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Exploring Perspectives of African American Pentecostal Clergy Scripture Teachings Regarding Mental Illness

Phyllis Bethea Foye
Walden University

Walden University

College of Social and Behavioral Sciences

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Phyllis Bethea Foye

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Review Committee
Dr. Georita Frierson, Committee Chairperson, Psychology Faculty
Dr. Alethea Baker, Committee Member, Psychology Faculty
Dr. Lisa Scharff, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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MA, Walden University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Previous literature has noted that African American Pentecostals (AAP) avoid seeking secular care for mental health concerns. The purpose of this phenomenological qualitative study was to explore the lived experiences of AAP pastors' beliefs and teachings associated with mental health care as well as stigmas regarding that care, using Niebuhr's synthesis theory, Arnheim's convergence theory, and Bronfenbrenner's ecological system theory of human development. Sixteen AAP senior pastors were interviewed to explore four research questions regarding their beliefs about secular mental health care, Bible Scripture teachings, seeking support from clergy, and mental health education that may impact the acceptance of secular mental health care. Their responses were coded and analyzed for emergent themes based on Moustakas's method and five main themes were identified in the data; (a) clergy have medical theories of mental illness despite minimal scientific training, (b) clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both, (c) stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a rejection of faith, (d) clergy cite biblical support, and (e) for help-seeking education should be provided to increase knowledge and acceptance of mental health care. The findings suggested that education and training for pastors and congregants in secular care may increase acceptance of secular care in AAP communities. These results can influence positive social change through developing collaborative mental health education initiatives and partnerships with AAP pastors who are willing to refer their members to secular mental healthcare professionals.

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Dedication

This dissertation is dedicated to several people in my life who had encouraged and supported me through my educational journey. To my mother, Bertha Bethea, who taught me how to live this Christian life and always provided me with unwavering love and wisdom. I say thank you for always reminding me of “the end goal”!

To my husband Bishop James E. Foye, Jr., my Son James, III and my daughter Jasmine, for all of their love, patience, and support. I appreciate all of the family time you sacrifice for me to complete my work.

To my sister Nona, my Kingdom Dimension Church Family and Bishop John T. Leslie, Jr., your constant urging for me to persevere help me to stay my course. Thank you all for always reminding me of the needs within our church community for more collaborative efforts for mental healthcare,

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This dissertation process has been one of the most difficult and challenging processes of my educational journey. I want to offer my sincere appreciation and gratitude to my committee: Dr. Georita M. Frierson, who serves as my chair and Dr. Alethea A. Baker, who serves as my methods expert. Thank you for your patience, support, and continual guidance. I would also like to thank the writing center staff for your feedback and editing that helped this study achieve its full potential.

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Chapter 1: Introduction to the Study

Introduction

Within African American Pentecostal (AAP) churches, the origin of all mental illness is believed to be spiritual (i.e., oppression or possession by the devil or demons) (Mercer, 2013). Although Scripture teachings are the foundation for beliefs and practices regarding illness, there was little discussion on the specific texts and teachings supporting those beliefs (Mercer, 2013). Individuals within AAP churches with psychological conditions, along with their families, often fear stigma. This fear derives from the responses to the religious and cultural beliefs held within this community regarding mental illness (Avent et al., 2015; Mercer, 2013; Nie, & Olson, 2016). Traditionally mental problems were addressed within the realm of the church, specifically by the pastor, and psychological treatment was discouraged (Cook & Wiley, 2014; Kehoe, 2016). Emblems such as the cross, and allegories (e.g., Bible passages, ceremonies, practices, and other narratives) have become the foundational and core values of the African American Church (Hays, 2015). Historically, the African American Church has been a resource for not only its congregants' spiritual well-being but also its biopsychosocial support. Today, however, mental illness has become a growing concern within this culture; pastors and congregants are consistently faced with realizing the need for mental health care (Hays, 2015).

According to Avent et al. (2015) and Cook and Wiley (2014), within the AAP churches, congregants typically seek mental health treatment from the clergy. However, many of the church leaders were uneducated in working with individuals with

psychological issues. Hays (2015) argued that many clergy within the African American church are called upon to provide support and guidance for the congregant's mental health needs. He explained that clergy are often limited in their abilities to assist individuals suffering from psychological issues.

My goal for this study was to explore, through pastors within the AAP religious communities, the specific texts of Scriptures associated with teachings, practices, and beliefs regarding mental illness. I explored through clergy the particular scripture texts, references, and teachings within the AAP churches regarding congregants seeking mental health services from members of the clergy. I also explored the specific scripture texts, references, and teachings within the AAP churches regarding congregants seeking mental health care from secular mental health care providers.

This research filled the gap in identifying the scripture teachings specific to mental illness and the contextual interpretations, beliefs practices, and stigmas associated with those teachings by clergy within African American Pentecostalism. The expectation of Biblical guidance is a consistent factor supporting African American congregants in seeking mental health care and is worthy of exploration (Mercer, 2013; Odulana et al., 2014). This project was unique because it addresses the under-researched root elements that are contributors to the avoidance of AAPs seeking mental health care (Odulana et al., 2014). Hamilton et al., (2013) suggested that further research be conducted to explore African American's usage of scripture passages as a mental health-promoting strategy to support mental health worker's in obtaining a more acceptable and sensitive approach to mental health issues among patients from culturally diverse populations.

Avent et al. (2015) have identified scripture teachings as one of the main barriers to African Americans seeking secular mental health care. The results of this study provided clarity and insight into the contextual interpretations of Scriptures by AAP clergy regarding mental illness. In this study, fundamental beliefs were highlighted to help provide clarity for clinicians working with members of AAP congregations. Insights from this study may be used by clergy and clinicians in providing a more integrative approach to mental health care Mercer (2013) for APPs.

This study contributes to the available literature and addresses the dearth in research and information exploring the teachings of the specific Scriptures which contribute to the reluctance of AAPs to seek mental health services. The results of this study could support the growing body of literature meant to better understand the development and implementation of an integrative faith-based approach to mental health care for AAPs. Although there was significant research regarding the integration of religious organizations and mental healthcare, the results of this study may also include a more comprehensive integrated paradigm of scripture selection and use by clergy to support clinicians' understanding of mental illness as viewed by AAPs. Also, the results of this study may foster a relationship between clergy and the mental health community to promote a basis for a widespread collaborative, integrative mental healthcare awareness initiative within the AAP churches. In this chapter I discussed the various components of this study that included, the background, conceptual framework, research questions, nature of the study, possible types and sources of data, assumptions, scope, delimitations, and limitations, and the summary.

Background

The beliefs, Scripture teachings, religious practices and influence of the clergy all play a major role in AAP congregants′ approach to seeking help for their mental health issues. Researchers have explored many of the religious beliefs that have contributed to AAPs' avoidance of mental healthcare (Avent et al., 2015). Findings from recent studies have shown that AAP pastors inferences and teachings have a profound effect on their congregant's views regarding mental health issues (Cook & Wiley, 2014; Plunkett, 2014). Avent et al. (2015) highlighted some of the main obstacles to African American Christians seeking secular mental health care. The authors argued that the barriers often included complex coping methods such as scripture teachings, prayers, and worship practices. Other obstacles involved the concerns of stigma, denial of symptomatology, and preference for pastoral or African American counselors.

Another barrier to African American Christians seeking mental health care is that clinicians often struggle to understand their Scripture teachings, beliefs, and religious experiences. Mercer (2013) and Nie and Olson (2016) stated that Scripture teachings, beliefs, and practices of African American religious congregants were considered mystical by many mental health clinicians. The authors used a qualitative approach to their research of the Presbyterian denomination in Boston, Massachusetts, but stated that a more comprehensive analysis is needed to compare the result from other faiths and sectors.

Hamilton et al., (2013) stated that, historically, African American Christians used Scriptures from the Bible for guidance, direction and to obtain mental health-promoting

strategies. The researchers also stated the significance of caregivers' understandings of the religious practices involving scripture usage was vital to patient's progressive spiritual and mental health. Hamilton et al. also posited that when confronting healthcare issues, AAPs look to secure validation through the Bible passages that they are on the right path with God and therefore on the path to wellness. Scripture teachings and beliefs are intertwined in the life experiences of AAs. Therefore, when confronting mental health issues, they seek support from clergy to ensure that sharing those experiences and beliefs are understood and not viewed as being 'mystical' (DeHoff, 2015). AAP clergy are highly revered by their congregants and play a major role in influencing their theological and cultural beliefs regarding mental illness (Plunkett, 2014).

Kehoe (2016) and Leavey et al. (2012) posited that more collaborative efforts between mental health professionals and religious leaders would help bridge the gap between faith-based organizations and secular mental health providers in offering services for African American congregants. Hays (2015) provided information regarding the expectations placed on the clergy for the delivery of mental health services among African American congregants. Hawes-Dawson et al. (2017) offered models for conducting studies on sensitive health topics involving African American and Latino churches. The study also showed how a project team collaboration could be tailor to address cultural and organizational contextual needs. Mercer (2013) also provided information showing that future training and collaboration with Pentecostal clergy and clinicians is needed to implement an integrative program of scripture teachings, spiritual beliefs, and mental health education for the benefit of the congregants.

In addition, Odulana et al. (2014) offered that the influence of pastors as well as the Bible-based teachings and motivational sermons were links to congregants' avoidance or openness to health care events on all domains. Payne (2009) stated that most African American clergy may share similar beliefs regarding the etiology of mental illness as the African American population in general. The shared beliefs of clergy are a major factor in African American health seeking practices (Payne, 2009).

Most African American clergy tend to place significant emphasis on spiritual causes of depression and other mental illnesses (which include not trusting God). Payne (2009) also stated that members of Pentecostal religious affiliations were three times more likely to suffer depression than those of other religious groups. Anthony et al. (2015) used a quantitative approach that showed that many African American congregants expected their clergy to provide treatment for their depression. However, the authors found that collaboration with clergy and professionals would be necessary to help reduce congregant’s avoidance of secular mental health treatment. The researchers also posited that future research for developing training for pastors in depression recognition and management would help forward the collaborative effort in servicing the mental health needs of AAPs.

The beliefs and practices of African Americans suffering with serious mental illness are often essential coping resources that affect their mental health outcomes (Kinghorn, 2016). Although mental health professionals may not be familiar with those specific religious beliefs and practices, they should seek to understand them (Kinghorn, 2016). African American Christians are often leery of mental health professionals who do

not understand their beliefs (Odulana et al., 2014). However, Payne (2009) argued it would be a mistake to ignore individuals from religious organizations that are suspicious of secular mental healthcare. Payne and Hays (2016) offered that in dealing with AAPs there are essential considerations that should be given when conducting mental health research with clergy. In a grounded theory examination of the study the authors using cross-sectional data found that the views of clergy once adamant in regard to theological beliefs and mental healthcare shifted dramatically after participating in the study. The authors suggested that a "reflection-in-action epistemology might help when researchers approach clergy on the subject of mental health, because their views may potentially change" (Payne & Hays, 2016, p.609).

According to Alexander (2011), there are over 10 million AAPs from different organizations within the United States today. Kinghorn (2016) recommended that mental health professionals ask pastors to describe their specific beliefs and approaches toward mental healthcare, because depending upon their level of training they may hold extremely different theological convictions in alignment or outside of the noted religious traditions. Current literature has indicated that further collaboration between clergy and mental health professionals would help improve clinicians' understanding of religious beliefs and practices that influence African American Christians' avoidance of secular mental healthcare (Kehoe, 2016; Leavey et al., 2012). However, there have been limited studies exploring those specific teachings and beliefs (Payne & Hays, 2016). This study may contribute to the literature with a focus on the specific Scriptures teachings and beliefs of AAP clergy regarding mental illness and secular mental healthcare.

Problem Statement

Within African American Pentecostal (AAP) churches, the origin of all mental illness is believed to be spiritual (i.e., oppression or possession by the devil or demons; Mercer, 2013). Although scripture teachings are the foundation for beliefs and practices regarding mental illness, there is little discussion on the specific texts and teachings supporting those beliefs **(**Mercer, 2013). Individuals within AAP churches with psychological conditions along with their families often fear stigma (Goffman, 1986). This fear derives from the responses to the religious and cultural beliefs held within this community regarding mental illness (Avent et al., 2015; Mercer, 2013; Nie, & Olson, 2016). Traditionally mental problems were addressed within the realm of the church by the pastor, and psychological treatment was discouraged (Cook, & Wiley, 2014; Kehoe, 2016; Schuurmans-Stekhoven, 2013). Emblems such as the cross, and allegories (i.e., Bible passages, ceremonies, practices, and other narratives) have become the foundational and core values of the African American Church (Hays, 2015). Historically, the African American Church has been a resource for not only its congregants' spiritual well-being but also their biopsychosocial support. Today, however, mental illness has become a growing concern within this culture and pastors and congregants are consistently faced with realizing the need for mental health care (Hays, 2015).

According to Avent et al. (2015) and Cook and Wiley (2014), within the AAP churches congregants typically seek mental health treatment from the clergy. However, many of the church leaders are uneducated in working with individuals with psychological issues. Hays (2015) argued that many clergy within the African American

church are called upon to provide support and guidance for congregants' mental health needs. Pastoral beliefs and perspectives regarding mental illness often have a major impact on congregants' decisions in seeking mental healthcare (Mercer, 2013). The extent to which pastors encourage religious or spiritual explanations and healing can be predicted by several interconnecting factors such as theology, cultural background, acceptance of bio-medical illness models, and education (Leavey et al., 2012).

Often, beliefs, Scripture teachings, and sermons relayed by pastors regarding mental illness, influence congregants in avoiding secular mental healthcare (Hamilton et al., 2013). Also, some pastors may relay messages from the pulpit that inadvertently influence congregants suffering with mental health issues from seeking treatment (Payne, 2009). Clergy attitudes, beliefs and perceptions play a significant role in congregants' mental health seeking decisions, however, there is a scarcity in information regarding those beliefs relative to secular mental health interventions (Payne, 2009; Payne & Hays, 2016). The problem addressed by this research was the dearth in information on the specific teachings that influence AAPs beliefs regarding mental illness and avoidance of secular mental healthcare. The authors recommended that professionals gain understanding of what clergy beliefs consist of considering their views about mental illness have significant impact in guiding the individuals who come to them for their mental health problems. Further exploration of the lived experiences of clergy's perceptions on scripture teaching and beliefs regarding mental illness and mental healthcare may provide understanding of AAPs reluctance or avoidance in seeking secular mental health services.

Purpose of the Study

This qualitative phenomenological study aimed to explore the perspectives of pastors within the AAP religious communities, on Scripture texts, teachings, practices, and beliefs in respect to mental illness and avoidance of secular mental healthcare. This study aimed to explore the lived experiences of the clergy's beliefs and practices regarding congregants seeking mental healthcare. The literature review provided a background of the existing knowledge related to the understanding of the reliance for guidance on pastors and Bible Scriptures by AAP congregants in need of mental health support. The purpose of this qualitative phenomenological study was to gain understanding of AAPs lived experiences of scripture teachings that influence their beliefs regarding mental illness and avoidance of secular mental healthcare.

Research Questions

Research Question 1 (RQ1): What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare?

Research Question 2 (RQ2): What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?

Research Question 3 (RQ3): What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy?

Research Question 4 (RQ4): What type of mental health education if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities?

Conceptual Framework

There are several relevant theories to the fundamental beliefs and teachings of AAPs. I drew upon the synthesis, convergence, and the ecological human development models for this study. The Black Church is complex in nature, and compilation of Christian concepts, African American historical and cultural experiences, along with the theological beliefs of Pentecostals requires unique considerations in understanding their lived experiences of AAPs (Mercer, 2013). I used these models because they can explain the religiosity, psychological and eco-social factors that impact AAPs beliefs regarding mental illness and secular mental healthcare. I used Niebuhr's (1951) synthesis model to provide the premise for integrating religious thought and psychological resources. In this model, Niebuhr argues the conflicts between Christ and culture. He posits Christians promote the idea that culture directs humanity to Christ, but Christ must enter into human circumstances with endowments from above," which cannot be received by natural ability" (Niebuhr, 1951, p. 42). This concept holds that Christianity and “worldliness” are separated by Christ’s purpose and society’s focus (Niebuhr, 1951). Niebuhr's synthesis model illustrated the impactful, productive effects of combining two opposing systems, Christianity, and society (Niebuhr, 1951). Niebuhr also posited that synthesis occurs when Christ "draws up" society while the church works to cultivate and prepare humanity. This model provided the framework for understanding the underlying psychological conflict between Christians and society, in making life decisions such as the seeking of secular agencies, instead of the church for their mental health needs.

I used Arnheim's (1982, 1986, 1996) convergence model to provide the foundation for psychologists to find ways to resolve the tension in the theological sector. Arnheim developed the convergence model to conceptualize that visual movement takes place between art and psychology, resulting in uniformity bringing them both to a single meeting point (1996). Understanding the meaning and interpretations of theological teachings and beliefs was germane to this study. This model also involves the process in which individuals strive to interpret and respond during communications for mutual understanding of the theological message, especially as it increasingly becomes more important or subtle (Arnheim, 1982, 1986, 1996).

I also used Bronfenbrenner's (1979) ecological system theory of human development to explain the role the interactions and influences between relationships, cultures, socioeconomic status, and other cultural contexts play in the development of the microsystems, mesosystems, exosystems, and macrosystems that shape an individual's psychosocial development. Fundamentally, in a microsystem, the core values and religious beliefs of individuals or families are commonly shared (Bronfenbrenner, 1979). However, because of other environmental influences, social settings, and relationships that interconnect (i.e., school, peers, teachers, work, etc.), mesosystems and exosystems create interactions and links that often redirects the successive generations' (macrosystem) eventually changing social, cultural, beliefs and religious views (Bronfenbrenner, 1996).

Nature of the Study

This qualitative study was phenomenological. I used internet video interviews to gather data from African American Clergy, ages 35 and older, on their perspectives and lived experiences regarding mental illness and secular mental healthcare. A phenomenological analysis and reflexivity will yield themes and ascribe meaning to the data (Creswell, 2014). Previous researchers have used this qualitative approach to explore the lived experiences of Christian clergy and other religious organizations' members regarding beliefs and teachings and their impact on mental healthcare (Mercer, 2013). My primary focus in this qualitative study was to provide a base for the collaboration of clergy and mental health professionals to explore the integrative possibilities of faith-based beliefs and secular mental healthcare.

The nature of this study was also for the exploration of Bible Scriptures, beliefs, and practices specific to mental health and to highlight mental health educational factors and services that may be more acceptable among the AAP populations. The German philosopher Edmund Husserl (2012) developed phenomenology, based on the philosophy that reality consists of objects and events (phenomena) as they are perceived or understood in man consciousness and not of anything independent of human knowledge. Phenomenology involves the exploration of lived experiences and feelings, which is consistent with this study’s scope (Husserl, 2012). This approach provided the bases in which the researcher describes the lived experiences of different individuals on a phenomenon (Creswell, 2014). The purpose of the research was to understand and capture the essence of the lived experiences of the participants.

Operational Definitions

African American: A Black individual born in the United States, whose ancestor is of African heritage (Merriam-Webster, 2010)**.** African American is also defined as one who is a resident or citizen of the United States whose ancestry originated from any of the populations of African (African American, n.d.).

Hermeneutics: Involves theories used for the accurate interpretation of text. Although 'hermeneutics' and 'interpretation' derive from the same Greek word, 'interpretation' is more commonly used in the English language (Schmidt, 2014). Hermeneutics also involves an approach to Scripture that is motivated by a theological perspective which values the authority, spiritual interpretations and understanding, and life changing power of the text (Martin, 2013).

Mental Illness: A health condition associated with distress or other issues related to a person's ability to function properly in their environment or society due to shifts in their emotions, behaviors or thinking (American Psychological Association (APA), 2020; Murthy, 2006).

Pastor: The pastor is the principal spiritual leader of any church congregation, whose main responsibilities are to help the congregants draw closer to God, keep God as the center of their lives, and to spread the gospel of Christ to the world. Spiritual depth of the pastor is crucial for supporting the other attributes (i.e., skills, intelligence, ability), for successfully serving the needs of the congregants (Vine, 1988).

Pentecostal/ Pentecostalism: A religious movement which believes in one experiencing a transformed life through a personal relationship with Jesus Christ and

being born again. Additional significant tenants held by the movement include the practices and beliefs of receiving of the baptism of the Holy Spirit (as experience by the disciples on the day of Pentecost, Acts 2:1–4), and the belief in healing, miracles speaking on tongues and the works of Christ as described in Scriptures (Hefner & Berger, 2013; Merriam-Webster, 1986;).

Religion/Religious: of or relating to devotion and worship of deity; particular faiths, or denominations which define specific texts, lived beliefs, ritual practices, observances, confessions, and historical, social, and theological traditions (Merriam-Webster, 2010; Schilderman, 2015).

