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Faith Leaders' Perceived Role in Mental Health Promotion in Impoverished Communities

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Abstract

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Kelly L. Cornish

MS, Walden University, 2017

MEd, University of Phoenix, 2005

BA, Rutgers University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The use of faith-based organizations (FBO) for health promotion in vulnerable communities has the potential to improve mental health outcomes by providing resources to community members. The purpose of this generic qualitative study was to explore how faith leaders perceived their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. The health belief model and theory of planned behavior were used as the conceptual framework. Purposeful and snowball sampling was used to recruit eight faith leaders who led a FBO and resided in Cumberland County, NJ. Data were collected using semistructured interviews. The data were analyzed using the six steps of thematic analysis: familiarize, code, generate, review, define and name, and report. Seven main themes were identified. Faith leaders identified poverty as a contributor to mental health problems and a factor to limited resources and also indicated that they had a positive role in mental health promotion as leader and influencer. They also indicated they needed to do more with mental health promotion because it was their responsibility to address the mind, body, and spirit of individuals. A key finding was that participants engaged in mental health promotion activities without realization or conceptualization of what they were doing. It is recommended that faith leaders are taught the conceptualization of mental health promotion to implement strategies more effectively. The findings may be used by service providers and faith leaders to establish collaborative relationships as a tool to improve mental health promotion in FBOs to improve mental wellness and resource linkage in underserved and vulnerable communities.

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Dedication

This is dedicated to my three reasons why Synquis, Reginal, and Taylin. I have been in school as long as you have been in my life. You three are the reason I kept going and going. There is nothing that you cannot achieve in life. You just have to choose and commit to accomplishing it. I pray I have made you proud and modeled for you strength and perseverance.

I also dedicate this work to those who are struggling with mental health. I began this journey to make a difference and I will.

Acknowledgments

First, above all things I want to give all the glory and honor to God for being my strength and refugee during this process. Next, to my family and friends that have listened to countless hours of the good, bad, and ugly of this process. Thank you for always listening even when you had no idea what I was talking about. I have a special thank you for my cohort sisters Akisa Jones and Rebekah Montgomery. I would not have survived this process without your friendship. We did it ladies!

This process was not without roadblocks, detours, and speedbumps. Dr. Scotten, I appreciate your excitement, wisdom, and expertise about mental health and the many resources you have provided to me. I thank you for your patience even when I did not have anymore! Dr. Matthey, I thank you for your expertise, direct feedback, and guidance. Dr. Jorissen, thank you so much for the abundance of feedback, tips, and suggestions. I also would like to thank my academic advisor, Dr. Judia Yael Malachi. I do not know what I would have done if I did not have your voice of reason. This process has taught me so much about myself, and I am thankful to all of you for teaching, guiding, and correcting me during this process. Thank you all for not giving up on me and encouraging me to move forward even when I could not see the end. I did it!

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Chapter 1: Introduction to the Study

Introduction

Mental illness that is underdiagnosed or untreated can have catastrophic results on society. Mental illness is a universal problem that has a global cost of $2.5T, with a projected cost of $16T by 2030 (World Health Organization [WHO], 2011). Mental health affects how people make health decisions, interact with others, and handle stress (Centers for Disease Control and Prevention [CDC], n.d.). Although mental illness affects people from all racial, ethnic, and socioeconomic backgrounds, poverty is a social determinant linked to health disparities (Thornton et al., 2016). More specifically, poverty is known to increase the likelihood of poor mental health outcomes (Burns, 2015; World Health Organization and Calouste Gulbenkian Foundation [WHO-CGF], 2014). Therefore, addressing mental health in impoverished communities may help improve mental health outcomes for vulnerable populations.

People who live in poverty experience access to care barriers in healthcare. Beyond the financial burden of health care, the availability and accessibility of healthcare are problematic (Saluj et al., 2019). As a response to the availability and accessibility of health care, government funding was allotted to assist communities with bridging the gap between low-income communities and service provisions (White House Faith-Based & Community Initiative, n.d.; White House President Barack Obama, n.d.; White House President George W. Bush, n.d.). The use of faith-based organizations (FBOs) was identified as a practical option to help improve treatment disparities in communities with limited resources (Berkley-Patton et al., 2019; Webb et al., 2019). FBOs (i.e., churches,

mosques, temples, synagogues) are nonprofit agencies located in communities founded on the principles of religious beliefs and faith (Tagai et al., 2018; Terry et al., 2015; Villatoro et al., 2016). According to the Pew Research Center (n.d.), 33% of Americans attend services weekly and 36% attended once or twice a month. Because FBOs have the ability to reach large numbers of individuals, the government identified them as viable options for service provisions in impoverished communities (Hikind, 2018).

Scholars have examined health promotion in FBOs (Harmon et al., 2016; Koenig et al., 2015; Martinez et al., 2016; Robles et al., 2019; Schwingel & Gálvez, 2016; Tucker et al., 2019; Wong et al., 2018). Yet, there has been a limited focus on mental health promotion in FBOs (CDC, n.d.). Physical and mental health should be viewed together because of their direct relationship with each other (Ohrnberger et al., 2017). Disease or chronic illness can negatively impact mental health, and poor mental health can create physical symptoms (American Heart Association, 2018; CDC, 2020). Although there is a link between physical and mental, there continues to be limited inclusion of mental health promotion programming in FBOs.

The government has allotted money for services in vulnerable communities, but FBOs are not leveraging the resources for mental health promotion (O'Neill, 2009). Faith leaders make decisions or approve programs within their organization, which is where the possible disconnect occurs (Tagai et al., 2018). Previous researchers who studied faith leaders and mental health promotion identified the lack of training on mental health literacy, lack of space, and conflict with doctrine or personal beliefs as reasons mental health is not included in health promotion (Andren & McKibbin, 2018; Brand, 2019;

Dossett et al., 2005; Leavey et al., 2016). The faith leaders identified barriers that focused on beliefs, education, and structural issues and not on the faith leader's actual role in health promotion. Therefore, how faith leaders perceive their role in mental health promotion should be studied to determine their role in mental health promotion. The focus of this study is on the faith leaders' perception of their role in mental health promotion.

Chapter 1 provides an introduction to the study. An overview of the literature on mental illness, poverty, FBOs, faith leaders, and mental health promotion is presented. Next, the problem statement, the purpose of this study, and the research question are provided. An overview of the conceptual framework developed using the health belief model (HBM) and the theory of planned behavior (TPB) will be explained. My rationale and methodology will be explored with consideration given to the study's scope, delimitations, and limitations. Finally, significance and social change implications are reviewed.

Background

Mental illness is characterized as a change in behavior, cognition, or mood that causes impairment, distress, or problems in functioning over multiple domains (work, school, family) in a person's life due to changes in emotion, thinking, or behavior (American Psychiatric Association, 2013). The National Institute of Mental Illness (NAMI, 2019) and the National Institute of Mental Health (NIMH, 2019) excluded developmental and substance-related diagnoses from the definition, which is relevant for this study. Mental illness is categorized as any mental illness or severe mental illness

with effects ranging from no impairment to severe impairment, and mental illness impacts 1 in 5 U.S. adults (NIMH, 2019).

The Department of Health and Human Services (2019) allotted $1.5 billion exclusively for mental health services, excluding substance abuse treatment, for 2020 to be used among the U.S. states. The lack of mental health treatment could include poor health outcomes, an approximate 25-year reduction in life expectancy, and substantial monetary loss for the individual (NAMI, 2019). The indirect costs of mental illness include the loss of workplace productivity, income loss, expenses for the inclusion of social support provisions, disability payments, and healthcare costs (Coduti et al., 2016; Trautmann et al., 2016). The ramifications of mental illness extend beyond the individual to the family (e.g., caregiver) and society indirectly due to the caregiver loss of workplace productivity, income loss, feelings of exhaustion and frustration, disability payments, and healthcare costs (Coduti et al., 2016; Schiffman et al., 2014; Trautmann et al., 2016).

Multiple factors contribute to the access and continuity of treatment modalities across the United States. Some individual barriers that impact mental health treatment include social and self-perceived stigma (Fox et al., 2018); accessibility (Saluja et al., 2019); racial disparities and culture (Ljungqvist et al., 2016); lack of health insurance (Ljungqvist et al., 2016); provider mistrust and inadequate amount of providers who are representative of community demographics (Fripp & Carlson, 2017); and poverty (Ljungqvist et al., 2016; Mesidor et al., 2011). Poverty is also directly linked to poor mental health outcomes due to the lack of education, referral services, effective

assessment, and treatment options (Carpenter-Song & Snell-Rood, 2017; Grace et al., 2016; Ljungqvist et al., 2016).

Efforts to reduce treatment barriers have included culturally relevant education and training for the professional, psychoeducation for the consumer, and policy interventions to improve the accessibility and quality of healthcare (Villatoro et al., 2016; Wahlbeck et al., 2017). Cherry et al. (2017) identified the need for alternative programming and delivery methods as a solution to improve mental health accessibility and care in impoverished communities. Alternate forms of mental health programming and resources include mental health literacy programs, church-based health promotion initiatives, distribution of educational pamphlets, and mental health training that are often deliverable through community-based venues (Cherry et al., 2017; Hays, 2018; Milstein et al., 2017).

I am focusing on the use of FBOs and the role of faith leaders in providing mental health promotion as a resource to improve mental health treatment care in impoverished communities. FBOs (e.g., churches, mosques, temples, synagogues) are community-based, 501 (c)(3) nonprofit agencies and are documented in research as practical resources for the improvement of mental health outcomes in impoverished locales (Andren & McKibbin, 2018; Tagai et al., 2018; Villatoro et al., 2016; Williams et al., 2014). Leaders of FBOs have the potential to provide mental health resources to a large number of diverse community members because of their influential role in the community and their ability to establish rapport and trust among members (Fripp & Carlson, 2017; Hays & Aranda, 2015; Sytner, 2018). Leaders can extend FBO services,

such as prayer and counseling, to include personal homes, incarceration facilities, hospitals, and nursing homes (Chatters et al., 2017).

Researchers have shown that some individuals prefer to seek help from clergy for an array of life problems, mental health disorders, and drug/alcohol problems before seeking help from mental health professionals, which supports the importance of the faith leader in mental health promotion (Chatters et al., 2017; Fripp & Carlson, 2017; Hardy, 2014; Sytner, 2018; Webb et al., 2013). Although some individuals prefer seeking assistance from clergy, there are documented barriers for sustainable collaborative relationships between FBO leaders and mental health providers, which include organizational capacity, personal bias, conflict with doctrine and medicine, the mental health literacy of FBO leaders, and the cultural competence of mental health providers (MHPs; Milstein et al., 2017; Sytner, 2018; Tagai et al., 2018; Vermaas et al., 2017). The perceptions of the faith leaders' role in mental health promotion at their organizations are important to the formation and substantiality of programs.

Previous researchers have identified numerous barriers to mental health treatment and solutions (Byrne et al., 2017; Cheesmond et al., 2019; Fox et al., 2018; Fripp & Carlson, 2017; Ljungqvist et al., 2016); yet, there is a lack of literature on mental health promotion in FBOs. There is a lack of literature on the faith leaders' perception of their role in mental health promotion. The faith leaders' perception of their role is critical to define because it may provide insight on why general health promotion is seen in FBOs more frequently than mental health promotion. Given such, further research was warranted that determines faith leaders' perception of their role in mental health

promotion as a resource to improve access to mental health care in impoverished communities.

Problem Statement

Mental illness impacts 1 in 5 adults, or approximately 44.6 million individuals, yearly (Bloom et al., 2011). NAMI (2019) and NIMH (2019) defined mental illness as a condition that affects a person's mood, feelings, thoughts, ability to relate to others, or daily functioning, excluding developmental and substance abuse disorders. Mental illness can affect anyone ranging in severity from mild to severe; yet, there is a disparity of mental illness incidences among impoverished individuals (NAMI, 2019; Thornton et al., 2016). People living in poverty are disproportionately affected by common mental health disorders, such as anxiety and depression (Herrman et al., 2005; Lund et al., 2010; Purtell & Gershoff, 2016; WHO-CGF, 2014). Mental illness and poverty have a cyclical relationship (Wahlbeck et al., 2017). Researchers have shown that a person living in poverty is more likely to experience poor mental health outcomes (Herrman et al., 2005; Wahlbeck et al., 2017) and that poor mental health is a contributor to the individual staying in poverty (Wahlbeck et al., 2017; WHO-CGF, 2014). With 34 million people living in poverty in the United States (United States Census Bureau, 2020), barriers to mental health care in impoverished communities can be detrimental to positive health outcomes.

Accessibility to mental health care in the United States is a problem, as evidenced by 57.2% of adults with mental illness not receiving treatment in 2019 (Reinert et al., 2019). Access to care barriers are documented in the literature as stoicism and social and

self-perceived stigma (Fox et al., 2018), lack of specialty care or limited providers (Cheesmond et al., 2019), eligibility gaps in government-funded programs (Cheesmond et al., 2019), service availability (Byrne et al., 2017), provider mistrust (Fox et al., 2018; Fripp & Carlson, 2017), lack of health insurance (Langholz, 2014; Ljungqvist et al., 2016), cost and transportation (Cheesmond et al., 2019; Sulat et al., 2018), and culture and poverty (Ljungqvist et al., 2016). Poverty is also a documented barrier to care and a contributor to a person being diagnosed with a mental illness, thus creating the need to improve access to mental health care in impoverished communities (Burns, 2015; Wahlbeck et al., 2017).

FBO leaders are viewed as trustworthy, influential gatekeepers who have the potential to provide mental health resources to a large number of diverse community members (Baruth et al., 2015; Fripp & Carlson, 2017; Hays, 2018; Sytner, 2018). Several researchers have identified FBOs as community-based organizations that can be resources for addressing mental health concerns in impoverished locales because of their reach (Berkley-Patton et al., 2019; Cherry et al., 2017; Kehoe, 2016; Terry et al., 2015; Webb et al., 2019). Cherry et al. (2017) recommended using established community agencies in impoverished communities, such as FBO and schools, to develop tailored treatment programs and to provide social support to individuals in need of mental health care. Hays (2018) proposed that African American, church-based health promotion (CBHP) programs have emerged to address mental health issues in African Americans. FBOs are underused as resources for mental health promotion (Kwon et al., 2017).

There is an abundance of literature about health promotion programming (HPP) in FBOs (Batada et al., 2017; Berkley-Patton et al., 2019; Chatters, 2000; Harmon et al., 2016; Koenig et al., 2015; Tucker et al., 2019). There are also researchers who have studied mental health and FBO leaders that have documented information on the topic that includes the faith leaders' attitudes and perceptions of mental illness (Leavey et al., 2016; Milstein et al., 2017), their mental health literacy (Vermaas et al., 2017), barriers to service provision (Leavey et al., 2016; Milstein et al., 2017), screening and referral practices (Sytner, 2018), their role in general health promotion (Tagai et al., 2018), and comfortability with providing counseling. However, there are gaps in the literature on faith-based mental health promotion and the role of the faith leader in mental health promotion. Hankerson and Weissman (2012) indicated that there continues to be a lack of literature on faith-based mental health programs. Levin (2014) argued that the FBO leader must buy-in before the establishment, implementation, and participation of any HPP can occur within an FBO. Baruth et al. (2015) observed that the role and influence of the faith leader in health promotion is not studied or understood. Therefore, further research is needed to understand the role of faith leaders, specifically in mental health promotion, to understand the use of FBOs as resources to improve access to mental health care in impoverished communities.

Purpose of the Study

The purpose of this generic qualitative study was to determine faith leaders' perceptions on their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. It is critical to understand faith leaders'

perceptions of their role with promoting mental health before FBOs can be used as a resource. Baruth et al. (2015) suggested the need for further research on the role and influence of FBO leaders in health promotion. This information is needed because the faith leaders' perception of their role may determine the potential usage of the FBO for mental health promotion as a resource to improve access to mental health care in impoverished communities.

Research Question

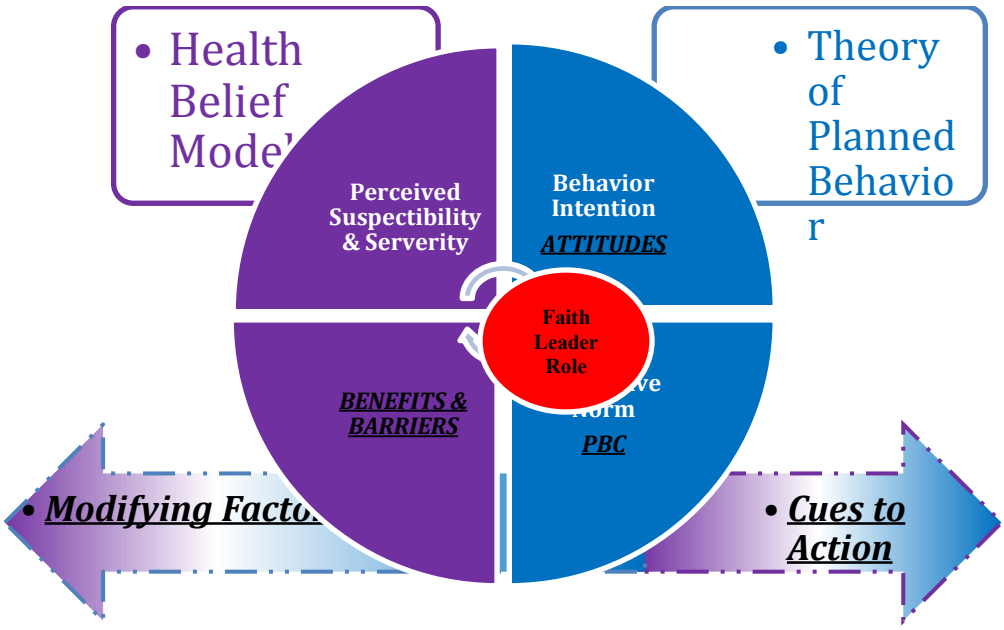
Research Question: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities?

Conceptual Framework

The conceptual framework for this generic qualitative study is the HBM and the TPB. I chose these frameworks because they are both designed to explain and predict human social behavior, along with the ability to be used as a conceptual framework for behavioral change interventions (Ajzen, 1991; Glanz et al., 2015; Sharma, 2017; Tornikoski & Maalaoui, 2019). Overlapping components are seen among the models (Aiken, 2010). The differences allow for the exploration of faith leaders' perspectives on mental health promotion in FBOs as a contributor to the perceived role in offering mental health promotion as a resource (see Figure 1). The HBM was used to conceptualize the faith leaders' perception of their role in mental health promotion, while the TPB allowed for the conceptualization of mental health promotion as a foundation to help with identifying the faith leader's role.

Figure 1

HBM and TPB Similarities and Differences



Health Belief Model (HBM)

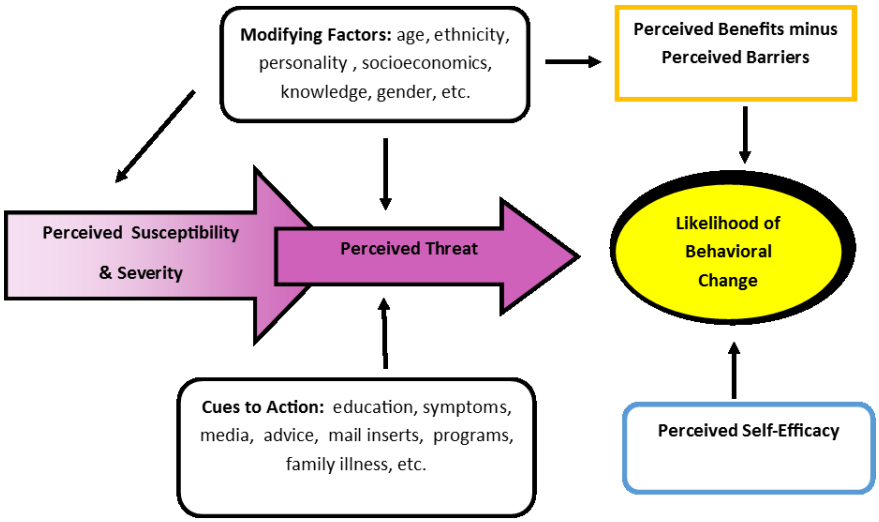
Hochbaum and Rosenstock are credited with the development of the HBM in the 1950s for use in the public health realm to explain why people would not participate in health programs that prevented or detected disease (Hochbaum, 1958). The model is based on personal beliefs, or interpersonal factors, that are justifications or explanations of behavior (Rosenstock, 1966). The HBM has six constructs that are presented as the foundation for the current study (Figure 2).

1. Perceived susceptibility is the belief of contracting a condition or disease.
2. Perceived severity is the belief about the seriousness of the condition or disease.

3. Perceived benefit is the belief in the benefits of engaging in an action to prevent or reduce a condition or disease or having positive effects.
4. Perceived barriers are beliefs about the tangible and nontangible costs of engaging in an action.
5. Cues to action refers to conditions that prompt a person to take action, such as environmental influence or personal change.
6. Self-efficacy is the confidence that the person can successfully implement the action or has the ability to take action (Glanz et al., 2015; Henshaw & Freedman-Doan, 2009; Rosenstock, 1966; Rosenstock et al., 1988).

Figure 2

Hochbaum & Rosenstock's Health Belief Model



According to the premises of the HBM, people are more inclined to take action to change health behaviors if a threat to the condition or illness is perceived by the person (Glanz & Bishop, 2010). Researchers have identified perceived barriers and benefits as strong predictors of behavior change (Carpenter, 2010; Janz & Becker, 1984). Beyond

the benefits and barriers, other factors known as cues to action or triggers can influence health behaviors. These factors include sociopsychological variables, level of education, demographics, personal experience, raised awareness heath related material, family history, or symptoms (Abraham & Sheeran, 2015; Henshaw & Freedman-Doan, 2009). Finally, self-efficacy involves the confidence and ability level of the person to make the change, which is the least studied construct (Carpenter, 2010; Champion & Skinner, 2008).

My focus was not on the faith leaders' threat of acquiring disease, but rather on the factors that shape the faith leaders' perception of their role in mental health promotion to improve accessibility to mental health care. Therefore, constructs two through six are applicable to this study. I used the HBM as a basis for the interview questions and to collectively look at interpersonal factors, external factors, individual perception, self-efficacy, benefits and barriers, and cues to action in an effort to determine the perceived role of the faith leader in mental health promotion.

Theory of Planned Behavior (TPB)

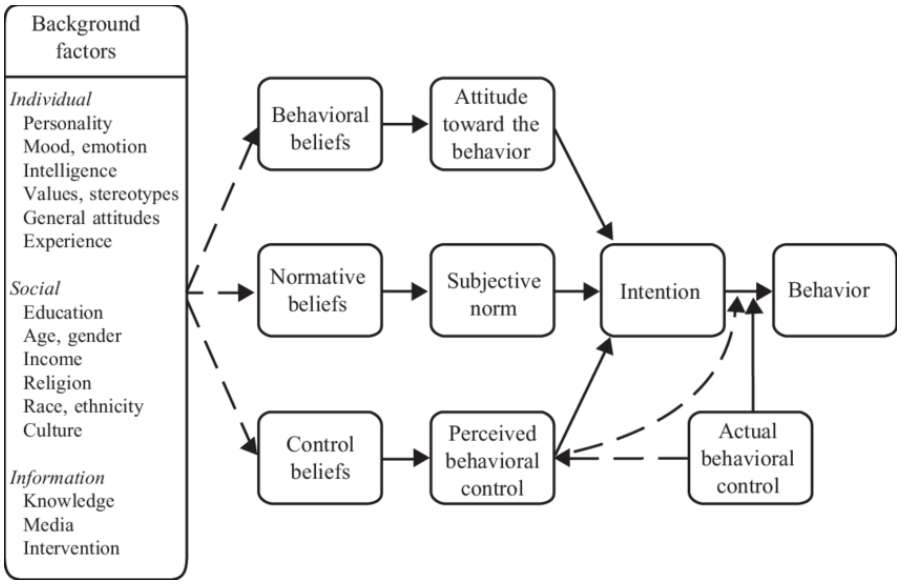
The theory of reasoned action (TRA) must be discussed to understand the development of TPB and its constructs. Fishbein and Ajzen (1975) developed the TRA as a result of their work on determining differences between behavior and attitude. The TRA posits that a change in behavior occurs based on a behavioral intention that is influenced by the attitudes a person has about the behavior and the influence of others who are deemed significant in the person's life (Ajzen & Fishbein, 1973, 1980). Ajzen (1991) expanded the TRA to the TPB in the late 1980s and early 1990s to include the construct

of perceived behavior control (PBC). PBC refers to the level of control a person feels they have over the behavior (Ajzen, 1991). The TPB has four major constructs (Figure 3). An overview can be seen below that include the influencer of each construct.

1. Behavioral intention, or motivation, is what drives the behavior and is seen as the key determinate to behavior change. It includes the likelihood of behavior engagement. Influencers: attitudes, subjective norms, and PBC.
2. Attitudes towards behavior is the value placed on the behavior based on favorable or unfavorable outcomes. Influencers: behavioral beliefs and the evaluation of the behavioral outcomes.
3. The subjective norm can be viewed as social pressure to perform behavior or the need to have approval or disapproval from others. Influencers: normative beliefs, or social norms and motivation to comply.
4. PBC, or ability/self-efficacy, is the level of control a person feels they have in the behavior change. Influencers: control beliefs, or internal and external factors that contribute to the performance of the behavior and perceived power, or the level of difficulty in the behavior (Ajzen, 1991; Ajzen & Fishbein, 1973; Sharma, 2017; Tornikoski & Maalaoui, 2019).

Figure 3

Ajzen's Theory of Planned Behavior



Note. This figure shows the relationship between the TPB constructs. Reprinted from *The handbook of attitudes* (94), by I. Ajzen & M. Fishbein, 2005. Lawrence Erlbaum Associates. Copyright 2005 by Icek Ajzen.

