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Black Women, Mental Health Treatment, and Spiritual Healing: A Transcendental Phenomenological Study

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Walden University
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Abstract

Counselor educators are ill equipped to train counselors to prepare to meet the needs of Black Christian Pentecostal Women (BCPW) because there is a lack of information on this population. To increase cultural competency, counselors need to be more aware of the experiences of this population. The purpose of this study was to explore the lived experiences of BCPW who sought community mental health counseling concurrent with deliverance practices through the church. Using Edmund Husserl's transcendental phenomenological approach as the conceptual framework, semi-structured interviews via zoom were conducted with 4 BCPW who were active members of the Christ Throne International Ministries in Maryland, had experienced church deliverance, and attended counseling within the last 12 months. Data were analyzed using the Transcendental Phenomenological process. Results indicated the following themes: Deliverance Versus Counseling; Christian Counseling in Outpatient Mental Health Clinics; and Mental Health Disorder or Demonic Possession? Within the Theme "Deliverance Versus Counseling," there were four sub-themes: Professional Collaboration, Training, Prayer, and Talk Therapy. The results of the study may bring positive social change by giving useful information to BCPW, Black church leaders, counselor educators and supervisors (CES), counseling professionals, international CES students, and policy makers.

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Dedication

I dedicate this dissertation to GOD Almighty, to my LORD and Savior JESUS CHRIST, and to the Holy Spirit who All gave me the inspiration to do this program and continued to spiritually guide and encourage me whenever my physical strength and knowledge failed me. There is absolutely no way I would have made it without YOU.

I also dedicate this dissertation to my extraordinary children, Ethel (Mimi), Joseph (Joey), and George; to Bridget Olajide (Bibi), my spiritual daughter, and my grandchildren, Jola, Kenan, Kendrick and Queen Jewel. You all have given me not only a reason to live but also a strong reason not to give up. I equally dedicate this dissertation to my mother, Ma Lombe, who always sat behind me even into the wee hours of the morning, cheering me on; to my priceless siblings, Sisi Mai, Ewane, AKA Dr. E., Mammie Gla, Ngeh, Epie, Ma'am, and Sumbele AKA Dr. S., as well as to my nieces and nephews, and to my brother-in-law, H.E. Chief Ephraim Inoni, my daughter-in-law, Larise, and my sister-in-law, Mariam.

Most importantly, I dedicate this dissertation to my father who has gone to be with the LORD, Hon. Emmanuel Epie Ngone, who was always proud of my educational and professional achievements, inculcated in me the value of education, and always told me never to stop learning as long as I had breathe in my nostrils. I am truly my father's daughter. "Poppa, when I eventually meet you, we'll join the Heavenly choir to sing those songs of praise, worship, thanksgiving and adoration to our LORD GOD.

I also dedicate this dissertation to my very special friend, Sam Nuvala Fonkem, AKA O'Sam, for the value of excellence he instilled in me. Although he did not live to see me complete this program, I can hear him in his legendary baritone voice saying, "Sugey, I knew you were going to make it. Kudos." I also dedicate this dissertation to my High school crony, Dr. Nelson Asek Makia, who did all he possibly could to encourage me to attain the highest academic and professional heights; to my longstanding precious friend, Philomena Tabe AKA Aboh Phi, for your wise guidance; to my Walden classmate, faithful and prayerful friend, Dr. Mala Hosmane; and to the inspirational and enduring love of my life, Pastor Joseph Anselme Ngalle Ekollo AKA Pastor Jojo. *Du fond de mon coeur, merci beaucoup, à Ndol'am*.

It is also with outstanding pride and honor that I dedicate this dissertation to the great nation of the United States of America, a nation that gave me as an immigrant, the unique opportunity to realize my life-long dreams of becoming a healthcare professional, a doctor who neither gives shots nor touches blood, a committed instrument of positive change in the Walden University spirit, a forward-looking businesswoman, and eventually a university professor. America has changed my life in ways I never could have imagined, and I will forever remain deeply grateful.

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It is equally important for me to acknowledge my daughter, Mimi and my spiritual daughter, Bibi who were relentless in their prayers. Mimi, you were my rock during those moments when other heart-wrenching issues weighed me down so much that I almost gave up continuing with the program. I also acknowledge my sweet niece,

Chaney, who spent valuable untiring days and nights proofreading my dissertation when my eyes were too tired to see and read anything. What unwavering support! I also acknowledge the Head of the Christ Throne Ministries International, Apostle Anthony Aladekoba for enabling me to reach out to my precious participants who displayed steadfast commitment and excitement to this project.

It really took a village made up of my family, Walden faculty, friends, professional colleagues, and classmates to successfully navigate the tumultuous and unstable waters to complete this dissertation. From the innermost recesses of my heart, I say “thank you” to everyone who directly or indirectly played a role in the accomplishment of this lofty mission. May the Almighty GOD continue to bless you all!

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Chapter 1: Introduction to the Study

Research has shown that individuals who go for spiritual healing through deliverance as well as seek treatment from outpatient mental health clinics (OPMHCs) are likely to have additional benefits from both treatment approaches (Bouwmeester, 2013; Cummings et al. 2014; Friedlander et al. 2014; Moore, 2017). However, in the mental health counseling profession, according to Richards et al. (2015), there is not enough evidence-based literature to back up the effectiveness of spiritual healing through deliverance. Some authors, such as Hecker et al. (2016), Richards et al. (2015), and Williams et al. (2014), have concluded that certain mental health disorders and illnesses can be treated through spiritual healing using deliverance practices. For example, Cummings et al. (2014) and Hecker et al. (2016) posited that there were significant correlations between perceived spirit possession and the severity of some mental health conditions such as posttraumatic stress disorder (PTSD). Research has shown that some Black Christian Pentecostal women (BCPW) seek both spiritual deliverance of their mental health conditions from what they believe to be demonic possessions (Mercer, 2013; Rowan & Dwyer, 2015) and mental health treatment from OPMHCs (Bledsoe et al. 2013; Friedlander et al. 2014; Moore, 2017).

Consequently, the American Counseling Association (ACA, 2014) Code of Ethics has recommended that for effective therapeutic results, counseling professionals should be multiculturally competent enough to respect the cultural leanings of their clients and even collaborate with those people who perform other forms of treatment that their clients are familiar with. Ratts et al. (2016) have also called on counseling professionals

to always take into consideration the religious and spiritual aspects of their clients as well as the social justice concerns that may have a negative impact on their mental health. This study, therefore, was grounded in the importance of adhering to Standards F.2.g., Section 2, and A.2.f., A.3.b., D.2.m., Section 5 of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014). These standards all stress the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014; CACREP, 2016). In addition, this study will inform counseling professionals about this special population of BCPW clients, with the implications for practice being that professional mental health counselors will have effective multicultural strategies to support this group of women (Ratts et al., 2016; Rowan & Dwyer, 2015).

Considering that the purpose of this study was to explore the lived experiences of BCPW who combine spiritual deliverance practices with treatment from OPMHCs to resolve their mental health issues (Friedlander et al., 2014; Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015), I used a qualitative, transcendental phenomenological approach for this study (Buser et al. 2016; Choi, 2018; Wilson, 2014). Walden University (2015) has defined positive social change as "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies" (para. 4). Positive social change leads to the improvement of social and human conditions (Walden University, 2015). This definition of positive social change provides an intellectually comprehensive

and socially constructive foundation for the programs, research, professional activities, and products created by the Walden academic community (para. 4). As a result, the implications of the findings of my study may inform counselors on the experiences of these women, which in turn may help them provide multiculturally competent services (ACA, 2014; Remley & Herlihy, 2016). Moreover, at the level of social justice advocacy, professional counselors will be able to advocate on behalf of this unique population (Mercer, 2013; Richards et al., 2015). In addition, listening to the experiences of BCPW could create a space for them to potentially feel validated by the counseling profession and the potential for further dialogue regarding empowering this population to access culturally aware mental health services (Alinia, 2015; Levitov, 2017; West-Olatunji & Wolfgang, 2017).

In the rest of this chapter, I will elaborate on the background of the study, providing an overview of the literature on BCPW going to their Black churches for spiritual deliverance from their mental health issues, and the reasons why they prefer their churches to going for treatment at OPMHCs. I will also state what professional counselors can do to include church leaders in their treatment plans. Additionally, I will discuss the problem statement and clearly state the purpose of the study, the research question, and the conceptual framework. I will equally mention the nature of the study and give explicit definitions of terms used, which will provide readers with better contextual understanding. I will then state the assumptions that I identified in this study, as well as the scope, delimitations, limitations, and significance of the study. I will end the chapter with a summary of its salient points as I briefly introduce Chapter 2.

Background

Many BCPW have relied on spiritual treatment from church leaders for their mental health issues such as anxiety and depression instead of going to OPMHCs (Anthony et al. 2015; Asamoah et al. 2014**;** Avent et al. 2015). The main reason that BCPW rely on church leaders for mental health treatment is because mental health conditions among this population are a result of demonic possessions that can only be dealt with through deliverance by a church leader in a church setting (Hecker et al. 2016). Abu-Raiya (2013) and Lea et al. (2015) confirmed that when clients with certain mental health conditions such as eating disorders and other stressors sought spiritual treatment based on their religious beliefs, there was a marked improvement in their psychological well-being.

According to Rowan and Dwyer (2015), although the presentation of demonic possessions appear to be strikingly similar to psychopathologies, experiential accounts of such possessions are still lacking. Richards et al. (2015) stated that despite the assertion that spiritual healing was widely used, a considerable number of the spiritual approaches described in some studies had been devoid of empirical evaluations. One of the reasons for this void could be that some BCPW diagnosed with anxiety and depression believe that such conditions are normal, thereby reducing the need to seek professional treatment (Hamm, 2014; Ward et al. 2014).

Consequently, although rates of anxiety, depression, and other mental health disorders are higher among Black women when compared to their Caucasian counterparts, BCPW still underuse OPMHCs (Anderson et al. 2015; Hamm, 2014;

Watson & Hunter, 2015). However, according to Capps (2014) and Ward et al. (2014), the different roles that pastors play in relation to mental disorders and illnesses are greatly underrepresented. Additionally, most African American and other Pentecostal leaders in Black churches are not formally trained in mental health counseling (Anthony et al. 2015; Baruth et al. 2015). As a result, it would be helpful if these leaders of Black churches could not only be educated and trained in mental health counseling, but also establish a healthy working relationship with their community professional mental health counselors so they can refer their church members to OPMHCs in a timely manner (Anthony et al. 2015; Dempsey et al. 2016; Hays, 2015).

To that end, Avent et al. (2015) have recommended the involvement of Black church leaders in health-promotion endeavors initiated by counseling professionals. Brown and McCreary (2014) have also suggested that if Black church leaders accept services rendered by professional counselors and, as a result, learn counseling approaches and strategies from them, they will be able to counsel their parishioners on different mental health-related issues**.** For example, Baumgartner et al. (2014) have also come up with a church-based strategy to screen pregnant women and their partners for mental health disorders and illnesses. Nevertheless, continued research will be necessary to conclude that church leaders could be adequately skilled to counsel their parishioners after they must have acquired counseling approaches and strategies from professional counselors (Dempsey et al. 2016; Hardy, 2014; Hedman, 2014; Jackson, 2015; Rowland & Isaac-Savage, 2014; Sperry, 2016).

From a cultural perspective, professional counselors are expected to be multiculturally competent for them to balance the ethnic/racial disparities in mental health care (Betancourt et al. 2014; Collins, 2015; Vieten et al. 2013). Therefore, it is important for counseling professionals to know the appropriate strategies that African American and other Pentecostal churches could use to promote mental health wellness among church members (Betancourt et al. 2014; Collins, 2015). It is, however, important for mental health therapists not to impose their cultural values on their clients but rather respect the values of their clients in order to build a healthy therapeutic relationship for effective outcomes (Cummings et al. 2014; Hecker et al. 2016). With greater understanding of the importance of not imposing their cultural values on their clients, counseling professionals will be able to address religious and spiritual matters during their counseling sessions (Bledsoe et al. 2013; Creswell, 2014a). Research needs to demonstrate not only that spiritual healing is a cost-effective therapeutic approach, but also that counseling professionals acknowledge the importance of this kind of treatment from a multicultural perspective (Barlow et al. 2013; Hamilton et al. 2013; Ratts et al. 2016).

Problem Statement

Research suggests that clients may receive additional benefits by seeking simultaneous mental health treatment and spiritual/religious healing practices (Bledsoe et al. 2013; Cummings et al. 2014; Friedlander et al. 2014; Moore, 2017). Within mental health circles, however, the idea of spiritual healing of mental health disorders and illnesses through spiritual deliverance practices does not yet have enough evidence-based

scientific research support (Richards et al., 2015). Nevertheless, some authors have concluded that certain mental health conditions can be treated through spiritual healing (Hecker et al., 2016; Williams et al., 2014). Researchers who have conducted evidence-based studies have stated that some BCPW seek spiritual deliverance from their mental health issues, believing that they are demon possessed, and attend OPMHCs for treatment (Bledsoe et al., 2013; Friedlander et al., 2014; Moore, 2017). For counselor education and supervision purposes, I am equating *spirit possession* with *perceived spirit possession.* To this end, after studying the relationship between spirit possession and mental health symptomology, Cummings et al. (2014) and Hecker et al. (2016) explained that there were significant correlations between spirit possession and severity of PTSD symptoms and other metal health disorders.

According to the ACA Code of Ethics (ACA, 2014) and Remley and Herlihy (2016), counseling professionals are recommended to collaborate with non-mental-health practitioners for effective therapeutic outcomes. Ratts et al. (2016) also called on mental health professionals to consider clients' religion and spirituality as an aspect of their identity along with the social justice concerns that may impact mental health. Ratts et al., 2016 further indicated that "a major aspect of understanding the role of social justice and advocacy in the MSJCC [Multicultural and Social Justice Counseling Competencies] includes integrating systemic-level change efforts into microlevel counseling practice" (p. 43). However, there is a dearth of literature related to the lived experiences of BCPW who seek both spiritual deliverance and mental health services (Adams et al. 2015; Friedlander et al. 2014; Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015).

Consequently, due to this lack of pertinent research, counselor educators are ill equipped to train counselors to prepare to meet the needs of their Black female Pentecostal clients (Mercer, 2013; Rowan & Dwyer, 2015). As a result, authors have not only recommended further research on collaboration between mental health professionals and leaders of the Black church, but also suggested that future research focus on the lived experiences of these women (Cummings et al. 2014; Sanders et al. 2015).

Purpose of Study

The purpose of this study was to explore the lived experiences of BCPW who sought spiritual deliverance and healing of their mental health conditions from their church clergy (Mercer, 2013; Rowan & Dwyer, 2015) and went to OPMHCs for treatment (Friedlander et al. 2014; Hays, 2015). To explore these experiences, I used a qualitative, transcendental phenomenological approach (Buser et al. 2016; Choi, 2018; Wilson, 2014) for this study. An article by Rowan and Dwyer (2015) indicated that more women than men tended to seek treatment from their church leaders through deliverance practices.

Consequently, I highlighted the importance of respecting the stipulations in Standards F.2.g., Section 2, and Standards A.2.f., A.3.b., D.2.m., Section 5 of CACREP (2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014). These standards all stressed the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study informed professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals will have effective

multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

Research Question

RQ1. What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church?

Conceptual Framework

The conceptual framework for this research study was transcendental phenomenology (Buser et al. 2016; Dowling & Cooney, 2012; Elo et al., 2014; Englander, 2012; Giorgi, 2012; Green, 2014; Holroyd, 2015; Jacobs et al. 2014; Lee et al., 2014; Sorsa et al. 2015; Sousa, 2014; Taipale, 2015). Edmund Husserl, the founder of transcendental phenomenology, posited that phenomenology could begin only after phenomenologists had performed transcendental-phenomenological reduction or epoche or bracketing by putting aside their personal knowledge and experiences so that they could objectively appreciate the experiences of others by getting into the essence of the phenomenon (Sorsa et al., 2015). As Dowling and Cooney (2012) explained, "Phenomenological reduction or bracketing is the distinguishing characteristic of Husserlian phenomenology … bracketing is the suspension of the researcher's prejudices, preconceptions and beliefs … so that they do not influence participants' descriptions of their experiences" (p. 23). In other words, after researchers have removed everything else, they will be able to identify the essences of the lived world because with the bracketing approach, they will not make any judgments because eidetic phenomenology

does not explain but rather describes the lived experiences of the individuals concerned (Taipale, 2015). Choi (2018) interpreted Husserl's transcendental phenomenology as a basic philosophy of happiness, and Csikszentmihalyi's positive psychology defined happiness as "flow", a psychic state of ongoing immersion guided by intrinsic motivations and rewards" (Choi, 2018, p. 126).

Instead of using a scientific approach, researchers could have access to this kind of happiness through personal confessions and reports of those concerned (Choi, 2018). In addition, according to Choi (2018), Husserl's phenomenology leans on intentionality, a theme that involves retaining the immediate past and expecting the immediate future by seeing what is not given while taking more than what has been given. This characteristic, in Husserl's original German language, is known as *Mehrmeinung,* and it constitutes the important piece of transcendental consciousness (Choi, 2018). Furthermore, this phenomenological approach identifies lived experiences and uses the responses that participants give to open-ended questions as they describe the way in which they experience the phenomena daily (Sousa, 2014). Researchers use phenomenological approaches to accentuate categories of people who have not been the focus of previous studies (Creswell, 2007). Consequently, I used a transcendental phenomenological approach for this study so that I could understand the meaning women gave to the experience of going to their churches for spiritual healing as well as seeking treatment from OPMHCs.

I used the bracketing approach to make sure I understood the experiences of my participants without including my own assumptions, personal biases, and preconceptions

(Buser et al., 2016; Dowling & Cooney, 2012; Englander, 2012; Sorsa et al., 2015). In other words, I had to discard my assumptions and make sure my participants shared their voices. Further, if I was to use the Husserlian descriptive phenomenological approach, in order to attain rigor, my data collection as well as my data analysis had to be descriptive (Englander, 2012). In a phenomenological study, therefore, my research question had to focus on discovering the meaning of a given phenomenon lived by not less than three participants (Tran et al. 2016). Additionally, for me to make any comparison, I had to note the number of times the phenomenon was described (Sorsa et al. 2015). Whether I used a face-to-face interview or asked for a recorded or written account of the experience, what I was seeking from this transcendental phenomenological research was to be a complete description of the experiences my participants must have lived through. However, because the traditional face-to-face interview, even when virtually conducted, was usually longer, it was also going to be richer in terms of its depth and nuances (Giordano & Cashwell, 2014).

Nature of Study

This study was qualitative, transcendental, and phenomenological in nature (Buser et al. 2016; Dowling & Cooney, 2012; Englander, 2012; Holroyd, 2015; Klinke et al. 2014; Lee et al. 2014; Sorsa et al. 2015; Sousa, 2014; Taipale, 2015; Wilson, 2014). This approach helped in understanding how BCPW got satisfactory outcomes as they sought spiritual healing through deliverance practices in their churches (Hays, 2015) and went to OPMHCs for treatment (Friedlander et al. 2014; Sullivan et al. 2014). Qualitative researchers generally conduct their research in real-life settings as they directly interact

with their study participants (Patton, 2015; Ravitch & Carl, 2016). In this study, due to COVID-19 considerations, I virtually met face to face with my participants in a convenient location of their choice (Frankfort-Nachmias et al. 2015). Given that in conducting qualitative research, the researcher is the data collection instrument (Patton, 2015; Ravitch & Carl, 2016), my role as the researcher in the study was to build a healthy relationship with my study participants (Miles et al. 2014).

The purpose of this study was to explore the lived experiences of BCPW who went to their churches for healing when they had been diagnosed with mental health issues (Mercer, 2013; Rowan & Dwyer, 2015) and still attended OPMHCs for treatment (Friedlander et al. 2014; Hays, 2015), Consequently, I highlighted the implications of the study from a diverse cultural perspective whereby the women felt affirmed about the cultural choice they had made to go to their Black churches for spiritual healing through deliverance and still attend OPMHCs for treatment (Friedlander et al. 2014; Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015). Women can take control of their lives and make their voices heard as they are empowered to decide on their own health choices (Alinia, 2015; Levitov, 2017; West-Olatunji & Wolfgang, 2017).

Definition of Terms

The terms used in this phenomenological study are included in this section to enable the reader, for better clarity, to understand how I contextually use them. In other words, it is important for readers to be familiar with the important terms I use throughout this study to facilitate their understanding of this specific cultural lens of spiritual healing

through deliverance practices in Black churches. For the purpose of this study, therefore, I use the following terms and definitions:

Exorcism: From a traditional stance, Innamorati et al. 2019 defined exorcism as the act of driving out evil spirits or demons from people who are believed to be possessed by these demons. Since the 1900s, the practice of exorcism has been on the increase, especially within the Roman Catholic Church (Young, 2016).

Deliverance: "Deliverance also known as exorcism or expulsion of demons, is the primary mode of treatment of mental illness thought to be caused by demonic possession" (Mercer, 2013, p. 602). According to Pentecostal and some charismatic Christians, deliverance is a higher form of healing because the deliverance minister directly confronts the demonic spirit that has held the deliveree in bondage. For effective intervention, therefore, the demon-possessed individual can only be cured when the Blood of Jesus Christ is pronounced to cast out the demonic spirit (Rowan & Dwyer, 2015). Church ministers who perform deliverance practices claim to treat mental disorders and illnesses that include depression, anxiety, attention-deficit/hyperactivity disorder (ADHD), reactive attachment disorder, and schizophrenia (Brown, 2014; Capps, 2014; Mercer, 2013; Rowan & Dwyer, 2015; Scrutton, 2015). The need for counseling professionals to understand beliefs in deliverance is highlighted by the existence of almost 80 million Pentecostal Christians in the United States (Mercer, 2013).

Mental health: In its constitution, the World Health Organization (WHO, 2003) defined mental health as a state of total mental and social well-being and not just the absence of a disorder or a disease. In other words, mental health is a state of well-being

whereby people recognize their abilities and can deal with the normal stresses of life as they productively and fruitfully work and make their own contributions to their different communities (WHO, 2003). Although no group is immune to mental health concerns, the risk of having mental disorders and illnesses is greater among vulnerable populations such as the poor, the homeless, the unemployed, the uneducated, immigrants, refugees, the elderly, abused women, children, and adolescents (Hays, 2015). Given, therefore, that mental, social, and physical health are tightly interwoven, it is becoming more and more obvious that mental health is of primordial importance to the holistic well-being of individuals and, as a result, of communities, societies, and countries. Unfortunately, to a large extent, mental health disorders and illnesses have been ignored or neglected in most countries (Betancourt et al., 2014).

Mental health disorders: Walvisch (2017) stated that there is no exact definition of a mental disorder, although it is easy to provide an example of a mental disorder. While a definition of *mental disorder* may include the mind somehow not working properly, or an internal condition that causes the thinking or behavior of an individual to be disordered or dysfunctional, it is, nevertheless, difficult to spell out what it means for someone's thinking or behavior to be dysfunctional or disordered. According to Walvisch (2017), "the way in which mental disorder is defined can configure and reconfigure the lives of real men and women" (p. 7).

In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V), the American Psychiatric Association (APA, 2013) defined a mental disorder as a syndrome characterized by clinically significant disturbances in emotional

regulation, cognition, and/or behavior that shows a dysfunction in the developmental, biological, and/or psychological processes that underlie mental functioning, with an increased risk of suffering disability, pain, significant loss of freedom, or even death. It is, however, noteworthy that several psychiatrists believe that because psychiatric diagnoses lack etiologic agents, these diagnoses should be considered more as disorders and not diseases (Falissard et al. 2017).

Mental health illnesses/diseases: The APA (2013) has defined mental illness/disease as a state characterized by a significant clinical disturbance in emotional regulation, cognition, or behavior that reflects a dysfunction in the biological, psychological, or developmental process that underlies mental functioning. According to Thirunavurakasu et al. (2013), all psychiatric diagnoses are considered mental illnesses. As medical professionals, these authors, aiming to promote mental health in their communities, conceptualized mind and mental health to eliminate all confusion and stigma linked to psychiatric illness and practice. Thirunavurakasu et al., therefore, conceptualized the biological entity known as mental health. This entity is known as "manas" (Thirunavurakasu et al. 2013, p. 197), an indivisible combination of three concepts: thought, intellect, and mood.

According to Thirunavurakasu et al. (2013), everyone has only one manas, which stops existing when the individual also stops to function and/or exist. When there is no manas, there is no behavior, and when the manas is not affected, the medical condition is no longer considered to be of psychiatric concern. Mental health is thus conceptualized by the following three clinical criteria: (a) the person's awareness of their own self, (b)

the person's ability to relate well with others, and (c) all the person's actions being either useful or not detrimental to their own self and others. When the impact of the person on themselves and others is least negative, going by the health status of their manas, that status is conceptualized as being mentally healthy (Thirunavurakasu et al., 2013). When an individual is mentally ill, the strategy is to treat that individual, and when the individual is mentally unhealthy, the strategy is to contain the damage by reducing the suffering (Thirunavurakasu et al., 2013).

Pentecostalism: "Pentecostalism is a movement of renewal or revival within other denominations that includes many different churches, and which emerged as the result of an amalgamation of … black and oral cultures … catholic and evangelical spiritualities" (Rowan & Dwyer, 2015, p. 441). Some Pentecostal Christians profoundly believe in the possibility of demonic spirits possessing some of them and the ability of their church leaders to cast these spirits out of them through deliverance or exorcism. After deliverance, the deliverees expect dramatic changes to occur in their lives (Mercer, 2013; Rowan & Dwyer, 2015).

Pentecostalism was founded on the principles described in the Biblical event in Acts 2 and 1 Cor. 12-14 (New King James Version) of the coming of the Holy Spirit of God on the followers of Jesus with the consequent manifestation, which included speaking in tongues (glossolalia) as well as the ability to perform miracles, carry out deliverances, and heal the sick (Rowan & Dwyer, 2015). The main belief in Pentecostalism is that faith must be powerfully experiential for the Pentecostal Christian, based on the active manifestation of the Holy Spirit and the direct experience of the

presence of God. At the heart of some forms of Pentecostalism is the deep belief that individuals can be possessed of oppressive and malevolent spirits, which can only be cast away through spiritual deliverance/exorcism (Mercer, 2013; Rowan & Dwyer, 2015; Wilström, 2014).