Scriptures: Writings that are regarded as sacred, holy, or authoritative, more specifically from the books of the Bible. The Bible is compiled of both the Old and New Testament, 66 sacred books, any passage from the Bible is considered sacred (Merriam-Webster, 2010).

Spiritual: Relating to or affecting the spirit or relating to sacred matters. Of or relating to supernatural beings or phenomena (Merriam-Webster, 2010).

Stigma: A phenomenon wherein a person with a particular attribute is viewed in a negative light by others and is therefore stereotyped, disqualified, discredited, or rejected from social acceptance. The individual may also perceive that the attribute is known by others and fear being discriminated against or discreditable resulting in their disengagement from social norms and involvements (Cooper & Mitra, 2018; Goffman, 1986).

Assumptions

I assumed that participants would be willing to share their beliefs as the entire project is dependent on their perceptions on mental illness and seeking secular mental healthcare. I used open-ended questions to avoid influencing the responses of the participants with leading questions. Also, to encourage open and honest participation during the interviews, attention was given to the informed consent to ensure participants of confidentiality and privacy, that all information disclosed will be confidential.

Scope of Delimitations

The scope of this study was limited to internet video interviews of pastors from African American Pentecostal Churches within the United States. This study was bound to explore the perspectives of African American clergy regarding scripture teachings relating to mental illness and secular mental healthcare within this religious population. The delimitations of this study involved the time, geographical location, and finances necessary to fully explore this topic. The scope of this study was limited to African American Pentecostal clergy of different churches in close proximity to my geographical location, to limit travel expenses.

Limitations of Study

The purpose of this study was to explore the interpretive views of clergy regarding to scripture teachings specific to mental illness. This study had many limitations. The first limitation was that the study only includes African American Pentecostal clergy. Although there are other ethnic and racial groups within Pentecostalism, no inferences can be made about all of their specific interpretations of

Scriptures, practices, or stigma regarding mental illness from this study. Another limitation involved the sample size of the study. A qualitative study provides rich, in-depth inquiry of the meaning individuals ascribe to a social or human problem; therefore, the number of participants was small, averaging between ten and fifteen. Also, qualitative research is not statistically representative, limiting the transferability of the data. Other limitations to this study included time, location, and transferability. Conducting this qualitative study included the potential for personal bias, especially because I shared the same background and culture of the population of the study.

Significance

This research filled the gap in identifying the scripture teachings specific to mental illness and the contextual interpretations, beliefs practices and stigmas associated with those teachings by clergy within African American Pentecostalism (Kehoe, 2016; Mercer, 2013). The expectation of Biblical guidance is a consistent factor supporting African American congregants in seeking mental health care and is worthy of exploration (Mercer, 2013; Odulana et al., 2014). This project was unique because it addressed the under-researched root elements that are contributors to the avoidance of AAPs seeking mental health care (Odulana et al., 2014). Hamilton et al., (2013) suggested that further research be conducted to explore African American's usage of scripture passages as a mental health-promoting strategy to support mental health workers in obtaining a more acceptable and sensitive approach to mental health issues among patients from culturally diverse populations.

Avent et al. (2015) have identified scripture teachings as one of the main barriers to African Americans seeking secular mental health care. The results of this study provided clarity and insight for clinicians into the contextual interpretations of scriptures by AAP clergy regarding mental illness and the avoidance of AAPs seeking secular mental healthcare. This study highlighted the fundamental beliefs to help provide clinicians working with individuals from the AAP population understanding of their beliefs about mental illness and avoidance of secular mental healthcare. Insights from this study should assist clergy and clinicians in providing a more integrative approach to mental healthcare for African American Pentecostals (Mercer, 2013).

This study may contribute to the available literature as well as address the dearth of research and information exploring the teachings of the specific scriptures that contribute to the reluctance of AAPs to seek secular mental health services. This study may also support the growing body of literature meant to better understand the development and implementation of an integrative faith-based approach to mental healthcare for AAPs. Although there is significant research regarding the integration of religious organizations and mental health care, the results of this study provided a more comprehensive integrated paradigm of understanding scripture selection used by clergy to help support clinicians' understanding of mental illness and secular mental healthcare, as viewed by AAPs. Also, information gathered from this study should `increase access to mental healthcare to AAPs and help mental health clinician understand how to successfully provide therapy to this population.

Summary

Recent studies pertaining to the African American Church and mental illness has been in relationship to historical, cultural, and religious beliefs (Mercer, 2013; Plunkett, 2014). African American congregants do not often seek mental health care outside of the church (Dempsey et al., 2015). Researchers have identified the pastor as the most sought-after guide for mental health issues among African American congregants (Dempsey et al., 2015; Hamilton et al., 2013; Payne, 2008). Although there have been collaborative efforts to bridge mental health care and spiritual counseling, there was a gap in the exploration of the perspectives of Scripture teachings on mental illness among African American Pentecostal clergy.

In this chapter, I presented the purpose of this study, outlined the research questions, and discussed the phenomenological philosophy. I also provided the operational definitions of key terms for the purpose of understanding the context of the pastor/clergy, hermeneutics, and the inter-relationship between the African American Pentecostal Church and the Black Church, I provided the significance, limitations, possibility for social change, and the outline of research strategies for collecting information from participants that is credible and dependable. In Chapter 2, I presented an exhaustive review of the literature regarding the African American Pentecostal Church, the influence of the pastor, the perception of mental illness in the African American religious community, and the phenomenological philosophy and methodology selected for this study.

Chapter 2: Literature Review

The perception of mental illness within the Black Church community historically has been viewed negatively (Mercer, 2013; Payne, 2009). Many congregants believe that psychiatric conditions are results of a type of spiritual issue (Mercer, 2013). Cultural and historical factors associated with the Black Church have contributed to the continuum and perpetuation of many congregants' lack of seeking secular mental health care (Mercer, 2013). These factors are pertinent in supporting and understanding the underlying beliefs, practices, and teachings of African American Pentecostals (AAPs), who formulate the most significant Black Christian movement in the world (Jaynes, 2005). In this literature review, I aimed to explore the existing empirical research specifically relative to AAP scripture teachings, texts, or references about mental illness or mental health care. My purpose in the study was to gather information from pastors and clergy of the AAP Churches to ascertain the specific, if any, theological hermeneutics, scripture texts, or fundamental teachings regarding mental illness. My goal was to provide clarity and understanding to mental health care providers for servicing this population.

Literature Search Strategy

l conducted the literature search strategy by gathering sources from the Walden University online library, the University at Buffalo Library, Buffalo and Erie County Public Libraries, the internet, and Google Scholar. I accessed articles using PsycINFO, PsycArticles, EBSCOhost, ProQuest Dissertations & Theses, PsycBooks, SocINDEX, and SAGE. The keywords that I used in the search included *African Americans*, *Black*,

Pentecostals, Pentecostalism, Azuza, Black Church, religious, religion, demons, possession, congregants, Bible, passage, texts, Scriptures, mental illness, mental healthcare, clergy, pastors, beliefs, teachings, barriers, stigmatization, psychosis, spiritual, biopsychosocial, leaders, convergence model, synthesis model, Christ and Culture, and *ecological human development model*. I used keywords individually and in various combinations. I also reference some of the articles as sources.

Conceptual Framework

In this study, I explored the particular scripture texts, references, and teachings among AAP Churches regarding congregants seeking mental health services, from members of the clergy. I also explored the specific scripture texts, references, and teachings within the AAP Church regarding congregants seeking mental health care from secular mental health care providers. I used (a) Niebuhr's (1951) synthesis model, (b) Arnheim's (1982, 1986, 1996) convergence model, and (c) Bronfenbrenner's (1979) ecological system theory of human development to better understand the lived experiences of integrating one's religious and cultural beliefs with beliefs about mental health care.

The Synthesis Model

Niebuhr's (1951) synthesis model provided the premise for integrating the theological and psychological resources necessary for this study. This model illustrated the productive effects of how combining two adverse elements can be impactful. Niebuhr, a professor of Christian Ethics at Yale Divinity School, introduced this model in respect to the Christ-culture problem in which Christians struggle to "distinguish loyalty

to Christ and responsibility to culture" (p. 149). Niebuhr (1951) posited that synthesis occurs when Christ who is above culture, "enters into human circumstances, endows and 'draws up' society with gifts, and the church works to prepare humanity; the integration of these two ideas results in the ultimate communion of the soul with God" (p. 42).

In the model, Niebuhr (1951) identified the different ways in which Christians historically reacted to a society based on religious beliefs. One of the methods included the theory of synthesis. The author posited that cultural preparation under the law, and the gospel, through the church, would create the integration process necessary for spiritual union with God (Niebuhr, 1951). Niebuhr also argued that if models are constructed in which the ethical beliefs or opinions of individuals are correlated with variables for different areas of scientific research, it is no more difficult to construct a model in which the variable is Christian faith. Niebuhr (1951) further explained that spirituality and reason unified, although adverse could result in a positive and gifting experience for humanity. The author questioned whether Christians formed in their own minds, their responsibilities of good and evil, or whether those guides are by societal, psychological, or cultural directives.

Congregants within the Pentecostal movement (whether Black or White) have often struggled with seeking secular mental health care due to fear of going against cultural or religious beliefs (Trice & Bjorck, 2006). While inferred through preaching or through the direct teachings from scripture texts, many adherents believe that they must turn to God for deliverance from illnesses or negative situations (Plunkett, 2014).

The author's typology of Christ above culture, illuminates the psychology of Christians regarding church and culture (Niebuhr, 1951). The author expresses how Christians engage culture, by synthesizing the elements of society (reason and law) with the elements of the Christianity (the gospel, and the church) (Niebuhr, 1951). The author also suggested that Christians respond to what they believe is their duty to adhere to or whether how they respond, may stem from Christian experiences they may encounter (Niebuhr, 1951). This model helps in understanding how the integration of both the theological and psychological elements of AAP clergy influence their perspectives on secular mental healthcare and will assist the development of those themes (Niebuhr, 1951).

The Convergence Model

Arnheim's (1982) convergence model provided the foundation for psychologists to find ways to resolve the tension in the theological sector. The convergence model was developed based on Arnheim's conceptualization that visual movement takes place between art and psychology, resulting in uniformity, bringing them both to a single meeting point (Arnheim, 1996). This model involves the process in which individuals strive to interpret and respond during communications for mutual understanding of the message, especially as it increasingly becomes more important or subtle (Arnheim, 1982, 1986, 1996).

In essays, Arnheim (1996) argued that the word *structure* is used within U.S. society when determining decisions as necessary, ascribing differences of parts as required by a whole. The author, therefore, posited that the process illuminated the power

of thought to its visual perceptual composition. Arnheim (1982, 1986, 1996) used art to convey the theory of convergence. The researcher conceptualized that visible movement takes place between art and psychology, resulting in uniformity, bringing them both to a single meeting point (Arnheim, 1996). This process involves the sender and receiver striving to mutually understand the communication, especially as the message becomes either more vague or important (Arnheim, 1982, 1986, 1996).

In studying the mind's cognitive process, Arnheim (1986) posited that the most crucial instrument in the process is sensory perception, more specifically, visual perception. The author argued that "perception was not simply an unconscious recording of stimulation place upon the physical being of humans or animal, but the immediate active comprehensive structure" (p. x). According to Arnheim (1986), the cognitive process traditionally involved gathering data acquired through the senses and processing that information through the central mechanisms of the brain. However, the author posited that in the cognitive process, perceiving was limited for its value in the operation of thought (Arnheim, 1986). Thinking does not possess the sole characteristics traditionally attributed to it. It requires a sensory basis which works along a "continuum of cognition from direct perception to the most theoretical construct" (Arnheim, 1986 p.13). Thinking and perception cannot operate separately, and intellect and intuition (which is identified by its ability to apprehend directly the effect of an interaction in a field or a gestalt situation) also plays a major role in the cognitive process (Arnheim, 1986).

Within gestalt psychology, the overall structure has also been analyzed, which provides the organism with an area of objects, shapes, colors, and musical tones. The arts are made possible through the extensive influences of perceptual expression (Arnheim, 1986). Arnheim defined intuition as ‘the cognition through perceptual field processes which functions through the secondary but indispensable help of the intellect.’ The author also explained that intuition and intellect produce thinking, which cannot be separated in either of the disciplines of science or art, because neither be separated from perception (Arnheim, 1986).

Also, in his convergence theory Arnheim (1982) posits that a center was a “field of force, a focus from which forces issue and toward which forces converge” (p. 13). Arnheim highlighted the fact that there is a point where art and architecture meet on shapes that share the same centers and grids that share the same patterns. The researcher also posited that, forms and how they artistically display is significant to the interpretations and revelation of the nature of the artist’s human experience. Arnheim explained that the "center" is not simply that which is geometrically the middle based on location alone, but it may be present without being explicitly identified. He stated that ‘in the dynamic sense of the term, it functions as a point of convergence from which energy spreads into the environment.’ The forces emitted from the center are distributed in its surroundings of external troops, otherwise known as the center’s visual field. Arnheim also argued that all visible objects are considered centers of forces and can be in any visual-spatial and that the interplay between different visual objects as centers of powers

is the foundation of the composition. These other forces may come from external centers (visual fields) in the environment (Arnheim, 1982).

The convergence model also provides the basis for understanding how one may view the world from a particular perspective centered upon self and how that view can be impacted by the external forces (Arnheim, 1982). The interplay between the forces all contributes to the individual's composited worldviews. Arnheim also emphasized that communication is a process in which the subtly of the message may confuse the interpretation of its meaning between the sender and receiver (Arnheim, 1982). The convergence model will help in providing a framework for exploring the meanings of the theological beliefs of AAP clergy and their views on mental illness and secular mental healthcare, to assist with the development of those themes for this study (Arnheim, 1982).

African Americans often find similarities between their lived experiences and meanings of text and stories in the Bible, based on interpretations and inferences relayed by the speaker (St. Clair, 2011). The task of the interpreter is to determine the meaning which is often based on the socio-cultural context of the interpreter (St. Clair, 2011). The meanings are derived from the residual effects of the sufferings and shame of slavery and other psychosocial problems of African Americans and the belief that according to the biblical texts, God will bring them wholeness and deliverance from their oppressions (St. Clair, 2011). Mental problems are often perceived among AAP clergy as spiritual, and that secular treatments are not conducive the deliverance of individuals suffering with such issues (Karadzhov & White, 2018; Mercer, 2013). The beliefs and teachings of clergy that the solutions for mental illnesses are only spiritual, continues to perpetuate the

tension experienced between individuals of theological and the psychological schools of thoughts (Belcher & Cascio, 2001). Understanding clergy perspectives, points of view, and the forces behind their thought processes is pertinent to the analysis process of recognizing the themes in this study.

In addition, Arnheim (1996) argued that it was normal within our society (i.e., schools, families, and religious denominations, etc.) when faced with dilemmas, to communicate and cooperate. Often compromising, agreeing, or making concessions is a part of the process to attain common ground (Arnheim, 1996). However, the researcher posited that two opposing forces, that are brought together through compromise, motivated by tension, creates a forced-flawed structure that may create the potential for the explosion (Arnheim, 1982). Arnheim explained that based on gestalt's theory, each need of the participants acts as 'directed tension,' which is 'vectors in a system of forces.' He posited that the forces are never separate, their fundamental struggle in both the physical and psychological realm is that they must move toward the most favorable state of physical balance in which all vectors are consistently equal in position, balancing the situation. Arnheim's convergence model provides the framework through art for communicating the subtle ways in which the 'mechanisms of perceptions' affect the worldviews of others. It helps those of different schools of thought (i.e., theology and psychology) understand how to interpret meaning between one another.

Bronfenbrenner's Ecological System Theory

Bronfenbrenner's ecological system theory (1979, 1996) helps explain how the role of the interactions and influences of the environmental human development system

shapes an individual's psychosocial development. Bronfenbrenner argued that the observation of human development required studies of an individual in multiple settings and different situations. The researcher also explained that development consisted of the forward empirical research of the mutual interaction of an active growing human and the changing environment in which the individual lives. He posited that the environment is affected by the process and is changed by the individual, therefore, the individual is not simply viewed as one without nous on whom the environment greatly effects, but as a powerful maturing being that moves through and changes the society in which he or she resides.

The first setting that influences a person's life is what Bronfenbrenner identifies as the microsystem. This system usually consists of face-to-face settings (i.e., family, friends, church daycare, etc.), where the developing individual experiences interact in physical activities, roles, and skills (Bronfenbrenner, 1979, 1996). The term "*experiences*" is important when defining microsystems; it indicates that the scientifically relevant features of any environment include not only its objectives properties but also individuals in that environment perceive them (Bronfenbrenner, 1979, 1996). Human behavior and development can occur solely through the observance of objective physical situations and circumstances and its meaning in shaping psychological growth. (Bronfenbrenner, 1979, 1996).

The next system described by Bronfenbrenner is the mesosystem. The mesosystem consists of the interrelationships between two or more settings (microsystems) in which the developing individual is in the process of participating with

at the same time (i.e., an adult, church member, family, co-worker) (Bronfenbrenner, 1979, 1996). When a person ventures into the new setting, they create a mesosystem. In addition to the original link, the individual moves actively in the other social environment, or others participate in both settings (Bronfenbrenner, 1979, 1996).

Bronfenbrenner referred to the exosystem as the next human development system. Then the exosystem occurs when one or more settings in which events occur affect the development of the person (i.e., a case of a young child might include a parent's place of work) or one or more setting in which the events are affected by what happens in the environment containing the developing person (i.e., a school class attended by an older sibling) (Bronfenbrenner, 1979, 1996). The macrosystem, which follows, is referred to as consistencies in the construct and content of lower order systems (micro-, meso-, and exo-) which involved or could consist of the level of what appears relative as the blueprints for society (Bronfenbrenner, 1979, 1996), the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies (Bronfenbrenner, 1979).

Bronfenbrenner then explains that there are references in society which provided the primary construct and familiarization of government or public buildings in different significant countries). Although they each may appear to be constructed from the same blueprint, they differ in function based on the microsystems of the society where they are (Bronfenbrenner, 1979). Each system contributes to the individual's psychosocial development, contributing to their cultural, religious, ethnic, moral, beliefs, and world views.

Clinicians working with AAPs need to understand their historical thought processes associated with possible societal engagements, the teachings associated with healing and deliverance, and the cultural, environmental worldviews that impact their decisions on seeking secular mental health care. The synthesis theory provides an explicit model for assisting with the understanding of the psychological and spiritual struggles experienced by Christians when attempting to integrate the ethical dualism involving their duty to Christ and secular concepts. The convergence theory provides the model that helps individuals from different schools of thought understand how to interpret meaning between one another. Bronfenbrenner's ecological system theory (1996) helps to explain how environments and systems may contribute to AAPs psychosocial development and how those contributions may influence their religious, cultural, moral, beliefs and worldviews. These theories provide the necessary frameworks that support the different aspects of this study's exploration of the lived experiences of AAPs clergy's beliefs regarding mental illness and avoidance of secular mental healthcare.

The Black Church

The defining of the term 'Black Church' is a matter of continuous dispute among researchers. According to Lincoln and Mamiya (1991), any institution whose attending congregation consisting of Black Christians is considered a Black Church. The term "*the Black Church*" is an abbreviated reference to the multiple doctrines of Black Christian Churches in the United States. The term derives from both the social and theological references made by scholars as well as the general population (Lincoln & Mamiya, 1991). Prior to the 1960's the Black Church was referred to by scholars as "the Negro

Church" (Lincoln & Mamiya, 1991). The term is general and inclusive; any Black Christian is considered a part of the Black Church if he or she is a member of a Black congregation (Lincoln & Mamiya, 1991). The Black Church is made of Christian churches of different denominations that ministers to predominantly African American groups (Warren & Herman, 2011). Disagreeing with the prior notion, Adksion-Bradley et al. (2005) argued that an institution might also be considered a Black Church if its' local congregation is African American, even if its organization is predominately Caucasian. However, Plunkett (2014) explained that spirituality and understanding God was well established within the Black Church. The significance of those factors was historically developed through African American denominations (i.e., Church of God in Christ, African Methodist Episcopal Church, National Baptist Convention, of the U.S.A., etc.) (Plunkett, 2014). The Black denominations are rooted in the Baptist, Methodist, and Pentecostal traditions (Plunkett, 2014).

After slavery former slaves began attending Christian church services (Warren & Herman, 2011). Christianity was the predominant religion spread among most slaves, and upon their freedom was embraced as their religious faith (Lincoln & Mamiya, 1991). There were many different churches associated with different denominations, which influenced the fundamental beliefs of slaves and their pursuit of religion after slavery (Lincoln & Mamiya, 1991). Former slaves attended the White churches within their immediate communities, Lincoln & Mamiya, however, differences arose between White Christians and Black Christians regarding spiritual experiences (Lincoln & Mamiya, 1991). White Christians viewed Black Christians as extremely emotional in their worship

expressions, forging a new order among the newly freed slaves (Lincoln & Mamiya, 1991). Black Christians began congregating and a universal order of spiritual worship was created among them across different denominational lines (Catholic, Baptist, Methodist, Pentecostal, etc.) (Lincoln & Mamiya, 1991).