According to TPB, the individual's attitude, subjective norm, and PBC contribute to a person's behavior intention when the attitudes and norms are positive and the PBC is high (Ajzen, 1991). The constructs work together to explain or predict a behavior change. I used the TPB to focus on the behavior intention of the faith leader to offer mental health promotion and normative influences on offering mental health promotion. Attitudes, subjective norms, and PBC combined will presumably determine the behavior intention of the faith leader to engage in mental health promotion, thus contributing to the determination of the faith leaders' perception of their role.

The TPB, combined with the HBM, contributed to determining the faith leader' perception of their mental health promotion as a resource to improve access to care

barriers in impoverished communities. Both theories guided the development of the interview questions. A more detailed explanation of the HBM and the TPB will be included in Chapter 2.

Nature of the Study

This study used a generic qualitative approach. A generic qualitative approach focuses more on the experience (opinions, experience, reflections, perceptions) of the subject than in the inward experience of cognitive processes and how it was lived (Percy et al., 2015). According to Kahlke (2014), generic qualitative research designs are less defined than other qualitative methodologies and work well with studies that do not fit neatly under one specific methodology. Because the generic qualitative approach is not exclusively aligned to one methodology, the researcher has more freedom to explore the phenomena of interest using various qualitative techniques with less restriction (Kahlke, 2014; Kennedy, 2016). The generic qualitative research design allowed me to acquire detailed descriptions of the faith leaders' role in mental health promotion, not on the lived experience of the faith leader with mental health that aligns more with phenomenology. Therefore, the use of a generic qualitative approach was appropriate for guiding this research. Data were collected from faith leaders in Cumberland County, New Jersey using eight to 15 semistructured interviews.

Definitions

Faith-based organizations (FBO): FBOs maintain religious identity when providing activities, decision making, and staffing (Bielefeld & Cleveland, 2013). Additionally, their primary or secondary mission has a social service component in the

form of programs or projects (Terry et al., 2015; Villatoro et al., 2016). Examples of FBOs include churches, mosques, synagogues, and temples (Tagai et al., 2018; Terry et al., 2015; Villatoro et al., 2016; Williams et al., 2014).

Health promotion: Health promotion includes social and environmental interventions to improve the quality of life by focusing on causation, not treatment or cures (WHO, 2016).

Mental health: Mental health extends beyond the inclusion of mental illness (Satcher, 2000; WHO-CGF, 2014). Mental health is inclusive of a person's emotional, psychological, and social wellbeing that impacts how a person thinks, feels, and acts throughout the course of their life (Galderisi et al., 2015; Mental Health.gov, 2020).

Mental illness: Mental illnesses is a health condition that causes impairment in functioning over multiple domains in a person's life due to changes in emotion, thinking, or behavior, and results in distress (American Psychiatric Association, 2013).

Assumptions

The purpose of qualitative research is to acquire in-depth knowledge on a topic through interviewing (Rutberg & Bouikidis, 2018). Quantitative research is nontextual and compiles numerical data through instruments, such as surveys (Rutberg & Bouikidis, 2018). The goal of this study was to explore the perception of faith leaders. Therefore, the first assumption was that the chosen qualitative methodology will provide better results to answer the research question as opposed to a quantitative study. Next, I assumed that all participants were authentic and truthful during the interview process (Grant, 2014). There was an assumption that incentives can improve research participation, but there was also

a concern that incentives are seen as coercion (Goldenberg et al., 2007). Therefore, it was assumed that the participants would volunteer to participate in the study without a tangible incentive. A final assumption was that faith leaders are sincerely interested in mental health promotion, which is a limitation of the HBM model.

Scope and Delimitations

The scope of this study was to determine the faith leaders' perception of their role in mental health promotion in an impoverished community. Delimitations are characteristics of the study that the researcher controls that limit its scope (Simon, 2011). Delimitations are seen in this study with geographic location and participant selection. The study included faith leaders in an impoverished community who may or may not engage in mental health promotion. Cumberland County, NJ was chosen because it is considered semirural and it is identified as the poorest county in the state, supporting the use of impoverished communities of the research question. The use of a specific geographic location and the specificity of the location as impoverished might limit transferability to more affluent areas. Although mental illness is universal, the results from impoverished areas might not be applicable in other areas that have different challenges. I did not exclude participants based on race or denomination. The main inclusion criteria was faith leaders living in Cumberland County, NJ.

McLeroy's socioecological model (SEM) was considered as a theoretical framework for this study. McLeroy's SEM is an expansion of Bronfenbrenner's ecological systems theory (EST) to explain the impact on human development from the changing relationship between a person and the environment (Bronfenbrenner, 1979;

McLeroy et al., 1988). McLeroy et al. (1988) identified hierarchical systems that encompass the individual/intrapersonal, interpersonal, community, organizational, and policy/enabling environment. SEM would have allowed for the exploration of the influential systems on the faith leader relating to engaging in mental health promotion in FBOs. Although SEM could have been conceptualized to focus on faith leader's individual system, it would not have defined the role of the faith leader in mental health promotion. SEM would have provided the framework for an explanatory model that documented experiences that would not have answered the research question.

Another theoretical framework considered in my quest to understand why faith leaders are not readily engaging in mental health promotion was the social learning theory (SLT; Boone et al., 1977). SLT posits that people learn from the attitudes and behaviors of others through observation, imitation, positive reinforcement, and psychological processing, and it is most effective when observing a similar person (Boone et al., 1977; Deeming & Johnson, 2009; McCullough Chavis, 2011). Using the SLT would have provided me with information on the faith leaders' attitudes and influences to include or exclude mental health promotion in FBOs. However, I wanted to understand how faith leaders perceived their role in mental health promotion, not what influenced and reinforced their attitude or behavior. SLT would not allow an in-depth exploration of many factors that might contribute to a faith leader's perceived role in mental health promotion.

Limitations

Potential weaknesses that are outside of the researcher's control are called limitations (Simon, 2011). A limitation of the study was the use of generic, qualitative research. Generic qualitative research does not have a prescribed plan like the other quantitative methods. Critics argue that it lacks rigor (Kennedy, 2016). To address this limitation, I demonstrated trustworthiness in research. I used transcript review to increase credibility (see Kennedy, 2016; Moser & Korstjens, 2018; Shenton, 2004). To address comfortability, I engaged in reflexivity to reduce researcher bias (see Attia & Edge, 2017; Moser & Korstjens, 2018). I improved dependability and transferability by using audit trails and thick description of the research design, implementation, setting, and participants (see Moser & Korstjens, 2018; Reid et al., 2018). The study also had limited transferability regardless of detailed descriptions due to the demographic characteristics of the potential study participants.

Establishing the boundary between my belief system and others' belief system was an identified challenge to the study. I had to focus on the data and use reflective journaling as an aide to reduce my personal bias when interpreting data. Another challenge was to separate my role as a mental health provider from my role as the researcher in this study. I could not assume participants were as knowledgeable about the topic as I am or use my knowledge to influence answers to questions. I had to remain neutral and accept all responses without bias. Because I am expressive nonverbally, I needed to control my nonverbal behaviors, such as hand movements and facial expressions, during the interview to reduce perceptions of judgement.

Significance

Faith leaders are uniquely positioned to influence people's positive health behavior because of their trustworthy and influential nature. Researchers have shown that individuals who attend FBOs prefer to seek assistance from clergy for an array of life problems, mental health disorders, and drug/alcohol problems before seeking help from mental health professionals (Chatters et al., 2017; Fripp & Carlson, 2017; Hardy, 2014; Sytner, 2018; Webb et al., 2013). Understanding the positionality of the faith leader with mental health promotion in FBOs was important because their perceived role is the key to establishing and sustaining mental health promotion initiatives in underserved areas. Brand and Alston (2018) found that pastors who used HPP in their congregations influenced congregants to participate. The faith leader's influential nature could create the opportunity for more individuals to gain awareness of mental health and available resources to receive care.

My results may contribute to filling the literature gap in the faith leaders' perception of their role, specifically in mental health promotion, not general health promotion. My results also have the potential to contribute to the broader gap in the literature on faith-based mental health promotion (see Brand, 2019; Brand & Alston, 2018; Harmon et al., 2016; Robles et al., 2019). This was important because people living in poverty often have limited resources. Understanding the perspective of a community leader may provide insight on ways to implement mental health promotion initiatives in FBOs. The results might also contribute to closing the literature gap identified by

Harmon et al. (2016) on the use of FBOs as resources for mental health support and services.

The results may be beneficial to MHPs, faith leaders, and mental health organizations for determining whether the faith leader has or does not have a perceived role in mental health promotion. This information may contribute to how faith leaders could be approached by other community entities seeking the use of FBOs to potentially reach more individuals who may have mental health needs living in poverty-stricken areas. Social change implications may include contributing to a potential paradigm shift of HPP in FBOs to include more focus on mental health in addition to already established physical health topics (Brand & Alston, 2018). A paradigm shift may aid in the reduction of mental health care disparities by improving access to mental health care in impoverished communities. This study has the potential to improve the quality of life for individuals who have limited access to mental health care in impoverished communities.

Summary

Background information was provided on key elements of the study, which included mental illness, poverty, FBOs, faith leaders, and mental health promotion. The literature aided in creating the problem statement, purpose of the study, and research question. The study was conceptualized using the HBM and the TPB. A brief description and rationale for the use of a generic qualitative study was provided. Definitions were given for the clarity of terminology used throughout the study. Delimitations and limitations were explored to show the strengths and weaknesses of the study. Finally, the potential significance and social change implications were identified.

Chapter 2 will provide a review of the relevant literature related to mental illness, poverty, FBOs, faith leaders, mental health promotion, and barriers to the formation of mental health promotion initiatives. The role of FBOs in general health promotion will be explored due to the limited research on mental health promotion. Review of the constructs from HBM and TPA will be given, including how they build the framework for this study.

Chapter 2: Literature Review

Introduction

An overarching problem in the United States is the disproportionate impact of mental illness in impoverished communities (Burns, 2015; WHO-CGF, 2014). Poor mental health outcomes and poverty are directly linked to each other (Acri et al., 2017; Campion et al., 2013). Because people living in poverty are more prone to health disparities, they are more likely to encounter barriers to health care (Burns, 2015; WHO-CGF, 2014). As a solution to addressing mental health in impoverished communities, FBOs are identified in the literature as locations that can assist in reducing access to care barriers in poor communities by engaging in health promotion activities (Andren & McKibbin, 2018; Tagai et al., 2018). Health promotion in FBOs is linked to positive health outcomes in impoverished communities (Batada et al., 2017; DeHaven et al., 2004), but health promotion is centralized around physical activity and lacks focus on mental health. The WHO-CGF (2014) found that a reduction in mental health outcomes cannot be achieved without the inclusion of physical health, thus showing a reciprocal relationship between physical and mental health (Harder & Sumerau, 2018; Ohrnberger et al., 2017). Research is limited regarding mental health promotion in FBOs and the role of the faith leader in this area. Baruth et al. (2015) suggested further research on the role and influence of FBO leaders in health promotion. Therefore, the purpose of this generic qualitative study is to determine faith leaders' perceptions on their role in mental health promotion as a resource to improve access to mental health care in impoverished communities.

Health promotion in most settings does not address mental health. Physical health and mental health are viewed in FBOs as separate entities. This is evidenced by various programs that exclude a mental health component in their HPP (see Robles et al., 2019; Schwingel & Gálvez, 2016; Tucker et al., 2019). The literature on health promotion varies by race (Baruth et al., 2015; Hays, 2018), culture (Kim & Zane, 2016), and denomination (Baruth et al., 2015; Bopp et al., 2019; Leavey et al., 2016; Sytner, 2018). However, the majority of mental health promotion focuses on the African American, Christian community, which is limited in scope (Brand, 2019; Brand & Alston, 2018; Chatters et al., 2017; Hankerson & Weissman, 2012; Harmon et al., 2016; Hays, 2018; Hays & Aranda, 2016; Jameson et al., 2012; Tagai et al., 2018; Wong et al., 2018).

This chapter will include a literature review for the conceptual framework and topic focus of this generic qualitative study. First, an overview of the HBM and the TPB will be given to support the rationale for the conceptual framework of this study. Next, the topic literature review will include the relationship between poverty and mental illness, a brief history of FBOs and health promotion, and federal initiatives to support the rationalization for the use of FBOs as a resource for health promotion. This information creates the foundation for the exploration of FBOs and the influence of faith leaders to understand the importance of their inclusion in mental health programming to improve health disparities in impoverished communities. A review of literature on physical health programming, mental health promotion, and barriers to the limited use of FBOs for mental health promotion will be included to support the gap in the literature on mental health promotion and the role of faith leaders in FBOs

Literature Search Strategy

This comprehensive literature review included research acquired from peer-reviewed sources from the following electronic databases: Medline, PubMed, ERIC, PsycINFO, ProQuest, Wiley Online Library, EBSCOhost, and SAGE Journals. Additionally, Google Scholar and Walden University's dissertation database were used. I also used the Google search engine to gather online sources relevant to the research topic. I reviewed peer-reviewed journal articles, book chapters, ebooks, systemic reviews, periodicals, blogs, government, and organizational websites. The following keywords and word combinations used to search for relevant literature were *faith-based organizations, rural community, urban community, community-based programs, mental health, mental health treatment, mental illness, psychiatric illness, mental disorder, mental wellness, health ministry, mental health ministry, health initiatives, clergy, religion, religiosity, organizational capacity, poverty, faith, laity, congregations, mental wellness, collaboration, help-seeking, faith-based health promotion, mental health promotion, faith-based health education, faith-based interventions, social services, spirituality, theory of planned behavior,* and *health belief model.* The initial literature search included decades of research and then focused on the past 5 years. When limited research was identified on mental health promotion, the search expanded to look at general health promotion and the role of the faith leader in general health promotion. When articles began to reappear with the combination of search terms and phrases relating to mental health promotion in FBOs, I identified the literature review as complete.

Conceptual Framework

The HBM and TPB were used to build the conceptual framework of this generic qualitative study. In this section, an extensive review of the HBM will be given to include a detailed overview of each model with the limitations and how the models have been used in other studies. This will provide the rationale for the appropriateness of use for each model for the current study. After each individual presentation, the models will be presented collectively as evidence to the support the conceptual framework. This section will include previous studies that have used both models to show the effectiveness of using both models together.

Health Belief Model (HBM)

Hochbaum and Rosenstock developed the HBM in the 1950s (Hochbaum, 1958). Traditionally, the HBM had four constructs and was used as a predictor of behavior to explain why people would not participate in health programs that prevented or detected disease (Carpenter, 2010; Hochbaum, 1958; Rosenstock, 1966). The framework was expanded to predict people's behavioral responses to health conditions, such as compliance with treatment and medication compliance (Abraham & Sheeran, 2015; Glanz et al., 2015; Obirikorang et al., 2018). The original constructs include (a) perceived susceptibility of getting the disease, (b) perceived severity or seriousness of the disease, (c) perceived benefit of taking some type action to prevent or treat the disease, and (d) perceived barriers to taking action towards a change in health behavior (Hochbaum, 1958). According to the HBM, people are more inclined to make behavior change if there is a perceived threat and the benefits outweigh the barriers to the desired change

(Hochbaum, 1958). The HBM was expanded to include two additional constructs identified as (e) cues to action or influences of behavior and (f) self-efficacy or the self-confidence of making a behavior change (Henshaw & Freedman-Doan, 2009; Rosenstock et al., 1988). It is thought that these additional constructs contribute to predictors of behavior change in conjunction with the original four constructs (Rosenstock et al., 1988).

The HBM is widely used for studying health behaviors, but there are limitations to the framework. Before the implementation of cues to action in 1988, Janz and Becker (1984) stated that there was no way of knowing if attitudes and beliefs impacted health behavior. Although cues to action were incorporated, there is still limited data to support the incorporation of this thought. An assumption of the HBM is that people think health is important, which suggests the model would not be beneficial to predicting behavior or suggesting change of those individuals (Janz & Becker, 1984). Glanz (2001) argued that the model was developed based on the assumption that people fear disease. If a person does not fear contracting disease, the likelihood of engaging in prevention activities may be moot. Another limitation is the type of behavioral change the model helps predict. Henshaw and Freedman-Doan (2009) indicated that the model is unable to predict long-term health-related behaviors. It can help identify what contributes to the health change, but not the sustainability of the change.

Constructs of the HBM

Perceived susceptibility and perceived severity are joined together to determine the perceived threat an individual has about contracting a disease (Hochbaum, 1958).

Threat is a determinant of the likelihood a person will engage in a health-related behavior. Perceived susceptibility is the belief a person holds that they will acquire a condition or disease (Rosentstock, 2000). Perceived severity is the belief a person holds about the severity or intensity of an illness or disease (Rosentstock, 2000). Other variables, such as demographics, personality, or social pressure, can modify the perception of threat (Conner, 2001). Higher perceived susceptibility or severity would equate to the likelihood of an individual engaging in activities that screen for or prevent disease (Janz & Becker, 1984).

Perceived benefit is the belief a person holds that there is a benefit from engaging in a health behavior (Rosenstock, 2000). Its opposite is perceived barriers, which is the belief an individual holds about the tangible and nontangible costs of engaging in an action (Janz & Becker, 1984). Barriers can include financial costs, inconvenience, potential danger or side effects, or unpleasant feelings such as pain (Jones et al., 2015). Perceived benefits and barriers are related because it is assumed that an individual will weigh the benefits against the perceived barriers to determine if a behavioral change is worth it (Becker, 1974). When a person perceives more barriers than benefits, it can deter behavioral change (Becker, 1974).

Champion and Skinner (2008) found that specific cues, such as the environment, can impact final behavioral actions. Cues to action were added to the original four constructs of the HBM in the mid-1980s (Rosenstock et al., 1988). Cues to action are viewed as the individual's identified triggers that contribute to the behavioral change (Abraham & Sheeran, 2015). Triggers can be both internal and external depending on the

individual (Rosenstock, 2000). Examples of triggers are symptoms of illness, social influence, and health education campaigns (Abraham & Sheeran, 2015).

Self-efficacy refers to the person's belief in their ability to complete a behavior change (Rosenstock et al., 1988). Little is known about the relationship between self-efficacy and behavioral change in research (Carpenter, 2010; Champion & Skinner, 2008; Sulat et al., 2018). However, a person's confidence level supports engagement in health behavior that may appear difficult or unobtainable (Loke & Chan, 2013).

Application of the HBM

The HBM is a frequently used theory in health behavior studies to predict behavioral change and create healthy interventions (Jalilian et al., 2014; Jones et al., 2015; Köhler et al., 2017; Mou et al., 2016; Sulat et al., 2018). The HBM framework can be seen in a variety of studies on health interventions and education on topics that included mental health help-seeking (Bird et al., 2020; Harmon et al., 2016), breast cancer education and screenings (Guilford et al., 2017), diabetes (Bourbeau et al., 2018), medication adherence (Alatawi et al., 2016), helmet safety and skateboarding (Peachey et al., 2016), cardiac issues (Lee et al., 2016; Long et al., 2017), weight (Martinez et al., 2016), and lung diseases (Arredondo, et al., 2013; Fripp & Carlson, 2017; Wang et al., 2014). As a result of limited studies on the HBM and mental health promotion, other applications on general health will be presented to establish the relationship between the framework and health promotion.

An analysis of the HBM in research yields different results as to which construct is a predictor of behavioral change. Predictors of behavioral change can include an

individual's health beliefs, personality traits, and attitude (Carpenter, 2010). Before 1974, a person's belief of contracting an illness or disease was the most powerful predictor of behavior change (Janz & Becker, 1984). Approximately 20 years later, a meta-analysis of 24 studies using the HBM continued to show perceived susceptibility as being a predictor of change in all the studies (Harrison et al., 1992). Perceived susceptibility and severity are coupled together to form a perceived threat a person has towards illness or disease (Hochbaum, 1958; Janz & Becker, 1984; Rosenstock, 1966). However, perceived severity was identified as the least powerful predictor of behavior change (Carpenter, 2010), which aligns with the finding from earlier studies from Becker (1974) and Janz and Becker (1984). Perceived susceptibility was unrelated to behavior change unless the person was health conscientious or believed there was a benefit to engaging in a behavior (Carpenter, 2010). This supports the acknowledgement of external factors and the inclusion of cues to action to the HBM because there is more to making a health decision then a person's perceived threat of acquiring disease (Abraham & Sheeran, 2015; Glanz et al., 2015; Obirikorang et al., 2018). A person may want to engage in a positive health behavior, but not have enough support or resources.

A shift was seen between the years of 1974 and 1984 away from perceived susceptibility to perceived barriers as the most powerful predictor of behavior change (Janz & Becker, 1984). Perceived barriers may vary based on cultural differences. Challenges navigating the health system and sociocultural concerns were identified as perceived barriers among undergraduate students for accessing mental health care services (Nobiling & Maykrantz, 2017). Also, Asian Americans reported more barriers

than White Americans with help-seeking behaviors but had lower intention for seeking help when emotionally distressed (Kim & Zane, 2016). Other factors may contribute to behavioral change, not just perceived threat. A review of the literature shows a pattern of inconsistency in identifying which construct is the strongest predictor of behavioral change (Becker, 1974; Bird et al., 2020; Janz & Becker, 1984; O'Connor et al., 2014; Sulat et al., 2018). The HBM can be universally applied, and depending on the mitigating factors, will determine which constructs will predict behavior change. The participant and study focus will determine which constructs will be contributors to the behavior change.

The HBM can be seen in studies where researchers were attempting to predict preventative health behavior (Bistricky et al., 2018; Carpenter, 2010; Janz & Becker, 1984; Montanaro et al., 2018; O'Connor et al., 2014). Health promotion does not prevent illness, but it does educate individuals on health topics that could contribute to a person's health knowledge or help-seeking behavior (O'Connor et al., 2014). Perceived barriers were identified as a predictor of health screening (Harrison et al., 1992). The most important predictors to preventative health, such as attending education programs or engaging in health screenings, were identified as perceived susceptibly and perceived benefits (Carpenter, 2010). Likewise, susceptibility and benefits are positively correlated in engaging in health screening and preventative behaviors, such as receiving influenza shots (Janz & Becker, 1984). Perceived benefits and perceived barriers were identified as predictors and moderators of mental health help-seeking behaviors in a study of young adults (Carpenter, 2010). Among the younger population ages 17-25, perceived benefits were a stronger predictor over perceived barriers for seeking mental health treatment

(Carpenter, 2010). External variables, such as personality type, social support, and current health knowledge, contributed to engagement in preventative health behaviors (O'Connor et al., 2014). Additionally, factors such as age, culture, or geographic location can impact which construct is more relatable to behavior change (Sulat et al., 2018). This is contradictory to Rosenstock (1990), indicating that psychological and key demographic factors, such as personality, social support, self-efficacy, knowledge, and education, do not have direct roles in predicting health behavior.

The HBM model is a viable model for treatment adherence (Yue et al., 2015). A meta-analysis of the HBM on an adult population showed perceived barriers was a predictor for treatment adherence (Harrison et al., 1992). Adherence with taking medication or using a medical apparatus, such as a CPAP machine, showed benefits and barriers are largest predictors (Carpenter, 2010). Medication adherence for individuals with Type-2 diabetes showed perceived susceptibility, perceived benefits, and self-efficacy were identified as significant HBM predictors for medication adherence (Alatawi et al., 2016). Interventions that seek to decrease perceived barriers and increase perceived benefits are effective to improving treatment adherence (Tola et al., 2017). Like predicting preventative health behavior, the HBM presents different constructs as significant for treatment adherence. The varied results may come from different health topics, demographics, or treatment type, which shows the need for research that includes cues to action and modifying factors.

Multiple scholars showed the measurement of the original four constructs of the HBM (Carpenter, 2010; Harrison et al., 1992; O'Connor et al., 2014; Sulat et al., 2018).

All four original constructs relate to behavior change, but not one consistently (Sulat et al., 2018). The newer constructs, cues to action and self-efficacy, are rarely used in studies with the HBM, so there are limited data to understand their influence on behavior change (Carpenter, 2010; Sulat et al., 2018). Self-efficacy was found to be an important factor among collegial, student athletes for seeking mental health treatment (Bird et al., 2020). Primary care physicians are viewed as important cues to action when making behavior change, such as reducing self-medicating behaviors to address mental health problems (Nobiling & Maykrantz, 2017). Specific cues, such as the environment, can also impact final behavioral actions (Champion & Skinner, 2008). The research on the HBM did not grow with the model expansion, so little is known about these areas and their relationship with behavioral change.

The Theory of Planned Behavior (TPB)

The TPB was developed by Ajzen (1991) as an expansion to the theory of reasoned action (TRA; Fishbein & Ajzen, 1975). According to the TRA, people's behavior is determined by their intent to perform the behavior, and the behavior is a product of their attitude towards the behavior and social influences (Fishbein & Ajzen, 1975). Ajzen (1991) added the perceived behavior control (PBC) to the original constructs of attitude and subject norm as an attempt to explain behaviors, such as smoking cessation and condom usage that may not be under volitional control (Ajzen, 1991; Sutton, 2001). The constructs of TPB that interact together to determine behavior intention are attitude, the subjective norm, and PBC (Ajzen, 1991). The basic premise of TPB is that a person's attitude, social influence, and PBC over the behavior contribute to

a person's behavior intention towards an action (Ajzen, 1991; Ajzen & Madden, 1986). It is assumed that when an individual has a positive attitude and influence, coupled with a high PBC, a person will engage in a positive health behavior (Sharma, 2017).

