among African Americans to seek mental health care services from a White mental health professional due to the residual effects of slavery and racism (Eyerman, 2002). The majority of mental health facilities are predominantly staffed by White people, and Black people may be reluctant to trust staff members with information pertaining to race issues. This prejudice leads to clouded or misconstrued expectations of the counseling process and White therapists in general (Constantine, 2007).

In a study conducted by Thompson et al. (2004), 201 African Americans were interviewed in focus groups to determine their beliefs about psychotherapy and psychotherapists, and about seeking or not seeking mental health treatment. A total of 201 participants (134 women and 66 men) were interviewed in 24 mixed-gender focus groups ranging from three to 12

members. Analysis of the focus group data showed that the participants believed that reasons for seeking therapy included serious mental illness such as schizophrenia and depression, major adverse life events or traumas, and grief and attempts to cope with life stressors.

Main barriers to seeking treatment disclosed by the participants in Thompson et al.'s (2004) study included stigma, lack of affordability, lack of knowledge, lack of trust, impersonal treatment, and lack of cultural sensitivity. Though participants believed that race should not be a factor in therapy, they still felt that many psychologists lacked cultural sensitivity when dealing with African American clients. The sample group mostly had negative feelings toward therapists, stating that they did not have the experience necessary to understand Black cultural beliefs of the particular needs of African Americans, with some of the participants describing psychotherapists as older white men who were not sensitive to their issues (Thompson et al., 2004). These results are in agreement with Wallace et al. (2005), who held that many African Americans distrust psychologists who are not actively involved in Black communities because they are perceived as being too far removed from the communities to truly understand their struggles.

There also exists a spiritual barrier between the White therapist and an African American client. White therapists may not share, respect, or acknowledge Black people's religious beliefs (Shumway & Waldo, 2011). Yarhouse (2003) suggested that counselors who fail to examine religious or spiritual issues may influence clients to assume those matters are not relevant for counseling and may exclude an important diversity issue. Research suggests that religious clients are more likely to trust a counselor who believes in God (Shumway & Waldo, 2011). Furthermore, devoutly religious clients prefer to work with counselors who share their same faith because that way the therapist can understand and will not try to undermine their beliefs (Shumway & Waldo, 2011).

The cultural competency level of counselors may also prevent some Black people from seeking counseling. Counseling is interactive; therefore, it is critically important to know how counselors' racial/cultural consciousness can affect Black people's attitude towards counseling. Counselors who are aware of themselves as cultural beings understand their own values and biases as well as have knowledge of their client's world views, understanding how those views may affect the therapeutic relationship (Want, Parham, Baker, & Sherman, 2004). The lack of cultural competence on behalf of the counselor can cause Black people to be more eager to end counseling services once started (Thompson et al., 2004).

A study by Constantine (2002) sampled 112 non-Caucasian college students who sought mental health services from their college counseling center and subsequently terminated counseling. The students were surveyed to determine their satisfaction with the counseling they had received. Of the 112 students, about 70% (78) were women. Participants self-identified as 46.4% (52) Black American, 25.9% (29) Latino, 22.3% (25) Asian American, 2.7% (3) American Indian, and 2.7% (3) biracial and ranged from first-year undergraduates to graduate students. A total of 37 counselors participated in the study, with 70.3% (26) being women. The racial/ethnic composition of the groups of counselors showed that over three-fourths were White (28, 75.7%). An additional 8.1% (3) were Black, 5.4% (2) were Asian, 5.4% (2) were Latinos or Latinas, and 5.4% (2) were biracial.

At the termination of counseling, students in the Constantine (2002) study completed an instrument to measure attitudes toward seeking professional mental health services, a counselor rating form, a cross-cultural counseling competency evaluation, and a counseling satisfaction questionnaire. Using hierarchical regression to analyze results of the instruments, the researchers found that attitudes toward counseling, perceived general counselor competence, and perceived

counselor multicultural competence all added significant variance to the students' counseling satisfaction. Constantine (2002) also found that perceptions of the multicultural competence of counselors mediated the relationship between perceptions of general counseling competence and satisfaction with counseling. In discussing results of the study, Constantine (2002) noted that the results suggested that multicultural training may be important for improving counselors' ability to effectively deal with a diversity of cultural populations by helping counselors close possible cultural differences between their clients and themselves. The researcher noted that this multicultural training may be especially important given the diverse cultural makeup of the United States population.

Noting that both Black and White elderly adults are less likely to seek out mental health treatment than younger adults, and that Black elders are less likely to engage in such treatment than White elders, Conner et al. (2010) examined barriers to treatment among depressed African-American elderly adults. The researchers held 37 interviews of African American elders (31 females and 6 males) living in Pennsylvania who reported mild to severe symptoms of depression on a patient health questionnaire. The semi-structured interviews were held in participants' homes and were audio-recorded and later transcribed.

Conner et al. (2010) analyzed the transcribed interviews using thematic analysis and found themes in three categories: beliefs about depression, barriers to seeking treatment, and cultural coping strategies. In regard to beliefs about depression, participants reported that in Black communities there is low tolerance for suffering from depression and it is not to be talked about openly. In addition, participants revealed that there is stigma associated with depression and fear of being treated worse for being depressed or seeking treatment. Participants also believed that the African American community is less knowledgeable about depression than

other communities. In regard to barriers to seeking treatment, participants mentioned stigma, lack of access to treatment, lack of confidence in or mistrust of treatment, lack of recognition of being depressed, and feeling too old for treatment.

Coping strategies of participants in the Conner et al. (2010) study included self-reliance, hiding depression from others, denying it to others and sometimes oneself, referring to it in non-stigmatizing ways, and using religious strategies such as reading the Bible and prayer. Conner et al. (2010) concluded that interactions between African Americans and the mental health system appear to result in negative attitudes about seeking treatment and exacerbate stigma about seeking treatment. This leads to using culturally accepted coping strategies that may be ineffective. The researchers recommended increased cultural competency among mental health practitioners, awareness of how African Americans elders may refer to and talk about mental health issues, and to possibly address issues of race and age with the client and what concerns he or she may have if the therapist is younger or of a different race.

Constantine (2007) noted that factors influencing the underutilization of mental health services by African Americans include service access barriers such as lack of transportation and inflexible work schedules, which make it difficult for African Americans to access the services (Constantine, 2007). In addition, there is a lack of knowledge about mental health among some African Americans (Constantine, 2007), which contributes to the underutilization of counseling by the African-American population. Such lack of knowledge may include the inability to recognize the symptoms of a mental illness, as reported by Conner et al. (2010). Even college-educated Black people are sometimes unable to understand the warning signs of depression or other mental illnesses (Thomas et al., 2004). It is a logical deduction that if a person in need of

mental health services does not realize there is a problem to begin with, then he or she will most likely not seek help.

The degree to which African Americans embracing Afrocentric cultural values may affect their psychological help-seeking attitudes has also been a subject of empirical research. Wallace and Constantine (2005) conducted a study of African American college students to determine any correlations between holding Africentric cultural values, psychological help-seeking attitudes, perceived stigma from counseling, and tendency to withhold personal information perceived as negative (self-concealment). Holding Africentric cultural values was defined by the researchers as adhering to "a worldview emphasizing communalism, unity, harmony, spirituality, and authenticity" (p. 369). Participants were 251 African American (147 female and 104 male) undergraduate and graduate students of a mainly White university in the U.S. Northeast. Participants were administered the Attitudes Toward Seeking Professional Psychological Help Scale–Short Form (ATSPPHS–S), the Africentrism Scale (AS), the Stigma Scale for Receiving Psychological Help (SSRPH), and the Self-Concealment Scale (SCS).

Results of Wallace and Constantine's (2005) study showed that women scored higher on the Africentrism scale than men and indicated more positive help-seeking attitudes than men. Separate multivariate multiple regression analyses were conducted for women and men. For female participants, analysis revealed that Africentrism was significantly positively associated with both stigma for psychological help and self-concealment at the $p < .001$ level. For men, Africentrism was significantly positively associated with stigma at the $p < .05$ level and with self-concealment at the $p < .01$ level. Africentrism was not significantly associated with attitude toward seeking professional help for either women or men. However, Wallace and Constantine (2005) noted that if the stigma associated with psychological help is high among African

Americans, this circumstance might lead individuals in need of psychological help to resist such help.

An additional factor that may constitute a barrier for African Americans to visit a White therapist is a lack of concordance with religious or spiritual concerns. White therapists may not share, respect, or acknowledge Black people's religious beliefs (Shumway & Waldo, 2011). Yarhouse (2003) suggested that counselors who fail to examine religious or spiritual issues may influence clients to assume those matters are not relevant for counseling and may exclude an important diversity issue. Research suggests that religious clients are more likely to trust a counselor who believes in God (Shumway & Waldo, 2011). Furthermore, devoutly religious clients prefer to work with counselors who share their same faith because that way the therapist can understand and will not try to undermine their beliefs (Shumway & Waldo, 2011).

Black Pastors as an Alternative to Mental Health Professionals

Researchers have found that Black pastors frequently engage in more counseling-related activities than pastors of other racial backgrounds (Young et al., 2003). It is understandable, when considering the historical adversities African Americans have encountered as well as the supportive nature of the Black church, why many congregants seek church leaders for counseling services as an alternative to traditional mental health professionals (Graham & Roemer, 2012; Mattis et al., 2007). In times of crisis, African Americans tend to look to their pastor for comfort, direction, and support (Aten et al., 2011). As a result, the Black church has historically been and continues to be a primary source of help and a gatekeeper in the delivery of community and mental health care services for many African Americans (Allen et al., 2010; Topping, Denney, & Bayne, 2010).

The underutilization of formal mental healthcare services by African Americans (Wallace & Constantine, 2005) and the tendency to instead go to their pastor for counseling may be partly attributed to traditions and values that emerged from the historical experiences of Africans and African Americans in the United States. The Afro-centric cultural belief is that family members, close friends, and trusted community members, such as church members and pastors, are to be the primary resources of assistance when they experience problems or concerns. These resources are usually exhausted before turning to formal mental health professionals (Constantine, Myers, Kindaichi & Moore, 2004). It has been well documented that Black people rely on an extended network of biological and non-biological kin for emotional and instrumental assistance (Pickett-Schenk, 2002). An important member of the kinship network includes the Black church. Statistically, African Americans use their religious beliefs and activities—such as prayer, church attendance, and fellowship with clergy and congregants—as coping mechanisms (Pickett-Schenk, 2002).

A focus-group study by Mattis et al. (2007) examined the ways in which African American adults use ministerial support, including the types of issue they do and do not take to their minister and what factors help determine whether they do or do not seek ministerial advice. The study included a total of 78 African American adults (39 of each gender) in 13 different focus groups. The focus groups were carried on by one main facilitator and one co-facilitator, with both being race- and gender-matched to the members of the group. Focus group discussions were audio-recorded and notes were taken. Results of the focus group discussions were analyzed by qualitative methods using two independent coders to determine themes in the discussions.

Mattis et al. (2007) found that the majority of members of the focus groups indicated that they went to ministers for help concerning issues of religious or spiritual guidance and

development. Such issues included clarification of scriptural passages, request for prayer or blessings, and christenings. The second most frequent reason for visiting ministers was for general or unspecified counseling about "life decisions" (p. 251) or advice on some unspecified matter(s). The third most frequent reason for seeking ministerial guidance was for romantic decisions such as marital or premarital counseling or relationship guidance. Other reasons for seeking ministerial counseling or advice included grief and bereavement issues, family problems or issues, health and hospitalization issues, reproductive issues, and financial or work-related issues.

Mattis et al. (2007) also found that a number of participants indicated that they never sought out their minister's advice for any issue at all or for particular specified issues such as family or marital problems, financial or work-related issues, or health and sickness issues. Several themes emerged that referred to reasons why participants did not seek out their minister's advice. These themes included the participant feeling that he or she had a personal relationship to God and therefore did not require the minister's advice, doubts about the minister's character or competence, uneasiness with turning to a minister, shame, availability of alternative support, unavailability of the minister, and lack of seriousness of the issue (Mattis et al., 2007).

In their discussion, Mattis et al. (2007) noted that the results of their study suggest that religious institutions and leaders play important roles in helping to meet the needs of African Americans in regard to a number of mental, physical, and relational health concerns. The researchers noted that especially in regard to health issues at times of sickness, ministerial advice was viewed by participants as helping them to interpret sickness in spiritual terms. Mattis et al. (2007) also noted that two minister factors participants reported as deterring them from seeking

ministerial support were perceived minister character, such as honesty and integrity, and perceived minister incompetence. The researchers reported that in regard to minister competence, participants considered whether the minister had received formal training in the area of concern, such as psychological counseling or financial counseling.

Because the Black Church is often one of the primary entry points for mental health care issues among African American people (Allen et al., 2010), Black pastors are sometimes called upon to counsel individuals with severe mental distress. This is in fact true of all clergy in the U.S. The National Institute of Mental Health (NIMH) found that clergy are as likely as mental health specialists to have a person with a *Diagnostic and Statistical Manual of Mental Disorders* diagnosis come to them for help. Clergy are seen for assistance with even the most severe forms of mental illness, including schizophrenia and bipolar disorder. Further highlighting the prominent role that ministers play in mental health, the U.S. Surgeon General's 2000 Report on Mental Health (USDHHS, 2001) found that one in six adults and one in five children annually obtain mental health services from a health care provider, the clergy, a social service agency, or a school. The public's frequent use of pastors is a function of the pastors' accessibility and the high trust that Americans place in them (Weaver, Flannelly, Larson, & Stapleton, 2002). Furthermore, it is not unusual for people to make use of their religion and spirituality to deal with the negative psychological effects of crises, often turning to their faith community for support and aid (Aten, Topping, Denney, & Hosey, 2011).

Because congregants often seek help for serious mental illnesses from their pastor rather than from mental health professionals (Milstein, Manierre & Yali, 2010), Black pastors often function as an alternative to mainstream health providers (Blank et al., 2002; Mattis et al., 2007). They tend to be highly accessible, shouldering a significant therapeutic responsibility for the

African American families in their church communities. Black pastors may also serve as gatekeepers for this underserved population and play a role in advising congregants to seek outside mental health care services (Adksion-Bradley et al., 2005).

As pastoral counselors, Black pastors may be more likely than mental health professionals to emphasize spiritual issues when counseling parishioners with mental health issues (Younce, 2011). Furthermore, when dealing with at least some mental health issues among congregants, Black pastors may be more likely to emphasize spiritual issues than White pastors (Payne, 2009). Viewing and dealing with congregants' psychological and emotional difficulties in terms of their spiritual aspects may set Black pastors aside from mental health practitioners and may be considered a mistake by some. However, there is evidence that taking religious or spiritual aspects of a mental problems into account may sometimes be beneficial. In the next section, literature concerned with the possible mental health benefits of religion and spirituality is reviewed.

Mental Health Benefits of Religion and Spirituality

Religion plays a large role in many American lives. As many as 95% of all American married couples and parents report a religious affiliation (Mahoney, Pargament, Tarakeshwar, & Swank, 2001). According to survey data, a substantial segment of the American population consider religion to be the most important influence in their life (Marks & Dollahite, 2011). Furthermore, according to the Surgeon General's report, 40% of individuals with a mental health problem sought out clergy as a primary aid and resource (USDHHS, 1999).