Former slaves took on the role of leaders, and pastors started holding meetings and forming congregations in the South and North in the 17th century (Warren & Herman, 2011). By the end of the 17th century, many former slaves left the white churches and began forming their own (Warren & Herman, 2011). Daniel Coker, a Black Methodist preacher, was one of the first leaders to organize African American Churches, establishing denominations within different cities (Gravely, 1979). This forming of the sects was known as part of the independent church movement in African American religious history (Gravely, 1979).

The Black Church emerged as the spiritual-religious and cultural womb that became a nurturing center for its congregants (Lincoln & Mamiya, 1991). As it continued to mature, it provided the Black community with a new-found sense of independence, continued to motivate a celebration of communal dignity and pride (Gravely, 1979). In addition to worship and moral concerns, this new institution became a support for the Black community in many other areas (i.e., social, educational, financial, artistic, musical, and economical) (Lincoln & Mamiya, 1991).

Therefore, the church had become a respectable institution and a resource for the needs of the Black community (Dempsey et al., 2015). The Black Church played a significant role in supporting its people. It established itself as the most faithful institution

within the community that continues to serve and support the spiritual well-being, health, and well-fare (Rowland & Isaac-Savage, 2014). Although in agreement with the Black Church's position as the spiritual and emotional support for its community Douglas and Hopson (2000) argued that it was much more. They posited that in addition to providing social services to the community, the Black Church has provided a platform that helped in developing and launching the careers of many of its local and national political leaders (Douglas & Hopson, 2000). Through the power of the church, blacks began to realize social and political privileges long denied them (Douglas & Hopson, 2000). Although the Black Church is one of the most enduring institutions, the expansion and development of the Black Church from its inception during the 16th century was partly due to its social and political influences within the Black communities (Lincoln & Mamiya, 1991). However, the social and political influences that impacted the Black Church's growth, attributed also to the emergence of differences in religious and theological interpretations within the Black communities (Warren & Herman, 2011).

As the "Black Church" developed as a whole, many of its traditions were presented through the individualized practices and beliefs imposed by the various religious denominations and movements of which they would become associated (Robeck, 2007). One of the largest Christian African American movements in the United States is Pentecostalism (Jaynes, 2005). Many evangelists and missionaries, races, denominations, etc. have been accredited and debated as founders and or originators of the movement of Pentecostalism Robeck, 2007. However, its origin and the forward movement continues without such empirical or unified attributions; other than the

scriptures upon which it was established (Alexander, 2011). According to Joel 2:28 (King James Bible, 2017), God promises the prophet Joel that he would one day pour out his spirit on both males and females and according to Acts 2: 4, the promise was fulfilled on the day of Pentecost, the final day of the celebration of the Passover (Alexander, 2011).

Pentecostalism

Although its origin and development has been attributed to various leaders within the United States, the Pentecostal movement has been dated by some scholars from England and Africa as far back as the 17th century and credited to Edward Irving, the founder of the Catholic Apostolic Church (Robeck, 2007). However, members of the Camp Creek Holiness Church (now known as the Church of God, Cleveland, TN) argued that they were the first Pentecostals (Robeck, 2007). John Wesley, an English evangelist whose teachings included living "spiritual perfection," has also been credited with founding the Pentecostal movement in the United States " (Jaynes, 2005), although his "methodical" way of worship resulted in him being labeled a "Methodist.

However, most historians agree that it was during a revival in Topeka, in 1901 when Charles Fox Parham, a White evangelist, proposed the doctrine of speaking in tongues as the "initial evidence" of the baptism of the Holy Spirit that the theological foundation of Pentecostalism was established (Alexander, 2011). Many individuals were responsible for bringing the Pentecostal movement to the United States. Different evangelists extended the Pentecostal message to all races and cultures. Its primary doctrinal tenant, as introduced by Parham, was the baptism of the Holy Spirit, "with the evidence of speaking in tongues" (Alexander, 2011 p.17). Another fundamental feature of

the doctrine of Pentecostalism introduced by Parham included the teaching that the experience of the baptism of the Holy Spirit, was an endowing "in-filling" of the Holy Spirit, as prophesied in the book of Joel in the Old Testament (Alexander, 2011).

The congregants believed that the supernatural power provided by the Holy Spirit empowers them to live a holy and righteous life and allows them to accomplish righteous works for the Kingdom of God (Alexander, 2011). The congregants seek to establish communion with God through prayer and to live their lives based on scripture principles and teachings (Alexander, 2011). The teaching from the Scriptures also required the congregants to spread the gospel and the message and the Pentecostal experience to all nations through their witness and teaching (Alexander, 2011). Parham established a school in Houston and had a small following of students (Alexander, 2011). He taught White and Black students the Scriptures (in separate rooms), howbeit, his goal was to fulfill the great commission given by Jesus to his disciples in Matt. 28:19, which was to spread the gospel to all nations (as cited in Alexander, 2011).

Parham’s vision was the worldwide evangelization of Pentecostalism that would include various cultures and languages. Although he preached salvation to all in separate settings, racial unity was beyond his tolerance (Alexander, 2011). Unfortunately, his personal insensitivity regarding interracial worship would impede his mission (Alexander, 2011). Despite Parham's personal failures, the doctrine of Pentecostalism would continue to impact his students and followers, especially William Joseph Seymour (Alexander, 2011). Joseph Seymour would become a strong advocate for the doctrine formulated by Parham. His influence would widen the debate of Pentecostalism's true

beginnings (Robeck, 2007). Although Parham formulated the doctrine of Pentecostalism, Seymour, a Black son of former slaves' contributions ultimately catapulted Pentecostalism into the national spotlight (Alexander, 2011).

African American Pentecostals

The African American (Black) Pentecostal movement was brought to prominence during a revival held by William Seymour on Azuza Street in 1906 in Los Angeles, California (Alexander, 2011). Since its inception, its history has become as diverse and complex as any other culture (Alexander, 2011). Differences in theological beliefs created divides among believers (i.e., the godhead, methods of baptism, women in ministry, sabbaths, leadership decisions, etc.; Alexander, 2011). Although many differences caused divisions, the fundamental beliefs remained consistent among Pentecostals including the baptism of the Holy Spirit with the evidence of speaking in tongues and holy and righteous living (Alexander, 2011).

Due to the religious differences and beliefs, various denominations were organized by a number of leaders from the African American Pentecostal movement (Alexander, 2011). Some of the first denominations established included: Church of God in Christ, the largest Pentecostal denomination in the world; Pentecostal Assemblies of the World, the second-largest Pentecostal denomination in the world, known as "oneness or Apostolic", Church of God, Church of Our Lord, Overcoming Holiness, and many other sects (Alexander, 2011). By the 21st Century, the African American (Black) Pentecostal movement continues to thrive with over 600 million adherents. It is estimated

that one-third of the mega (2,000 members or more) Black churches have embraced Pentecostalism (Alexander, 2011).

Despite the differences that resulted in the many denominational divides, the Pentecostal movement has continued to thrive to this day, still holding to the central beliefs of its core (Alexander, 2011). The African American Pentecostal church also has long held its negative views on what they considered "worldly" (non-biblical or contemporary) influences (Millner, 2009). Many theological beliefs of African American Pentecostal churches are commonly shared by most of the other denominations within the Pentecostal movement (i.e., baptism of the spirit, speaking in tongues, living righteous, etc.) (Alexander, 2011). Also, most Pentecostals regardless of race, also believe that their physical and mental health needs are matters that should be address within the church (Dempsey et al., 2015; Payne, 2008).

Mental Illness

Congregants in the Pentecostal churches at large (whether White or Black) mostly seek guidance for psychological issues, from the pastors or leaders of the church (Dempsey et al., 2015; Santos & Kalibatseva, 2019; Trice & Bjorck, 2006). Congregants of the Pentecostal community are not often seen by clinicians within professional mental health settings. The minister is usually called upon to provide psychological the services and to become the therapist that will help them with their mental issues (Belcher & Cascio, 2001; Dempsey et al., 2015). According to Belcher and Cascio (2001), clergy are now being encouraged to seek more formal education and training in mental health counseling. However, one hindrance impeding the training of pastors is that the

arguments or disputes involving theological and church concerns are not answered, referenced, or settled through secular or scientific disciplines (Belcher & Cascio, 2001; Santos & Kalibatseva, 2019).

In respect to mental illness, the religious beliefs of Pentecostals have only presumed one persuasion regarding the option of seeking or avoiding professional help (Dempsey et al., 2015; Trice & Bjorck, 2006). The authors posited, that prevailing religious beliefs among Pentecostals is that mental illness is a sign that there is a type of spiritual weakness in one's life. The belief that mental health is an indication of spiritual soundness, may dissuade adherents from seeking help (Dempsey et al., 2015; Trice & Bjorck, 2006). Also, according to the authors, Pentecostals believe that there may be many causes for mental issues. However, the majority of them feel that faith is their course of action for the cures (Dempsey et al., 2015; Trice & Bjorck, 2006). Hence, Pentecostal clergy are often faced with perplexing behaviors, when counseling individuals with mental health issues, which experienced professionals recognize as insignificant, because they lack the information required from post-secondary education (Belcher & Cascio, 2001). Therefore, in attempt to understand those puzzling behaviors, they will rely on the skills and tools most familiar, which are experience and the Bible (Belcher & Cascio, 2001; Dempsey et al., 2015).

African American Pentecostals are even more likely to seek help for their mental health needs within the church. Furthermore, many view the Black church as the sole resource for dealing with psychological issues and have never tried services from mental health professionals (Dempsey et al., 2015). African Americans within the community

not only relied on pastoral guidance but culture as well (Payne, 2008). The Black church has not only been a source for spiritual help, but it has also been the place where African Americans seek emotional refuge from their daily problems (Dempsey et al., 2015).

Historical and Religious Influences

*I*n addition to the principles of the Pentecostal movement, historically, there have been significant elements that have influenced the Black Church regarding mental health. Since slavery, the Black Church has been the place of resource for the social and psychological needs of members of the community (Dempsey et al., 2015). Distrust of professionals and comfortability with church leaders continue to perpetuate African American congregants seeking the assistance of their pastors or other clergy for their mental health needs (Dempsey et al., 2015).

Minorities mistrust of the medical and research fields is historical and stems from the unethical treatment of African American males in the Tuskegee Syphilis study (Frierson et al., 2008). The fear of exploitation has fostered skepticism and reluctance among African Americans in participating in medical or mental health activities (Frierson et al., 2008). Also, African Americans may fear misdiagnoses by clinicians based on stereotypes and representations of minorities in the media (Dempsey et al., 2015). Inattentiveness of cultural values, institutionalized racism and lack of ethnically matched practitioners inform African Americans that mental health professionals may not meet their needs (Dempsey et al., 2015).

Also, most of the influences and beliefs regarding mental illness stem from within the Black culture and is deeply rooted in religious values. Congregants may struggle with

seeking secular help against believing God for his divine intervention for their healing (Plunkett, 2014). African American congregants may also think that clinicians may not understand their religious beliefs and values but judged them instead (Plunkett, 2014). Religious beliefs and values have long played a significant role in the medical and mental health care decision of Black Congregants (Plunkett, 2014). The author posited that historically within the Black Church a school of thought exists supporting the belief that a particular situation such as a mental problem, requires spiritual intervention. Thus, the individual suffering with the mental problem must only pray about it for healing or relief or must give it to God (Plunkett, 2014).

However, Plunkett argued that individuals suffering from medical issues are rarely encouraged "only to pray," sometimes posing a conflict for individuals with mental health issues and presenting a struggle of guilt and a battle for them to seek mental health care (Plunkett, 2014). The religious beliefs of most African American congregants have been the motivation for seeking spiritual guidance through the church for their mental health issues (Dempsey et al., 2015). In the African American Church, the pastor is esteemed in high honor by the members who view him as the spokesman of God and one who is called by God to help guide his people to him and through life's pathways (Alexander, 2011). The role of the pastor is significant in the Black Church, and congregants often seek help for the spiritual and mental health issues they face in their lives (Hamilton et al., 2013). The pastor's views have a profound impact on how their congregants perceive mental illness.

Pastoral Views

Pastors of Black Churches have different views of mental illness and the most effective approach to treating congregants (Dempsey et al., 2015; Payne, 2008). The definition of depression includes a persistent sad, anxious, or "empty" mood, loss of pleasure and interest in activities once enjoyed, irritability, and fatigue (APA, 2020). However, Payne (2009) offered that many African American Pastors' perceptions within the Pentecostal church, of the definition of clinical depression is an individual's unwillingness to engage in the worship service.

Within the African American (Black) Church community, congregants often seek help from the pastor for their mental health crises (Dempsey et al., 2015; Payne, 2009). The authors posited that in many instances, the pastor's beliefs about the spiritual definitions (i.e., weakness, lack of faith, etc.) and etiology of psychological issues (i.e., sin, spirit oppression or possession) may hinder treatment for African American congregants. Pastors often conferred through sermons, teaching and counseling sessions that congregants should trust God, pray, or follow other spiritual practices for their mental health needs (Mercer, 2013). More often, African American Pentecostal pastors believe that depression is due to a moment of weakness when facing trials and tribulations in life, whereas Caucasian American pastors are more willing to agree that depression is a biological (Karadzhov & White, 2018; Millner, 2009). Therefore, religious affiliation often shapes how the clergy view and intervene regarding depression, and the socio-economic status of members of religious groups play a significant role in their perception of mental health treatment (Karadzhov & White, 2018; Millner, 2009).

Pastors who understand that there are both biological and spiritual aspects of depression can refer out when necessary and still utilize their religious expertise (Hamilton et al., 2013). However, pastors who are not open to both of those concepts (biological and spiritual) of depression, may send messages from the pulpit that inadvertently hinder the necessary treatment for individuals suffering from clinical depression (Hamilton et al., 2013; Payne, 2009). African American Pentecostal clergy, more than other mainstream Christian clergy, believe in religious and spiritual interventions as treatment for severe psychological distress (Karadzhov & White, 2018).

Early research has highlighted the influence of pastoral conceptualizations of mental illness and mental health treatment on congregants' mental health seeking decisions. According to Mercer (2013), Black Pentecostal clergy who believe that mental issues are of a spiritual nature, readily discussed beliefs regarding spiritual deliverance of individuals with a mental illness. The author also found that pastors attributed lack of deliverance efficacy to the lack of forgiveness, any involvement with religious occult matters, or unconfessed sins. Although Pentecostal clergy agreed that some mental illnesses might have biological causes, they argued that medical interventions are not capable of penetrating the spiritual depth of suffering (Karadzhov & White, 2018).

One of the main issues within the Black Church is the pastor's perception of the role of the church regarding mental health care, education, or awareness for its congregants (Dempsey et al., 2015; Millner, 2009). The authors posited that congregant's etiological beliefs play a role in their early terminate of treatment. According to the authors, many African American congregants were likely to reject the idea that mental

illness was due to their genetics or unhealthy family rearing. The authors argued that because of these views, congregants rely upon clergy for guidance for their mental health issues and concerns. Clergy within the Black church encounter parishioners that experience several mental health problems (Rowland & Isaac-Savage, 2014). Regarding the power and influence leaders had over congregants regarding seeking outside mental health services: congregants who had closer contact with their pastors seem to have the same views as their pastor (Dempsey et al., 2015).

Pastoral Support

Although White congregants may be more likely to seek outside help for their mental issues (Payne, 2008). Historically, African Americans will look to their church leaders for their mental health needs (Dempsey et al., 2015). African Americans reportedly are strongly connected to their religion and would preferably depend on their faith than medications for their mental health issues (Hamilton et al., 2013). However, there is no standardized training among clergy within the Black church regarding mental health illness or in relationship to counseling the mentally ill (Dempsey et al., 2015). As opposed to trained counselors and clinicians, many clergy in the Black Church have not been educated in the field of mental health to deal with mental health illnesses (Dempsey et al., 2015). They counsel congregants base on their individualized methods (Dempsey et al., 2015).

Many pastors within the Pentecostal movement interpret mental health issues entirely in religious terms (Mercer, 2013; Payne, 2009). However, studies on clergy perspectives on secular mental healthcare found that some clergy seek other levels of

education to address the growing mental health needs of congregants. For example, many clergy believed that pastoral care and pastoral counseling overlap in different areas, but that counseling required an additional level of education and training (Stansbury et al., 2018). Payne and Hays (2016) found that clergy whose views leaned toward the psychological or secular end of the spectrum, of causes for mental illness, felt there was a need for qualified counselors within the church or for pastors to receive secular mental health training (Payne & Hays, 2016). However, they continue to face the long-time issue that pertains to resolving the disagreements involving the sciences and theology (Belcher & Cascio, 2001; Dempsey et al., 2015).

In a grounded theory analysis involving 35 clergy Payne and Hays (2016) used cross-sectional data and found that clergy beliefs regarding mental health treatments ranged from extremely spiritual to more biological/psychological. The researchers found that some of the clergy believed solely in spiritual treatments and that faith and dependence on psychology did not agree. Therefore, they believe that mental issues need to be prayed for and dealt with as suggested in the scriptures (Payne & Hays, 2016). On the other hand, clergy whose views leaned toward the psychological or secular end of the spectrum, of causes for mental illness, felt there was a need for qualified counselors within the church or for pastors to receive secular mental health training (Payne & Hays, 2016). The study also showed that there were no clergy members who viewed mental illness solely as biological/psychological. Thus, most of the clergy expressed belief that religion/spirituality should be incorporated in some way in mental health treatment (Payne & Hays, 2016). On both ends of the spectrum, African Americans use the Bible as

a guide and comfort for mental health, promoting strategies, and stress relief. Different scripture passages of the Bible have specific meanings that help the individual cope with life's events (Hamilton et al., 2013; Mercer, 2013).

The Black church has been a constant provision for the African American community. It has become a preferred institution for the members of the community when seeking assistance, help, or aide for social, spiritual, mental, or emotional problems. The Black church provides a range of social services that include food services, youth programs, education, financial assistance, and health resources (Avent et al., 2015). The African American Church is historical and today remains to be the central institution for the support of the Black communities' social, spiritual, mental, and political well-being (Warren & Herman, 2011).

Etiological Beliefs

Many Pentecostals believe that mental illnesses are the results of some type of spiritual condition (Mercer, 2013; Payne, 2009); they firmly believe such situations (i.e., weakness, failure, etc.) may incite demonic possession (Mercer, 2013; Trice & Bjorck, 2006). Also, many adherents believe that certain factors are consistent and expected as part of the sufferings of the Christian faith; that one is to be oppressed by an external agent (i.e., demons), as Christ was tempted, this belief is most consistent with Pentecostal theology, and is also more widely accepted among those individuals who may not be open to the implication of personal weakness as the cause of depression or causes for demonic oppression (Leavey, 2010; Mercer, 2013; St. Clair, 2011; Trice & Bjorck, 2006).

However, to many Pentecostals, the origin of conditions such as bipolar disorder, depression, and schizophrenia are believed to be direct causes of demonic spirits that have entered the individual (Mercer, 2013). Researchers highlights the beliefs of demonic possession among Pentecostal clergy. For example, in a study on clergy beliefs on mental health Payne and Hays' (2016) found that among 35 of the participating clergy some of them believed that the cause of mental illnesses such as chronic PTSD or depression was due to demonic oppression. Others believed that the individuals may be possessed with a demon and need prayer to cast the demon out.

Also, in a qualitative study involving 15 clergy and 17 other participants (believed to be possessed by demons), Rowan and Dwyer (2015) found that all of the clergy and participants believed in demonic possession and participated in deliverance ceremonies. Mercer, (2013) argued that there is sufficient literature to support the beliefs of Pentecostals regarding mental illness and demon possession and deliverances (Mercer, 2013). The author posited that there were numerous examples and publications supporting Pentecostals' beliefs regarding mental illness and demonic possession which involve their causes and treatments (see: *Pigs in the parlor: The practical guide to deliverance* (Hammond & Hammond, 1973).*; A manual for children's deliverance* (Hammond & Hammond, 1996)*;* and *Deliverance for children and teens (*Banks, 1985). Mercer (2013) also posited that the cause of the mental illness is believed spiritual, by many clergy, therefore the treatment for the illness is believed to be spiritual (i.e., prayer, laying on of hands, renouncing sin, and pleading the blood of Jesus (a statement that declares the delivering power of Jesus' blood). According to the author, some

Pentecostals avoid medical and psychological treatment for mental illness and believe that such treatment may possibly make their issue worse, however, others may be open to secular treatments for their mental issue but require that the treatment is in agreement in some ways, with their Pentecostal beliefs. For many adherents who may seek secular mental healthcare, their beliefs and practices often resulted in psychiatrists and psychologists having little or no success in their treatment (Mercer, 2013). Also, etiological beliefs and the lack of discussion about beliefs and faith during secular mental health treatment, played a role in adherents' early termination of treatment services (Brown & McCreary, 2014; Dempsey et al., 2015; Millner, 2009).