There are limitations to the TPB. Sniehotta et al. (2014) argued that the TPB was focused mostly on rational reasoning and excluded unconscious influences on behaviors. Additionally, predictive validity was noted (Sniehotta et al., 2014). Sheeran and Orbell (1999) stated that a person who has the intention yet fails to act (inclined abstainers) is not addressed by the theory. For example, a person has the intention to quit smoking, but never follows through. This limitation is in line with McEachan et al.'s (2011) declaration that TPB does not provide insight into future behavior or the effects of behaviors on cognitions. The TPB does account for individual and social factors, prior knowledge, and external influences (Ajzen, 1991). However, the theory excludes other factors like fear, threat, mood, and economic and environmental factors as contributors to behavior intention (Sniehotta et al., 2013). Although critics argued that TPB is outdated, Azjen did not feel the theory needed to be updated, although other theories have evolved over the years (as cited in Sniehotta et al., 2014). Despite the limitations, the TPB continues to be a widely used theory to predict health behavior.

Constructs of the TPB

Behavioral intention, or motivation to engage in the behavior, is what drives the behavior according to the TPB (Ajzen, 1991; Ajzen & Fishbein, 1980). Behavior intention is influenced by a person's attitude, subjective norm, and perceived behavioral control. Other internal and external factors such as age, personality, media influence,

previous interventions, gender, and income, also influence a person's behavioral, normative, and control beliefs and contribute to all the constructs (Ajzen, 1991). These factors contribute to the individualization of behavior intention.

Attitudes and its related behavior(s) is the value placed on the behavior based on favorable and unfavorable outcomes (Ajzen, 1991). A person's attitude towards a behavior is influenced by their beliefs and evaluation of the behavior outcome (Ajzen, 1991). Multiple factors shape a person's beliefs, such as learned behavior and past experiences (Ajzen & Fishbein, 1973).

Influence from others is seen in the subjective norm construct (Ajzen & Fishbein, 1973, 1980). Pressure and approval from others can influence behavior intention (Sutton, 2001). The subjective norm is influenced by the normative beliefs and the motivation to comply (Ajzen & Fishbein, 1973). Motivation to comply refers to the person's desire to follow the perceived opinions of those who shape the normative beliefs (Etcheverry & Agnew, 2016).

Perceived behavioral control (PBC) is the person's perception of difficulty in engaging in a behavior (Ajzen, 1991). PBC is what differentiates TPB from TRA (Ajzen, 1991). A person's PBC is influenced by the level of control or power they feel they have over the behavior (Ajzen, 2006). Also, self-efficacy of the ability to perform the behavior is a contributor of a person's PBC (Kovess-Masfety et al., 1980). Internal and external factors contribute to the control beliefs and self-efficacy (Ajzen, 1991; Sharma, 2017; Tornikoski & Maalaoui, 2019). Depending on the person's perception of control over the outcome will impact their behavior intention (Ajzen, 2006).

Application of the TPB

The TPB can be seen in studies where researchers have focused on health related motivation (Catalano et al., 2017; Rahimdel et al., 2019), prevention (Bohon et al., 2016; Montanaro et al., 2018), and treatment behaviors (Blue, 2016; Rahimdel et al., 2019) and include topics such as vaccination (Agarwal, 2014; Catalano et al., 2017), diabetes (Blue, 2016), hypertension (Rahimdel et al., 2019), contraception use (Montanaro et al., 2018), and mental health (Bohon et al., 2016). The use of the TPB framework in health related studies resulted in varying contributors to behavior intention. Providing information on nutrition through booklets and education seminars increased a person's behavior intention to reduce salt intake (Rahimdel et al., 2019). Subjective norm and PBC are seen as predictors of the intent to become more physically active with individuals who identified as at-risk for diabetes (Blue, 2016). Attitudes, subjective norm, and PBC contributed to the intention to eat healthy (Blue, 2016). However, a person's risk of becoming a diabetic was not related to behavior intention (Blue, 2016). Blue's (2016) study could have explored perceived threat to identify risk by incorporating the HBM. The TPB is seen in vaccination studies. Attitudes and subjective norm shaped behavior intention of unvaccinated college men, ages 18-26, for the HPV vaccine (Catalano et al., 2017). Gerend and Shephard (2017) found all three constructs to be applicable to behavior intention in women of the same age group. A varied result is seen based on factors such as gender and disease type. Additionally, results may vary by peer groups who influence the subjective norm, as seen with condom use intentions (Asare, 2015).

Adults feel they have lower PBC over their mental health opposed to their physical health (Breslin & McCay, 2013). Breslin and McCay contributed to understanding why individuals place more focus on physical health instead of mental health. The TPB argues that a person who has a higher PBC is more likely to have a higher positive behavior intention because of the perceived control (Ajzen, 1991). A person with a lower PBC for mental health might have lower participation in adopting behaviors that improve mental health outcomes (Breslin et al., 2017). PBC was also identified as the largest predictor of behavior prevention in a suicide awareness program and help-seeking behavior among U.S. veterans (Karras et al., 2018). Participating in programs might increase behavior intention to seek help for mental health related concerns.

In a study on the Mood Matters program, Breslin et al. (2017) found an increase in participants mental health knowledge, intent to be supportive of others, and confidence (PBC) in their ability to get help after the program completion. In contrast, PBC was found to be the least influential construct in identifying alcohol-related behavior among college students (Bhochhibhoya & Branscum, 2018). The varying strength of the PBC construct on behavior intention may fluctuate based on individual traits, such as age and study focus. Also, substance abuse is not included in the official definition of mental health, which might show different results because of the use of substances versus a health condition (NIMH, 2019). The participation in mental health education programs has the potential to strengthen knowledge and confidence, thus resulting in behavior intentions to support mental health promotion. Therefore, short-term mental health

awareness programs are efficacious to increasing knowledge, intent, and confidence for faith leaders desiring to engage in mental health promotion (Breslin et al., 2017). More specifically, topic-specific health promotion has been identified in the literature as a viable means to promote health outcomes (Brand, 2019; Holt et al., 2017).

Attitudes about mental health services has been identified as the strongest predictor of behavior intention among young adults (Bohon et al., 2016; Rickwood et al., 2005; Vanheusden et al., 2008). Alcohol-related behaviors among college students was found to be most significant (Bhochhibhoya & Branscum, 2018). Likewise, college students with more positive attitudes towards mental health services, with less perceived barriers, showed a greater intention to seek services for depression (Bohon et al., 2016). The identification of less perceived barriers supports the merging of HBM and TPB to gain a deep understanding of faith leaders' role in mental health promotion (Ajzen, 1991; Rosenstock et al., 1988).

Ajzen and Fishbein (1980) also identified the subjective norm in addition to attitude as the largest determinant of behavior intention. The subjective norm was the second predictor of behavior among college students with alcohol-related behaviors (Bhochhibhoya & Branscum, 2018). On the contrary, subjective norms were not associated with attitudes to seek mental health services among college students when seeking mental health services (Bohon et al., 2016). People are influenced both internally and externally and seek approval when making decisions whether it is consciously or unconsciously (Ajzen, 1991). Descriptive norms, which influence subjective norms, were associated with suicide-related intentions among U.S. veterans (Karras et al., 2018).

The combination of the predictors of attitude towards the behavior, subjective norms, and PBC were effective with predicting behavior intention. Attitudes towards the behavior, which is influenced by behavioral beliefs and the evaluation of the possible outcome, is noted most frequently as the largest predictor of behavioral changes (Bhochhibhoya & Branscum, 2018). Bhochhibhoya and Branscum (2018) identified the strongest predictor as attitudes, which supports Bohon et al. (2016) findings, but it contradicts Breslin and McCay's (2013) and Karras et al.'s (2018) findings that PBC is the strongest predictor to behavioral change among U.S. veterans and adults. The contradiction of influential constructs suggests that the research topic and study participant demographics will determine which construct will prevail as the strongest predictor.

Application of the HBM and the TPB as a Conceptual Framework

Throughout the years, the HBM and the TPB have been viewed as identifying and explaining almost identical constructs, but have been described differently (Aiken, 2010; Noar & Zimmerman, 2005; Weinstein, 1993). The theories are similar as both have an attitudinal belief component. It is seen in the HBM through perceived benefits and perceived benefits (Janz & Becker, 1984), and in the TPB as attitudes (Ajzen, 1991). Also, self-efficacy and PBC are similar (Ajzen & Madden, 1986; Rosenstock et al., 1988). Both theories include external factors identified as cues to action in the HBM and information in the TPB (Janz & Becker, 1984; Rosenstock et al., 1988). The notion of threat from the HBM (Stretcher et al., 1997) is not a component of the TPB, and behavior intentions are unique to TPB (Ajzen, 2011). TPB also identifies subjective norms

allowing for the factor of influence from significant others, which does not exist in the HBM (Ajzen & Fishbein, 1980). The overlapping constructs allow for easy application of common constructs and provides an opportunity to integrate the theories as a way to expand the theories beyond their identified constructs.

Researchers have sought to prove which theory is more effective. The HBM and TPB were combined and evaluated in studies on symptom reduction strategies and preventative interventions to determine if one model was stronger over the other in predicting behavioral change (Bistricky et al., 2018; Montanaro et al., 2018). A comparison of constructs between HBM and TPB showed the HBM only accounted for 1.6% variance in behavior change in risky sexual behavior, whereas the TBP was 32.8%. (Montanaro et al., 2018). Previous knowledge and all the HBM constructs predicted variability in behavior intention to use stress reduction techniques, with only descriptive norms being a factor from the TPB (Bistricky et al., 2018). In a study on behavior intention for condom use among 18 ≤ 20-year-olds, Montanaro et al. (2018) showed one construct from each theory (attitudes - TPB; self-efficacy - HBM) prevailing as predictors. One theory did not surpass the other on predicting health behavior. Comparatively, both theories are effective in predicting health behavior and results vary based on the study topic and participant type.

Researchers who have used the HBM and the TPB provided insight on health behavior on different health-related topics (Chin & Mansori, 2019; Gabriel et al., 2019; Payton et al., 2015). Women participating in breast cancer screenings identified perceived benefits (HBM) and knowledge (TPB) as the largest influencers for engaging in the test

(Chin & Mansori, 2019). When study participants are not exclusive to one gender or age demographic, predictors to behavior change expand (Bistricky et al., 2018; Montanaro et al., 2018). A diverse pool of active adults participating in an exercise related-injury prevention program identified the biggest contributors to participating as perceived benefits (HBM, TPB), social norms (TPB), self-efficacy (HBM), and general health cues (HBM; Gabriel et al., 2019). The more diverse the participants are in a study, the more likely more constructs will impact health decisions.

The HBM and the TPB are respected as theoretical frameworks in health-related fields of study. Used together, scholars can explore additional factors that may contribute to health behavior beyond the limitation of their individual constructs. There is enough overlap in the theories that both can be used effectively to achieve stronger results by asking questions that the other one cannot (Aiken, 2010). For example, a researcher using the HBM will not directly ask a participant about their intention of engaging in a behavior like the TPB (Ajzen, 1991). The HBM has potential to support planning change as well (Glanz, 2001). Payton et al. (2015) combined the models to collect baseline data on African American legislators' perceptions on firearm violence in the African American community. The HBM was used to determine predictors of supporting firearm violence legislation, while the TPB addressed voting behavior of violence prevention legislation (Payton et al., 2015). Payton et al.'s study served as a model for conjoining both constructs to help determine the role of faith leaders in mental health promotion.

HBM and TPB Rationale

The integration of the HBM and the TPB will allow for the in-depth exploration of faith leaders' perceptions of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. Based on the constructs of the HBM, faith leaders who perceive mental health as a threat among their congregants or in the community would presumptively be doing more to promote mental health in their FBOs as a resource to access mental health care (see Hochbaum, 1958; Rosenstock, 1966). Likewise, the TPB presumes that faith leaders who have more positive attitudes about mental health promotion, positive peer influence (subjective norms), and a strong PBC will identify a more positive role in mental health promotion (Ajzen, 2002). The included constructs for this generic qualitative study are identified as perceived severity, perceived benefits and barriers, cues to action, self-efficacy/PBC, and behavior intention (attitude and subjective norm). The decision to add the TPB to the HBM expands the predictors of behavior to include the faith leaders' attitudes about mental health promotion and the personal influencers that may contribute to shaping the perceived role of the faith leader in mental health promotion.

Faith leaders determine the inclusion or exclusion of health promotion in their organizations because of their leadership role (Fripp & Carlson, 2017). The faith leaders' attitudes and beliefs about mental health could directly or indirectly influence how the member perceives individual susceptibility and severity because of their influential nature (Bopp et al., 2019). Perceived severity will be used to determine if faith leaders perceive mental illness as a threat in their community. According to HBM, if the faith leader perceives mental illness as a viable threat to their congregations, it might suggest there is

inclusion of mental health topics in health promotion (Hochbaum, 1958; Rosenstock, 1966). This information might provide understanding about their decision to promote or not promote mental health in their organizations. As a consequence to not understanding the severity of a health issue, the needs of the congregants can become misaligned with health promotion efforts. Health messaging and promotion should be relevant by aligning with the congregational need or support of current health statistics (Harmon et al., 2016). Breast and prostate cancer are frequently messaged about in the African American church; yet, lung and colorectal cancer have a higher cause of death among the community (Harmon et al., 2016). It is critical to evaluate the perceived severity of mental illness in faith leaders' communities to gain an understanding of how their perception drives mental health promotion.

Perceived barriers and perceived benefits might influence the likelihood of the faith leader's engagement in mental health promotion (Champion & Skinner, 2008). The exploration of perceived benefits might determine if faith leaders feel there is value to having mental health promotion within their organizations (Rosenstock, 2000). Weighing the benefits against the barriers will help identify factors that may be hindering or assisting with the inclusion of mental health in broader HPP (Rosenstock, 2000). The analysis of the perceived benefits and perceived barriers to mental health promotion will help shape the faith leaders' perceived role in mental health promotion.

Cues to action are what the faith leaders will rely on to decide their role in mental health promotion (Abraham & Sheeran, 2015). The faith leaders could define their role in mental health promotion based on personal experiences, raised awareness through media

outlets, or prior exposure to mental health promotion at other venues (Glanz, 2015). This notion mirrors the external variables identified as information from the TPB (Ajzen, 1991). These cues to action or personal triggers may lead to the faith leader having an active or inactive role in mental health promotion.

Self-efficacy in the HBM is similar to PBC in the TPB (Ajzen & Fishbein, 1973; Rosenstock et al., 1988). Both may provide information about the faith leaders' perception of their confidence and ability to create a new program, expand a current program, or to sustain either, thus contributing to their self-identified role (Ajzen & Fishbein, 1973; Rosenstock, 1966). Also, the PBC may create the opportunity to explore if the faith leaders believe it is their place to take the lead on implementing mental health promotion (Sharma, 2017). Modifying factors, also called personal factors, such as age, gender, education level, income, mood, race, ethnicity, personality, and prior knowledge are factors that may influence the perceived susceptibility, the perceived threat, the perceived barriers, and the perceived benefits of the faith leader (Glanz et al., 2015). In the TPB, they are identified as external variables or background factors that shape behavior intention (Ajzen, 2011). These variables are important because they are unique to the individual and contribute to how the faith leaders perceive their role in mental health promotion.

Finally, the faith leaders' perception of their role may be influenced by their attitude about mental health promotion and how they perceive others will perceive them if they participate in promotion efforts. Attitudes and the subjective norm inform behavior intention (Ajzen, 1991). By using TPB, the faith leader can be asked about the

intention of offering mental health promotion or expanding current programs (Ajzen & Fishbein, 1973). Although the HBM provides focus on the benefits and barriers of health promotion, the TPB looks at the faith leader's attitude towards mental health promotion and the intention to include it in the FBO (Ajzen, 1991; Janz & Becker, 1984). The conceptual framework will provide the opportunity to understand how faith leaders perceive their role in mental health promotion as a resource for mental health care in impoverished communities.

Literature Review Related to Key Variables and/or Concepts

Key variables in this section will begin with the presentation of the relationship between poverty and mental illness, a brief history of FBOs and health promotion, and a review of federal initiatives that support the use of FBOs as a resource for health promotion. The characteristics of FBOs and the types of health programming available in FBOs will be provided, along with views that oppose the use of FBOs for mental health promotion. The influential nature of the faith leaders and help-seeking preferences of individuals will be presented as an argument for the use of FBOs for mental health promotion. A review of literature on physical and mental health promotion in FBOs that include examples of mental health programs in FBOs will be provided. Finally, barriers to the use of FBOs for mental health promotion will be included.

Poverty and Mental Illness

Poverty and poor mental health outcomes are directly related through a complicated relationship impacted by other social determinants, such as inequality, unemployment, and lack of education (Burns, 2015). Rural and urban communities differ

geographically, but health disparities and access to care barriers are similar for individuals living in poverty (Atkins et al., 2015). Closing industries and unemployment have contributed to depressive symptoms in rural communities (Snell-Rood & Carpenter-Song, 2018). Increased poverty levels in rural communities contribute to mental health disparities, increased suicide rates, and depression for residents (Carpenter-Song & Snell-Rood, 2017). In urban communities, person's living in poverty are at a higher risk for depression, post-traumatic stress disorders, and oppositional disorders (Anakwenze & Zuberi, 2013). Children who live in poverty are at a higher risk for being diagnosed with disruptive behavior disorders, cognitive skills deficits, and lower educational attainment (Acri et al., 2017; Anakwenze & Zuberi, 2013). Additionally, families living in extreme poverty with incomes under $10,000 are 40% more likely to have clinically significant levels of depressive symptoms (Acri et al., 2017; Office of the Assistant Secretary for Planning and Evaluation, 2020). A family of one is considered impoverished with an income of $12,760 and a family of four with an income of $26,000 according to the federal government (Office of the Assistant Secretary for Planning and Evaluation, 2020). Children who are raised in environments that are impacted by economic factors increase their likelihood of having poor mental health outcomes continuing into adulthood.

There is a need for more viable options to improve access to mental health care in impoverished communities. In Los Angles, the availability and accessibility of healthcare is an on-going problem for individuals with low-income (Saluja et al., 2019). In rural communities, there is a shortage of primary care providers (Saluja et al., 2019). Similarly,

there is a shortage of mental health providers and a lack of mental health treatment accessibility in rural communities (Carpenter-Song & Snell-Rood, 2017). Alternate methods of service delivery for mental health are needed to fill the gap in treatment accessibility due to budget cuts, lack of health insurance, eligibility gaps for government-sponsored programs, and health care access (Cherry et al., 2017). An option to improve mental health care in impoverished communities is to provide more mental health programming (Carpenter-Song & Snell-Rood, 2017). It is also recommended that schools and FBOs provide mental health resources to improve treatment accessibility in their community (Cherry et al., 2017). Collaborative efforts between mental health providers and FBO leaders to create resource manuals, referral lists, and workshops are additional ways to address mental health in the rural communities (Smith et al., 2018). The creation of nontraditional healthcare resources in underserved communities is seen as beneficial to improving healthcare accessibility.

The relationship between poverty and mental illness is seen in the demographic location chosen for this study. In Cumberland County, NJ, 18.8% of the population is identified as living in poverty, which is higher than the 13.1% national average (Data USA, n.d.). The largest demographic living in poverty is females ages 25-34, followed by females ages 35–44 and males ages 6-11 (Data USA, n.d.). The most common racial or ethnic group living below the poverty line in Cumberland County, NJ, is White, followed by Hispanic and Black (Inspira Healthcare Network [IHN], 2013). Additionally, the IHN (2013) indicated that in comparison to the state's averages, Cumberland County has a higher percentage of disabled individuals overall and particularly among those 18 to 64

years of age. Vulnerable populations, such as minorities and disabled, are at a higher risk of living in poverty (Goodman et al., 2017).

History of FBOs in Health Promotion

The historical context of FBOs providing health services to marginal populations provides the foundation for rationalizing its use in health promotion. Regardless of the denominational affiliation, a common theme throughout history is the helping nature of religious organizations. Almshouses ran by religious organizations that provide care for the poor were considered the first hospitals (White, 2000). Almshouses and their charitable nature have spanned throughout history beginning in the Medieval Times (The Almshouse Association, n.d.). The charitable nature of the almshouse is visible in the mission of major religions. For example, the Catholic Church's mission was founded on servicing the poor and afflicted by providing free care, room, and board. They serviced the poor by providing "houses of charity and mercy" (White, 2000, p. 217).

The same charitable behavior is seen in Christianity. The first Christian hospitals were called *xenodecheia* and serviced the ill, poor, and pilgrims (Davis, 2020). Christian's view on charity models the principle of self-giving love, or *agape* (Guinan, 2004). Their focus was on caring for others in a Christlike way (Porterfield, 2005). Additionally, Muslim principles of humanitarian, such as *waqf,* included behaviors that provided free social services and medical care to those in need at mosques and hospitals to the poor, chronically ill, and blind (Abuarqub & Phillips, 2009). The commonality among the denominations for caring for others and charity has created a platform for

FBOs in history to contribute to servicing the needs to communities, especially those who are impoverished or viewed as vulnerable.

Federal Government, FBOs, and Health Promotion

The Clinton administration signed P.L. 104-193 in 1996 as a Charitable Choice initiative to allow religious organizations to receive federal money to provide federally mandated services similar to nongovernmental providers, with the same parameters (The White House President George W. Bush, n.d.). This initiative provided consumers with a choice in social service provision that applied to four federal programs: Temporary Assistance to Needy Families (TANF) and the Community Services Block Grant (CSBG), programs for substance abuse and mental health, HIV/AIDS, and the Welfare-to-Work. The initiative did not receive universal acceptance as proponents for separation of church and state indicated that there was no regulation on using the funding to promote religious agendas (Anti-Defamation League, 2012; Kramer, 2010).

The Bush administration further expanded Clinton's Charitable Choice in 2000, creating the White House of Faith-Based and Community Initiative (OFBCI). The focus of OFBCI was to help strengthen faith-based and community organizations by providing funding opportunities to provide programs for vulnerable populations, such as children, individuals with a history of substance abuse, individuals who have been incarcerated, individuals who have experienced homelessness, and those who have lived in poverty (Carlson-Thies, 2009; White House Faith-Based & Community Initiative, n.d.).

In 2009, the OFBCI was renamed as the Office of Faith-Based and Neighborhood Partnerships (OFBNP) by the Obama administration to continue with funding initiatives.

However, a stronger focus was seen on creating and strengthening partnerships with secular and faith-based nonprofit organizations (The White House Barak A. Obama, n.d.). Most recently, Trump's Faith & Opportunity Initiative was established to provide more recommendations on partnership, policies, and programs that offer solutions to poverty (U.S. Department of Housing and Urban Developments, 2018).

Through all the presidential administrations presented, a pattern can be seen related to the funding of partnerships to address problems related to poverty. Although initiatives are seen on a federal level for FBOs for funding of programs, a lack of funding is a barrier to the implementation of a sustainable health promotion initiatives (Bopp et al., 2019; Brand, 2019; Fox et al., 2018; Mesidor et al., 2011; Williams et al., 2014). Even with the availability to secure funds for programs in FBOs, Levin (2014) argued that FBOs continue to be underused for health promotion in general. Similarly, Hankerson and Weissman (2012) and Villatoro et al. (2016) argued that FBOs are underused for health promotion for the Latino and the African American communities.

Rationale for FBOs in Health Promotion

Characteristics of FBOs

FBOs (i.e., churches, mosques, temples, synagogues) are 501 (c) (3) nonprofit agencies that are founded on the principles of religious beliefs and faith (Tagai et al., 2018; Terry et al., 2015; Villatoro et al., 2016). They maintain religious identity when providing an array of services to include spiritual, social, physical, mental, or cultural needs of their members, the community, and the human condition (Tagai et al., 2018; Terry et al., 2015). FBOs are seen as the backbones of communities and are trusted

organizations by the community members (Baruth et al., 2015; Robles et al., 2019). Their ability to reach a large number of people in their natural setting makes them unique (Krukowski et al., 2010; Terry et al., 2015). Schwingel and Gálvez (2016) found that the trustworthy nature of the FBO environment allows for them to provide comfort and nurture when addressing health issues in marginalized communities.

Not only are FBOs seen as beneficial to health promotion activities, they are documented in research practical resources to aid in the reduction of mental health treatment disparities in impoverished locales (Andren & McKibbin, 2018; Tagai et al., 2018; Williams et al., 2014). FBOs are diverse organizations that vary in size, demographics, and denominations. Therefore, faith-based mental health interventions are culturally responsive ways to address mental health (Hays & Aranda, 2016). Villatoro et al. (2016) argued that FBOs can help reduce Latino mental health care disparities by providing religion-based mental health services, increasing health-seeking behavior, and providing support services to address access to care barriers. Likewise, FBOs can be used to help reduce stigma towards mental health to improve help-seeking behavior, and link individuals to mental health resources in Latino and African American communities (Fripp & Carlson, 2017).

Types of Promotional Activities

According to the WHO (2016), the purpose of health promotion is to educate and provide resources to people as a tool to improve their quality of life by addressing and preventing causes of illness, not with the sole focus on treatment or cure. Health promotion is not a replacement for health treatment (WHO, 2016). An array of health

promotion activities can aid in the reduction of access to care barriers in vulnerable communities. The list of health promotion activities includes

- Physical and mental health messaging in sermons (Berkley-Patton et al., 2019; Harmon et al., 2016; Robles et al., 2019; Rogers & Stanford, 2015; Williams et al., 2014)
- Dissemination of printable literature (i.e., educational pamphlets, psychoeducation, bulletin boards; Berkley-Patton et al., 2019; Bopp & Fallon, 2013; Brand, 2019; Brand & Alston, 2018; Cherry et al., 2017; Milstein et al., 2017)
- Incorporation of messaging using technology (i.e., video announcements, texting, information on social media platforms; church website, email, apps; Bopp & Fallon, 2013; Brand, 2019; Brand & Alston, 2018; Holt et al., 2017)
- Educational workshops, seminars, content-specific programs, and training (Batada et al., 2017; Berkley-Patton et al., 2019; Bopp & Fallon, 2013; Brand, 2019; Chatters et al., 2017; Cherry et al., 2017; Cronjé et al., 2017; Hays, 2018; Holt et al., 2017; Pyne et al., 2019; Robles et al., 2019)
- Themed health promotion activities (i.e., guest speakers from the community, health fairs, monthly themes; Bopp & Fallon, 2013; Brand, 2019; Holt et al., 2017)
- Referrals to community mental health providers (Andren & McKibbin, 2018)
- Peer-lead programs (Byrne et al., 2017; Rogers & Stanford, 2015; Vally & Abrahams, 2016)

- Incentives and giveaways (Batada et al., 2017; Holt et al., 2017)
- Creating teams and physical activities (i.e., aerobics, walking; Bopp & Fallon, 2013; Brand, 2019)
- Pastoral individual counseling or group counseling (Bopp & Fallon, 2013; Hankerson et al., 2013)
- Collaboration between health providers, community organizations, and FBOs (Baruth et al., 2015; Fripp & Carlson, 2017; Idler et al., 2019; Pyne et al., 2019; Smith et al., 2018; Sytner, 2018; Terry et al., Villatoro et al., 2016; Wong et al., 2018).