In the United Kingdom, Pentecostals are the fastest growing group of Christians, with a surge in the establishment of many Pentecostal churches, many of which are not part of any overseeing body. Dein and Cook (2015) and Mercer (2013) stated that the rise in Pentecostalism has accentuated the need for counseling professionals to understand deliverance beliefs because mental health disorders and illnesses seem to be much higher among Pentecostals than among mainstream Christians. In their study of 1,208 religious and nonreligious American adults, Poloma and Lee (2013) found that experiences of interpersonal interaction with God such as feeling a divine call to perform a specific act such as deliverance were surprisingly common.

Religion: Religion, according to Elkonin et al. (2014), is a social group or an institution that ascribes a specific meaning and value to life. Religion is considered inflexible, rigid, prescriptive, and specifically developed to provide structure and control. Hays (2015) posited that religious African Americans (AAs), and other Black people are not likely to seek professional help for mental concerns and feel that they can instead cope through God. However, considering that social scientists and theologians had given several definitions of religion and had not succeeded in reaching a consensus, Hays (2015) concluded that any definition of religion will most likely be satisfactory only to its author.

With relevance to the phenomenon of health and well-being, Abu-Raiya (2013) defined religion as a search for sacred-related significance through divine beings, Higher Powers, or God. What gives religion its distinct characteristic is the involvement of the sacred in the individual's search for significance (Abu-Raiya, 2013; Chaves & Anderson, 2014). According to Hays (2015), because AAs and other Black people are not likely to seek professional help for mental health concerns and may believe that they can instead cope through God, AAs who go to their church leaders first for mental health problems will, subsequently, not likely go to see a mental health counseling professional (Hays, 2015).

Spirituality: According to MacDonald et al. (2015) and Moore (2017), the definition of spirituality does not satisfy all fronts. Nevertheless, for the purpose of this study, based on the relationship between mental health and spirituality, spirituality is defined as the sacred domain that deals with ideas of God and divinity, which include positive psychological constructs such as harmony, peacefulness, as well as satisfaction and fulfilment of life's purpose (MacDonald et al., 2015). To this end, spirituality is an organized system of beliefs, ritualistic practices, and symbols meant to facilitate closeness to God Who is the Ultimate truth and reality (Moreira-Almeida et al., 2014).

Religion and spirituality (R/S): Although the concepts of R/S seem difficult to define, they nonetheless have powerful influences on therapy because they form an integral part of human existence (Cummings et al., 2014). Spirituality is, however, different from religion because it is the way a person seeks, finds, creates, and uses personal meaning in the world. This search for meaning can be expressed through

religious practices. R/S can, therefore, be successfully used as a coping mechanism to deal with mental disorders, prevent unhealthy behaviors and foster resilience (Elkonin et al., 2014). Religious and spiritual beliefs are common all over the world, and recent surveys have shown that at least 90% of the world population is presently involved in one form of religious and/or spiritual practice or another. There is also enough proof that R/S play significant roles in many aspects of life, especially mental health (Moreira-Almeida, et al. 2014).

Spiritual healing: *Therapy*, a medical term, is a derivative of the Greek word that means healing. The Greek form, θεραπευω, means "I heal" (Apata, 2013, p. 33). Meanwhile, the Hebrew expression "*epram marpe"* (Apata, 2013, p. 33), means "elements that cure." However, healing practices in the church are of a miraculous nature, and spiritual healing is perceived to be an important necessity due to the several physical and mental predicaments causing people not to be in good health (Apata, 2013). As a result, the Black church has found it necessary to continue with spiritual therapy despite the introduction of modern medical practice and the use of medication that not only has side effects, but also does not always cure the ailment (Barlow et al., 2013). Consequently, according to Apata (2013), the power to heal is not in the hands of any human being, but solely in the Hands of the Almighty God.

Rao et al. (2015) stated that based on faith, spiritual healing through deliverance is belief in the alleviation of illnesses/diseases as church leaders use the power of the Holy Spirit and Name of Jesus Christ to cast out demons. In addition, Barlow et al. (2013) stated that spiritual healing is perhaps one of the oldest paramedical treatments,

with an acknowledgment of the connection between the concept of wellness and spiritual well-being. Given, however, that spiritual healing of mental health conditions is considered complementary and/or alternative medicine, any attempt to introduce it into mainstream health care must be based on research evidence (Barlow et al., 2013). In their study, however, Barlow et al. (2013) reported that all their participants acknowledged physical and mental relaxation as a result of spiritual healing approaches. Participants also reported that they felt as though a weight had been lifted off their shoulders, resulting in increased self-confidence and a positive outlook on life (Barlow et al., 2013).

Additionally, spiritual healing practices such as Reiki, with its Christian form known as Holy Fire Reiki, "a spiritual energy that creates wholeness through purification, healing, empowerment and guidance" (Rand, n.d. para. 22), are becoming widely accepted as adjuncts to medical treatment. "Reiki is a holistic biofield energy therapy beneficial for reducing stress. [It] treats the entire person incorporating the totality of one's physical, mental, emotional, and spiritual dimensions" (Rosada et al. 2015, p. 489). Practitioners of these forms of spiritual healing claim to channel universal energy for holistic restorative (mind, body, soul, spirit) balance within the individual as they alleviate symptoms of mental health conditions, hasten recovery, and engender a state of overall well-being (Rosada et al. 2015).

Spirit possession: According to Hecker et al. (2016), spirit possession is identified when an individual expresses distress from dissociative symptoms because all dissociation is believed to be caused by some form of demonic possession by evil spirits. Significant correlations have, therefore, been found between spirit possession and other

mental health disorders/illnesses, psychological functioning impairment, as well as somatic complaints (Hecker et al. 2016; van Duijl et al. 2014; Wilström, 2014). Despite the experiential nature of demon possession and deliverance/exorcism, few studies have provided descriptive accounts of manifestations of demonic possession, the resulting exorcism/deliverance, and the deliveree's restorative assessment after deliverance. Consequently, more testimonies of deliverees having undergone deliverance and immediate recollections of deliverance sessions will be necessary for a coherent understanding of these deliverance experiences (Rowan & Dwyer, 2015). It should, however, be noted that deliverance experiences are not always positive because of instances whereby the deliverance is considered unethical in the counseling profession (Sanders et al. 2015). For example, in some Pentecostal churches, congregants are being delivered from homosexuality, a situation that has led to some congregants leaving the church (CNN Wire, 2020; Cook, 2017; Ratinen, 2017).

The Black Church: The Black Church is defined as "those independent, historic, and totally black controlled denominations, which were founded after the Free African Society of 1787 and which constituted the core of black Christians" (Hardy, 2014, p. 3). It has always been the place where the private and public lives of AAs intersect, with the congregants believing in the creation of a spiritual atmosphere for therapeutic change. At the head of this important institution is the pastor, who is tremendously respected in the AA community. As shepherds who tend to the spiritual needs of their congregants, pastors also carry out other responsibilities, which increasingly include the provision of pastoral counseling (Collins, 2015; Dempsey et al., 2016; Hays, 2015).

The church clergy also continues to be the main support system of church members, who generally choose these spiritual leaders as their go-to resources over professional counselors for their mental health and other psychological concerns. Consequently, the messages that congregants receive from their church leaders determine whether they go to OPMHCs (Avent et al., 2015). The Black Church is, therefore, a place where its members get encouraged to rebuild their lives (Dempsey et al., 2016) as they get useful advice, spiritual guidance, general counseling, and support for all their health-related and other personal/family issues (Collins, 2015; Hays, 2015). For the purpose of this study, the Black Church does not only refer to "Black Christian churches in the US that are historically and completely Black-controlled" (Hays, 2015, p. 300), but also to other Pentecostal and charismatic churches that are predominantly made up of Black people (Asamoah et al., 2014).

Assumptions

In this study, based on transcendental phenomenology, I assumed that all participants would voluntarily accept to be interviewed, considering that they would understand and sign the informed consent, and that they would be honest and truthful in answering the questions that I would ask them without leaving out any important details. I also assumed that all participants would understand that their documented lived experiences were going to add to a body of scientific knowledge that, from a physical, mental, spiritual, and socioeconomic perspective, would improve the possibilities of better mental health care for BCPW. For this study, I also assumed that compensation of a $50 gift card would motivate them to provide deep, detailed, and rich information on

their individual lived experiences with spiritual deliverance and treatment from OPMHCs. Finally, I assumed that with English being the first language of all participants, they would be able to understand the questions I was going to ask them, thereby needing no assistance from an interpreter.

Scope and Delimitations

A good number of BCPW prefer to go to their churches for spiritual deliverance from their mental health concerns (Mercer, 2013; Hays, 2015; Rowan and Dwyer, 2015), instead of seeking treatment from OPMHCs (Hamm, 2014; Moore, 2017; Ward et al. 2014). When they even go to OPMHCs, the tendency is for them to prematurely terminate the therapeutic sessions (Adams et al. 2015). Consequently, exploring ways to build healthy therapeutic alliances between church leaders and counseling professionals may enable these two groups of professionals to collaborate in ways that will produce positive therapeutic outcomes (Cummings et al. 2014; Sanders et al. 2015).

Based on similar studies, I continued recruiting and interviewing participants until I reached a saturation point (Tran et al. 2016), most likely between three and seven BCPW from an urban northeastern state of the United States, based on the guidelines of phenomenological qualitative research whereby the researcher selects just a few participants for a study (Tran et al. 2016). The findings of this study may not only help in bridging a gap between mental health professionals and leaders of the Black Church (Avent et al. 2015; Dempsey et al. 2016), but also bring positive social change into the Black Christian Pentecostal community as the women get satisfactory treatment for their mental health issues and strive to be the best expression of themselves in their families

and communities (Alinia, 2015). The results of the study might also enable professional counselors to get a much better understanding of how best they can provide treatment to this special population of BCPW from their Black churches (Adams et al. 2015). In order to improve the credibility of the findings of this study, I used the triangulation approach to establish trustworthiness.

For delimitations, the data collection sample for this study was delimited to include data before February 2020 only due to the impact of COVID-19 on support access for participants. In addition, BCPW do not stay for treatment in OPMHCs as do White American clients, having the tendency to prematurely terminate their therapeutic sessions (Hays, 2015; Villatoro & Aneshensel, 2014). For this study, I limited the recruitment of participants to those women who identified themselves as BCPW and not only had gone through at least one spiritual deliverance session with their pastor, but also had attended or were still going to OPMHCs for treatment. Considering that I did not include other populations such as Black Christian Pentecostal men in addressing the gap in the literature, the results of this study might not be transferable to other special minority populations. In addition, I was interested in BCPW due to the literature reviewed and because of my personal experience as a BCPW and a licensed mental health professional counselor. I was also fascinated because evidence-based studies affirmed some of my own beliefs surrounding spiritual deliverance practices by BCPW and their going for treatment in OPMHCs.

Limitations

Although a phenomenological study generally has several advantages when the researcher is exploring lived experiences, a phenomenological study still has its limitations (Creswell, 2014b). I identified some limitations to this study. The first limitation was the requirements for participation. In order to participate in this study, individuals had to be adult women. This meant that the opinion of Christian men was not known. I, however, chose this special population because statistics have shown that more women go to church than men. Second, although it was not my intention, all the participants had at least a bachelor's degree. Nevertheless, the advantage was that the participants found it a lot easier to describe their experiences using the appropriate counseling diction. Third, all participants were recruited from the same church, so there was no opportunity to hear from women who had had deliverance experiences from other churches. Fourth, this study was limited to only women who had experienced deliverance from a Christian church. Meanwhile, there are other spiritual experiences such as Reiki that could help give more insight on how such experiences could be.

Significance

The results of this study may demonstrate how BCPW seek and receive healing of their mental health illnesses from their church leaders (Mercer, 2013; Rowan & Dwyer, 2015) while also seeking treatment from OPMHCs (Friedlander et al. 2014). The emergent themes from this phenomenological study may also provide information to help in identifying factors related to seeking healing from church leaders and going to OPMHCs for treatment as well (Dempsey et al. 2016). This information may enable

counselor educators and other counseling professionals to have new therapeutic options as they get churches involved in the concurrent treatment of their BCPW (Jackson, 2015).

The information may also bring the awareness of the general public to the mutual inclusiveness of spiritual healing and treatment from OPMHCs (Anthony et al. 2015; Asamoah et al., 2014). The information may equally help build a strong and healthy relationship between clergy and professional counselors (Adams et al. 2015; Anthony et al., 2015; Jackson, 2015) and potentially improve client outcomes because of culturally relevant and responsive counseling practices (Collins, 2015). Furthermore, the correlation between spirit possession and mental health is that Sutton et al. (2016) recommended spiritually related activities for clients during therapeutic sessions. In that way, clinicians may understand pathological spirit possession so they might be able to develop treatment strategies that are culturally sensitive (Dempsey et al. 2016; Hays, 2015; Moore, 2017). It is equally important to note that there are significant correlations between spirit possession and severity of PTSD symptoms and other mental health disorders (Hecker et al. 2016).

In addition, this information might bring about much-needed positive social change and social justice for a minority population of voiceless women (Heppner, 2017; Marbley et al. 2015; Ratts et al. 2016) who have chosen a certain way of taking care of their mental health issues (Hecker et al. 2016). Some of the positive social change may include the reduction of stigma (Egbe, 2015; Stewart et al. 2015) as church leaders and family members start positively talking about OPMHCs to an extent that these women

may now freely go for treatment in these OPMHCs (Ben-David et al. 2016; Hays, 2015; Villatoro & Aneshensel, 2014).

Furthermore, this may be the beginning of increasing access to quality culturally aware interventions for the mental health needs of these women, who may be able to willingly, confidently, and freely go for OPMHC services (Baumgartner et al. 2014; Cole, 2016; Hays, 2015). The study may also increase awareness and knowledge of how these women can assert themselves to the possibility of choosing what treatment method is best for them. As a result, clinicians may use this awareness and knowledge to advocate for and empower women to assert themselves and go for what they believe is best for them (Alinia, 2015; Levitov, 2017; Lumpkins et al. 2013).

Summary

In Chapter 1, I started by making an introduction of the study as I stated the phenomenon of BCPW who go to their churches for spiritual deliverance from mental health conditions and go for treatment in OPMHCs. Due to a dearth of literature related to the lived experiences of BCPW who seek both spiritual deliverance as well as mental health services (Adams et al. 2015; Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015), counselor educators have been ill equipped to train counselors to prepare to meet the needs of their female Pentecostal clients (Mercer, 2013; Rowan & Dwyer, 2015). As a result, authors have recommended further research on collaboration between mental health professionals and spiritual healers (Sanders et al. 2015).

Additionally, I mentioned the implications of this study for social change, gave information on the background, presented the problem statement, mentioned the purpose

of the study, and stated the research question. I also elaborated on the conceptual framework and the nature of the study and gave contextual definitions of important terms used throughout the study. I then explained the assumptions that I made of the study and gave the scope delimitations, limitations, and significance of this study. In Chapter 2, I review related literature, highlighting issues of spiritual deliverance, the gap in the literature, and the importance of building a healthy professional relationship between counseling professionals and leaders of the Black church so that the two groups can collaborate with the intention of providing their BCPW clients with satisfactory therapeutic outcomes.

Chapter 2: Literature Review

Bledsoe et al. (2013), Bouwmeester (2013), Cummings et al. (2014), Friedlander et al. (2014), and Moore (2017) have all stated that clients may receive additional benefits by seeking simultaneous mental health treatment and spiritual/religious healing practices. However, within mental health circles, the idea of spiritual healing of mental health disorders and illnesses through deliverance practices does not yet have enough evidence-based scientific research (Richards et al., 2015). Nevertheless, some authors have concluded that certain mental health conditions can be treated through spiritual healing (Hecker et al., 2016; Richards et al., 2015; Williams et al., 2014). Some BCPW seek both spiritual deliverance and mental health treatment from what they believe to be demons (Bledsoe et al., 2013; Friedlander et al., 2014; Moore, 2017). After studying the relationship between spirit possession and mental health symptomology, Cummings et al. (2014) and Hecker et al. (2016) explained that there were significant correlations between spirit possession and severity of PTSD symptoms and other mental health disorders.

Participants in a study by Asamoah et al. (2014) stated that mental disorders and illnesses were a result of demonic manipulations of the soul of a person. The participants further disclosed that medical science could not only explain, but also treat many of the mental health conditions that they as pastors considered spirit possession. According to Asamoah et al., while seizures may be epileptic symptoms, personality changes may also be as a result of mental disorders or psychological malfunctioning such as hysteria, paranoia, or schizophrenia. In addition, Avent et al. (2015) mentioned that the Black Church was considered a less stigmatized place for AAs to receive help for many mental

health concerns such as anxiety, depression, grief, obsessive compulsive disorder (OCD), substance abuse, and suicide (Hays, 2015). Furthermore, Mercer (2013) explained that in Pentecostal churches, the indwelling of demons within the bodies of certain congregants was manifested in mental disorders and illnesses such as ADHD, autism, bipolar disorder, anxiety, depression, reactive attachment disorder, schizophrenia, and seizures (Brown, 2014; Capps, 2014; Mercer, 2013; Rowan & Dwyer, 2015; Scrutton, 2015).

Additionally, according to Dempsey et al. (2016), heads of community-based mental health institutions had not always sought the wisdom of faith-based communities because "AAs and mental health professionals have long been opposing forces in America" (p. 73). Adams et al. (2013) even stated that in their qualitative study, pastors presented negative perspectives to their church members about seeking help from OPMHCs and using psychotropic medications for their mental health conditions. Capps (2014) mentioned that the mental health community first came to interact with faith communities as far back as the 1920s. During this period, the pastoral movement encouraged seminary students considered to be experts both in exorcizing demons and in ministering to the mentally ill to spend many weeks during the summer attending to patients in state mental hospitals (Capps, 2014).

Today, there are many chaplaincies in general hospitals, hospices, retirement communities, prisons, and the military (Capps, 2014). Additionally, the National Institute of Mental Health (NIMH) has noted that just like mental health professionals, pastors can interact with individuals seeking help for serious mental conditions that they consider resulting from demonic possessions (Bledsoe et al., 2013). Consequently, several

researchers, including Brown and McCreary (2014), have recommended a very close collaboration between the clergy and mental health professionals. To this end, pastors, mental health professionals, and researchers are beginning to look for community-based mental health prevention interventions that will have a positive impact on the mental health behaviors of church congregants (Collins, 2015).

For the mental health community to effectively and successfully work with pastors in a bid to support BCPW, mental health and government institutions have created culturally informed protocols for working with pastors. For example, the federal government, using different cultural competence programs through the Health Resources and Services Administration (HRSA), which is in partnership with the Institute for Healthcare Improvement (IHI), has created Health Disparity Collaboratives to specifically address ethnic and racial disparities at the level of OPMHCs (Betancourt et al., 2014). In addition, the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) continue to fund education and research in cultural competence (Betancourt et al. 2014). Pastors can also assist counseling professionals to provide services that are not only culturally sensitive, but also culturally congruent (Brown & McCreary, 2014).

According to the ACA Code of Ethics (ACA, 2014) and Remley and Herlihy (2016), counseling professionals are recommended to collaborate with non-mental-health practitioners for effective therapeutic outcomes. Ratts et al. (2016) have also called on mental health professionals to consider clients' religion and spirituality as an aspect of their identity along with the social justice concerns that may impact mental health. Ratts

et al. 2016, further indicated that "a major aspect of understanding the role of social justice and advocacy … includes integrating systemic-level change efforts into microlevel counseling practice" (p. 43). However, there is a dearth of literature related to the lived experiences of BCPW who seek both spiritual deliverance as well as mental health services (Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015). Consequently, due to this lack of pertinent research, counselor educators are ill equipped to train counselors to prepare to meet the needs of their female Pentecostal clients (Mercer, 2013; Rowan & Dwyer, 2015). As a result, authors have recommended further research on collaboration between counseling professionals and spiritual healers (Cummings et al., 2014; Sanders et al., 2015).

The purpose of this study was to explore the lived experiences of BCPW who seek resolution of their mental health issues through a combination of spiritual practices and counseling (Friedlander et al. 2014; Hays, 2015; Mercer, 2013; Rowan & Dwyer, 2015). To explore these experiences, I used a qualitative, transcendental phenomenological approach (Buser et al. 2016; Dowling & Cooney, 2012; Elo et al. 2014; Englander, 2012; Giorgi, 2012; Green, 2014; Holroyd, 2015; Jacobs, 2012; Lee et al. 2014; Sorsa et al., 2015; Sousa, 2014; Taipale, 2015). An article by Rowan and Dwyer (2015) indicated that more women than men tend to seek treatment from their church leaders through deliverance practices.

To this end, I will highlight the importance of respecting the stipulations in Standards F.2.g., Section 2, and Standards A.2.f., A.3.b., D.2.m., Section 5 of CACREP (2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014). These

standards all stress the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study will inform professional counselors on this special subculture of female clients, with the study pointing to implications for practice being that counseling professionals may have effective multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

Major Sections of Chapter

The major sections of this chapter include the following: (a) the conceptual framework of the study; (b) BCPW coping with mental health concerns as they seek spiritual healing from their clergy through deliverance; (c) attitudes of BCPW toward mental health services, including barriers to using mental health services; (d) BCPW and religious support following the significance of religion in Black culture as well as the response of religious leaders to the mental health issues of BCPW; and (e) collaboration between Black clergy and counseling professionals.

Literature Search Strategy

For this literature review, I used different sources of information, with one of the sources being the search engines in the Walden library database. These search engines included Academic Search Complete, Expanded Academic ASAP, ERIC, MEDLINE with Full Text, National Alliance for Mental Illness (NAMI), ProQuest Central, ProQuest Dissertations & Theses Global, Psychology Databases Combined Search (PsycARTICLES, PsycBOOKS, PsycCRITIQUES, PsycEXTRA, PsycINFO), SAGE

Journals, ScholarWorks, SocINDEX with Full Text, Thoreau Multi-Database Search, Ulrich's Periodicals Directory, and WHO.

Additionally, I used other web search engines such as Google Scholar and Bing to search for complete peer-reviewed articles on mental health disorders and illnesses, Pentecostalism, religion and spirituality, deliverance, exorcism, and OPMHCs. I also used information from associations such as the ACA and NAMI as well as Walden's qualitative dissertation database in order to get useful data on issues related to my dissertation topic. I equally used search engine databases for key search terms and combinations of search terms such as *deliverance*, *exorcism*, *healing*, *mental health*, *mental health disorders and illnesses*, *Pentecostalism*, *Pentecostal Christians*, *religion*, *spirituality*, *spirit possession*, *religion and spirituality*, *spiritual healing*, and *the Black Church.*

Considering that there is dearth of literature on Pentecostal-type spiritual healing through deliverance/exorcism, I reviewed literature that is generally related to healing through other means such as prayers, praise and worship, and reading biblical scriptures in the Black church in the United States and other parts of the world (Büssing et al., 2015). I also reviewed literature on the role that the Black church continues to play in Black culture and why BCPW prefer going to their church leaders for spiritual healing instead of attending OPMHCs (Collins, 2015; Cummings et al., 2014).

Conceptual Framework

The conceptual framework for this research study was transcendental phenomenology. Edmund Husserl, the founder of transcendental phenomenology, posited

that phenomenology could begin only after phenomenologists had performed transcendental-phenomenological reduction, also known as epoche or bracketing. This form of reduction occurs when phenomenologists put aside their personal knowledge and experiences so that they can objectively appreciate the experiences of others by getting into the essence of the phenomenon (Sorsa et al., 2015).

According to Dowling and Cooney (2012), "phenomenological reduction or bracketing is the distinguishing characteristic of Husserlian phenomenology" (p. 23). Bracketing occurs when researchers suspend their own beliefs, prejudices, and preconceptions in such a way that they have no influence on how participants describe their own experiences (Berger, 2015; Buser et al, 2016). Choi (2018) interpreted Husserl's transcendental phenomenology as a basic philosophy of happiness, and Csikszentmihalyi's positive psychology has defined happiness as "flow" (p. 126), a state of continuous immersion guided by inner motivations and rewards (Choi, 2018).

Instead of using a scientific approach, researchers can have access to this kind of happiness through personal confessions and reports of those concerned (Choi, 2018). In addition, according to Choi (2018), Husserl's phenomenology leans on intentionality, a theme that involves retaining the immediate past and expecting the immediate future by seeing what is not given and taking more than what is given. This characteristic, in Husserl's original German language, is known as *Mehrmeinung*, and it constitutes an important piece of transcendental consciousness (Choi, 2018).

Furthermore, this phenomenological approach identifies lived experiences and uses the responses that participants give to open-ended questions as they describe the way

in which they experience the phenomena daily (Grimes et al., 2013; Sousa, 2014). Researchers use phenomenological approaches to accentuate categories of people who have not been the focus of previous studies (Creswell, 2007). Consequently, I used a transcendental phenomenological approach for this study so that I could focus on the experiences that women provided about going to their churches for spiritual healing as well as seeking treatment from OPMHCs, rather than on the meaning/interpretation of the experience.

I used bracketing to make sure that I understood the experiences of my participants without including my own assumptions, personal biases, and preconceptions (Buser et al. 2016; Chan et al. 2013; Dowling & Cooney, 2012; Englander, 2012; Sorsa et al. 2015). In other words, I discarded my assumptions and made sure that my participants had their voices heard. Further, if I was to use the Husserlian descriptive phenomenological approach, in order to attain rigor, my data collection as well as my data analysis would have to be descriptive (Chan et al. 2013; Holroyd, 2015).

I aimed to use between five and seven participants so that I would be able to make better comparisons as I noted the number of times the phenomenon was described (Malterud et al. 2015; Tran et al., 2016). In previous studies such as those of Buser et al. (2016), Holroyd (2015), and Sorsa et al. (2015), the concept of transcendental phenomenological research had been applied and articulated, as they all "employed the method of transcendental phenomenology, which is concerned with understanding participant experiences without the lens of personal biases, assumptions, and preconceptions" (Buser et al. 2016, p. 328).

My research benefited from this flexible and adaptable framework that generally suited the phenomenon under study (Holroyd, 2015). As I used a virtual face-to-face interview, which was usually longer and richer in terms of its depth and nuances (Stuckey, 2013; Tran et al. 2016), what I was seeking was a complete description of the experiences my participants must have lived through. To attain this goal, I used the bracketing approach "to increase [my] awareness, to put aside [my] assumptions and to look at [the] phenomenon with an open mind" (Sorsa et al. 2015, p. 10).