Spiritual Origins

Within the Pentecostal movement, the belief that spiritual agents are responsible for severe mental issues (Belcher & Cascio, 2001; Mercer, 2013). One of the beliefs involving mental illness is that the individual is possessed and the only way to provide treatment is casting out the demon that has possessed them (Belcher & Cascio, 2001; Mercer, 2013). Congregants believe that pastors and spiritual leaders possess gifts of the Holy Spirit, which enables them to cast out those demons (Mercer, 2013). The minister of the church is often the first individual of leadership the parishioners meet. The pastor is viewed by many of the members as their advisor and counselor. The pastor in the Black Church takes on a variety of roles based on the needs of the congregants (Mercer, 2013; Payne, 2008).

Most of the roles of clergy in the Black Church are in alignment with their ministerial and religious training, such as bereavement and supporting the medically

infirmed. However, many congregants rely on the clergy to address their mental health problems and psychological issues (Plunkett, 2014). Therefore, clinicians may seek the help of a pastor or spiritual leader for a more cooperative effort of treatment (Mercer, 2013). A Successful therapeutic process may require that the clinicians create a strong alliance by incorporating the client's pastor in the consulting relationship (Mercer, 2013). Consulting the clergy may ensure that both the client and clergy are aware and accepting of the reasons for the therapeutic strategies (Adksion-Bradley et al., 2005; Dempsey et al., 2015). However, the fear of stigmatization has long produced concerns for those seeking treatment outside of the Black Church (Dempsey et al., 2015).

Stigmas

Goffman (1986) defined stigma as a term that is extremely negative and stereotypical, which is presumed "different" about the individual. This term may affect individuals in two different ways. In one way, the individual may think others are already aware of his difference, causing him to feel 'discredited' or, the individual may believe that others are not aware of his differences, which then would cause him to be 'discreditable' (Goffman, 1986; Wharton et al., 2018). Congregants in the Black Church often fear being stigmatized even when professional treatment has been endorsed or supported by their pastor or leaders of the church (Wharton et al., 2018).

Stigma is a major barrier for many African American Christians in seeking mental health care (Armstrong, 2016). African Americans are often suspicious of the labels that are associated with mental illness and seek to distance themselves from such (Armstrong, 2016). The portrayals of severe cases of mental illness in the media have played a major

role in perpetuating the avoidance of mental health care seeking among this population (Armstrong, 2016). Many viewers are left with the perception that anyone needing counseling or psychotherapy are suffering with a severe mental illness (i.e., bipolar disorder, schizophrenia, etc.; Armstrong, 2016). Also, contributing to the fear of stigma for African Americans suffering with psychological issues is often the lack of support or discouragement they may receive from their family, church members or community (Armstrong, 2016).

Unfortunately, when individuals within the African American church community need mental health treatment, they are reluctant to seek mental health care (Dempsey et al., 2015). Seeking mental health support from a secular agency may result in the individual or their families feeling shame or guilt (Dempsey et al., 2015). The stigmas continue as a lasting phenomenon based not only on historically African American cultural beliefs and practices but other barriers as well (Dempsey et al., 2015). Most African Americans believe that seeking mental health care implies that they are "crazy" or emotionally weak (Dempsey et al., 2015). Many others believe that it is a sign of being spiritually weak that it is an indication of some type of spiritual imperfection manifesting in the individual's life (Dempsey et al., 2015; Payne, 2008). In addition to stigmas, other barriers to mental health care are due to religious beliefs and cultural practices (Mercer, 2013).

Scripture Teachings and Hermeneutics

Within the African American Church, congregants believe that Scriptures are the Word of God, in accordance with John 1:1(a), which states that in beginning was the

word the word was with God the word was God (Plunkett, 2014). They also believe that there are teachings and interpretations of Scriptures that refer to God's divine plan for deliverances and healings for his people. For many of the congregants, the Scripture teachings and promises are the principles on which they derive their beliefs regarding mental health issues (Plunkett, 2014). Scripture texts such as Psalms 41, Isaiah 53:5, and Jeremiah 17:14, which describes God as, respectively; helper, healer, and one who heals are passages that are also guides for healing.

Congregants of the Black Church depend upon the Scriptures, which they believe is God's Word, the anchor to their faith and hope in their healing (Plunkett, 2014). Thus, there are many other scripture references and Biblical inferences that have been extracted by leaders from stories in the Bible for generalized teachings within the African American church. Within most African American Pentecostal Churches, the belief that God heals is rooted in their understanding of the scriptures (Plunkett, 2014). Luke 8:26–39, which accounts where Jesus heals a man who was demon possessed living in the cemetery, and Matthew 17:15–21, which accounts where Jesus heals a boy, described in the Scriptures as a lunatic, who often threw himself into the fire and water, are examples of Scriptures that leaders use to impart faith healing through prayer and believing God (Plunkett, 2014). Subsequently, it is Scriptures such as, 'I can do all things through Christ who strengthens me' Philippians 4:13 that lead congregants to feel that secular counseling is not necessary; therefore, they continue to seek mental health support and guidance through the Scriptures (Cook & Wiley, 2014).

The African American Pentecostal movement continues to thrive with over 10 million adherents in the United States. It is estimated that one-third of the mega (2,000 members or more) Black churches have embraced Pentecostalism (Alexander, 2011). Many AAPs continue to avoid secular mental healthcare and seek help for their mental health issues within the church (Mercer, 2013). Payne and Hays (2016) argued that literature on the promotion of faith-based mental health continues to grow. However, the authors recommended that researchers continue to seek culturally specific methods to approach clergy on issues regarding mental health. The authors posited that there is a lack of literature that explores the beliefs and perceptions of clergy regarding the etiological direction, and common responses to mental issues, and that clergy perceptions and beliefs help guide their interactions with the congregants who come to them with their mental problems.

St. Clair (2011) argued that clergy beliefs regarding life issues and decisions are based on their interpretation of Bible Scriptures. Payne and Hays (2016) argued that to fully understand the mental health guidance provided by clergy to their congregants, it is important to better understand the attitudes and beliefs they hold about mental health and mental health services. Mercer (2013) recommended future research on historically African Americans denominations that involves inquiring into core beliefs and attitudes regarding secular mental healthcare, to help further professionals' understanding of the beliefs among African American Christians regarding secular mental healthcare.

Summary and Conclusion

A review of the literature has revealed that the views of clergy play a major role in influencing the decision-making processes congregants seeking mental health treatment. The message pastors relay from the pulpit about mental health issues may inadvertently discourage congregants suffering with mental health problems from seeking secular mental health care (Payne, 2009). Previous research has suggested further qualitative studies for understanding clergy's distinctions and beliefs regarding religious experiences and mental disorders (DeHoff, 2015), and their belief systems as relating to causes, origins, deliverances, and healings for mental illness (Mercer, 2013). However, there is little research that explores the perspectives of the Scripture teachings of African American Pentecostal Clergy regarding mental illness. This study aimed to extend the understanding of this phenomenon by exploring this gap in the literature.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to provide understanding of the Scripture texts, references, and teachings of clergy within the African American Pentecostal churches regarding mental illness and secular mental healthcare. It was also to explore the beliefs of the origin of mental illness, and adherents' practices of seeking pastoral help for mental health issues. Also, it was to obtain better understanding of their avoidance of seeking mental health professionals for their mental health problems. In this chapter I provided the information for the methodological plan for this study which included: the research design and its rationale, the role of the researcher, procedures used for participation recruitment, the data collection plan, data analyses, trustworthiness issues, ethics, and a summary.

Research Design and Rationale

The central phenomenon I explored in this study was the perspectives of African American Pentecostal clergy Scripture teachings to gain further understanding and insight into their beliefs regarding mental illness and seeking mental health care. The research questions that guided the study were as follows:

RQ 1. What are AAP clergy's lived experiences of integrating one's religious beliefs with beliefs about secular mental health care?

RQ 2. What are the Bible Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?

RQ 3. What are the scripture texts, beliefs, references, and interpretations specific to AAPs seeking mental health support from Clergy?

RQ 4. What type of mental health education if any, do clergy believe may impact the acceptance of mental health care in the AAP communities?

To explore this study, I used a qualitative approach. The differences in qualitative and quantitative research are based on the assumptions presented, and the strategies and methods used by the researcher (Creswell, 2014). Quantitative research is an approach which provides a way for variables to be generalized, measured, and analyzed numerically (Creswell, 2014). Qualitative research is a process that allows researchers to collect data from participants of a particular group within their own settings, to discover and understand the meaning they attribute to a social or human problem (Creswell, 2014; Ravitch & Carl, 2016). A qualitative study requires the researcher to approach the data collection process inductively to understand the meaning and the complexity an individual or group may ascribe to a problem (Ravitch & Carl, 2016). The data gathered is then reviewed deductively by the researcher to assess evidence supporting themes or the necessity for additional information (Creswell, 2014).

Important factors in both qualitative and quantitative approaches to research are philosophical assumptions and research methods or procedures (Ravitch & Carl, 2016 p. 5). The most common philosophical worldviews observed in literature are postpositivism, constructivism, transformative, and pragmatism (Ravitch & Carl, 2016 p. 5). The constructivist philosophy is one that is built upon the concept that individuals seek

meaning and understanding of their experiences and their world (Creswell, 2014). Constructivism involves subjective meanings and interpretations influenced by both personal, social, cultural, and historical experiences of both the participants and researcher (Creswell, 2014). Constructivism in conjunction with interpretivism is often used in qualitative research as an approach to explore a phenomenon (Creswell, 2014).

Rationale for Phenomenological Method

Phenomenological research according to Husserl (1962), requires one to be willing to "see what stands before eyes, to distinguish, to describe, calls moreover for exacting and laborious studies " (p.39). It has been a study directed by most researchers toward human behavior and development (Husserl, 2012). It is the separate study of how or to what extent the experiences of physical conditions and events within an individual's environment has on shaping the individual psychologically or socially. The states, events, background, and experiences are meaningful to the individual, providing the foundations, inclinations they perceived as real and relevant for their lives (Husserl, 2012).

Humanist concepts are essential to phenomenology. The perceptions of the participants provide meaning and understanding to their experiences and how they feel about a phenomenon (Burkholder et al., 2016). A phenomenological qualitative research design was appropriate for this study because it provided the bases for patterns and themes to be identified in the data (Ravitch & Carl, 2016). It also provided the framework for collecting data, that helped fill the gap in literature, regarding the exploration and understanding of the lived experiences of pastors within the African American Pentecostal Churches Scripture teachings, practices, and beliefs of mental illness.

Phenomenological Approach

There are five methodological traditions commonly identified in qualitative research, narrative research, grounded theory, ethnography, case study and phenomenological research (Creswell, 2014). Phenomenological research is a design of inquiry which is best suited for this study. It allowed me to describe the lived experiences of the individuals regarding a phenomenon as described by the participants (Creswell, 2014). Phenomenology is the study of the lived experiences of individuals based on their reflections, opinions, and thoughts. The views of the groups or populations within the research are without any theoretical or prejudicial influences (Husserl, 2012).

The phenomenology study is driven by historical and cultural experiences that have, along with other changes through time, had a lasting effect on a particular region (Husserl, 2012). Husserl (1962) argued that pure phenomenology was about "consciousness" and that it deals with all of the different experiences, along with the behaviors and how they correlate one with the other and are most influential in our habits and thoughts. The extreme effort is necessary for seeing beyond normal perceptions and views (Husserl, 1962). The researcher also explained that a phenomenological study requires that the researcher should not enter into the study with preconceived thoughts or habits, recognize the mental barriers which have hindered their thinking, and free their minds to look at things in a different way.

Role of the Researcher

The role of the researcher is central to a qualitative study as the instrument for recruiting participates, and collecting and interpreting data (Creswell, 2014). Positionality

is both the researcher's role and identity in relationship to the research participants, topic and setting (Creswell, 2014).

Research Bias

Qualitative phenomenological research is interpretive and involves the experiences of all the participants within the study (Creswell, 2014). Researchers must be aware of their own biases, values, personal background, and other worldviews which affect their interpretations during a study (Creswell, 2014). The researcher must be aware of the biases, assumptions and worldviews which shape the way they think and approach their research study (Creswell, 2014; Ravitch & Carl, 2016). Therefore, reflexivity is pertinent for the qualitative process, it requires the researcher to be observant in questioning the participants, and themselves, and to note the responses of everyone involved in the research study (Ravitch & Carl, 2016). Epoche' bracketing is also important in the research process. Bracketing provides a means for researchers to visually recognize and evaluate their personal reactions to data (Ravitch & Carl, 2016). Researchers must strive to maintain objectivity. Researchers identifying their personal biases prior to and during the research process will help ensure participants' ability to rely on their own experiences without the influences of the researcher (Burkholder et al., 2016). Bracketing will help the researcher to highlight those feelings, experiences, and biases which they inherently bring to the study (Ravitch & Carl, 2016).

I was born and raised in the beliefs and traditions of the African American Pentecostal Church. Over the last 40 years, I have been licensed and ordained as a member of the clergy and have pastored a congregation for the last 12 years. One of my

roles as an ordained clergy has been to provide counseling to individuals, couples and families within the congregation and community. Another role as an ordained clergy involves providing spiritual counsel and support to other church leaders, and pastors for themselves and concerns they may have in respect to their congregants. Counseling and working with African American Pentecostals has made me sensitive to their intense religious and cultural beliefs regarding mental health care. Also, consultations with other AAP pastors regarding mental health issues among congregants has brought to light the need for more understanding about beliefs and Scripture teachings and led me to this topic.

Considering my personal and professional background, beliefs, and experiences as a member of the African American Pentecostal community, I am aware of the potential for bias during the collection and interpretation process of the phenomenon in this study. However, the awareness I have of my background, experiences and beliefs will help me to recognize and set aside my biases which may surface regarding the issues being explored in this study. I collected information about the perceptions and lived experiences of the participants in this study through semi-structured interviews. I used open ended questions, probing questions as needed, and also present opportunity for participants to expound upon their lived experiences. I approached this qualitative phenomenological study in a reflexive manner by bracketing my personal experiences and views throughout this study to ensure that the views of the participants are captured (Creswell, 2014). I conducted this study with clergy from different African American Pentecostal churches and organizations than my own. I spoke with potential participants

during the selection process to ensure that no one selected has any family, friendship, organizational, or relationship with me. I discussed with the participant the purpose of the study, the voluntariness of their participation, confidentiality of their participation and identity, and the informed consent. I informed the participants that I would be recording and taking notes of the interviews and inform them that the information collected would be kept private.

Methodology

Appropriateness of the Phenomenological Research Method

A qualitative phenomenological research approach is appropriate for this study because it aligns with the objectives of this study to explore the in-depth first-person information of the lived experiences of individuals of a phenomenon (Moustakas, 1994).

Participants Selection Logic

The entire population of this study included African American Pentecostal clergy residing within the United States who are part of the Pentecostal movement. The African American Pentecostal movement consists of a conglomeration of different churches, organizations and denominations including the Church of God in Christ, the Pentecostal Assemblies of the World, and the Pentecostal Churches of the Apostolic Faith, etc., (Alexander, 2011). The sub-population will include senior clergyperson, pastors, co - pastors and bishops. This study will target the senior leadership of the churches within the African American Pentecostal faith, therefore other leadership of the churches (ministers, deacons, chaplains, reverends, etc.) will be excluded from the study.

The sampling strategies I used for this study included purposive and snowball sampling strategies. Purposive sampling is a deliberate in nature (Ravitch & Carl, 2016). It provides the context for allowing me the opportunity to choose the participants who are specifically knowledgeable about and have experiences regarding this research phenomenon (Ravitch & Carl, 2016). Purposive sampling is appropriate because it requires that participant selections align with the research questions, and the goals, context, and population of the research study (Ravitch & Carl, 2016).

Sample Size

The criteria for the participate selection was as follows: The participants must be (a) at least 35 years old at the time of research, (b) presently serving in the role of senior pastor or clergy for a minimum of 3 years, (c) and available to participate in an interview that may last up to 1 hour. The participants were given a consent form and asked to return them signed to the researcher prior to the start of the interviews.

Creswell (2014) suggested that a sample size for a phenomenological research study typically ranged from three to ten participants. However, Ravitch and Carl (2016) posited that qualitative research is for explorative and not generalizing purposes, and that there are no define rules relating to the participant sample size. To ensure the perspectives of the participants are being captured, the sample size must not be too small or too large. Therefore, in this qualitative study the sample size goal was 12, however, the end of recruitment was determined when saturation of themes or categories is evident (Creswell, 2014).

Instrumentation

Creswell (2014) posited that the researcher is the key instrument in qualitative research. The responsibilities of the researcher are significant and impactful throughout the entire research process, which includes, recruiting participants, collecting, and analyzing data and reporting the findings. The original source of data collection for this study was intended for face-to-face interviewing, however because of the Covid-19 pandemic, concessions for this study are being made. Therefore, I collected data from selected participants (see appendix A), using semi-structured interviews through various media sources (see Appendix D). I developed and used open-ended questions, prompting questions and follow-up questions relative to the research question, to promote a more in-depth interviewing process (Ravitch & Carl, 2016). To ensure that the participants experiences, and perceptions are captured accurately, I audio-recorded the interviews and reported the findings.

Procedures for Recruitment, Participation, and Data Collection

Procedures for recruitment and participation for this study required distancing measures. In consideration of COVID-19 risk/benefits analysis and COVID19-related social-distancing modifications the recruitment and interviewing of participants were conducted via flyer, email, phone, video conference, or online format and demographic information gathered from the participants (see Appendix A and B), to comply with both CDC and local guidelines and requirements. I posted flyers on Facebook. Upon response of interested individuals, I emailed each participant and provided them with a demographic questionnaire (see Appendix C), and consent form. The consent form was

emailed in the body of the email, with response options “I consent” or “Yes” (see Appendix E). Upon consent, I contacted participants by telephone or video conference, to review the details of the study and the informed consent. I conducted a one-time interview (45 to 90 minutes), utilizing the semi-structured interview questions (see Appendix F), I established the necessary interview protocols by audio recording, and video recording interviews in password secured Zoom accounts, and by writing notes during the interviews. Creswell (2014) recommended that researchers should take notes when audio or videotaping interviews, in the event that technical difficulties occur. and recording fails. I then reviewed and correlated these different data sources with each other to identify all aspects of the phenomenon described by the participants. I bracketed my responses and personal biases throughout the research process. Bracketing is an approach which helps the researcher capture reflexive personal assumptions, biases, and preconceived ideas during the research process (Creswell, 2014).

Data Analyses Plan

Creswell (2014) posited that qualitative research is interactive, involving many different levels of analysis. Data analyzes in qualitative research is a developing process of collecting data, writing memos, and organizing and reporting findings (Creswell, 2014). The author reported that phenomenology research involves analyzing of relevant statements, the clustering of those meanings into themes and the development of what Moustakas (1994) called ‘an essence description’ (p. 120). For this study I used Moustakas’ (1994 p. 120-121) modification of the Van Kaam method of analysis of phenomenological data which included:

1. List and group all relevant experiences.
2. Reduce and eliminate irrelevant data to determine the invariant constituent.
3. Clustering and thematizing the invariant constituents to categorize and identify themes core experiences.
4. Final identification of the invariant constituents and themes against the complete record of the research participant for verification of compatibility and relevancy.
5. Use the relevant, validated invariant constituents, themes, and verbatim examples from the transcript to construct an *Individual Textual Description* of the experience for each participant in the study.
6. Construct for each participant an *Individual Structural Description* of the experience based on the *Individual Textual Description and* imaginative variation.
7. Construct for each research participant a Textural Structural Description of the meaning and essences of the experience, incorporating the invariant constituents and themes. From the Individual Textural-Structural Descriptions, develop a composite description of the meaning and essences of the experience, representing the group as a whole.

I used NVivo, a data analysis software program to transcribe, organize, code and store all of the data from the interview transcripts. Creswell (2014) argued that despite the differences in research analysis strategies, researchers often use a general a procedure. The author suggested that seven specific steps are followed in the qualitative data

analysis process. The steps include: (1) organizing and preparing data, (2) reading or reviewing the data, (3) coding, (4) clustering data into themes, (5) advance narrative of findings, (6) interpreting findings, and (7) validating the accuracy of the information.