The ability of FBOs is doubted because most initiatives or interventions offered in FBOs are not evidenced-based or lack formal data collection (Holt et al., 2017; Koenig et al., 2015; Terry et al., 2015). Religion and spirituality are tools to help people cope with problems in the mental health domain, but controversy exists between the faith leaders and providers based on the lack of therapeutic boundaries (Koenig et al., 2015). Negative perceptions of pastors and pastoral counseling from licensed professional counselors stemmed from the lack of evidence-based approaches, professionalism, and limited training (Jackson, 2015). Because the focus is on pastoral versus secular counseling, it is not related to health promotion activities due to the therapeutic nature. Bopp and Fallon (2013) recommended that researchers focus more on FBOs and their health and wellness activities because of the potential to significantly impact public health, especially if the interest is on chronic disease prevention as opposed to evidence-based practices. An FBO does not have to provide psychotherapy to be effective in linking people to therapy

through education and referrals given from the FBO. Furthermore, health promotion does not need to be evidence-based because its focus is on education and resource linkage not treatment modalities (WHO, 2016).

Opposing Viewpoints on Faith-Based Health Promotion

FBO health promotion seems promising, but not everyone agrees that it is beneficial. Weber and Pargament (2014) found that religion can negatively impact people due to negative religious beliefs and coping, misunderstandings, and miscommunication. In addition, there is a concern that vulnerable populations, such as women, prisoners, and the lesbian, gay, bisexual, transgender, and queer (LGBTQ) could be harmed or have their human rights violated by some biblical interpretations (Watkinson, 2015). A faith leader can improve nonmaleficence by increasing mental health training and collaboration with mental health professionals (Leavey et al., 2016). FBO engagement in mental health promotion may be one way to provide information to the individuals on mental health that would possibly guide people to the proper help sources.

There are also conflicting views on the importance of health promotion in FBOs. Some FBO members do not feel that health-related programming is imperative within their organization (Bopp et al., 2019). Other members value the importance of health promotion activities, and they are either currently participating or desire to participate in health ministry initiatives (Whitt-Glover et al., 2014). The contradiction in desirability of health promotion initiatives could mean that the individual person, cultural influences, faith leader influence, or the denominational values might contribute solely or collectively to the acceptance or rejection of health promotion activities in FBOs.

The Faith Leader's Influential Nature in the FBO

Faith leaders are viewed by some community members as gatekeepers, role models, and authority figures in the community (Baruth et al., 2014; Heward-Mills et al., 2018; Wilcox et al., 2015). According to Baruth et al. (2015), most faith leaders of diverse races and denominations, felt they were role models and had influence over the health and wellness issues in the congregation. Some leaders offered faith healing, scriptures, short-term counseling, and referrals to mental health professionals for depression (Hankerson et al., 2013; 2015). In contrast, not all faith leaders agreed on engaging health promotion. Some felt that they should not be influencing congregants on their health due to their own unhealthy habits or current health status (Baruth et al., 2014). The faith leader's influence can impact the inclusion or exclusion of any type of health promotion in the FBO and congregant participating.

Faith leaders are known to have a higher level of communication skills and ability to inform congregants on health issues (Anshel & Smith, 2014; Baruth et al., 2015). The ability to communicate effectively makes them suitable candidates to influence positive health behaviors. Furthermore, the level of the faith leader's involvement in church programming influences health activities and aids in the development of sustainable and practical health programming (Bopp et al., 2019). The influential nature of the faith leader can influence members for or against participation in health promotion. Therefore, it is critical to understand the perception of the faith leader's role in mental health promotion because they are the key to using FBOs as resources in underserved communities.

Help-Seeking Preferences: Secular or Spiritual

Some individuals prefer to seek clergy for an array of life problems, mental health disorders, and drug/alcohol problems before seeking help from mental health professionals (Chatters et al., 2017; Hardy, 2014; Webb et al., 2013). Culture and faith can impact help-seeking behaviors (Leavey et al., 2012). The African American Christian church has been studied in relation to mental health (see Hankerson & Weissman, 2012; Hays & Aranda, 2016). Members of the Black church are more likely to turn to clergy than other professionals for emotional distress due to conceptualizing it as a spiritual problem (Crosby & Varela, 2014; Kovess-Masfety et al., 2016). This may also be due to African Americans having more general interactions with clergy (Chatters et al., 2017). The location of the church also mediates the relationship for use of clergy for problems (Chatters et al., 2017). In contrast, non-Hispanic Whites were more likely to seek help from clergy for depression and anxiety as opposed to African Americans (Chatters et al., 2017). The difference in help-seeking preference among culture and race indicates there are multiple factors that can contribute to a person's help-seeking behavior.

FBOs and Health Promotion

Physical Health

There is an abundance of research available on the religion and health relationship, along with HPP for vulnerable populations (Chatters, 2000; DeHaven et al., 2004; Ellison & Levin, 1998; Koenig et al., 2015). Although the primary focus of the current study is not on general health promotion, it is essential to visit the literature on HPP to understand how health promotion in FBOs has the potential to reduce access to

care barriers in vulnerable communities. Because research is limited on mental health promotion in FBOs, the knowledge gained from research on HPP is beneficial in understanding what has been done and how to include mental health as an equivalent focus. For example, FBOs engaging in educational programs to increase health awareness (see Berkley-Patton, et al., 2019; Tucker et al., 2019), or incorporating health messages in weekly bulletins or sermons (Batada et al., 2017; Harmon et al., 2016).

Scholars have shown the efficacy in health promotion programs in a variety of general health-related areas (see Davis et al., 1994; Duan et al., 2000; Wiist & Flack, 1990). More recent researchers mirror their predecessors through results of studies on physical health such as cardiovascular disease, cancer, diabetes, HIV/AIDS, nutrition and weight, physical activity, and mammograms (e.g., Harmon et al., 2016; Koenig et al., 2015; Martinez et al., 2016; Robles et al., 2019; Schwingel & Gálvez, 2016; Tucker et al., 2019; Williams et al., 2014). However, there appears to be no connection to mental health when there is a relationship between physical and mental health. For example, the American Heart Association (2018) and the CDC (2020) agreed that depression, chronic stress, and anxiety can contribute to cardiovascular disease and cardiovascular can cause stress, anxiety, and depression.

Successful faith-based health promotion programs are seen in FBOs. Programs that offered education on diverse health topics, such as nutrition (Batada et al., 2017; Tucker et al., 2019), general health (Batada et al., 2017), healthy lifestyles (Hardison-Moody & Yao, 2019; Tucker et al., 2019), and HIV/AIDs (Berkley-Patton et al., 2019) have shown positive health behavior change and positive health outcomes. Whether the

programs were single promotion efforts, such as health fairs, or short-term programs (6-9 weeks), the post outcome measures showed an increase in health screening engagement (Batada et al., 2017; Berkley-Patton et al., 2019), engagement in exercise classes (Batada et al., 2017), knowing personal health information (Batada et al., 2017), and nutrition label literacy (Tucker et al., 2019). The overarching theme is health promotion efforts focused on education are efficacious in FBOs. A lack of mental health presence is seen in physical health programs that target healthy lifestyles and chronic or terminal illness. Although positive health outcomes are seen in HPP there was no mental health promotion or activities seen. Because physical and mental health directly impact each other they should be conjoined to improve health (Ohrnberger et al., 2017).

Mental Health

Mental health initiatives in FBOs are not nonexistent in the literature but are limited (Hankerson & Weissman, 2012; Hays & Aranda, 2016; Wong et al., 2018). The first systematic review of church-based mental health interventions among African Americans was conducted between the years of 1980-2009 (Hankerson & Weissman, 2012). In the review, eight studies were identified, but the majority of the researchers focused on substance-related disorders (Hankerson & Weissman, 2012), which does not align with the NIMH's (2019) definition of mental health. Similarly, Hays and Aranda (2016) conducted a systematic review of faith-based mental health intervention outcomes among African Americans between the years of 1980-2013, which showed similar results to their predecessor. Both groups of researchers showed that there is research on mental health initiatives, but fall short because they lack exclusivity to the definition of mental

health. FBOs continue to be underused to aid in the improvement of health care disparities for African Americans. Not only do the researchers show a gap in literature for faith-based mental health interventions, but they also show a gap in usage among diverse populations.

Church-based health promotion programs are a viable option to address mental health issues among African Americans due to their connection with the church (Hays, 2018). Scholars have examined interventions that were focused on the individual (Hankerson & Weissman, 2012; Hays & Aranda, 2016). Health promotion takes a broader approach by focusing on education and resource linkage (Kumar & Preetha, 2012). The reconceptualization of CBHP to include group, family, congregation, and community instead of just focusing on individual health behaviors might align better with mental health promotion (Hays, 2018). Reconceptualization of health promotion from the individual to the group is viewed as more culturally responsive to African Americans (Hays, 2018). The cultural responsiveness indicates potential applicability to other cultures, which can be applied to impoverished communities.

The inclusion of mental health programming in FBOs is attributed to higher incomes, more staffing, the presence of health-focused programs, community involvement, and being located in an African American community (Wong et al., 2018). Like Bopp and Fallon (2013), Wong et al.'s (2018) participants represented a diverse demographic population. Wong et al. separated mental illness and substance use disorders in their National Congregations Study and found more services for substance abuse disorders. There is comorbidity between mental illness and substance abuse, and

one can impact the other in a reciprocal relationship (National Institute of Drug Abuse, 2020). FBOs that offer substance-related programs yet lack a mental health component are out of alignment with the definition of mental illness, which excludes developmental and substance abuse disorders (NIMH, 2019). Therefore, a focus on mental health, such as depression, is not being offered. Further exploration is needed on health promotion activities such as individual health counseling, dissemination of materials, educational materials, development of teams or interest groups, and health fairs among varied cultures and denominational affiliations (Bopp & Fallon, 2013; Wong et al., 2018).

Connections between Physical Health and Mental Health

According to the WHO-CGF (2014), physical and mental health influence each other and should not be treated as separate entities when attempting to improve health disparities among vulnerable populations. Yet, there is scant research available on programs that incorporate both. Examples of both components can be seen in Turner et al. (1995) and Cronjé et al. (2017). Although Turner et al. found an increase in community awareness of cardiovascular disease and increased participation in health-promotion activities, they failed to report anything on the mental health component. This negates any connection between physical and mental health outcomes. In contrast, Cronjé et al. reported statistically significant changes between pre and post data on the effects of attending a 5-day faith-based education program in the areas of physical, mental, and spiritual parameters. Faith-based programs contribute to improved awareness or health outcomes in all domains. Cronjé et al. also showed acknowledgment of mental health as a parallel health component. Although both groups of researchers did not focus on the

direct relationship between physical and mental health, they showed equity among health components through the inclusion of mental health.

Examples of Mental Health Promotion Programs in FBOs

There is limited research on health programs specifically for mental health or mental health ministries in FBOs between 2015 and 2020. Due to the limited research, an exploration of programs from earlier years is used in this section to show the types of mental health programs and their efficacy in FBOs. The different programs focus on mental health education for faith leaders, relationship building between FBO leaders and members, skill training for FBO member, prevention programs, and mental health stigma reduction.

Helping Alleviate Valley Experiences Now

The Helping Alleviate Valley Experiences Now program was designed to prevent suicide for African American teens who are identified as at-risk (Molock et al., 2008). There are four components to the program that interact to increase education on suicide, risk factors, and referrals (Molock et al., 2008). Lay helpers (church members as natural caregivers) and gatekeepers (shepherds) are trained in a community education curriculum on suicide (Molock, et al., 2008). Community organizations and a mental health resource directory serve as resources for the church (Molock, et al., 2008). The lay helpers and gatekeepers refer youth who show signs of suicide to a mental health provider. The model relies on relationship building, which strengthens the entire church not just persons identified as at risk (Molock et al., 2008). There is an inclusion of the community in the program to increase awareness through a faith-based curriculum. There is also a

collaborative component between mental health agencies and the church to have open dialogue about members' mental health needs and related services (Molock et al., 2008). There were no results showing efficacy, but the implementation of the program shows the use of education and screening tools to aid in symptom identification and referral (Molock, et al., 2008).

Calmer Life Project

The Calmer Life Project is a collaboration between researchers, community organizations, and FBOs targeted on decreasing barriers to anxiety treatment for low-income, underserviced, African Americans 50-years-old or older (Jameson et al., 2012; Shrestha et al., 2017). The program is a mental health intervention using cognitive behavioral therapy that lasts for 6 months (Jameson et al., 2012). The program consists of skill training to reduce anxiety within the first 3 months, in which participants had to practice skills independently (Jameson et al., 2012). Community providers are trained in the model to provide skills, along with individuals in the community-academic partnership. During the skill training, participants had the option to receive 10 to 15-minute phone contact to review skills between sessions (Jameson et al., 2012). Resource counseling was provided if basic needs were identified as unmet during baseline data collection (Jameson et al., 2012). There is also an optional religion/spiritually component (Shrestha et al., 2017). Data are collected at baseline, 6 months, and 9 months. Preliminary data are showing success, as the data collection and analyses are ongoing (Shrestha et al., 2017).

Promoting Emotional Wellness & Spirituality Program

Williams et al. (2014) implemented and informally evaluated the 10-hour training program Promoting Emotional Wellness and Spirituality (PEWS) program in New Jersey designed to educate clergy on depression, reduce the stigma of depression, and promote mental health treatment-seeking behavior. PEWS was designed as an effort to promote mental health treatment for depression among African Americans, not for formal research, which is listed as a limitation to the study (Williams et al., 2014). Church leaders were trained and offered assistance to expand current health ministries to include mental health or create an exclusive mental health focused ministry (Williams et al., 2014). The training included videos and power point presentations to elicit in-depth discussion about mental health, spirituality, and stigma (Williams et al., 2014). Williams et al. found that after the training one churched added a mental health committee, and another created a health and wellness ministry (Williams et al., 2014). An implication of the study was to expand the PEWS Program to different religious affiliations and racial and ethnic groups to expand the inclusion of mental health ministry committees (Williams et al., 2014).

Barriers to Mental Health Promotion in FBOs

The characteristics correlated with mental health programming in FBOs are larger congregations, members with higher incomes, other health-focused programs, collaboration with other community agencies, and funding to employ staff for programs (Bopp & Fallon, 2013; Tagai et al., 2018; Wong et al., 2018). These characteristics are not necessarily seen in smaller FBOs or ones in impoverished areas, which demonstrates a need to focus on efforts in the vulnerable locations with smaller FBO congregants.

Therefore, it is critical to identify the barriers in these locations to create sustainable solutions to mental health promotion. The common barriers identified to the limited offering of mental health promotion are lack of finances (Bopp & Fallon, 2013; Brand, 2019; Dossett et al., 2005; Wong et al., 2018); organizational capacity (Brand, 2019; Pyne et al., 2019; Wong et al., 2018); lack of education or training for the faith leader (Leavey et al., 2012; Leavey et al., 2016; Milstein et al., 2017; Pyne et al., 2019; Wong et al., 2018); lack of staff and volunteers (Holt et al., 2017); lack of resources (Dossett et al., 2005; Wong et al., 2018); lack of leadership or influence from the faith leader (Sytner, 2018; Vermaas et al., 2017; Wong et al., 2018); and the faith-leader's attitude, personal beliefs, or lack of interest (Leavey et al., 2016; Wong et al., 2018). The influential nature of the faith leader may be the key to understanding the presence or absence of mental health promotion in FBOs.

Organizational capacity hinders FBOs from offering effective mental health promotion programs. Although limited in scope, Hays (2015) argued that understanding capacity is needed for successful mental health programs in the Black church. The Faith-Based Organization Capacity Inventory (Tagai et al., 2018), Brand's Predicting Readiness to Engage African American Churches in Health Survey (Brand & Alston, 2018), and the Faith-Based Organization Health Integration Inventory (Williams et al., 2020) were designed to assess FBO readiness in health promotion, frequency of HPP, infrastructure, processes, resources, and communication. Scholars showed the capacity tools are promising for analysis of FBOs, but a limitation to the results is that the lack of diversity beyond the African American community. This is important because financial

resources were consistently identified as a problem in the sustainment of mental health promotion in FBOs among the African American community (Brand, 2019; Tagai et al., 2018). This supports the identification of funding as a common barrier cited by faith leaders in earlier studies that hinder the creation and sustainability of mental health promotion in FBOs (Bopp & Fallon, 2013; Dossett et al., 2005). Based on the limited research presented, a false assumption can be made that the African American community lacks financial resources. Without proper research on diverse populations and denominations using assessment tools, there are not any additional resources to support or negate the findings of one population.

Financial resources can also improve organizational capacity. Churches with more infrastructure had more HPP (Brand & Alston, 2018; Wong, et al., 2018). Additionally, larger congregations participated in more health programming than smaller congregations (Tagai et al., 2018). Tagai et al. (2018) identified more paid staff and volunteers as contributors to sustainable health programming. The ability to maintain a larger facility and pay staff shows more financial resources. An FBO that has limited resources may not be able to apply the same, thus contributing to the lack of mental health promotion.

Collaborative efforts between FBOs and community providers are suggested as a resource to assist with creating and sustaining mental health promotion and programming in FBOs (Leavey et al., 2012; Milstein et al., 2017; Pyne et al., 2019; Smith et al., 2018). However, some barriers contribute to the lack of a collaborative relationship between the two entities. Barriers documented to collaborative partnerships between FBO leaders and MHPs are personal bias (Milstein et al., 2017), a conflict between doctrine and medicine

(Sytner, 2018), the mental health literacy of FBO leaders (Pyne et al., 2019; Sytner, 2018; Vermaas et al., 2017), distrust between providers and clergy (Milstein et al., 2017; Pyne et al., 2019; Smith et al., 208), lack of local resources to support the collaboration (Wong et al., 2018), the beliefs and levels of engagement of some clergy (Sytner, 2018; Vermaas et al., 2017), and the cultural competence of mental health providers (Sytner, 2018). Barriers that hinder collaborative relationships between mental health professionals and faith leaders are not seen in general health promotion because successful programs exist more frequently in FBOs (e.g., Batada et al., 2017; Berkley-Patton et al., 2019; Tucker et al., 2019). This could imply that mental health is not readily accepted as a health condition, hence the lack of inclusion of mental health promotion in FBOs. Breslin et al. (2017) stated that the public does not give the same level of importance on mental health as they do with physical health. Because faith leaders are viewed as influential in communities (Fripp & Carlson, 2017), it is possible for them to redefine collaborative relationships with service providers if they perceive their role in mental health promotion as significant.

Conclusion

The conceptual framework for the HBM and the TPB was explored through the literature to provide support for their appropriateness to this study. Each model was presented separately with its constructs and limitations, and then collectively to provide the rationale and application for this study. This study may fill the gap in research on mental health promotion in FBOs, more specifically on the faith leaders' role in mental health promotion. The results may extend knowledge in the area of using FBOs to

promote mental health in communities that are more prone to poor mental health outcomes.

The major themes in the literature provided by this review are as follows. Poverty and mental illness are directly linked (Harder & Sumerau, 2018), and the U.S. government has provided resources to impoverished communities to improve health outcomes (White House Faith-Based & Community Initiative, n.d.). Some of the initiatives targeted FBOs because of their long-standing history in the community, but there are opposing viewpoints (Bopp et al., 2019; Watkinson, 2015). Faith leaders are identified in literature as people who can influence a large number of people for different outcomes (Baruth et al., 2015; Hays, 2018). Additionally, research supports that individuals were seeking out faith leaders for support on health topics (Chatters et al., 2017). Health programming in FBOs are identified as a strong resource for the prevention of disease, but there lacks a strong mental health component (Andren & McKibbin, 2018; Tagai et al., 2018). Multiple barriers were identified as reasons mental health promotion is not being implemented or sustained in FBOs, but this is not true for physical health promotion (Milstein et al., 2017; Sytner, 2018; Tagai et al., 2018; Vermaas et al., 2017). There is a lack of understanding on why physical health promotion is readily accepted and implemented, but mental health is not, even though great success is seen in these similar programs (Breslin & McCay, 2013). The answer may lie in the perception of the faith leader on their role mental health promotion efforts.

The next chapter is a presentation of the research plan that will provide the foundation for collecting data to determine the faith leaders' perceptions of their role in

mental health promotion as a resource to improve mental health care in impoverished communities. The answer to the research the question will fill the gap in literature on the influence of faith leaders in mental health promotion. Chapter 3 will include the research design and rationale, along with the identification of the researcher's role in the study. Next, the research methodology will be explored in-depth to include participant selection, instrumentation, and procedures for recruitment, participation, and data collection. Finally, a data analysis plan will be provided, and trustworthiness and ethical procedures will be addressed.

Chapter 3: Research Method

Introduction

The purpose of this study was to determine faith leaders' perceived role in mental health promotion as a resource to improve access to mental health care in impoverished communities. In this chapter, I provide the research design and rationale for its use, followed by the researcher's role. I also provide the details of my methodology to include the study population, sampling strategy, and recruitment process. The next section focuses on data collection and the data analysis plan. Finally, issues of trustworthiness and ethical considerations are discussed. A chapter summary is provided with an introduction to Chapter 4.

Research Design and Rationale

The research question for this study was: What are faith leaders' perceptions of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities? The focus of the study was on how faith leaders perceive their role in mental health promotion in an attempt to understand why FBOs are not frequently used for mental health promotion in impoverished communities (Cherry et al., 2017; Kwon et al., 2017).

I considered different research methodologies for my study before deciding to use a general qualitative research method. I considered quantitative research methodologies, which allow the researcher to collect and analyze numerical data seeking relationships between variables (Frankfort-Nachmias & Leon-Guerrero, 2018). I did not choose a quantitative methodology because I am not seeking to find a relationship between

variables, but rather to deeply understand the beliefs and perceptions of participants. I also considered mixed methods, where quantitative and qualitative methodologies inform each other (Babbie, 2017). Although mixed methodology increases validity in research, it is complex and time consuming (Burkholder et al., 2016). I did not choose this method because of its complexity. Finally, qualitative research is contextual and occurs in a specific place and time (Dodgson, 2019). Overall, the use qualitative research allows for the acquiring of a deep understanding of how people interpret their experiences and the meaning they assign to those experiences (Merriam, 2009).

I chose the generic, qualitative design because it allowed me to collect data from the interviewees that explored their attitudes, opinions, perceptions, and beliefs about their role in mental health promotion. A generic, qualitative approach, also called basic qualitative or interpretive, focuses more on the person's experience with an issue or problem (attitudes, beliefs, opinions, reflections), rather than the inward experience of cognitive processes and how it was lived (Cooper & Endacott, 2007; McCusker & Gunaydin, 2015; Percy et al., 2015). Kahlke (2014) indicated that generic, qualitative research is appropriate to study the perceptions of an issue, and Bellamy et al. (2016) described generic, qualitative research as the interviewer trying to extract ideas from the participants about things "outside themselves," seeking to understand the process, phenomena, or perspective (p. 674). Because I explored the faith leaders' perceptions of their role in mental health promotion, a generic, qualitative design was appropriate for the study.

The uniqueness of generic, qualitative research allows for the inclusion of the other qualitative designs as it fits in the study (Bellamy et al., 2016). There are several designs for qualitative research, which include case studies, grounded theory, phenomenology, ethnography, action research, and feminist research (Cooper & Endacott, 2007). Phenomenology is used in research to understand a subjects' lived experience with a phenomenon (Percy et al., 2015). Grounded theory is used when a researcher desires to create new theory (Kahlke, 2014). My study did not focus on creating theory to explain a phenomenon. I did not choose phenomenology because I am not interested in faith leaders' experiences, but rather their perceptions. In ethnography, the researcher has a participatory role in the data collection (Bhattacherjee, 2012). This design was not appropriate for my study because I did not explore culture through a participatory role. Although I chose not to use these qualitative designs, the generic, qualitative design allowed me to use techniques from them in my study.

Role of the Researcher

In qualitative research where interviews are conducted, the researcher is considered the instrument used to collect data (Dodgson, 2019; McGrath et al., 2019; Pezalla et al., 2012). I conducted semistructured in-depth interviews during the data collection process. Pezalla et al. (2012) presented different interview styles (energetic, neutral, self-disclosure) and found that, depending on the topic, each interview style provided different results. I engaged in a mock interview to familiarize myself with my interview style. As the instrument, I was also responsible for analyzing the data and preparing a report.

I was a member and ministry leader at an FBO in the community where I collected my data. However, I interviewed participants with whom I did not have a previous or ongoing close relationship in that role. There may be a loose association with participants due to my connection in the religious community, specifically with some African American churches; however, this did not create a hierarchal power differential as we are in the same types of role in the community. My experiences in the faith community and mental health community may create conscious or unconscious bias, which could limit my objectivity. By not articulating and addressing my roles and potential bias, I risked presenting study results that do not reflect the population, but rather my views.