Key Variables and Concepts

This literature review has a thematic focus on peer-reviewed articles that were relevant to this phenomenological study of BCPW who went to their churches for spiritual deliverance from their mental health issues and attended OPMHCs. For this study to be clearly understood, it was important for me to review literature that dealt with the following: BCPW and coping from a religious/spiritual perspective; BCPW and mental health services, including barriers to using those services; BCPW with mental health issues and religious support from their leaders; and collaboration between Black pastors and counseling professionals.

Black Women and Religious/Spiritual Coping

Based on faith, Rao et al. (2015) posited that spiritual healing through deliverance was performed on CPBW who believed in the alleviation of their health concerns when their church leaders, who used the power of the Holy Spirit and Name of Jesus Christ, cast demons out of them. In addition, Barlow et al. (2013) stated that spiritual healing was perhaps one of the oldest paramedical treatments, with an acknowledgment of the

connection between the concept of wellness and spiritual well-being. To this end, Turner et al. (2019) stated that women were more likely than men to report the importance of spiritual healing for dealing with their health issues as they turned to God for strength.

In the same vein, women are also more likely to use OPMHCs than men (Pattyn et al. 2015). Recruiting 50 Black participants who were members of Black churches in Boston, Massachusetts, with 52% of them identifying as females, Pattyn et al. (2015) conducted another study on the relation between racism and mental health issues such as generalized anxiety and other anxiety-related concerns. The results of this study agree with other research studies that concluded that support from Black churches was a very important resource that CPBW used not only to deal with traumatic reactions to racism, but also to greatly reduce negative consequences on their mental health (Pattyn et al. 2015). As a result, Black ministers played determinant roles in the improvement of the mental health conditions of their church members (Smith, 2017).

In another study by Avent et al. (2015), almost 80% of AAs stated that religion was an important part of their lives, with 50% attending church at least once a week and 59% reporting being part of the Black Church. The Black Church, therefore, generally played an important role in supporting the emotional well-being of these female church members, and studies have shown that more than 40% of AAs sought help from their Black clergy when suffering from mental health issues (Bledsoe et al., 2013). The ways that church leadership provided emotional support to CPBW included but were not limited to (a) providing pastoral counseling on intimate partner violence, (b) furnishing resources to help battered women and their children find safe places to live, (c) providing

women with food and clothing, and (d) empowering and helping women to get help from social services and/or be self-employed.

Many BCPW have relied on spiritual treatment from church leaders for mental health issues like anxiety and depression instead of going to OPMHCs (Anthony et al., 2015; Asamoah et al., 2014**;** Avent et al., 2015). Church attendees like CPBW rely on church leaders for mental health treatment since they tend to believe that mental health issues are as a result of demonic possessions. Hence, they can only be through deliverance by a church leader in a church setting (Hecker et al., 2016). Abu-Raiya (2013) and Lea et al. (2015) confirmed that when clients with certain mental health conditions like eating disorders and other stressors sought spiritual treatment based on their religious beliefs, there was a marked improvement on their psychological wellbeing. There is, however, a lack of consensus in the literature with regards to the nature and cause of the distress which could lead BCPW to seek spiritual treatment rather than treatment from out-patient mental health clinics (OPMHCs, Anderson et al., 2015).

Black Women and Barriers to Using Outpatient Mental Health Clinics

Although the rate of anxiety, depression, and other mental health disorders and illnesses are higher among Black women when compared to their Caucasian counterparts, Black women still underuse OPMHCs (Hamm, 2014; Watson & Hunter, 2015). Rowan and Dwyer (2015) also stated that more BCPW than men had the tendency to seek treatment from their church leaders through deliverance practices, hence the underuse of out-patient mental health clinics (OPMHCs) by BCPW (Hamm, 2014; Watson & Hunter, 2015).

The reasons why Black women do not go to OPMHCs are that first, from a cultural perspective, most professional counselors are not multiculturally competent enough for them to balance the ethnic/racial disparities in mental health care (Betancourt et al. 2014; Collins, 2015; & Vieten et al. 2013). Consequently, counselors often lack the appropriate strategies that Black Pentecostal churches could use to promote mental health wellness among church members (Betancourt et al. 2014; Collins, 2015; & Vieten et al. 2013). Second, these Black women mistrust the professional counselors who they believe would impose their own cultural values on them rather than respect the values of their clients in order to build a healthy therapeutic relationship (Cummings et al. 2014; Hecker et al. 2016). Third, Smith (2017) stated that Black women were more unlikely to seek treatment from OPMHCs because of lack of trust, societal stigmas, cost of care, and unavailability of OPMHCs that had Black mental health professionals (Brown & McCreary, 2014; Dempsey et al., 2016; Egbe, 2015).

In other words, White mental health professionals were not equipped to provide culturally-competent services to their Black clients, hence the resulting cultural mistrust (Brown & McCreary, 2014; Cadoret & Garcia, 2014; Dempsey et al. 2016; Smith, 2017). For example, Dempsey et al. (2016) reported that many AAs were wrongly diagnosed with schizophrenia. Fourth, the drop in the use of OPMHCs may also be partly attributed to inconvenient schedules, long wait times, and a dislike of psychotropic medication side effects (Ben-David et al. 2016; Elliott & Hunsley, 2015). As an alternative, BCPW preferred to get mental health treatment from their Black churches (Ben-David et al. 2016) with their Black pastors often being the first and only persons they went to for their

mental health needs. In other words, the Black church has become the most trusted solution when its members need mental health services since they consider spirituality and the church and as an important coping mechanism (Dempsey et al. 2016; Pietkiewicz & Bachryj, 2014).

Also, according to Filippi et al. (2014), instead of going to OPMHCs, AAs preferred to seek mental health care from their Black churches because: (a) church services were free of charge since church members were neither weighed down with unnecessary financial pressure to pay for the services, nor were refused services for lack of health insurance (Dempsey et al. 2016); (b) Familiarity and positive experience with the pastor created a healthy therapeutic relationship especially as the intake process of the church was generally informal, with a more relaxed and stress-free environment (Sutton et al. 2016; Ward et al. 2013); (c) The ethnic matching with someone from the same cultural background usually resulted in a culturally-sensitive understanding of rituals and heritage, which could quickly lead to building a healthy and trusting therapeutic relationship; (d) The Black church service that includes fellowship, confession of sin, and the outward expression of praise, worship, singing and prayer created a therapeutic church experience as it helped to manage stress and avoid depressive tendencies (Sutton et al. 2016; Ward et al. 2013). This external display of emotions caused a therapeutic release that restored faith, hope, and love (Dempsey et al. 2016). Black clients would, therefore, go for treatment in OPMHCs if their services could be culturally tailored to their needs (Filippi, et al. 2014).

Mental health researchers like Fiasorgbor and Aniah (2015); and Hays (2015) have also concluded that AA women will more likely prefer their spiritual practices which are more culturally-relevant strategies over OPMHCs and medication for treating their mental disorders/illnesses. Furthermore, religious practices among Black women were usually associated with fewer lifetime personality and other mood disorders (Hamilton et al. 2013). Consequently, the key barriers to out-patient mental health treatment include stigma, cultural mistrust, knowledge, affordability, cultural understanding and trust, denial of symptomatology resulting from an alternative belief about the etiology of mental health conditions, lack of awareness to the BCPW experience among mental health professionals, and preference for a Black counseling professional (Avent et al. 2015, Hays, 2015).

Black Women and Church Support

Baruth et al. (2015) reported that pastors did not only have significant authority, but were also trusted by their congregants, thereby making them well-suited to encourage, organize, and invigorate positive health behavioral changes. Abernethy, Grannum, Gordon, Williamson, and Currier (2016) also reported that in the US, Black pastors played a very major role in promoting the mental health well-being of inhabitants in Black communities. Consequently, pastors of Black churches are highly respected in their communities (Hardy, 2014) and Blacks who went to their Black churches first for their mental health issues would less likely go to an OPMHC (Hays, 2015). A study by Avent et al. (2015) found that Black pastors were always the first support system when their parishioners had mental health issues and had maladaptive forms of coping with the

condition. The most common mental health concerns addressed by pastors during pastoral counseling were anxiety, depression, and suicidal ideations among other mental health conditions. Participants in one study reported feeling a lot more confident in dealing with those issues when presented to their church leaders (Hedman, 2014).

In Ghana, for example, mental health has recently been acknowledged as an important issue for national policy intervention, hence the need to integrate indigenous mental health care practices into formal governmental systems. To that end, considering how religious groups dealt with mental health issues in Ghana and how the government properly engaged them in mental health-care delivery, in their study, Asamoah et al. (2014) examined the views of 20 Pentecostal clergymen on the role their churches played in delivering mental health-care in Ghana. Using thematic analysis, the findings showed that instead of using a biomedical perspective, leaders in Pentecostal churches used a deliverance/exorcism explanatory model of mental health (Asamoah et al. 2014).

Bledsoe et al (2013) stated that the U.S. Surgeon General found that in a year, the church was one of the places where one in six adults obtained pastoral counseling for mental health issues. Even the National Institute of Mental Health (NIMH) concluded that church leaders were just as likely as mental health professionals to interact with people seeking help for a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis. These diagnoses included people with severe mental illnesses like dissociative identity disorder (DID), bipolar disorder, or schizophrenia. Other studies have also stated that millions of Americans with mental health conditions would seek the help of their

churches first before going to any other mental health professional (Brown & McCreary, 2014; Jackson, 2015).

Although BCPW reportedly had a higher severity of untreated mental health disorders and illnesses than other known racial groups, historically, BCPW have been more likely to rely on their church leaders as well as their spiritual beliefs, instead of seeking support from mental health professionals (Dempsey et al. 2016). As a result, research suggests that the number of individuals seeking help from church ministers for mental health problems is by far greater in the US compared to other countries like Canada and the United Kingdom (Hall & Gjesfjeld, 2013). To that end, religious-minded individuals have reported having lower rates of depression and higher rates of recovery from depression and other mental health-related issues (Brown et al. 2014; Dempsey et al. 2016; Hays, 2015).

Pearce et al (2015) have posited that spiritual healing was more effective in the reduction of depression than conventional mental health therapy. This assertion, according to Lumpkins et al. 2013), is a Christian faith-based perspective that places Jesus Christ as the central part of health and belief in holistic healing. The reason is that the Jesus of the Bible was not only a spiritual leader but also One who not only healed people and performed miracles, but also delivered them from demonic possessions (Lumpkins et al. 2013). It should be noted that many North American Christian groups and organizations have encouraged their members to refuse conventional mental health treatment and instead promote spiritual healing (Avent et al. 2015; Brown et al. 2014; Capps, 2014).

Collaboration Between Black Pastors and Counseling Professionals

Although there have been barriers to collaborative services between Black pastors and counseling professionals (Asamoah et al. 2014), there have been successful collaborative approaches as well (Capps, 2014). For example, some church leaders are known to refer their members to OPMHCs (Avent et al. 2015). However, when clergy referred their congregants to mental health professionals, they generally recommended those counseling professionals who not only shared their religious/spiritual values, but also demonstrated excellent spiritual awareness (Sperry, 2014; Sperry, 2015a; Sperry, 2015b; Sullivan et al. 2014).

Barriers to Collaborative Services

Professional counselors are expected to be multiculturally competent for them to balance the ethnic/racial disparities in mental health care (Betancourt et al., 2014; Cadoret & Garcia, 2014); Collins, 2015; Vieten et al. 2013). Dempsey et al (2016) reported that historically, the relationship between church ministers and counseling professionals has been dampened by mistrust. To that end, in a study of 213 churches from five different denominations, Bledsoe et al. (2013) found that the pastors hardly made referrals to OPMHCs and rather preferred to counsel their congregants themselves. The reason was that many church leaders considered that the focus made by counseling professionals on scientific research and secular psychotherapeutic approaches conflicted with their Christian values (Sperry, 2014; Sperry, 2015a; Sperry, 2015b; Sullivan et al. 2014).

Consequently, when clergy referred their congregants to mental health professionals, they generally recommended those counseling professionals who not only shared their religious/spiritual values, but also demonstrated spiritual awareness (Sperry, 2014; Sperry, 2015a; Sperry, 2015b; Sullivan et al., 2014). In addition, Hedman (2014) supported another report of a study which used 179 Christian clergy members in Kent County, Michigan, and the participants affirmed that they would preferably refer their congregants with mental health issues to a Christian professional counselor (Vander Waal, Hernandez, and Sandman, 2012, as cited in Hedman, 2014). Nevertheless, since pastors always report that a significant part of their pastoral duties involves pastoral counseling, collaboration between them and mental health professionals is of primordial importance (Hays, 2015). However, unlike clinical counselors, pastoral counselors integrate spirituality, theology, faith, and psychotherapy to help individuals resolve their personal, marital, family, and faith issues (Hedman, 2014).

Successful Collaborative Approaches

According to Bledsoe et al. (2013), the types of relationships between pastors and mental health counseling professionals that could be most beneficial to congregants would include some innovative approaches. For example, counseling professionals could facilitate small group meetings for conflict resolution when there was a division among congregation members. Counseling professionals could also be called upon to establish caregiving programs in the church. In addition, counseling professionals could invite church leaders to participate in continuing education seminars for them to (a) know when and how to refer their congregants to OPMHCs; (b) create a church-specific resource list;

(c) know how to deal with mental health-related issues like anxiety, depression, suicidality, family/domestic violence, child abuse, anger management, premarital and bereavement counseling. Furthermore, training in undergraduate and seminary institutions could include additional curriculum to prepare clergy for the practical realities of their pastoral roles whereby they are regularly exposed to different types of mental health problems (Bledsoe et al. 2013; Capps, 2014).

Furthermore, Dempsey et al. (2016) reported a scientific research which concluded that when church leaders succeed in developing long-term collaborative working relationships with mental health counseling professionals, this relationship will facilitate collaborative mental health-related retreats, workshops, and conferences in Black church communities. Also, since church leaders have reported feeling inadequate because they lack the skills needed to deliver effective mental health therapy, a healthy collaboration between clergy and mental health professionals will start bridging the gap between these two professional bodies for more effective therapeutic outcome (Ano et al. 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016).

As far as CACREP is concerned, considering that one of its tenets is to uphold cultural diversity (CACREP, 2016), accentuating religion/spirituality through the inclusion of pastoral counseling in its training programs will result in effective therapeutic outcomes for clients. Clergy will equally gain useful knowledge on how to effectively collaborate with ethically-minded mental health counseling professionals who have the expertise in providing mental health care to clients with an R/S background (Cummings et al. 2014; Abernethy et al. 2016; Currier et al. 2018). Additionally, mental

health professionals will also give advice and offer training on service skills and techniques as well as provide a support network to reduce the effects of mental and emotional burnout of church leaders (Hardy, 2014; Jackson, 2014).

Furthermore, a study by Jackson (2015) concluded that licensed professional counselors wanted to learn a lot more about the role of the pastor, the possibility of referrals, as well as training to provide pastors not only with the ability to know why and when referrals should be made to professional mental health counselors, and how to do the referral to an OPMHC without causing unnecessary stress in the process (Jackson, 2015). Collaboration between researchers and counseling professionals will, therefore, help bridge the gap between spiritually-oriented approaches and secular psychotherapies (Lea et al. 2015), especially as it has now been recognized that mental health care professionals are ethically obliged to be competent in the R/S aspects of the cultural diversity and treatment of their clients (Richards et al. 2015).

Surveys have even provided evidence that sizable percentages of mental health professionals, about 30 to 90% based on the group surveyed, use spiritual approaches, strategies, and interventions. It will, therefore, be important for counseling professionals to know the appropriate strategies that African American and other Pentecostal churches could use to promote mental health wellness among church members (Ano et al. 2017; Betancourt et al. 2014; Collins, 2015). Therapists should equally be aware of the importance not to impose their cultural values on their clients but rather respect the values of their clients in order to build a healthy therapeutic relationship that will help in the attainment of positive therapeutic outcomes (ACA, 2014; Cadoret & Garcia, 2014;

Cummings et al. 2014; Hecker et al. 2016). Professional counselors dealing with clients who believe in deliverance practices will, therefore, need to understand the worldview of clients who seek deliverance practices (Adams et al. 2015; Mercer, 2013). With this understanding, professional counselors will be able to address religious and spiritual matters during their counseling sessions (Ano et al. 2017; Bledsoe et al. 2013; Creswell, 2014a).

To this end, researchers have reported that church leaders and mental health professionals can successfully unite to carry out preventive mental health information programs, especially as AA pastors believe they can effectively communicate good mental health behavior among church members (Lumpins, et al. 2013; Collins, 2015). This collaborative approach will enable counseling professionals to understand and discuss the religious/spiritual perspectives of their Black clients (Cummings et al. 2014). Clergy will also be able to help counseling professionals with ethical issues like praying with a client and incorporating other religious/spiritual acts during therapy sessions. It should be noted that ministers have expressed their desire to build healthy working relationships with mental health counseling professionals, increase their knowledge in mental health-related disorders and illnesses, and know the available treatment options, considering that the demands for the churches often exceed the available resources (Hedman, 2014).

Avent et al. (2015) posited that Black pastors considered Christian counselors to be the most competent and trustworthy professionals to provide mental health services to their congregants. To this end, if clergy actively established collaborative liaisons with

counseling professionals, the stigma associated with mental health conditions would be greatly reduced, and people would seek treatment earlier, thus improving their quality of life (Anthony et al. 2015). In addition, collaboration between counseling professionals and church leaders will encourage Black churches to draw up policies for the training and empowerment of the clergy so they can have the right skills, strategies, and approaches to effectively take care of their clients with mental health problems (Ano et al. 2017; Asamoah et al. 2014; Hays, 2015). In the study by Avent et al. (2015) on collaboration between counseling professionals and church leaders, all participants reported having positive experiences with mental health professionals in their communities with whom they had had personal connections.

One of the participants even said God had provided mental health professionals to assist Ministers of the Gospel. However, participants advocated for Christian counselors whom they seemed to trust, as potential resources for treatment (Avent et al. 2015). Considering that congregants sought healing within their churches, it was important for clergy to be educated about mental health disorders and illnesses, and be able to collaborate, facilitate, and refer their members to the mental health professionals who could best meet their psychological and emotional needs (Bledsoe et al. 2013). For example, Baumgartner et al (2014) have also come up with a church-based strategy to screen pregnant women and their partners for mental health disorders and illnesses. Furthermore, since OPMHCs are underutilized by the Black community, to effectively combat this situation, it will be important for mental health professionals to form partnerships with Black church leaders (Turner et al, 2019). To this end, if clergy actively

established collaborative liaisons with counseling professionals, the stigma associated with mental health conditions would be greatly reduced, and people would seek treatment earlier, thus improving their quality of life (Anthony et al. 2015).

Summary, Conclusions, and Transition

In this literature review, the problem statement and purpose were restated as well as a concise synopsis of current literature establishing relevance of the problem. This was followed by major sections of the chapter including BCPW and religious/spiritual coping; CPBW and barriers to using OPMHCs; BCPW and church support; as well as collaboration between Black pastors and counseling professionals. Overall, although this literature review highlighted the important role Black pastors played in assuring the spiritual and mental well-being of their Black congregants (Smith, 2017), findings from these studies as well as the dearth of literature in this area show a need for further research to better understand the role of Black clergy in recognizing and managing the mental health concerns of their congregants (Hall & Gjesfjeld, 2013; Hedman, 2014).

Additionally, in several studies, church leaders have acknowledged their lack of knowledge about the biological and psychological causes of mental health disorders and illnesses (Hall & Gjesfjeld, 2013; Hedman, 2014). Black clergy also overwhelmingly agree that as pastoral counselors, their approaches are theologically grounded in the belief that mental health problems result from demonic oppression, spiritual poverty, faithlessness, and personal sin. In other words, with this type of theologically-based views on mental conditions, clergy will less likely recognize the symptoms and severity

of mental disorders and illnesses and as a result will provide less effective counseling (Rowland et al. 2014).

Chapter 3: Research Method

The purpose of this study was to explore the lived experiences of BCPW who sought deliverance and healing of their mental health illnesses from church clergy and other religious leaders. However, in addition to this method of spiritual healing, these women still attended OPMHCs for treatment (Hays, 2015). The study, therefore, addressed these mental health concerns by exploring the experiences of the women from a dual perspective by using a qualitative, transcendental phenomenological approach (Buser et al. 2016; Choi, 2018). An article by Rowan and Dwyer (2015) indicated that more women than men tend to seek treatment from their church leaders through deliverance practices.

I highlighted the importance of respecting the stipulations in Standards F.2.g., Section 2, and Standards A.2.f., A.3.b., D.2.m., Section 5 of CACREP (2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014). These standards all stress the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study may inform professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals may have effective multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

Research Design and Rationale

This study was qualitative, transcendental, and phenomenological in nature. This approach was helpful in understanding how BCPW had satisfactory outcomes as they sought spiritual healing and deliverance practices through their churches (Hays, 2015)

and also went to OPMHCs for treatment (Friedlander et al. 2014). Given that in conducting qualitative research, the researcher is the data collection instrument (Patton, 2015; Ravitch, & Carl, 2016), my role as the researcher in the study was to build healthy relationships with my study participants (Frankfort-Nachmias et al. 2015; Miles et al. 2014). However, due to COVID-19 considerations, I used a Health Insurance Portability and Accountability Act (HIPAA)-compliant web and videoconferencing Zoom service. I also made sure that there was a possibility of telephone communication not only to maximize the availability of participants, but also as a backup to address any technical issues with the Zoom service. I also recorded the interviews using an audio recording device (McDowell, 2019). Additionally, I used the bracketing technique to make sure that I understood the experiences of my participants without including my own assumptions, personal biases, and preconceptions (Buser et al. 2016; Sorsa et al. 2015). In a phenomenological study, therefore, my research question had to focus on discovering the meaning of a given phenomenon lived by not less than three participants (Tran et al. 2016).

Primary Research Question

RQ1. What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church?

Central Concept of Study

The central concept of this research study was transcendental phenomenology, which has been heavily documented over many years by researchers (Buser et al. 2016;

Dowling & Cooney, 2012; Englander, 2012; Holroyd, 2015; Klinke et al. 2014; Lee et al. 2014; Sorsa et al. 2015; Sousa, 2014; Taipale, 2015; Wilson, 2014). Edmund Husserl, the founder of transcendental phenomenology, posited that phenomenology could begin only after phenomenologists had performed transcendental-phenomenological reduction or epoche or bracketing by putting aside their personal knowledge and experiences so that they could objectively appreciate the experiences of others by getting into the essence of a phenomenon (Sorsa et al. 2015). Phenomenological reduction or bracketing or epoche "is the distinguishing characteristic of Husserlian phenomenology" (Dowling & Cooney, 2012, p. 23).

With bracketing, phenomenological researchers suspend their natural attitudes arising from their own beliefs, preconceptions, and prejudices, for them not to have any influence on how participants describe their experiences (Dowling & Cooney, 2012). In other words, with bracketing, researchers can identify the essences of the lived world of their participants without making any judgments (Dowling & Cooney, 2012) In addition, Choi (2018) has interpreted Husserl's transcendental phenomenology as a basic philosophy of happiness, and Csikszentmihalyi's positive psychology has defined happiness as a "flow, a psychic state of ongoing immersion guided by intrinsic motivations and rewards" (Choi, 2018, p. 126). However, instead of using a scientific approach, researchers can have access to this kind of happiness through personal confessions and reports of those concerned (Choi, 2018).

Furthermore, researchers who employ Husserl's phenomenology lean on intentionality, a theme that involves retaining the immediate past and expecting the

immediate future by seeing what is not given while taking more than what is given. This characteristic, in Husserl's original German language, is known as *Mehrmeinung,* and it constitutes the important piece of transcendental consciousness (Choi, 2018). Additionally, this phenomenological approach identifies lived experiences and uses the responses that participants give to the open-ended questions as they describe the way they experience the phenomenon daily (Sousa, 2014). Researchers also use phenomenological approaches to accentuate categories of individuals who have not been the focus of previous studies (Creswell, 2013). Consequently, I used a transcendental phenomenological approach for this study so that I could understand the meaning that women gave to the experience of going to their churches for spiritual healing as well as seeking treatment from OPMHCs.

With this approach, I used the bracketing technique to make sure that I understood the experiences of my participants without including my own assumptions, personal biases, and preconceptions (Buser et al. 2016; Dowling & Cooney, 2012; Englander, 2012; Sorsa et al. 2015). In other words, I had to discard my assumptions and make sure that the voices of my participants were heard as I applied the bracketing technique. "Bracketing in descriptive phenomenology entails researchers setting aside their pre-understanding and acting non-judgmentally" (Sorsa et al. 2015, p. 8). Descriptive research targets the study of participants' detailed experiences from their perspective. In other words, with Husserl's philosophical phenomenology, bracketing is the suspension of researchers' natural assumptions about the world so that they can, putting aside past knowledge of the phenomenon they had encountered, and with open minds and without

prejudice, understand what is important to the participants' lived phenomenon (Holroyd, 2015). Descriptive phenomenologists who strive to capture exact and deep experiences of life and see situations as they are, will, when bracketing, set aside their previous understanding of the phenomenon under study and completely focus on participants' perspectives as they create deep insights using thorough descriptions of the phenomenon (Lee et al., 2014).

They will step out of their own frame of reference, rigorously reflect on their opinions, biases, and socioeconomic and cultural backgrounds in order to understand their participants' viewpoint (Sorsa et al. 2015). The process of bracketing, therefore, enables researchers to focus on what is before them so that they can understand the lived experiences of their participants and not use what they have experienced to understand the experiences of participants (Holroyd, 2015). In other words, it involves "understanding participant experiences without the lens of personal biases, assumptions, and preconceptions" (Buser et al. 2016, p. 328). In order to attain rigor, I used the Husserlian descriptive phenomenological approach for my data collection and my data analysis (Sorsa et al. 2015). In a phenomenological study, my research question had to focus on discovering the meaning of a given phenomenon lived by not less than three participants (Tran et al. 2016). The reason for that number was that with less than three participants, based on their imagination, it would have been difficult for me to make any comparisons, as I would have had to take note of the number of times the phenomenon was described (Tran et al. 2016).