The first step in qualitative data analysis involves the transcription of the interviews. Due to monetary limitations all transcribing was completed in NVivo. Then I separated and re-connect data to make sense of the information collected (Creswell, 2014). Because text data from interviews are dense, I reduced the information by categorizing them into a small number of themes. The second step involves reflecting on the meaning or ideas of the participants interviewed to ensure the credibility of the information (Creswell, 2014). The third step involves coding data, organizing the data by bracketing chunks or texts, and labeling the writings with terms (Creswell, 2014). The fourth step involves using the coding process to generate themes for the terms (Creswell, 2014). The fifth step involves providing a descriptive narrative for the themes generated from the coding process (Creswell, 2014). The fifth step is interpreting the findings or result of the qualitative research, which requires researcher to capture the meaning and understanding the essence of the study (Creswell, 2014). The final step is for all information to be validated for accuracy (Creswell, 2014).

As the researcher, exploring perceptions of African American clergy Scripture teachings regarding mental illness will require familiarization with the Scripture text. Burkholder et al. (2016) posited that hermeneutic analysis used by Sallman in 2010 was necessary to clarify themes presented within the transcripts from participants' interviews (see Sallmann, 2010). Moustakas (1994) posited that:

> Hermeneutics involves the art of reading text or experiences in such a way that the intention and meaning behind the appearances are understood. The point of view is known as well as the cultural and social forces that may influence it (p.9).

As an ordained, licensed pastor within the Pentecostal movement, I am versed in Scripture texts. Therefore, I used hermeneutic analysis solely for the purpose of identifying themes as generated by the participates.

Summary

In Chapter 3, I discussed the research methodology I used in this study. I used a qualitative phenomenological framework with a hermeneutic approach. I used a combination of purposive and snowball sampling. The number of participants I recruited was as suggested by Creswell (2014) between three and ten participants or until saturation. I used a semi-structured open-ended interview protocol to collect data. I also bracketed my personal responses and observations during the study. I uploaded the data into NVivo for data organization and analysis. I analyzed data and present results of study in Chapter 4. A discussion of the results will follow in Chapter 5.

Issues of Trustworthiness

Validity and reliability have different meanings in qualitative research than in quantitative research. In quantitative research validity refers to the meanings or inferences obtained from specific tests and scores, and reliability refers to whether those measurements are consistent across constructs (Creswell, 2014). The term ‘validity’ in qualitative research differs in that it connotates that the findings have been checked for accuracy by the researcher and faithful to the participants’ experiences, and the term

"reliability' means that that researcher's approach is consistent (Creswell, 2014; Ravitch & Carl, 2016).

The term *trustworthiness* is often used interchangeably with *validity* in qualitative research; meaning the rigor and credibility standards have been met (Ravitch & Carl, 2016). There are four concepts which assess the value and rigor in qualitative research: credibility, transferability, dependability, and confirmability (Ravitch & Carl, 2016; Toma, 2011). In this study I used various validity strategies to establish the following:

Credibility is related to how well the researcher is able to design the research study. Credibility involves; triangulation, member checking, and researcher reflexivity, (see Creswell, 2014). It also involves the researcher's ability to accurately draw meaning from all of the participants, the researcher's instrument and the information collected (Ravitch & Carl, 2016). Triangulation involves converging and evaluating different research data sources to support thematic structuring (Creswell, 2014). Member checking involves the process of allowing the participants to review the findings of the report to ensure they feel the description or themes are accurate (Creswell, 2014). Researcher reflexivity is a primary aspect of qualitative research which requires a constant assessment of identity, positionality, and subjectivities (Ravitch & Carl, 2016). Reflexivity is an awareness throughout the research process which keeps in focus the researcher's role, biases that influences meaning and interpretation (Ravitch & Carl, 2016).

Transferability means rich, thick descriptive data, context-relevant statements developed by the researcher which can be applicable or transferable to broader contexts

(Ravitch & Carl, 2016). Dependability means that there is logic and meaning to research argument and data collection method and the data collected is relevant to the research study. It also means that the data is answering the research question, the appropriate methods are used and involves making the argument of why the method is appropriate to answer the core construct of the study (Ravitch & Carl, 2016). Confirmability means researcher seek to ensure the meanings, experiences, and feelings of the participants are accurately captured and interpreted throughout the research process. Also, reflexivity will assist in helping to recognize and mediate prejudices and personal biases.

Ethical Procedures

The 1949 Nuremburg Code and the 1964 Declaration of Helsinki were ethic codes developed in response to questionable experimental research studies (Given, 2008). The researcher is responsible for seeking the approval of their institution review board (Creswell, 2014). The institutional review board IRB oversees the research study to ensure the safety of the participants of the study (Ravitch & Carl, 2016). The researcher is responsible for providing the participants with the information relative to the study such as, the purpose of the study, the process of data collection, and confidentiality (Creswell, 2014). Recruits were informed about the research study and participation must be voluntary. Therefore, an informed consent was presented to the participants at the beginning of the research study (see Appendix E), as pertaining to the American Psychological Association (2017) Ethical Principles of Psychologists and Code of Conduct. Ethics in qualitative research requires attention to communicating and safeguarding participants, and the accountability held by the researcher throughout the

entire research process (Creswell, 2014). The criteria for this study are African American Pentecostal pastors 35 years old and older. Upon approval from the IRB for this study the following protocols were implemented:

- To ensure that information provided during this study will be kept confidential and participants identity will be kept confidential and any personal information will not be used outside of this research study. Participants were provided with a consent form prior to the study in accordance with IRB protocol.
- I provided participants with the informed consent and the details of the study which included, the purpose of the study, their right to discontinue the study at any time, and the potential risk for participating in the study.
- To ensure privacy, I instructed participants to enclose themselves in a privately secluded room during the Zoom interviewing process.
- To ensure privacy during the Zoom interviewing process, as the researcher, I enclosed myself in a privately secluded enclosed room.
- In compliance with IRB ethical protocols, data collected has been stored in a secured locked cabinet file and electronic protected password file. All documents will be shredded and discarded from files and deleted from all electronic files five years after the completion of the study.

Data Collection

Data was collected through one semi-structured, one-to-one interview with each participant, and were conducted remotely, through the videoconference application Zoom. The interviews were audio recorded using Zoom's integrated audio-recording feature. The duration of each interview was approximately one hour. No unanticipated conditions were encountered during data collection, and there were no deviations from the planned data collection procedures.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the perspectives of pastors within the African American Pentecostal (AAP) religious communities, on Scripture texts, teachings, practices, and beliefs in respect to mental illness and avoidance of secular mental health care. This study involved an exploration of the lived experiences of the clergy's beliefs and practices regarding congregants seeking mental healthcare. The following four research questions were used to guide this study:

RQ1: What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare?

RQ2: What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?

RQ3: What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy?

RQ4: What type of mental health education, if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities?

This chapter will provide a description of the setting of data collection as well as the study participants. Next, this chapter includes a description of the study participants. This chapter then includes descriptions of the execution of the data collection and data analysis procedures, followed by a discussion of the evidence of the trustworthiness of the study results. A presentation of the study results is then provided, followed by a summary of the findings.

Setting

All interviews were conducted remotely, via the videoconference application Zoom, to ensure participant safety through compliance with social-distancing guidelines during the COVID-19 pandemic (CDC, 2020a). The COVID-19 pandemic and strategies to mitigate its spread constituted a set of unusual personal and organizational conditions at the time of data collection (CDC, 2020a). The reader is asked to bear in mind that effects of the pandemic, such as restrictions on public gatherings, closure of workplaces, financial hardship, and loss of congregation members or loved ones to COVID-19 had the potential to influence participants' perspectives at the time of data collection. These

concerns were particularly heightened among African Americans due to the disproportionately effect of Covid 19 with their communities (CDC, 2020b).

Demographics

All the research participants identified as African American, ranged in age between 45 and 85 years, and most resided in the Eastern Seaboard of the United States. Only one of the pastors resided in the state of Kentucky. Each of the pastors at time of study had at least three years of experience in their current position. The sample included 16 senior pastors of AAP churches, (nine of which also held the office and title of Bishop within their various organizations). To maintain the confidentiality of participants' identities, the participants were designated with alphanumeric codes in this chapter. Participants who are Bishops were assigned alphanumeric codes beginning with the letter B and including a number (i.e., B1, B2, B3, etc.). Pastor participants were assigned alphanumeric codes beginning with the letter P (i.e., P1, P2, P3, etc.).

Table 1. Participants Codes

N=16 *B=Bishop (n=9)* *P=Pastor (n=7)*			
Bishop's Codes		Pastor's Codes	
Bishop 1	B1	Pastor 1	P1
Bishop 2	B2	Pastor 2	P2
Bishop 3	B3	Pastor 3	P3

Bishop 4	B4	Pastor 4	P4
Bishop 5	B5	Pastor 5	P5
Bishop 6	B6	Pastor 6	P6
Bishop 7	B7	Pastor 7	P7
Bishop 8	B8		
Bishop 9	B9		

Evidence of Trustworthiness

Credibility

The participants identified the scripture beliefs and teachings regarding mental illness and mental healthcare. The participants described their experiences of integrating their religious beliefs with secular mental healthcare. Upon completion of the interviews, transcription and data analysis, credibility was achieved through the rich descriptions of experiences provided by the participants, member checking, subsequent comparison to findings in published literature, peer review (my committee chair), and reflexivity (Ravitch & Carl, 2016).

Transferability

Transferability is the way in which qualitative studies can be duplicated (Ravitch & Carl, 2016). To ensure transferability, I provided a rich and detailed description of the participants' characteristic as well as the context so that other researchers can make comparisons of the findings to other study populations based on as much information as possible, using similar target populations in similar contexts (Ravitch & Carl, 2016).

Dependability

Dependability refers to the stability of the data and that using the same contexts and types of participants will result in replication of the findings.

Dependability refers to the replication of the findings using the same contexts and types of participants (Ravitch & Carl, 2016). In Chapter 4, I report the results in detail so that future researchers can repeat this qualitative study and expect similar results. Audit trails were established through careful documentation of all components of the study, which involved a calendar with interview dates, transcriptions of the participants' responses to the interview questions, and observation of participants' language and tone of voice during the interviews (Roberts, 2010).

Confirmability

Confirmability refers to the idea that qualitative researchers seek to have confirmable data, relative neutrality, and reasonable freedom from unacknowledged research bias (Ravitch & Carl, 2016). The results are supported by the data collected during the interviews. An audit trail was created to confirm the findings in which I used member checking and triangulation to avoid researcher bias.

Data Analysis

Data analysis were conducted in NVivo (2018) QSR version 12 software using the seven-step procedure recommended by Creswell (2014). The seven steps were: (1) organizing and preparing data, (2) reading or reviewing the data, (3) coding, (4) clustering data into themes, (5) advance narrative of findings, (6) interpreting findings, and (7) validating the accuracy of the information (Creswell, 2014). The first step,

organizing and preparing the data, was conducted by using Zoom's automated transcription feature to transcribe the audio-recorded interviews into Microsoft Word documents. I verified the transcripts by reading and rereading them and editing them while listening to the audio recordings. Next, the researcher-verified transcripts were imported into NVivo 12 software as source files.

The second step of the analysis, reading and reviewing the data, involved rereading the transcripts in full (Creswell, 2014). The purpose of this rereading was to view the dataset holistically and to make preliminary notes of potential patterns in participants' responses. These preliminary notes were handwritten, with references to specific transcripts and responses within those transcripts also noted as needed.

The third step of the analysis involved initial coding of the data (Creswell, 2014). In this step, the data was broken down into the phrases or groups of consecutive phrases that each expressed a meaning relevant to describing participants' lived experience of the phenomenon of interest (i.e., participants' perspectives on scripture texts, teachings, practices, and beliefs related to mental illness and avoidance of secular mental health care). Each of the relevant chunks of data units identified in this way was labeled with a brief, descriptive phrase to summarize its meaning. In NVivo, labeling the transcript excerpts involved assigning them to nodes. Each node represented an initial code. Different transcript excerpts that expressed similar meanings were assigned to the same code, such that the codes were formed inductively, by clustering excerpts with similar meanings. Table 2 is a list of the 20 initial codes identified during this step.

Table 2. Initial Codes

Initial code	*n* of participants contributing (*N*=16)	*n* of transcript excerpts included
Analogizing mental health care to physical health care	4	4
Biblical guidance to seek help from those with knowledge	11	15
Classes without certification or degree	6	6
Concurrent Biblical theory of mental illness	4	4
Degree or certification	4	4
Disseminating medical knowledge	10	11
Encourage congregants to take a holistic approach to mental health	14	22
Faith healing	5	7
Incorporating medical interventions into faith-centered approach	10	15
Medical theories of mental illness	14	27
Mental health care should be analogized to physical care	5	6
Mental illness as demonic possession	6	8
Mental illness as punishment for sins	9	11
On-the-job experience	7	8
Only God should be relied upon to heal	11	27
Preference for Christian medical practitioners	9	10
Recognizing the need for medical intervention	9	13
Role of clergy is to facilitate faith-centered component of care	7	8
Role of clergy is to provide compassion and emotional support	9	13
Scriptural support for counseling and prayer	13	28

The fourth step of the analysis involved clustering the initial codes into themes (Creswell, 2014). Codes were clustered when they were related as parts of a larger, overarching theme relevant to describing participants' lived experiences of the phenomenon of interest. In NVivo, nodes representing related initial codes were assigned to the same parent node, which represented a theme. The themes were assigned preliminary, descriptive labels.

In the fifth step of the analysis, narrative definitions were created for the themes (Creswell, 2014). The narrative definitions indicated the overarching meaning expressed

in the theme. The definitions included supporting evidence in the form of direct quotations from the data.

The sixth step of the analysis involved interpreting the findings (Creswell, 2014). The themes were interpreted in light of the research questions to clarify their alignment with the study objectives. Each preliminary theme label was replaced with a proposition that addressed the research question to which the theme was relevant. Table 2 indicates how the initial codes were clustered to form the finalized themes.

Table 3. Emergent of Themes

Themes Initial code grouped to form theme	*n* of participants contributing (*N*=16)	*n* of transcript excerpts included
Theme 1. Clergy have medical theories of mental illness despite minimal scientific training	16	47
Classes without certification or degree		
Concurrent Biblical theory of mental illness		
Degree or certification		
Medical theories of mental illness		
On-the-job experience		
Theme 2. Clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both	16	71
Analogizing mental health care to physical health care		
Encourage congregation members to take a holistic approach to mental health		
Faith healing		
Incorporating medical interventions into faith-centered approach		
Recognizing the need for medical intervention		
Role of clergy is to facilitate faith-centered component of care		
Role of clergy is to provide compassion and emotional support		
Theme 3. Stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a failure of faith	16	42
Mental illness as demonic possession		
Mental illness as punishment for sins		
Only God should be relied upon to heal		
Theme 4. Clergy cite Biblical support for help-seeking	15	53
Biblical guidance to seek help from those with knowledge		
Preference for Christian medical practitioners		
Scriptural support for counseling and prayer		
Theme 5. Education should be provided to increase knowledge and acceptance of mental health care	14	17
Disseminating medical knowledge		
Mental health care should be analogized to physical care		

Table 4. Themes used to address research questions

	Theme(s) used to address research question
RQ1: What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare?	Theme 1. Clergy have medical theories of mental illness despite minimal scientific training
	Theme 2. Clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both
RQ2: What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?	Theme 3. Stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a failure of faith
RQ3: What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy?	Theme 4. Clergy cite Biblical support for help-seeking
RQ4: What type of mental health education, if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities?	Theme 5. Education should be provided to increase knowledge and acceptance of mental health care

The seventh step involved validating the accuracy of the findings (Creswell, 2014). A thorough review of the original transcripts was undertaken. The codes and themes were compared to the data to confirm that they accurately represented patterns in participants' responses.

Results

This presentation of the results is organized by research question. Under the heading for each research question, subheadings indicate the themes used to address the question. The discussion of each theme includes evidence from the data.

Research Question 1

RQ1 was: What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare? Two themes emerged during data analysis to address this question. The first theme was: clergy have medical theories of mental illness despite minimal scientific training. The second theme was: clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both. The following subsections are discussions of these themes.

Theme 1: Clergy Have Medical Theories of Mental Illness Despite Minimal Scientific Training

All 16 participants contributed to this theme. Most participants reported that they had minimal training in secular mental health care, with only four participants indicating that they had a degree or certification in any mental health-related field. Despite minimal formal exposure to scientific theories of mental illness, however, all participants described the causes of mental illness in predominantly scientific terms, referencing chemical imbalances, trauma, substance abuse, heredity, and excessive stress. Only four participants continued to credit Biblical theories of mental illness, reporting that they still considered mental illness to be related in part to demonic influences. However, those four participants also joined the rest of the sample in reporting an understanding that centered a secular, medical paradigm of mental illness.

Twelve out of 16 participants reported that their exposure to scientific theories of mental illness through formal coursework was minimal. The most common form of exposure, reported by seven out of 16 participants, was confined to on-the-job

experiences of assisting congregation members with mental health concerns. For example, B3 said of training in secular mental health care, “I haven't had the training, only experience.” B5 reported experience of working with mental healthcare providers in a supporting role: “I guess that my training has been working with psychiatrists and psychologists that dealt with [prison] staff and inmates that may have suffered loss or casualty.” P1 stated, “All of my practice [in counselling] was on the job. I didn’t go to school for it. I wish I may still can.” Five participants expressed that their formal exposure to secular theories of mental illness was limited to a small amount of coursework or seminars in programs where they did not receive a degree or certification. For example, B4 reported taking one college class: “In my early years, I did take a psychology class in my early college years, and other than that, my personal reading and things of that nature. No formal training in mental health care.” P7 took classes through a church-based program: “I did some classes at another church . . . so part of that course dealt with counseling, not necessarily mental health per se.” Only four participants provided discrepant data, reporting degrees or formal certifications in mental health-related disciplines. B2 described extensive formal exposure to secular theories of mental illness: “I have a bachelor’s degree in sociology and social welfare, and I also . . . supervised a staff of mental health workers in a mental health agency.” B8 reported, “I've had courses in counseling and pastoral counseling. I've been certified in that, actually.” B8 reported participating in biannual continuing education to keep the certification current.

Most participants reported minimal formal training in secular mental health care, but all participants reported an understanding of mental-illness risk factors grounded in scientific knowledge. Nine participants reported that mental illness could be a consequence of excessive stress, with an example being found in P1's response: "Either they [the patient] were given too much that they could not handle, or they were not given enough so that they would be able to handle life. That's what I believe." P2 provided another example of belief in excessive stress as a risk factor for mental illness in stating, "I believe it's [mental illness is] a number of disappointments, heartaches, pain, painful situations that have happened in our lives that we cannot control." Six participants referred to heredity or genetics as a risk factor for mental illness, with an example being found in B2's response, as follows:

> You look at family history, and you can see in a lot of instances patterns of family issues related to mental health. Mother had mental health problems, grandfather, grandmother had mental health problems. You can see there have been genetic-related patterns.

Five participants referred to trauma as a risk factor for mental illness. B4 referred to trauma as an overwhelming stressor, stating that a risk factor for mental illness was, "Overstressing by traumatic experiences and not being able to properly deal with that could result in a person having mental illness." Four participants referred to chemical imbalances in the brain as risk factors for mental illness, including B1, who said that a risk factor for mental illness was, "We have a chemical imbalance in the person."

Four participants provided partly discrepant data, indicating concurrent beliefs in a Biblical theory of mental illness, in which mental illness was understood as an effect of demonic influences. B5, who expressed the beliefs that mental illness could be caused by heredity or childhood trauma, added that he continued to believe that demonic influences might be involved:

> I also see it as being a demonic force as well. There was a lunatic in the Bible, in Matthew 17:15, that was throwing himself in the fire for years, and there were issues as to somebody trying to heal him of his issue, and they bought the boy Jesus oftentimes casting out because there were demonic forces at work.

B6 reported the beliefs that mental illness could be caused by heredity and chemical imbalances. B6 also reported the belief that demonic influences were relevant, stating: "We have opposing forces. We believe in God. You also have to believe in Satan, and satanic powers, they can possess you. But I believe if you are spirit-filled, they cannot possess you, they can [only] oppress you."

In summary, most participants had minimal formal exposure to secular theories of mental illness. However, all participants reported scientifically grounded understandings of mental illness, referencing factors such as chemical imbalances, excessive stress, trauma, and heredity as risk factors. Only four participants reported concurrent belief in a Biblical theory that associated mental illness with demonic influences. However, all four of those participants also reported secular beliefs about risk factors for mental illness.

Theme 2: Clergy Integrate Faith and Secular Medicine by Advocating for a Holistic Approach that Incorporates Both

All 16 participants contributed to this theme. Participants reported that they perceived secular medicine as the primary instrument for addressing mental illness. All the participants reported that when they recognized signs of mental illness in a congregant who sought their counsel, they would strongly encourage the individual to consult and cooperate with a secular mental healthcare provider. However, they all also believed that faith played an important role in addressing mental illness in religious persons. The participants therefore advocated for a holistic approach, in which religious approaches and secular medicine were integrated into a coordinated support system. Participants stated that while secular practitioners undertook a medical approach to addressing mental illness, the role of the clergy was to provide ongoing compassion, emotional support, and spiritual guidance to the patient, as well as to encourage the patient to consult and cooperate with healthcare providers. Participants reported that they emphasized to congregants who sought their advice that religion and secular medicine were not in conflict but were instead complementary and mutually reinforcing.