Mental Health Benefits of Religion and Spirituality for the Overall Population

There is evidence that religion and spirituality often have positive effects on Americans' lives. Hill and Pargament (2008) argue that there is evidence that religion and spirituality are

different from other psychological and social constructs inasmuch as they are "distinctive dimensions that add unique explanatory power to the prediction of physical and mental health" (p. 13). Indeed, research has found that religious activity has physical and mental health benefits for many. Studies have shown religious activity is associated with lower mortality rates (Morton, Lee, Haviland, & Fraser, 2004), improves psychosocial functioning (Hackney & Sanders, 2003; Krause, 2009), and reduces stress reactivity (Ano & Vasconcelles, 2005; McCullough & Willoughby, 2009; Seeman, Dubin, & Seeman, 2003).

These physical and mental health benefits of religious engagement accrue to both men and women, though the mechanisms may differ by gender (Maselko & Kubzansky, 2006; Maselko, Kubzansky, Kawachi, Seeman, & Berkman, 2007). Among women, for example, health may be linked with religious engagement (including both subjective religious experience and worship frequency) by the positive emotions it engenders (Maselko, Kubzansky, Kawachi, Staudenmayer, & Berkman, 2006); whereas among men, the effects of religious engagement on health may be explained by social support (Krause, Ellison, & Marcum, 2002).

Researchers have also found that religious commitment is associated with lower rates of mortality, suicide, drug and alcohol use, criminal behaviors, divorce, and depression. At the same time, higher rates of well-being and marital satisfaction have been found among those with a religious commitment (Russell & Yarhouse, 2006). Ways in which religious commitment may promote mental health include fellowship, worship, prayer, forgiveness, spiritual strengthening, protection against worldly pressures, helping individuals to avoid self-preoccupation, teaching to be unselfish, helping develop a sense of belonging, providing a sense of purpose, and providing assistance in coping with a variety of problems (Russell & Yarhouse, 2006). An examination of 100 studies on religion revealed that 80% reported positive correlations between religiousness

and greater well-being, life satisfaction, high morale, and other positive measure of well-being. Religious affiliation, activities, and belief have been shown to be consistently correlated with decreased levels of depression, suicide, anxiety, alcohol and drug use, and with increased levels of well-being (Russell & Yarhouse, 2006).

Spirituality, a somewhat different construct than religiosity, has also been shown to have health benefits. Helms and Cook (1999) asserted that a large aspect of our identity is comprised of our spirituality, and research suggests that spirituality provides benefits for physical and mental health by offering a way to cope with symptoms, frustrations, and difficulties, thereby serving a self-protective function (Bellamy, Jarrett, Mowbray, Peter Mowbray, & Holter, 2007). Defining spirituality presents challenges for researchers and practitioners. Some researchers describe religion as a component of spirituality (Kaye & Raghavan, 2002), while others exclude formal religious practices, focusing only on the personal and subjective experiences of the individual (Berry, 2005). Kaye and Raghavan (2002) described spirituality "as the central philosophy of life which guides people's conduct and is the core of individual existence that integrates and transcends the physical, emotional, intellectual, more-ethical, volitional, and social dimensions" (p. 231). Spirituality thus serves as a motivational element that guides people's daily interactions and experiences, particularly to help them make sense of pain and suffering (Kaye & Raghavan, 2002).

While many studies on the mental health effects of religious or spiritual behaviors show only positive correlations between such behaviors and mental health measures, the results of a study by Bellamy et al. (2007) showed both positive and negative associations between religious or spiritual behaviors and measures of mental health. Bellamy and associates (2007) conducted their study to determine the relevance of spirituality to individuals with mental illness and to

examine several possible correlates of religious or spiritual behaviors. The researchers collected data from 1,835 individuals with some form of mental illness who visited at least one of 62 consumer-centered services clubhouses and consumer-run drop-in centers in Michigan. Participants could choose to take a self-administered survey or to have an interviewer administer the survey. Participants were asked to report the duration of their mental illness and whether they had a problem with alcohol or drugs, and they responded to items asking about depressive and psychotic symptoms over the past 30 days. They also responded to items on global quality of life, sense of community, and state of hope scales. In regard to spirituality, they were asked whether spirituality was important to them. Participants could answer either "not at all or a little" or "A lot." If their answer was "a lot," they were then asked, in an open-ended question, to report what kinds of religious activities they participated in. Responses to this question were analyzed by qualitative methods and four categories of answers were determined: public spiritual activities, private spiritual activities, mutual support program activities, and nonspiritual activities. Data for all 1,835 participants were analyzed by descriptive statistics, and data for 1,491 were analyzed by binary logistic regression (344 participants had missing data, mostly from the question asking about duration of mental illness).

Results of Bellamy et al.'s (2007) study indicated that of the 1,835 participants, 320 (17.4%) were African American. Of 1,740 participants who reported how important spirituality was to them, 64.1% said "a lot." The logistic regression showed that importance of spirituality was positively associated with age, gender (percentage of women higher), having higher quality of life globally, sense of hope, and sense of community. At the same time, importance of spirituality was positively associated with depressive symptoms and psychotic symptoms. Bellamy et al. (2007) noted that the association between spirituality and symptoms of mental

illness was contrary to the findings of some research. The researchers also noted that the associations need not be seen as spirituality resulting in stronger symptoms of mental illness. Instead, the causality may work in the opposite direction, with the association being explained by the possibility that during times of stress or illness, spirituality may be called on by the individuals affected as a way of coping and providing hope for feeling better. In that case, an increase in symptoms of mental illness may result in greater spirituality. It is also notable that there was no significant difference between White and Black participants in the associations of spirituality and other variables.

The results of two other studies suggest that the mental health benefits of religiosity may depend on the particular types of religious coping methods used. A study by Pargament, Koenig, and Perez (2000) examined possible correlations between type of religious coping and measures of health and well-being, including current distress levels, religious changes such as growing closer to God, and stress-related growth. The study included a sample of 450 college students who had recently experienced significant stressful life events. Using hierarchical regression, Pargament et al. (2000) found that current emotional distress levels among the college students were significantly associated with higher scores on several forms of religious coping that were considered to be negative forms: Pleading for Direct Intercession, Punishing God Reappraisal, Reappraisal of God's powers, Spiritual Discontent, and Interpersonal Religious Discontent. More positive forms of religious coping such as religious helping and seeking support were positively correlated with better religious changes and stress-related growth.

In addition, a meta-analysis conducted by Ano and Vasconcelles (2005) of 49 studies found that overall the studies found that positive forms of religious coping were associated with positive psychological adjustment to stress and negative forms of religious coping were

associated with negative psychological adjustment to stress such as depression and anxiety. However, according to the meta-analysis, negative forms of religious coping were not inversely related to positive psychological adjustment such as self-image, life purpose, and spiritual growth. Ano and Vasconcelles (2005) noted the possible importance of mental health workers exploring clients' strategies for religious coping and determine to what extent the coping amounts to a resource or a hindrance in their coping with psychological/emotional difficulties.

Mental Health Benefits of Religion and Spirituality for African Americans

As evidenced by various measures, including worship frequency, subjective religiousness ratings, and religious coping, Blacks are more religious than Whites, with research suggesting that overall, they may experience more mental and physical health benefits from religiosity than their White counterparts (Taylor et al., 2004). The African American church has a specific social, cultural, and historical significance as the center of the African American community, and it is a place of communal togetherness and healing. Indeed, researchers have suggested that religious involvement and prayer may be an important aspect of the psychological well-being of African Americans (Taylor et al., 2004).

Religiosity and spirituality may promote African Americans' mental health in several ways. For instance, one important aspect of spirituality for many African Americans is what they consider to be the Word of God as expressed in the Bible, which may provide them comfort in times of suffering and sorrow. Indeed, the African American church can be viewed as a place of healing, where members lay hands on ill or hurting members and ministers preach in such a way that the people are moved to nod their heads and exclaim "Amen." The minister may become so engaging that the congregation feels a sense of connection with each other that is supportive of the nature of their experiences. According to Cook and Wiley (2000), the pastor's sermons help

strengthen the relationship of church members to the church and church members to God. In addition, by attempting to lead their congregation into psychological and spiritual health, pastors may use their Sunday sermons to challenge distorted thought processes among their listeners (Cook & Wiley, 2000).

Allen et al. (2010) described prayer as a cultural tool used by the Black church to foster the health and wellness of its members. Prayer is a large part of religious upbringing as many African Americans express their worries, problems, stress, and other negative experiences to God through prayer and believe they will find relief. For many spiritual African Americans, prayer is the first action taken toward solving a problem or dilemma (Cook & Wiley, 2000). Prayer is used in and out of church and may help provide relief of pain and suffering associated with life experiences.

Cultural tools other than prayer, such as altar call and music, are also viewed as coping mechanisms. In addition, the social support gained from religious and spiritual organizations may make life seem more satisfying than for their non-religious counterparts (Krouse, 2004). As cultural traditions that are passed from generation to generation, these tools promote spiritual wellness. Conversely, often unintended messages about mental illness can be integrated within the culture of the Black church. In some cases, having mental illnesses that might require more professional mental health care services outside the spiritual realm may be viewed as a sign of weakness in congregants or failure to have faith in God (Mattis et al., 2007). Indeed, there is a strong need to understand the various religious and spiritual factors that are deeply embedded in the culture of the African American community.

Older, in comparison to younger, African Americans may be especially receptive to the idea of spirituality as a way of coping with mental health problems. For instance, older African

Americans may interpret depression as a sign of weakened faith and seek spiritual relief as a means of treatment instead of counseling (Wittink et al., 2009). These individuals may view their spiritual practices as coping mechanisms for depression and better suited to them than professional mental health treatment because spiritual practices are more closely aligned with their values, morals, and beliefs. Spiritual relief for depression may include prayer, attending church, and religious activities, which may be their only treatment for depression (Wittink et al., 2009).

A study by Frazier, Mintz, and Mobley (2005) investigated the relationship between religious involvement and psychological well-being among elderly African Americans. The sample consisted of 86 African Americans (50 female and 36 male) ages 65 to 89, with a mean age of 68.7 years, from three senior centers and three public service organizations, all in New York City. The participants completed the Multidimensional Measure of Religious Involvement for African Americans (MMRI-AA) to measure three dimensions of religious involvement: formal public religious behaviors, informal private religious behaviors outside any religious institution, and subjective religiosity such as the importance of religion in one's life and attitude to religion. The participants also completed scales to measure six dimensions of psychological well-being: Self-Acceptance, Environmental Mastery, Purpose in Life, Positive Relations with Others, Personal Growth, and Autonomy. Results of the surveys were analyzed by bivariate correlational analysis to determine any correlations between scores on the MMRI-AA and the measures of psychological well-being (Frazier et al., 2005).

Results of Frazier et al.'s (2005) investigation showed significant correlations at the $p < .05$ and $p < .01$ levels for the three dimensions of religious involvement and all dimensions of psychological health except for autonomy. In particular, both formal public religious behaviors

and subjective religiosity were significantly associated with all dimensions of psychological well-being except Autonomy, and informal religious behavior was significantly associated with all dimensions of psychological well-being except Autonomy and Environmental Mastery. After conducting a canonical analysis to determine which particular aspects of religious involvement were most strongly associated with which aspects of psychological well-being, the researchers concluded that their results indicated that religious behaviors among elderly African Americans are positively associated with their psychological well-being. Frazier et al. (2005) recommended that counselors working with elderly African American clients assess the status of their religious involvement and take this into account. For example, counselors could encourage elderly African American clients to determine whether increasing religious behaviors might alleviate distress.

Lack of Including Religion and Spirituality in Psychological Treatment

Religious and spiritual issues are salient for many clients who seek counseling outside the church (Crook-Lyon et al., 2012). Researchers have shown that highly religious clients desire therapy that respects as well as integrates their religious beliefs (Worthington & Sandage, 2001). Unfortunately, in the past, the mental health field has been reticent to include religion and spirituality in the treatment process (Boyd-Franklin, 2003; Parham, 2002). A study conducted in 2002 showed 82% of counseling psychology training directors reported that religious and spiritual issues were not regularly discussed as issues of diversity or considered as important as other kinds of diversity in their programs (Schulte, Skinner & Claiborn, 2002). As a result, training directed toward therapists' understanding of and sensitivity to clients' religious and spiritual worldviews is unsystematic, limited, and often absent.

According to Milstein (2003), prevention, collaboration, and referral efforts between the church and the mental health field are crucial to help persons with mental disorders and their

families. There are several notable aspects of African American spirituality that may be significant to take into consideration in the counseling process. Cook and Wiley (2000) suggested that the client's spirituality should be discussed and respected. Both negative and positive experiences of spirituality should be assessed as part of the counseling process in addition to both the personal and social aspects. In assessing the personal aspects of spirituality, Cook and Wiley (2000) also noted that it is important to consider "who God is in their life, how they experience God apart from the church, how they communicate with God, and ways they draw spiritual strength from God" (p. 388). Assessment of the social aspects of spirituality should include determining how involved clients are in their church, family church involvement, and the involvement of significant others. It is also important to evaluate the spiritual tools that have been helpful in the past for the client, as they can become building blocks in the therapeutic process (Cook & Wiley, 2000).

Many African Americans with strong religious convictions express that they are more trusting of an African American counselor because they believe the counselor can identify with their African heritage and spirituality (Cook & Wiley, 2000). Regardless of a counselors' race, it is important for the counselor to recognize and validate clients' spiritual beliefs and to be honest about their own spirituality and traditions to further build a trusting therapeutic relationship (Cook & Wiley, 2000). Because African Americans have reported that their personal information is too private to share and that the right to be given that information must be earned, it is recommended that an African American client not be asked for their history before establishing rapport. Counselors must also be cautious in recommending psychiatric consultation. In some cases, the church preaches that the use of psychiatric medication is evidence of one having doubts about God's power to heal. In the case of depression, African Americans may feel that

taking medication means their faith is weak and therefore refuse to comply (Cook & Wiley, 2000).

Black Pastors' Competence in Dealing with Mental Health Conditions

This study seeks to explore the counseling competence of Black pastors, making the concept of competence central to the study. Over time, different commentators have provided various definitions of competence. It is thus fitting to define the concept.

Competence Defined

According to the World Health Organization (WHO), competence is "sufficient knowledge, psychomotor, communication and decision-making skills and attitudes to enable the performance of actions and specific tasks to a defined level of proficiency" (WHO, 2011, p. vi). The key words in this definition are "knowledge," "attitude," and "skills," which are all important components of competence. Knowledge "enables an individual to confidently understand a specific subject, with the ability to use it for a specific purpose" (WHO, 2011, p. vi). Attitude is "a person's view (values and beliefs) about things, a process or person that often leads to positive or negative behaviors (WHO, 2011, p. vi). Skills can be defined as "the ability learned through education, training, and/or experience, to perform specific actions or tasks to a specified level of measurable performance" (WHO, 2011, p. vi). Furthermore, competence is not only the knowledge, attitude, and skills that allow an individual to perform some task properly; it also entails understanding one's limit and making referrals when appropriate (WHO, 2011).