I have shared experiences with the study participants as the religious community connects us. Buetow (2019) discussed the need to bring unconscious bias into awareness to deter the expectations of the research and focus on the data. My shared experiences may create bias, and I had to be cognizant of similarities and differences between myself and the participants (see Berger, 2015; Teh & Lek, 2018). To address my personal bias, I used reflexivity in research. Reflexivity is a deliberate process that involves researchers being aware of their reactions to participants and how the information is constructed (Berger, 2015; Teh & Lek, 2018). It requires constant reflection and self-awareness (Dodgson, 2019). Anderson and Stillman (2013) stated that reflective journals are pedagogical instruments to be used for reflection, self-analysis, and criticism. The use of reflective journaling or analytic memos allowed for me to constantly examine and reflect on my assumptions, bias, positionality, and personal identity, thus increasing the

trustworthiness of the research (see Attia & Edge, 2017; Reid et al., 2018; Shenton, 2004). I kept a journal to engage in reflexivity throughout the research process, starting with recruitment. I also used the reflective journal before and after interviews to document my feelings and thoughts that arose during the interview as a tool to address bias.

Methodology

Participant Selection Logic

Population

The study population consisted of seven male and one female faith leaders from Cumberland County, NJ. Cumberland County, NJ is considered semirural and is the poorest county in the state (Data USA, n.d.). The 2010 United States Census (2012) reported over 157,000 residents. The county consists of three cities, 10 townships, and one borough (Cumberland County New Jersey, 2020). The ethnic composition of the county is composed of White (48%), Hispanic (27%), Black (18%), two or more races (3%), Asian (1%), and other (3%; Data USA, n.d.). According to Inspira Healthcare Network (2013), a higher proportion of Black residents, and fewer White and Asian residents, is seen compared to the overall state totals. Hispanics, specifically Mexican and Puerto Rican populations, represent a higher proportion (27.1%) than the state rate of 17.7% (Inspira Healthcare Network, 2013).

Sampling Strategy

The sampling strategies that were used for this study included purposeful sampling and snowball sampling. Purposeful and snowball sampling are widely used in

qualitative research and appropriate for generic, qualitative research (Cooper & Endacott, 2007; Palinkas et al., 2015). In purposeful sampling, participants are identified by a predetermined criterion relevant to the research question (Lopez & Whitehead, 2013; Padilla-Diaz, 2015). This created the opportunity for the in-depth study of the topic because the participants will meet the criteria to answer the research question (Patton, 2015). The use of snowball sampling allowed the participants to tell others who may meet the study criteria about the study and provide them with the researcher's information so that they can potentially volunteer to participant (Cooper & Endacott, 2007). This was needed because I initially relied on the internet to locate FBOs in the Cumberland County area. Some of the information was outdated, and snowball sampling allowed for participants to inform others about the study and how to contact me.

Inclusion Criteria

The criteria to become a participant of this study included (a) being 18 years of age or older; (b) currently residing in Cumberland County, New Jersey; (c) currently being the faith leader or assistant faith leader of a 501 (c) (3) nonprofit faith-based organization in Cumberland County, New Jersey; (d) having a weekly attendance below 300 members; and (e) understanding and speaking English. A prescreening document (Appendix A) was sent with the invitation (Appendix B). Individuals who did not meet the criteria set forth were not able to participate.

Church size of fewer than 300 weekend attendees was a criterion for the study. Church size is determined by weekend attendance (McIntosh, 1999). McIntosh (1999) provided a typology of church sizes and identified small churches as having 15-200

members, medium churches having 201-400 members, and large churches having over 400 members. In comparison, USA Churches.org (n.d.) identified the small church as having under 50 people, the medium church having 51-300, the large church having between 301-2000, and the mega-church having more than 2,000 people. Additionally, Bopp and Webb (2013) identified mega-church weekend attendance as 2,000 or more. There is incongruence with numbers for medium and large churches. Therefore, for this study, small and medium churches will be considered up to 300 people in weekly attendance. The rationale for church size in this study was from research that showed large churches, with weekly attendance of over 300 people, were more likely to implement health promotion activities (see Bopp et al., 2019). Therefore, the probability of randomly recruiting FBOs that do not engage in health promotion was higher.

Sample Size

A smaller number of participants is seen in qualitative studies as opposed to quantitative studies. Mason (2010) indicated that larger sample sizes are more time consuming to analyze and can yield redundant results citing the need for saturation. Saturation occurs when data collection is stopped because there is no new information to provide on the topic being studied (Guest et al., 2006). Malternud et al. (2016) posited that sample size is more about the sample's information power, meaning it is about quality, not quantity. Information power means the more information collected in the qualitative study, the fewer participants who will be needed (Malternud et al., 2016). The areas that contribute to information power are the purpose of the study, a specific study sample, the use of established theory, the quality of interview dialogue, and the analysis.

Patton (2015) indicated that the way participants are selected purposefully will contribute to sample size. In a systemic review of single-interview-per-participant design, Vasileiou et al. (2018) found sample sizes ranging between 10 and 50 participants. I interviewed eight participants and reached saturation.

Sample Identification

I recruited faith leaders for this study by first using the Google search engine to identify churches, synagogues, mosques, and temples in Cumberland County, NJ. According to Church Finder (n. d.), there are 184 churches listed in Cumberland County, NJ of various denominations (Baptist, Presbyterian, Catholic, Pentecostal, Non-Denominational, Seventh Day Adventist, Lutheran, Greek Orthodox, Methodist, Assembly of God, Roman Catholic). I found eight synagogues, two mosques, one Buddhist temple, and one Church of Jesus Christ of Latter-day Saints (Mormons) in Cumberland County, NJ. The list of FBOs was not exhaustive due to FBOs closing and opening or the potential of inaccurate reporting to local directories. I am familiar with the area, and there are approximately four FBOs that would not qualify for the study. There was an adequate participant pool to recruit eight to 15 participants and also let them know that they can pass on the information about my study to others who may qualify to participate.

After the identification of FBOs, I looked for those that had websites and social media sites to acquire email addresses to directly send the flyer (Appendix C) and invitation letter (Appendix B). I also posted a flyer (Appendix C) on the social media sites Facebook and LinkedIn weekly. For those FBOs that did not have websites or social

media platforms, I called the designated number and left a message for lead clergy and a request for a return phone call. Because there was a possibility that internet information was not accurate, I used snowball sampling to identify other FBOs that may not have been updated online. I included a reference request on the invitation letter (Appendix B) and the informed consent document. I considered using the U.S. Postal Service to mail invitations as needed, but I was able to acquire all participants through internet and snowball sampling. I used the prescreening questionnaire (Appendix A) to determine eligibility for study participation.

Instrumentation

Percy et al. (2015) recommended using open-ended questions to generate deeper responses. I created an interview guide (Table 1) using the constructs of the HBM and TPB to serve as the foundation for the semistructured interview of faith leaders. The first part of the interview guide collected demographic information. The HBM and TPB allowed for the collection of demographic information to explore factors related to health decisions (Ajzen, 1991; Rosenstock et al., 1988). The demographics included the faith leader's title, years as a faith leader, denomination, race, age, and level of education with the major. I grouped like constructs to ensure there were no duplicate questions because the theories are similar. I referenced Ajzen's (2002) guide to create interview questions using TPB. I reviewed qualitative studies that used the HBM (Herrmann et al., 2018; Mincey et al., 2017; Quick et al., 2012), the TPB (Catalano et al., 2017; Eaton & Stephens, 2019), and both (Bistricky et al., 2018; Montanaro et al., 2018) to guide the development of questions that were meaningful and in alignment with my study. The

review of other qualitative studies assisted me with visualizing how theory develops aligned questions. I created preliminary questions from notes I collected while researching the theories. I then condensed those questions by merging similar questions. I had the initial questions reviewed for biased language and neutrality. I received feedback from my chair and two individuals who were familiar with FBOs and mental health. I eliminated and revised the questions to make them more generalized. The interview questions I developed are original and specific to factors that shape the faith leaders perceived role in mental health promotion. Therefore, question prompts were incorporated into the interview guide.

Table 1

Interview Guide

Constructs	Questions
Demographics	Denomination Title Years as a faith leader or assistant faith leader Race Age Gender Level of education and major
Knowledge, modifying factors, external variables(HBM & TPB)	1. In your own words, what is mental health? a. Other areas of health include physical, social, spiritual 2. Can you tell me what you know about mental health promotion? a. Mental health promotion can range from giving members literature, screenings, display tables, and thematic months 3. Can you name five mental health resources? (local, national) 4. Do you currently have a health ministry? a. If yes, describe what the health ministry does. b. If no, ask to explain c. If yes, does your health ministry have a mental health ministry? i. If yes, explain. ii. In no, ask to explain
Perceived severity (HBM)	5. Can you tell me what you know, think, or understand about the relationship between poverty and mental health?
Attitude (TPB)	6. Can you tell me your thoughts or feelings on mental health promotion in FBOs? 7. How do you perceive your role in mental health promotion? a. Do you think it is your responsibility to offer mental health promotion?
Perceived benefits & barriers (HBM & TPB)	8. What would be the benefits of engaging in mental health promotion at your FBO? 9. What are the barriers to engaging in mental health promotion at your FBO?
Subjective norm (TPB)	10. Do any of your peers (other FBOs) engage in mental health promotion? Explain. a. If yes, do you know how the program is going? Is it beneficial? Problematic? b. If no, ask to provide a reason 11. How do you think your members would feel about the incorporation of mental health promotion, a mental health ministry, or the addition of mental health to a health current ministry?
Cues to action (HBM)	12. Can you describe any experiences that you have had with mental health education, and/or mental health promotion? 13. Would you like to share any personal experiences that you or someone you know has had with mental health?
Behavior intent (TPB)	14. Have you engaged in any mental health promotion in the past 12 months? Describe. a. Mental health promotion can range from giving members literature, screenings, display tables, and thematic months. 15. How likely are you to engage in mental health promotion in the next 6 months?
Perceived behavior control and self-efficacy (TPB & HBM)	16. How confident/comfortable are you in incorporating some type of mental health promotion? Explain.

The HBM and TPB have overlapping constructs. Therefore, I considered this during the development of the interview guide to avoid the repetition of questions. The constructs used for this study explored the faith leaders' knowledge about mental health promotion (TPB) and their attitudes about mental health promotion (HBM, TPB). I identified the faith leaders' self-assessed ability to engage in mental health promotion (HBM, TPB), their peer influences (TPB), and their intent (TPB) to engage in mental health promotion. External variables, other factors, or cues to action (HBM, TPB) that contribute to behavior intention and behavior change include a prior education, mass media influence, and personal experiences. I explored these factors to determine other contributors to faith leaders' engagement in mental health promotion. I used addressed the modifying factors (HBM, TPB) using the demographic questionnaire and interview questions related to knowledge of the topic.

Content validity is seen when the instrument's items represent the content of the study (Zamanzadeh et al., 2015). Additionally, the questions need to be comprehendible, reflect the conceptual framework, and be consistent with the participant's perspective and language (Brod et al., 2014). One strategy I used to establish content validity is align my questions with the research focus of mental health promotion. Another strategy I used was to consult with my committee members to review my interview questions. I conducted a mock interview with someone who knows the faith-based community before conducting the formal interviews.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

First, I used purposeful sampling to recruit potential participants via email addresses obtained from the FBO website and social media outlets, such as Facebook and LinkedIn. I only directly emailed potential participants once. I repeated social media posts weekly and relied on people sharing the flyer until eight interviews were completed. Due to the slow progression of acquiring participants, I contacted FBOs that did not have websites or social media by telephone and left a message. I also used snowball sampling to ask participants to give my contact information to others they felt might be interested in participating in the study. I included a statement on the invitation letter (Appendix B) to share information with their affiliates so that snowball sampling occurred throughout the recruitment process. I did not request any changes to the recruitment procedures through Walden University's Institutional Review Board (IRB).

Participation

After invitations were distributed via email and the flyer posted on social media, I waited for responses. The prescreening form (Appendix A) was sent via email. When a faith leader showed interest in participation, I evaluated the form for study inclusion once the form was completed and returned via email. If the faith leader met the inclusion criteria, I emailed the informed consent document with a request to review the document and state consent, provide availability to schedule the interview, and indicate a desired digital platform for the interview. At the beginning of the scheduled interview, I began to establish rapport by asking for any questions about the consent form. If a participant did not meet the inclusion criteria for the study, I contacted the faith leader via email to thank

them for their desire to help and time, along with a request to share the study information with their peers.

Data Collection

If the faith leader met the study criteria, I emailed informed consent in preparation for the interview with the directions to read the document and reply their consent directly to the researcher through email within two days. I asked each participant to provide availability for a virtual interview on the platform of their choice when responding. I sent each participant a Zoom link once the date and time was established. I resent information the day before the scheduled interview as a reminder. I began the approximate 60-minute, Zoom meeting with the introduction script in the interview guide (Appendix D) to summarize the study and reiterate confidentiality. Next, I informed the participants that I am recording the interview using a hand-held device, and I notified them when the recording began. I used an interview guide (Appendix D) for consistency to ensure the language did not vary across interviews and the questions were aligned with the conceptual framework. I used prompts (Table 1) if an interviewee was had difficulty answering a question or asked for clarification. After completing the questions from the interview guide, I informed the participants that I was stopping the audio recording. I asked the participants if they had any questions or concerns. I then asked participants if they knew of any other individuals who may be eligible for the study. Next, I explained that I would contact them after I transcribe the interview for the opportunity to check for accuracy. Then I asked participants if they will participate in a follow-up interview if needed. Finally, participants were emailed a thank you letter via email (Appendix G) that

contained my contact information, the reminder about transcript review, and getting a copy of the study results.

Data Analysis Plan

Using field notes, audio-recordings, and transcripts are thought to strengthen data analysis (Tessier, 2012). I have experience with verbatim transcribing with two-person dialogue. Therefore, after the interviews, I transcribed the data in preparation for the analysis of data. Transcripts are verbatim and overcome the weakness of taking field notes (Tessier, 2012). Whereas, listening to the recording gives more meaning than reading the transcripts (Tessier, 2012). After each transcription I listened to the recording while reading along with the transcript for accuracy, twice. I referenced the field notes I created to add additional meaning to the interview. Once I completed my accuracy check, I sent the participant an email to remind them about the transcript review discussed at the end of the interview. I included the information in the thank you email (Appendix E) I sent a thank you email with the same information. I emailed the participant who requested to see his transcript and asked for any changes or approval within a week. I sent a follow-up email to the participants who did not respond and waited a week for a response. I continued with the data analysis process, and all eight transcripts were used.

I used thematic analysis (TA) to answer the research question. Thematic analysis is a flexible data analysis approach that allows for identifying emergent themes through a six-step model (Clarke & Braun, 2006, 2017). Step 1 is the familiarization with the data (Nowell et al., 2017). I listened to the audio recording and read the transcripts more than once. I used reflexive journaling to address my preexisting thoughts and beliefs (see

Nowell et al., 2017). The next step is coding (Clarke & Braun, 2006). According to Saldaña (2016), coding is subjective and occurs when a word or short phrase is assigned to the data to symbolize or convey meaning.

Additionally, coding is a cyclical process and is used to link information. I manually coded the data. I created and used Microsoft Excel to sort and code data. I then used a codebook to label, define, and track the codes, which is used in inductive coding. My coding strategy was to first precode by highlighting keywords in transcripts (Saldaña, 2016). I then created preliminary codes using open coding, the line-by-line technique (Saldaña, 2016). I then completed second-cycle coding to reorganize and rename codes from the first cycle (Saldaña, 2016), which allowed me to narrow and group like codes. I repeated the coding process several times and then formed final codes. I did not use any software to help sort the data and identify codes.

The third step in TA is generating themes from the codes (Clarke & Braun, 2006). After the coding process, I looked for initial themes and patterns that answered my research question. Next is Step 4, reviewing themes to determine if the theme reflects the data set or can be combined with another theme (Clarke & Braun, 2006). During this step, I reviewed the themes multiple times and made changes to preliminary themes as needed. Once the themes accurately reflected the data, I progressed to the fifth step of defining and naming the final themes (Clarke & Braun, 2006). During this process, I used researcher triangulation. Finally, the last step in TA is to write a concise and coherent report (Clarke & Braun, 2006). A concise report of the results is available in Chapter 4, including direct quotes from participants to increase credibility.

Issues of Trustworthiness

Critics of qualitative research argue that it lacks rigor, and the findings are just a collection of people's opinions subjected to researcher bias during analysis (Leung, 2015; Noble & Smith, 2014). Therefore, establishing trustworthiness in research is essential to validate the study. Tessier (2012) suggested taking notes during the interview. Field notes are recommended in qualitative research because they record immediate researcher thoughts and contribute to the rich, thick descriptions qualitative research seeks (Phillippi & Lauderdale, 2017; Tessier, 2012). Field notes can be descriptive, such as setting observations and reflective to include the researcher's thoughts (Schwandt, 2015). According to Nowell et al. (2017), trustworthiness is established by demonstrating that the data's analysis is precise, consistent, and exhaustive by being descriptive through analysis. The four areas that strengthen trustworthiness are credibility, transferability, dependability, and confirmability.

Credibility

Also known as internal validity, credibility was identified by Shenton (2004) as the most important factor in establishing trustworthiness. Credibility or internal validity refers to the believability of the results from people with shared experiences (Connelly, 2016). Believability occurs when the researcher reflects the respondents' perspectives, not the researchers (Nowell et al., 2017; Shenton, 2004). Strategies to address credibility include prolonged engagement, data triangulation, persistent observation, researcher triangulation, and peer debriefing (Nowell et al., 2017; Patton, 2015). I maintained the accuracy of the participants' responses by seeking clarification during the interview

process and then using verbatim translation. I also offered transcript review so participants can validate their responses after transcription (see Moser & Korstjens, 2018). Shenton (2004) posited that triangulation with peers is needed to reduce bias and improve credibility. I used researcher triangulation during data analysis from a minister and youth pastor. I consulted with my committee chair and peers throughout the research process.

Transferability

Transferability refers to how generalizable the data are to similar situations, populations, or phenomena (Nowell et al., 2017; Patton, 2015; Shenton, 2004). Providing sufficient details through thick description is a strategy to address this area (Nowell et al., 2017; Reid et al., 2018; Shenton, 2004). Transferability occurs during research preparation when similar studies are identified with the same methods in different environments (Shenton, 2004). I kept detailed records on each step of the research process including methodology, sampling strategies and recruitment procedures, processes, data collection and analysis, and memos. By keeping records I created transferability so another researcher can easily use the procedures of my study to inform their study.

Dependability

Dependability contributes to trustworthiness when the research process is documented for another researcher to replicate the study (Nowell et al., 2017; Shenton, 2004). One strategy for establishing dependability is conducting an inquiry audit using an outside person to review the research process and data analysis for consistency (Nowell

et al., 2017). Another strategy is keeping detailed records explaining the research design, operational detail, and researcher reflexivity (Moser & Korstjens, 2018; Shenton, 2004). The goal of the record-keeping is to guide the next researcher to conduct a similar study yielding similar results. I kept detailed notes on the research process and consulted with committee members and peers to strengthen the consistency.

Confirmability

According to Nowell et al. (2017), confirmability is established when credibility, transferability, and dependability are achieved. Confirmability is the neutrality in the findings by showing steps on how the study's findings emerged from the data (Nowell et al., 2017; Shenton, 2004). The study results should be based on the data, not the researcher's subjectivity (Qu & Dumay, 2011). The use of audit trails, analytical memos, transcripts, field notes, and the decision-making process will show transparency during the research process. Reflexivity is a deliberate process of the researcher's self-reflection during the research process (Berger, 2015). Reflexive journals are tools used by researchers to address potential bias, thoughts, beliefs, feelings, assumptions, motivations, positionality, and personal experiences (Attia & Edge, 2017; Berger, 2015; Moser & Korstjens, 2018; Reid et al., 2018). Berger (2015) indicated that when the researcher describes the intersecting relationships between themselves and the participants, it deepens their understanding and increases credibility. I kept detailed records, a reflexive journal, and consulted with peers to increase confirmability.

Ethical Procedures

Before beginning data collection, I obtained the Walden University Institutional Review Board (IRB) approval number 01-20-21-0529113. IRB approval was needed to ensure the protection of human participants. This study did not have any red flag issues, such as conducting the study in my workplace, sensitive topics, or vulnerable populations. The study did not have any physical risk factors for participants. However, potential risks included misunderstandings and feelings of embarrassment, inadequacy, or conflict may occur.

Informed consent allows the participant to review the study and voluntarily decide to participate (Nijhawan et al., 2013). Informed consent includes participant rights, the study's purpose and procedures, the risks and benefits of the study, the expected duration of the interview, and confidentiality procedures (Manti & Licari, 2018; Nijhawan et al., 2013). Each participant was emailed a letter of consent when they agreed to participate and prior to the scheduled interview. I asked participants to review and consent via email. To reduce any language barriers, one inclusion criteria is for the participant to understand and speak English (Nijhawan et al., 2013). I informed the participants of their right to refuse any questions that created discomfort or withdraw from the study. There was no participant withdraws from the study.

Confidentiality is an important consideration when asking participants for full disclosure, so my committee members and I were the only individuals who knew the actual names of the participants. Each participant was assigned a pseudonym in Chapter 4 and Chapter 5. Specific demographic information, such as church location within the

county, was not reported to increase confidentiality. I stored all transcripts and documents in a locked cabinet in my home that I only have access to. All electronic documents and audio files are stored in password protected computer, in a file nestled in two other files. The audio recordings were deleted from the recording device after it was transferred to a folder. According to the IRB, all original data from the research study should be kept for 5 years and then destroyed.

Summary

Chapter 3 focused on the detailed research methodology of this generic qualitative study. Major sections included in the chapter were the research design, study rationale, methodology, and trustworthiness issues. Participant selection logic was provided for faith leaders in Cumberland County, NJ. The use of audio recordings, field notes, and an interview guide was presented and rationalized. The relationship between the development of the interview guide and the HBM and TPB was provided, showing that the original questions were developed using theory. I provided the procedures for recruitment, participation, and data collection. Thematic analysis was discussed as the method for data analysis. Finally, I discussed how I ensured trustworthiness in my research to increase reliability, validity, and ethical considerations. Chapter 4 will present the data and findings of this study.

Chapter 4: Results

Introduction

The purpose of this generic qualitative study was to explore how faith leaders perceived their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. The research question was the following: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities? The contents of this chapter include information about the setting where interviews were conducted. In addition, the demographics of the participants are discussed, and the data collection and analysis process are outlined in detail. Lastly, evidence of trustworthiness and the study results are provided.

Setting

Semistructured interviews were conducted with eight faith leaders in Cumberland County, NJ. Due to COVID-19 restrictions, all semistructured interviews were conducted through Zoom video conferencing. The date and time of the interviews were determined by the participant. I conducted interviews in my home office alone with the white noise machine at the door to ensure others would not hear the content of the interview. I asked that each interviewee be in a setting where they would not be heard by others. Each interview lasted between 30 and 70 minutes and fluctuated depending on how responsive the participant was to the interview questions.

I used the Voice Recorder mobile application developed by TapMedia Ltd. on my Android phone to record the interviews. There were no issues with the recording device.

The unstable internet warning was displayed twice during one interview but did not negatively impact the interview or the later transcription. To my knowledge, there were no personal or organizational conditions that influenced participants or their experience at time of study that may influence interpretation of the study results.

Demographics

Participants in this study were either a pastor or an assistant pastor from different denominations of FBOs. Church size reported ranged from 20 to approximately 250-300 weekly attendees. The years in pastoral leadership reported ranged from 1.4 to 35 years, which is an average of 15.3 years. Participants ranged from 46 to 76 years of age. Seven participants were male, and one was female. Reported race included five Whites, two African Americans, and one individual who was Hispanic. Levels of education included some college (one), three completed associate degrees, two completed bachelor's degrees, two bachelor's degrees in progress, four completed master's degrees, and one doctorate degree in progress. Table 2 provides an overview of participant demographics.

Table 2

Participant Demographics

Participant number	Gender	Race	Age	Title	Years in leadership	Church size	Denomination	Education/major
P1	M	Caucasian	50	Pastor	10.5	20	Nondenominational	AA Marketing & Management
P2	M	Caucasian	76	Pastor	35	250-300	Nondenominational	Some college
P3	M	Caucasian	59	Associate pastor	6	225	Methodist	BA Bible & Leadership
P4	M	African American	46	Pastor	1.4	65	Baptist	BA Literature
P5	M	Caucasian	46	Pastor	2.10	140	Pentecostal	MA Social Work
P6	M	African American	58	Associate pastor	20	250-275	Baptist	AA – Education BA – In progress
P7	M	Hispanic	58	Associate Pastor	17	150	Pentecostal	AA – Theology BA – In progress
P8	F	Caucasian	64	Pastor	31	75	Episcopal	MA (2) – Divinity, Early Christian Literature MS – Library Science PhD – in progress

Data Collection

I received IRB approval on January 20, 2021 (approval number 01-20-21-0529113) to recruit eight to 14 participants. Participants were recruited using email, social media, and telephone (see Chapter 3). Six ineligible individuals were emailed to thank them for their time and consideration and asked to share the study with peers who may be interested (snowball sampling). Eight eligible participants were identified. Each participant was sent the informed consent document via email with the direction to read the document and reply with their consent via email within 2 days. Each participant was asked to provide availability for a virtual interview on the platform of their choice when responding. Once the date and time was established, a Zoom link was sent to the participant.

Interviews were conducted between February 5, 2021 and March 15, 2021 using the approved IRB interview guide and process outlined in Chapter 3 (Appendix D). Each participant was interviewed once via Zoom due to COVID-19 restrictions. Two participants participated from their home, one was in the home with a spouse present, one was in a parked car, and four were alone in their organizations. Their location did not interfere with their ability to participate in the interviews. Interviews lasted between 30 and 70 minutes depending on the depth of responses from the participant, questions about me, questions about my intent (four participants), and asking to pray for me (two participants). The interview consisted of seven demographic questions and 16 interview questions. Seven of the questions had prompts or additional probing questions that could be used if necessary.