Some participants referred to their advocacy for secular medicine as a deviation from Pentecostal traditions. For example, P2 stated, “Growing up, I don't even recall mental health ever being mentioned in the church. I never recall being taught anything about mental health.” B9 reported, “I came into Pentecostalism just like anyone else, and I thought if there was anything malfunctioning, it was a spirit, it was a demon.” B7 said of some AAP clergy, “Some pastors don't like that word, psychiatrist. It's like it's a put-

down towards what they're teaching. They feel that ‘God is my doctor’.” B2 spoke more generally than B7 in stating:

> One of the fundamental beliefs of Pentecostal ministers is that there should be trust in God and his healing when it came to mental health sickness and disease, so there was not much faith in the medical communities, in psychiatrists and psychologists, to deal with mental health problems that people face, and so the healing mechanism tended to be the altar.

One way in which participants became more accepting of secular mental health care was by likening it to secular physical health care. B3 pointed out a perceived inconsistency in Pentecostal traditions in stating, “We go to the doctors for our foot, we go to the doctors for our heart and various body parts, but never for the mind.” B3 therefore decided to be consistent in advising congregants: “If I find that it's something that's beyond my control, I do refer them to counseling, to a psychiatrist.” B4 made the analogy between physical and mental health care in stating, “Mental health as well as physical health, I think they’re parallel, I think they go beside each other.” B5 spoke of needing to diverge from earlier beliefs in Biblical theories of mental illness, stating, “It took me some time just to come to that realization that mental illness, mental health, should be categorized the same as physical health or physical illness.”

Participants reported that an important part of their lived experience consisted of recognizing their own limitations in order to better serve their congregants through advocacy for a holistic approach to mental health care. B2 discussed his perception of his limitations in addressing mental illness, stating,

> I've had people in my church who have actually had mental health breakdowns, suffering from manic depression, dramatic issues. I was not reticent about referring people [to secular mental healthcare providers]. There were things that I consider to be out of my paygrade.

B7 also described willingness on the part of clergy to refer members to secular practitioners as a recognition of limitations:

> I think that we have the physicians and psychologists come in to find out where is this [mental illness symptom] coming from. We have this [symptom] happening, and they [healthcare providers] are trained to do that, and I am not trained. So that's why, when I have a pastors' meeting, or when I'm at a conference, I say we have to recognize that there are people that know more than us, and we have to give them more credit, and we have to recognize that there is help out there and be willing to direct people to the help that's out there.

P3 joined the other participants in recognizing that being qualified as clergy did not entail being qualified to address mental illness symptoms: "I don't try to put myself into the position of a doctor giving medical advice. I try to get people to go to the doctor." P3 added in another response, "I don't have all the answers. I know that I'm limited, and I know to do what is right" by referring congregants to secular mental healthcare providers. P6 recommended secular medicine to congregants as a means of ensuring that the right approach was used: "I want to help. I don't want to do any harm. To cast out demons is a problem if they [congregants] need some medication."

All participants believed that clergy continued to play an important role in caring for members of their congregation who were receiving care from secular providers. One vital role of the clergy, according to nine participants, was to provide compassion and emotional support to individuals suffering from mental illness. P4, for example, stated that the role of clergy was to provide, "A lot of love, a lot of patience and understanding." P1 offered a perspective similar to P4's in stating of the role of clergy in mental health care, "I believe the first thing is to comfort them." B5 said of working as clergy to complement the role of secular providers, "My role is to provide support—scripture support, emotional support—to be forgiving, and be patient, and have endurance."

Another important role of clergy was to refer congregants to secular mental healthcare resources, according to all 16 participants. P3 referred to this role in stating, "I believe my role as the pastor is to pray for them [the congregants], and then advise them to get whatever other help they may need, if I can't help them." B4 stated of the roles of clergy in mental health care,

> I think our role is multiple. The first one is prayer, praying with the individual, whether they come to us themselves or the caretaker brings them . . . and to give them hope that there is help available, and then to give them the good advice [to seek help from a secular mental healthcare provider].

B8 also stated that the role of clergy was twofold: "Pray with them [congregants], but you should be able to make sure that they are getting the necessary help." P4 spoke of reinforcing secular providers' contributions from a position of spiritual authority:

> [Secular medical] treatment with prayer is the best combination you can have. So, we had to constantly encourage them [congregants] to be faithful to their treatment plan. It could be medication or therapy, but we encourage them not to give up on that.

All the participants reported that they integrate faith and secular medicine by advocating for a holistic approach that incorporates both. B5, for example, advocated for reliance on mental healthcare providers who could incorporate faith-based and secular approaches into an integrated, holistic program of spiritual and medical care:

> I believe in Christian psychology. I believe in a psychologist or psychiatrist that is Christian based, that is using the word of God to assist their expertise. I think that is a wonderful mixture of the spiritual, and also, they are trained to get to the root cause, to dig deep into what is really causing the person's issues.

For other participants, a holistic model of mental health care took the form of advocating for and reinforcing a secular component. B8 reported a decades-long history of facilitating the spiritual component of holistic mental health care while simultaneously advocating for the integration of secular medicine:

> I have been pastoring for 30 years-plus. One of the things I began to do, I began to partner with the mental healthcare facilities, to be able to refer after we have given scripture and prayed for them [congregants]. I pulled it from the angle that this is not just a God problem, this was a problem that we could pray over and quote scripture over, but we needed to get them the mental health that they needed, and some of it came through medication.

B9 described a perspective on holistic mental health care that evolved from an exclusively faith-based understanding over the course of a career. B9 reached a perspective from which, "I tell them they need some help." P1 spoke of trying religious approaches first and then reaching out to secular providers if a faith-based solution did not resolve the mental illness symptoms:

> We always start with prayer. We share with them [congregants] a scripture, maybe, that is related to the experience that they are going through right now, and then if that is not conducive for the healing, then we would give them over to someone that could help them in the mental health community.

In summary, participants reported that Pentecostal tradition encouraged exclusive reliance on religious approaches to mental health care. However, through reflecting on the similarities between mental health and physical health, and through a recognition of their own limitations in assisting congregants who exhibited symptoms of mental illness, participants began to integrate faith-centered and secular approaches to mental health care. Participants believed that clergy had two roles in assisting congregants who suffered from mental illness. The first role was to provide emotional support, compassion, and faith-centered guidance. The second role was to encourage the congregant to consult and cooperate with secular mental healthcare providers.

Research Question 2

RQ2 was: What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs? The theme used to address

this question was: (Theme 3) stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a rejection of faith. The following subsection is a discussion of this theme.

Theme 3: Stigmatization and Avoidance Are Promoted by Teachings That Characterize Reliance on Secular Medicine as a Rejection of Faith.

All 16 participants contributed to this theme. Participants indicated that reliance on secular medicine was sometimes stigmatized and avoided as a result of AAP teachings that characterized it as an implicit rejection of religious understandings explanations and solutions. The teachings were based on literalist interpretations of scriptural passages which suggested that only God should be relied upon for healing, or that mental illness is a punishment for sins or an effect of demonic influences. Notably, participants expressed disagreement with literalist interpretations that stigmatized secular medicine.

Eleven participants reported that they were aware of teachings that stigmatized secular medicine by indicating that only God should be relied upon to heal. P2 referred to this teaching and on its scriptural referents in stating, “God can do anything, Genesis 18:14: ‘Is anything too hard for the Lord?’ And [pastors] would say it so it would put fear in you to think that if I go to a counselor then I'm not trusting God.” B7 disputed AAP teachings based on a Biblical passage describing the laying-on of hands:

> The Lord told the disciples in Mark 16:18, “They would be able to lay hands on the sick and they shall recover.” Many times, the clergy, especially in the African American Pentecostal Church, they take it literally . . . that is what many of them

> go by. They don't even want to alter a little bit, and it's a shame, especially with mental health.

Participants reported that other scriptural passages on which the stigmatization of secular medicine was based included Romans 12:2 (“Be not conformed to this world, but be transformed by the renewing of your mind,” referenced by three participants), Peter 5:7 (“Casting all your cares upon him for he cares for you,” referenced by three participants), Isaiah 53:5 (“By his [Christ’s] stripes we are healed,” referenced by three participants), and Isaiah 26:3 (“I will keep thee in perfect peace whose mind is stayed on me because he trusts in the Lord,” referenced by two participants). B2 said of the interpretation of such passages as stigmatizing help-seeking through secular medicine,

> People sometimes will point to Biblical examples and passages of scriptures that don't mean don't get help. God is sovereign, and he can use any of the world’s systems to bring a person to that place of wholeness . . . A person who is steeped in [Biblical] literalism . . . can have a positive scripture that can be interpreted negatively, which may hinder you from getting the kind of help that you may need.

Nine participants cited literalist interpretations of passages in which mental illness symptoms are characterized as deserved punishments for sins as stigmatizing secular medicine. Biblical passages that participants referenced as relevant included Hebrews 10:26 (“There remains no more sacrificed to them that sin willfully,” referenced by one participant); Daniel 5:4 (in which God casts a “spirit of confusion” on King Nebuchadnezzar for disobedience, referenced by one participant); II Timothy 1:7 (“God

is not given us the spirit of fear but of love, power, and a sound mind," referenced by three participants), and Exodus 15:26 "If you obey all of my commandments then none of these diseases that are laid on the Egyptians shall come nigh thee," referenced by one participant). B3 stated of the conception that mental illness was divine punishment, "There is a stigma that we [most AAPs] believe that because they [congregants] have a mental issue they've 'lost their faith'." B7 said of literalist interpretations of the foregoing passages,

> There has been a misconception, there has been an ignorance . . . some ministers believe that God has caused a person's mind to go away because possibly they have not acknowledged Him, or because they didn't get saved, because they've been out in the world, or because they were doing things contrary to what God wants. So, this is a curse that got placed in the mind of individuals who are having some psychological issues.

Six participants cited teachings characterizing mental health symptoms as evidence of demonic influences. P5 stated, "Stigma is more or less about demon possession and not understanding that there can be some inherent hurts that need to be dealt with." As one of the scriptural bases for this belief, P5 cited Luke 11:26, which P5 described as, "The case where the person was demon-possessed, and they said go your way and stay clean, otherwise seven more will come in." B4 referenced a different passage from Luke in stating,

> In the church, we certainly have scriptural areas of Christ dealing with people who would be categorized as having mental health issues. You have a young man

in Luke 9:39-40, who was casting himself in the fire. You see evidence of suicidal ideation, Jesus, dealing with him in a spiritual manner, cast the demon out.

P5 and B8 both cited Mark 5:1-7, which B8 summarized in stating, "When Jesus came to the country of the Gadarenes, and he saw this young man living in the tombs, possessed with unclean spirits." P4 said of II Timothy 1:7 ("God is not given us the spirit of fear but of love, power, and a sound mind") as a basis for interpreting mental illness symptoms as demonic possession, "I guess from a biblical point of view, it could be interpreted that if you don't have a sound mind, then that is not from God."

Research Question 3

RQ3 was: What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy? The theme used to address this question was: clergy cite Biblical support for help-seeking. The following subsection is a discussion of this theme.

Theme 4: Clergy Cite Biblical Support for Help-seeking

Fifteen participants contributed to this theme. One participant (P6) provided partially discrepant data. The participants who supported this theme described a scriptural basis for AAPs' seeking two kinds of mental health support from clergy. First, participants believed there was strong scriptural support for congregants to seek mental health support directly from clergy in the form of counseling and prayer. Second, participants believed there was also strong support in scripture for clergy to provide mental health support by encouraging congregants to seek help from medical practitioners. The participant who provided partly discrepant data did not engage directly

in counseling for mental health issues, but instead referred congregants to medical practitioners, and so had not contemplated a scriptural basis for the clerical practice of providing mental health support.

Thirteen participants cited a scriptural basis for clergy providing mental health support in the form of spiritual counseling and prayer. No participants indicated a belief that such a basis did not exist. For B6, the scriptural basis for clergy providing mental health support was found in I Corinthians 1:3-4 ("The God of all comfort, who comforts you in your tribulation that you may be able to comfort others in all their troubles as you are comforted"). B6 said of this passage, "I call it having a sensitivity to hurting people." B6 also cited I Thessalonians 5:14 ("comfort the feeble minded") as an imperative to provide support to congregants suffering from mental illness. As support for clerical interventions to provide mental health support, B9 cited James 5:14 ("If there are any sick among you, call for the elders of the church"), stating of the pertinent interpretation, "I believe there are pastors and elders that know how to deal with people who are suffering with mental illness, and if they really have true love, they will try to get that person some help." B1 cited James 5:16 ("Confess your faults one to another, and pray one for another, that ye may be healed. The effectual fervent prayer of a righteous man availeth much") as a basis for seeking mental health support from clergy in the form of prayer and counsel. B2 cited Philippians 4:13 ("I can do all things through Christ who strengthens me") as a basis for the belief that faithful clergy could provide effective assistance. B4 referenced I Peter 5:7 ("Cast all our cares upon Christ because he cares for us"), stating, "We have to turn to God and prayer and supplication and asking for

answer," as a basis for seeking mental health support in the form of prayer from clergy. Citing Philippians 4:7 ("and the peace of God that passes all understanding shall keep our hearts and minds"), B4 added, "The scripture teaches also that he [God] will give us the peace that we need." As a basis for clergy providing mental health support in the form of prayer, P3 cited John 14:1 ("Do not let your hearts be troubled. Trust in God; trust also in me") and added that partly on the basis of this verse, "I have prayer with them [congregants suffering from mental illness], and usually they seem to do better feel better, and I ask God to lead and guide me as we talk."

Eleven participants cited a scriptural basis for clergy providing mental health support by referring congregants to mental healthcare providers. No participants indicated a belief that such a basis did not exist. P3 summarized the need to refer some congregants to mental healthcare practitioners in stating,

> Sometimes people say, "Just believe God," and we [AAP clergy] are bad about saying that. I do believe in God, but I do believe God gave us some common sense, too, to go and find some help, and along with that, would also give you the wisdom you need to know how to deal with it [mental illness].

As a scriptural basis for encouraging congregants to seek help from secular medicine, B1 and B9 cited Hosea 4:6 ("My people are destroyed because of the lack of knowledge"), which B1 interpreted as referring also to, "Discounting of information that you would receive from physicians." In discussing the same verse, B9 said, "Of a lack of knowledge, many people suffer needlessly, 'cause they should have seen and got some help for mental illness." B6 cited Matthew 9:12 ("They that be whole need not a

physician, but they that are sick"), adding, "There was a time they [AAP clergy would] tell you that if you went to a medical doctor, you will compromise your faith. They put the wrong spin on what Jesus said." Also referencing Matthew 9:12, P4 stated, "In other words, letting people know that the Lord understood that we would have these kinds of [medica] issues in our lives, and therefore he has ordained physicians. He's not anti-physician." B9 cited another verse as support for the belief that medical practitioners' knowledge was ordained by God:

> I believe that all healing, all anointing, and all knowledge comes from God, so any doctors and nurses or psychologists, if they have any knowledge, it comes from God. So according to Colossians 3:17, "Whatever you do, whether in word or deed, do it all in the name of the Lord Jesus."

B8 referenced a different Biblical verse in discussing the belief that a secular, medical intervention was needed for some congregants because of limitations in the capabilities of clergy:

> According to the book of James 1:8, about, "The double-minded man is unstable in all his ways," it was a spirit of being schizophrenic or bipolar in today's society. So, what I have done in my ministry, we have prayed for them [congregant with mental illness] and referred them to the proper counselor. We just can't come to church and shout it out and lay hands on them. We believe God can do anything but fail, but there are some conditions that there are chemical imbalances that must be balanced with medications.

Nine participants expressed the belief that AAP clergy should provide mental health support for congregants by encouraging them specifically to seek help from providers who practiced secular medicine from a Christian perspective. B1 expressed this belief in stating, “Most clinicians I know, they don't understand the spiritual aspect . . . The clinician should be able to deal with the spiritual also.” B3 stated, “If they [practitioners] say, ‘I don't believe God,’ I don't know how good they will be able to help. So that's why I would rather refer to a Christian counselor.” B4 expressed in medical terms why AAPs were advised to seek help from medical practitioners who at least understood their faith: “I think they need at least a basic understanding of what Pentecost means and what Pentecostal churches are about. It will take [the practitioner] a long way, and it goes to understanding your patient and their background belief system.” B8 believed Christian practitioners were more appropriate mental healthcare providers for AAPs because,

> I know there are people out there that are qualified or capable, who are not spirit-filled, that can diagnose properly, but many times I think that when you are dealing with people’s psychological wellbeing, I really believe that it should come from someone who is spirit-filled, who has the capability of what I call “multitasking in the spirit.”

B9 expressed a belief similar to B4’s about the need for providers to understand patients’ beliefs, stating, “I would first research and seek out one that is a Christian because I believe that person could know the best practices in psychology, but they need to be able to identify with the person’s religious beliefs.” P4 regarded Christian

practitioners as optimal but added that if one was not available, a practitioner who would not invalidate deeply held beliefs should be sought: “If they [practitioners] don't really have a spiritual background, at least if someone is tolerant and willing to know and understand a little bit about the African American Pentecostal experience.”

Research Question 4

RQ4 was: What type of mental health education, if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities? The theme used to address this question was: (Theme 5) education should be provided to increase knowledge and acceptance of mental health care. The following subsection is a discussion of this theme.

Theme 5: Education Should Be Provided to Increase Knowledge and Acceptance of Mental Health Care

Fourteen participants contributed to this theme. The remaining two participants did not provide discrepant data, but instead did not address the theme. Participants believed that to increase the acceptance of mental health care in AAP communities, it was necessary either to bring in experts in secular medicine as guests to instruct pastors and congregants, or to facilitate training in secular medicine for congregants, who could then inform other church members. Participants further recommended that the analogy between physical and mental health care (discussed under Theme 2) should be promoted to increase the acceptability of secular mental health support for AAPs.

Ten participants recommended bringing secular medical expertise into AAP faith communities, either by inviting experts to give seminars or classes, or by cultivating expertise within the community by facilitating the education of congregants. B2 recommended bringing in secular medical experts to facilitate in-services for clergy: “I think that an educationally progressive church will bring in leaders from the medical establishment specializing in mental health issues to have in-services for leaderships in congregations.” B6 also recommended training for clergy, citing as an example, “I think that in our ministry or development classes we need a lot of training . . . one of the major [AAP] churches has a woman, that's what she does, that's her field of expertise, is to inform pastors.” B7 recommended education for clergy in the form of, “More seminars, more workshops, just to familiarize them [clergy] with what people are dealing with when they are having mental issues and problems or psychological struggles.” B7

recommended specifically that the seminars or workshops be led by secular medical experts because, “It’s good for physicians to let the clergy know these are things that are affecting a lot African American people in your churches.” Like B7, P1 recommended, “A workshop given by clinician or someone who has knowledge of the psychological community.” Two participants recommended using or cultivating medical expertise within the AAP Church. P3 stated, “We have nurses, we have doctors now in Apostolic churches . . . These people should be utilized. The church can never know enough.” B3 recommended cultivating expertise among congregants: “Sending some of our congregants to school and have them in our congregations so that you can have them and refer the congregants to them.”

Five participants indicated that emphasizing the close analogy between mental and physical health care could increase the acceptability of secular mental health care in AAP faith communities. P4 stated, “The congregation needs to be made aware that just like we have heart disease and epilepsy, we have mental health issues.” B4 expressed a similar view in saying, “I think we have an obligation to let them [congregants] know mental health conditions are not all demonic, they may be no different than diabetes or high blood pressure.” P2 emphasized the medical nature of mental illness, stating that AAPs needed, “Any type of any information that we could get that will enable us to understand that mental health is not a bad word, that mental health is not a demon, that it is a true illness.” P6 said of the information he provided to congregants who might need mental health care, “I would say if they want to seek out mental health services, I'm all

for it that is really something that is advantageous, and if they need to do it, they should. It's just like going to a physical doctor."

Summary

Four research questions (RQs) were used to guide this study. RQ1 was: What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare? Two themes emerged during data analysis to address this question. The first theme was: clergy have medical theories of mental illness despite minimal scientific training. All 16 participants contributed to this theme. Most participants reported that they had minimal scientific training, with only four participants indicating that they had a degree or certification in any mental health-related field. Despite minimal formal exposure to scientific theories of mental illness, however, all participants described the causes of mental illness in predominantly scientific terms, referencing chemical imbalances, trauma, substance abuse, heredity, and excessive stress. Only four participants continued to place credence in Biblical theories of mental illness, reporting that they still considered mental illness to be related in part to demonic possession or interference. However, those four participants joined the rest of the sample in reporting actions and understandings that centered a scientific paradigm of mental illness.