WHO (2011) indicated that an individual's performance must meet certain criteria before he/she is considered competent. The Dreyfus model, developed in the 1980s, is a model of professional expertise that describes an individual's progress in skill development up to and beyond competence (Dreyfus, 2004; Pena, 2010). The Dreyfus model is composed of five stages:

novice, advanced beginner, competent, proficient, and expert. In the novice stage, individuals are only concerned with following the rules, focusing solely on completing the task, which is normally done without question. Advanced beginners obtain a better understanding of what they are doing, yet there is a limited understanding of the big picture. Competence develops only after considerable experience and practice. Individuals at this stage are more likely to provide their own perspective and make informed decisions. Proficiency is shown in individuals who use pattern-recognition in identifying a problem and making decisions. Lastly, expertise is characterized by a fluid performance that happens unconsciously, automatically, and no longer depends on explicit knowledge (Dreyfus, 2004; Pena, 2010). For this stage, whatever the goal, due to the practitioner's "vast repertoire of situational discriminations, he or she also sees immediately how to achieve this goal" (Dreyfus, 2004, pp. 179-180).

Based on the Dreyfus (2004) model, counseling competence is the third stage of expertise development in counseling and only comes after considerable experience in actual counseling practice. According to WHO (2011), reaching this stage requires obtaining a certain level of knowledge, skills, and attitude. It can also be added that competence for counselors includes having cultural competence in dealing with individuals who come to them for counseling. In the case of Black pastors who counsel Black parishioners, cultural competency is presumed. But the question remains of what degree of counseling competence Black pastors have other than cultural competence.

Black Pastors' Knowledge of and Attitudes toward Mental Conditions

One of the key aspects of developing competence in dealing with mental health issues is knowledge of mental conditions and how to address them that can be used in counseling individuals appropriately and effectively (WHO, 2011). Evidence suggests that Black pastors

vary in their knowledge of mental health issues. Several studies have illustrated the lack of educational training in counseling received by pastors in assisting individuals who are experiencing basic problems of daily life circumstances. Certain daily life circumstances that exist may be completely unfamiliar to pastors due to their lack of training to identify psychopathology and symptoms of severe mental illness (Thompson et al., 2004).

African American pastor participants from a study by Aten et al. (2011) reported that they felt overwhelmed by the mental health problems that their congregation and community members were bringing to them for help. Previous research suggests that Black pastors may sometimes misinterpret the severity of psychotic symptoms. For example, in contrast to professional mental health counselors, Black pastors are less likely to be familiar with suicide ideations (Thompson et al., 2004).

According to Allen et al. (2010), well-educated African American pastors are better informed regarding mental health care issues and the services available from professionals and public agencies. Well-educated Black pastors tend to be more confident in their understanding of mental health issues and deal more appropriately than those who are less educated. Allen et al. (2010) also suggested that well-educated Black pastors tend to be aware of the kinds of concerns that their congregants are uncomfortable coming to them for. However, according to a study by Thompson et al. (2004), despite the sense that therapy was required to address certain issues, even educated Black pastors reported a lack of sufficient knowledge of the signs and symptoms of mental illness, and participants had difficulty discerning when a situation required professional services.

A second key aspect of developing competence in dealing with mental health issues is *attitude* toward mental conditions (WHO, 2011). In order to understand Black pastors' attitudes

toward counseling, it is important to realize that since Black pastors are charged with the pastoral care of a congregation, the type of counseling they perform is pastoral counseling. Pastoral counseling generally has a dual aim, which is to work toward two goals: the counselee's emotional and psychological well-being and the counselee's spiritual well-being (Howe, 1981; Pattison, 1995). Black pastors must attempt to balance and integrate the two aims of pastoral counseling, with the pastors serving as both spiritual advisors and mental health counselors (Adksion-Bradley et al., 2005). This dual counseling aim of Black pastors may affect their attitude toward and conceptualization of mental conditions. Because of the unique nature of pastoral counseling, Christian clergy in general may often have different attitudes toward counseling than mental health professionals. Furthermore, there is evidence that Black pastors balance and integrate the two objectives of pastoral counseling differently from White pastors (Payne, 2009).

Due to the paucity of research, literature on the conceptualization of Black pastors concerning mental health and illness relies more on assumption than valid documentation (Stansbury & Schumacher, 2008). However, a few studies have been conducted suggesting that religious and ministerial training may cause pastors to construe mental or emotional issues in religious terms or interpret clinical symptoms as sign of religious conflict (Kramer et al., 2007; Snowden, 2001; Stansbury & Schumacher, 2008). Evidence about Black pastors' attitude toward mental problems and approach to counseling is provided by research that has focused on their attitudes toward depression, one of the most prevalent mental health issues for African Americans (Payne, 2008). According to results from the National Survey of American Life, the majority of depressed African-Americans forego seeking assistance for their condition from any source. Those who do seek out help for depression usually do so from non-mental-health-care

professionals, including religious or spiritual advisors and social workers, more often than from professionals in mental health care (Payne, 2008; Williams et al. 2007).

One study providing evidence about African American pastors' perceptions of mental health issues among their parishioners was conducted by Payne (2009) to determine whether there were differences between Black pastors and White pastors in their conceptualization of depression. Payne developed a 45-item questionnaire exploring the definition and etiology of depression that was intended for clergy. The researcher mailed and e-mailed the questionnaire to a sample of Protestant pastors and ministers in California. A total of 204 usable responses were received, with 51 (25%) being from Black clergy, 133 (65%) being from White clergy, and 20 (10%) being from clergy with some other racial designation.

The results of Payne's (2009) study showed significant differences between Black clergy and White clergy in their conceptualization of depression. Caucasian pastors were in greater agreement with the statement that depression is a biological mood disorder than African American pastors. In addition, African American pastors were significantly more likely to agree with the statement that "Depression is hopelessness that happens when one does not trust God." In addition, Payne (2009) found some significant differences between mainline Protestant pastors on the one hand and Pentecostal and non-denominational pastors on the other.

For instance, in response to the statement "Depression is due to a lack of faith in God," Pentecostal and non-denominational pastors were significantly more likely to affirm the statement than were mainline Protestant pastors. Payne (2009) concluded that her study suggested that race influences how pastors define depression, with African American pastors, in comparison to White pastors, being more open to defining depression in terms of a spiritual meaning and less open to defining depression in biological terms. In regard to differences in

survey responses associated with religious affiliation, Payne (2009) noted that African American pastors sampled were more likely than White pastors to be affiliated with Pentecostal or non-denominational churches.

The study by Payne (2009) partially corroborated the results of a 2008 study by the same researcher about the attitudes of some African American clergy. In the Payne (2008) study, a qualitative analysis was done on the 90-minute sermons of 10 African American Pentecostal preachers. Qualitative analysis of the sermons showed that the preachers discussed depression in their sermons using a multiplicity of terms to refer to depression. It was determined that the preachers discussed situational depression, but it was unclear from the sermons to what extent they referred to clinical depression. Generally, the pastors spoke of depression as being a weakness, and psychiatrists and psychotropic medicines were not referred to favorably. Taking medications for depression was referred to as being embarrassing and to be hidden from others. Reliance on the church family and on Jesus was stressed by the African American preachers, while depending on mental health systems outside the church were de-emphasized (Payne, 2008).

Kramer et al. (2007) also examined the perceptions of pastors regarding depression. The researchers conducted two focus groups, one consisting of seven pastors of African American churches and the other consisting of five pastors of predominantly Caucasian churches. Focus groups lasted for about two hours, with the conversation audio-recorded then transcribed and accuracy-checked. Data analysis was by ethnographic software.

Results of the Kramer et al. (2007) study showed that most of the pastors viewed counseling individuals with depression as one of the main mental health challenges they face. The pastors affirmed several non-exclusive beliefs about the etiology of depression, including

psychological, biological, spiritual, and cultural or social explanatory models. The findings

illustrated that pastors reported a filtering process in which they attempted to distinguish between

individual incidents that may be categorized as a mental health crisis (which may include

potential violence, suicidal ideation, or psychosis), a life crisis that might result from some

tragedy, a spiritual crisis such as a disruption in faith, or a social crisis that might result from a

condition such as homelessness or unemployment. It was noted that pastors also evaluated their

own ability to provide adequate assistance. Only one of the 12 ministers affirmed sufficient

familiarity with criteria for diagnosis to be able to determine whether a person had major

depression.

Kramer et al. (2007) also found differences between the African American ministers and

the Caucasian ministers. In particular, the African American ministers referred more often to the

stigma of mental illness and mistrust of mental health professionals in Black communities. The

African American ministers also were more likely to refer to racial health disparities, the lack of

access to mental health resources, disparities in the quality of mental health resources in Black

communities, and socio-cultural influences as a cause of depression among African Americans.

Kramer et al. (2007) noted that the African American ministers expressed concern and frustration

about the challenges of referring persons in their congregation or community to mental health

care that is safe, effective, and affordable.

Findings are mixed in regard to the attitudes of African American pastors toward

professional mental health providers. The results of a study by Allen, Davey, and Davey (2010)

suggested that attitude toward recommending that a parishioner seek outside mental health

services may differ among levels of leadership in large African American churches. Allen et al.

(2010) conducted a cross-sectional survey of three levels of leadership in an African American

mega-church to determine church leaders' views about non-church mental health services. The final sample included 22 associate pastors or ministers, 34 deacons or deaconesses, and 56 congregation caregivers or deacon aides, all African American. Participants were administered the National Survey of American Life: Coping with Stress in the Twenty-first Century and four other questions to examine views on seeking outside help for mental health issues among the different levels of the church leadership. Analysis of the data showed that the closer the church leader participants were to the senior pastor of the church, the more favorable were the views of the participant about recommending that a congregant seek help from an outside mental health service.

The results of a study by Aten, Topping, Denney, and Bayne (2010) suggest that the attitudes of African American pastors are often positive about professional mental health providers. The researchers interviewed 41 African American pastors in south Mississippi, finding that the pastors were largely amenable to cooperating with mental health professionals in dealing with minority mental health issues after Hurricane Katrina. The researchers reported that most of the pastors were interested in collaborations "to (a) develop educational and outreach opportunities, (b) lead assessment procedures, (c) offer consultation activities, (d) provide clinically focused services, and (e) utilize spiritual resources and support" (p. 167).

Avent (2013) conducted a qualitative study in which she interviewed eight Black pastors to determine (a) the frequency they encountered mental health issues in their congregation, (b) how they responded to such issues, (c) factors that influenced their referrals to non-church mental health services, (d) how they perceived mental health delivery in their community, (e) to what degree they recognized spiritual, psychological, biological, and social coping methods, and (f) whether they distinguished adaptive from maladaptive religious coping. Avent found that

African Americans frequently seek their pastor's help regarding mental health issues and that the pastors attributed anxiety and depression among their parishioners to social and spiritual causes. For the most part, the pastors endorsed coping strategies that were spiritual, social, and integrative. The researcher also concluded that the pastors appeared to differentiate between adaptive and maladaptive religious coping.

Avent (2013) did not investigate the pastors' degree of knowledge, training, or competence in regard to mental health counseling of parishioners. However, the fact that only one of the eight pastors mentioned biological factors as potentially singular causes of mental distress suggests a lack in most of the pastors' knowledge about current scientific views about relationships between biological factors and mental illness. Furthermore, lack of knowledge about or distrust of psychological coping methods among the pastors was suggested by the finding that only two of the pastors endorsed psychological approaches to mental illness as an independent coping method. For the most part, psychological and biological coping methods were endorsed by the pastors only in conjunction with other coping methods, primarily spiritual methods.

Further insight into Avent's (2013) findings were supplied by Avent, Cashwell, and Brown-Jeffy (2015). The researchers reported interviewing eight African American Protestant senior pastors to determine their views on dealing with parishioners with mental health issues, coping strategies, and counseling services. Avent et al. (2015) found that all eight pastors spoke positively about local mental health care providers and about providers with whom they were personally acquainted. Pastors who spoke about referring parishioners outside the church appeared to prefer Christian counselors. While some interviewed pastors spoke of negative experiences with mental health care providers, more often they spoke about positive experiences.

It should be noted that the present study is in some ways similar to Avent's (2013) and Avent et al.'s (2015) studies, as it involved interviewing a sample of Black pastors to learn their activities and perceptions regarding counseling their parishioners with mental health issues. However, the present study differed substantially from the other two studies in the research questions being addressed. Most of Avent's (2013) and Avent et al.'s (2015) research questions were relatively more targeted than those that guided the present study. In both cases, the researchers attempted to learn, among other things, what specific factors influenced Black pastors' referrals to mental health services; how the pastors perceived mental health delivery in their community; and to what degree they recognized spiritual, psychological, biological, and social coping methods.

The research questions guiding the present study were comparatively broader and more open, simply asking Black pastors about their experiences, practices, training, and self-described competence in dealing with mental health issues and about their attitudes toward mental health treatment. The interview questions that were asked of the Black pastors were open as well, allowing the pastors to talk freely about the issues of interest without being guided toward answering more specific questions. This openness was intended to encourage responses that might provide new insights into how Black pastors experience, perceive, and address mental health issues among their parishioners. Both kinds of qualitative research, studies guided by more specific research questions, as Avent's (2013) and Avent et al.'s (2015) studies were, and research guided by more general and open research questions as the present study was, have value and are important to pursue.

Overall, in regard to the *knowledge* aspect of competence, the research reviewed in this section suggests that the education of African American pastors in mental health issues may

often be inadequate for preparing them to properly assess and address mental illness that they may encounter among parishioners who come to them for counseling. In regard to the *attitude* aspect of competence, the studies reviewed in this section suggest that African American pastors may often differ from White pastors in regard to their attitudes toward and perceptions about mental conditions and about treatment by non-religious mental health services. Furthermore, attitudes toward and perceptions about mental health and mental health services may differ among African American pastors depending on variables including their particular religious persuasion and to what degree they view a parishioner's mental health issue as being a spiritual issue.

The research on Black pastors' knowledge and attitude has a bearing on the final aspect of competence, which is *skill*. WHO (2011) defined skill as an ability gained by way of education, training, or experience that enables one to perform to a certain level of performance. However, if education and training in mental health issues among some Black pastors is deficient, skill in competently assessing and dealing with mental conditions may be very difficult for those pastors to develop. What may make counseling skill development even more difficult for some Black pastors is their having a negative attitude toward biological models of mental illness and toward referral of parishioners to professional mental health services. Notably, the WHO (2011) document also maintains that one's achieving competence includes being aware of one's limits and making referrals to others who are better able to deal with a problem. To the extent that Black pastors are limited in their education and training about mental health and illness, they may be unaware of their limits in assessing mental illness and may lack understanding of when to make a referral. To the extent they are limited in these ways, their competence may be limited.

Summary and Conclusion

This review of literature focused on several issues that are relevant to the present study. In the first main section, the theoretical framework of the study was explained. This framework was pastoral counseling, which is distinguished from counseling that is typically done by mental health professionals by having two aims: the psychological/emotional health of the counselee and the spiritual well-being of the counselee. The second main section of the review consisted of a discussion of the history and contemporary role of the Black church in the United States. This discussion included information about the central role of the Black church in African American communities.

The third main section of the chapter reviewed literature related to mental health services and the Black community. The degree of psychological distress among African Americans was documented along with the substantial distrust among African Americans of mental health services. A number of barriers to the use of professional mental health services that are faced by African Americans were identified and discussed. In the fourth main section of the chapter, literature related to Black pastors serving as an alternative to mental health professionals among the African American community was reviewed.

In the chapter's fifth main section, the focus was on literature related to the mental health benefits of religion and spirituality. Based on that review, it can be seen that a number of studies have found positive mental health benefits of religion and spirituality. These benefits accrue to both the general population and to African Americans, especially to older African Americans. The section closed with a discussion of the lack of attention to religion and spirituality in the mental health field.