Prior to the interview, the recording device was placed in airplane mode to limit disruptions during the recording. At the beginning of each interview, the introduction script from the interview guide (Appendix D) was read, and participants were informed when the recording began. The interview was audio recorded using the Voice Recorder App developed by TapMedia Ltd. on my Android phone. During the interview, notes were taken to document key words and initial thoughts.

The participant was notified the recording was being terminated after the last interview question was answered. The conclusion script from the interview guide (Appendix D) was read to close the interview. I asked the participants to share my information with peers who they thought might be interested in participating in the study. Three participants gave me the name of local pastors and the organization that they thought might be interested in participating. I emailed each participant the thank you letter (Appendix E) the day after the interview. I immediately transferred the audio file from my cellular device to a folder nestled in another folder on a password-protected computer after interview completion. Next, the file was deleted from my recording device. I then reflected on the interview by writing my thoughts, questions, and potential biases in my field notes.

No follow-up interviews were needed. However, two interviewees were contacted via email after their interview to determine if nondenominational was an appropriate term for their FBO because I was concerned their response would be a possible identifier to others. Both faith leaders agreed nondenominational was appropriate and gave me approval to use that terminology. Transcripts were created in Microsoft Word and saved

with password protection. The files were then transferred to my Google drive where they are nestled in another file. Print copies of the transcripts were stored in a locked filing cabinet when not being used for analysis. I contacted each participant to ask if they wanted to review the transcript once it was transcribed. One asked to read the transcript, but no changes were made. Three declined and wished me well with my endeavors, and four did not respond.

Variations from the data plan in Chapter 3 included the absence of using U.S. Postal services, as it was not needed to recruit. Additionally, variations were made to a couple questions after the first interview. The first change was made to Question 12: *Can you describe any experiences that you have had with mental health education and/or mental health promotion?* I realized I did not need to include mental health promotion in this question based on the responses to other questions related to mental health promotion. I needed to focus the question on experiences with mental health education. The second change was to Question 14*: Have you engaged in any mental health promotion in the past 12 months*? *Describe.* P1 pointed out that COVID-19 has impacted church activities, which prompted me to ask about the time prior to the pandemic. I do not believe that any of these situations negatively impacted data collection or results.

Data Analysis

I used the six-step TA model. TA allowed me to explore the data set of eight interviews to find repeated "patterns of meanings" (Clarke & Braun, 2006, p. 86). The first step in TA is to become familiar with the data (Nowell et al., 2017). After transcription, I listened to the interviews again and read through the transcripts multiple

times. I took notes and highlighted words on the printed transcripts and used reflexive journaling to address my preexisting thoughts and beliefs, reactions, and reflections (see Nowell et al., 2017). To prepare for coding, I transferred participant responses to the interview questions into a Microsoft Excel document separated by interview questions. I began the first cycle coding by assigning words or short phrases to the responses of each participant, which is also known as open coding (Percy et al., 2015) Next, I completed the second round of coding. During the second cycle, I narrowed the codes by connecting and combining codes (see Saldaña, 2016).

Step 3 in TA is generating themes from the codes (Clarke & Braun, 2006). I began to conceptualize and identify patterns and themes. Table 3 provides an example of the process of identifying preliminary codes, initial theme identification, and theme identification that I used to answer the research question. In initial coding, I derived keywords and short phrases from the participant responses. Next, I removed duplicates, grouped like codes, and identified three initial themes for review: a direct relationship and cause-and-effect relationship identified between poverty and mental health, limited accessibility to resources, and limited resources have mental health consequences.

I then reviewed the initial themes to ensure the themes reflected the data set, which is Step 4 of TA (see Clarke & Braun, 2006). I then engaged in researcher triangulation by sending the data to a youth pastor and minister who were not participants in the study. Once I received theme identification from the triangulation team, I compared their themes to mine. I named the final theme as poverty and mental health negatively associated. The final step in TA is to create a report (Clarke & Braun, 2006).

Using discrepant cases in research increases validity (Rose & Johnson, 2020) if this exists, and I classified one participant as discrepant case because his views differed from the others. He referred to himself as a "boot pastor" because his focus is on ministry outside the walls of the church. The discrepant case was considered in the analysis because it provided a different perspective, hence increasing validity.

Evidence of Trustworthiness

Establishing trustworthiness in research contributes to the validity of study results (Nowell et al., 2017). Trustworthiness in qualitative research is established by demonstrating that the analysis is precise, consistent, and exhaustive by being descriptive through analysis (Nowell et al., 2017). I engaged in strategies throughout the research process to ensure I achieved credibility, transferability, dependability, and confirmability.

Credibility

Credibility, or internal validity, refers to the believability of the results from people with shared experiences (Connelly, 2016). The respondent perspectives related to the phenomena are portrayed from their point of view in the results and not the researcher's thoughts or preconceived notions (Grossoehme, 2014; Nowell et al., 2017). Initial credibility was established by creating semistructured interview questions using the theory constructs of the HBM and the TPB. This allowed me to analyze responses from the participants to answer the research question from a theoretical lens. I maintained the accuracy of the participants' responses by seeking clarification during the interview process and then using verbatim translation. Transcript review by participants for accuracy is a tool used in member checking (Birt et al., 2016). I offered participants the

opportunity to validate their responses (Moser & Korstjens, 2018). Because only one participant participated in transcript review, this strategy was a limited contribution to credibility. Direct quotes from the transcripts were used in the results section to increase credibility.

The use of researcher triangulation helps reduce bias and improve credibility (Nowell et al., 2017). I engaged in triangulation during the data analysis process by emailing a minister and youth pastor the data collected from the interview questions for their theme identification. Method triangulation involves the use of previous research, theory, and literature throughout the research process to aide in theme identification and to draw conclusions (Cope, 2014). I referenced previous research, literature, and theory during the research process. I also triangulated using previous research from the literature review and theory to increase the credibility of the study in Chapter 5.

Transferability

Transferability, or external validity, refers to how generalizable the data are to similar situations, populations, or phenomena (Nowell et al., 2017; Patton, 2015). Preparation for this study included the reference of other studies that used the HBM and TPB, which improves transferability because similar studies were identified with the same methods in different environments (Shenton, 2004). Thick description is a detailed description of the context of the research process and is a commonly used strategy to address confirmability (Connelly, 2016; Cope, 2014; Nowell et al., 2017; Reid et al., 2018). I provided thick description of participants by collecting demographic information and describing the geographic location. Thick description was used in Chapters 3 and 4 to

provide details on methodology, sampling strategies and recruitment procedures, and data collection and analysis. This allows for another researcher to accurately replicate procedures that I used. I also kept detailed notes about each step of the research process.

Dependability

Dependability occurs when the research process is clearly documented for another researcher to replicate the study and yield similar results (Nowell et al., 2017; Shenton, 2004). Strategies for dependability include keeping detailed records explaining the research design, operational detail, and researcher reflexivity (Moser & Korstjens, 2018; Shenton, 2004). I kept detailed field notes and records of data collection activities. Audit trails allow for transparency in the researcher's process and decision-making (Cope, 2014). I kept an audit trail of decisions I made during coding and theme identification.

Confirmability

Confirmability is the neutrality in the findings by showing steps on how the findings emerged from the data (Nowell et al., 2017; Shenton, 2004). I created tables to document how themes emerged from the data using keywords and phrases from the participant transcripts (see Appendix F2). As a member of a faith-based community, I deliberately engaged in reflexivity during my research process to aide in reducing bias and recording thoughts, feelings, beliefs, positionality, and personal experiences (see Attia & Edge, 2017; Berger, 2015; Moser & Korstjens, 2018; Reid et al., 2018). I used researcher triangulation to reduce researcher subjectivity (see Qu & Dumay, 2011).

Results

Responses to interview questions were used to answer the research question: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities? I identified seven themes from the interviews that contributed to the faith leaders' perceived role in mental health promotion. The themes are the following: Theme 1: Negative relationship between poverty and mental health identified; Theme 2: Limited knowledge of mental health resources; Theme 3: Limited engagement of mental health promotion perceived; Theme 4: Positive attitude and role in mental health promotion; Theme 5: Mental health experiences shape role in mental health promotion; Theme 6: Barriers to mental health promotion in FBOs influence faith leaders' role; and Theme 7: COVID-19 influence on mental health promotion.

Theme 1: Negative Relationship Between Poverty and Mental Health Identified

Participants explained the relationship between poverty and mental health and the impact the relationship has on individuals and resource accessibility. All participants identified a negative relationship between poverty and mental health. Participant (P) 6 said, "Poverty has a way of compounding mental health issues because you just feel like you're in an endless cycle, you can't get out, you can't break free." P3 stated, "I would think that poverty would be close. People with mental health would be really tight with poverty because they are unable to maintain a job." Two participants used a broader terminology to connect the relationship between poverty and mental health. P2 stated, "Well, I think poverty affects every, every part of the human being," and P4 said, "So

social economics plays a big, big role, how we deal with, um, the problems that we have in life." Faith leaders identifying a negative relationship between poverty and mental health contribute to their perceived role in mental health promotion.

Half of the participants felt that poverty is a contributor mental health problems. P2 expressed that poverty impacts the whole person when he stated, "I think poverty affects every, every part of the human being." Three participants (P1, P6, P7) identified specific mental health occurrences as a result of poverty. P7 said, "Because as you know, financial crisis can, can lead to some mental issues." P1 said, "And so what happens is your mental health starts to get affected. Depression starts to creep in. Anxiety starts to creep in." Likewise, P6 stated, "So that becomes, that adds to depression, stress, anxiety, worry, doubt, fears that start to really weigh in on the individual and not just individual, but families, families, and generations." Faith leaders showed perceived the severity of mental health by identifying a cause-and-effect relationship between poverty and mental health shows the perceived severity of the relationship between them.

Three participants identified poverty as an inhibitor of accessing resources (P4, P5, P8). P8 stated, "Well, poverty aggravates mental health, like, um, your capacity, your ability to access the resources," and P5 said, "So it's definitely a, there's a correlation I believe there between poverty and the access and availability that people will access the things they need to get help and to have their health and wellness improved." P3 offered that not having a job keeps individuals on the poverty line. Two participants (P1, P2) mentioned the inability to access quality food and its' mental health impact on an individual. P2 explained,

> By the food that they have to eat because they can't afford healthy food. So to eat a lot of starches and all that stuff, and then consequently because they lack kind of a diet, it mentally affects the way they look or the way they feel."

The identification of adverse outcomes and limited resource accessibility created by the relationship of poverty and mental health contributes to the faith leaders' perceived role in mental health promotion.

Theme 2: Limited Knowledge of Mental Health Resources

Participants were asked if they could name five mental health resources to evaluate their knowledge of available resources. Half of the participants (P1, P4, P6, P7) needed the question prompt of national or local to assist with resource identification. Two participants identified four resources, two identified two resources, and two identified one resource. Only two participants were able to provide five resources. From the participants who could not name five mental health resources, two (P3, P7) indicated that they could find the resources when necessary. P3 stated, "I know if I need it; I know I can find it." Four participants expressed some type of difficulty with spontaneously answering the question. P2 replied, "Off the top of my head? No." From the resources identified, seventeen mental health resources were identified collectively from the participants with 75% of those resources identified as local community resources, and 25% as national resources (see Appendix G, Figure G1). Additionally, six of faith leaders failed to identify their FBOs as a resource. While seven participants linked mental health promotion to resources, two participants (P2, P5) mentioned having resources available in their FBOs. P2 shared, "We have, we have all kinds of resources available to them."

Overall, most participants could not name five mental health resources, which showed limited knowledge of available resources.

Most participants did not refer to their FBO as a mental health resource, which is supported by the limited presence of a formal health ministry as a health resource. Responses showed seven respondents did not have a formal health ministry, and six did not have a mental health ministry or a mental health component of a health ministry. One participant has a formal health ministry at his FBO. P2 stated, "Yeah we have a whole medical response team. It has a security personnel. It has nurses, registered nurses, all that. From time to time we have other specialists that tend to church that are also part of that team." When prompted about a mental health component or ministry, he replied "Not their [members] responsibility. It's the staff and pastor's responsibility." Three participants who did not have a health ministry did identify efforts to address mental health. P6 explained,

> Currently we have, what's known as, it used to be the [name of ministry] … [name of person] actually brought to the church, because again, we've seen the need because drugs. Normally people using drugs to try to go ahead and cope with these mental issues. They're self-medicating.

Two participants expressed desire to have a health ministry or collaborate with someone to provide mental health resources. P1 noted, "No, but that is something that we would like to have. We're definitely interested either partnering with or possibly creating, probably partnering with it'd be more the better bet." Although some participants reported some engagement in counseling (P2, P5, P6) and the identification of members

in the church that are more qualified to help (P7, P8) faith leaders reported no or limited formal health and mental health ministries, which are resources for the engagement of mental health promotion.

Theme 3: Limited Engagement of Mental Health Promotion Perceived

All faith leaders expressed a value in engaging in mental health promotion but showed limited conceptualization of mental health promotion as a resource. Three faith leaders attempted to define mental health promotion. P4 associated mental health promotion as a platform to converse about it. He expressed, "When you're talking about promoting let's provide the space, let's just provide the space so that people can, you know, let's take the mask off and let's be ourselves." P6 shared, "Where you give people the tools they need to be able to successfully deal with those issues that will cause them to have mental disruptions or mental issues." P7 explained,

> When you say mental health promotion, mental health promotion, well promotion, meaning going up a ladder. Going up another level, so the level promotion, mental health promotion, as far as it looks to me as someone that's getting a better, might've gone to some counseling.

Other faith leaders (P3, P5, P8) identified mental health promotion as community resource linkage opposed to internal organizational activities. P1 shared, "So I know the County does that kind of stuff. I don't know a tremendous amount about it, but I know that the County definitely has things for mental health." P3 stated, "Um, I realized that the County has things, uh, you know, there's, um, different services that the County provides."

Most faith leaders showed limited understanding of mental health promotion by identifying outside resource linkage as a way to promote mental health.

All of the participants identified some form of mental health promotion in the past 12 months, during or prior to COVID-19, throughout the interviews. Six participants indicated yes to engaging in mental health promotion. P4 elaborated and said, "Yeah. We've had some small things, but they're inadequate I have to be honest. Like if I was grading it, I'd say that's it like a D plus that's, that's like bare minimum." Two participants (P1, P6) stated no, but described engagement prior to COVID-19. Similarly, P6 explained, "No, because we haven't been in church…Prior to COVID, we have all those things." Faith leaders perceived they had limited engagement in mental health promotion at their FBOs before and during COVID-19.

A commonality manifested among faith leaders that they were discussing mental health promotion activities throughout the interview but failed to recognize it conceptually as evidenced by their responses to Question 14 of the interview guide. This was an unexpected finding. In Appendix F, Table F3 shows a comparison of the mental health promotion identified in Question 14 and additional instances of mental health promotion engagement identified throughout the interview. The lack of mental health promotion conceptualization might be a contributor to how the faith leader perceives their role in mental health promotion. Faith leaders were engaging without realization, which would create limited perception of their roles to shaping the faith leaders' role in health promotion.

Theme 4: Positive Attitude and Role in Mental Health Promotion

Participants shared varying thoughts and feelings about mental health promotion in FBOs. Two faith leaders (P6, P7) said mental health promotion should be included in FBOs. P7 felt mental health promotion should be in the church. He stated, "Definitely. Definitely. It should be in a church." P1 offered a reason the church is not using mental health resources. He indicated, "So I, I feel like the church has grossly underestimated the situation…I think there's a lot of different resources and things that we have yet to tap into." One participant felt mental health promotion did not exist in the church. P3 stated,

> It probably really isn't there unless, um, I've never really heard it as being a ministry in a church. I think the pastor deals with it when he has to. As much as our workload is I don't think that it's something we're chasing after.

Faith leaders held various thoughts on mental health promotion in FBOs ranging from it being needed in the church to only dealing with mental health on an as-needed basis. Faith leaders' responses evidenced a positive attitude and role towards mental health promotion in FBOs. Six subthemes contributed to the theme: physical, mental, and spiritual health are connected, biblical support for mental health promotion, helping others by engaging in mental health promotion, faith leaders' confidence in ability and member support with mental health promotion, faith leaders' role in mental health promotion, and intent to engage in mental health promotion, and confidence in member support of mental health promotion.

Subtheme 1: Physical, Mental, and Spiritual Health are Connected

The identification of a physical, mental, and spiritual health connection among faith leaders supports a positive attitude and role towards mental health promotion. Five participants implied that the mind, body, and spirit are connected or health is for the whole body. P1 shared the connection when he stated, "So it's mind, body and spirit, father, son, Holy Spirit. We're made in his image. And if one thing is off the whole thing could be off." P5 stated,

> Some of my sermons, you know, touch on not only the spiritual health, but I look at the whole person, you know, we're spirit, soul, and body, and the soul is the mind, the will, and the emotions…you want your soul to align to your spirit and you want to make sure you're, you're healthy in all the areas of the person.

Five participants acknowledged that mental health problems are not always spiritually rooted. P7 offered alternative explanation for mental health problems beyond spirituality. He stated,

> Uh, understand that church is church and, and some people that form one extreme to the other extreme, not everything is spiritual. So when, when people go to church, they think that, you know, you're demon possessed or whatever the case may be and that's not true because sometimes we have an imbalance in our own mental and physical body. There's an imbalance. It could be a chemical imbalance. It could be a medication that someone might take in a reaction. (P7)

The acknowledgement of the mind, body, and spirit shoes shows a positive attitude on promoting mental health because the person is being viewed as a whole and not compartmentalized in different areas of health.

Subtheme 2: Biblical Support for Mental Health Promotion

Six participants provided scriptural references or examples of biblical characters in mental turmoil to rationalize mental health promotion in FBOs. Four participants (P1, P2, P6, P7) referenced scripture. P2 said the **B**ible said, "Be transformed by the renewing of your mind." P7 pointed out the biblical perspective of a consequence to lacking knowledge. He provided, "The word of God plainly says that people are perishing because of the lack of knowledge." P4 presented several examples of biblical characters in mental distress when he shared,

> Whether you're talking about Jesus and his anguish in the, in the garden…Think about Job and getting that news that he lost his children…even Joseph, when, when they brought the bloody robe of colors. Think of the visual, you get that your son who you love, you doted on him…what did that do to Hannah to be crying and sobbing like, I just want a child and just that somebody thought that she was drunk. So think about what were her thoughts were.

The faith leaders' use of Bible references to rationalize mental health promotion in FBOs shows a positive attitude and role about engaging in mental health promotion.

Subtheme 3: Helping Others by Engaging in Mental Health Promotion

The value of helping others by using mental health promotion was seen among seven of the faith leaders. P1 directly identified the benefit of engagement. He said, "The benefit would be to offer as many people as possible help." P5 identified providing support as a way to help others live their life to the fullest. He stated,

> So benefits you're providing support people need. You're, you're helping to encourage and hopefully improve a person's wellbeing and their overall health when you're addressing all these different concerns. So there's a lot of benefits to just helping people live life to the fullest. (P5)

P7 focused on bringing awareness when he stated, "I mean, it will bring the awareness, knowledge, uh, to some people." The helping nature of the faith leader contributes to the positive attitude and role of the faith leader in mental health promotion.

Subtheme 4: Faith Leaders' Confidence in Ability and Member Support with Mental Health Promotion

Participants were confident in their ability to implement mental health promotion and their members supporting mental health promotion within their organization. Seven participants communicated confidence and comfortability with engaging in mental health promotion. P5 attributed his comfortability to his personality, background, training, and profession. He shared,

> Probably a combination of factors. Yeah, my background, definitely my training. My training because I'm coming from out of the counseling world into this role, so that's a big part of it. Another factor is who I am as a person, kind of wired a certain way. I'm wired more as a, you know, we're all given different gifts and talents and I'm more of the listener. So, you know, I've always found it comfortable to talk with people, listen, and try to provide support. (P5)

P6 explained his comfort:

> I think I'm fine. I'm fine with it. The reason why I say I'm fine with it Kelly is because I've already in my own way, started the process…I have no problem being the one who, who can promote it, steer it or at least help to steer in that direction that we need.

Additionally, all faith leaders were confident that their members would be or are already supportive of mental health promotion efforts, which solidifies support. Member support was perceived by the faith leaders if they presented mental health promotion as an option, not by members' desire or need to engage in mental health promotion. P1 stated, "150% behind it." When asked if members were behind mental health promotion based on them asking or the passion seen from leadership he replied, "Both. We've talked about it. "P5 indicated members would be open to mental health promotion. He said, "Yeah. Yeah. They received it. They're open to it." P7 shared the willingness of his congregants when he offered, "Uh, they're willing to learn. They're willing to get educated. We have, uh, a nice group of people that are, they'll take it in." Faith leaders reported their members would support mental health promotion in their FBOs if they presented the information.

Subtheme 5: Intention to Engage in Mental Health Promotion

All faith leaders stated they would engage in mental health promotion in the next 6 months. Two participants (P1, P3) stated yes, but expressed uncertainty. P3 inquired, "How can we get our church involved in a mental health program?" Four participants (P2, P5, P7, P8) noted that they will continue to engage in mental health promotion. P7 stated, "Yeah. If, if, uh, as I'm doing it now I'll continue." P5 discussed expanding his current efforts. He stated, "Yeah, we're thinking of utilizing the American Association of

Christian Counselors they have some different certification programs to provide some training and then, you know, I'll be able to help supervise them." Faith leaders articulated they will continue, increase, or begin engagement in mental health promotion, which supports a positive attitude and role.

Subtheme 6: Faith Leaders' Role in Mental Health Promotion

Six faith leaders identified their role in mental health promotion as the leader and influencer. P2 confirmed his role with individuals with mental health struggles when he said,

> We have [a number] pastors on staff. My responsibility is to make sure they're watching out for the church congregational members and to keep my eye on the church, you know, uh, to make sure that we don't see signs of, uh, isolation, uh, signs of depression or any of those kinds of things.

P4 discussed his role as part of his job description as a pastor. He offered,

> As a pastor and talking about equipping the saints for what they have to do. Um, you have to, uh, I feel it's an imperative that I speak on mental health. It's imperative that we talk about how to do self-care and to, and, and protecting yourself and getting stronger in light of the different things that you're facing on a daily basis ... it's a very important, I feel, uh, um, as part of our job description to be part of your, your wellness and any parishioners wellness to say, I want the best for you. So mental health is a big part of that.

P5 identified a leadership role in mental health promotion. He explained, "My perception of it is, um, like the shepherd, you know, as a pastor. So I'm trying to care for the flock that I have, that I'm given the responsibility for here at my church." Likewise P6 shared,

> Well its' based on what I just said. I have to be the one to sit at the table with whatever ministry I'm in. And being an assistant pastor I can also help influence and prayerfully direct some of the things we need to do. Um, I think that being a leader that you cannot act as though you're impervious to any of this…I think my role is to, to be honest and to educate myself.

P8 discussed her role as an influencer. She noted,

> Um, in the congregation I think that it is a part of my role is to determine what is okay…I would not have known that as a beginning pastor, but it's definitely part of my role at this point. So, um, when I think about it, it assumes that my mental health is okay, so then I'm willing to name the norm. I tend to do that in company with the other leadership, the lay leadership. (P8)

Faith leaders acknowledged their influential nature and identified their role in mental health promotion as leader and influencer.

Theme 5: Mental Health Experiences Shape Role in Mental Health Promotion

Participants shared personal and general experiences they had with mental health that contributed to their role in mental health promotion. In Appendix F, Table F4 presents the varied experiences participants had with mental health ranging from self, family, and others. To protect the confidentiality of participants, I will not identify the

family member's relationship through direct quotes from the transcript. All participants shared mental health experiences with others outside of their self and their families.

P2 shared his experience with suicidal ideation from a member. He shared, "we dealt with someone who we thought was right on the verge of suicide." P3 discussed his experiences with serious mental illness (SMI). He stated, "with people at our [organization name] that are either schizophrenic or, you know, there's some other mental health issues where uh, they lash out or they just, uh, just not normal." P8 discussed experiences with the older population:

> And if you have a group like ours, you have lots of depression and a lot of adjustment issues. Our group is older, so they're going into retirement and they're adjusting and sometimes not so well. And then children and grandchildren have drug issues. And then there's the little suicide ideations, fortunately not accomplished.

Half of the participants reported having a previous personal struggle with mental health. P1 shared, "By age 40 we had lost everything. We went from upper-middle-class to below poverty level just like that. So as we came here and got help, um, I had bad anxiety, bad depression, sometimes even suicidal thoughts." P6 stated, "I have been dealing with myself, dealing with depression." Three participants had experiences with mental health in their immediate and extended families. P4 discussed his family experiences: "My [family member] suffered from depression. So you get up to speed very quickly." P5 shared, "I got to see firsthand mental health issues every day because I had [family member]. She struggled with bipolar and schizophrenia." He further shared:

> I got to experience a lot of different things. I saw substance abuse, I saw marriage, family issues. So there was a lot of things in the mental, mental health realm that I got to see and experience growing up. So it kinda gave me a, it kind of helped shape my heart, I think, to have compassion for people and, you know, here I am. So I think it was a factor. (P5)

Faith leaders' array of experiences with mental health across different life domains contributed to their perception of their role in mental health promotion.