I, nevertheless, continued to interview participants until I got to a saturation point. "Data saturation is the point in data collection and analysis when new information produces little or no change to the codebook" (Tran et al. 2016, p. 88). To that end, when I realized that I was collecting no new information from my participants and redundancy occurred, then I knew that the study had reached its saturation point, and at that stage, I stopped collecting data. As I was using a virtual face-to-face interview, what I was seeking for from this transcendental phenomenological research was a complete description of the experiences that my participants must have lived through (Buser et al. 2016; Cleary et al. 2014; Lee et al. 2014).

Research Tradition/Rationale for Transcendental Phenomenology

According to the Center for Innovation in Research and Teaching (CIRT, n.d.), phenomenology is rooted in a 20th century philosophical movement following the work of the philosopher Edmund Husserl. As a research tool, phenomenology, which has its foundation on the academic disciplines of psychology and philosophy, has become a widely accepted way to describe human experiences. Additionally, phenomenology is a qualitative research method used to describe the way human beings experience a certain phenomenon (Holroyd, 2015). Consequently, in this phenomenological study, I attempted to set aside preconceived assumptions and biases about human feelings, experiences, and responses to a specific situation. This enabled me to delve into the perspectives, perceptions, feelings, and understandings of those individuals who had personally experienced or lived the phenomenon of interest.

Phenomenology can, therefore, be defined as a method that involves describing the meaning of lived experiences of people who are intimately involved with a given phenomenon as it specifically focuses on subjective experiences (Buser et al., 2016). Phenomenological research is typically conducted using in-depth interviews of small samples of participants. By studying the perspectives of multiple participants, a researcher can begin to generalize regarding what it is like to experience a certain phenomenon from the perspective of those who have lived the experience (Holroyd, 2015).

To that end, the main characteristics of phenomenological research are that (a) researchers strive to understand how people experience a particular phenomenon; (b) research is primarily conducted through the use of in-depth interviews as well as drawings, journals, and/or observations, as the case may be; (c) small sample sizes, often 10 or fewer participants, are commonly used; (d) interview questions are generally open ended so as to enable participants to fully describe their experiences from their own perspectives; (e) phenomenology focuses on the lived experiences of participants regardless of traditions, cultural norms, or preconceived ideas about the phenomenon; (f) phenomenology focuses on the lived body, lived space, lived time, and lived human relations of the lived human being; and (g) the collected data are qualitative in nature, and the data analysis includes either an identification of themes or an attempt to make generalizations on how a particular phenomenon is actually experienced (CIRT, n.d.). According to Sheehan (2014), through qualitative research, transcendental phenomenology brings in other dimensions to the study of human experiences.

Understanding and effectively using philosophical constructs of transcendental phenomenology such as epoche can be challenging, due to their abstract complexity.

Role of Researcher

According to Christensen and Brumfield (2010), the role that phenomenological researchers play is of primordial importance because they are the main instruments for the collection and analysis of data. As a result, my role as the researcher/participant was to observe and give credence to the significance of participants' lived experiences through actively listening as I attempted to understand these experiences from their different perspectives and illustrate this understanding of the concepts that participants described. These illustrations could be descriptions of findings, visual representations of themes, and the use of participants' words (Christensen & Brumfield, 2010).

To this end, I had to first attempt to limit the impact of my own worldview and be able to get into the participants' worldview (Buser et al., 2016). Second, I acknowledged polydimensionality as well as the nonlinear and contextual nature of human experience. Third, I focused on content and process as I used the empowerment approach as a goal (Christensen & Brumfield, 2010; Ravitch & Carl, 2016). In order to ensure that I was meeting these three components in my study, I used different sources and methods that included consulting with a peer debriefer and member checking to collect pertinent information that I used to support any assertions and interpretations (Christensen & Brumfield, 2010; Ravitch & Carl, 2016). Additionally, as the primary instrument for data collection and data analysis, I used semistructured interviews to collect data, and during the interviews, I observed the behaviors of my participants. I then went on to transcribe

the interview notes and analyze the collected data. I had no personal or professional relationships with the participants that would have involved any power influence over them (Christensen & Brumfield, 2010; Ravitch & Carl, 2016).

Researcher Bias

Following Creswell (2013), I understood that as the researcher in this study and as someone who was personally connected to the topic as a Born-Again Christian who had experienced spiritual deliverance, it was imperative that I understand and put my own experiential biases into perspective and make sure that I accurately interpreted and analyzed the collected data. To this end, my desire to minimize all biases had to be deliberately intentional. For example, I had to be aware of my lived experiences and assumptions as a Born-Again Christian.

I also had to engage in personal reflections and analysis of my own perceptions about spiritual healing and OPMHCs by keeping a journal of my experiences while conducting this research (Berger, 2015). The reason for journaling was so that I could document my thoughts, assumptions, and biases throughout the data collection process so that I could replace my personal biases with the lived experiences of my participants (Berger, 2015). My dissertation committee supported these efforts by helping me to determine the accuracy of my study. It was able to explore my reflective journal during the data collection and data analysis process and then determine whether the results of the study could be dependable (Christensen & Brumfield, 2010).

Consequently, being the primary instrument in the data collection process, I had to suspend my biases to minimize the impact that I would have on analyzing the collected

data. I therefore used the bracketing approach to deal with any biases from my end. Bracketing, which is a unique characteristic of Husserlian phenomenology, occurs when researchers suspend their preconceptions, beliefs, and prejudices in order not to negatively influence the descriptions of participants' experiences (Tran et al., 2016). Bracketing also gave me an opportunity to set my beliefs, thoughts, and experiences aside and instead focus on the reality surrounding the world of my participants (Lee et al., 2014). My intentional and deliberate focus on the phenomenon equally enabled me to objectively appreciate, look at, and notice how participants experienced and associated meaning to the phenomenon. In other words, my perceptions, meanings, and descriptions were mainly developed from all collected data (Green, 2014).

Possible Ethical Issues

In its preamble, the fundamental values of the counseling profession are clearly stated in the ACA Code of Ethics (ACA, 2014). These values include but are not limited to the respect of diversity and the use of a multicultural approach to promote the uniqueness, worth, potential, and dignity of participants within their sociocultural settings (Remley & Herlihy, 2016). Some of the ethical concerns that could, therefore, have arisen involved conducting the study within my own living environment with people I had known under different situations (Giordano & Cashwell, 2014). To address this issue, I went to places where I had never been before, and if for any reason I met a participant I had earlier known, that participant would be eliminated from the group. Additionally, because in qualitative research, participants and researchers connect during the data gathering process, I had to collect and interpret the data based on the verbal exchanges

between participants and myself (Elo et al. 2014). Additionally, I had to ensure that before I reported any information disclosed by participants, they had given their approval through the process of member checking (Ravitch & Carl, 2016).

Methodology

Participants, who are also known as co-researchers, were generally selected because not only had they experienced the phenomenon under study, but they were also willing to share these experiences based on their feelings and thoughts. Although the number of participants could vary, following the nature of the research**,** between one and eight participants could be enough when conducting qualitative phenomenological research (Christensen & Brumfield, 2010; Frankfort-Nachmias et al. 2015).

Recruitment of Participants

After receiving the Walden Institutional Review Board (IRB) approval, I recruited participants for this study by calling for participation of between 4 and 7 BCPW from one church in an urban Northeastern state of the United States, based on the guidelines of phenomenological qualitative research whereby the researcher selects just a few participants for the study (Tran et al. 2016). Once potential participants showed interest in the interview, I communicated with them by phone to determine their interest in continued participation and set up zoom interviews ranging from about 25 to 50 minutes. All participants completed an informed consent and demographic form before taking part in the interview. Potential questions in the semi-structured interview included questions about (a) reasons for participating in spiritual deliverance as well as attending OPMHCs (b) type of mental health diagnoses, (c) impact of this dual treatment method on

participant and (d) which of the methods they preferred. A semistructured virtual interview facilitated a smooth flow of the conversation into unexpected and unplanned areas as participants responses directed the interview. All interviews were audio-taped and later transcribed. I also assigned pseudonyms to all participants.

Population

The main goal of this transcendental phenomenological research was to collect rich data from specific participants who described their phenomenological lived experience, so I was able to gain clarity on the phenomenon under study (Creswell, 2013). The research population included active members from one Pentecostal church in the state of Maryland in the United States. As the researcher, I had a zoom call with the Founder and President of Christ Throne Ministries and explained the purpose of my study, after which I forwarded flyers to him with my contact information for any interested participants to contact me on or before a given date.

Sampling Strategy

In qualitative research, purposeful sampling provides a detailed and context-rich account of a given population and qualitative researchers have the tendency to deliberately select participants based on their unique ability to appropriately and satisfactorily answer the questions. This approach is considered purposive, or purposeful strategic sampling (Patton, 2015; Ravitch & Carl, 2016). Purposeful sampling, therefore, is when the researcher purposefully choses certain individuals to participate in the study because they, for example, have experienced a particular phenomenon, in other words,

are particularly knowledgeable in what I desire to explore in the study, and live in a specific geographical location.

Purposeful sampling also enables researchers to intentionally select participants and research locations that will permit them to get the information needed to answer their research questions (Patton, 2015; Ravitch & Carl, 2016). Consequently, I used purposive sampling for my research as it enabled me to include interviews with rich data that most closely resembled the objectives of the study (Ames, Glenton, & Lewin, 2019). “This involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest” (Palinkas et al. 2015, p. 2). I presented my study to Founder and President of Christ Throne Ministries and then sent him flyers so that willing participants with experience of the phenomenon being studied could volunteer to participate in the study. I also focused on participants living in the state of Maryland. They. however, were participants I had never met, and I had no knowledge of them.

Saturation and Sample Size

I chose a purposive sample (Frankfort-Nachmias et al. 2015) of about 4-7 BCPW as participants in the state of Maryland. I gathered additional participants until I reached a saturation point (Malterud et al. 2015; Marshall et al. 2013; Sousa, 2014; Tran et al. 2016). The choice of a purposive sample was because sample size is an important consideration that researchers give when selecting their participants depending on what they desire to know, the purpose of the study, what is at stake in terms of credibility, what will be useful, as well as what can be achieved within a given time and resources (Cleary

et al. 2014; Marbley et al. 2015; Marshall et al. 2013; Ravitch & Carl, 2016). The purposeful sampling strategy that I used was saturation or redundancy sampling in which I analyzed patterns as the interviews proceeded and I continued to add to the samples until I realized that nothing substantive was added to the collected data. In other words, until I reached my saturation point (Ravitch & Carl, 2016; Tran et al. 2016). To reach this saturation point, after using purposive sampling beginning with two or three interviewees with information-rich and relevant information, I then used the chain sampling approach whereby I asked the selected participants for more relevant contacts who could give different but useful perspectives. By so doing, I developed a chain of potential participants from individuals who knew other people who could be useful sources and recruited them as the need arose or until I got to my saturation point (Ravitch & Carl, 2016 Tran et al. 2016).

Instrumentation

In qualitative research, research instruments are tools that researchers use to collect their study data. These instruments which could also be called guides or protocols, include the research questions, procedures, and/or prompts that guide data collection (Ravitch & Carl, 2016). The instruments I, therefore, used for this research topic included observation sheets, interview protocols, video and audio tapes. I also used semistructured interviews to gather data from the participants and then continued with follow-up interviews to address unclear or missing information, misunderstandings, and fill gaps in data. I also used journaling to document any preconceptions, biases, concerns, or new collected data. Journaling not only enabled me to delve into the rich descriptions as I

noted important interactions between participants and myself (O'Brien et al. 2014) but also added value to the study by helping me to document body language and meaning (Creswell, 2013).

Data Collection

According to Englander (2012), in transcendental phenomenological research, there are two ways of gathering data if the researcher needs information about the lived experiences of another person. The first way is the traditional face-to-face interview while the second way is to request for either a written or a recorded account of the lived experience. Generally, the face-to-face interview is longer and richer in terms of its depth and nuances. However, in order to build trust with my participants, review ethical considerations and fill consent forms, I conducted a preliminary meeting via zoom with my research participants about a week before the actual interview. During this preliminary meeting, I reviewed the research question so that the participants would have time to dwell and ponder on their lived experiences. As the researcher, during the interview, I was also able to get a richer description of the phenomenon without having to ask many questions (Englander, 2012). To collect data from my participants for this research study therefore, due to COVID-19 considerations, I used a HIPAA compliant, web and videoconferencing zoom service. I also made sure there was the possibility of telephone communication not only to maximize the availability of participants, but also as a backup to address any technical issues with the zoom service. I recorded the interviews using an audio recording device (McDowell, 2019). I also used a semi-structured interview protocol and conducted follow-up interviews to fill any gaps in data.

The follow up interviews specifically addressed missed or unclear information, and misunderstandings that arose during the first interview. I also used journaling for data reflection as well as to document new textual data, and/or any preconceptions, concerns, and biases (O'Brien et al., 2014). It also added value to the research by enabling me to register rich and deep descriptions as well as note body language and document transferability of the findings any obvious interactions between the participants and me as the researcher (O'Brien et al., 2014; Phillippi & Lauderdale, 2017).

Data Analysis

Considering that there has been no research in this area, I have deemed transcendental phenomenology to be an appropriate method for this research topic because it is about understanding the participants' lived experiences "without the lens of personal biases, assumptions, and preconceptions" (Buser et al., 2016, p. 329). Hence, to guard against my own experiences having a negative impact on the data analysis process, I discussed potential biases that might negatively influence data analysis with my research committee members. I also discussed my own personal experience with this topic in that I had witnessed a few spiritual deliverance sessions in a church, and also highlighted clinical experiences I had had with clients who had undergone spiritual deliverance for mental health-related issues. As the researcher, I agreed to remain conscious of these preconceptions and experiences when engaged in my data analysis to minimize the impact on codes and themes identified in the stories of participants. This was the epoche stage of transcendental phenomenology (Buser et al., 2016).

Hand-Coding Steps

In order to highlight descriptive themes that bring out the essence and meaning of participants' lived experiences (Moser & Korstjens, 2018), I will apply Moustakas' (1994) modified Van Kaam data analysis in this transcendental phenomenological study to provide meaning to the lived experiences of Black women who go to OPMHCs for treatment after going for spiritual healing in their churches. Manual hand-coding without the use of any electronic software not only enabled me to maneuver the generally complex and distinctive elements of analyzing data but also maintain ownership and control of the data analysis process (Saldaña, 2016; Peoples, 2021).

Moustakas' (1994) modification of the Van Kaam method of analyzing phenomenological data is made up of the following seven steps that I will carefully apply to participants' data (Sullivan & Bhattacharya, 2017): horizonalization, reduction and elimination, clustering and thematizing, validation, individual textual description, and textural- structural description. Considering that Moustakas' (1994) modified Van Kaam method of phenomenological data analysis is one of rigor and structured processes, in this phenomenological research study, the transcript of each participant was extensively reviewed following this method. I then followed the epoche protocol by taking out any bias and preconceived thoughts so that I was able to appreciate the experiences from an objective perspective (Moustakas, 1994).

To this end, the first step that I applied in the modified Van Kaam data analysis method was horizonalization. This step required a listing of all expressions that were pertinent to the lived experiences as I gave corresponding value to each statement made

(Moustakas, 1994). In the second step, I identified invariant elements and determine if the language used would provide understanding and a faithful representation of the experienced phenomenon (Moustakas, 1994). The third step in my data analysis process was to put together similar invariant elements into thematic labels that became central themes of the lived experience (Moustakas, 1994). I then clustered the constructed meaning units and themes as I used horizonalization to bring out meaningful expressions from the interview transcriptions (Moustakas, 1994).

The fourth step was the application validation, which necessitated checking the central themes against the entire transcript to make sure the themes were clearly expressed and compatible, if not they were eliminated (Moustakas, 1994). This step required "evidence from the participant's own words" (Grumstrup & Demchak, 2019, p. 118). In the fifth step, I used the validated themes to build an individual textural description of the lived experience for each interview transcription of the participant (Moustakas, 1994). The sixth step involved the development of structural descriptions of the overall experience of each participant based on the previous constructed textual description and the incorporation of imaginative variation (Moustakas, 1994).

For the seventh and last step, I came up with a textural-structural description of the lived experience for every participant as I conveyed the essence and meanings of these lived experiences, and included the invariant elements and themes (Moustakas, 1994). I then brought together all the individual structural descriptions into a group of universal structural descriptions of the meanings and essences of the lived experiences of BCPW during their mental health treatment and spiritual healing sessions. The

culmination of the modified Van Kaam data analysis method required creating one general description that embodied the overall meanings, essences, and lived experiences of the participants as individuals and as a group (Carter & Baghurst, 2014; Moustakas, 1994).

This modified Van Kaam data analysis method has been used in other phenomenological studies to identify themes, relationships, and connections between the lived experiences of participants (Anthony & Weide, 2015; Grumstrup & Demchak, 2019). Consequently, this method enabled me to develop themes from the data I collected to assign and describe the essence and meaning of how BCPW who have undergone mental health treatment as well as spiritual healing described their lived experiences.

Software

Although I did not use any software to code data for this phenomenological research study, I, nevertheless, used Nvivo to organize and manage data storage. I manually hand-coded the collected data for this research study based on Moustakas' (1994) modified Van Kaam data analysis method. Nvivo could be restrictive and limiting for researchers like myself who preferred visual and kinesthetic work processes (Maher, Hadfield, Hutchings, & de Eyto, 2018). For example, with Nvivo there was a limited amount of data that could be easily seen on a computer screen at any one time (Maher et al., 2018). In the end, therefore, the obligation to analyze data remained mine (Najda-Janoszka & Daba-Buzoianu, 2018).

Coding

Coding began as I reviewed the interview transcript of each participant following the modified Van Kaam method of data analysis (Moustakas, 1994). Considering that coding is part and parcel of data analysis in a qualitative research study, the coding process was made up of labels, themes, or tags that I generated to give meaning to the data (Williman, 2017) and describe the essence of the data (Clark & Veale, 2018). I manually coded data for this phenomenological research study by using the 7 steps of the modified Van Kaam method (Moustakas, 1994). Qualitative research usually generates huge quantities of data so during the process of developing codes, I had a codebook with code descriptions to back up the organization and trustworthiness of the collected data (Rogers, 2018).

Specific Recruitment Steps

Inclusion criteria for selection was made up of the following: 1) the participant must identify as a Black female over the age of 20; 2) she must have undergone at least one deliverance session within the last 12 months; 3) she must have attended an OPMHC within the last 12 months; 4) she must be an active member of Christ Throne Ministries; 5) she must have a lived experience of the phenomenon being studied; 6) she must have had an interest in understanding its essence; 7) she must be willing to take part in an extensive recorded interview; 8) she must have granted permission for the research to be published in a dissertation (McDowell, 2019). After selecting seven participants for the study, I used the network and snowball technique associated with purposive sampling by

asking the originally selected candidates to recommend potential participants who met the qualifying criteria (Merriam & Tisdell, 2016).

Network and snowball sampling is the most popular method for identifying research participants in purposive sampling and is administered by requesting a small group of current participants to refer others they know who may meet the sample criteria (McDowell, 2019). Consequently, I applied the network and snowball technique to this phenomenological study because it increased the possibility of identifying an unknown sample population that I might not have been aware of (Jorgensen & Brown-Rice, 2018).

Participants for this study were recruited via the social media site Facebook which is the number one social media site pastors are now using to communicate with their church members due to Covid-19 demands for social distancing. “The size and reach of the Facebook platform offers researchers an unprecedented opportunity to acquire large and diverse samples of participants” (Kosinski et al. 2015, p. 544). Request for participation in this study was therefore be sent via sharing direct messages on the church’s Facebook site where I used the snowball technique. According to Kosinski et al. 2015, snowball sampling is one of the cheapest ways of drawing out of the Facebook participant pool and of convincing Facebook users to invite their friends to join a given study and rapidly increase sample size.

In analyzing my data, I reached a consensus on codes, units, themes, and textural–structural descriptions. First, I coded each transcript and in the coding process, I labeled all participant comments which were ‘‘significant for the description of the experience’’ (Buser et al. 2016, p. 329). Following my agreement on codes, I identified meaning

units/horizons for every transcript and identified themes in each transcript as I found similarities in the meaning units (Buser et al., 2016). In this process of data analysis, I also engaged in transcendental-phenomenological reduction whereby I aimed "to formulate a rich, accurate, detailed description of the participant experience, returning to the original transcript and incorporating the participant's own voice in the description" (Buser et al., 2016, p. 329). As I followed this process for each participant, I compiled a list of common themes that ran across participants' stories. My dissertation committee members then read about 25% of the transcripts and provided comments and feedback on areas of agreement as well as make suggestions for modification. After reviewing their comments, I revised the themes to conduct a member check as I was able to contact all four participants.

Researcher-Developed Protocol

I developed a protocol which I used to capture the lived experiences of the BCPW. The questions I used were developed following the proposal I submitted to the Internal Walden IRB to make sure the open-ended questions were adequate to collect rich and deep data on the phenomenon under study (Buser et al., 2016). The purpose of the open-ended questions in this study was not only to have a guided conversation but also to elicit free and honest responses. Transcendental phenomenology encourages the researcher to collect data from interviewees during the researcher's conversational interview with the participant (Holroyd, 2015). These interview questions enable the interviewer to focus the topic and to analyze the collected data (Buser et al., 2016). Consequently, I developed two instruments to focus the topic and help in the analysis of

the collected data. The first instrument was the short demographic information sheet (See Appendix A) which I used to determine who would not meet all qualifications. The second instrument comprised the interview questions (See Appendix B). Answers to the research question were registered in an audiotape and I later transcribed these answers. After transcription and data analysis, the transcriptions were sent back to the participants for clarification of meaning and interpretation of what they said.

The researcher-developed protocol used to explore the lived experiences of BCPW who go for spiritual healing in their churches and attend OPMHCs were interview questions developed by me as the researcher. The questions were developed following the proposal I submitted to the Walden University Internal Review Board (IRB) to make sure the questions were appropriate to collect the right data for the given phenomenon. In this 7-question protocol, I used open-ended questions to get deeply rich responses from participants who had lived the experience (Bradbury-Jones et al. 2014).

Following the analysis steps of Creswell (2014), considering that in qualitative research, data analysis proceeds together with data collection, while I was still conducting interviews, I was also analyzing an interview I had earlier conducted. I was equally writing memos that I could eventually include as a narrative as I organized the structure of the final report. I also observed the body language and other non-verbal clues of my participants as I interviewed them. However, considering that text and image data could be densely rich, in the analysis of my data, I focused on some of the data and disregarded other parts of it. The answers to the research questions which were later transcribed, were recorded by audiotape. In order to enable member checking, I sent the transcriptions to

the different participants for them not only to check for accuracy, but also to clarify and validate the meaning and interpretation of what I recorded (Creswell, 2014).

Issues of Trustworthiness

According to Christensen and Brumfield (2010), the soundness of all qualitative research is based on its trustworthiness which includes the study's transferability, credibility, confirmability, and dependability. In other words, as opposed to validity and reliability, trustworthiness means consistency, applicability, truth value, and neutrality (Christensen & Brumfield, 2010).

Credibility

Credibility is when qualitative researchers demonstrate believability and give assurance that the conclusion they have drawn in their studies make sense through persistent observations, prolonged engagement, triangulation, dependability, transferability, and confirmability (Creswell, 2014). Prolonged engagement which offers scope and persistent observations that provide depth, are processes which prove that as the researcher, I have invested enough time to establish trust with my participants as I learned about their environmental culture and socialization process inherent in the phenomenon being studied. With persistent observation, I assessed different opportunities in order to identify characteristics within several situations that were most relevant to the phenomenon under investigation. I will, therefore, have to address dependability, transferability, and confirmability to ensure credibility of my findings though triangulation, prolonged contact, member checking, saturation, reflexivity, and peer review. I had continuous consultation with my participants in order to present a direct test

of the effective fit of findings and interpretations of data as they emerge. This meant that as a phenomenological researcher, I asked my participants to review their descriptions and interpretations of their experiences (Christensen & Brumfield, 2010). As for saturation, "when a category becomes saturated, the gathering of new data fails to stimulate additional theoretical insights and adds nothing substantive to the emerging theory" (Buckley, 2010, p. 128). I, as a result, stopped gathering data when the information collected loses its relevance.

Reflexivity happens when the researcher scrutinizes the research process, interpretations and decisions, and the extent to which the researcher's positions, interests, and assumptions are influenced during the study. As theory is built up, therefore, reflexivity helps put the researcher's personal biases, preconceived ideas, and values into perspective (Buckley, 2010). As for peer reviewers, they also help in providing feedback on the quality of the study, its scientific merit, as well as the degree to which the study will inform future work (Cashwell & Kardatzke, 2010).

Transferability

Transferability is the degree to which results of a study could be applicable to other settings and contexts (Ravitch & Carl, 2016). To that end, therefore, as a qualitative researcher, I provided only the thick description which helped an individual decide whether a transfer could be possible. In other words, I provided as many details and the widest extent of information as possible for inclusions in the interpretation of data and final report of the study. Rich and detailed in-depth descriptions of the participants, interviews and observations, and the specific steps that I took as I collected, interpreted,

and reported the data using my reflexive journals, were some of the ways I was able to give a full and satisfactory report of the research process (Ravitch & Carl, 2016).

Dependability

The appropriate strategies that I used to establish dependability which is the qualitative counterpart to reliability, and which demonstrates the consistency of the study results across researchers and over time, was for me to use the strategies of audit trials and triangulation (Christensen & Brumfield, 2010). To establish dependability which was inextricably linked to the credibility of my study, therefore, I used the services of my dissertation committee members who were able to explore my reflective journal during the data collection and data analysis process, and then, determine whether the results of the study could be dependable (Christensen & Brumfield, 2010). As I used the triangulation strategy, I also used many different methods and sources to gather information that were pertinent to the study. I equally used participants who were able to back up my assertions and interpretations of the collected data (Christensen & Brumfield, 2010).

Confirmability

As for the establishment of confirmability which is the qualitative counterpart to objectivity, I used the reflexivity strategy to establish it considering that with confirmability, the study's findings reflected the natural environmental perspectives of the participants. As such, confirmability directly addressed whether my subjectivities and biases interfered neither with data collection and analysis nor with the ongoing interpretations and my final report (Christensen & Brumfield, 2010). In terms of

researcher bias, I had to present life circumstances, my opinions, and any potential assumptions or biases that could have a negative impact on the study from the outset and throughout the data collection and data analysis process (Christensen & Brumfield, 2010).