The sixth main section of the review of literature focused on the issue of the competence of Black pastors in dealing with mental health conditions. The section began with a definition of "competence." Literature related to two aspects of Black pastors' competence in dealing with mental health conditions—knowledge and attitude—was then reviewed. At the end of the section, the third aspect of Black pastors' competence in dealing with mental health conditions, skill, was discussed in relation to studies concerned with their mental health education and their attitude toward mental conditions and professional mental health services.

Overall, this review of literature makes clear that Black pastors fill an important role as counselors in African American communities. The fact that they are pastoral counselors with two objectives to their counseling is very relevant to their work as counselors, because it implies that they must attempt to balance and integrate the two objectives of seeking a counselee's psychological and emotional health and his or her spiritual health. The review also makes clear that much more research is needed on the counseling roles of Black pastors. None of the studies reviewed provided an in-depth focus on Black pastors' counseling experiences, practices, attitudes, and training. In addition, none of the studies examined the self-evaluations of Black pastors in regard to their competence. The phenomenological study reported in this dissertation focused on these key aspects of Black pastors' counseling efforts by conducting semi-structured interviews of a sample of 12 Black pastors and qualitatively analyzing their responses. The study provides needed first-hand information about how Black pastors assess and address mental health conditions within their congregations, the extent of their mental health education and training, and how they evaluate their own competence as counselors.

CHAPTER III

METHODOLOGY AND AXIOLOGY

Introduction

Chapter III explains the study's research methodology. The chapter is divided into five main sections following this introduction. The first section reiterates the purpose of the study, while the second section restates the five research questions that guided the study. The third section explains the epistemological basis for using the qualitative phenomenological method, and the theoretical framework for the study, which is pastoral counseling.

The fourth main section of the chapter focuses on the study's research design, including the rationale and appropriateness of the qualitative phenomenological approach, and the reliability and validity in the sense of the trustworthiness of the study. The fifth section explains the research method and process, including selection of the sample and the data collection and analysis methods. The section also reports on axiological considerations.

Purpose of the Study

The study purpose was to investigate the practices and competency of African American pastors in dealing with their parishioners' mental health issues by interviewing a sample of those pastors. The study was phenomenological in nature, which is to say that its focus was to solicit and analyze informants' descriptions of phenomena in order to provide an overall description of the informants' experiences (Creswell, 2014). In the proposed study, the key phenomena were the experience and practices of African American pastors in the state of Texas.

The researcher interviewed 12 pastors to ask about their experiences and practices in dealing with parishioners who come to them with mental health issues and about their self-described competence in counseling parishioners. They were also asked to describe their training

for and attitudes toward mental health treatment. The responses of the pastors were audio recorded, transcribed, and analyzed by qualitative methods to determine patterns and themes in their responses and to construct an overall description of the practices and competence of the pastors based on the identified patterns and themes.

Research Questions

The study had five research questions.

Research Question 1: What are the experiences of African American pastors in counseling parishioners with mental health issues?

Research Question 2: What are the practices of African American pastors in counseling parishioners with mental health issues?

Research Question 3: What are the attitudes of African American pastors toward mental health treatment?

Research Question 4: What training do African American pastors have for dealing with mental health and illness issues among their parishioners?

Research Question 5: How competent do African American pastors feel they are for dealing with mental health and illness issues among their parishioners?

Theoretical and Methodological Framework

This section of the chapter explains the rationale for the study's qualitative approach. The particular approach and its epistemological basis are first described. The theoretical perspective that was taken in the research is then identified and discussed.

Epistemology

Rossman and Rallis (1998) described three approaches to qualitative research: case studies, ethnology, and phenomenological studies. After reviewing these approaches,

phenomenological in-depth interviewing was chosen as the most appropriate qualitative

methodology for the study as it involves exploring key informants' first-person reports of their

experiences, perceptions, and attitudes in regard to some phenomenon or phenomena. In the case

of the present study, the key informants were Black pastors, who were asked to report their lived

experiences, perceptions, and attitudes in regard to their engagement in mental health counseling.

Phenomenological qualitative inquiry has its roots in phenomenological philosophy,

which was introduced and developed by Husserl in the late 19th century (Davidsen, 2013; Kafle,

2011). Husserl was interested in the study of conscious experience. He held that we should not

define our experience of the world through preconceived theories but rather let our experience of

the world determine our theories (Davidsen, 2013). He wanted to learn how phenomena appear

to consciousness and how consciousness constitutes the phenomena (Davidsen, 2013). Husserl's

philosophical view is reflected in the phenomenological research method by the fact that the

method looks for the meaning or essence of some human phenomenon by inquiring about the

experiences of people involved in the phenomenon. In the case of the present research, the

phenomena at issue were African American pastors' behavior and attitudes in regard to mental

health counseling. The phenomenological research method assumes that the best way of learning

about these phenomena is from understanding the experiences of the pastors' themselves.

Theoretical Perspective

The theoretical framework for the study was *pastoral counseling,* which consists of

activities of Christian ministers that are dedicated to counseling their parishioners. Black pastors

engage in pastoral counseling as a main aspect of their responsibility to provide pastoral care to

their congregation. In regard to how pastoral counseling is an intrinsic part of pastoral care,

Adams (1975, p. 172) maintained:

> Pastoral counseling is special, but not a separate area of pastoral activity; indeed, biblically it is close to the heart of shepherding. It involves the extension of help to the wandering, torn, defeated, dispirited sheep who need the restoring mentioned in Psalm 23:3 ('He restoreth my soul').

The unique nature of pastoral counseling, in comparison to other kinds of counseling, can be seen by understanding that pastoral care comprises activities undertaken by ministers that have the objective of fostering the well-being of individuals and communities, but that also have the ultimate aim to "increase love between people and between people and God" (Pattison, 1995, p. 423). Pastoral counseling, as an aspect of pastoral care, also has the aim of fostering individuals' well-being within the larger spiritual context of promoting Christian values. This dual purpose of pastoral counseling distinguishes it from counseling within a secular context.

The unique nature of pastoral counseling can also be seen by understanding how it differs from the pastor's other pastoral care responsibilities. This difference can be elucidated in terms of the main functions of pastoral care, which consist of ministers' attempts to sustain, nurture, guide, reconcile, and heal individuals who are considered to be under the spiritual care of the ministry (Pattison, 2005). These primary functions may be carried out through various public means such as sermons, talks, communions, and educational activities, or through parishioners gathering together for mutual prayer, hymn singing, or communing with one another. In some cases, however, the minister may be called upon to privately counsel a congregant who may need support, guidance, or psychological/emotional or spiritual healing.

Concerns brought to a pastor for private counseling may span a wide range. At any given time, a congregation may include individuals who are having one or more of a variety of issues or even crises in their lives that are causing them emotional distress and for which they require some form of healing. These may range from needing advice on how to best deal with a troublesome neighbor or coworker, to spiritual questions and doubts, to serious emotional or

psychological distress that is interfering with the day-to-day life of the parishioner. Possible issues include relationship problems, addictions, depression, anxiety, alienation, and other psychiatric problems (Younce, 2011). As a result, a pastor may be called upon to provide counseling directed toward relieving the individual's distress and helping him or her to move forward with hope. The practice of pastoral counseling as an aspect of pastoral care is thus integral to the spiritual and practical responsibilities of pastors of Christian churches, including pastors in the Black Church.

There are several specific counseling theories that pastors may follow in providing pastoral counseling; however, in this study, the theory of pastoral counseling does not refer to any particular counseling theory but rather to the overall theory of pastoral counseling. This overall theory holds that pastoral counseling has two objectives: (a) the counselee's emotional/psychological well-being and (b) his or her spiritual well-being in a Christian context (Howe, 1981; Pattison, 1995). Younce (2011) comments on the dual objectives of pastoral counseling by noting that the objective of pastoral counseling is holistic healing, which includes psychological, theological, and spiritual aspects. Therefore, according to the theory of pastoral counseling, the dual objectives and holistic nature of pastoral counseling makes it different from non-pastoral forms of counseling.

The theory of pastoral counseling formed the framework of this study in two main ways. First, the theory helps define the objective of the counseling relationship between a pastor and a parishioner. This objective is holistic healing, which includes both psychological and spiritual aspects (Younce, 2011). Second, because the counseling aim is holistic healing, the theory of pastoral counseling implies that pastoral counselors need skills in more than one discipline. One such discipline is counseling psychology, since the pastoral counselor must have skills that

enable him or her to enter into a psychological treatment relationship with the counselee. To gain this competence, the pastoral counselor may consider education in psychology and psychological treatment. Another discipline needed by pastoral counselors is the ability to take a theological perspective while counseling parishioners. In particular, pastoral counselors should be well informed about theological systems and historical theology, and should be knowledgeable about the Bible and the Christian tradition (Younce, 2011). The pastoral counselor also needs the ability to combine these skills in counseling psychology and theological perspectives by understanding the spiritual life of the counselee and how the counselee's problems are related to his or her spiritual development. Thus, the needed skills of the competent pastoral counselor go beyond those of other mental health therapists.

Research Design

The rationale for choosing the qualitative phenomenological approach is further explained in this section. Assumptions of the research design are identified, and the appropriateness of the approach is addressed. Reliability and validity considerations are also discussed.

Assumptions and Rationale for the Qualitative Phenomenological Approach

A qualitative research methodology was chosen for the study because qualitative methods, unlike quantitative methods, are not constrained to gathering and analyzing data in numerical form. Reductions to only numerical data may not be able to capture more than one facet of multi-faceted phenomena. In contrast, use of qualitative methods enables phenomena to be examined from multiple perspectives (Runciman, 2002). This makes qualitative methodology especially useful for investigating complex human activities from various perspectives

(Runciman, 2002. Furthermore, qualitative methodology is especially valuable for guiding exploratory studies where the relevant variables are not well understood.

The particular qualitative methodology for this study was the phenomenological method. An assumption of the phenomenological method is that some phenomena are best understood by learning about the experiences of individuals who are involved in the phenomena. The method of in-depth interviewing was used to investigate African American pastors' experiences in counseling parishioners on mental health issues. The foundation of in-depth interviewing is "interest in understanding the experience of other people and the meaning they make of that experience" (Seidman, 1998, p. 3). Asking the pastors questions relevant to the study's research questions enabled them to explain, in their own words, their experiences and practices in counseling parishioners on mental health issues. By analyzing and comparing their responses to the interview questions, patterns in the pastors' responses that suggested similar practices and attitudes were identified. Out of such patterns and similarities, an interpretation of the counseling activities of the pastors was able to be developed and the research questions answered.

The Appropriateness of the Qualitative Phenomenological Approach

Complex activities that Runciman (2002) holds are an appropriate subject for qualitative research were deemed to include the activities of Black pastors as they counsel parishioners with mental health issues, where a number of relevant factors are poorly understood. These factors included the pastors' training in mental health, their attitude toward professional mental health services, how religious concerns affect their counseling, and their overall self-described competence in mental health counseling. Qualitative methodology was also appropriate for investigating the counseling activities of African American pastors because it could help us better understand these important activities from more than one perspective.

The goal of phenomenological research, to "seek to understand the lived experience of a small number of people" (Rossman & Rallis, p. 68), describes the primary goal of the present study, which was to capture and understand the experiences and meanings of Black pastors' mental health counseling activities as stated in their own words. Phenomenological inquiry was thus appropriate for the study because it offers a research method that facilitated the collection of data on the lived counseling experiences of Black pastors from the pastors themselves.

Through in-depth interviewing, the researcher was able to better understand the attitudes of the participants, thus giving context to their behaviors and actions. When participants described a behavior, the researcher could then put that behavior into context, creating an understanding of the participant's actions from the information gained through the interview (Seidman, 1998). Therefore, the research tradition of phenomenology enabled the researcher not only to explore the experiences of Black pastors as they engage in mental health counseling, but also to understand the meaning that they make of that experience (Rudestam & Newton, 2001). Based on the pastors' descriptions of their experiences in regard to the phenomena of their mental health counseling practices, attitudes, training, and self-described competency, the researcher was able to formulate an overall description of the phenomena (Creswell, 2014).

Learning from first-hand accounts about Black pastors' mental health counseling activities and answering the study's research questions were important for several reasons. First, there is little research investigating the issues addressed by the research questions. This lack of information can lead to inaccuracies, misinterpretations, and unrealistic expectations regarding the counseling activities of African American pastors. Second, the research aimed to provide useful information to the African American community as well as to pastors not participating in the study. Third, phenomenological inquiry offered participants the chance to have their stories

authenticated through their own voices. And fourth, through phenomenological inquiry, the study

subjects became co-researchers and co-designers of the study through the process of interviewing

(Rudestam & Newton, 2001). Information available from the study may help open a pathway in

Black congregations for discussions on mental health and how best to address mental health

within congregations. The information may be beneficial to other pastors, expand knowledge

regarding mental health in the African American community, and serve to lessen the stigmas

associated with seeking counseling outside the church.

Reliability and Validity

Golofshani (2003) holds that for qualitative research, validity and reliability become

matters of trustworthiness, rigor, and quality. Of these three concepts, the *quality* of qualitative

research applies to all aspects of the research, beginning with the development of the research

questions, and would include, in a phenomenological study, the development of interview

questions, selection of participants, conducting the interviews, and the qualitative analysis of

interview responses (Bergman & Coxon, 2005). To achieve quality, these aspects of the study

must be done with rigor, and therefore the concept of quality in qualitative research appears to

imply the concept of *rigor*. Furthermore, Krefting (1991) identified the concept of rigor in

qualitative studies with the concept of *trustworthiness*. The three aspects that Golofshani (2003)

defines as equating to validity and reliability in qualitative research therefore appear to all point

to the one essential aspect of trustworthiness.

To help ensure trustworthiness of the collected data, interviews were audio recorded and

transcribed, with the transcriptions double-checked for accuracy. The strategy of member

checking was used to further ensure the trustworthiness of the data. Member checking consisted

of the researcher providing each interviewee with the transcript of his or her interview to check

for accuracy. The interviewee was then able to provide any feedback for the researcher to consider.

To help ensure trustworthiness of interpretations of the data, the qualitative analysis included attentively reading each transcript a minimum of three times, while developing and applying codes to responses. Trustworthiness of the analysis was also be improved by using Atlas.ti software (http://atlasti.com/) during coding development. Use of this software helped ensure that codes were recorded properly and aided in connecting codes and identifying themes reflected in several of the pastors' interview responses. Trustworthiness of the analysis of the data was supported by the fact that the analysis process is reported in detail in Chapter 4, and quotes from the interviews are presented as evidence of the themes that are identified.

Trustworthiness of the study was also supported by the fact that the data consisted of Black pastors' responses to interview questions about their own experiences, practices, attitudes, training, and self-described competence. The pastors were the definitive sources for information on these issues on the assumption that their responses to the interview questions were honest and accurate.

One aspect of trustworthiness is authenticity (Edmunds & Scudder, 2009), which is reflected in the degree the research is based on a genuine desire to understand some phenomenon or phenomena (Milne, 2005). Interactions of the researcher with participants should be genuine, with the researcher dedicated to allowing interviewees to speak openly and honestly in response to questions posed. Trustworthiness and authenticity are also a matter of making sure that the methods used to collect data are proper and appropriate (Milne, 2005). In the present study, the researcher took care to ensure that she remained friendly but neutral as to what she expected

from interviewees' responses. She did not make any comment during the interviews that might lead a pastor to answer a question in a certain way. Furthermore, she:

1. Provided each participant with exactly the same information about the study.

2. Asked each participant the same set of questions.

3. Provided each participant with the same amount of response time.

Another aspect of trustworthiness of a study is a researcher's guarding against possible bias. The researcher's role in a qualitative study can be viewed as that of an instrument (Xu & Storr, 2012). Therefore, just as it is important to guard against any biases in any other research instrument, it is important for the researcher to evaluate her or his role as a researcher and to guard against possible biases. Furthermore, when interviewing participants, analyzing their responses, and describing their experiences, it is important for the researcher to remain as free as possible from the theoretical or social constructs.