Theme 6: Barriers to Mental Health Promotion in FBOs Influence Faith Leaders' Role

Seven participants contributed to the theme of barriers to mental health promotion in FBOs. Leadership and deficiencies were identified as barriers, and a couple of participants identified stigma. According to Shrivastava et al. (2012), stigma is caused by a lack of education, perception, and awareness, which also means deficient. Half of participants discussed leadership as a barrier to mental health promotion. P5 stated, "It could be definitely the leadership of the church. If they don't really value the benefits of helping people that struggle with mental health, then you know, you're never addressing it. So that's not a healthy thing." P6 discussed the faith leader's worldview as a barrier. He stated,

> So you know, you see for yourself and that's, to me, um, it's almost horrific to see people who need to have that kind of help and the church judged them based on what they see rather than take the time to listen, observe, and think beyond their own worldview. You know, my worldview is so, so skewed that I can't see

> beyond it. That's the barrier. That's the issue right there that my worldview prohibits being able to see when someone else is mentally dealing with, emotionally dealing with. (P6)

P4 identified leader ego and added the lack of transparency as a barrier. He shared,

> And it's like, you know, that ego, you know, I can't let people see me fail and that's a that's a big one. You know, you have to say, you know, failure, there's nothing wrong with failure. We, we fail. We fail, pick ourselves up, and we learn from it. We shouldn't treat that as a, as a, you know, we shouldn't treat that as a weakness…We preach it but then when it comes to our lives, you know, the ego fact, we can't let anybody see you sweat and it's like, no, yes I can. I can, you can see me cry. (P4)

Five participants (P1, P3, P4, P6, P7) identified the lack of something as a barrier to mental health promotion. Varied responses included lack of resources, education, money, imagination, discussion, understanding, and stigma. P1 identified, "A lot of the issues are resources, people, and money, you know, and knowledge." P3 indicated there was a lack of discussion when he answered, "Not that I'm aware of. Yeah. That's a great question. That's a great question. It's something that we never really spoke about." P4 offered various barriers. He stated,

> The barriers being just lack of resources, money, um, lack of education, stigma, imagination Oh, I said ego. I mean, I said stigma, but you know, also ego … And I think another reason why people don't touch it because they don't understand it fully. (P4)

The identification of church leadership, leader ego, and lack of resources, education, money, knowledge, and stigma were identified as barriers to mental health promotion in FBOs, but not as a personal barrier to implementation. Identifying barriers to mental health promotion in FBOs did not appear to be contributors to the faith leaders' past, current, or future role identification in mental health promotion.

Theme 7: COVID-19 Influence on Mental Health Promotion in FBOs

The impact of COVID-19 on mental health and the faith leaders' perception of their role in mental health promotion emerged during the data analysis process. Six of the eight participants spoke about COVID-19 in their interview. P1, P2 and P3 mentioned COVID once. P4 and P6 mentioned it eight times. P7 mentioned it five times. P2 noted the impact on church membership. He stated, "Talking to a majority of pastors that we're in association with, this COVID has taken a mental health hit really seriously upon church membership…I got people who have been locked in their house since it began in March." P4 talked about COVID making life even more stressful. He illustrated, "People approaching life and how they deal with life isn't stopping because of COVID. If anything else it gets even more stressful because of what we're going through with the pandemic and how that's impacted our life." P6 talked about the now and later effects of COVID-19:

> Talking about after COVID and everything else we're going to have to deal with the residual effects. The residual effects of COVID is not going to go away once the vaccine kicks in. That's not gonna go away. We still have people who have said spousal abuse has grown since, uh, COVID. You know substance abuse has

> grown since COVID. Child abuse has grown since COVID. And so we had to go what made a person think like that in the first place and then the results of the people who were abused. How can we help them now? You know, because we have to, we have to learn, uh, how to deal with this because it's not going to go away because the virus is gone. Which who knows when that's going to happen, but I think that's something we need to be ready for. So we need to get ready now.

Some faith leaders contended that the COVID-19 pandemic has impacted their FBOs in various ways to include membership, member needs, mental health, pastoral support, and the residual effects to come. COVID-19 has contributed to the faith leaders' perception of their current and future role in mental health promotion.

Discrepant Case

Identifying discrepant information strengthens validity because it supports different explanations of the researcher's analysis (Rose & Johnson, 2020). I classified one participant (P3) as a discrepant case. He had a different view on some questions than the other participants. I did not devalue P3's contribution to the data but instead included them in the data analysis. His responses to some questions showed that his thoughts on mental health focused on the community. He stated, "I think the pastor deals with it when he has to. As much as our workload is I don't think that it's something we're chasing after." When asked why his FBO did not have a health ministry he replied, "Probably something that we've never thought of …What it is we decided that we try to determine what the community needs and not what we think the community needs because what we think

may not really what they need." His responses to the benefits and barriers to mental health promotion were outliers as well. He discussed resources when asked about the benefits and stated, "Not that I'm aware of," when asked about barriers. P3 provided an explanation that provided insight to his perspective. He referred to himself as a "boots on the ground" pastor. He explained,

> I think the pastor's role is many and not all people have the pastor that his role is just leading the sheep and they come through the doors and he focuses on his message. And then you have guys like myself that do more hands on. (P3)

The responses that did not align with the other participants allowed me to infer that the perspective on mental health promotion might be different based on a faith leader's primary role in the organization.

Summary

The purpose of this generic qualitative study was to determine faith leaders' perceptions on their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. I used TA to analyze the data, and seven themes were generated to include negative relationship between poverty and mental health identified, limited knowledge of mental health resources, limited engagement of mental health promotion perceived, positive attitude and role in mental health promotion, mental health experiences shape role in mental health promotion, barriers to mental health promotion in FBOs influence faith leaders' role, and COVID-19 influence on mental health promotion. I determined through eight interviews that the faith leaders' perception of their role in mental health promotion as a resource to improve

access to mental health care in impoverished communities is positive, necessary, and intended. Their role was self-identified as leader and influencer.

Several factors shaped the faith leaders' perceived role in mental health promotion. . Their knowledge of mental health and understanding of the relationship between poverty and mental health supported the serious nature of the relationship. Overall, faith leaders communicated a positive attitude about mental health promotion. Faith leaders showed difficulty defining and conceptualizing mental health promotion. The lack of conceptualization contributed to the lack of perceived engagement, as evidenced by faith leaders identifying mental health promotion activities throughout their interviews, such as seminars, health fairs, and resource tables, but did not realize their organization was a resource. Most participants linked mental health promotion with outside resources opposed to activities and formal health ministries within their FBOs. Faith leaders showed a desire to continue or start engaging in mental health promotion over the next six months. COVID-19 influenced the faith leaders' perceived role in mental health promotion as well. Faith leaders perceive their role in mental health promotion as positive, needed, and intended, and self-identify their role as leader and influencer.

In Chapter 5, I interpret the findings of the research results in the context of past literature and the conceptual framework. I discuss the study's limitations and provide recommendations for further research. I discuss social change implications followed by the study's conclusion.

Chapter 5: Discussion, Recommendations, and Conclusions

Introduction

The purpose of this generic qualitative study was to determine faith leaders' perceived role in mental health promotion as a resource to improve access to mental health care in impoverished communities. How the faith leaders perceived their role in mental health promotion needs to be understood before successful implementation of activities or programs can occur in FBOs because they are the decision makers of the organization. The HBM and the TPB were used as the conceptual framework to answer the research question: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities?

The data showed that multiple factors contributed to the perceived role of the faith leaders. Faith leaders showed knowledge about mental health and an understanding of the relationship between poverty and mental health. Faith leaders showed positive attitudes relating to mental health promotion as evidenced by their acknowledgment that physical, mental, and spiritual health are connected, the offering of biblical support to rationalize engaging in mental health promotion, and their level of confidence in their ability to implement mental health promotion, and member support relating to implementing promotional activities. Faith leaders showed a positive attitude by providing the benefit of mental health promotion as helping others and their intention to continue or begin implementing mental health promotion in their organizations. Furthermore, faith leaders self-identified their role in mental health promotion as leaders and influencers. The role

identification is critical because the level of faith leaders' involvement with the church programming influences the health activities of the members and aids in developing sustainable and practical health programming (Bopp et al., 2019).

In this chapter, I provide an analysis and interpretation of the results from Chapter 4 relating to the literature review and conceptual framework. Next, study limitations, recommendations, and implications are discussed. Finally, I provide an overview of the study.

Interpretation of the Findings

Findings Related to Literature Review

As a review of Chapter 4, seven themes emerged during data analysis using TA. The themes were the following: negative relationship between poverty and mental health identified, limited knowledge of mental health resources, limited engagement of mental health promotion perceived, positive attitude and role in mental health promotion, mental health experiences shape role in mental health promotion, barriers to mental health promotion in FBOs influence faith leaders' role, and COVID-19 influence on mental health promotion.

Poverty and Mental Health

Without establishing the faith leaders' thoughts and understanding of the relationship between poverty and mental health, the research question would be moot. It indirectly contributes to the faith leaders' perceived role because if there were no understanding of the relationship between poverty and mental health, there would be no need for mental health promotion as a resource in impoverished communities. Previous

researchers identified the relationship between poverty and mental health outcomes as cyclical and directly linked (Acri et al., 2017; Ohrnberger et al., 2017; Wahlbeck et al., 2017). The findings of this study mirrored prior research findings. Faith leaders described the relationship between poverty and mental health as direct and cause-and-effect. Half of the participants reported that they felt that living in poverty causes mental crises or affects mental health. Faith leaders identified to include depression and anxiety, which aligns with the notion that people living in poverty are disproportionately affected by common mental health disorders (Lund et al., 2010; Purtell & Gershoff, 2016; WHO-CGF, 2014).

Increased poverty levels have also been associated with mental health treatment disparities and increased suicide rates (Carpenter-Song & Snell-Rood, 2017). Some faith leaders discussed dealing with suicidality with self and others and SMI, such as schizophrenia and bipolar, among family and community members. P3 shared,

> I know I deal with people on the street, the homeless people personally that have mental health issues. And I try to, um, I don't know that I've ever tried getting services for them because I think a lot of people, when I try to get services just don't want to deal with it. Um, you know, whether its rehab, whether it's housing, you know, unfortunately I don't find that I get the family that just lost their job and just lost their house and they want to be better.

P3's experiences with the homeless population and SMI support Sylvestre et al.'s (2018) argument that poverty is an intractable problem among individuals with SMI. The findings of this study showed that some faith leaders feel poverty can contribute to the

onset of mental illness or exasperate the symptoms of mental illness. Alignment is seen with Wahlbeck et al.'s (2017) finding that having an untreated mental illness increases the chances of living and staying in poverty due to the inability to work.

People living in poverty are more prone to health disparities and are more likely to encounter barriers to healthcare (Burns, 2015; WHO-CGF, 2014). The current study confirmed previous research because participants reported that consequences of a person living in poverty included the accessibility of resources. P5 said, "So it's definitely a, there's a correlation I believe there between poverty and the access and availability that people will access the things they need to get help and to have their health and wellness improved." Likewise, P8 added, "Well, poverty aggravates mental health, like, um, your capacity, your ability to access the resources." P8's statement supports Saluja et al.'s (2019) finding that the availability and accessibility of healthcare is an ongoing problem for individuals with low-income. The findings of this study confirmed previous research findings and added to the literature on the negative relationship between poverty and mental health, its consequences, and the limited accessibility to mental health resources in impoverished communities.

Faith Leaders and Mental Health Resources

Literature showed that FBOs are practical resources to aid in the reduction of mental health treatment disparities in impoverished locales (Andren & McKibbin, 2018; Tagai et al., 2018; Williams et al., 2014). For FBOs to be viable options for mental health promotion (Hays, 2018), the organization needs to understand they are or can be the resource. Faith leaders identified an average of 2.5 mental health resources. Seventy-five

percent of the resources identified were local resources, and 25% were national resources (see Appendix G). Only two participants identified their FBO as a mental health resource. This is problematic because prior research showed that many people would seek clergy for help before a mental health professional (Chatters et al., 2017; Hardy, 2014; Webb et al., 2013). In my opinion, FBOs need to recognize that they have the ability to be the resource for mental health just as they are resources for any other need their organizations fulfill. The FBO as the resource allows for cultural responsiveness when addressing mental health in communities (Hays & Aranda, 2016).

Limited formal health ministries were reported, which implies that faith leaders do not identify their FBOs as a resource. Previous researchers found that physical health ministries are present in FBOs focusing on health topics such as cardiovascular disease, cancer, diabetes, HIV/AIDS, nutrition and weight, physical activity, and mammograms (Harmon et al., 2016; Koenig et al., 2015; Martinez et al., 2016; Robles et al., 2019; Schwingel & Gálvez, 2016; Tucker et al., 2019; Williams et al., 2014); yet, one faith leader reported a formal health ministry. Woodard et al. (2020) found a positive association between having a health ministry and the number of health topics and programs addressed. The lack of health ministry may contribute to the limited engagement in mental health promotion among participants.

Seven faith leaders did not report having a formal health ministry, and six did not report any mental health component or ministry or programming, which challenges previous research that showed health ministries were present. Because formal health ministries were not seen in this study as resources, it is difficult to determine if that is the

reason mental health promotion is limited. Although FBOs are deemed viable options to improve treatment disparities in communities with limited resources (Berkley-Patton et al., 2019; Webb et al., 2019), the results of this study confirmed that of FBOs are underused in communities as resources to reduce mental health treatment disparities in impoverished communities (Cherry et al., 2017). A more formalized approach to health promotion through ministry may be needed to organize and implement mental health promotional activities.

Faith Leaders and Mental Health Promotion

As a reminder from the literature review (see Chapter 2), research on mental health promotion in FBOs was scant. Therefore, research on general or physical health promotion in FBOs was needed to conceptualize mental health promotion in FBOs. Because researchers argued that topic-specific health promotion is a feasible way to promote health outcomes (Brand, 2019; Holt et al., 2017), mental health should not be the exception. Health promotion focuses interventions on education and resources for causation, not treatment (WHO, 2016). Initial thoughts about mental health promotion varied among participants. Responses included the church grossly underestimates mental health, it should definitely be there, it is helpful, it is not talked about, and it does not exist. The data did not support Bopp et al.'s (2019) finding that members of FBOs did not feel health programming is imperative. The data showed the opposite. The data supported earlier findings that FBOs valued mental health promotion activities (Whitt-Glover et al., 2014). Even when a participant did not think it existed, he still communicated the importance.

Only three participants attempted to offer an actual definition of mental health promotion. Furthermore, five faith leaders linked mental health promotion to local resources and services. Community resource linkage is an important component of health promotion (Andren & McKibbin, 2018; WHO, 2016), but responses showed a lack of understanding of what mental health promotion entails. Through research, I identified 11 types of mental health promotion activities (see Chapter 2). From the 11 activities identified in the literature review, 82% were represented in this study. Faith leaders discussed mental health promotion activities but did not identify the activities when specifically asked in Question 14 to name activities they have participated in (see Appendix F, Table F3). If faith leaders are engaging in mental health promotion and not realizing it, then the foundation may already be present to expand into more formal efforts to educate the faith leader on mental health promotion. Lack of conceptualization and the realization of engagement in mental health promotion is an unexpected finding of this study.

Faith Leaders Attitude and Role in Mental Health Promotion

Overall, faith leaders communicated a positive attitude and role in mental health promotion. Faith leaders identified the benefits of engaging in mental health promotion in FBOs as helping others. The identification of helping as a benefit to mental health promotion aligns with the traditional role of religious organizations throughout history (see Chapter 2). Further data show a positive attitude and role among faith leaders as evidenced by participants connecting physical, mental, and spiritual health, using biblical references to rationalize addressing mental health in FBOs, identifying helping others as

a benefit to engagement, displaying confidence in their ability and member support, articulating their intention to engage in mental health promotion, and defining their perceived role.

Physical, Mental, and Spiritual Health Connection. The WHO-CGF (2014) identified the influential relationship between physical and mental health and the need for them to collectively be addressed when attempting to improve health disparities among vulnerable populations. Faith leaders showed solidarity when identifying the necessity of connecting physical, mental, and spiritual health. Faith leaders identified that mental health is not always a spiritual issue. This finding contradicts the identified conflict in the literature between doctrine and medicine deemed a barrier to mental health promotion in FBOs (Brand, 2019; Sytner, 2018; Tagai et al., 2018). P6 argued, "We have to overcome the ignorance of what this mental, what mental health is versus what spiritual health is. That they are not exclusive one to another." This is a promising finding, as it attests that faith leaders understand that addressing mental health concerns and illness extends beyond a spiritual model to include imbalances (P7), life stressors (P5), and traumas (P6). This acknowledgment shows that religion and spirituality can be a tool to help people cope with mental health (Koenig et al., 2015) and serve as a protective factor towards a healthier lifestyle (Tetty et al., 2017). Acknowledging the connection of various areas of health contributes to the faith leaders' positive attitude and role in mental health promotion.

Biblical Support. Six faith leaders provided biblical references to support addressing mental health in FBOs. The use of biblical references also denounces critics

who feared that biblical interpretations, negative religious beliefs and coping, and misunderstandings could negatively impact individuals and individuals in vulnerable populations, such as the LGBTQ community (Watkinson, 2015; Weber & Pargament, 2014). There is no evidence in the data that supports this notion. Faith leaders used biblical characters and scripture as a reference to support mental health promotion in FBOs.

I opine that the data provides hope that faith leaders are willing to look beyond exclusive spiritual reasoning for situational and medical occurrences that contribute to changes in mental health or possibly mental illness. P6 stated, "We have to overcome the ignorance of what this mental, what mental health is versus what spiritual health is. That they are not exclusive one to another." Because religiosity is seen as a protective factor in treating common mental illnesses, such as depression (Ronneberg et al., 2016), the acknowledgment can potentially impact how mental health is viewed in FBOs, thus improving resources for those in need. This study showed alignment with the WHO-CGF (2014) guidance that suggests addressing physical and mental health together improves health outcomes. It also supports the notion that physical and mental health should be viewed together because of their direct relationship with each other (Ohrnberger et al., 2017). Citing scripture and referring to the bible to rationalize engagement in mental health promotion supports a positive attitude and role.

Faith Leader Confidence. Seven faith leaders in this study were comfortable or confident with incorporating mental health promotion in their organizations. One participant (P1) was more comfortable collaborating with someone else or supporting an

already accomplished program. Reasons for comfortability included education, previous work experience, already engaging in activities, and experiences with mental health. The finding contradicts past literature on faith leaders being uncomfortable with providing mental health counseling (Leavey et al., 2016, Vermaas et al., 2017). This is most likely due to providing counseling, which is treatment, not education and resource provision, which is the central idea of health promotion (WHO, 2016). Faith leaders may be uncomfortable engaging in mental health counseling because it is out of their scope.

A study on Masters of Divinity (MDiv) directors from 70 seminaries in North America showed that these programs offered elective courses on counseling to include premarital counseling, couples counseling, family counseling, and grief counseling, but not counseling for mental illness (see Ross & Stanford, 2014). One participant had higher education relating to clinical mental health. Previous researchers suggested a barrier to faith leaders engaging in mental health promotion is lack of education or training (Leavey et al., 2016; Milstein et al., 2017; Pyne et al., 2019; Wong et al., 2018). Based on the study results, I argue that most faith leaders had a vague understanding of mental health promotion, but did not show discomfort with engagement when they understood the concept. This study showed the importance of educating faith leaders on the types of resources that are available for implementation that support positive mental health outcomes and clinical resource linkage in communities that are underserved and lack resources. Equipping faith leaders with organizational level strategies for resource linkage might supplement the faith leaders' limited mental health education in school or continuing education.

All faith leaders in this study were confident that their members would support or continue to support mental health promotion in the FBO. Bopp et al. (2019) and Brand and Alston (2018) argued that the level of faith leader involvement influences church programs and activities. This finding showed that the congregation will support it when or if the faith leader includes mental health promotion at the FBO. The data also showed that the faith leaders' choice to engage in mental health promotion is the determining factor for program inclusion, not the members' decision. This finding contradicts previous findings that health messaging and promotion should be relevant by aligning with the congregational need or support of current health statistics (Harmon et al., 2016). A positive role is identified because faith leaders reported they will be or want to engage in mental health promotion over the next 6 months. Six participants were confident in engagement, and two expressed uncertainty about not knowing what is next and how to engage. Faith leaders' confidence in their ability to implement mental health promotion, the support of their FBO members with implementation, and their reported intention to engage contribute to the positive attitude and role.

Faith Leader Role. Previous research has shown that the role faith leaders take in health promotion can influence the inclusion (Bopp et al., 2019; Brand & Alston, 2018) and exclusion (Baruth et al., 2015; Fripp & Carlson, 2017; Hays, 2018; Sytner, 2018) of engagement in FBOs. The majority of faith leaders (P 2, 4, 5, 6, 8) identified their role in mental health promotion as leaders and influencers, which is promising to the inclusion of mental health promotion activities among FBOs. The data showed that faith leaders felt responsible for their members' wellbeing as part of their job function to educate,

equip, speak, and influence. Two faith leaders (P5, P8) discussed being cautious due to their influential nature, especially about opinions for treatment. Their concern confirms Weber and Pargament's (2014) findings that religion can negatively impact people. Faith leaders believe that it is their role as an FBO leader to engage in mental health promotional efforts, thus solidifying a positive role.

Faith Leaders' Experiences with Mental Health

Faith leaders revealed varied experiences with mental health to include self, family, members, and others outside the congregation. Costello et al. (2020) found that faith leaders and members of the faith community had experiences with mental illness or other mental health problems. A sample size of 27 found that 26 respondents had an experience with mental illness, and 25 had contact with someone with a mental illness in the past 6 months (Costello et al., 2020). Similarly, all faith leaders had experiences with people outside of their families in this study. Personal experiences included common mental health disorders, such as depression and anxiety, bipolar, schizophrenia, and suicidality, similar to Hays and Shepard's (2020) findings of faith leaders' experiences. Some faith leaders felt their personal experiences with self and family members shaped their role in mental health promotion in the FBO. P5 shared,

> So there was a lot of things in the mental health realm that I got to see and experience growing up. So it kinda gave me a, it kind of helped shape my heart, I think, to have compassion for people and, you know, here I am. So I think it was a factor.

Past and present literature showed a pattern that faith leaders have personal and general experiences on the continuum of mental health. These findings correlated with a positive role in mental health promotion.

Barriers to Mental Health Promotion

Faith leaders referred to leadership as a barrier to mental health promotion. Deficiencies in leadership included lack of education, understanding, imagination, discussion, ego, worldview, and work ethic. These findings are consistent with previous research, which identified lack of leadership or influence from the faith leader (Sytner, 2018; Vermaas et al., 2017; Wong et al., 2018); the faith-leader's attitude, personal beliefs, or lack of interest (Leavey et al., 2016; Wong et al., 2018); and the lack of education or training for the faith leader (Leavey et al., 2016; Milstein et al., 2017; Pyne et al., 2019; Wong et al., 2018) as barriers.

The other barriers identified by faith leaders were resources, money, and stigma, consistent with previous research findings. Previous research showed lack of finances (Brand, 2019; Wong et al., 2018), lack of resources (Wong et al., 2018), lack of staff and volunteers (Holt et al., 2017), and organizational capacity (Brand, 2019; Pyne et al., 2019; Wong et al., 2018). Financial resources were consistently identified as a problem in sustaining of mental health promotion in FBOs among the African American community (Brand, 2019; Tagai et al., 2018). However, the racial demographic of this study was predominately White. A White pastor was the only participant to specifically mention the lack of money, which does not support previous research. The data showed that access to resources was more of a barrier than the resource itself.

Additionally, lack of staff and volunteers as a barrier was contradicted by three participants (P2, P5, P6) due to identifying staff and volunteers in their organizations for mental health-related tasks. Their responses may be attributed to the three faith leaders having larger church congregations, which aligns with previous research indicating that larger congregations have more resources (Bopp et al., 2019; Tagai et al., 2018; Wong et al., 2018). P2 contradicted this statement and shared,

> The smaller the church the more people are engaged in the operations of the church …. I know when we first started in the church we had 70 people. Well, we had probably 80% present involvement. Now we're 300. We probably have 20, 30% total involvement. People with attend, but they don't get involved.

The findings from this study emphasized the barrier of leadership instead of the lack of other resources, such as money as previous researchers indicated (Brand, 2019; Tagai et al., 2018). The data showed leaders' self-identification of ego as a barrier, which means acknowledgment. The place to begin mental health promotion initiatives is with the faith leader through education, training, and modeling.

Regardless of identified barriers, all faith leaders reported having engaged in mental health promotion in the past 12 months or before COVID-19. Additionally, they reported intention to engage in mental health promotion over the next 6 months. Looking at faith leaders' previous mental health promotion efforts and future intent to implement shows that overall mental health knowledge may not be the barrier to implementation, but rather the lack of conceptualization of mental health promotion.

COVID-19 Influence on Mental Health Promotion in FBOs

This study was conducted during a pandemic, and six participants mentioned COVID-19 in their interviews. By the faith leaders' accounts, COVID-19 impacted functioning, church membership, the mental health of the members and clergy, and the overall impact of life during and after the pandemic. P6 shared,

> This pandemic has helped to extenuate problems in the mental, in folk who had mental issues in the first place. And those are people developing them now because the social distance that they had, can't visit families and depression and fear and anxiety is what they've been wrestling with.

Ivbijaro et al. (2020) found that COVID-19 increased mental health problems triggered by financial and health concerns and exasperated symptoms for individuals with mental health disorders. Faith leaders felt COVID-19 impacted individuals mentally also. This can be seen as an additional influencer of the faith leaders' current and future perceived role in mental health promotion.

Findings Related to Conceptual Framework

The HBM and the TPB theories have overlapping components that allowed for the easy merging of the two to explore the perceived role of faith leaders in mental health promotion (Aiken, 2010). Based on the premise of the HBM, faith leaders who perceive mental health as a threat among their congregants or in the community would presumptively be doing more to promote mental health in their FBOs as a resource to access mental health care (see Hochbaum, 1958; Rosenstock, 1966). Likewise, the TPB presumes that faith leaders with more positive attitudes about mental health promotion, positive peer influence (subjective norms), and a strong PBC will identify a higher

behavioral intention to engage in mental health promotion (Ajzen, 2002). The HBM was used to conceptualize the faith leaders' perception of their role in mental health promotion, while the TPB allowed for the exploration of faith leaders' attitudes, social influences, and behavior intent to engage in mental health promotion. Combined, I used them to identify the perceived role in mental health promotion.