Accordingly, it behooved me as the qualitative researcher to state my perceptions regarding any personal and professional motives for conducting this study; describe any personal or professional connections with the participants and/or the phenomenon under study and mention any assumptions or biases that I had about the phenomenon being studied (Christensen & Brumfield, 2010). As I maintained and reviewed a reflexive journal and audit trail throughout the duration of the study, peer debriefers continued to ensure my biases did not interfere with the research process and findings (Christensen & Brumfield, 2010).

Ethical Procedures

In qualitative research, considering that the researcher interacts with participants as observer and data collector, ethical issues would likely occur before conducting the study, at the beginning of the study, during data collection and data analysis, while reporting the data, and when publishing the study (Creswell, 2013). Consequently, prior to the study, ethical issues in qualitative research included seeking university approval, examining ACA Standards, gaining local permission from participants, selecting a site without a vested interest in the outcome of the study, and negotiating authorship for publication. I addressed these issues by submitting for the Walden University IRB's approval (Creswell, 2013).

As I began to conduct the study, the type of ethical issues that arose included disclosing the purpose of the study, putting pressure on participants to sign consent forms, and being aware of the needs of the female vulnerable population. I addressed these issues by contacting participants and informing them of the purpose of study, telling them that they were not obliged to sign consent forms, and finding out about their diverse cultural differences that I needed to respect (Creswell, 2013). During the data collection and analysis process, the ethical issues that could likely arise included deceiving participants, disrespecting potential power imbalances, using participants by gathering data and leaving without giving back, siding with participants, disclosing only positive results, and disrespecting the privacy of participants. I addressed these issues by building trust with participants, discussing the purpose of the study and how data would be used, avoiding to use leading questions, not sharing personal impressions, not disclosing sensitive information, providing rewards to participants, reporting different perspectives and contrary findings, and assigning fictitious names (Creswell, 2013).

While reporting data, the types of ethical issues that might likely occur included the falsification of authorship, evidence, data, findings, and conclusion; plagiarizing, disclosing information that would harm participants, and not communicating in clear, straightforward, appropriate language. In addition, during the interviews, I could learn of the abuse of a child or an elderly person. I addressed these issues by honestly reporting collected data, consulting ACA (2014) guidelines for permission needed to reprint or adapt work of others, using composite stories so that individuals could be identified, and using the appropriate language for the research audience (Creswell, 2013). As for

learning of the abuse of a child or an elderly person, if I had learned of any, I would have been mandated as required by Standard B.2.a of the ACA Code of Ethics (ACA, 2014) to report the matter to the appropriate authorities. However, the general requirement that counselors keep clients' information confidential "does not apply when disclosure is required to protect … others from serious and foreseeable harm…" (p. 7).

Ethical issues that might likely occur while publishing the study will include not sharing data with others, duplicating or piecemealing publications, not completing proof of compliance with ethical issues and lack of conflict of interest, if requested. I would address these issues by providing copies of report to participants and stakeholders, share practical results, consider website distribution and publishing in different languages, not using the same material for more than one publication; and disclosing funders for research as well as those who will profit from the research (Creswell, 2013).

Summary

In Chapter 3, I re-stated the purpose of the study, followed by a discussion on the research design with the central concept being transcendental phenomenology. I then explained the role of the researcher, researcher bias and my deliberate use of the bracketing approach to minimize all biases. I equally mentioned possible ethical issues and how I will address them. I then outlined my methodology which included population with choice of purposive sampling and use of semi-structured interviews. I also explained my sampling strategy, the difference between sample size and saturation, the kinds of instrumentation used with the development of a protocol. For the soundness of my research study, I delved into issues of trustworthiness which included transferability,

credibility, confirmability, dependability, as well as ethical issues likely to come up and how I would address the issues.

Consequently, facilitating a healthy professional collaboration between church leaders and mental health professionals would result in much improved mental health services to congregants (Bledsoe et al, 2013). Also, considering that there seems to be a cultural gap between mental health counseling professionals and the congregants they treat (Dein, 2018), and that there is a dearth of research to examine the mental health effects of religious experiences like deliverance/exorcism (Dein, 2018), healthy collaboration between these two professional bodies will potentially provide mental health expertise within a culturally-relevant context to the needy congregants (Dempsey et al., 2016).

Chapter 4: Results

The purpose of this transcendental phenomenological study was to explore the lived experiences of BCPW who seek spiritual deliverance and healing of their mental health conditions from their church clergy (Mercer, 2013; Rowan & Dwyer, 2015) and go to OPMHCs for treatment (Friedlander et al. 2014; Hays, 2015). To explore these experiences, I used a qualitative transcendental phenomenological approach (Buser et al. 2016; Choi, 2018; Wilson, 2014) for this study. An article by Rowan and Dwyer (2015) indicated that more women than men tend to seek treatment from their church leaders through deliverance practices. Consequently, I highlighted the importance of respecting the stipulations in Standards F.2.g., Section 2, and Standards A.2.f., A.3.b., D.2.m., Section 5 of CACREP (2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014).

These standards all stress the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study will inform professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals will have effective multicultural strategies to deal with this group (Ratts et al. 2016; Rowan & Dwyer, 2015). In this chapter, I also present the research setting, demographic data, data collection and analysis procedures, evidence of trustworthiness of the qualitative data, and finally, a composite of the study results.

Research Question

RQ1. What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church?

Preview of Chapter Organization

I explain the results of this study by first describing the setting in which the interviews took place. Second, I review the demographics of the four participants to identify similarities and differences among them. Third, I review the data collection process and any effect it might have had on the study. Fourth, I review the coding analysis process and the outcome of the collected data. Fifth, I evaluate the trustworthiness of the research process as well as the research findings. Finally, I summarize the resulting themes that I identified from the collected data.

Setting

Due to COVID-19 restrictions, all interviews were held virtually via Zoom. According to Woodyatt et al. (2016), the use of an online modality such as Zoom for qualitative research has proven effective in the collection of information-rich data from participants. I also obtained a protected Zoom membership, which was in compliance with HIPAA regulations. I equally requested all participants to choose securely convenient and quiet locations to ensure their privacy. They all chose the comfort of their homes to participate in the virtual meetings, probably due to COVID-19 restrictions that required people to stay in their homes, maintain strict social distances, and only go out in case of extreme necessity. At the time of this study, the COVID-19 virus was widespread,

with “common signs of infection includ[ing] respiratory symptoms, fever, cough, shortness of breath, and breathing difficulties. In more severe cases, the infection can cause pneumonia, severe acute respiratory syndrome, kidney failure, and even death” (Priyadarshini et al., 2020, p. 148).

At the time of this interview, although some individuals had already been vaccinated in Maryland, church services were still being held virtually, as most church members preferred to stay home and watch online church services. Semistructured interviews were, therefore, conducted to explore the lived experiences of BCPW who sought community mental health counseling concurrent with deliverance practices through the church. They were expected to have lived these experiences within the last 12 months before COVID-19 restrictions were put in place. One technological challenge that I encountered had to do with one of the participants whose internet connection kept freezing and sometimes completely disconnected. As a result, we had to reschedule the interview session for the next day. Aside from this challenge, the rest of the interview sessions went smoothly, and transcription was seamless.

Demographics

Each participant completed a demographic form (Appendix A) before participating in the study, and study criteria included a minimum of three to seven participants needed to comply with data saturation (Ravitch & Carl, 2016). Following the procedures that I outlined in Chapter 3, participants included only female Christian Pentecostal women. Participant pseudonyms, along with race/ethnicity, age, level of

education, occupation, and first language information for the female participants, are presented in Table 1.

Table 1

Participants' Demographic Information

Participant pseudonym	Race/Ethnicity	Age	Level of education	Occupation	First language
Beauty	Black/African	28	Master's degree in civil	Project manager	English
Happy	Black/African	24	Master's degree in applied intelligence	Job applicant	English
Mystic	Black/African American	41	Bachelor of Science	Registered psychiatric nurse	English
Lovey	Black/African American	42	Doctor of Philosophy	University professor	English

Data Collection

Following procedures outlined in Chapter 3, I recruited seven participants. However, I stopped interviewing participants after I realized that the information I had gathered from the fifth and sixth participants was not different from what I had collected from the first four participants. In other words, I believed that I had reached my saturation point. According to Trans et al. (2016), "data saturation is the point in data collection and analysis when new information produces little or no change to the codebook" (p. 88). Consequently, a total of seven participants were recruited, and data collected from the above-mentioned four participants were used for data analysis. All participants were Pentecostal Christians who were also members of Christ Throne Ministries. All other demographic information can be found in Table 1 and Table 2. I

started the data collection process after receiving IRB approval # 03-09-21-0337633 on March 9, 2021, from the dissertation process of Walden University.

Based on the guidelines in Chapter 3, I started by presenting my study invitation to the Founder and President of Christ Throne Ministries, who posted the study invitation on the Ministry's Facebook page inviting interested participants to directly contact me. Although I received more than 10 calls from women who were interested in participating in the study, some of them did not meet the study criteria. Through a process of elimination, I ended up choosing seven of them. Although I interviewed six participants, I chose four of them for data analysis when I realized that I had reached my saturation point, considering that no new theme or additional information emerged from the fifth participant's responses.

According to Trans et al. (2016), "data saturation is the point in data collection and analysis when new information produces little or no change to the codebook" (p. 88). Consequently, a total of seven participants were recruited, and data collected from the above-mentioned four participants were used for data analysis. For purposes of confidentiality, the four participants whom I chose were each provided a pseudonym. To that end, Participant A is known as Beauty, Participant B as Happy, Participant C as Mystic, and Participant D as Lovey. In this transcendental phenomenological qualitative study, the data I collected came from the information and experiences of participants. Due to COVID-19 restrictions, the interviews were virtually conducted via Zoom. Demographic information was also electronically collected via email, and only the participant and I were present on each Zoom call in the comfort of our respective homes.

A total of six interviews took place during a 1-month period, and four were used for data analysis. I met once with each participant for a duration of 30–45 minutes. I recorded all the Zoom calls and used the recordings to transcribe the data.

Participant 1 - Beauty

Beauty, who stayed cool, calm, and collected, had earlier said that she was not comfortable accepting the invitation to be a participant in the study. On second thought, however, she decided to participate because she believed that it would be important for her to give her own experience of church deliverance and treatment from an OPMHC. After the initial debriefing and confirmation of her consent to participate, the interview went smoothly as she gave detailed descriptions and examples while answering her questions. Although Beauty talked of the need to believe in GOD and have the experience of an extraordinary power to help her go through her mental health concerns, she believed there were good and bad aspects of deliverance, with the good aspect being that the Presence of GOD could be felt. Nevertheless, she thought the deliverance process was scary because of the casting-out-of-demons experience. She added that although her first deliverance session started with prayer and the feeling of GOD's Presence, all other deliverance sessions she had were bad experiences, and as a result, she was never again going to subject herself to any deliverance session.

As she compared and contrasted deliverance and treatment from an OPMHC, Beauty said that her "experience with seeking treatment at an OPMHC was far better than my experience with deliverance." Concerning the role her pastor played in her mental health well-being, Beauty responded that her pastor always reminded her to follow her

faith and trust God. She also encouraged anyone having mental health issues to go for counseling at an OPMHC because counselors were better trained to handle mental health problems and they used a lot of compassion, were nonjudgmental, and always encouraged their clients to have hopeful expectations of their therapeutic outcomes. In other words, looking at the good even in a bad situation. She thought that was not only spiritually uplifting, but also helped her have a positive outlook on life, a disposition that deliverance ministers failed in guiding her to have.

Participant 2 - Happy

Happy, unlike Beauty, was excited to talk about her deliverance experience and said she would always prefer deliverance to going for treatment in an OPMHC. She said that deliverance in her church occurred through the casting out of demons, sharing the Word of God, or praying and sometimes fasting. Happy also explained that the reason she went for deliverance and for counseling at an OPMHC was because she was having serious issues with insomnia. Happy added that the experiences that she was having with insomnia had resulted in mental health issues such as depression, anxiety, and fear, and that was when her friend advised her to see a mental health therapist. Talking about which of the two (i.e., deliverance or counseling) helped her more, she said that although both helped her, she would always prefer to first go for deliverance. However, one difference she pointed out between her therapist and her pastor was that when it was time for her counseling sessions, her therapist would call her, while she was the one who always called her pastor whenever she needed help.

Participant 3 - Mystic

Mystic had professional experience working with patients diagnosed with mental health disorders and illnesses. Due to her professional background, therefore, she was excited and even passionate to participate in this study and was the very first participant to call me. However, she was the third participant I interviewed because of the time she chose to have the interview. After listening to her, I realized that not only did her responses englobe all that the first two participants had said, but she went into finer and richer details in her answers. She said that she had had several deliverances in her church and had also had to go to OPMHCs for therapy due to the nature of her job as a nurse case manager with the homeless and disenfranchised population in the Baltimore Inner City, and she explained that the sessions were very helpful. Describing the relationship between her counseling sessions and her deliverance experience, Mystic explained that they were mutually inclusive. She also said that her pastor played a very important role in supporting her for her mental health concerns.

Expressing her feelings about encouraging everyone to go for treatment at an OPMHC, Mystic thought that from a Black perspective, it was likely that because the term “mental health” was used, it seemed as if there was something wrong with the minds of the clients. Mystic, therefore, suggested that the term could be changed from “mental health” to “mental wellness” or “wholeness.” In that way, the expression would be accepted because people do not get upset when they are told to go see a doctor to check their diabetes, high blood pressure, or any other physical health condition. Consequently,

there would be nothing wrong with seeing someone for their mental wellness or wholeness, hence a normalization of mental health.

Participant 4 - Lovey

Lovey, just like Mystic, was not only excited in being a study participant, but also very emotional when she started narrating her lived experiences. She explained that she had had more experiences with counseling in OPMHCs than in the church, and like Beauty, her preference would be to choose counseling over deliverance, except the deliverance had to come about as a result of constant and persistent prayers. She also believed that deliverance was synonymous with demon possession, exorcism, and healing, and she added that prayer was an important ingredient for successful deliverance. Talking about her experiences in an OPMHC, Lovey explained that the experience was mixed due to the kind of therapists she had. On the use of medications, Lovey was emphatic about the importance of taking medications if the need arose and vilified those counselors who shied away from referring their clients to psychiatrists for the prescription of psychotropic medications.

Talking about the importance of training, Lovey was unapologetic about the importance of pastors being trained in counseling techniques and said that it would go a long way toward helping them understand what counseling professionals were doing, thereby creating a healthy working relationship between those two groups of professionals. Although she encouraged Christians to go for counseling at an OPMHC, she nevertheless recommended professional Christian counselors. On whether she

believed that deliverance in the church and going for treatment in an OPMHC were mutually inclusive if well handled, Lovey emphatically responded, “Yes.”

Data Recording Procedure

Before I started recording the interviews, the chosen participants all provided their consent to participate in the recorded interviews. Once completed, I saved a recording of each interview via Zoom and used the audio recordings for transcription purposes while the video recordings were used only by me to review the transcripts. Following the formal recruitment of six participants based on the guidelines in Chapter 3, each participant scheduled a specific time to virtually meet with me via Zoom. I had earlier obtained a paid Zoom membership that was HIPAA-compliant for my participants. Each interview session started with both of us discussing consent and process debriefing while I gave participants the opportunity to ask questions. I then started recording the interview, and each recording time was between 35 and 50 minutes.

The participants appeared to be comfortable and were very willing to answer all the questions I asked, including my follow-up questions, which provided for better clarity and richer data. However, while two of the participants maintained a calm and collected composure during the interview sessions, the other two, who seemed to be more knowledgeable in mental health issues, responded with stronger emotions throughout the interviews. After completion of the four interviews, I manually transcribed the audio recordings, causing the transcription process to be longer than if I had used the computerized automatic transcription program called NVivo Transcription. I then reviewed and listened to each interview for the purpose of accuracy and to edit any

mistakes and errors. After completing the transcription process, I emailed the transcripts to the participants, giving them options to review them and make any necessary corrections.

Variations in Data Collection

Following the plan presented in Chapter 3, there were no variations in the data collection process. Additionally, during the data collection process, I registered no unusual circumstances except the technological challenge that I encountered with one of the participants whose internet connection kept freezing and sometimes completely disconnected. However, we rescheduled the interview session to the next day and there was no problem anymore with her internet connection.

Data Analysis

According to Peoples 2021, "the term *data analysis* is not completely in line with phenomenological inquiry simply because '*analysis*' means *to break into parts* whereas phenomenological inquiry seeks to understand a phenomenon as a whole" (p. 57). However, in transcendental phenomenology, "the goal is to illuminate the essence of a phenomenon, the entirety of it without the corruption of personal bias" (Peoples, 2021, p. 57). For the data analysis of this study, therefore, I used the notion of phenomenological reduction/bracketing/epoche by intentionally suspending my judgments (Moustakas, 1994; Peoples, 2021). According to Husserl, the real essence of a situation resulted from lived experiences of individuals. Consequently, as I was coding and analyzing my transcripts, I had to remain faithful to participants' demographic forms, my journal entries, and interview transcripts. These three sources helped the triangulation process of

the collected data thereby ensuring that I completed the coding process in an unbiased manner (Moustakas, 2014; Patton, 2015).

Transcription

Once I completed the zoom interviews, I went on to manually transcribe the audio recordings. According to Saldaña (2016), "there is something about manipulating qualitative data on paper and writing codes in pencil that gives you more control over and ownership of the work" (p. 22). Also, in (Peoples, 2020), the narrator encouraged researchers to hand code their transcripts to stay in the transcendental experience of empathy and intuition. As soon as I finished transcribing each interviewee's transcript, to make sure I missed out on nothing, I had to listen to and review each interview, editing the scripts as many times as I could for the sake of accuracy. Once this process was completed, I emailed the transcripts to the participants for their review. Two participants added more information that was not on the original transcript, and I was happy because the additions helped improve the richness of the collected data.

Codes, Categories, and Themes

Based on Saldaña, (2016), "coding in most qualitative studies is a solitary act" (p. 26). Consequently, before starting the coding process, I first listened to the interview recordings at the same time as I was reading the transcriptions. I was also following systematic content analysis to remove any potential assumptions and/or biases (Moustakas, 1994). Second, instead of using a computer or a monitor, I followed the recommendation of Saldaña (2016) to code on hard-copy printouts since I was doing a study for the first time. I, therefore, printed out each participant's transcript and started

using different colored highlighters to represent the codes, categories, themes, concepts, and theories as "part of my codus operandi" (Saldaña, 2016, p.22). Third, I re-read and coded the printed transcripts, one participant at a time. This approach not only enabled me to remain faithful to Husserl's perspective of understanding the lived experience of each individual participant (Husserl, 1931), but it also gave me an opportunity to continue with systematic content analysis with each interview before coding. Fourth, I used bracketing to combine the codes into categories which I then put them under specific themes which emerged during the bracketing process.

During this process, three main themes and three sub-themes under the first theme continually emerged from the collected data for data analysis. These themes included: (1) Deliverance versus Counseling with the sub-themes being: A) Professional Collaboration, B) Training, C) Prayer, D) Talk Therapy, (2) Christian Counseling in OPMHCs; and (3) Mental Health Disorder or Demonic Possession?

Table 2

Table of Themes and Subthemes

Theme	Beauty	Happy	Mystic	Lovey
Deliverance versus counseling	X	X	X	X
Christian counseling in OPMHCs	X	X	X	X
Mental health disorder or demonic possession	X	X	X	X
Subtheme				
Professional collaboration	X	X	X	X
Training	X	X	X	X
Praying	X	X	X	X
Talk therapy	X	X	X	X

Theme 1 - Deliverance Versus Counseling

According to Mercer (2013) "deliverance also known as exorcism or expulsion [casting out] of demons, is the primary mode of treatment of mental illness thought to be caused by demonic possession" (p. 602). Christians attending Black Pentecostal churches consider deliverance as a higher form of healing since the deliverance minister commands the demonic spirit which has held the deliveree in bondage to come out in the Name of Jesus. For effective intervention, therefore, the demon-possessed individual can only be healed when the Name of Jesus Christ is pronounced to cast out the demonic spirit (Rowan & Dwyer, 2015). The need for counseling professionals to understand

beliefs in deliverance is highlighted by the existence of almost 80 million Pentecostal Christians in the United States (Mercer, 2013).

Mental health counseling is when counselors or therapists have therapy sessions that include traditional psychotherapy approaches and problem-solving techniques with the intent of changing the presenting problem(s) of their clients (Kowalczyk, 2013). Mental health counseling is also referred to as clinical mental health counseling since it is based on evidence-based research and uses techniques that have been proven to be effective (Peterson, 2019). In this study, the four participants all stated that deliverance and mental health counseling/therapy had the same goals which are to help people to be free from the presenting mental health issue they are dealing with. The only difference is that deliverance is based on spiritual beliefs while counseling is based on evidence-based clinical approaches.

On the theme of Deliverance versus Counseling, Beauty, stated,

> I think my experience with counseling has been far better than my experience with deliverance. The fear factor of casting out of demons makes me not like to go for deliverance because it increases my anxiety and depression. Meanwhile, with mental health, the therapist calms me down and always reassures me that as long as I cooperate with her, I'll be alright and there's nothing to be afraid of. It's always reassuring. My first deliverance session I felt that it was real, I guess there was a good aspect of it but then the bad aspect of it was that it was scary for me because it was like I was under some sort of demonic oppression and the demons

were being cast away, but then I did feel the Presence of God and I think for me that was where my life took a different.

Happy also said,

> They both wanted to help me out, like they were so interested in helping me go through this phase of the insomnia. However, my counselor was more concerned about my mental health and other things that affected my sleep while the pastor was using the Word of God to help me. Both of them were helping me change my mindset, but at the same time one was from the knowledge and experience of counseling with no prayer while my pastor was doing it from the knowledge of how the Scriptures had helped deliver other people. With my pastor it was more spiritual, casting and binding, use of anointing oil, Holy water, prayers, which I would say did work. I would still encourage everyone to go for counseling if they don't have the faith that they can be healed through prayers and the Word of God. Deliverance in my church is by casting out of demons. You could also be delivered in church by the Word of God… we also had several sessions of prayers to cast and bind all of these problems…I'd say that the time that deliverance has been most effective in my life has been when in my heart I've had the burning and the desire of GOD, and I don't know where to find it. I needed an extraordinary power to help me go through what I was going through.

Mystic explained,

> Counseling will never do what deliverance will do but counseling is a form of deliverance. I strongly believe that anxiety is a form of bondage that can very

easily be broken off with deliverance but after that has been broken off, if you are dealing with a Christian counselor who understands about using the Word of God to build you up, counseling is a good way to maintain your deliverance. They are mutually inclusive, and I recommend both for everybody. You don't therapy demonic oppression, you don't therapy yokes and bondages, you can't fix them with medication. They can only be broken in the church through deliverance. Unfortunately, a lot of churches only wanna do deliverance every day, every day, every day, and after that deliverance the people keep going back to bondage because churches are just being scared that if people go to therapy and take medications, it means that God's Power is not strong enough for them. Mental health treatment is very necessary. The only thing that I would encourage and advocate for in the Christian community and in the mental health community is that both communities should be humble enough to accept that they don't have all the answers and that for the benefit of their congregants and clients, they should have a healthy and cooperative working relationship. A holistic perspective of treatment will be **a** wise person who has a therapist and a deliverance minister. If you can recite positive affirmations one of the things that they tell you all the time is to speak positive words yet there's nothing that's more positive and effective than the Words in the Bible. I've sometimes seen them work even better than medications. The mental health community should be ok with that especially if they are more concerned about the success of their clients. Deliverance is anytime you're transformed from darkness into God's Light, anytime you go from any

> form of bondage into freedom, that's deliverance. I've gone to deliverance services, and they would for pray for you deliverance prayers to break spiritual bondages so maybe if you're suffering from insomnia, they'd pray for you to deal with the demonic oppression that is causing insomnia. I used to have a lot of very terrifying and horrific dreams and it is in the place of deliverance that I stopped having all those dreams. It's only as I went to several deliverance sessions that now I'm able to sleep very well without any sleep aids whatsoever. I've had healings that came at the place of deliverance and I'm a very strong proponent of deliverance for every single person. The church also grooms some people too who are well-versed in spiritual warfare, who are well-versed in casting out demons and breaking yokes and shackles.

Lovey equally said,

> I think they both have value because to me, mental health counseling that's done through Christ is a form of healing, a form of deliverance. As a practicing Christian, if you're demon-possessed, you'll need deliverance. It's not something that the mental health profession can help you with. At the same time, I don't like it when pastors say that mental health counseling is not good because it is the secular way of doing things. "All you need is the Bible, and you need to pray because that's how you're going to get your healing." I think both have value and I believe God gave us brains to have counseling to help people, but I also believe that without the power of God, counseling will not work. God has different ways to heal people so, I think that the Christian community and the mental health

> community need to learn the value of both and instead of attacking each other, they should accept and embrace each other so they can better help their people. I remember there was a demon-possessed woman, and they were going to exorcise her, and they were planning to fast and pray to exorcise the demon possession. People need God in their lives for real healing. You can't put a band aid on a bleeding hurt, you can help only so much if you don't bring God into it. I strongly believe that people who have a personal relationship with God fare much better than those who don't because the missing aspect keeps them stuck in their mental health problems. I still have mine but it's much better than someone who has the same problems without God.

Subtheme A - Professional Collaboration

In scientific research, it is stated that since church leaders lack the skills needed to deliver effective mental health therapy, a healthy collaboration between clergy and mental health professionals will bridge the gap for more effective therapeutic outcome, as clergy attend retreats, workshops, and conferences organized by counseling professionals (Ano et al., 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016). Through this collaborative relationship, clergy will also be able to help counseling professionals with ethical issues like praying with clients and incorporating other religious/spiritual acts during therapy sessions. In addition, collaboration between counseling professionals and church leaders will encourage Black churches to draw up policies for the training and empowerment of the clergy so they can have the right skills, strategies, and approaches to

effectively take care of their clients with mental health problems (Ano et al., 2017; Asamoah et al., 2014; Hays, 2015).