The researcher who conducted this study is a Licensed Professional Counselor-Supervisor (LPC-S) who works as a Mental Health Therapist at a county jail in Texas. She is also a member of the congregation of an African American church located in Texas. The researcher's experiences as a member of an African American church and as a mental health therapist led her to a strong interest in the activities, attitudes, and competence of African American pastors. She had no particular expectations for what would be revealed in the study and was open and eager to learn what Black pastors would say in response to the interview questions and what the analysis would reveal.

The researcher was aware of the importance of guarding against any biases in interviewing the pastors and analyzing their responses. One possible source of bias could have been the researcher's knowledge, skills, and appreciation/acceptance about mental health. Being

aware of this possible source of bias, she took care not to impose any of her knowledge or experience onto the pastors that might alter their responses to interview questions. To help ensure an unbiased approach, she audio recorded and transcribed the interviews. She also guarded against any biases in analyzing the interviews by keeping an accurate record of the analysis process, including the process of coding to identify main concepts and categories, and the identification of themes.

<p style="text-align:center">Research Method and Process</p>

A description of the study's specific research procedures is provided in this section. The description includes details of the recruitment of participants and the procedures followed for collecting data. The qualitative analysis procedures used to analyze interviewees' responses are also explained.

Recruitment of Participants

A convenience sample of 12 pastors of historically African American church denominations were asked to participate in the study. Participants were male or female pastors of churches in the state of Texas belonging to one of the following denominations: The African Methodist Episcopal Church; African Methodist Episcopal Zion Church; Christian Methodist Episcopal Church; National Baptist Convention, USA, Incorporated; National Baptist Convention of America, Unincorporated; Progressive National Baptist Convention; and the Church of God in Christ. The study was restricted to the state of Texas due to limited resources to travel to other regions of the country to conduct interviews. Although the limitation to the state of Texas restricted the generalizability of the study, it is believed that the sample from Texas of African American pastors of historically African American church denominations did not differ substantially from such pastors in other parts of the country.

To recruit participants, the researcher used a snowball sampling method (Robinson, 2014). This method consisted of asking individuals who were initially invited to participate in the study to suggest other individuals who might be interested in participating, and then asking these other individuals to suggest still other individuals who might be interested in participating, and so on, until enough participants were recruited. At the beginning, the researcher called or visited African American pastors who she was familiar with to explain to them the nature of the study and to request their participation. If a pastor showed interest, she mailed the pastor an invitation to participate in the study (Appendix A), an information sheet to explain details of the study (Appendix B), and a demographic questionnaire to be returned in a self-addressed stamped envelope (Appendix C). She also asked pastors who she initially contacted to suggest other African American pastors who might be interested in participating in the study. When contacted, any of those other pastors who showed interest in participating were also mailed the invitation to participate, the information sheet, and the demographic questionnaire and were asked to suggest yet other pastors who might be interested in participation. The snowball sampling method continued until 12 pastors of historically African American church denominations had agreed to participate in the study. At the time a pastor agreed to participate in the study or soon after, the researcher made arrangements with the pastor for a time and place to conduct the interview.

It should be noted that the fact that participants constituted a convenience sample and were not randomly selected limits the generalizability of the study. Due to the convenience selection method and the restriction of participants to Black pastors of historically African American churches in Texas, but not those located in other regions of the country, any extrapolation of results to pastors of other historically African American churches should be done with care.

Data Collection Procedures

Semi-structured interviews were held at locations and times that were convenient for the participants. The researcher began the interviews by establishing rapport with each interviewee and provided each participant with the same information sheet (Appendix A) that was previously mailed to him or her, which informed the participant about the anonymity and confidentiality of the study and about their rights. The pastor was asked to examine the information sheet again and ask any questions. The pastor was then asked to orally indicate to the researcher his or her consent to participate in the study.

The audio recorder was then turned on and the researcher asked the pastor a total of eight open-ended interview questions, with one or two interview questions for each research question. Follow-up questions were asked depending on an interviewee's responses. The eight interview questions are listed below underneath the relevant research question.

RQ1 – What are the mental health counseling experiences of African American pastors:

- What mental health issues have you been called on to address with your parishioners?

- To what extent do you feel you have had success in dealing with mental health issues among your parishioners?

RQ2 – What are the mental health counseling practices of African American pastors:

- How would you describe your approach to counseling parishioners with mental health issues?

- What principles or strategies guide your approach to counseling parishioners?

RQ3 – What are the attitudes of African American pastors toward mental health treatment:

- To what extent do you feel that mental health problems are spiritual problems?

- To what extent do you think that some mental health issues are best dealt with by a mental health professional?

RQ4 – What is the mental health training of African American pastors:

- What formal or informal training have you had for dealing with mental health and illness issues among your parishioners?

RQ5 – What is the self-described competence of African American pastors in dealing with mental health issues:

- How competent do you feel you are to assess and treat mental health issues among your parishioners?

Each interview lasted 30 to 60 minutes. If, during the interviews, any of the participants had stated that they were experiencing discomfort of any kind, whether related to the study or not, the participant would have been asked whether he or she wanted to continue the study. If they had indicated in the negative, further work with the participant would have ceased immediately. None of the participants indicated that they were experiencing any discomfort during the interviews. Once the interview was concluded, the researcher thanked the participant. Each audio recording of an interview was identified by an interview number only, beginning with 1 and then subsequent numbers. The interviewee's previously returned demographic questionnaire was given the same number and attached to the audio recording. No identifying name appeared on the audio recording or the demographic questionnaire. The audio recording was then transcribed and checked for accuracy by the researcher.

This method of collecting data had the advantage that the data came directly from the African American pastors whose mental health counseling experiences, practices, and attitudes were the focus of the study. It was assumed that the pastors were honest and accurate in

describing their experiences. Given this assumption, the pastors themselves can be viewed as having been the most authoritative voices for providing information to answer the study's research questions.

Data Analysis Procedures

Prior to analysis, the completed demographic questionnaire from each pastor was attached to his or her transcript. A qualitative analysis of each African American pastors' responses to the interview questions was then conducted. This analysis consisted of five separate analyses, one for each of the five research questions. For each research question, the responses to the one or two interview questions that were associated with that research question was analyzed by thematic data analysis to allow major themes to emerge from the data and provide an answer to the research question. The Atlas.ti qualitative analysis program was used to assist in the qualitative analysis.

The thematic data analysis process, as applied to the responses to an interview question, consists of several main steps (Guest, MacQueen, & Namey, 2012). First, evaluate the frequency of occurrence of identical and similar words and phrases in the responses to the particular interview question and determine which of these are the key words and phrases. Second, determine initial themes consisting of explicit and implicit ideas that are represented by the key words and phrases in responses to the interview question. Third, represent identified themes by codes and apply them to the responses to the interview question. Finally, compare the frequencies of codes and on this basis identify major themes present in the responses to the interview question.

The way in which this thematic data analysis was done for a particular interview question was to first display all of the pastors' responses to that interview question, and then identify the

repeated and similar concepts in the responses. Key words and phrases were then coded. After all pastors' responses to an interview question had been coded, the responses were reviewed and compared again to determine any necessary re-coding of passages in the responses. Codes were then reviewed and major themes were identified in the pastors' responses. Identification of these major themes enabled the research questions to be answered.

Axiology

Before conducting the study, the researcher applied for approval to the Institutional Review Board (IRB) of St. Mary's University. All requirements of the IRB were adhered to during the study.

An information sheet was provided to potential study participants along with the letter that invited them to take part in the study (Appendixes A and B). The information sheet informed the participant of the anonymity and confidentiality of the study and that he or she had the option to terminate participation at any time during the study. The participant was informed that no personal benefit would result from the study and that there were no substantial risks for being in the study. Participants were provided with the name and email address of the researcher and the IRB Board in the event they had any questions regarding the study.

The identity of the pastors who participated in the study remained anonymous. The pastors were identified by numbers 1, 2, 3, and so on in all of the transcripts of the interviews and in all reports of the results of the study. The particular churches that the pastors led were also anonymous. The anonymous nature of the study was explained to potential participants in the information sheet.

All data gathered in the study were and will remain confidential. Audio recordings and transcripts of the audio recordings were stored in a locked file cabinet to which only the

researcher has a key. The only exception was that the transcript of each pastor's interview were mailed to the pastor for his or her review and verification of the contents of the transcript. All computer files with data from the study were stored in a password-protected and encrypted file on the researcher's private computer.

In the future, the researcher will store all data records securely to ensure reasonable future access. Records will be maintained according to state and federal statutes that govern records keeping. Disposal of records will be done so as to protect participants' confidentiality (ACA Code of Ethics, 2005).

CHAPTER IV

RESULTS

Introduction

The purpose of this study was to learn the practices and competency of African American pastors in dealing with their parishioners' mental health issues. The study was phenomenological in nature. The phenomena investigated were the practices, attitudes toward mental health treatment, and self-described competence of African American pastors ministering in the state of Texas in their dealing with parishioners' mental health issues. To determine these pastors' practices, attitudes, and self-described competence, the researcher interviewed 12 pastors about their (a) experiences and practices in dealing with parishioners who come to them with mental health issues, (b) training and attitudes toward mental health treatment, and (c) self-described competence in counseling parishioners. The pastors were asked eight interview questions and their responses were audio recorded and transcribed. The transcribed responses were analyzed by qualitative methods to determine themes in the responses. The conceptual framework informing the study was the concept of pastoral care.

This chapter reports the results of the study. The chapter is divided into three main sections following this introduction. In the first section, demographic profiles of the 12 pastor participants are presented. The second main section reports the results of the qualitative analysis of the interview responses and how these results answer the study's five research questions. This section is divided into six subsections, one for each of the research questions, and a summary. A total of 10 themes based on the pastors' responses to research questions are identified in this section. The last section of the chapter considers the pastors' combined responses to the interview questions to determine three overall themes of the research.

Participant Profiles

Among the 12 pastors who participated in the study there were five Baptist Church, five Pentecostal Church, one Episcopal Church, and one Church of God in Christ pastors. Of the 12 pastors, 11 were male and 1 female. The participants' ages ranged from 43 to 68 years. Participants' number of years as a pastor of their present church ranged from one and one-half to 20 years, and they had congregations ranging in size from 23 members to more than 500 members. Six of the churches had more than 100 congregants, and six had fewer than 100 congregants. Table 1 provides a summary of these demographic characteristics of the study sample.

Education of the 12 pastors varied widely, ranging from having only a high school diploma or a GED certificate to having attained the PhD educational level. Eight pastors had a higher education degree or certificate, with five of those being in either Theology or Ministry. Four of the eight also had non-theological degrees or certificates, including in Elementary Education, Speech and Language Pathology, Industrial Electronics and Water Operations, and Business.

In the category of Training, five participants indicated having counseling courses, three indicated substance abuse training, two reported having social work classes, one reported marriage and family training, and two reported having a further unspecified seminar or class. In response to the question of how many academic classes, seminars, or workshops involving issues of counseling they had attended, four pastors did not report any, seven reported from two to more than 20 academic classes, three reported having attended workshops, and two pastors reported having gone to seminars. Table 2 provides a summary of the education and training reported by the 12 pastors.

Table 1

Demographic Profile of the Pastors

Pastor	Sex/Age	Years Pastor in Present Church	Size of Church	Denomination
1	M 55	1.5	200	COGIC[a]
2	M 48	13	75+	Baptist
3	M 50	8	500+	Episcopal
4	M 50 .	20	150	Pentecostal
5	M 43	3.5	90	Pentecostal
6	M 49	20	40	Pentecostal
7	F 49	10	40	Pentecostal
8	M 43	13	120	Baptist
9	M 63	20	200-300	Pentecostal
10	M 43	9	165	Baptist
11	M 54	9	75	Baptist
12	M 68	10	23	Baptist

[a] Church of God in Christ

Table 2

Education and Training of the Pastors

Pastor	Degree/ Field	Institution	Training	Academic Classes/ Seminars/Workshops
1	BA/BS, Elem Ed.	TCU	None reported	None reported
2	Associates Theology	Cornerstone U.	Counseling, 10+ hours	None reported
3	BA, M Divinity Theology	CDSP[a]	None reported	Acad. classes, 6 hrs.
4	BA	NTS[b]	Soc. Work, Marr. & Family, Subst. Abuse, Seminar	Acad. classes 2, Seminars 6, Workshops 4
5	High school		Counsel. courses	Acad. classes 2
6	GED		None reported	None reported
7	BS, Speech/Lang Pathology	Texas Woman's U.	None reported	Workshops, 2
8	BS in Business MS & PhD in Theology	U. Texas, Slidell Seminary	Counsel. courses, 12 hours	Acad. classes 4, Workshops 3
9	Honorary PhD Counseling Ministry	Potter's Wheel Ministry	Counsel. courses & 3- month course unspecified	Acad. classes, 20-40 hrs.in
10	36 hrs. General Studies	Dallas Theol. Seminary, others	Social work classes, military training	Acad. classes, 20+
11	Some college	Coll. Biblical Studies	Counsel. courses, 24 hrs., Subst. Abuse	Acad. classes, 4
12	Certificate: Indust. Elec. & Water Ops.	Not reported	Class in Alcoholism	None reported

[a] Church Divinity School of the Pacific; [b] Newburgh Theological Seminary

Results for Research Questions

Qualitative analysis of the African American pastors' responses to the eight interview questions revealed 10 themes. These themes provided answers to the study's five research questions. This section is divided into six subsections, one for each research question and a summary.

Research Question 1

Research Question 1 was the following: What are the experiences of African American pastors in counseling parishioners with mental health issues? Two of the eight interview questions were directly pertinent to answering this first research question. Interview Question 1 was: What mental health issues have you been called on to address with your parishioners? Interview Question 2 was: To what extent do you feel you have had success in dealing with mental health issues among your parishioners?

In their responses to the first interview question asking what mental health issues they had been called on to address, the pastors reported having dealt with 13 different mental health conditions or situations. The most commonly reported condition was depression, which was mentioned by five of the pastors. Bipolar disorder and anxiety were the next most reported conditions, being mentioned by three pastors each. Suicide attempt/contemplation, addiction/dependency, and ADD (attention deficit disorder) were reported by two pastors each. Other conditions or situations mentioned by one of the pastors were PTSD (post-traumatic stress disorder), ADD (attention deficit disorder), ADHD (attention disorder, hyperactivity disorder), stress, schizophrenia, anger management, and outbursts in church.

One of the pastors indicated that he had not dealt specifically with mental health issues among parishioners, and another stated he had not dealt with such issues recently. A third

participant, Pastor 1, stated that he had not dealt with any such parishioners because mental health professionals who were also members of the congregation were the ones designated to deal with parishioners identified with a mental health issue.

Pastor 1: We've had two or three people that we've noticed with mental health issues, but I don't think I've dealt with them personally. I have some congregants, people that are members of the congregation that normally deal with that. I personally don't.