Previous research showed that high perceived severity (Janz & Becker, 1984), positive attitude (Ajzen, 1991; Ajzen & Madden, 1986), intended behavior to engage (Ajzen & Fishbein, 1980), peer influences (Ajzen & Fishbein, 1973), self-efficacy (Rosenstock et al., 1988), and if benefits of engaging outweigh the barriers to engaging in the behavior a person is more likely to engage in behaviors that promote wellness (Glanz & Bishop, 2010; Rosentstock, 2000). The results of this study aligned with previous researchers' findings except for peer influence. Unlike Asare's (2015) findings that peer influence motivated intention to use condoms, peer influence was not a factor in the perceived role of the faith leader. The faith leader identified as the influencer over the members, not the members influencing the health topic.

A positive attitude towards mental health promotion in FBOs was seen among all faith leaders by identifying it as a way to help others. This finding aligned with previous researchers using the TPB to demonstrate that attitude is a predictor of prevention efforts (Bohon et al., 2016; Montanaro et al., 2018) and treatment behaviors (Blue, 2016; Rahimdel et al., 2019), which aligns with the faith leaders' attitude and identified role in mental health promotion. Mental health promotion is considered an educational tool that can be itemized as a prevention effort, not prevention of illness (O'Connor et al., 2014;

WHO, 2016). Like Montanaro et al.'s (2018) findings showed increased intention to use condoms through attitudes (TPB) and self-efficacy (HBM), faith leaders had a positive attitude and expressed confidence in their ability to implement mental health promotion, which they were currently engaged on some level.

Confidence is a commonality among the theories presented as self-efficacy in the HBM (Henshaw & Freedman-Doan, 2009) and PBC in the TPB (Ajzen, 1991). Researchers contended that little is known about the relationship between self-efficacy and behavioral change in research (Carpenter, 2010; Champion & Skinner, 2008; Sulat et al., 2018). This study showed that all faith leaders were engaged in mental health promotion and reported being confident in their ability to engage in mental health promotion. Confidence was further confirmed by faith leaders' reported intention to continue to implement mental health promotional activities over the next 6 months. Breslin et al. (2017) found that a person with a lower PBC for mental health might have lower participation in adopting behaviors that improve mental health outcomes. The results of this study showed the opposite, which supports Ajzen's (1991) finding that a person with a higher PBC is more likely to have a higher positive behavior intention because of their perceived control. Therefore, it can be assumed that self-efficacy and PBC are contributors to faith leaders' engagement in mental health promotion as part of their role as the FBO leader.

Carpenter's (2010) meta-analysis on the HBM determined that perceived benefits contributed to health promotion engagement, such as attending education programs or engaging in health screenings. It is difficult to determine if the faith leaders' role was

impacted by the perceived benefits outweighing the perceived barriers due to their current or desired engagement in mental health promotion. Faith leaders indicated it was their role to help others. For example, P4 highlighted the job description of pastors when he said, "I feel, uh, um, as part of our job description to be part of your, your wellness and any parishioner's wellness to say, I want the best for you. So mental health is a big part of that." The helping nature of the faith leader (Chatters et al., 2017) appears to be outweighing any barrier to engagement in mental health promotion.

Other factors influenced the faith leaders' perceived role in mental health promotion. The factors included education, personal experiences, family history, and symptoms which are consistent with previous researchers' identification of behavioral triggers or influence (Abraham & Sheeran, 2015; Henshaw & Freedman-Doan, 2009; O'Connor et al., 2014; Sulat et al., 2018). More specifically, faith leaders' experiences with mental health influenced their perceived role. The data showed that faith leaders had various experiences that involved themselves, family members, church members, and community members, in which five of them indicated that their personal experiences with self and family increased their mental health education and shifted their worldview or lens. I also found that faith leaders considered their experiences with mental health as education. These findings align with Abraham and Sheeran's (2015) findings that internal and external triggers (i.e., symptoms of illness, experiences, health education) contribute to behavior change or engagement. Experiences with mental health and experiences labeled as an educational source helped shape the positive role of the faith leader in mental health promotion.

The analysis of the HBM and TPB through the research findings validates the use of the conceptual framework for this study to answer the research question: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities? The findings of this study aligned with the premise of the HBM because faith leaders perceived mental health as a threat (perceived severity) and identified the benefit of helping others without directly linking barriers to mental health promotion in FBOs (Glanz & Bishop, 2010; Rosentstock, 2000). This study also validated the premise of the PBC because faith leaders had a positive attitude, a high PBC, which can be seen as the reason for current or intended engagement in mental health promotion (Ajzen, 1991; Ajzen & Madden, 1986). The adjoining of the HBM and TPB was effective in answering the research question.

Limitations

The first limitation in this study was the use of a generic qualitative design due to the criticism that it lacks rigor (Kennedy, 2016). Qualitative research is subjective, and the results may be impacted by researcher bias. To demonstrate rigor in qualitative research, I established trustworthiness in credibility, transferability, dependability, and comfortability (see Chapter 4; Maher et al., 2018). I provided detailed steps to my research process and documented each step in a research journal to improve generalizability. Another limitation to the study was the lack of heterogeneity among participants. There was only one female participant. Lack of heterogeneity of the sample might impact transferability (Cope, 2014) because the results may not be transferable to

different study samples. Therefore, readers cannot make interpretations on homogeneous samples that are female-dominated or heterogeneous.

Another limitation was the geographic location used for the study. The participation criteria limited the inclusion of potential participants who lived outside of Cumberland County, NJ. It also limited the use of FBOs outside of Cumberland County, NJ. The results of the study may not be transferable to faith leaders in other locales. In future research, expanding the location criteria might yield different results. Lastly, researcher bias is a limitation to this study because I was the instrument, analyzer, and reporter (see Burkholder et al., 2016). I am an African American female and mental health provider who lives and attends an FBO in Cumberland County, NJ. My racial identity, professional role, and worldview may have contributed to bias in data collection and analysis. To address any personal bias, I assessed my positionality, used reflective journaling, and engaged in researcher triangulation.

Recommendations

This study captured faith leaders' perceptions of the faith leaders on their role in mental health promotion as a resource to improve access to mental health care in impoverished communities. Seven of the research participants were male. Homogenous samples work well when analyzing sociodemographic information (Jager et al., 2017), but they can reduce generalizability. There was no reliance on sociodemographic variables to answer the research question. Therefore, the first recommendation is to complete the study with more heterogeneity among participants relating to gender because it will improve generalizability (Smith, 2018). Another recommendation is to

replicate this study and include faith leaders and FBOs outside of Cumberland County, NJ. I focused on a specific county with higher level of poverty, so studying this topic in other geographic areas with similar and different socioeconomic statuses is recommended. This will allow the analysis of data across different socioeconomic systems to determine transferability to other settings (Smith, 2018) and to contribute to the literature gap on faith leaders' role and influence in mental health promotion (Baruth et al., 2015).

A significant finding of this study was that faith leaders were engaged in mental health promotion but did not realize the informal engagement as such. Because Carpenter-Song and Snell-Rood (2017) recommended providing more mental health programming to fill the gap in treatment accessibility in impoverished areas, a study is recommended to explore the concepts of health promotion to understand where the disconnection occurs to more formalized promotional efforts. A qualitative study on the faith leaders' lived experiences with mental health and how it has shaped their cultural lens or worldview also has the potential to provide information about how their experiences shape their role in mental health promotion. A study using ministry leaders, such as deacons and deaconesses, is recommended because their insight could offer a different perspective on mental health promotion. They are not the organizational leader but work under the leader and serve the needs of others in the organization and community, which makes them a valuable information source of communal needs (Fairchild, 2020).

Previous researchers showed that FBOs are viable options to improve treatment disparities in communities with limited resources (Berkley-Patton et al., 2019; CDC, n.d.; Webb et al., 2019). However, I found that formal health and mental health promotional programs or health ministries were not being used, which supports the findings of these researchers. I recommend that future researchers develop or find a short-term mental health awareness program for faith leaders who desire to engage in promotional activities to determine if program participation increases intent and engagement (Breslin et al., 2017). I also recommend future research to determine if organizational leaders feel mental health should be included in general health ministries or if it would be better to separate them. This would provide insight into the role of mental health in physical health ministries.

Cues to action and self-efficacy are the two least studied constructs of the HBM, and studies focusing on those constructs would add to the limited research in those areas (Carpenter, 2010). Future researchers could design a study that focuses on which cues to action influence faith leaders' engagement in mental health promotion or what factors contribute to the confidence levels of faith leaders implementing mental health promotion. Quantitative studies on mental health promotion and faith leaders could be done using the HBM and TPB separately. This would allow for specific data collection that does not require subjective interpretation from qualitative interviews. Studies using the theories separately will allow for a deeper exploration into specific behaviors, attitudes, intentions, or interventions that contribute to or hinder the use of mental health promotion in FBOs.

Implications

Baruth et al. (2015) observed that the role and influence of the faith leader in health promotion are not understood and infrequently studied. The data from the interviews provided detailed information on how faith leaders perceived mental health, mental health promotion, and their role in mental health promotion. Understanding the role of the faith leader in mental health promotion is pivotal because nothing can happen without their support (Levin, 2014). Participants indicated that mental health is a concern in their geographic area, resources are limited to the residents of that area, and the desire to engage in mental health promotion is present. Still, they are lacking in understanding strategies and interventions to address the problem. The findings supported the need to educate faith leaders in mental health promotion to possibly use FBOs as resources in impoverished communities.

Cronjé et al. (2017) found statistically significant changes in pre and post-assessments after completing a faith-based education program that included physical, mental, and spiritual health components, supporting the inclusion of mental health promotion in FBOs. Because faith leaders reported a positive role and showed support of mental health promotion, FBOs can use this information to shift the paradigm of traditional health promotion to include mental health promotion (Brand & Alston, 2018). The results of this study could also be used to inform faith leaders, who may be hesitant in addressing mental health at their FBO, that their members might be more supportive of such efforts than presumed (Bopp et al., 2019; Watkinson, 2015; Weber & Pargament, 2014).

Faith leaders had limited conceptualization of mental health promotion even though they were engaging in promotional activities. Increasing faith leader knowledge in this area might provide more resources to FBO members, their families, and community members. Faith leader engagement in mental health promotion has the potential to bridge the gap that currently exists in areas with limited mental health services and the limited knowledge that faith leaders have about available services (Carpenter-Song & Snell-Rood, 2017; Saluja et al., 2019).

The use of the HBM and TPB showed the likelihood of faith leaders engaging in mental health promotion and their intention to engage. The results may increase confidence among community mental health care providers and organizations to approach FBO leaders to create or enhance sustainable collaborative relationships and vice versa (Idler et al., 2019; Leavy et al., 2016; Milstein et al., 2017; Pyne et al., 2019; Smith et al., 2018; Sytner, 2018). The collaboration may aid in decreasing mental health treatment disparities in impoverished communities by increasing referrals to access to care and providing education to determine the level of care (Cherry et al., 2017; Hays, 2018; Milstein et al., 2017).

The most significant potential social change implication is mental health promotion's potential impact on the individual. Faith leaders who are willing to include mental health promotion in their FBOs could begin to address stigma about mental health issues and help-seeking behavior by showing support (Bopp et al., 2019), educating members about mental health (O'Connor et al., 2014), engaging in prevention activities (O'Connor et al., 2014), and providing resources to those who may need mental health

treatment (Andren & McKibbin, 2018). The quality of life for individuals with mental health concerns could be improved if they have the support and are helped to find treatment as needed (WHO, 2016).

Conclusion

This study contributed to the literature by addressing the gap in research on mental health promotion in FBOs and the faith leaders' role in mental health promotion. Understanding faith leaders' perceived role in mental health promotion was critical to identifying a place to start with the inclusion of mental health promotion in the context of FBOs. Faith leaders' embracement of mental health promotion has the potential to reduce stigma through acceptance and education of members, provide activities that focus on mental wellness for everyone, and provide resource linkage to those who are struggling. Because faith leaders are the decision makers in their organization, their buy-in is essential for collaboration with community entities and to the formation of sustainable programs.

Faith leaders held a positive attitude about mental health and the need to address it in their communities. Additionally, I discovered positive attitudes about mental health promotion and the perceived role of the faith leader in mental health promotion. The results of this study are promising in using FBOs as resources in impoverished communities to improve access to mental health care because the faith leader has a perceived positive role. The TPB connects faith leaders with positive attitudes on mental health promotion, and their role will more likely be to engage in mental health promotion activities. Similarly, the HBM indicated that faith leaders who perceive mental health as a

threat and mental health promotion as a benefit to others will participate in activities. The problem with implementing mental health promotion is not the faith leaders' attitude or not wanting to participate, but rather the missing dialogue or not knowing how to effectively incorporate a concept that faith leaders had limited knowledge. Mental health promotion activities seek to educate and provide preventative activities, which is a mental wellness win for all individuals but a critical exposure to those who desperately need education and service linkage. Educating faith leaders on mental health promotion and how to implement strategies may be the key to improving mental health care disparities in impoverished communities.

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Appendix A: Prescreening Questionnaire

Pre-Screening Questionnaire

Faith-based Organization Name: _____

Name of faith leader:_____

1. Are you the leader or co-leader of the organization? ____yes _____no
2. Are you a 501 (3)(c) in Cumberland County, NJ? _____yes _____no
3. Approximate number of weekly Sunday attendees (not membership)_____
4. Do you currently reside in Cumberland County, New Jersey? ___yes ___no
5. Do you understand and speak English? _____yes _____no

If you meet the criteria, what is the best method to contact you?
_____

Contact Information

Email: _____

Phone #: _____

Address:_____

_____

_____

For Official Use Only: Please do not write below.
Meets criteria: _____yes _____no
Interviewee Number Assigned: _____
Best method for contact: _____phone _____email _____other:_____

Appendix B: Invitation Letter

Study Invitation Letter

Formats: Print, Email

Dear _____:

Good day! My name is Kelly Cornish, a PhD. candidate at Walden University that resides in Cumberland County, NJ. As you may know, Cumberland County, NJ is identified as the poorest county in the state. Research has shown that people who live in poverty have unequal access to services, thus creating health disparities. Also, people living in poverty have a higher incidence of mental health issues. As a resident of Cumberland County, I am conducting a research study to determine what the perceived role of the faith leader is in mental health promotion as a resource to improve access to mental health care in an impoverished community.

You are being invited to participate because you are a leader of a faith-based organization in Cumberland County, NJ. If you are interested in participating, you will need to fill out a prescreening questionnaire. If you are eligible to participate, you will be assigned a number to protect your identity. The zoom or telephone interview will be approximately 60-minutes at time and location of your convenience or via a digital resource, such as Zoom. The interview will be recorded using a digital voice recorder, and the researcher will take notes during the interview. The interview will be transcribed and you will have the opportunity to review it for accuracy. You can also have a copy of the study if you wish. A more detailed informed consent document will be given upon the acceptance to the study.

If you are interested in participating in this study, or have any questions that I can answer about the study, please contact me at [redacted] or [redacted].

If you know of anyone who may be interested in participating in the study that meets the criteria, please forward them this invitation letter.

Thank you very much for your time and consideration.

Sincerely,

Kelly L. Cornish, M.Ed., MS, LAC

Appendix C: Recruitment Flyer

Are you a faith leader interested in contributing to mental health research?

Seeking Faith-Based Organization Leaders or Co-leaders of all denominations in Cumberland County, NJ

- Are you 18+ years old and a faith leader or coleader of a 501 (c)(3) faith-based organization in Cumberland County, NJ?
- Do you live in Cumberland County, NJ?
- Do you understand and speak English?

If you answered yes to the above, then please give consideration to...

Purpose of the Study

The purpose of this study is to interview 8-15 faith leaders to determine what the perceived role of the faith leader is on mental health promotion as a resource to improve access to mental health care in an impoverished community.

Procedure

Approximate 60 minute audio-recorded virtual or telephone interview at a time of your convenience. All information will be confidential and used just for this study.

This research project is being conducted by Kelly L. Cornish, a doctoral candidate at Walden University as a requirement for an advanced degree. If you are interested call [redacted]

There is no compensations, gift, or reimbursement for participating in the study.

Appendix D: Interview Guide

Interview Guide

Identification Number: _____

Introduction Script

Hello. Thank you for agreeing to participate in my study.

My name is Kelly Cornish, and I am a PhD student in the Human and Social Services program at Walden University. I currently reside in Cumberland County, as well.

I have found through research that FBOs are viable options for physical health promotion, yet mental health promotion is rarely seen. Because of the differences in health promotion initiatives, I want to understand how you perceive your role in mental health promotion.

By participating in my study, your answers will help me answer my research question: What are faith leaders' perception of their role in mental health promotion as a resource to improve access to mental health care in impoverished communities?

Before we get started I want to remind you that you can elect not to answer certain questions or leave the interview at any time. Again, thank you for helping me. Are you ready to begin? I am starting the audio recording now. Are you ready?

First, I would like to collect some demographic information.

- Denomination of your faith-based organization:_____
- Your title at the faith-based organization: _____
- How many years have you been a pastor? _____
- Gender: _____
- Race:_____
- Age: _____
- Highest Level of education and major:_____

Knowledge of Mental Health and Mental Health Promotion (HBM & TPB)

1. In your own words, what is mental health?

a. Other areas of health include physical, social, spiritual

2. Can you tell me what you know about mental health promotion?
    a. Mental health promotion can range from giving members literature, screenings, display tables, and thematic months
3. Can you name five mental health resources? (local, national)
4. Do you currently have a health ministry?
    a. If yes, describe what the health ministry does.
    b. If no, ask to explain
    c. If yes, does your health ministry have a mental health ministry?
        i. If yes, explain.
        ii. In no, ask to explain

Perceived Susceptibility & Severity (HBM)

5. Can you tell me what you know, think, or understand about the relationship between poverty and mental health?

Attitude (TPB)

6. Can you tell me your thoughts or feelings on mental health promotion in FBOs?
7. How do you perceive your role in mental health promotion?
    a. Do you think it is your responsibility to offer mental health promotion?

Perceived Benefits & Barriers (HBM & TPB)

8. What would be the benefits of engaging in mental health promotion at your FBO?
9. What are the barriers to engaging in mental health promotion at your FBO?

Subjective Norm (TPB)

10. Do any of your peers (other FBOs) engage in mental health promotion? Explain.
    a. If yes, do you know how the program is going? Is it beneficial? Problematic?
    b. If no, ask to provide a reason
11. How do you think your members would feel about the incorporation of mental health promotion, a mental health ministry, or the addition of mental health to a health current ministry?

Cues to action and Modifying Factors (HBM & TPB)

12. Can you describe any experiences that you have had with mental health education, and/or mental health promotion?
13. Would you like to share any personal experiences that you or someone you know has had with mental health?

Behavior Intent (TPB)

14. Have you engaged in any mental health promotion in the past 12 months? Describe.

   a. Mental health promotion can range from giving members literature, screenings, display tables, and thematic months.
15. How likely are you to engage in mental health promotion in the next 6 months?

Perceived Behavioral Control and Self-Efficacy (HBM & TPB)

16. How confident/comfortable are you in incorporating some type of mental health promotion? Explain

Conclusion Script

This concludes our interview. I am turning off the recording device.

Do you have any questions?

If there is anyone you think may be interested in this study, please forward them my contact information.

Again, thank you for your participation. I will contact you once I have transcribed our interview to see if you would like to review it before I conduct my data analysis.

If you have any additional questions, comments, or concerns, please reach out to me at the phone number and email address I provided.

Appendix E: Thank You Letter

Thank You Letter
Available Formats: Print, Digital

Dear_____,

I want to express my sincerest gratitude for your participation in my study. Not only have you helped me reach my academic goals, your interview will contribute to the limited research on mental health promotion in faith-based organizations. You have made a difference through your participation and again I thank you and appreciate you!

As a reminder, you will be given the opportunity to review your transcript for accuracy after I transcribe it. I will send it to you via email. If you chose the option on the informed consent document to receive a copy of the study, it will be sent after final approval is received from Walden University.

Again, I can't thank you enough for your time. If you have any further questions, please do not hesitate to call me [redacted] or email at [redacted].
Sincerely,

Ms. Cornish

Appendix F: Tables

Table F1

Participant Demographics

Participant number	Gender	Race	Age	Title	Years in leadership	Church Size	Denomination	Education/major
P1	M	Caucasian	50	Pastor	10.5	20	Nondenominational	AA Marketing & Management
P2	M	Caucasian	76	Pastor	35	250-300	Nondenominational	Some college
P3	M	Caucasian	59	Associate pastor	6	225	Methodist	BA Bible & Leadership
P4	M	African American	46	Pastor	1.4	65	Baptist	BA Literature
P5	M	Caucasian	46	Pastor	2.10	140	Pentecostal	MA Social Work
P6	M	African American	58	Associate pastor	20	250-275	Baptist	AA – Education BA – In progress
P7	M	Hispanic	58	Associate pastor	17	150	Pentecostal	AA – Theology BA – In progress
P8	F	Caucasian	64	Pastor	31	75	Episcopal	MA (2) – Divinity, Early Christian Literature MS – Library Science PhD – in progress

Table F2

Theme Identification Using Thematic Analysis

Preliminary codes	Initial theme identification	Themes defined
Endless cycle, cycle of poverty, are connected, would be really tight, take a token, effects, plays a big role, compounds, impacts, effects every, can lead to, affected, adds to, and if you're poor, you're trying to put food on the table, they can't afford healthy food, they don't have a job. So therefore there on the poverty line, ability to access resources, there between poverty and the access and availability	A direct relationship and cause-and-effect relationship identified between poverty and mental health, limited accessibility to resources, limited resources has mental health consequences	Negative relationship between poverty and mental health identified
No, off the top of my head no, I can't recall, I'd be hard pressed, bare bones, resources, different services, county has things for mental health, local resource, resource table, tools, person from the community	Limited knowledge of mental health resources, none or limited health or mental health ministry, mental health promotion linked to resources	Limited knowledge of mental health resources
Small things, inadequate, no, figure out, do more, need, health fair, sermons, lay counseling, packets, flyers, classes, pamphlets, groups, directory, collaboration, substance abuse, resources, tools, talk, space, another level	Limited engagement in mental health promotion, engagement without conceptualization	Limited engagement of mental health promotion perceived
Hand and hand, helpful, underestimated, didn't talk about, did not exist		Positive attitude and role in mental health promotion
Mind, body and spirit, spirit, soul, and body, spirit, soul, and body, whole body We're made in his image, Jesus fed, be transformed by, word of God plainly says, Jesus, Job, Joseph, Hannah	Physical, mental, and spiritual health are connected Biblical support for mental health promotion	
Help, deal with, will bring, support	Helping others by engaging in mental health promotion	
Responsibility, equipping, I speak, shepherd, responsibility, influence, direct, educate, my job, part of my role	Faith leaders' role in mental health promotion	
Already promoting, very comfortable, training, I'm fine, no problem, do already, yeah, received, willing to	Faith leaders' confidence in ability and member support with mental health promotion	
Yes, definitely, involved, doing, continue	Intention to engage in mental health promotion	

Preliminary codes	Initial theme identification	Themes defined
Not everything is spiritual, demon, devil, sin, depression, anxiety, addiction, schizophrenia, not right, not normal, suicide, altered, bipolar, PTSD, family, self, others, homeless, veterans, elderly	Types of experiences: Personal, family, congregant, community	Mental health experiences shape role in mental health promotion
Laziness, don't really value, judge, worldview, ego, resources, education, money, imagination, discussion, understanding, stigma, ignorance	Leadership and deficiencies as barriers for others	Barriers to mental health promotion in FBOs influence faith leaders' role
Mental strain, stress, regrouping, restrictions, hit, membership, affected, stressful, pandemic, impacted, mental health, a need, life, residual effects, help, get ready now, coronavirus		COVID-19 influence on mental health promotion in FBOs

Table F3

Type of Mental Health Promotion Engagement

Participant	Past 12 months	Type of mental health promotion identified in Question #14	Type of mental health promotion identified throughout the interview
P1	No Yes pre-COVID	Health fair (focus drugs & alcohol abuse), Cumberland Cares	collaboration, substance abuse, health fair, in-house resources,
P2	Yes	Resource bible, protocol to help	Organizational website, counseling services, assigned personnel for check-ins, county-wide directory, collaboration, referral
P3	Yes	Available to listen	Referral, basic needs
P4	Yes - minimal	Sermons, resource table	seminars/symposiums, discussions, assigned personnel for check-ins, fellowship
P5	Yes	Lay counseling	Sermon inclusion, small groups, counseling services, presentations, referral
P6	No Yes pre-COVID	Health fair, counseling, packets, [name] ministry (addiction), display tables, teach classes, pamphlets, flyers	Counseling services, discussions, presentations
P7	Yes	Thinks they engage in prompt items (literature, screenings, display tables, thematic months)	Substance abuse, in-house resources, referral, grief group
P8	Yes	Agrees with prompt items (literature, screenings, display tables, thematic months)	Host AA, collaboration

Table F4

Types of Experiences with Mental Health

Participant number	Self	Family	Other population experience noted	Overall experience type shared
P1	Yes	Yes	Members, homeless	Depression, anxiety, addiction, suicidal ideation
P2	No disclosure	No disclosure	Members	Suicidality
P3	No disclosure	No disclosure	Veterans, homeless	Schizophrenia, PTSD, addiction
P4	Yes	Yes	Members, men, youth	Depression, anxiety, suicidal ideation, altered mental state
P5	No disclosure	Yes	Members, men	Previous employment, grief, schizophrenia, bipolar, trauma
P6	Yes	No disclosure	Members, young lady, men, young people	Depression, not sure, knew something was not right psychologically, addiction
P7	Yes	No disclosure	Members, elderly, members	Grief, anxiety, paranoia (safety), isolation
P8	No disclosure	No disclosure	Members, homeless, elderly, developmentally disabled, LGBTQ	Previous employment, grief, depression, bipolar, schizophrenia, addiction, adjustment

Appendix G: Figure: Types of Mental Health Resources Identified

Figure G1

Type of Mental Health Resources Identified