In their interviews, therefore, Beauty explained,

> I think first the mindset in going into deliverance … the eagerness, the desire, or the want for something and it's not happening. For me, I'd say that the time that deliverance has been most effective in my life has been when in my heart I've had the burning and the desire of GOD, and I don't know where to find it. However, I know that going to an out-patient mental health clinic to see a professional counselor is very important in balancing my mental health state because I have anxiety, I overthink situations which could easily lead to depression and so it's important for me to know my mind needs to always be in a healthy state, in a state where it is fruitful, and I can give love to other people and share myself with others. Although I prefer seeing a professional counselor, I think it will be a very good idea if church leaders who perform deliverances could cooperate with professional counselors. In that way, the person will have the best of both worlds creating a much better mental health balance.

Happy also said,

> deliverance is mainly of faith. It will really work for someone who has the faith that it will work for them. For people who believe in therapy, I'd say it's better to see a mental health therapist. That's why I believe it will be good for church goers if their pastors could collaborate with professional counselors because professional counselors are more knowledgeable in mental health problems and

> continue to see the person. Unfortunately, most pastors do not seem to know that mental health counselors exist. It's a pity.

Mystic equally explained,

> So, like people who are dealing with deep long-term trauma, people that are dealing with a lot of complex identity issues, yes, it should be done in tandem. I'm also looking forward to the day when both deliverance and therapy would be normalized with one done after the other.

In the same line of thought, Lovey insisted,

> I think that mental health treatment and folks that are from the Christian wing need to better communicate with one another. I have heard a lot of bashing of secular mental health counseling from the church and I feel like they're not really enemies. My church is not open to all these different and helpful views that they can glean from by communicating between each other because pastors could give them mental health referrals and therapists could give pastors some referrals too.

Subtheme B - Training

One of the reasons counseling professionals are wary of dealing with church leaders is because they do not believe in the effectiveness of their deliverance practices since they are not based on research evidence (Barlow et al., 2013). In scientific research, it is stated that church leaders lack the skills needed to deliver effective mental health therapy (Ano et al., 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016).

To that end, both church leaders and counseling professionals will need to be trained in what the other professionals do. For example, while clergy helps counseling professionals

with ethical issues like praying with clients and incorporating other religious/spiritual acts during therapy sessions, counseling professionals will encourage Black churches to draw up policies for the training and empowerment of the clergy so they can have the right skills, strategies, and approaches to effectively take care of their clients with mental health problems (Ano et al., 2017; Asamoah et al., 2014; Hays, 2015). Considering, therefore, that congregants seek healing within their churches, it will be important for clergy to be educated about mental health disorders and illnesses, and also be able to collaborate, facilitate, and refer their members to the mental health professionals who could best meet the mental, psychological, and emotional needs of their congregants (Bledsoe et al., 2013).

In their interviews, therefore, Beauty explained,

> I can conveniently conclude that as a Born-Again Christian, because of the experiences that I've had with deliverance, I'd rather go to an OPMHC and see a therapist for treatment of my mental health problems. They are trained professionals although I'll prefer a therapist with a Christian background who will incorporate biblical principles, wisdom, and even prayers during our counseling sessions. That'll be like a one-stop shop. Although there are a few trained pastoral counselors, most pastors are not trained to counsel their congregants.

Happy also said,

> Pastors need to be trained because their approach to counseling is very different from the way professional counselors talk during counseling sessions. It's like day and night. Maybe they should just conduct deliverance sessions, pray and give

> Bible verses and not try to get into counseling…not all pastors are trained pastoral counselors.

Mystic equally explained,

> I believe that pastors should be open to recommending that people go to counselors that are trained for that because most of them aren't trained to do counseling. So, like people who are dealing with deep long-term trauma, people that are dealing with a lot of complex identity issues, yes, it should be done in tandem. I'm also looking forward to the day when both deliverance and therapy would be normalized with one done after the other.

In the same line of thought, Lovey insisted,

> What I criticize my church leaders for is that they only have one uninformed view of counseling because they are not trained. I think that mental health treatment and folks that are from the Christian wing need to better communicate with one another. I have heard a lot of bashing of secular mental health counseling from the church and I feel like they're not really enemies. My church is not open to all these different and helpful views that they can glean from by communicating between each other because pastors could give them mental health referrals and therapists could give pastors some referrals too.

Subtheme C - Prayer

According to Sanford (2020), prayer is having a conversation with God not only by talking with Him, telling Him what is on your mind, but also by listening to what He has to say to you as you remain quiet before Him. Prayer can also be a petition to God in

word or thought (Sandford, 2020). To this end, the four participants all mentioned the inclusion of prayer during deliverance sessions as an effective way of spiritually healing the individual with a mental health concern. Beauty said, “The pastor was just praying with me, and it happened…deliverance. To me, prayers, fasting, and reading of GOD’s Word are more effective and longer-lasting ways of getting spiritual deliverance instead of casting out of demons.” Happy also explained, “It was a normal service in church, and the pastor prophesied, and he mentioned my case. I came out and he prayed for me.” Mystic clearly expressed,

> I’ve gone to deliverance services and what they would do there is that they would pray for you deliverance prayers to break spiritual bondages that cause physical reactions … everybody will be praying, and you would just pray all these deliverance prayers and as you’re praying, God is working on you in different ways.

Lovey explained,

> they had prayer meetings, they were very lively, I used to attend them, they taught me a lot about prayer. They would pray over topics, and you know deliver people. They even prayed over me, and you know there was a negative proxy over me, and the person turned me around and turned me around along with some other people and they prayed over me that the opposite would happen and instead of bad things that I would have prosperity and good things happen in my life. I’ve had people pray for me over the years for mental health issues like I’ve had

> mental health diagnosis. I sincerely believe that even in secular counseling, prayer is important … we need that in order to succeed, to move past the surface stuff.

Subtheme D - Talk Therapy

During the interviews, the four participants all seemed to appreciate that their therapists took time to ask them open-ended questions that made them talk as they actively listened to them. This was an effective approach which was very different from how their pastors handled their mental health issues as they never gave them the opportunity to express themselves.

Beauty reported about her therapist, "that's all we did … talk. It appears she loved to hear me narrate my experiences the African traditional way … she'd listen and ask me questions and more questions."

Happy also said that her therapist "made me talk as much as I could and she always talked back to me…every time I saw her, all we did was talk."

Mystic explained that during her therapy sessions, "what we were to do there is just to GO over there, express our feelings and just get support from the therapist. So, it was mostly what we call talk therapy."

In comparing her pastor and her therapist, Lovey said,

> sometimes I find him inappropriate in the way he would try to counsel me because he would throw scripture in my face, and I really just wanted someone to listen and I told him that but he just didn't have the timing. Meanwhile, with my therapist, he or she always listened and asked more questions … we spent time just talking and I liked that … it was freeing.

Theme 2: Christian Counseling in Outpatient Mental Health Clinics

In their articles, Hamm, (2014), Watson and Hunter, (2015) mentioned that although the rate of anxiety, depression, and other mental health disorders and illnesses were higher among Black women when compared to their Caucasian counterparts, Black women still underused OPMHCs. The reasons why Black women did not go to OPMHCs were that from a cultural perspective, most professional counselors were not multiculturally competent enough for them to balance the ethnic/racial disparities in mental health care (Betancourt et al., 2014; Collins, 2015; & Vieten et al., 2013). Consequently, Black women mistrusted professional counselors who they believed were inadequately equipped to provide culturally-competent services to their Black clients and so would impose their own cultural values on them (Cummings et al., 2014; Hecker et al., 2016).

Additionally, Black women were hesitated to seek treatment from OPMHCs because of societal stigmas, cost of care, inconvenient schedules, long wait times, as well as a dislike of psychotropic medication side effects (Ben-David et al., 2016; Elliott & Hunsley, 2015; Smith, 2017). To this end, Dempsey et al., (2016) reported that many AAs were wrongly diagnosed with schizophrenia and as a result given the wrong medications. However, Filippi, et al., (2014) have stated that Black female clients would go for treatment in OPMHCs if their services could be culturally tailored to their needs. Furthermore, Avent, Cashwell, and Brown-Jeffy (2015) posited that Black pastors considered Christian counselors to be the most competent and trustworthy professionals to provide mental health services to their congregants. In the study, therefore, by Avent et

al. (2015) one of the participants even said God had provided mental health professionals to assist Ministers of the Gospel. Consequently, if clergy actively established collaborative liaisons with counseling professionals, the stigma associated with mental health conditions would be greatly reduced, and people would seek treatment earlier from OPMHCs thus improving their quality of life (Anthony et al., 2015).

All four participants also emphasized on the importance of counseling professionals being culturally competent and knowledgeable in their cultural background. As a result, they all recommended Christian counselors whom they seemed to trust, as potential resources for treatment. However, considering that congregants sought healing within their churches, it was important for clergy to not only be educated about mental health disorders and illnesses, but also be able to collaborate, facilitate, and refer their members to the mental health professionals who could best meet their mental, psychological and emotional needs.

To that end, Beauty said, "I'm a strong proponent of seeking treatment from OPMHCs, especially if the therapist is a Born-Again Christian who will incorporate biblical principles, verses, wisdom, and even prayers during therapy sessions." Happy also explained,

> I hardly sleep at night, so I started going for a counseling session and during my counseling process we went over the issue of insomnia and she was helpful. She told me to be more focused on positive directions in my thoughts rather than on negative thoughts of the past. She was trying to help me unlearn all the negativity and focus on positivity.

Mystic explained,

> Due to the nature of our job which was very taxing physically, mentally, and emotionally, working with a very disenfranchised population from the Baltimore inner city, we were required every 90 days to have therapy with a therapist at a particular OPMHC … that was my first formal experience with therapy.

Lovey insisted,

> I'm totally in support of going for therapy at an OPMHC, but I would always recommend Christian counseling, a Christian counselor who accepts your insurance because some Christian counselors are not accepting insurance and it's very difficult to pay and I paid for counselor for so many years and I had to get expensive insurance or I had to pay out-of-pocket to see them, over a hundred dollars, I think a hundred and ten dollars.

Concerning medications, Beauty explained,

> I generally don't like taking medications and I'm happy my counselor never brought up the suggestion of making me take any medications. She assured me that if I used the tools she was suggesting to me, I'll be able to deal with my issues … she was right!

Happy also said, "My counselor never ever suggested medication … she told me to stop watching horror movies because they triggered the nightmares I had … and I think she was right … I didn't need medication."

Mystic explained,

> If I had not gone through deliverance, I believe that I am one of those people who would have been addicted to sleep medication, unfortunately, because even in my early 20s when I was going through that, no sleep medication was working. However, the other thing that I tell the church people, instead of sending people from one deliverance session to the other because the people keep going from one bondage to the other because they cannot maintain their deliverance, send them to counseling, medication could help them. There are a lot of church people who don't even want people to take medication, but I can tell you for a fact there are sometimes when you cannot even do deliverance because the people are already too way gone. Sometimes you must allow them to take medication for a little bit to calm down before you can do their deliverance. It is wisdom, it is not weakness.

Lovey said,

> I did pray and I did read the Bible and you know many good and well-intentioned Christians told me I shouldn't take psych meds, that they were not good for me, and I tried for many years not to take them and I got worse and worse and worse and when I finally listened to my counselor that I needed to take psychotropic medication, I finally got better, much better, in a short time, and if I'd listened to her before instead of stubbornly refusing for two years, I could have avoided a lot of problems including losing my job.

Theme 3 - Mental Health Disorder or Demonic Possession?

Walvisch (2017) stated that a definition of mental disorder may include the mind somehow not working properly, or an internal condition that caused the thinking or behavior of an individual to be disordered or dysfunctional. According to Walvisch (2017), "the way in which mental disorder is defined can configure and reconfigure the lives of real men and women" (p. 7). In the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, the American Psychiatric Association (APA, 2013) defined mental disorder as a syndrome characterized by clinically significant disturbances in the emotional regulation, cognition, and/or behavior that shows a dysfunction in the developmental, biological, and/or psychological processes that underlie mental functioning, with an increased risk of suffering disability, pain, significant loss of freedom, or even death. When an individual is mentally ill, the strategy is to treat that individual, and when the individual is mentally unhealthy, the strategy is to contain the damage by reducing the suffering (Thirunavurakasu et al., 2013).

Concerning demonic possessions, Innamorati, Taradel, and Foschi (2019) have defined exorcism as the act of driving out evil spirits or demons from people who are believed to be possessed by these demons. According to Young (2016), since the 1900s, the practice of exorcism has been on the increase especially within the Roman Catholic Church. "Deliverance also known as exorcism or expulsion of demons, is the primary mode of treatment of mental illness thought to be caused by demonic possession" (Mercer, 2013, p. 602). Pentecostal and some charismatic Christians also believe that deliverance is a higher form of healing since the deliverance minister directly confronts

the demonic spirit which has held the deliveree in bondage. For effective intervention, therefore, the demon-possessed individual can only be healed when the Name of Jesus Christ is pronounced to cast out the demonic spirit that is causing the mental health disorder and/or illness (Brown, 2014; Capps, 2014; Mercer, 2013; Rowan & Dwyer, 2015; Scrutton, 2015).

During the interviews with my four participants, it was clear that they believed mental health disorders and illnesses were as a result of demonic possessions which could, therefore, be treated through deliverance methods which sometimes included prayer.

Beauty said,

> I know that a good mental health is very important in balancing, for me I have anxiety, I overthink situations which could easily lead to depression and so it's important for me to know my mind needs to always be in a healthy state, in a state where it is fruitful, and I can give love to other people and share myself with others.
>
> My first deliverance session I felt that it was real, I guess there was a good aspect of it but then the bad aspect of it was that it was scary for me because it was like I was under some sort of demonic oppression and the demons were being cast away, but then I did feel the Presence of God and I think for me that was where my life took a different.

Happy explained,

> The insomnia led to fear, anxiety, depression, nightmares … that's why I decided to go for counseling … my friend told me to see a mental health therapist. Deliverance in my church is by casting out of demons. You could also be delivered in church by the Word of God … we also had several sessions of prayers to cast and bind all these problems … I'd say that the time that deliverance has been most effective in my life has been when in my heart I've had the burning and the desire of GOD, and I don't know where to find it. I needed an extraordinary power to help me go through what I was going through.

Mystic said,

> I used to suffer a lot from anxiety which led to depression and the anxiety stemmed from a lot of anger and hate toward a particular person … and I think that's where my issues with insomnia also came from but as I started going for deliverance, the Lord started breaking these things off me. Deliverance is anytime you're transformed from darkness into God's Light, anytime you go from any form of bondage into freedom, that's deliverance. I've gone to deliverance services, and they would for pray for you deliverance prayers to break spiritual bondages so maybe if you're suffering from insomnia, they'd pray for you to deal with the demonic oppression that is causing insomnia. I used to have a lot of very terrifying and horrific dreams and it is in the place of deliverance that I stopped having all those dreams. It's only as I went to several deliverance sessions that now I'm able to sleep very well without any sleep aids whatsoever. I've had healings that came at the place of deliverance and I'm a very strong proponent of

> deliverance for every single person. The church also grooms some people too who are well-versed in spiritual warfare, who are well-versed in casting out demons and breaking yokes and shackles.

Lovey also explained,

> I've been diagnosed with Bipolar Type 2, I also have a diagnosis of Generalized Anxiety Disorder, I also have personality problems like traits of borderline though not fully borderline, so over the years people in my church have prayed for me and you know, it does make a difference. I find that going to church helps me with my mental health. I need that fellowship; I need that spiritual encouragement each week. I remember there was a demon-possessed woman, and they were going to exorcise her and they were planning to fast and pray to exorcise the demon possession. People need God in their lives for real healing. You can't put a band aid on a bleeding hurt, you can help only so much if you don't bring God into it. I strongly believe that people who have a personal relationship with God fare much better than those who don't because the missing aspect keeps them stuck in their mental health problems. I still have mine but it's much better than someone who has the same problems without God.

Discrepant Cases

In this study, I registered no discrepant cases. Consequently, no discrepant case was factored into the analysis.

Evidence of Trustworthiness

According to Christensen and Brumfield (2010) the soundness of all qualitative research is based on its trustworthiness which includes the study's transferability, credibility, confirmability, and dependability. In other words, as opposed to validity and reliability, trustworthiness means consistency, applicability, truth value, and neutrality, as well as an increase in the study's level of rigor (Christensen & Brumfield, 2010). As I was completing this study, therefore, to ensure trustworthiness, I took those factors into consideration through the process of journaling and notetaking.

Credibility

Credibility is when qualitative researchers demonstrate believability and give assurance that the conclusion they have drawn in their studies make sense through observations, triangulation, dependability, transferability, and confirmability (Creswell, 2014). I, therefore, addressed these constructs to ensure credibility of my findings as I also used member checking, peer review, saturation, interviews, coding, and transcriptions (Ravitch & Carl, 2016). As a phenomenological researcher, I asked my participants to review the transcripts of their experiences (Christensen & Brumfield, 2010). As for saturation, "when a category becomes saturated, the gathering of new data fails to stimulate additional theoretical insights and adds nothing substantive to the emerging theory" (Buckley, 2010, p. 128).

Consequently, I stopped collecting data when the information already gathered lost its relevance. For this study, I also gave the interview questions ahead of time to each participant, and they all said having the semi-structured interview questions before time

enabled them to prepare their answers with detailed and richer descriptions of their experiences of the phenomenon. In addition, with the use of a semi-structured interview and follow-up questions, I took notes during the interviews, thereby sustaining the credibility of this study and its results through the process of coding and the reporting of thematic findings. Although all four interviews were of varying lengths, all the thematic findings reported were similar. During this process, I also made sure the voice of each participant stood out as I was coding and analyzing the collected data as well as reporting the study results (Patton, 2015).

Transferability

Transferability is the degree to which results of a study could be applicable to other settings and contexts (Ravitch & Carl, 2016). To that end, therefore, as a qualitative researcher, I provided as many details and the widest extent of information as possible for inclusions in the interpretation of data and final report of the study. Rich and detailed in-depth descriptions of the participants, interviews and the specific steps that I took as I collected, interpreted, and reported the data using my reflexive journals or memos, were some of the ways I was able to give a full and satisfactory report of the research process (Ravitch & Carl, 2016).

Furthermore, transferability of the results I got from this study will help support the work of future researchers in the promotion and growth of their work in the counseling profession field (Patton, 2015) as they compare deliverance in a church setting and treatment in an OPMHC for Black women. Bracketing the transcripts also helped in strengthening the findings while the similarities and consistencies found

between the participants could positively have an influence on the development of new academic and professional training programs, as well as appropriate ethical guidelines for future clinical practices.

Dependability

The appropriate strategies that I used to establish dependability which is the qualitative counterpart to reliability, and which demonstrates the consistency of the study results across researchers and over time, was for me to use the strategy of triangulation (Christensen & Brumfield, 2010). To that end, in order to establish dependability which is inextricably linked to the credibility of my study, I used the services of my dissertation committee members who were able to determine whether the results of the study could be dependable (Christensen & Brumfield, 2010). As I used the triangulation strategy, I also used eligible participants to gather information that was pertinent to this study. In addition, dependability in this study was assured as I followed the laid down check-and-balance procedure of Walden University considering that the prospectus, proposal, first defense, IRB, and final defense, all had to be approved (Walden, 2018). Also, the discussion and detailed reporting of the research process as well as the approval of the committee chair and her dissertation team gave more assurance that if future researchers repeated this study, they would obtain the same results (Patton, 2015; Moustakas, 1994).

Confirmability

As for the establishment of confirmability which is the qualitative counterpart to objectivity, I used the reflexivity strategy to establish it considering that with confirmability, the study's findings would reflect the natural environmental perspectives

of the participants. Furthermore, as the researcher, it was important for me to ensure that the responses of my participants were, in no way, influenced by my thoughts and biases (Patton, 2015). To that end, giving participants the opportunity to review their transcripts helped in this important construct of the study. I also made sure I reviewed each transcript for accuracy and, using the bracketing approach, I identified potential themes and eliminated all aspects of potential bias as the researcher. As I coded and reported in this way, I increased the rigor of this study and made sure the results could be used as basis for future research studies.

General Narrative

All four participants agreed on the importance of follow-up treatment at an OPMHC, and one participant, Beauty, stated that her experience with counseling was far better than her experience with deliverance due to the fear factor of casting out demons which left her feeling more anxious and depressed. She added that her counselor calmed her down and assured her that if she cooperated with her, she was going to be alright. They experienced disconnectedness with either their fathers or mothers, mostly fathers. All other three participants stated that although they will still go for deliverance in the church, continuing at an OPMHC was necessary because their counselors were more knowledgeable about their mental health conditions and said they will encourage everyone to go for treatment in an OPMHC.

General Description

All four participants who identified themselves as BCPW had all lived the experience of spiritual healing through deliverance practices in their church and had also

gone for treatment in an OPMHC. They all spoke of the importance of the importance of building a healthy collaborative relationship between church leaders and mental health professionals. The reason was because in so doing, that collaboration will bridge the gap for more effective therapeutic outcomes as clergy attend retreats, workshops, and conferences organized by counseling professionals (Ano et al., 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016). All participants also attested that it will be more effective if they had Christian professional counselors who will incorporate biblical principles, wisdom, and even prayers during their counseling sessions. That'll be like a one-stop shop.

In addition, the four participants all seemed to appreciate that their therapists took time to ask them open-ended questions that made them talk as they actively listened to them. This was an effective approach which was very different from how their pastors handled their mental health issues as they never gave them the opportunity to express themselves. All four participants also emphasized on the importance of counseling professionals being culturally competent and knowledgeable in their cultural background. As a result, they all recommended Christian counselors whom they seemed to trust, as potential resources for treatment. However, considering that congregants sought healing within their churches, it was important for clergy to not only be educated about mental health disorders and illnesses, but also be able to collaborate, facilitate, and refer their members to the mental health professionals who could best meet their mental, psychological and emotional needs.

All four participants also recommended taking medications if the need arose despite medication side effects. During the interviews with my four participants, it was clear that they believed mental health disorders and illnesses were as a result of demonic possessions which could, therefore, be treated through deliverance methods which sometimes included prayer. At the end of my analysis, it was clear to me that the deliverance experience was not a one-time deal because new problems emerged and sometimes the previous problems even got worse. The participants all agreed, therefore, that there was a need to follow-up treatment at an OPMHC.

Connection to the Theoretical Framework

As the researcher for this project, I used the transcendental phenomenological framework. In using this framework, I applied phenomenological reduction /bracketing/epoche considering that I set aside or suspended my own focus and judgments as I analyzed the experiences of my participants (Peoples, 2021). As I used noema and noesis, I thought about the experiences that my participants had during deliverance and treatment from OPMHCs. I also thought about the horizon which was the present experience I was having while listening to my participants, a present experience that I could not suspend or bracket because I was currently in it. “So, when we look at something, even though we suspend our judgments to try to get this pure essence of something, we come to the horizon, and the horizon is the understanding that we have” (Peoples, 2021, p. 30). While I was analyzing the data, it was not possible for me to bracket or set aside my present experience or horizon because I could not have realized everything.

In addition, using intentionality, I kept my focus on the topic under study as I slowed down and dwelt on each narrative and making sure I did not overlook any important details claiming that I already understood it. In analyzing my participants' experiences using the transcendental theoretical framework, I saw different horizons of their experiences. I also identified examples of my participants' intentionality, their consciousness of the presence of the Holy Spirit that was directed by their horizon, which meant that the power of GOD was moving and setting them free from the demonic oppression.

Results

All 3 themes and 4 sub-themes were directly linked to the research question, "What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church?" These themes included: (1) Deliverance versus Counseling with the sub-themes being: A) Professional Collaboration, B) Training, C Prayer, D) Talk Therapy. (2) Christian Counseling in OPMHCs; and (3) Mental Health Disorder or Demonic Possession? The themes provided detailed insight into the lived experiences of the four participants.

Table 3

Themes and Participants' Descriptions

Theme	Participant's description
Deliverance versus Counseling	Beauty: "I think my experience with counseling has been far better than my experience with deliverance. The fear factor of casting out of demons makes me not like to go for deliverance because it increases my anxiety and depression. Meanwhile, with mental health, the therapist calms me down and always reassures me that if I cooperate with her, I'll be alright and there's nothing to be afraid of." Happy: "My counselor was more concerned about my mental health and other things that affected my sleep while the pastor was using the Word of God to help me. Both were helping me change my mindset but at the same time one was from the knowledge and experience of counseling with no prayer while my pastor was doing it from the knowledge of how the Scriptures had helped deliver other people. With my pastor it was more spiritual, casting and binding, use of anointing oil, Holy water, prayers, which I would say did work. I would still encourage everyone to go for counseling if they don't have the faith that they can be healed through prayers and the Word of God." Mystic: "Counseling will never do what deliverance will do but counseling is a form of deliverance. I strongly believe that anxiety is a form of bondage that can very easily be broken off with deliverance but after that has been broken off, if you are dealing with a Christian counselor who understands about using the Word of God to build you up, counseling is a good way to maintain your deliverance. They are mutually inclusive, and I recommend both for everybody." Lovey: "I think they both have value because to me, mental health counseling that's done through Christ is a form of healing, a form of deliverance. As a practicing Christian, if you're demon-possessed, you'll need deliverance. It's not something that the mental health profession can help you with. At the same time, I don't like it when pastors say that mental health counseling is not good because it is the secular way of doing things. I think both have value and I believe God gave us brains to have counseling to help people, but I also believe that without the power of God, counseling will not work. God has different ways to heal people so, I think that the Christian community and the mental health community need to learn the value of both and instead of attacking each other, they should accept and embrace each other so they can better help their people."
Christian counseling in OPMHCs	Beauty: "I'm a strong proponent of seeking treatment from OPMHCs, especially if the therapist is a Born-Again Christian who will incorporate biblical principles, verses, wisdom, and even prayers during therapy sessions." I generally don't like taking medications and I'm happy my counselor never brought up the suggestion of making me take any medications. She assured me that if I used the tools she was suggesting to me, I'll be able to deal with my issues …she was right!" Happy: "I hardly sleep at night, so I started going for a counseling session and during my counseling process we went over the issue of insomnia, and she was helpful. She told me to be more focused on positive directions in my thoughts rather than on negative thoughts of the past. She was trying to help me unlearn all the negativity and focus on positivity. My counselor never ever suggested medication…and I think she was right…I didn't need medication." Mystic: "Due to the nature of our job which was very taxing physically, mentally, and emotionally, working with a very disenfranchised population from the Baltimore inner city, we were required every 90 days to have therapy with a therapist at a particular OPMHC… that was my first formal experience with therapy. However, the other thing that I tell the church people, instead of sending people from one deliverance session to the other because the people keep going from one bondage to the other because they cannot maintain their deliverance, send them to counseling, medication could help them. There are a lot of church people who don't even want people to take medication, but I can tell you for a fact there are sometimes when you cannot even do deliverance because the people are already too way gone. Sometimes you must allow them to take medication for a little bit to calm down before you can do their deliverance. It is wisdom, it is not weakness." Lovey: "I'm totally in support of going for therapy at an OPMHC, but I would always recommend Christian counseling, a Christian counselor who accepts your insurance because some Christian counselors are not accepting insurance and it's very difficult to pay and I paid for counselor for so many years and I had to get expensive insurance or I had to pay out-of-pocket to see them, over a hundred dollars, I think a hundred and ten dollars. I did pray and I did read the Bible and you know many good and well-intentioned Christians told me I shouldn't take psych meds, that they were not good for me, and I tried for many years not to take them and I got worse and worse and worse and when I finally listened to my counselor that I needed to take psychotropic medication, I finally got better, much better, in a short time, and if I'd listened to her before instead of stubbornly refusing for two years, I could have avoided a lot of problems including losing my job."