Qualitative analysis of the varied responses to Interview Question 1 indicated that as a group, the pastors had dealt with a wide variety of mental health issues among their parishioners. Due to this commonality in the responses to the first interview question, it was concluded that a theme present in the pastors' statements is the following:

Theme 1: As a group, African American pastors deal with a wide variety of mental health issues among their parishioners.

This theme is supported by several direct statements made by the pastors, including the following:

Pastor 3: Dependency.… a lot of people have been dealing with depression within the life of the church. PTSD. I have people that have gone through posttraumatic stress in being involved in combat even in Vietnam or more recently in Iraq and Afghanistan …. those are the majority of the issues right there.

Pastor 4: "Some of the mental health issues we've been called on to address, one is verbal and mental outbursts in the midst of our services."

Pastor 5: "You deal a lot with depression. Some might say even oppression. I've even had to deal with schizophrenia and that type of thing. So I would say depression, anxiety, schizophrenia, among other things."

Pastor 8: "Mainly depression, anxiety disorder, bipolar. Those are the main three."

Pastor 11: "But that [suicide contemplation] and stress that has to deal with family matters is the most common. Just stress with coping. And the feeling of hopelessness where people just feel like things won't change … everything will always be the same, so there's deep-seated depression that sets in."

The second interview question asked the pastors to report on the extent they felt they had had success in dealing with mental health issues among their parishioners. Responses to this interview question were directly relevant to answering Research Question 1 about the pastors' experiences in counseling parishioners with mental health issues.

Qualitative analysis of responses to Interview Question 2 indicated that all but one of the pastors believed they had at least some success in dealing with mental health issues among their parishioners, though one participant stated it was a "work in progress." The one pastor (number 11) who refused to say he had success dealing with mental health issues did so because "the counseling that I try to give them is not only you know the psychological aspect of it but the spiritual aspect of it…."

Qualitative analysis also suggested that the pastors had different understandings of "success." Most of the pastors appeared to be referring to their own personal success in counseling parishioners. However, two pastors (1 and 3) indicated they were successful in referring parishioners to mental health professionals. Also, Pastor 7 indicated she was successful in the sense that parishioners knew they could come to her for help, adding that if she was capable of doing so she would try; otherwise, she would refer the person to an agency for help.

The responses of several of the pastors indicated that their success in counseling for mental health issues was relative to the seriousness of the issue. Several of the pastors (5, 9, 10,

and 12) indicated having some success when dealing with specific mental health issues. These issues included suicide ideation, depression, and bipolar disorder. Two pastors (5 and 8) mentioned specific conditions they had not had success with: schizophrenia, bipolar disorder, and chemical imbalance.

Overall, qualitative analysis of the pastors' responses to Interview Question 2 indicated that as a group, the 12 pastors believed they had varying degrees of success in dealing with mental health issues among their parishioners. In addition, the pastors' responses suggested that they had varying definitions of success. While most of the pastor's gauged success by the responses of troubled parishioners to the pastor's counseling, two pastors measured success in terms of referring the parishioner to an appropriate mental health professional. Due to these variations found in the responses to the second interview question, it can be concluded that two themes present in the pastors' responses are the following:

> *Theme 2: African American pastors vary in how successful they believe they are in dealing with mental health issues among their parishioners.*
>
> *Theme 3: African American pastors have different views on what constitutes success in dealing with mental health issues among their parishioners, with some measuring success by the effectiveness of their one-on-one counseling, some measuring success by their referring parishioners to appropriate mental health professionals, and some measuring success in both ways.*

> These themes are supported by several direct statements the pastors made, including:
>
> Participant 1: "We've had real good success because … we have a couple of ladies that directly work with mental health issues on a daily basis, so they generally address those issues for us."

Participant 3: "I think we've had success in regard to trying to make sure that they are resourced to the appropriate parties…. whenever there's any kind of pastoral counseling there's a maximum of three meetings that you have with a person and then we outsource them to someone else."

Participant 7: "I think the only thing I can qualify myself being successful in is that they know that they can come there for help. And if I am capable of helping them, I'll do whatever I can. And if I can't, I'll try and give them a number or an agency that can help them. That's my level of success."

Participant 8: "I would say 60/40 because there were a couple situations to where there was a need for medicine, some kind of help with the chemical imbalances."

Participant 9: "The success rate for people that's dealing with low self-esteem, depressed over whether it's death or anything of that nature, I think the success rate has been pretty good."

Based on the qualitative analysis of the 12 pastors' responses to Interview Questions 1 and 2, the answer to Research Question 1 is that African American pastors deal with a wide variety of mental health issues among their parishioners and self-describe themselves as having varying degrees of success in their efforts. Furthermore, pastors measure their degree of success in different ways. Some measure it in terms of the effects of their one-on-one counseling, some measure it by their referring parishioners to appropriate mental health professionals, and some measure it in both ways.

Research Question 2

Research Question 2 was the following: What are the practices of African American pastors in counseling parishioners with mental health issues? The third and fourth interview

questions were directly relevant to answering Research Question 2. The third interview question was: How would you describe your approach to counseling parishioners with mental health issues? The fourth interview question was: What principles or strategies guide your approach to counsel parishioners?

In their responses to the Interview Question 3 asking them to describe their approach to counseling parishioners with mental health issues, the pastors mentioned several different kinds of approach. The most prevalent approach mentioned was to either refer a person to a mental health professional at the outset (Pastor 1) or to do so if the mental health issue is serious or beyond the pastor's capability to deal with properly (Pastors 3, 5, 7, and 9). Examples of such remarks are the following:

Pastor 3: "… have a couple meetings with people. A max of three meetings. Sometimes it doesn't even need to be that many meetings if you can see that somebody is clearly going through depression or what have you and it seems as though that's part of the inner workings of their lives, so we deal with it with contact and then also telling somebody about it and giving them an option of being outsourced to someone else."

Pastor 5: "I would describe my particular approach is to observe then make an informed I would say decision or what really is going on and then from there I decide if it's something that I can handle or do I need to pass it on to a professional."

Two pastors (2 and 9) stated they approach a troubled parishioner with love, and two (Pastors 2 and 4) said they approach a parishioner nonjudgmentally. Pastors 7, 8, and 9 stated their counseling is always or usually scriptural only. Such comments include the following:

Pastor 2: "The approach that I've noticed that worked for me is to meet the person where they are and give them a feeling of love and not of judgment and to reassure

them that I understand where they are and what's going on at the magnitude that they

can understand and comprehend."

Pastor 9: "I approach it from the spiritual side and I approach it with love and in order for

the person to feel secure to be able to open up."

The fourth interview question asked the pastors to report the principles or strategies that

guide their approach to counseling parishioners. The responses to this interview question were

directly relevant to answering Research Question 2 about the practices of African American

pastors in counseling parishioners with mental health issues.

Qualitative analysis of responses to the fourth interview question showed that the most

common element among the responses was identification of the Bible or spiritual considerations

as a basis of their counseling, which was expressly stated by four pastors (5, 8, 9, and 11). These

remarks include the following:

Pastor 5: "Number one I'm going always go biblical and then past that, you go into things

that you've learned in different classes and courses and also in studying different books

and literature that's related to the issue.

Pastor 9: "Again, my approach my guidance is always scripturally based because my

counseling is scripturally based…. I do view a significant amount of mental illness as

spiritual or spiritual attack from our enemy."

Participant 11: "I approach everybody in a different way so through prayer and seeking

God, that's what I believe is key, to seek the knowledge of God, the wisdom of God, and

God, you know, the Holy Spirit."

Even if they did not mention it in their responses, more of the pastors may make spiritual

considerations a basis for their counseling parishioners with mental health issues.

In their responses to the fourth interview question, other pastors identified a number of specific strategies they use when counseling parishioners. Examples of these comments are the following:

Pastor 2: "The one principle that I stand on is we all have areas of weaknesses and if we focus on turning the weaknesses into strengths, that has made some progress for us. So that's an area that I tend to focus on."

Pastor 4: "I think a lot of times you get them to talk, that lowers the stress level. Making them laugh…. just to make yourself transparent for them to be able to relate…. and the last one is food. A lot of times you put some snacks on the table and you can get a person to open up and tell a lot about themselves."

Pastor 7: "I just let them talk. And then I'm hearing things and I pick up on things and as I pick up on it I'll ask deeper questions, 'well I heard you say this and I heard you say that. Well what about this or … how is this connected?' And so then when I find out … what I call a core issue, a lot of times it goes to the family."

Pastor 10: "You go to where the people are and you be their mother, their sister, you know. Someone to walk with. So I guess my approach and strategy is just to show that, you know, I'm available, but I'm also human just like everybody else."

Overall, analysis of the pastors' responses to Interview Questions 3 and 4 shows the following three themes in their remarks:

Theme 4: Many African American pastors refer parishioners to a mental health professional if they judge the mental health issue to be beyond the pastor's capability to deal with properly.

Theme 5: African American pastors often make spiritual considerations a basis for their counseling of parishioners with mental health issues.

Theme 6: African American pastors use various strategies in counseling parishioners with mental health issues.

Together, these three themes provide an answer to Research Question 2, which is that African American pastors use a variety of strategies and principles in counseling parishioners with mental health issues, and their counseling often has a spiritual basis. In addition, many of these pastors refer a troubled parishioner to a mental health professional if they judge the mental health issue to be outside the pastor's capability to deal with properly.

Research Question 3

Research Question 3 was the following: What are the attitudes of African American pastors toward mental health treatment? The fifth and sixth interview questions were directly relevant to answering Research Question 3. The fifth interview question was: To what extent do you feel that mental health problems are spiritual problems? The sixth interview question was: To what extent do you think that some mental health issues are best dealt with by a mental health professional?

Qualitative analysis of the pastors' responses to Interview Question 5 showed that the predominant response (Pastors 2, 3, 4, 6, 9, 10, and 12) indicated that the pastor believed that all mental health problems are also spiritual problems. Examples of these remarks include the following:

Participant 2: "I believe right at a hundred percent that there is … spirits that control or dictate a lot of our actions and they -- the mental health field and the spiritual field they run parallel. They have different terminologies, but yet they parallel each other."

Participant 6: "If I'm working on my natural man to become a better person, then I'm automatically going to be working on my spiritual man to become a better person."

Participant 9: "I believe that the individuals have been afflicted by some spirit that caused them to be in that particular way. So on the natural side then, that's also we would refer them also to individuals that will deal with them on the natural side as well."

The responses of four other pastors (1, 5, 8, and 11) indicated that they believed that some proportion of mental health problems are spiritual problems, but there are mental health problems that are not spiritual or that are not to be dealt with spiritually. The response of Pastor 7 suggested that she thinks that mental problems and spiritual problems are connected, but separate. Examples of these pastors' responses are the following:

Pastor 5: "Sometimes you might be trying to cast out what need to be medicated. And sometimes you might be trying to medicate what needs to be cast out. So every situation is different…. especially in Pentecostal persuasion we think everything can be prayed away … That's not always the case realistically…. you have to be able to see past the dogma and the doctrine that you've been taught for so long and be able to make a sound and informed decision."

Pastor 7: "I believe that … our mind is separate from our spirit, however that's a part of who we are and our makeup …. so I think they're connected but separate."

Pastor 11: "I understand that a lot of times when people don't understand the spiritual aspect of it and what's going on with them is spiritual is rooted in the spiritual so we need to attack it and address it through spiritual means…. but some problems you know that people who are really you know spiritually or mentally handicapped and they don't know

what they're doing they can't listen to logic they can't listen reason and so that's a totally different thing."

The pastors' responses to Interview Question 6, asking to what extent they feel that some mental health issues are best dealt with by a mental health professional, were also relevant to answering Research Question 3. Qualitative analysis of those responses indicated that 10 of the interviewed pastors believed that at least some mental health issues are best dealt with by a mental health professional, and the other two remarked that counseling by a mental health professional can be helpful. Pastors 1, 5, 6, and 7 went further by indicating their belief that all diagnosed mental health issues or mental illness should be dealt with by mental health professionals. Examples of remarks made by the pastors are the following:

Participant 3: "I would say the majority of them…. I think it needs to be a partnership between the church and mental health community, and too often the church is dismissive of the mental health community."

Participant 5: "For me, I don't count myself as a mental health professional and so if I'm not a professional then I do the person that's in need of help a disservice by acting as if I'm a professional. When I might be a professional in prayer but I'm not a professional in mental health issues. I might can dissect a scripture or text in the Bible but I'm not maybe qualified to deal with the ups and downs of mental health issues."

Participant 6: "I can help them you know to a certain extent but as far as dealing with the actual mental issue, I think it should be a doctor or someone that's certified that operates in that particular area."

Participant 7: "I think that if it is a true diagnosis that it is a mental issue, I think that we should direct them to someone who's qualified to help them."

Two of the pastors (2 and 10) remarked that it was preferable if the mental health professional knew God or made a spiritual connection with the person being treated. Participant 11 explicitly stated that treatment by a mental health professional is not appropriate for some mental health issues, saying, "Clinical counselors only deal with the physical, psychological aspect of a person; and it can help. But if the problem is rooted in the spirit realm, then it needs to be addressed with spiritual methods."

Overall, qualitative analysis of the pastors' responses to the fifth and sixth interview questions indicated two themes expressed in their remarks.

Theme 7: African American pastors generally believe that all or some proportion of mental health problems are also spiritual problems.

Theme 8: The majority of African American pastors believe that all or some serious mental health issues should be dealt with by a mental health professional.

Combined, these two themes provide an answer to Research Question 3, which is that African American pastors generally have a positive and receptive attitude toward professional mental health treatment and believe that serious mental health issues should be dealt with by a mental health professional. In addition, African American pastors generally believe that mental health problems are also spiritual problems.

Research Question 4

The fourth research question was the following: What is the mental health training of African American pastors? Interview Question 7 was directly relevant to answering this research question, along with the pastors' responses to several questions on the demographic profile questionnaire. Interview Question 7 asked the pastors what formal or informal training they had for dealing with mental health and illness issues among their parishioners.

Qualitative analysis of the responses to the seventh interview question showed that three of the pastors answered that they had no formal or informal training; however, the results from the demographic profile questionnaire showed that one of these three pastors had had a class on Alcoholism. In addition, in his response to Interview Question 7, one of the pastors who reported no training remarked he had "on-the-job training."

Combining the results from Interview Question 7 and the demographic profile results for training and academic classes/seminars/workshops, 10 of the 12 pastors had some training in dealing with mental health issues. This training included Counseling courses, Pastoral Counseling, and training in the areas of Social Work, Marriage and Family, Substance Abuse, MHMR (Mental Health Mental Retardation), and Alcoholism. The most frequently mentioned type of training was for Counseling. Statements made by the pastors in response to Interview Question 7 include the following:

Pastor 3: "I had two semesters of pastoral counseling but I've got a PhD in just dealing with people. And over the years have seen how ill equipped I am to deal with all the issues that are out there and how ill equipped a lot of pastors are to try to deal with it on their own."

Pastor 4: "I've done some state and local MHMR training. I'm in the MHMR field, so that helps when you go back to the church. And then all of us have a little MR or something going on with us. So in dealing with MHMR type personalities every day, it helps you be able to deal with your parishioners and people in the community. So I've gone through some seminars and things of that nature."

Pastor 10: "I do read a lot and I do have a lot of material that I read from…. Some of the material that I read deals a lot with mental health, spiritual health. Some of it deals with some of the challenges that we are now seeing at the time drug use abuse and how to minister to, you

know, those type of disorders…. a lot of my reading and studying which I have in library deals a lot with the youth and where they are, the challenges that they have, changing times where, you know, they're dealing with, you know, their minds affected by the things that are being accepted widely today that weren't, you know, 30, 40 years ago, not on this level."