The second RQ1 theme was: clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both. All 16 participants contributed to this theme. Participants reported that they perceived secular medicine as the primary instrument for addressing mental illness. All the participants reported that when they

recognized signs of mental illness in a member of their congregation who sought their counsel, they would strongly encourage the individual to consult and cooperate with a secular mental healthcare provider. However, all the participants also believed that faith played a necessary role in addressing mental illness in religious persons. The participants advocated for a holistic approach, in which religious approaches and secular medicine were integrated into a coordinated, wraparound support system. Participants stated that while secular practitioners undertook a medical approach to addressing mental illness, the role of the clergy was to provide ongoing compassion, emotional support, and spiritual guidance to the patient, as well as to encourage consultation and cooperation with secular mental healthcare providers. Participants reported that they emphasized to congregants who sought their advice that religion and secular medicine were not in conflict but were instead complementary and mutually reinforcing.

RQ2 was: What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs? The theme used to address this question was: stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a rejection of faith. All 16 participants contributed to this theme. Participants indicated that reliance on secular medicine was sometimes stigmatized and avoided as a result of AAP teachings that characterized it as an implicit rejection of religious explanations and solutions. The teachings were based on literalist interpretations of scriptural passages which suggested that only God should be relied upon for healing, or that mental illness is a punishment for sins or an effect of

demonic influences. Notably, participants expressed disagreement with literalist interpretations that stigmatized secular medicine.

RQ3 was: What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy? The theme used to address this question was: clergy cite Biblical support for help-seeking. The 15 participants who supported this theme described a scriptural basis for AAPs' seeking two kinds of mental health support from clergy. First, participants believed there was strong scriptural support for congregants to seek mental health support directly from clergy in the form of counseling and prayer. Second, participants believed there was also strong support in scripture for clergy to provide mental health support by encouraging congregants to seek help from medical practitioners.

RQ4 was: What type of mental health education, if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities? The theme used to address this question was: education should be provided to increase knowledge and acceptance of mental health care. Participants believed that to increase the acceptance of mental health care in AAP communities, it was necessary either to bring in experts in secular medicine as guests to instruct pastors and congregants, or to facilitate training in secular medicine for congregants, who could then inform other church members. Participants further recommended that the analogy between physical and mental health care (discussed under Theme 2) should be promoted to increase the acceptability of secular mental health support for AAPs. Chapter 5 includes discussion and interpretation of these themes.

Chapter 5

Introduction

The purpose of this qualitative phenomenological study was to address the gap in the literature by describing the meanings of the lived experiences of AAP clergy of their biblical scripture teachings and beliefs regarding mental illness and secular mental healthcare. I used a phenomenological research design to inquire about the phenomenon of avoidance of secular mental healthcare and fear of stigma in this sample. The results of the analysis of the transcriptions provided details explaining this phenomenon.

To guide this study, I developed the following research questions:

1. What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare?
2. What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?
3. What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy?
4. What type of mental health education if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities?

All 16 African American Pentecostal senior pastors in this study shared their lived experiences regarding their scripture teachings and beliefs of mental illness that influence fear of stigma and avoidance of secular mental healthcare among African American

Pentecostal congregants. Pastors of African Americans are more likely to be sought out to provide guidance for their congregants' mental and emotional issues. DeHoff (2015) suggested further qualitative studies for understanding clergy's distinctions and belief regarding religious experiences and mental disorders. Although studies have been conducted on the religious beliefs of African American Pentecostal clergy regarding mental illness and mental healthcare, there has been a gap in the literature relevant to studies of scripture beliefs and teachings among AAP clergy.

I developed the research questions to explore four areas. The first area was clergy religious beliefs and beliefs on secular mental healthcare. This allowed me to understand how pastors within this population experienced personal integration of the two perspectives. The second area to be explored was the clergy Biblical teaching and beliefs regarding mental illness. This allowed me to explore the specific scriptures and teachings that influence the fear of stigma and avoidance of secular mental healthcare among AAPs. The third area of exploration was clergy beliefs on mental health seeking methods. This allowed me to understand the specific scriptures teachings that influence AAPS seeking mental healthcare support from clergy. The fourth and final area of exploration was clergy perspectives on mental healthcare education. This allowed me to understand the possible interventions that may impact acceptance of secular mental healthcare within the AAP community.

Analysis of the data provided valuable information that answered the research questions and sub-questions. I found that each of the clergy had experiences that required the integration of their religious beliefs with beliefs regarding secular mental healthcare.

The data showed how each pastor had challenging experiences integrating their religious teachings and beliefs when faced with mental health issues within their congregation. Second, the pastors believed that specific scripture teachings and references regarding faith, healing and in some cases demonic possession influenced the fear of stigma and avoidance of mental healthcare among their congregants. Third, the data showed that pastors believe that scripture teachings regarding faith, trusting God and divine healing influence beliefs supporting mental healthcare seeking from clergy. The pastors believed that secular mental healthcare may be needed and was not a sign of the lack of faith or trusting God and that referral behaviors beyond the scope of their training require secular mental health care treatments. Lastly, the data showed the pastors believed that cultural and religious awareness and understanding of AAP beliefs among secular mental health care workers along with effective mental health education would impact the acceptance of mental healthcare within the community.

The purpose and findings of this study helped to close the gap in the literature by providing the lived experiences of clergy regarding scripture teachings and beliefs that influence fear of stigma and the avoidance of secular mental healthcare within the AAP community. Previous studies regarding pastors' views on mental illness and secular mental healthcare highlighted how the participants' experienced challenges involving the beliefs and barriers which often resulted in the lack of acceptance of professional mental healthcare within the AAP community (Anthony et al., 2015; Armstrong, 2016). In this chapter, I analyzed the information collected from this qualitative study based on the research questions and summarize the key findings. I discussed how these findings

confirm, disconfirm, or extend the knowledge of the Bible scriptures teachings that influence AAPs fear of stigma and avoidance of secular mental healthcare as described in the context of the literature I reviewed in Chapter 2. In this chapter I interpreted my research findings, discuss limitation of the study, recommendations, implications, and conclusion.

Interpretation of the Findings

The phenomenological approach provided the bases for me to obtain the detailed accounts of AAP pastors' lived experiences regarding scripture teachings in respect to mental illness and secular mental healthcare. This qualitative approach allowed me the opportunity to explore the participants worldviews from their perspectives (see Creswell, 2014). The participants in this study discussed their lived experiences as AAP clergy who influenced the mental health decision making processes of congregants suffering with mental health issues.

Participants discussed their lived experiences as AAP pastors who influence their congregants' spiritual and natural decision-making process through teachings, sermons, and scripture references. The analysis was based upon my interpretations of the participant's descriptions of their lived experiences. Analysis of the lived experiences of clergy demonstrated how scripture teachings and beliefs influence the lack of acceptance of secular mental health care within the AAP community. The pastors provided detailed accounts of their lived experiences of integrating their religious beliefs regarding mental illness with secular mental healthcare. The pastors identified specific scriptures and teachings that influenced the fear of stigma and avoidance of secular mental health

services among AAPs. Analysis of their experiences and beliefs highlighted their perceptions on mental illness and secular mental healthcare along with the impact that scriptures teachings and beliefs have on influencing AAPs decision making processes seeking help for their mental health needs.

The analysis was based upon my interpretations of participants' responses to the twelve interview questions I developed for this study. Through the process of paraphrasing and summarizing the rich and in-depth descriptions provided by the participants, I developed the themes in this study (see Creswell, 2014). Results from generated 20 codes (sub-themes): analogizing mental health care to physical health care, biblical guidance to seek help from those with knowledge, classes without certification or degree, concurrent Biblical theory of mental illness, degree or certification, disseminating medical knowledge, encourage congregation members to take a holistic approach to mental health, faith health, incorporating medical interventions into faith-centered approach, medical theories of mental illness, mental health care should be analogized to physical care, mental illness as demonic possession, mental illness as punishment for sins, on-the-job experience, only God should be relied upon to heal, preference for Christian medical practitioners, recognizing the need for medical intervention, role of clergy is to facilitate faith-centered component of care, role of clergy is to provide compassion and emotional support, and scriptural support for counseling and prayer.

From the 20 sub-themes I formulate clustered which helped in developing five primary themes. The five main themes were: clergy have medical theories of mental illness despite minimal scientific training, clergy integrate faith and secular medicine by

advocating for a holistic approach that incorporates both, stigmatization and avoidance are promoted by teachings that characterize reliance on secular medicine as a rejection of faith, clergy cite Biblical support for help seeking, and education should be provided to increase knowledge and acceptance of mental health care.

Themes That Support Research Question 1

Analysis of the transcriptions identified two themes that answered RQ1: What are AAP clergy's lived experiences of integrating their religious beliefs with beliefs about secular mental healthcare? The first theme was: clergy have medical theories of mental illness despite minimal scientific training. The second theme was: clergy integrate faith and secular medicine by advocating for a holistic approach that incorporates both. An underlining theme presented by the pastors was their understanding of the influence, responsibility, and role they played in the lives of their congregants. Many of the pastors acknowledge that they knew little regarding mental illness or mental healthcare but were responsible for guiding their congregants suffering with mental health issues in their mental health treatment decisions.

NVivo coded forty-seven references from all of the 16 AAP clergy perceptions in regard to Theme 1: AAP clergy believe that there are various medical and psychological causes of mental illnesses. I developed Theme 1 from the following sub-themes the emerged from the analysis of the data: classes without degrees, degree or certification, medical theories of mental illness, on-the-job experience, concurrent and biblical theory of mental illness. These sub-themes supported the clergy perspectives.

Most of the clergy acknowledged that the scope of their educational backgrounds relating to mental health was limited to informal training. Many of them attended seminars and classes to support their pastoral counseling requirements, often receiving certification in those areas. I found that

According to Hays (2015) within the African American community pastors are mainly sought for the support for the mental health needs of their congregants. All of the pastors acknowledged using personal experiences and biblical sources to support congregants' mental health needs. The clergy perspectives on the etiological factors on mental illness ranged from spiritual to biological. According to Payne and Hays (2016), clergy beliefs regarding mental illness span from the spiritual end of the spectrum (i.e., demon possession) to a biological cause. Not many of the clergy had formal education in mental healthcare, however all of them acknowledged that their positions provided them with years of on-the-job training working with congregants with mental health issues. Stansbury et al. (2018) noted that the lack of professional training of pastors in mental health was a concern when providing counseling for congregants. All of the pastors, both informally trained and formally trained used scientific terms to identify the causes of mental illness (i.e., stress, depressions, abuse, addiction, etc.). Many of the clergy used scientific terms such as schizophrenia, bipolar, and PTSD, to identify certain conditions they believed suffered by individuals within their congregations. I found that the clergy perspectives on mental illness were based on information obtained while attending various classes and seminars in pastoral counseling.

I also found that concurrently, some of the pastors regardless of their level of training held to the Biblical theory that mental illness was due to spiritual factors, such as demonic possession. This belief aligned with finding from Dein (2018) who showed that some AA clergy believed that certain mental health problems were associated with demonic activity or possession. Karadzhov and White (2018) found that although some of the Pentecostal clergy believed certain mental illness were due to biological causes, they also believed that medical intervention was unable to treat the spiritual dimensions of suffering.

For all of the pastors, prayer and Bible scriptures has been a major part of their counseling process. Hays (2015) posited that clergy systematically use informal resources to meet the mental health concerns of their congregants. I found that all of the clergy were aware that the type of support they offered was not always sufficient and that they needed additional resources to assist congregants with mental health issues. According to Stansbury et al. (2018), clergy are aware of their lack of professional training when assisting their congregants with their mental health needs. Therefore, many of the pastors sought training and mental health education through various independent courses, seminars, or classes that provided basic resources for mental health treatments.

NVivo coded seventy-one references from all 16 AAP clergy perceptions in regard to Theme 2: Clergy Integrate Faith and Secular Medicine by Advocating for a Holistic Approach that Incorporates Both. I developed Theme 2 from the following sub-themes: analogizing mental health care to physical health care, encourage congregation members to take a holistic approach to mental health, faith healing, incorporating medical

interventions into faith-centered approach, recognizing the need for medical intervention, role of clergy is to facilitate faith-centered component of care, role of clergy is to provide compassion and emotional support.

Niebuhr's (1951) synthesis model illustrated the impactful productive effect of combing two opposing systems, Christianity, and society. This model provided the premise for integrating religious thought and psychological resources. For many years, the church was considered the only place for believers to receive support for all of their physical and mental health concerns. According to Dein (2018) African American Pentecostals believe that physical and psychological healing is through the power of God. The pastors had various experiences counseling congregants in need of mental healthcare and were aware of the weight of their role, responsibilities, and influences as spiritual leaders in the mental and emotional decision making of members. All of the pastors had similar experiences during their former years relating to church teachings and beliefs regarding mental illness. All of the clergy believe that God is the source for healing all of both mental and physical illnesses.

Although their fundamental beliefs have not changed, the pastors believe that mental health issues need clinical attention the same as medical issues. Most of the pastors compared mental health care with physical health care. They believed that just as medical healthcare is sought for physical needs, mental health treatment should be sought for mental problems. Therefore, the pastors encouraged congregational members to take a holistic (spiritual and scientific) approach to mental health. The pastors acknowledged

that they have come to recognize the need for a more integrative approach to mental health.

The pastors believe that this approach would require incorporating faith-based concepts and clergy collaboration with mental health treatments. Dempsey et al. (2015) explained that collaboration was necessary between healthcare clinicians and clergy to provide faith-based and culturally sensitive services to the African American religious community. The pastors expressed openness to working with professional mental health workers if there was a willingness for faith-based practices to be part of the process. A study conducted by Karadzhov and White (2018) showed that clergy desired that professional and faith-based interventions would be included for the mental health needs of their congregants. This idea was echoed in the statement by B4:

B4: I think it's tough strong aspect of my biblical beliefs in Bible teaching that was sickness and diseases including mental health I think there is a biblical aspect of us counseling I shouldn't say counseling I should say Bible teaching on mental health as well as physical health but I think they parallel I think they go beside each other we can do so much as clergy with those who are suffering through mental health conditions and then there's always every follow up that we have to do and get them to professional help when that occurs.

Themes That Support Research Question 2

Analysis of the transcriptions identified one theme that answered research question RQ2 What are the Biblical Scriptures teachings, beliefs, references, and interpretations of AAP clergy specific to mental illness that influence stigmatization and

avoidance of secular mental health treatment among AAPs? NVivo coded forty-two references for AAP clergy perceptions in regard to Theme 3: Stigmatization and Avoidance Are Promoted by Teachings That Characterize Reliance on Secular Medicine as a Rejection of Faith. I developed this theme from the following sub-themes that emerged from the analysis: Mental illness as demonic possession, Mental illness as punishment for sins, and Only God should be relied upon to heal.

I used Bronfenbrenner's (1979) ecological system theory of human development to illustrate how interactions and influences between relationships, and other cultural contexts play a role in the development of the microsystems, mesosystems, exosystems, and macrosystems in psychosocial development of AAPs. Bronfenbrenner's model helped me in understanding how religious beliefs and scripture teachings played a major role in developing the perception and decision-making processes of AAPs regarding mental illness.

The pastors acknowledged that although they personally may not have taught or preached messages depicting mental illness as spiritually negative or a product of sin, they were aware of all of the many scripture references and texts that tend to support those views. Most of the pastors identified the similar scripture references and teachings among AAPs that perpetuated the avoidance or fear of stigma of mental illness. I found that most of the scriptures that were identified related to negative spiritual issues such as, lack of faith, sin or having an "unsound" mind.

I found that some of the pastors did believe that mental illness could be caused by demonic possession. The scripture reference was based on the young man who lived in

the cemetery, who was possessed with demons. The Bible described him as a “lunatic” and Jesus cast the spirits out of him. According to Payne (2009) some pastors believed that mental illness was due to spiritual issues such as demonic possession, sin, and ungodliness. As pastors, all of the participants believed that anyone suffering with mental problems was in need of prayer, however they also felt that at times professional assistance may be necessary.

Themes That Support Research Question 3

Analysis of the transcriptions identified one theme that answered research question RQ3 What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAP seeking mental health support from clergy? NVivo coded fifty-three references for AAP clergy perceptions in regard to Theme 4: Clergy cite Biblical support for help-seeking. I developed this theme from the following sub-themes that emerged from the analysis: Biblical guidance to seek help from those with knowledge, Scriptural support for counseling and prayer and Preference for Christian medical practitioners.

The pastors were grounded in their spiritual and religious beliefs and their roles as leaders of their congregations. The pastors considered their roles to be significant because of the influence they had with the people they served. The clergy were aware of this influence because their help would often be the first sought out by members of their congregation in need of care. According to Hays and Payne (2020), pastors are gatekeepers to formal care and can influence the mental healthcare decision making of their congregants.

The pastors felt the scriptures supported congregants seeking mental healthcare from clergy. The scriptures the pastors identified highlighted the roles they believed they were to play (i.e., such as comforter, encourager, and consoler) and support they were to provide in the lives of congregants suffering with mental issues. The pastors also believed that their roles were to provide scriptural support for counseling, interceding, and prayer for the emotional and psychological needs of their congregants.

The clergy also understood that there were some mental illnesses that were beyond their level of expertise and required professional assistance. In many of their experiences, the pastors acknowledged referring members of their congregation out to secular mental health agencies. This was echoed in the following statements made by B2 and B4:

B2: I was not reticent about referring people there was things that I consider to be out of my pay grade in some instances a person may be having an organic issue of course we pray for them there's no mistake about that but sometimes a person can be helped quite well if they seek some medical care.

B4: I believe so as clergy I I think we want to praise our profession but oftentimes we are the first line people dealing with somebody that's having a mental health experience and the initial thing is talking with them and we might make informal assessments of where they really are and so we're helping through praying for them and trying to consoled them and whatever way that we can and often time my personal experience if I since that somebody is dealing with a mental health crisis I'm definitely

referring them through a family member or whoever caretaker you need to get them to a doctor get them appointment or the ER so they can get some help that they need.

The pastors felt that clinicians working with their congregants should, however, be Christians or at least culturally sensitive to their religious community and beliefs. This supported research by Campbell and Littleton (2018) who found offering Christian-based services would promote mental health seeking treatment for African American church members among secular clinicians. DeHoff (2015) found that "mystical" experiences (internal or external experiences with God), expressed by patients in clinical setting were often misunderstood and labeled as psychotic experiences. The author argued that it is important for clinicians to understand how 'religion fits, or how it does not fit within the context of mental health.' The pastors believed that clinicians/ understanding of Pentecostal experiences, vernacular, and beliefs would create a more secure and safe environment for referring members of their congregants for mental health treatment. This idea is echoed in the following statements by P4, and P1:

P4: Ideally, is good if you have a clinician that has a spiritual perspective or at least is more tolerant, if they don't. If they don't really have a spiritual background at least if someone is tolerant and willing to know and understand a little bit about the African American Pentecostal experience, because I think that is a little bit different than other's experiences because in the African American church Pentecostal church we talk about heaven and hell and church and demons and save the loss and if you don't have any idea of the vocabulary at least than every other word that that person says you're thinking they are deteriorating they are deteriorating that is religiosity.

P1: They have to have knowledge not much I would say some biblical knowledge. I mean they don't have to memorize every scripture, they don't have to know every story of the bible, but they have to have a general knowledge.

Themes That Support Research Question 4

Analysis of the transcriptions identified one theme that answer research question RQ4 was: What type of mental health education, if any, do clergy believe may impact the acceptance of mental healthcare in the AAP communities? NVivo coded seventeen references for AAP clergy perceptions in regard to Theme 5: Education should be provided to increase knowledge and acceptance of mental health care. I developed this theme from the following sub-themes that emerged from the analysis: Disseminating medical knowledge and Mental health care should be analogized. to physical care.

I used Arnheim's (1982, 1986, 1996) convergence model, which helped lay the foundation for psychologists to find ways to access the religious sector for the purpose of providing mental health education and resolving the tensions in the theological sector. The model involved a process which helped both individuals strive to interpret and respond during communications for mutual understanding of the message, especially as it increasingly becomes more important or subtle bringing them both to a meeting point, resulting in uniformity. I found that all of the pastors felt that education in the form of seminars, or classes facilitated by secular mental health professionals would have a positive impact on the views of clergy and congregants regarding mental health treatment.

According to Dempsey et al. (2015), clergy who are educated regarding mental health treatment and its benefits, are more likely to share their information with their congregants. The pastors expressed the need for mental health professionals to provide education and awareness to their congregants. The pastor acknowledged that although they may not have the expertise in the mental health field, as leaders, they have the influence that can impact the mental health care decisions of their congregants. This idea is expressed in the following statements by B7:

B7: I think that we have the physician physicians and psychologists come in to have that conversation to be able to find out where is this coming from, we have this happening, and they are trained to do that, and I am not trained. So that's why when I have pastors meeting or when I'm at conference I say we have to recognize that there are people that know more than us that's out there and we have to we have to give them more credit and we have to recognize that there is help out there but are we willing to direct people to the help that out there.