Theme	Participant's description
Mental health disorder or demonic possession?	Beauty: "I guess there was a good aspect of it but then the bad aspect of it was that it was scary for me because it was like I was under some sort of demonic oppression and the demons were being cast away, but then I did feel the Presence of God and I think for me that was where my life took a different." Happy: "The insomnia led to fear, anxiety, depression, nightmares…that's why I decided to go for counseling… my friend told me to see a mental health therapist. Deliverance in my church is by casting out of demons. You could also be delivered in church by the Word of God… we also had several sessions of prayers to cast and bind all of these problems…I'd say that the time that deliverance has been most effective in my life has been when in my heart I've had the burning and the desire of GOD, and I don't know where to find it. I needed an extraordinary power to help me go through what I was going through." Mystic: "I used to suffer a lot from anxiety which led to depression and the anxiety stemmed from a lot of anger and hate toward a particular person …and I think that's where my issues with insomnia also came from but as I started going for deliverance, the Lord started breaking these things off me. Deliverance is anytime you're transformed from darkness into God's Light, anytime you go from any form of bondage into freedom, that's deliverance. I've gone to deliverance services, and they would for pray for you deliverance prayers to break spiritual bondages so maybe if you're suffering from insomnia, they'd pray for you to deal with the demonic oppression that is causing insomnia. I used to have a lot of very terrifying and horrific dreams and it is in the place of deliverance that I stopped having all those dreams. It's only as I went to several deliverance sessions that now I'm able to sleep very well without any sleep aids whatsoever. I've had healings that came at the place of deliverance and I'm a very strong proponent of deliverance for every single person. The church also grooms some people too who are well-versed in spiritual warfare, who are well-versed in casting out demons and breaking yokes and shackles." Lovey: "I've been diagnosed with Bipolar Type 2, I also have a diagnosis of Generalized Anxiety Disorder, I also have personality problems like traits of borderline though not fully borderline, so over the years people in my church have prayed for me and you know, it does make a difference. I find that going to church helps me with my mental health. I need that fellowship; I need that spiritual encouragement each week. I remember there was a demon-possessed woman, and they were going to exorcise her, and they were planning to fast and pray to exorcise the demon possession. People need God in their lives for real healing. You can't put a band aid on a bleeding hurt, you can help only so much if you don't bring God into it. I strongly believe that people who have a personal relationship with God fare much better than those who don't because the missing aspect keeps them stuck in their mental health problems. I still have mine but it's much better than someone who has the same problems without God."

Table 4

Subthemes and Participants' Descriptions

Subtheme	Participant's description
Professional collaboration	Beauty: "Although I prefer seeing a professional counselor, I think it will be a very good idea if church leaders who perform deliverances could cooperate with professional counselors. In that way, the person will have the best of both worlds, creating a much better mental health balance." Happy: "For people who believe in therapy, I'd say it's better to see a mental health therapist. That's why I believe it will be good for church goers if their pastors could collaborate with professional counselors because professional counselors are more knowledgeable in mental health problems and continue to see the person. Unfortunately, most pastors do not seem to know that mental health counselors exist. It's a pity." Mystic: "I'm also looking forward to the day when both deliverance and therapy would be normalized with one done after the other." Lovey: "I think that mental health treatment and folks that are from the Christian wing need to better communicate with one another. I have heard a lot of bashing of secular mental health counseling from the church and I feel like they're not really enemies. My church is not open to all these different and helpful views that they can glean from by communicating between each other because pastors could give them mental health referrals and therapists could give pastors some referrals too."
Training	Beauty: "I can conveniently conclude that as a Born-Again Christian, because of the experiences that I've had with deliverance, I'd rather go to an OPMHC and see a therapist for treatment of my mental health problems. They are trained professionals although I'll prefer a therapist with a Christian background who will incorporate biblical principles, wisdom, and even prayers during our counseling sessions. That'll be like a one-stop shop. Although there are a few trained pastoral counselors, most pastors are not trained to counsel their congregants." Happy also said, "Pastors need to be trained because their approach to counseling is very different from the way professional counselors talk during counseling sessions. It's like day and night. Maybe they should just conduct deliverance sessions, pray and give Bible verses and not try to get into counseling…not all pastors are trained pastoral counselors." Mystic: "I believe that pastors should be open to recommending that people go to counselors that are trained for that because most of them aren't trained to do counseling. So, like people who are dealing with deep long-term trauma, people that are dealing with a lot of complex identity issues, yes, it should be done in tandem." Lovey: "They [pastors] only have one uninformed view of counseling because they are not trained. I think that mental health treatment and folks that are from the Christian wing need to better communicate with one another. I have heard a lot of bashing of secular mental health counseling from the church and I feel like they're not really enemies. My church is not open to all these different and helpful views that they can glean from by communicating between each other because pastors could give them mental health referrals and therapists could give pastors some referrals too."
Prayer	Beauty: "The pastor was just praying with me, and it happened…deliverance. To me, prayers, fasting, and reading of GOD's Word are more effective and longer-lasting ways of getting spiritual deliverance instead of casting out of demons Happy: It was a normal service in church, and the pastor prophesied, and he mentioned my case. I came out and he prayed for me." Mystic: "I've gone to deliverance services and what they would do there is that they would pray for you deliverance prayers to break spiritual bondages that cause physical reactions…everybody will be praying, and you would just pray all these deliverance prayers and as you're praying, God is working on you in different ways." Lovey: "They had prayer meetings, they were very lively, I used to attend them, they taught me a lot about prayer. They would pray over topics, and you know deliver people. They even prayed over me, and you know there was a negative proxy over me, and the person turned me around and turned me around along with some other people and they prayed over me that the opposite would happen and instead of bad things that I would have prosperity and good things happen in my life. I've had people pray for me over the years for mental health issues like I've had mental health diagnosis. I sincerely believe that even in secular counseling, prayer is important…we need that in order to succeed, to move past the surface stuff."

Subtheme	Participant's description
Talk therapy	Beauty: "That's all we did…talk. It appears she loved to hear me narrate my experiences the African traditional way…she'd listen and ask me questions and more questions." Happy: "My therapist made me talk as much as I could and she always talked back to me…every time I saw her, all we did was talk." Mystic: "What we were to do there is just to GO over there, express our feelings and just get support from the therapist. So, it was mostly what we call talk therapy." Lovey: "Sometimes I find him [my pastor] inappropriate in the way he would try to counsel me because he would throw scripture in my face, and I really just wanted someone to listen, and I told him that but he just didn't have the timing. Meanwhile, with my therapist, he or she always listened and asked more questions…we spent time just talking and I liked that…it was freeing."

Discrepant Cases/Nonconforming Data

I registered no discrepant cases as I conducted this semi-structured interview. Apart from Table 1, I included no other tables and figures to illustrate the results of this study.

Summary of Answers to Research Question

Based on the research question in this study which is: "What are the lived experiences of Black Christian Pentecostal Women who seek community mental health counseling concurrent with deliverance practices through the church," all four participants were unanimous on the point that although deliverance in the church was an experience that they all had, they, nevertheless, agreed that for purposes of sustainability and to have a better and long-lasting therapeutic outcome, it was necessary for BCPW who went for deliverance in their churches to also go for treatment in OPMHCs. They all also agreed that both methods were mutually inclusive. Here below are the summaries of each participant:

Participant 1 - Beauty

Beauty who presented herself as cool, calm, and collected and earlier said she was not comfortable accepting to be a participant in the study. On second thought, however,

she decided to participate because she believed it will be important for her to give her own experience of church deliverance and treatment from an OPMHC. After the initial debriefing and confirmation of her consent to be a participant, the interview went smoothly as she gave detailed descriptions and examples while answering her questions. Although Beauty talked of the need to believe in God and have the experience of an extraordinary power to help her go through her mental health concerns, she believed there were good and bad aspects of deliverance, with the good aspect being that the Presence of God could be felt. Nevertheless, she thought the deliverance process was scary because of the casting-out-of-demons experience. She added that although her first deliverance session started with prayer and the feeling of God's Presence, all other deliverance sessions she had were bad experiences and as a result, she was never again going to subject herself to any deliverance session.

As she compared and contrasted deliverance and treatment from an OPMHC, Beauty said that her experience with seeking treatment at an OPMHC was far better than her experience with deliverance. Concerning the role her pastor played in her mental health wellbeing, Beauty responded that her pastor always reminded her of follow her faith and trust God. She also encouraged anyone having mental health issues to go for counseling at an OPMHC because counselors were better trained to handle mental health problems and they used a lot of compassion, were non-judgmental, and always encouraged their clients to have hopeful expectations of their therapeutic outcomes. In other words, looking at the good even in a bad situation. She thought that was not only

spiritually uplifting but it helped her have a positive outlook on life, something that deliverance ministers did not do.

Participant 2 - Happy

Happy, unlike Beauty, was excited to talk about her deliverance experience and said she will always prefer deliverance to going for treatment in an OPMHC. She said that deliverance in her church was either through the casting out of demons or sharing the Word of God, praying and sometimes fasting. Happy said the reason she went for deliverance and for counseling at an OPMHC was because she was having serious issues with insomnia. Happy added that the experiences she was having with insomnia had resulted in mental health issues like depression, anxiety, fear, and that was when her friend advised her to see a mental health therapist. Talking about which of the two, deliverance and counseling helped her more, she said that although both helped her, she would always prefer to first go for deliverance. However, one difference she pointed out between her therapist and her pastor was that when it was time for her counseling sessions, her therapist called her while she was the one who always called her pastor whenever she needed help.

Participant 3 - Mystic

Mystic has professional experience working with patients diagnosed with mental health disorders and illnesses. Due to her professional background, therefore, she was excited and even passionate to participate in this study and was the very first participant to call me. However, she was the third participant I interviewed because of the time she chose to have the interview. After listening to her, I realized that not only did her

responses englobe all that the first two participants had said, but she went into finer details in her answers. She said she had had several deliverances in her church and had also had to go to OPMHCs for therapy due to the nature of her job as a nurse case manager with the homeless and disenfranchised population at the Baltimore Inner City and she explained that the sessions were very helpful. Describing the relationship between her counseling sessions and her deliverance experience, Mystic explained that both were mutually inclusive. She also said her pastor played a very important role in supporting her for her mental health concerns.

Expressing her feelings about encouraging everyone to go for treatment at an OPMHC, Mystic thought that from a Black perspective, there should be a change of the expression from mental health to mental wellness or wholeness. The reason for this change will be because people do not complain when they are told they need to be checked out for their medical conditions like diabetes or high blood pressure. There will, therefore, be nothing wrong with seeing individuals for their mental wellness since it will be the same thing as seeing them for the wellness of their liver, their kidneys, their reproductive organs or their skin. In that way, their mental wellness or wholeness will be normalized and no more considered as a stigma.

Participant 4 - Lovey

Lovey, just like Mystic, was not only excited in being a study participant, but was also very emotional when she started narrating her lived experience. She explained that she had had more experiences with counseling in OPMHCs than in the church, and like Beauty, her preference would be to choose counseling over deliverance, except the

deliverance had to come about as a result of constant and persistent prayers. She also believed that deliverance was synonymous with demon possession, exorcising, and healing, and added that prayer was an important ingredient for successful deliverance. Talking about her experiences in an OPMHC, Lovey explained that the experience was mixed due to the kind of therapists she had. On the use of medications, Lovey was emphatic about the importance of taking medications if the need arose and vilified those counselors who shied away from referring their clients to psychiatrists for the prescription of psychotropic medications.

Talking about the importance of training, Lovey was unapologetic about the importance of pastors being trained in counseling techniques and said that it will go a long way to helping them understand what counseling professionals were doing, thereby creating a healthy working relationship between those two groups of professionals. Although she encouraged Christians to go for counseling at an OPMHC, she, nevertheless, recommended a professional Christian counselor. On whether she believed that deliverance in the church and going for treatment in an OPMHC were mutually inclusive if well handled, Lovey's response was an emphatic yes.

Summary

Transcendental phenomenology focuses on lived experiences of individuals. This framework was crucial to monitoring my interaction with this research study to eliminate any form of bias. Throughout the interview process, I was with the participants and made sure I did not suggest any information or make any assumptions of their meanings. After carefully and closely reviewing all four transcripts, I concluded that I had successfully

completed transcribing all the interviews. As I continued with bracketing and analyzing the transcripts for coding, I realized the repetition of the same themes. Going from one level of coding to the next level through the bracketing process, I made sure my own biases did not influence my coding in any way. I also reviewed each transcript over and over to make sure I missed no theme.

Furthermore, in Chapter 4, I made sure the responses I considered from participants were directly related to the research question, "What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church?" I explained the setting, gave the demographic information of all four participants, continued to explain the data collection and data analysis processes and findings. All themes that I identified were supported by direct quotes from the participants. I also highlighted all evidence of trustworthiness and the results. As I continue to Chapter 5, after an introduction, I will give an interpretation of the findings, point out the limitations of the study, and make certain recommendations which will include implications for positive social change, methodological, theoretical, and/or empirical implications, as well as recommendations for practice. Finally, in my conclusion, I will provide a strong take-home message that will capture the key essence of this transcendental phenomenological qualitative research

The purpose of this study was to explore the lived experiences of BCPW who sought spiritual deliverance and healing of their mental health conditions from their church clergy (Mercer, 2013; Rowan & Dwyer, 2015) and went to OPMHCs for treatment (Friedlander et al., 2014; Hays, 2015). To explore these experiences, I used a

qualitative, transcendental phenomenological approach (Buser et al., 2016; Choi, 2018; Wilson, 2014) for the study. According to Rowan and Dwyer (2015), more women than men sought mental health treatment from their church leaders through deliverance practices. Consequently, I highlighted the importance of respecting the stipulations in standards F.2.g., Section 2, and standards A.2.f., A.3.b., D.2.m., Section 5 of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), as well as standard E.8. of ACA Code of Ethics (ACA, 2014). These standards all stressed the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study would inform professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals would have effective multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

General Narrative

The participants experienced new realizations about their mental health issues. They experienced frustration over spiritual healing through deliverance because they realized that not all the demons were cast out as they walked out of the horizon. They were also able to see that something seemed to be lost as they experienced the chasm between the effectiveness of deliverance in the church and the positive results attained when treatment continued in an OPMHC. In addition, the participants noticed that other BCPW were still suffering because their mental health needs were not met despite the deliverance experiences in church.

As they moved out of the horizon and embraced their experiences, all participants saw the need to come out of the spiritual bondage and create a bridge between their church leaders and counseling professionals. This bridge would be built by developing a healthy collaborative relationship between their pastors and counseling professionals in OPMHCs for successful and long-lasting therapeutic outcomes. The reason was because they all posited that treatment of mental health issues was not a one-time deal that spiritual healing through deliverance in church could fix considering that sometimes new problems emerged that even got worse.

All participants experienced that deliverance and mental health counseling had the same goals which were to help people to be free from the presenting mental health issues they were dealing with. The only difference was that deliverance was based on spiritual beliefs while counseling was based on evidence-based clinical approaches. All four participants expressed the need for there to be a healthy collaborative working relationship with counseling professionals and church leaders. All four participants also agreed on the important role training played for effective therapeutic outcomes.

Consequently, they insisted on the training of the church leaders who performed deliverances for mental health conditions so that church leaders could refer their congregants to OPMHCs whenever the need arose. All four participants equally mentioned the importance prayers played during deliverance sessions as an effective way of spiritually healing individuals with mental health concerns. Furthermore, all four participants expressed the need to have Christian counselors who could include prayers as needed during their counseling sessions. In addition, the four participants all seemed to

appreciate that fact that their therapists took time to ask them open-ended questions that made them talk as they actively listened to them. This was an effective approach which was very different from how their pastors handled their mental health issues as they never gave them the opportunity to express themselves. All four participants also emphasized the importance of counseling professionals being culturally competent and knowledgeable in their cultural background.

As a result, they all recommended Christian counselors who they seemed to trust, as potential resources for treatment. However, considering that congregants sought healing within their churches, it was important for clergy to not only be educated about mental health disorders and illnesses, but also be able to collaborate, facilitate, and refer their members to mental health professionals who could best meet their mental, psychological and emotional needs. They also emphasized the need for medications which could only be prescribed when a counseling professional in an OPMHC referred the individual to a psychiatrist.

During the interviews with my four participants, it was clear that they believed mental health disorders and illnesses were as a result of demonic possessions which could, therefore, be treated through deliverance methods which sometimes included prayer. Nevertheless, they all agreed that although mental health disorders could be traced to demonic possessions, counseling professionals could help treat these issues in their OPMHCs. Only one participant, Beauty, expressed her preference for treatment in OPMHCs. She said she thought her experience with counseling had been far better than her experience with deliverance. The reason was due to the fear factor of casting out of

demons which made her not like to go for deliverance because it increased her anxiety and depression. Meanwhile, with mental health, the therapist calmed her down and always reassured me that if she cooperated with her, she would be alright and there was nothing to be afraid of.

General Structure

Black Christian Pentecostal Women experience new realizations about their mental health issues because they now know that God has other ways of helping them get treatment for their mental health conditions. They experience frustration over spiritual healing through deliverance because they realize that not all the demons are casted out as they walked out of the horizon. They are also able to see that something seems to be lost as they experience the chasm between the effectiveness of deliverance in the church and the positive results to attain when treatment continues in an OPMHC. In addition, BCPW notice that other BCPW are still suffering because their mental health needs are not met despite the deliverance experiences in church.

As they move out of the horizon and embrace their experiences, all BCPW see the need to come out of the spiritual bondage in which they are and create a bridge between their church leaders and counseling professionals. This bridge is built by developing a healthy collaborative relationship between their pastors and counseling professionals in OPMHCs for successful and long-lasting therapeutic outcomes. The reason is because they all posit that treatment of mental health issues is not a one-time deal that spiritual healing through deliverance in church can fix considering that sometimes new problems emerge that even got worse.

Black Christian Pentecostal Women experience that deliverance and mental health counseling have the same goals which are to help people to be free from the presenting mental health issues they are dealing with. The only difference is that deliverance is based on spiritual beliefs while counseling is based on evidence-based clinical approaches. Black Christian Pentecostal Women express the need for there to be a healthy collaborative working relationship with counseling professionals and church leaders. Black Christian Pentecostal Women also agree on the important role training plays for effective therapeutic outcomes.

They insist on the training of the church leaders who perform deliverances for mental health conditions so that church leaders can refer their congregants to OPMHCs whenever the need arises. Black Christian Pentecostal Women equally mention the importance prayers plays during deliverance sessions as an effective way of spiritually healing individuals with mental health concerns. Furthermore, BCPW express the need to have Christian counselors who can include prayers as needed during their counseling sessions. (In addition, the four participants all seemed to appreciate that fact that their therapists took time to ask them open-ended questions that made them talk as they actively listened to them. This was an effective approach which was very different from how their pastors handled their mental health issues as they never gave them the opportunity to express themselves.) Black Christian Pentecostal Women also emphasize the importance of counseling professionals being culturally competent and knowledgeable in their cultural background.

They all recommend Christian counselors whom they seem to trust, as potential resources for treatment. However, considering that congregants seek healing within their churches, it is important for clergy to not only be educated about mental health disorders and illnesses, but also be able to collaborate, facilitate, and refer their members to mental health professionals who can best meet their mental, psychological and emotional needs. Black Christian Pentecostal Women also emphasize the need for medications which can only be prescribed when a counseling professional in an OPMHC refers the individual to a psychiatrist.

Black Christian Pentecostal Women believe mental health disorders and illnesses are as a result of demonic possessions which can, therefore, be treated through deliverance methods which sometimes include prayers. Nevertheless, they all agree that although mental health disorders can be traced to demonic possessions, counseling professionals can help treat these issues in their OPMHCs.

They understand that church deliverance does not necessarily exorcise demons once they get out of the horizon. For that reason, they feel frustrated and lose confidence in the deliverance process. They end up experiencing the chasm between church deliverance practices and treatment from OPMHCs once they get introduced to other options. They also understand that God has other tools He uses to resolve their presenting mental health concerns especially when they realize their counseling professionals are Christians like them who are knowledgeable in deliverance practices.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore the lived experiences of BCPW who sought spiritual deliverance and healing of their mental health conditions from their church clergy (Mercer, 2013; Rowan & Dwyer, 2015) and went to OPMHCs for treatment (Friedlander et al., 2014; Hays, 2015). To explore these experiences, I used a qualitative, transcendental phenomenological approach (Buser et al., 2016; Choi, 2018; Wilson, 2014) for the study. According to Rowan and Dwyer (2015), more women than men seek mental health treatment from their church leaders through deliverance practices. Consequently, I highlighted the importance of respecting the stipulations in Standards F.2.g., Section 2, and Standards A.2.f., A.3.b., D.2.m., Section 5 of CACREP (2016), as well as Standard E.8. of the ACA Code of Ethics (ACA, 2014). These standards all stress the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study may inform professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals may have effective multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

The main research question that guided this study was the following: What are the lived experiences of Black Christian Pentecostal women who seek community mental health counseling concurrent with deliverance practices through the church? The major themes that stood out during data analysis included deliverance/demonic oppression, prayer, mental health disorder, OPMHCs, talk therapy, medication, training, and

deliverance versus counseling. The themes provided detailed insight into the lived experiences of the four participants. Consequently, in Chapter 5, I review my interpretations and findings from the research study and relate them to the literature. I then identify the limitations of the study and provide recommendations for future research. Finally, I review the implications of the research and how they might relate to social change and progress.

Interpretation of Findings

Based on the specific themes and categories that emerged from the collected data, three main themes and three subthemes under the first theme emerged after data analysis. These themes were (a) deliverance versus counseling, with the subthemes professional training, prayer, and talk therapy; (b) Christian counseling in OPMHCs; and (c) mental health disorder or demonic possession. These identified themes and subthemes, which addressed the lived experiences of participants as they went for deliverance sessions in their church and went for treatment at OPMHCs, continually emerged with each participant during the interviews. Compared to the peer-reviewed literature in Chapter 2, based on the emerging themes:

Theme 1 - Deliverance Versus Counseling

In this study, the four participants all stated that deliverance and mental health counseling/therapy had the same goals, which were to help people to be free from the presenting mental health issue that they were dealing with. The only difference was that deliverance was based on spiritual beliefs, whereas counseling was based on evidence-based clinical approaches. Mercer (2013) stated that deliverance was the primary mode of

treating mental health disorders and/or illnesses that were believed to be caused by demonic possessions. In addition, evidence-based research had concluded that some Black women sought both spiritual deliverance and mental health treatment from what they believed to be demonic possessions (Bledsoe et al. 2013; Friedlander et al. 2014; Moore, 2017). These authors had, therefore, all stated that clients could receive additional benefits by seeking simultaneous mental health treatment and spiritual/religious healing practices.

However, according to Richards et al. (2015), within mental health circles, the idea of spiritual healing of mental health disorders and illnesses through deliverance practices did not yet have enough evidence-based scientific research. This evidence-based literature aligns with my findings, in that all four participants affirmed, like Mercer (2013), that mental health disorders were as a result of demonic possessions and that they thought that mental health conditions could be dealt with through deliverance as well as treatment from OPMHCs. They also agreed that healthy professional relationships between church clergy and counseling professionals would help counseling professionals understand the cultural implications of deliverance and be able to include it in their clinical practice. This understanding would also encourage them to make further research on this study topic.

Subtheme A—Professional Collaboration

In their interview responses, all four participants expressed the need for there to be a healthy collaborative working relationship between counseling professionals and church leaders. Barlow et al. (2013) indicated that one of the reasons that counseling

professionals were wary of dealing with church leaders was because they did not believe in the effectiveness of their deliverance practices because they were not based on research evidence. In scientific research, therefore, it has been stated that because church leaders lack the skills needed to deliver effective mental health therapy, a healthy collaboration between clergy and mental health professionals would bridge the gap for more effective therapeutic outcomes as clergy attend retreats, workshops, and conferences organized by counseling professionals (Ano et al., 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016).

This collaboration may also encourage Black churches to draw up policies for the training and empowerment of the clergy so that they can have the right skills, strategies, and approaches to effectively take care of their clients with mental health problems (Ano et al., 2017; Asamoah et al., 2014; Hays, 2015). On the other hand, clergy can help counseling professionals with ethical issues such as praying and incorporating other religious/spiritual acts during therapy sessions, as pastors can assist counseling professionals in providing services that are not only culturally sensitive, but also culturally congruent (Brown & McCreary, 2014). Ratts et al. (2016) have also called on mental health professionals to consider clients' religion and spirituality as an aspect of their identity along with the social justice concerns that might have a positive impact on the mental health of individuals.

Subtheme B - Training

All four participants agreed on the important role that training played for effective therapeutic outcomes. Consequently, they insisted on the training of the church leaders

who performed deliverances for mental health conditions so that church leaders could refer their congregants to OPMHCs whenever the need arose. Barlow et al. (2013) indicated that one of the reasons that counseling professionals were wary of dealing with church leaders was because they did not believe in the effectiveness of their deliverance practices because they were not based on research evidence. In scientific research, therefore, it has been stated that because church leaders lack the skills needed to deliver effective mental health therapy, a healthy collaboration between clergy and mental health professionals may bridge the gap for more effective therapeutic outcomes as clergy attend retreats, workshops, and conferences organized by counseling professionals (Ano et al., 2017; Collins, 2015; Dein, 2015; Dempsey et al., 2016). Furthermore, a study by Jackson (2015) concluded that licensed professional counselors wanted to learn a lot more about the role of the pastor and the possibility of referrals; additionally, they wanted training to provide pastors with the ability to know not only why and when referrals should be made to professional mental health counselors, but also how to do a referral to an OPMHC without causing unnecessary stress in the process.