Pastor 12: "Nothing but the word of God."

Based on their responses to the seventh interview question and the questions on training on the demographic questionnaire, the pastors who reported the most training in mental health issues appeared to be the following:

Pastor 2: Over 10 hours in Counseling.

Pastor 4: Training in Social Work, Marriage & Family, Substance Abuse, and MHMR; two academic classes, six seminars, and four workshops.

Pastor 8: Twelve hours Counseling; four academic classes, four workshops.

Pastor 9: Counseling courses, a three-month unspecified course; 20-40 academic classes.

Pastor 10: Extensive reading, Social Work classes, military training; more than 20 academic classes.

Pastor 11: Twenty-four hours Counseling; Substance Abuse; four academic classes.

Qualitative analysis of the results from Interview Question 7 and the training questions on the demographic questionnaire indicate that the pastors' responses reflect the following theme:

Theme 9: The majority of African American pastors have had some formal or informal training in areas of mental health, especially in Counseling, although their formal training is not extensive.

The identification of this theme provides an answer to Research Question 4, which asked about the mental health training of African American pastors. The qualitative analysis indicates that the answer to the fourth research question is that most African American pastors have some mental health training, especially in Counseling, though their formal training is not extensive.

Research Question 5

The fifth research question was the following: What is the self-described competence of African American pastors in dealing with mental health issues? Interview Question 8 was directly relevant to answering this research question. The eighth interview question asked the pastors to state how competent they felt they were to assess and treat mental health issues among their parishioners.

Qualitative analysis of the pastors' responses to Interview Question 8 showed widely varying views on their competence to deal with mental health issues among their parishioners. Three pastors (1, 6, and 7) remarked that they were not competent at all to assess and treat mental health issues, while two (4 and 11) indicated feeling very competent. Of the remaining pastors, four (2, 3, 5, and 8) indicated that they felt competent to detect that someone has a mental health issue, but not competent to treat it. Three others (9, 10, and 12) remarked that they felt competent to a certain degree to help a person but not to treat certain mental health issues.

Several statements that illustrate these various types of responses are the following:

Pastor 2: "I feel as though I'm decent in regard to identifying an issue, not diagnosing anything because I'm not an expert at that, I'm a preacher and that's it. But I know when there is a problem and I know how to, you know, get help and get the appropriate help."

Pastor 4: "Confident, very confident in my counseling ability but … I know how to sense the cut off that, okay, this isn't going anywhere. It's time to transition. I listen to my own

triggers that says okay, let's move on from this…. I'm actually glad to hear about what you're doing here. I think the church as a whole needs to have a plan that the pastors the leaders, the members are trained how to deal and recognize mental health issues and not start beat the person on the head, 'Oh, it's the devil' and sling oil on them and stuff like that. No, it's not always the devil."

Pastor 6: "I don't feel like I'm competent at all. Once again, just dealing with the natural aspect and my personal experiences, having the Bible base … to help them. But as far as their mental health issue, I don't think I'm able to treat them."

Pastor 10: "I think in terms of ministry, the encouragement that is there, the daily walk with an individual, praying with them, assisting them with life, helping them get to a point of changing the way that they think and … decisions that they're making, you know. I don't feel that my calling is to assess as if you know I was… a mental professional. I believe that's their calling. And when things are out of my reach as a pastor it's for me to get you to where you can get the help that you need.

The qualitative analysis of the pastors' responses to Interview Question 8 indicated that the following theme is reflected in their comments:

Theme 10: African American pastors vary in their self-described competence to assess and treat mental health issues among their parishioners.

This theme provides an answer to Research Question 5, which asks about the self-described competence of African American pastors in dealing with mental health issues. The answer to this research question is that the pastors varied in their descriptions of their competence, with some pastors feeling very competent, some not competent at all, and some feeling somewhat competent.

Summary

A total of 10 themes were identified based on qualitative analysis of the pastors'

responses to eight individual interview questions. These themes are summarized in Table 3.

Table 3

Themes Identified from Responses to Individual Research Questions

_____

Number	Theme
1	For the most part, African American pastors deal with a wide variety of mental health issues among their parishioners.
2	African American pastors vary in how successful they believe they are in dealing with mental health issues among their parishioners.
3	African American pastors have different views on what constitutes success in dealing with mental health issues among their parishioners, with some measuring success by the effectiveness of their one-on-one counseling, some by their referring parishioners to appropriate mental health professionals, and some in both ways.
4	Many African American pastors refer parishioners to a mental health professional if they judge the mental health issue to be beyond the pastor's capability to deal with properly.
5	African American pastors often make spiritual considerations a basis for their counseling of parishioners with mental health issues.
6	African American pastors use various strategies in counseling parishioners with mental health issues.
7	African American pastors generally believe that all or some proportion of mental health problems are also spiritual problems.
8	The majority of African American pastors believe that all or some mental health issues should be dealt with by a mental health professional.
9	The majority of African American pastors have had some formal or informal training in areas of mental health, especially in Counseling, although their formal training is not extensive.
10	African American pastors vary in their self-described competence to assess and treat mental health issues among their parishioners.

The next main section consists of an overall description of the practices and self-described competence of the pastors. The description is based on qualitative analysis of the pastors' responses to interview questions when they are considered in combination.

Overall Themes Based on Combined Responses to Interview Questions

This section presents a synthesis of the results of the interviews with the 12 African American pastors. The synthesis is based on considering together the pastors' responses to all eight interview questions and the 10 themes that were identified in the qualitative analysis of the responses to the questions. The synthesis provides three additional overall themes that are reflected in the results.

Overall Theme 1

The first overall theme is the following:

For the most part, African American pastors are aware of having limited competence for dealing with the mental health problems of their parishioners. As a result, they counsel and advise parishioners who approach them with relatively common mental health issues such as minor depression, grief, and mental stress from day-to-day living, but they refer parishioners to mental health professionals if they have a serious mental health issue.

This overall theme is evidenced by a number of the African American pastors' specific responses reported earlier to the eight interview questions, especially in regard to Interview Questions 4, 6, and 8.

This overall theme applies to the majority of the interviewed pastors, but not necessarily to all. In their answers to Interview Question 1, asking what mental health issues they had been called on to address with their parishioners, several of the pastors mentioned dealing with serious mental health issues, including attempted and contemplated suicide, schizophrenia, depression,

and bipolar disorder. However, the meaning of "dealt with" was somewhat vague in the interview question. It may have been that a pastor dealt with the issue only in the sense of encountering a parishioner with the problem and offering some spiritual comfort. The pastor may have not dealt with the problem in the sense of developing a detailed and extended treatment plan with the objective of reducing the parishioner's mental discomfort. It seems probable on the basis of the pastors' responses to other questions that none of the pastors interviewed dealt with any of their parishioners' mental health issues in ways other than responding to the individual through pastoral counseling. Most of the pastors made clear that for treating a serious mental health problem, they referred parishioners to a professional.

Overall Theme 2

The second overall theme of the research is an extension of Themes 4 and 8 and is the following:

> *African American pastors have respect for the professional expertise of mental health professionals and show that respect by referring parishioners to professionals if they feel they cannot deal with a parishioner's mental health issue.*

This overall theme found in the pastors' responses to the interview questions is important to acknowledge because it suggests that African American pastors understand the value of mental health professionals for dealing with mental health issues that occur among their parishioners. Furthermore, though at least two of the pastors expressed the view that it was better if the mental health professional was religious or made a spiritual connection with the client, most of the pastors did not state such a condition. This suggests that most of the pastors respect the knowledge and ability of mental health professionals even if they are secular.

The positive view that the pastors expressed toward mental health professionals was especially evident in one pastor's remarks about using mental health professionals who were members of the congregation to deal with mental health issues among parishioners. It was also evident in the comments by one pastor who suggested that some pastors have too much faith in the power of religious methods to deal with mental illness, suggesting that professionals are better equipped for that purpose.

Overall Theme 3

The third overall theme reflected in pastors' responses to various interview questions is the following:

> *African American pastors make a distinction between cases where they believe they can help a parishioner who comes to them with mental distress and cases where a mental health professional is needed. When they judge they can help, the pastors use various strategies to counsel parishioners. These strategies are generally based on the Bible and spiritual considerations, and they may also take into account practical knowledge about how to engage people and get them to discuss their issues openly.*

This overall theme suggests that for the most part, African American pastors distinguish their pastoral counseling of parishioners from professional mental health treatment. In their role as a spiritual leader, they are required to respond to parishioners who come to them with mental distress and advise them as well as they can. But in doing so, they are also faced with the task of determining whether the person needs professional psychological help.

As pastoral counselors, Christian pastors naturally base their counseling on Biblical and spiritual principles, as a number of the interviewed pastors made clear. It is also evident in their responses that they often use practical strategies, based on their understanding of human nature

and communication, to help them in their pastoral counseling. Such practical knowledge

mentioned by various pastors included approaching people non-judgmentally and non-

authoritatively, creating opportunities for discussion, asking questions, attentive listening, and

using humor to put people at ease.

CHAPTER V

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

The previous chapter presented results of the study. The goal of this chapter is to bring all the information together by summarizing the study and discussing implications of the results and the study's limitations. The chapter also provides recommendations for future research.

Summary

The purpose of this phenomenological study was to learn the practices, attitudes, and self-described competencies of African American pastors in dealing with their parishioners' mental health issues. To fulfill this purpose, the researcher interviewed 12 pastors with churches in the state of Texas who represented several different religious traditions. The pastors were posed interview questions to learn about their experiences and practices in dealing with parishioners who come to them with mental health issues, their training for and attitudes toward mental health treatment, and their self-described competence in counseling parishioners. The pastors' responses were analyzed by qualitative methods to determine patterns and themes in their responses and to construct an overall description of the practices, attitudes, and self-described competence of the pastors. The conceptual background informing the study was pastoral care, a concept that refers to pastors' working for their parishioners' and the community's spiritual well-being by fostering the love of God and neighbors. Pastoral care was an appropriate conceptual framework for the study because it can be viewed as including pastors' efforts to promote both their parishioners' psychological and spiritual well-being.

Qualitative analysis of the pastors' responses revealed a total of 10 themes. A synthesis of these 10 themes resulted in three overall themes that were reflected in the responses. These overall themes were the following.

1. For the most part, African American pastors are aware of having limited competence for dealing with the mental health problems of their parishioners. As a result, they counsel and advise parishioners who approach them with relatively common mental health issues such as minor depression, grief, and mental stress from day-to-day living, but they refer parishioners to mental health professionals if they have a serious mental health issue.

2. African American pastors have respect for the professional expertise of mental health professionals and show that respect by referring parishioners to professionals if they feel they cannot deal adequately with a parishioner's mental health issue.

3. African American pastors make a distinction between cases where they believe they can help a parishioner who comes to them with mental distress and cases where a mental health professional is needed. When they judge they can help, the pastors use various strategies to counsel parishioners. These strategies are generally based on the Bible and spiritual considerations, and they may also take into account practical knowledge about how to engage people and get them to discuss their issues openly.

Implications

The findings of this study have several implications based on insights that were gained into the experiences, practices, attitudes, and self-described competence of African American pastors as they deal with parishioners who come to them with mental health issues. The chief insights gathered from the study are expressed by the overall themes that were found in the pastors' responses. In shortened form, these themes state that for the most part, the African American pastors interviewed (a) were aware of having limited competence for dealing with mental health problems among their parishioners; (b) believed that mental health professionals have greater competence for dealing with their parishioners' serious mental health issues; (c)

distinguished between common mental health issues such as minor depression, grief, and mental stress from day-to-day living, where they felt they may be able to help a parishioner, and cases where they judged a mental health professional was needed; and (d) referred the parishioner to a professional in the latter cases, while using Bible-based and spiritual considerations along with practical knowledge in the former cases.

These insights have implications for three groups: African American pastors, mental health professionals, and parishioners of African American churches. First, in regard to African American pastors, the results imply that in dealing with their parishioners' mental health issues, the actions of the interviewed pastors were consistent with their dual role as pastoral caretakers. This dual role consists of caring both for their parishioners' spiritual well-being and their emotional and psychological well-being (Adksion-Bradley et al., 2005; Howe, 1981; Pattison, 1995).

In light of this dual role, several researchers have suggested that because of their religious training, African American pastors may be likely to emphasize spiritual issues when counseling parishioners with mental health issues, may interpret mental and emotional issues in religious terms, or may view clinical symptoms as a sign of religious conflict (Kramer et al., 2007; Snowden, 2001; Stansbury & Schumacher, 2008; Younce, 2011). However, the results of the present study suggest that the interviewed pastors were sensitive to the difference between relatively minor cases of mental distress and cases in which a parishioner displayed clinical symptoms. The pastors referred the latter cases to mental health professionals, while spiritual and Bible-based counseling was reserved for parishioners with everyday issues. This finding appeared to be in contrast to Avent's (2013) finding that only two of eight African American pastors interviewed endorsed psychological approaches as independent methods to cope with

mental illness. However, Avent et al. (2015) also reported finding that interviewed African American pastors generally spoke positively about local mental health care providers, though they appeared to prefer Christian counselors.

Notably, the findings of the present study in regard to African American pastors' views of mental health professionals appear to be in agreement with those reported by Aten et al. (2010). In their study, Aten et al. found that 41 interviewed African American pastors from Mississippi were mostly agreeable to the idea of collaborating in several ways with mental health professionals in dealing with African Americans' mental health issues in the aftermath of the disaster caused by Hurricane Katrina. These ways included the provision of clinically focused services. The findings of the present study, combined with those of Aten et al. (2010), suggest that many African American pastors may be amenable to cooperating with mental health professionals and referring parishioners to those professionals when needed.

By referring parishioners with serious mental health issues to mental health professionals, the pastors in the present study were able to balance their two pastoral care roles of caring for both the mental and spiritual health of parishioners with mental health issues. For the most part, their responses suggested that they did not treat clinical cases with spiritual methods. Rather, the pastors recognized that serious mental health issues were better dealt with by a trained mental health professional. They served as gatekeepers by advising such parishioners to seek outside help (Adksion-Bradley et al., 2005). The pastors' recognition of their limitations can be considered an admission of not feeling competent to treat serious mental illness. However, that recognition also implies the pastors' possessed an important aspect of competence, because competence entails not only knowledge, skills, and attitude; it also entails an individual is aware of his or her limits and makes referrals when appropriate (WHO, 2011).

The study has implications for mental health professionals based on the finding that the interviewed pastors acknowledged the value of mental health professionals who are trained to deal with serious cases of mental illness. Their recognition of the important role played by mental health professionals suggests that African American pastors may be receptive to an increased degree of cooperation between themselves and the professional mental health community. Cooperation between African American pastors and the professional mental health community could benefit mental health professionals by helping them better understand the role that spirituality plays in the mental well-being of many African Americans.

Research indicates that the majority of counseling psychology training directors report that religious and spiritual issues are not considered to be as important as other kinds of diversity in their training programs (Schulte et al., 2002). Yet, highly religious clients want professional therapists to respect and integrate their religious beliefs into therapy (Worthington & Sandage, 2001). Cook and Wiley (2000) advised professional therapists to assess how their religious clients and their families are involved in their church and to determine what spiritual tools have been useful for the client. Cooperation between mental health professionals and African American pastors could increase the professionals' sensitivity to the important role religion may play in the mental health of some of their clients.

It should be noted that Williams, Gorman, and Hankerson (2014) have reported on a program to promote partnerships between African American congregations and mental health providers. In particular, the researchers described steps toward the development of a Mental Health Ministry Committee in African American churches. The committee is meant to educate clergy, reduce stigma, and further the seeking of treatment for depression. Main features of the program are the formation of relationships between mental health providers and church

leadership, use of a community-based and participatory approach, and flexibility in developing the program.

The possibility of increased cooperation between African American pastors and mental health professionals creates a third implication of the study's findings. This implication concerns the parishioners of African American churches and the stigma they often associate with mental health treatment. This perceived stigma, combined with shame and feeling embarrassed, results in African Americans being reluctant to seek the help of mental health professionals (Snowden, 2001). Given this reluctance, if parishioners of African American churches become aware that their pastor has a positive view of mental health professionals and the work they do, their own attitudes toward the work done by mental health professionals may become more accepting and positive. By addressing the issue of the value of the work done by mental health professionals in their sermons, newsletters, or other communications, African American pastors may help lessen their congregants' perceived stigma associated with visiting mental health practitioners.

Limitations

One limitation of the study was the size of the sample. Though a sample size of 12 pastors was sufficient to gather a variety of responses, a larger sample size including several pastors from different denominations would have been preferable. With only one or a few pastors from each denomination, it was impossible to draw any conclusions about the possible differences among pastors representing different dominations.

A second limitation of the study was that the pastors interviewed were all from the state of Texas. African American pastors from other states or other regions of the country may have substantially different practices and attitudes regarding dealing with their parishioners' mental health issues.

A third limitation was the study's focus on the practices, attitudes, and competencies of members of one specific ethnic group of pastors, i.e., African American pastors. Including other pastors from other ethnic-racial populations might have allowed for a broader understanding of pastors' counseling competence as it relates to addressing mental health within the congregation.

A fourth limitation was the time limit of 30 to 60 minutes placed on the length of the interviews. Pastors are generally very busy people, and it was judged that setting this time limit was necessary in order to respect the pastors' time and for a sufficient number of pastors to agree to be interviewed. If it had been possible to interview the pastors for a greater length of time, then more questions could have been asked and responses to the questions could have been explored further.

A fifth limitation of the study was that there were no interview questions focused on eliciting the criteria the pastors use to determine whether or not a parishioner who comes to them with mental distress needs to be referred to a mental health professional. Though it is clear from the results of the study that the pastors interviewed did make such an evaluation at times, it was not clear from their responses what criteria they used in making those evaluations.

Recommendations

Several recommendations for further research can be made on the basis of the study's results. Overall, research on the practices, attitudes, and competence of African American pastors as they deal with their parishioners' mental health issues is sparse. Additional research on these individuals could provide a more extensive and holistic body of information from which to draw conclusions and implications.

In particular, further research is needed on the attitudes of African American pastors toward professional mental health providers and their practices in regard to referring parishioners

to mental health providers. Some prior research suggests that African American pastors are reluctant to refer their parishioners to mental health providers. However, findings from the present study indicate that the interviewed pastors were mostly amenable to making such referrals. The findings from the studies by Aten et al, (2010) and Avent et al. (2015) also suggest that many African American pastors have positive views of mental health providers. Further research is needed to determine the views and practices of African American pastors regarding professional mental health providers.

Additional research could target participants that are not only from one particular state, but rather include African American pastors from a broader selection of states and regions. It would be valuable, for example, to know whether African American pastors from the Western and Eastern regions of the United States are similar in their practices, attitudes, and self-described competence in their dealings with parishioners with mental health issues.

It is also recommended that future similar studies be conducted comparing African American pastors in different religious traditions in regard to their practices, attitudes, and competency when dealing with mental health issues of their parishioners. Such research could reveal whether there are differences among pastors in different denominations. For example, a future study might compare evangelical Protestant pastors with mainstream Protestant pastors.

A third recommendation for future research is to conduct a study that focuses on what criteria African American pastors use in deciding whether a parishioner with mental distress needs to be referred to a mental health professional. Such a study might be of benefit to African American and other pastors by helping them understand the various criteria that their colleagues use to make a determination of referral.

Finally, it is recommended that research be conducted on ways African American pastors and mental health professionals could increase their communication and cooperation. The program of cooperation between African American clergy and mental health professionals reported by Williams et al. (2014) holds promise for the development of similar programs promoting collaboration between the African American church and providers of professional mental health services. The results of the present study suggest that many African American pastors might be open to such expanded collaboration. Increased communication and cooperation between the two parties could benefit both sides and might ultimately be of benefit to parishioners of African American churches.

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APPENDICES

Appendix A

St. Mary's University

Information Sheet for Participation in a Research Project

Title: The Experiences of African American Pastors Treating Mental Health Issues among

Parishioners in the State of Texas

You are being asked to participate in a research study that addresses the competence of Black pastors on addressing mental health and illnesses within the church. I understand that participation is voluntary.

This research study is being conducted by Rosalind Smith to complete the requirements for the Counseling Education and Supervision PhD program. The participants will consist of Black pastors only, male or female. Questions on a brief demographic questionnaire will cover demographics of the participant and questions relating to knowledge, skills and training regarding mental illness. I estimate that the demographics of the questionnaire will take approximately 5 minutes to complete. The interview portion of the study will take 30 to 60 minutes to complete. This study is confidential, meaning that your identity will not be revealed. The records for the study will be kept private. Research records will be stored securely and only Rosalind Smith and Dr. Montilla will have access to the records.

If you agree to participate in this study, understand that:

1. No physical or emotional risks are likely to occur to you.

2. No monetary rewards will be given to you personally for your participation. A donation of $10 will be donated to the church.

3. You may refuse to answer any questions that may make you uncomfortable.

4.   You can withdraw at any time without suffering any penalty.

5.   There will not be an alternate set of interview questions or an alternate

demographic questionnaire for those who do not wish to or are unable to complete this

study.

The results will be compiled in the coming months and made available upon request for

you to view at the conclusion of the study. This study will provide additional information to

African American research and may help in the effort to build stronger community/church

relationships.

If you have any questions regarding your rights as a participant or concerns about this

study, you can contact: Rosalind Smith at 512-293-2526 or browndelta@aol.com and/or Dr.

Estaban Montilla at 210-438-6400.

Any questions regarding your rights as a research participant may be addressed to the St. Mary's University Institutional Review Board Human Subjects (210-436-3315). All research projects that are carried out by investigators at the university are governed by requirements of the university and the federal government.

Appendix B

Letter to Pastors

January 2017

Dear Pastor:

My name is Rosalind Smith. I am a doctoral candidate at St. Mary's University in San

Antonio, Texas in the Counseling Education and Supervision program. Currently, I am doing

research on **The Experiences of African American Pastors Treating Mental Health Issues**

among Parishioners in the State of Texas.

My interest in this topic is directly related to my affiliation with a Black church and my

profession as a licensed professional counselor in the mental health field. I value and respect the

role pastors play in the lives of their congregants daily. As a church member, I understand that

pastors are called upon to assist in many capacities. In doing this research, my desire is to

provide additional resources specifically for pastors as they guide their congregants to spiritual,

mental and social maturity. According to Proverbs 4:7, "Wisdom is the principal thing; therefore

get wisdom. And in all your getting, get understanding."

Pastor, I am seeking your assistance in this study by asking you to participate by

completing a demographic questionnaire and a 30-60 minute interview to be arranged at a time

and place that is convenient for you. Your participation is completely voluntary and confidential,

and your identity in the study will remain anonymous. The enclosed information sheet specifies

ethical guidelines and provides further details for the research.

If you would be so kind as to agree to participate in my research project, please complete the enclosed demographic questionnaire and return it in the self-addressed envelope provided for your convenience. **Please return as soon as possible.** My goal is to collect all data as soon as possible. If you have any questions about completing the form or about the interviews, please feel free to contact me at (512) 293-2526 or by email at browndelta@aol.com. Dr. Montilla is my dissertation committee chair and you may also contact him with questions or concerns related to this research at (210) 438-6400. Once again, your participation is voluntary, confidential and very important.

Thank you so much for your cooperation and attention in this matter. Your help would be truly appreciated!

Sincerely,

Rosalind Smith, M.S., NCC, LPC-S

Appendix C

African American/Black Pastors' Demographic Questionnaire

1.   What is your gender?   Male ____   Female ____
Other ____

2.   What is your current age? _____

3.   What type of diploma or degree do you currently possess? GED, BA/BS, High School diploma, MA/MS, PhD/MD/JD, Associate's degree, Other _____

4.   Please specify the field in which this degree was earned? _____

5.   Name of the institution issuing the degree, if applicable. _____

6.   Do you have any formal or informal training in the following counseling disciplines? (Please circle any applicable letters.)

     a.   Counseling courses (how many hours total) _____

     b.   Licensed Professional Counselor (Masters-level)

     c.   Psychologist

     d.   Psychiatrist

     e.   Social Worker

     f.   Licensed Marriage and Family Therapy

     g.   Substance Abuse Counselor

     h.   Workshop

     i.   Seminar

     j.   Other _____

7.   How many years have you been the pastor of this congregation? _____

8.   How many members are in your current congregation?
_____

9.   What is your current religious denomination? Baptist, AME, Church of Christ, Pentecostal, Catholic, Methodist, Other

_____

10.   Please indicate below how many classes, seminars or workshops you have attended involving issues of counseling. Provide your best guess or estimate for each.

Academic Classes _____

Seminars   _____

Workshops   _____

Thank you for your assistance in completing this questionnaire. Any information that you provide will be kept strictly confidential. Please return by _____ 2017.

Sincerely,

Rosalind Smith, M.S., NCC, LPC-S

Rosalind Smith, NCC, LPC-S, ABD

SUMMARY OF QUALIFICATIONS

- Highly skilled professional with over 10 years of supervisory experience in school and clinical settings.
- Exceptional knowledge of individual and group counseling methodologies.
- Adept in providing professional training and classroom instruction.
- Outstanding ability to interact positively with consumers, staff members, and community agencies.
- Experienced in supervising master-level student clinicians for licensed professional counseling and public school counseling.

EDUCATION

St. Mary's University, **San Antonio, TX**

PhD, Counseling Education and Supervision, expected December 2017   2010 - 12/2017
Dissertation: The Experiences of African American Pastors Treating Mental Health Issues among
                Parishioners in the State of Texas
Chair: Dr. Montilla

Tarleton State University, **Killeen, TX**   2007 - 2009
Master of Science, Counseling Psychology

Texas A& M-Commerce, **TX**   1996 - 1999
45 hours in Education Administration

Paul Quinn College, **Dallas, TX**   1991 - 1995
Bachelors of Science, Physical Education and English

PROFESSIONAL REGISTRATIONS, LICENSURES & CERTIFICATIONS

- Licensed Professional Counselor in Texas-Supervisor #66000
- National Certified Counselor
- Texas State Certification in Guidance Counseling

RESEARCH INTERESTS

- The Experiences of African American Pastors Treating Mental Health Issues among Parishioners in the State of Texas

PUBLICATIONS

Smith, R. (2011). Parent-Teacher Relationship: Evidence of Positive Educational Outcomes for Children. *The Hutto News.*

Smith, R. (2011). Parent-Child Relationship: Building and Maintaining a Positive Relationship. *The Hutto News & Manor Newspaper*

HIGHER EDUCATION TEACHING EXPERIENCE

Teacher Assistant, **Group Process**   Fall 2011
St. Mary's University, San Antonio, TX

Served as an assistant instructor for a Group Process counseling course for master-level graduate students. Responsibilities included leading class discussions, facilitating groups, weekly consultation with professor, grading assignments and weekly quizzes, and responding to students' emails.

Teacher Assistant, **Human Growth & Development**   Spring 2011
St. Mary's University, San Antonio, TX

Co-instructed a Human Growth and Development course. Responsibilities included leading class discussions, consulting with professor on assignment, facilitating group discussions, and answering student questions.

Teacher Assistant, **Human Growth & Development (Online)**   Fall 2010
St. Mary's University, San Antonio, TX

Responsibilities included co-teaching an online Human Growth and Development course. In addition, responded to discussion questions, provided feedback to students, replied to student emails in a timely manner, and consulted with professor regarding lessons, assignments & final exam papers.

LICENSED COUNSELING EXPERIENCE

Director of Behavioral Management and Life Skills at Mental Health Co-Op
                                                        (1/16-present)

- Work with Adults in the Life Skills program
- Develop programming for the mental health co-op
- Provide individual and group counseling
- Intake alternative for new residents

- Assessment
- Consultation with staff
- Educate and train master level interns
- Work and train residential care staff
- Documentation
- Participate in professional development
- Transport residents
- Crisis Management
- On-call clinician for the weekend shift

Clinical Supervisor @Correct Care Solutions, LLC at Ft. Bend County Jail
10/15-1/16

- Supervised master-level interns and fully licensed clinicians
- Weekly report on inmates seen
- Conduct assessment with patient inmates
- Triage inmate request forms or other staff forms
- Respond to inmate mental health crisis
- Maintain proper documentation
- Consult with other professional staff members
- Participate in professional development
- Provided professional support and educational training

LPC-S Therapist, **MHMRA-Harris County Jail, Houston, TX**   2/2015 - 8/2015

- Conducted individual supervision with master-level clinician interns.
- Performed assessments of patient inmates.
- Intakes
- Maintained proper documentation.
- Consulted with other staff, including doctors, psych technicians, and nurses.
- Triaged inmate request forms and deputy requests forms.
- Responded to inmate mental health crisis.
- Participated in all aspects of professional development.

Clinical Supervisor Therapist, **Cambridge Hospital, Houston, TX**   8/2014 - 1/2015

- Supervised clinical staff members
- Conducted individual, group counseling and family therapy
- Developed treatment plans.
- Performed assessments and discharge planning.
- Maintained proper documentation in files in a timely manner.
- Fostered community resource relationships.

- Conduct and Participate in professional development and staff meetings.
- Consulted with psychiatrist, utilization management, and other staff.
- Assisted psych technicians, as needed.

Clinical Supervisor/Team Lead, **Family Innovations LLC, Charlotte, NC**
9/2013- 7/2014

- Supervised clinical staff members
- Facilitated daily morning meetings with the team.
- Reviewed clinician notes and documentation.
- Established community resource relationships.
- Provided professional development training for staff.
- Completed staff performance evaluations.
- Conducted individual and group counseling.
- Developed client treatment plans.
- Performed client assessments in the community.
- Maintained proper documentation.

ADDITIONAL PROFESSIONAL EXPERIENCE

Counselor, Faith Counseling & Psychotherapy, Round Rock, TX	3/2010 - 8/2013
Counselor, Elgin Elementary, Elgin TX	8/2012 - 8/2013
Counselor, Travis Science Academy-Middle School, Temple TX	8/2011 - 6/2012
Counselor, **Casis Elementary, Austin, TX**	9/2010 - 6/2011
Substitute Counselor, **Bluebonnet Trail Elementary, Manor, TX**	2/2010 - 4/2010
Physical Education Teacher, **Oak Meadows Elementary, Manor, TX**	8/2008 - 9/2010
Vice Principal, **Bluebonnet Trail Elementary, Manor, TX**	8/2006 - 6/2008
Vice Principal, **Manor High School, Manor, TX**	7/2005 - 6/2006
Vice Principal, **West Avenue Elementary, Waco, TX**	7/2003 - 6/2005