Subtheme C - Prayer

In this study, all four participants mentioned the importance of praying during deliverance sessions as an effective way of spiritually healing individuals with mental health concerns. They also expressed the need to have Christian counselors who could also include prayers as needed during their counseling sessions. Rao et al. (2015) stated that based on faith, spiritual healing through deliverance is belief in the alleviation of mental health conditions as church leaders use the power of the Holy Spirit and prayers in

the Name of Jesus Christ to cast out demons. In addition, Barlow et al. (2013) stated that spiritual healing is perhaps one of the oldest paramedical treatments, with an acknowledgment of the connection between the concept of wellness and spiritual well-being, including the incorporation of prayers. Further, some authors have concluded that certain mental health conditions can be treated through spiritual healing, including prayer (Hecker et al., 2016; Richards et al., 2015). The Black church service that includes fellowship, confession of sin, and the outward expression of praise, worship, singing, and prayer creates a therapeutic church experience as it helps to manage stress and avoid depressive tendencies (Sutton et al., 2016; Ward et al., 2013). As a result, research suggest**s** that the number of individuals seeking help from church ministers using deliverance and prayer for mental health problems is by far greater in the United States compared to other countries such as Canada and the United Kingdom (Hall & Gjesfjeld, 2013).

Subtheme D - Talk Therapy

During the interviews, the four participants all seemed to appreciate that their therapists took time to ask them open-ended questions that made them talk as they actively listened to them. This was an effective approach that was very different from how their pastors handled their mental health issues, as they never gave them the opportunity to express themselves. According to Anonymous (2014), “talking about issues enabled me to find relief from ailments lodged in my subconscious, which affected me constantly … in therapy, I do most of the talking and my therapist guides me toward answers I have trouble finding” (p. 1307).

Theme 2: Christian Counseling in Outpatient Mental Health Clinics

All four participants emphasized the importance of counseling professionals being culturally competent and knowledgeable in their cultural background. Consequently, they all recommended Christian counselors, whom they seemed to trust as potential resources for treatment. However, considering that congregants sought healing within their churches, it was important for clergy to not only be educated about mental health disorders and illnesses, but also be able to collaborate, facilitate, and refer their members to mental health professionals who could best meet their mental, psychological, and emotional needs. They also emphasized the need for medications, which could only be prescribed when a counseling professional in an OPMHC referred the individual to a psychiatrist.

To this end, in their articles, Hamm (2014) and Watson and Hunter (2015) mentioned that although rates of anxiety, depression, and other mental health conditions were higher among BCPW when compared to their Caucasian counterparts, Black women still underused OPMHCs. The reasons why Black women did not go to OPMHCs were because they mistrusted professional counselors, whom they believed were inadequately equipped to provide culturally competent services to them and so would impose their own cultural values on them (Betancourt et al. 2014; Collins, 2015; Cummings et al. 2014; Hecker et al. 2016; Vieten et al. 2013). The absence of mental health care services and the mistrust of mental health counseling professionals generally contribute to the low utilization of OPMHCs among people living in disadvantaged communities (Fifield & Oliver, 2016). Additionally, BCPW hesitated to seek treatment

from OPMHCs because of societal stigmas, the cost of care, inconvenient schedules, long wait times, as well as a dislike of psychotropic medication side effects (Ben-David et al. 2016; Elliott & Hunsley, 2015; Smith, 2017). To this end, Dempsey et al. (2016) reported that many AAs including Black women were wrongly diagnosed with schizophrenia and as a result were given the wrong medications.

Nevertheless, Avent et al. (2015) posited that Black pastors considered Christian counselors to be the most competent and trustworthy professionals to provide mental health services to their congregants. In their study, therefore, one of the participants stated that God had provided mental health professionals to assist Ministers of the Gospel. Consequently, if clergy actively established collaborative liaisons with counseling professionals, the stigma associated with mental health conditions would be greatly reduced, and people would seek treatment earlier from OPMHCs, thus improving their quality of life (Anthony et al. 2015).

Theme 3 - Mental Health Disorder or Demonic Possession?

During the interviews with my four participants, it was clear that they believed that mental health disorders and illnesses were the result of demonic possessions, which could, therefore, be treated through deliverance methods that sometimes included prayer. Nevertheless, they all also agreed that although mental health disorders could be traced to demonic possessions, counseling professionals could help treat these issues in their OPMHCs. In a study by Asamoah et al. (2014), the participants disclosed that medical science could not only explain, but also treat many of the mental health conditions that they as pastors considered spirit possession. Additionally, NIMH noted that just like

mental health professionals, pastors can interact with individuals seeking help for serious mental conditions that they consider to result from demonic possessions (Bledsoe et al. 2013).

Furthermore, many BCPW have relied on spiritual treatment from church leaders for mental health issues such as anxiety and depression (Anthony et al., 2015; Asamoah et al. 2014; Avent et al. 2015, Hays, 2015; Turner et al. 2019). Consequently, Pearce et al. (2015) posited that spiritual healing was more effective in the reduction of depression than conventional mental health therapy. This assertion, according to Lumpkins et al. (2013), was a Christian faith-based perspective that placed Jesus Christ as the central part of health and belief in holistic healing. The reason was that the Jesus of the Bible was not only a spiritual leader, but also One who not only healed people and performed miracles, but also delivered them from demonic possessions (Lumpkins et al., 2013).

Additionally, after studying the relationship between spirit possession and mental health symptomology, Cummings et al. (2014) and Hecker et al. (2016) explained that there were significant correlations between spirit possession and severity of PTSD symptoms and other mental health disorders. Further, Brown (2014), Capps (2014), Mercer (2013), Rowan and Dwyer (2015), and Scrutton (2015) explained that in Pentecostal churches, the indwelling of demons within the bodies of certain congregants manifested in mental disorders and illnesses such as ADHD, autism, bipolar disorder, anxiety, depression, reactive attachment disorder, schizophrenia, and seizures.

Limitations of the Study

I identified some limitations to this study, which included the following. The first limitation was the requirements for participation. In order to participate in this study, individuals had to be adult women. This means that the opinion of Christian men was not known. I, however, chose this special population because statistics have shown that more women go to church than men. Second, although it was not my intention, all the participants had at least a bachelor's degree. Nevertheless, the advantage was that the participants found it a lot easier to describe their experiences using the appropriate counseling diction. Third, all participants were recruited from the same church, so there was no opportunity to hear from women who had had deliverance experiences from other churches. Fourth, this study was limited only to women who had experienced deliverance from a Christian church. Meanwhile, there are other spiritual experiences such as Reiki that could help give more insight on how such experiences could be.

Recommendations

This transcendental phenomenological qualitative study provided several insights into the lived experiences of African American and other Black women who go for treatment in OPMHCs and concurrently go for deliverance in their church. An insight gained was that whenever they had a mental health concern, the women would go first to their church for deliverance before going to an OPMHC. Consequently, based on the strengths and limitations of this current study as well as the literature reviewed in Chapter 2, I have the following recommendations to make: First, researchers could conduct a study exploring the experiences of not only Christian men, but also women who go for

deliverance sessions in non-Pentecostal churches such as Roman Catholic churches where deliverance in the form of exorcism is practiced. Second, researchers could conduct a similar study on women who go for other spiritual healing practices such as Reiki, for example, to deal with their mental health issues and go for treatment in OPMHCs. Third, researchers could conduct a study to identify the specific training needs for church leaders on pastoral counseling so that pastors can have better understanding of what exactly they are engaged in whenever they conduct deliverances in the church. Fourth, the counseling profession may need to be more proactive in reaching out to church leaders and building a healthy professional relationship with them so that they can cooperate with each other for better therapeutic results for their church members cum clients.

Implications

Positive Social Change

The findings of this study will help in bridging the gap between mental health professionals and leaders of the Black Church (Avent et al. 2015; Dempsey et al. 2016). The study may also bring positive social change into the Black Christian Pentecostal community as the women get satisfactory treatment for their mental health issues and strive to be the best expression of themselves in their families and communities (Alinia, 2015). In addition, the results of the study may enable professional counselors to get a much better understanding of how best they can provide treatment to this special population of BCPW from their Black Churches (Adams et al. 2015).

Furthermore, this information may bring about much needed positive social change and social justice for a minority population of voiceless women (Heppner, 2017; Marbley et al. 2015; Ratts et al. 2016) who have chosen a certain way of taking care of their mental health issues (Hecker et al. 2016). Some of the positive social change will include the reduction of stigma (Egbe, 2015; Sirey et al. 2014; Stewart et al. 2015; Ward et al. 2013) as church leaders and family members start talking positively about OPMHCs to an extent that these women can now freely go for treatment in these OPMHCs (Baumgartner et al., 2014; Ben-David et al. 2016; Hays, 2015). Also, this study will help promote access to quality culturally-aware interventions for the mental health needs of these women who will be able to willingly, confidently, and freely go for OPMHC services (Ben-David et al. Cole, 2016; Hays, 2015; Villatoro & Aneshensel, 2014). In addition, this study will be an eye-opener for most women who are not yet aware of other options they have in the treatment of their mental health issues.

Implications for Practice

This study will show several implications for counseling professionals. For example, because Black Christian women would have the possibility of choosing what treatment method is best for them, clinicians will use this awareness and knowledge to advocate for and empower the women to choose what they believe is best for them (Alinia, 2015; Levitov, 2017; Lumpkins et al. 2013). This study will also have a positive impact on clinical practice as counseling professionals will be better informed about the mental health choices that CPBW must make. According to CACREP (2016) Standards, doctoral degree programs in Counselor Education and Supervision (CES) are meant to

prepare graduates to work in clinical and academic settings as practitioners, supervisors, teachers, researchers, and advocate for the profession. All these sectors necessitate strategies that are ethically and culturally relevant in the different leadership roles they play as they exercise their profession.

Additionally, based on Interiano and Lim (2018), due to the increasing rate of interconnectedness in the world, across the U.S., institutions of higher education are attracting an important number of foreign-born students (FBSs) such as international students and first-generation immigrants. Kuo, Woo, and Washington (2018) have also stated that the contribution these students who are enrolled in counselor education (CE) programs in the US are making cannot be overlooked. Considering, therefore, that spiritual healing through deliverance in churches is more prevalent in Black churches, and that a good number of these international students in CE programs are Black, (Interiano et al. 2018), the CE identity which includes supervision, training, counseling, research, and advocacy, will be enhanced with the information that will be collected in this study in the following manner:

Supervision

According to Interiano (2018), "many doctoral FBSs in counseling will face arduous task of teaching and supervision in an environment they may not fully understand" (p. 311). With this study, however, Black immigrant students will begin to have confidence that they will be able to have access to supervisors who are ethically and culturally equipped to supervise them. Clinical supervision is a supervisory relationship between a licensed clinical professional and a supervisee who performs the task of a

clinician (Sahebi, 2020). The supervision relationship is, therefore, a complex and sometimes challenging one that includes the supervisor, the supervisee, and the clients.

Clinical supervisors oversee the safety of clients as they guide their supervisees in ways that promote their clinical practice and positively influence their professional and personal development (Sahebi, 2020). Consequently, deliverance knowledge will be incorporated into the supervision practice if clients, at any stage of their counseling sessions, say they are Christians and mention the important role prayer and other church activities play in their holistic wellbeing. The supervisor, who, hopefully, is knowledgeable in deliverance practices, could then encourage the supervisee to ask the clients if they have ever undergone deliverance in their churches. That discussion could help the supervisee ask the clients if they would like to be referred to a counselor who does Christian-based counseling in case the supervisee has no knowledge of deliverance practices. During my interviews, all four participants mentioned the importance of their counselors being knowledgeable in deliverance practices. In other words, being Christian counselors who could use Biblical wisdom and principles during their counseling sessions.

Consequently, what supervisors will need to be aware of when supervising counselors working with this population will be that their supervisees might not be familiar with this kind of non-clinical treatment for mental health concerns. For that reason, supervisors will need to inform their supervisees that this special population of clients will expect to be dealing with counseling professionals who are knowledgeable in deliverance practices as a treatment alternative and as a result will not judge them but

rather validate their choice. They will need to also make them understand that spiritual healing using deliverance methods and treatment from OPMHCs are mutually inclusive and will produce better and longer-lasting results. Counselors will need to recognize the role religion and spirituality play on the effective treatment approach of this special population (ACA, 2014).

Training

With this study, international Black CE students will strengthen training programs as they offer different perspectives to curricula that are usually Western-centric. "International CE students facilitated learning among fellow classmates with culturally-rich views" (Kuo et al., 2018, p. 153). At the masters and doctoral level, training on spiritual healing practices and their role in the healing/counseling process might further be expanded by making students aware of the possibility of having clients who, for cultural reasons, could prefer deliverance practices for the treatment of their mental health concerns. According to Clark, Moe, and Hays (2017), an increase in the training of counseling professionals in multicultural counseling competence will have a significant impact on the cultural awareness of professional counselors. In other words, the kind of training needed for counselors and counselors in training will be training that is multiculturally-based. To that end, what counselor educators will need to know to prepare our students for working with this population will be for them to be "aware of and address the role of multiculturalism/diversity in the supervisory relationship" (ACA, 2014, p. 13) Also, counselor educators will need to make their students recognize that culture affects the way in which the problems of clients are not only defined but also

experienced. Counselor educators will equally have to actively train their students to acquire skills, as well as attain awareness and knowledge in multicultural competencies (ACA, 2014).

Counseling

According to Kuo et al., (2018), international students help the counseling profession grow globally as they actively contribute to the promotion of the profession through their counseling, leadership, research, advocacy, and other services. “Their contributions in the U.S. or in their countries of origin can also ensure the quality of the international profession and support efforts towards the internalization of counseling” (Interiano et al, 2018 (p. 322). As far as international students are concerned, especially those coming from African countries where most Christians especially Pentecostal Christians believe in deliverance practices, it will be of interest to them to know that even here in the United States, there are Black churches that practice deliverance for mental health conditions. It should, however, be noted that in most Black African countries, mental health is a concept that is neither well understood nor practiced.

As a result, the international CES masters and doctoral students who come to the United States will be able to return to their countries, introduce mental health and make their communities understand that mental health in OPMHCs and deliverance practices in churches are mutually inclusive and that both practices will help the individual have better therapeutic outcomes. These international students in CES programs will also be able to assist their students in developing counselor training and counseling programs that collaboratively work with spiritual leaders. In my interviews, that was the conclusion of

my participants as they all encouraged the building of a cordial and healthy professional relationship between counseling professionals and church leaders. In their article, Crumbs et al., (2019) stated, "participants conveyed that their counseling relationships allowed for trust and flexibility that enabled them to…intentionally building resource networks with churches…to help meet clients' basic needs" (p. 27). To this end, what counselors will need to be aware of when counseling this population will be that the women will be more comfortable with counselors who understand the important role spiritual healing through deliverance plays in their lives and even be willing to incorporate prayers as well as biblical wisdom and principles during their counseling sessions.

Consequently, what counselor educators need to put in place to ensure ethical counseling services are provided will be for them to be "aware of, and avoid imposing their own values, attitudes, beliefs, and behaviors… especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (ACA, 2014, p. 5). In other words, counselor educators must respect the cultural diversity of their clients and be ready to refer them to other counselors who are more knowledgeable in this multicultural field (ACA, 2014). As a result, the multicultural competencies which counselor educators will need to incorporate into the work will be that of understanding that this special population has multiple cultural identities which include their race, ethnicity, sex, religion and spirituality (Ratts et al., 2016).

The counseling professionals will, therefore, must continue addressing the needs of these culturally diverse clients as well as the social justice concerns that shape and contextualize not only their mental health but their overall well-being as well (Ratts et al.,

2016; Singh, Nassar, Arredondo, & Toporek, 2020). As Murray-Brown (2021) stated in her article, a White female therapist told her that she was retiring her bias that nonclinical healing was not powerful enough for her Black clients. The reason was because she finally realized that community options could be healthier than she thought since they engendered greater self-respect and self-determination.

Research

Considering that this study has limitations, international and immigrant CE professionals will be able to consider the limitations of this study, expand on and enrich it as they include other aspect of spiritual healing (Dollarhide, Gibson, & Moss, 2013). Further research in this field of spiritual healing will then include the scholarly interests of researchers who desire to understand the special needs and issues of this unique Black population (Interiano et al, 2018). Future research will also be needed as the field of CES continues to recommend more diversity in doctoral programs and in program faculty (Interiano et al, 2018).

Furthermore, findings reported in this study will be used as a launching pad for more research which will help in the evaluation of healthy multi-dimensional acculturation approaches for FBSs that inform counseling instruction and curriculum in several other host societies (Interiano et al, 2018). Additionally, according to Crumbs et al. (2019), counseling professionals would increase their understanding of poverty among the underprivileged as they become more multiculturally aware of the living conditions of this special group of people. Nevertheless, it would be necessary for more research to be conducted “to explore how this information is applied to provide counseling

professionals with evidence-based illustrations of social justice advocacy in practice" (Crumbs et al., 2019, p.22).

Leadership/Advocacy

Based on Ratts et al., (2016), the multicultural and social advocacy movement is on the rise. To that end, Kuo et al. (2018) affirmed, "enthusiasm in empowerment and advocacy for underserved populations in the U. S…. was a common phenomenon among international CE doctoral students" (p. 165). With this study, therefore, the training of counselors will include advocacy techniques and competencies like Multicultural and Social Justice Counseling Competencies (MSJCC). As a result, this study will encourage students to foster advocacy and empowerment efforts in areas they are passionate about as they work with marginalized groups (Kuo et al., 2018). This study will also inform university programs on how to develop and provide extensive curriculum to include spiritual healing via deliverance practices in churches. To this end, as stated by Kuo et al., (2018), students will accept their responsibilities to always improve their professional skills that will include counseling practice, supervision, teaching, research, and advocacy. They will also accept the responsibility to train future counseling professionals (Kuo et al., 2018).

Additionally, in a bid to promote social and economic justice, international students will be able to advocate on behalf of women who are known to go to their churches for deliverance of their mental health issues. A lot of work will, however, have to be done and the starting point will be to educate their respective governments on the importance of introducing OPHMCs in their countries, as well as also educating their

church leaders on the importance of encouraging their female congregants to go to OPMHCs as they collaboratively work with counseling professionals for better therapeutic outcomes. To this end, Crumbs et al. (2019) emphasized the importance of advocating for the promotion of social and economic justice that will support the mental health of the population, especially those in the lower income bracket. Consequently, international CES masters and doctoral students will need to be ready to address systems of marginalization, discrimination, and oppression as well as the negative impact these factors will not only have on counseling services but also on the well-being of clients (Ratts et al., 2016).

Moreover, counselors are expected to actively prevent harm and help in eradicating the social processes and structures that create mental health disparities in vulnerable populations (ACA, 2014; National Board for Certified Counselors, NBCC, 2016). In Crumbs et al., (2019), the authors stated they identified as counselor–advocate–scholars who, as CES, incorporated advocacy for underserved populations into their counseling practices, supervision, teaching, and research. In this study, two of my participants, Mystic and Lovey were very vocal on the importance of counseling professionals advocating on the importance of incorporating spiritual healing through deliverance in their clinical practice as they understand the cultural implications of deliverance and how it will result in better therapeutic outcomes for their clients.

Consequently, what the counseling profession needs to be doing in terms of advocacy for this population will be for it to strive to remove systemic obstacles and barriers as they respect the dignity and promote the welfare of this special population.

This kind of advocacy with the direct involvement of the clients or on behalf of the clients, will have to be carried out at public/societal, school/community, institutional, group, and individual levels, through systemwide interventions (ACA, 2014; Singh et al., 2020). In addition, as far as multiculturalism and social justice is concerned, counselor educators will need to generate a united and collective voice for the development of multicultural competence (Singh et al., 2020).

Policy Implications

On policy implications, based on the findings of this study, I will make recommendations for future research on the experiences of BCPW going to their churches deliverance as they concurrently attend OPMHCs for mental health treatment. The findings may also have a positive impact on social change by bringing awareness to policymakers on the issues of mental health treatment through deliverance practices in churches and attendance of OPMHCs. In addition, considering that policy changes and government action are often driven by research, increasing peer-reviewed literature on BCPW may drive policy makers to enact changes and create legislation that will support women of color to overcome the barriers and limitations experienced by women from marginalized populations (Martinez Dy et al., 2017).

Theoretical Implications

The absence of any research on the lived experiences of BCPW who seek community mental health counseling concurrent with deliverance practices through the church has resulted in theoretical frameworks devoid of a representation of this minority group of women. The findings of this empirical study will, therefore, provide original

qualitative data to this study's conceptual framework which will aim at promoting the knowledge of BCPW going to their churches for deliverance of their mental health issues as well as going for treatment in OPMHCs. Consequently, these theoretical implications will open new opportunities for research to inform institutions, practitioners, policymakers, university leaders, academics, and marginalized Black Christian Pentecostal women. In addition, theoretical lenses that support spiritual healing practices could be developed to serve as an evidence-based approach to assisting clients for whom spiritual healing and mental health support is sought.

Conclusion

The purpose of this study was to explore the lived experiences of AA and other BCPW who seek spiritual deliverance and healing of their mental health conditions from their churches (Mercer, 2013; Rowan & Dwyer, 2015), and also go to OPMHCs for treatment (Friedlander et al. 2014; Hays, 2015). To explore these experiences, I used a qualitative, transcendental phenomenological approach (Buser et al. 2016; Choi, 2018; Wilson, 2014) for this study. Based on the article by Rowan and Dwyer (2015), more women than men tend to seek treatment from their church leaders through deliverance practices. Consequently, I highlighted the importance of respecting the stipulations in standards F.2.g., Section 2, and standards A.2.f., A.3.b., D.2.m., Section 5 of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016), as well as standard E.8. of ACA Code of Ethics (ACA, 2014). These standards all stressed the importance of counseling professionals being multiculturally competent in dealing with the spiritual beliefs of their clients (ACA, 2014). In addition, this study informed

professional counselors on this special subculture of female clients, with the implications for practice being that counseling professionals will have effective multicultural strategies to deal with this group (Ratts et al., 2016; Rowan & Dwyer, 2015).

At this time, no peer-reviewed literature exists on the spiritual healing through deliverance in churches and concurrently attend OPMHCs for treatment. In other words, this topic under study has been seriously under-researched and has typically been researched under the umbrella term of "spirituality and minority women" which tends to group Black Christian Pentecostal women. This study will, therefore, extend the literature to include the spiritual and mental health experiences of BCPW who, in the traditional mental health treatment approach, are usually subjected to microaggressions and marginalization (Mekawi & Todd, 2018). They are also discriminated against not only because of their gender, but also due to the color of their skin (Mora & Davila, 2014).

The findings of this study will, therefore, not only help in bridging a gap between mental health professionals and leaders of the Black Church (Avent et al. 2015; Dempsey et al., 2016), but may also bring positive social change into the Black Christian Pentecostal community as the women get satisfactory treatment for their mental health issues and strive to be the best expression of themselves in their families and communities (Alinia, 2015). The findings of this study may equally be an eye-opener to BCPW that God has other options they can use to treat their mental health presenting problems. The results of the study may also enable professional counselors to get a much better understanding of how best they can provide treatment to this special population of BCPW from their Black Churches (Adams et al. 2015).

In addition, this study may bring about much needed positive social change and social justice for a minority population of voiceless women (Heppner, 2017; Marbley et al. 2015; Ratts et al., 2016) who have chosen a certain way of taking care of their mental health issues (Hecker et al., 2016). Some of the positive social change will include the reduction of stigma (Egbe, 2015; Sirey et al., 2014; Stewart et al., 2015; Ward et al. 2013) as church leaders and family members start talking positively about OPMHCs to an extent that these women can now freely go for treatment in these OPMHCs (Baumgartner et al. 2014; Ben-David et al. 2016; Hays, 2015; Villatoro & Aneshensel, 2014). Furthermore, this will be the beginning of increasing access to quality culturally-aware interventions for the mental health needs of these women who will be able to willingly, confidently, and freely go for OPMHC services (Baumgartner et al. 2014; Ben-David et al. Cole, 2016; Hays, 2015; Villatoro & Aneshensel, 2014). Finally, in the field of counseling professionals, counselor educators and supervisors will be equipped with the necessary strategies that will be ethically and culturally relevant in the different leadership roles of practitioners, supervisors, teachers, researchers, and advocates they play as they exercise their profession.

Based on this study, therefore, attending OPMHCs for treatment of mental health issues as well as going to a church for spiritual healing through deliverance are two activities that are mutually inclusive and will be beneficial for not only the individual but also for the church leaders as well as counseling professionals as they build a healthy collaborative relationship so they can learn from each other, with the aim of helping those individuals who are both church congregants as well as clients get all the benefits of

spiritual healing in church as well as continuous treatment from OPMHCs. As Mystic succinctly put it, “I believe that pastors should be open to recommending that people go to counselors that are trained for that because most of them aren’t trained to do counseling… I’m also looking forward to the day when both deliverance and therapy would be normalized with one done after the other.”

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Appendix A: Demographic Questionnaire

1. Name_____Age_____
2. Race/Ethnicity_____
3. Gender_____
4. Level of Education _____
5. Occupation_____
6. Are you a Pentecostal Christian? _____
7. Where is your church located? _____
8. What is your church's denomination_____?
9. Is English your first language? _____

Appendix B: Research Interview Protocol

1. Please share with me your experiences with Deliverance.
2. Please share with me your experiences with mental health treatment at an Out-Patient Mental Health Clinic (OPMHC).
3. Describe the relationship between your mental health counseling experience and your experience with deliverance.
4. What's your pastor's role when supporting you for mental health concerns?
5. What are your feelings about encouraging someone to go for treatment at an OPMHC?
6. How do you view counseling and/or mental health treatment?
7. Is there any other issue you would like to share which we have not discussed concerning your thoughts and feelings about mental health treatment?

Date of Interview: _____

Time of Interview: _____

Place of Interview: _____