I found that the pastors not only believed that more education was needed within the AAP churches on mental health care, but also that they were willing to collaborate with clinicians to create a congruent pathway for meeting the mental health care needs of the members of their congregations.

Recommendations

Recommendations for future research are as follows: Consequently, the study could not explore the lived experiences of AAPs' biblical scripture teachings and beliefs that influence fear of stigma and avoidance of secular mental healthcare. Further research

is needed to explore collaborative strategies for working with clergy to help increase AAPs acceptance of secular mental healthcare. Researchers have found that collaborative faith-based initiatives have indicated an increase in knowledge relating to mental health (Payne & Hays, 2016).

The findings from this study will help clinicians understand the specific scriptures that influence the avoidance of secular treatment and other mental health care seeking decisions of AAPs. Further research is recommended to explore educational collaborations and strategies between mental health professionals and clergy to help enhance understanding of mental illness and healthcare among AAPs.

For example: a study conducted by Dempsey et al. (2015) found that providing training for clergy, who are a major source of resource and support within the African American community, would be a vital step in the collaborative process. The researchers posited that such training would provide the platform for discussions between clergy and clinicians on mutual and differing philosophies that may exists between the two schools of thought. Such discussions will assist in understanding and clarifying the roles and expectations during the collaborative process (Dempsey et al., 2015).

Social Change Implications

Study of the African American Church has long been an area for addressing the avoidance, barriers and stigma regarding mental illness and secular mental health treatment (Dempsey et al., 2015). However, skepticism due to the religious beliefs and cultural insensitivity continue to contribute to the avoidance of African Americans' mental health care seeking decisions (Dempsey et al., 2015).

The findings from this study could be used by mental health professionals to understand better both the religious beliefs associated with both the avoidance and the possible acceptance of mental illness and mental healthcare treatment. Information provided in the literature continues to support previous findings that pastors are the gatekeepers of mental health services for their members (Hays & Payne, 2020). By exploring the biblical teachings and references from the clergy perspectives, this study provides insight into those beliefs that influence the mental health seeking decisions among AAPs. The results of this study provided a more comprehensive integrated paradigm of understanding scripture selection used by clergy to help support clinicians' understanding of mental illness and secular mental healthcare, as viewed by AAPs.

Exploring clergy perspectives and beliefs gave insight into their professional mental healthcare referral methods. Pastors prefer referring congregants in need of mental health services to clinicians who are Christians. Because AAP clergy are more likely to refer members of their congregations to Christian mental health professionals, mental health clinicians may consider collaboratively incorporating culturally sensitive initiatives into their programs. According to Dempsey et al. (2015), collaboration with the African American faith-based communities and mental health agencies establishes opportunity for providing both mental health expertise and culturally sensitive services. This study can assist the mental health community in making positive change through developing collaborative relationships and partnerships with African American Pentecostal pastors who are receptive to mental health education initiatives and referring congregants to secular mental health professionals for treatment.

Conclusions

Most of the clergy were forthcoming in expressing that because of their unfamiliarity with the field of psychology and mental healthcare, they were a little hesitant at first with participating in the study, but then reconsidered. I found the interviewing process to be interesting in that as expected, the pastors automatically fell into their positions and roles: providing answers, reasonings and understandings to their theology and religious beliefs. However, I also found as the research questions focused on mental illness and mental healthcare, the pastors began to quickly acknowledge they were out of there area of expertise. All of the clergy held to their religious convictions of scripture-based counseling and prayer for supporting the spiritual and emotional needs of their congregants, however for mental illness all of the pastors favored mental health referral as a resource. Acknowledging the prevalence of the avoidance and fear of stigma, the pastors expressed the importance of the need for more mental health education within the African American Pentecostal Churches, and how willing and open they would be in receiving such education. The clergy also emphasized the need for collaborative efforts between faith-based leaders and mental health clinicians to help in facilitating treatment culturally sensitive to the AAP community.

References

Adksion-Bradley, C., Johnson, D., Sanders, J., Duncan, L., & Holcomb-McCoy, C. (2005). Forging a Collaborative Relationship Between the Black Church and the Counseling Profession. *Counseling And Values, 49(*2), 147-154. https://doi.org/10.1002/j.2161-007x.2005.tb00261.x

African American. (n.d.). In Urban Dictionary. Retrieved from www.urbandictionary.com.

Alexander, E. Y. (2011). *Black fire: one hundred years of African American Pentecostalism.* InterVarsity Press, 16-20.

American Psychological Association. (2020). https://www.apa.org. Retrieved 31 May 2020, from https://www.apa.org/.

American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct.* (2003, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code/index.aspx

Anthony, J. S., Johnson, A., & Schafer, J. (2015). African American clergy and depression: what they know; what they want to know. *Journal of Cultural Diversity, 22* (4), 118-126. 9.

Armstrong, T. D. (2016). African American Congregational Care and Counseling: *Transcending Universal and Culturally-Specific Barriers. Journal of Pastoral Care & Counseling, 70* (2), 118-122.

Avent, J. R., Cashwell, C. S., & Brown-Jeffy, S. (2015). **African American pastors** on mental health, coping, and help-seeking. *Counseling and Values, 60(1),* 32-47.

Arnheim, R. (1982). *The power of the center.* University of California Press, 13-29.

Arnheim, R. (1986). *New Essays on the Psychology of Art*. University of California Press, x-xi.

Arnheim, R. (1996). *The Split and the Structure: Twenty-Eight Essays.* University of California Press, 17-19.

Banks, B. (1985). Deliverance for children and teens, Kirkwood, MO: Impact Christian Books.

Babbie, E. (2014). *The Basics of Social Research* (6th ed.). Cengage Learning.

Belcher, J., & Cascio, T. (2001). Social Work and Deliverance Practice: The Pentecostal Experience. *Families In Society: The Journal of Contemporary Social Services*, *82*(1), 61-68. https://doi.org/10.1606/1044-3894.216

Bronfenbrenner, U. (1979). *The Ecology of Human Development.* Harvard University Press, 16 -42.

Bronfenbrenner, U. (1996). *The ecology of human development experiments by nature and design.* Harvard University Press, 21- 47.

Brown, J. Y., & McCreary, M. L. (2014). Pastors' Counseling Practices and Perceptions of Mental Health Services: Implications for African American Mental Health Journal of Pastoral Care & Counseling, vol. 68, 1: pp. 1-14.

Burkholder, G. J., Cox, K. A., & Crawford, L. M. (Eds.) (2016). *The scholar practitioner's guide to research design.* Laureate Publishing.

Campbell, R. D., & Littleton, T. (2018). Mental health counselling in the Black American church: Reflections and recommendations from counsellors serving in a

counselling ministry. *Academic Journal Mental Health, Religion & Culture,* 21(4), 336-352.

Centers for Disease Control and Prevention Works (CDC). (2020a). Corona Virus, COVID-19. Retrieved 20 June 2020, from https://www.cdc.gov/

Centers for Disease Control and Prevention Works (CDC). (2020b). Corona Virus, COVID-19. Retrieved 20 December 2020, from https://www.cdc.gov/

Cook, D. A., & **Wiley**, C. Y. (2014). *Psychotherapy with members of African American churches and spiritual traditions*. *In:* Handbook of psychotherapy and religious diversity., (2nd ed). Richards, P. Scott (Ed); Bergin, Allen E. (Ed); American Psychological Association, 373-397.

Cooper, W. P., & Mitra, R. (2018). Religious disengagement and stigma management by African American young adults, Journal of Applied Communication Research, 46:4, 509-533, DOI: 10.1080/00909882.2018.1502462

Creswell, J. W. (2014). *Research design: qualitative, quantitative and mix methods Approaches* (4th ed.). Sage Publishing.

DeHoff, S. L. (2015). Distinguishing mystical religious experience and psychotic experience: A qualitative study interviewing Presbyterian Church (U.S.A.) professionals. *Pastoral Psychology, 64*(1), 21-39. 19. DOI: 10.1007/s11089-013-0584-y.

Dein, S. (2018). Against the Stream: Religion and mental health−The case for the inclusion of religion and spirituality into psychiatric care. *BJ Psych Bulletin, Vol 42*(3), 127-129.

Dempsey, K., Butler, S., & Gaither, L. (2015). Black Churches and Mental Health Professionals: Can this collaboration work? *Journal Of Black Studies*, *47*(1), 73-87. https://doi.org/10.1177/0021934715613588

Douglas, K. B., & Hopson, R. E. (2000). In understanding the Black Church, the dynamics of change. *The Journal of Religious Thought. 56, 57*, 95-113,19. http://dx.doi.org/10.15241/jra.5.1.81

Frierson, G. M., Williams, D. M., Shira Dunsiger, S., Lewis, B. A., Whiteley, J. A., Albrecht, A. E., Jakicic, J. M., Horowitz, S. M., & Marcus, B. H. (2008). Recruitment of a racially and ethnically diverse sample into a physical activity efficacy trial. *Clinical Trials, vol. 5*, 5: 504-516.

Given, L. M. (2008). Ethics Codes. In: *The SAGE Encyclopedia of Qualitative Research Methods*. DOI: https://dx-doi. org.ezp.waldenulibrary.org/10.4135/9781412963909.

Goffman, E. (1986). *Stigma* (1st ed., pp. 3-4). Simon & Schuster, Inc.

Gravely, W. B. (1979). "The Social, Political and Religious Significance of the Formation of the Colored Methodist Episcopal Church (1870)." *Methodist History*. 3–25.

Hamilton, J. B., Moore, A. D., Johnson, K. A., & Koenig, H. G. (2013). Reading *The Bible* for guidance, comfort, and strength during stressful life events. *Nursing Research, 62*(3), 178-184.

Hammond, F., & Hammond, I. M. (1973). *Pigs in the parlor: The practical guide to deliverance.* Impact Christian Books.

Hammond, F., & Hammond, I. M. (1996). *A manual for children's deliverance*. Impact Christian Books

Hawes-Dawson, J., Derose, K. P., Aunon, F. M., Dominguez, B. X., Felton, A., Mata, M. A., Oden, C. W., & Paffen, S. (2017). Achieving broad participation in congregational health surveys at African American and Latino churches. *Field Methods, 29*(1), 79-94. DOI: 10.1177/1525822X16648588

Hays, K. (2015). African American Churches' capacity to respond to the **mental health** needs of **African Americans**; *Social Work & Christianity*, *42*(3), 296-312.

Hays, K., & Payne, J. S. (2020). Lived experience, transparency, help and humility: four characteristics of clergy responding to mental and emotional problems. *Journal of Pastoral Care & Counseling, 74*, (1) 4-11.

Hefner, R. W., & Berger, P. L. (2013). *Global Pentecostalism in the 21st Century.* Indian University Press: ISBN number:9780253010810

Husserl, E. (1962). *Ideas: General Introduction to Pure Phenomenology*. Collier Books: 38-39.

Husserl, E. (2012). *Ideas: General Introduction to Pure Phenomenology*. Routledge. https://doi.org/10.4324/9780203120330

Jaynes, G. (2005). Pentecostalism: In *Encyclopedia of African American Society* (p. 491). DOI: http://dx.doi.org.ezp.waldenulibrary.org/10.4135/9781412952507.

Karadzhov, D., & White, R. (2018). Between the "whispers of the Devil" and "the revelation of the Word": *Christian clergy's mental health literacy and pastoral*

support for BME congregants Journal of Spirituality in Mental Health. https://doi.org/10.1080/19349637.2018.1537755

Kehoe, N. C. (2016). Religious professionals, ethical dilemmas, and **mental** illness. *Spirituality in Clinical Practice, 3*(3), Special Section: Ethics and Spiritually Sensitive Psychiatric Practice,163-166.

Kinghorn, W. A. (2016). American Christian Engagement With Mental Health and Mental Illness. *Psychiatric Services. Vol.* 67/1, 107-110. DOI: https://doi.org/10.1176/appi.ps.201400542

King James Bible. (2017). King James Bible Online. https://www.kingjamesbibleonline.org/ (Original work published 1769)

Leavey, G. (2010). The Appreciation of the Spiritual in Mental Illness: A Qualitative Study of Beliefs Among Clergy in the UK. *Transcultural Psychiatry, vol. 47*, 4: pp. 571-590., First Published October 12, 2010.

Leavey, G., Dura-Vila, G., & King, M. (2012). Finding common ground: The boundaries and interconnections between **faith**-based organizations and mental health services. *Mental Health, **Religion** & Culture, Vol 15*(4), 349-362. http://dx.doi.org/10.1080/13674676.2011.575755

Lincoln, C., & Mamiya, L. (1991). *The Black church in the African American experience* (2nd ed., pp. 24-25). Duke University Press.

Martin, L. R. (2013). *Pentecostal Hermeneutics: A Reader. ISBN 9004258256, 9789004258259*

Mercer, J. (2013). Deliverance, demonic possession, and **mental illness**: some considerations for **mental** health professionals. ***Mental*** *Health, Religion & Culture 1*6 (6), 595-611. 17. https://DOI: 10.1080/13674676.2012.706272.

Merriam-Webster. (1986). *Third New International Dictionary; and Seven Language Dictionary*, unabridged. Library of Congress Cataloging in Publication Data. Main Entry Under Title: Philip Babcock, IL

Merriam-Webster. (2010). In Webster's New World College Dictionary 4th Edition. Houghton Mifflin Harcourt.

Millner, M. (2009). One, One, One… One Way to God? A review essay of "In Jesus Name": Pneuma: The History and Beliefs of Oneness *Pentecostals. The Journal of the Society for Pentecostal Studies, 31*, 2, 275-282, 8. Brill Academic Publishers.

Moustakas, C. (1994). Phenomenological research methods. Sage Publication.

Murthy, S. (2006). Mental Illness In. *Encyclopedia of Disability*. Sage Publications, Inc.

NVivo. (2018). Qualitative data analysis software: QSR International Pty Ltd. Version 12.

Nie, F., & Olson, D. V. A. (2016). Demonic influence: The negative mental health effects of **belief** in **demons**. *Journal for the Scientific Study of Religion*, *55*(3), 498-515. https://doi.org/10.1111/jssr.12287

Niebuhr, R. (1951). *Christ and culture.* Harper & Brothers (First Ed.), 42 -44.

Odulana, A. A., Kim, M. M., Isler, M. R., Green, M. G., Taylor, Y. J., Howard, D. L., Godley, P. A., & Corbie-Smith, G. (2014). Examining characteristics of

congregation members willing to attend health promotion in African American Churches. *Health Promotion Practice, 15*(1) 125-133. https://doi: 10.1177/1524839913480799

Payne, J. S. (2008). Saints Don't Cry": Exploring Messages Surrounding Depression and Mental Health Treatment as Expressed by African American Pentecostal Preachers. *Journal of **African American** Studies. 12*, 3, 215-228. 14. 1 Chart. https://DOI: 10.1007/s12111-008-9044-7.

Payne, J. S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community **Mental Health** Journal, Vol 45*(5), 355-365. https:// doi:10.1007/s10597-009-9210-y

Payne, J. S., & Hays, K. (2016). A spectrum of belief: A qualitative exploration of candid discussions of clergy on mental health and healing. *Mental Health, Religion & Culture,19*(6), 600-612.

Plunkett, D. P. (2014). The Black Church, Values, and Secular Counseling: Implications for Counselor Education and Practice. *Counseling & Values.59*, 2, 208-221. 14. https://DOI: 10.1002/j.2161-007X.2014.00052.

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: bridging the conceptual, theoretical, and methodological.* Sage Publication, Inc.

Robeck, C. M., Jr. (2007). Pentecostalism and Mission: From Azusa Street to the Ends of the Earth. *Missiology, 35*, 1, 75-92. https://doi.org/10.1177/009182960703500106

Roberts, C. M. (2010). *The Dissertation Journey: A Practical and Comprehensive Guide to Planning, Writing, and Defending your Dissertation* (2nd Ed. p. 38). Sage.

Rowan, K., & Dwyer, K. (2015). Demonic possession and deliverance in the diaspora: Phenomenological descriptions from Pentecostal deliverances. *Mental Health, Religion & Culture, 18*(6), 440-455.

Rowland, M. L., & Isaac-Savage, E. P. (2014). As I see it: A study of African American pastors' views on health and health education in the Black church. *Journal of religion and health, 53,* 4, 1091-1101. https://DOI:10.1007/s10943-013-9705-2

Sallmann, J. (2010). Living with stigma: Women's experiences of prostitution and substance use. Affilia: *Journal of Women & Social Work, Vol 25*(2), 146-159.

Santos, L. G., & Kalibatseva, Z. (2019). Perceptions of depression among Hispanics with Pentecostal beliefs. *Mental Health, Religion & Culture, Volume 22,* 8.

Schilderman, H. (2015). The Concept of Religion: Defining and Measuring Contemporary Beliefs and Practices. https:// DOI:10.1163/9789004299320

Schmidt, D. J. (2014). *Understanding Hermeneutics (7th Ed).* Routledge. SBN13:9781844650774

Schuurmans - Stekhoven, J. B. (2013). Is God's call more than audible? A preliminary exploration using a two-dimensional model of theistic/spiritual beliefs and experiences. *Australian Journal of Psychology, Vol 65*(3), 146-155.

St. Clair, R. A. (2011). So, What Does the Bible Say About This…?: Context, Questions, and Correspondence as a Means of Refracting a Cultural Lens for African American Biblical Interpretation. *Interpretation, vol. 65, 3:* 276-284.

Stansbury, K. L., Marshall, G. L., Hall, J., Simpson, G. M., & Bullock, K. (2018). Community engagement with African American clergy: faith-based model for culturally competent practice. Aging & Mental Health, Vol. 22 (11).

Toma, J. D. (2011). Approaching rigor in applied qualitative research. In C. F. Conrad & R.C. Serlin (Eds.) *The Sage handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry* (2nd ed.) pp. 263-280). *(Google Scholar)*

Transcripts, interviews from various African American Pentecostal clergy and congregational leaders.

Trice, P. D., & Bjorck, J. P. (2006). Pentecostal perspectives on causes and cures of depression. Professional Psychology: *Research and Practice*, *37*(3). 283-294. https://doi.org/10.1037/0735-7028.37.3.283

Vine, W. E. (1988). *Expository Dictionary of New Testament Words. ISBN 0 551 00282 4*

Warren, N., & Herman, C. (2011). Keep the Faith! Working With African American/Black Churches. Health Promotion Practice, 12, 789-794. https://doi.org/10.1177/1524839911428748

Wharton, T., Watkins, D. C., Mitchell, J., & Kales, H. (2018). Older, church-going African Americans' attitudes and expectations about formal depression *care. Research on Aging*, *40*(1), 3-26. https://DOI:10.1177/0164027516675666

Appendix A: Recruitment Email

Volunteers Needed for A Dissertation Research Study
"African American Pentecostal Clergy Perceptions of Scripture teachings regarding mental illness"

Greetings:

My name is Phyllis Bethea Foye, I am a Doctoral student at Walden University. I am seeking African American clergy from COGIC, PAW, PCAF, WAR, etc., or any other organization which identifies with the Pentecostal faith for participation in my dissertation research study. The purpose of the research study is to gain understanding of clergy's perceptions of Scripture teachings regarding mental illness and secular mental healthcare. It also seeks to understand the practices and methods of treatments used to address the mental health needs of members of the congregations.

The research study will include questions such as:

1. What do you believe causes mental illness?
2. What do you believe is the role of the clergy in treating congregants suffering with mental illness?
3. What do you feel are the Biblical Scriptures, teachings, beliefs, references, and interpretations of clergy specific to mental illness that influence fear of stigma and the avoidance of secular mental health treatment among AAPs?

I am seeking participants who meet the following criteria:

a.) Clergy identifies as Black or African American decent

b.) Clergy is the Senior Pastor/or Co Pastor of the congregation

c.) Participant is a minimum of 35 years of age and older

d.) Participant must have pastored at least 3 years

e.) Participant must provide mental health counseling to members of the congregation.

If you decide to participate, the interviewing process will consist of two parts, a semi-structured interview, and the signing of the consent form and then a follow-up interview to verify the data. Because of COVID 19 ("CDC Works 24/7", 2020) the semi-structured interview will occur either through Zoom, FaceTime, telephone, or Skype, depending on which is more convenient for you, which will last approximately 45-90 minutes and will be recorded.

Your participation is voluntary and confidential. Your name or any other personal information will not be known to anyone else. There will be no compensation for your time. Upon request, the results of the study will be available to you via email, once the study is completed. You may withdraw from the study at any time.

If you decide to participate, please be assured that all information you provide will remain confidential and stored and locked appropriately. Your participation will help mental healthcare professionals gain understanding in working with African American Pentecostals in need of mental healthcare. It will also assist to broaden research in the counseling profession through its collaborative relationship between clinicians and faith-based leaders.

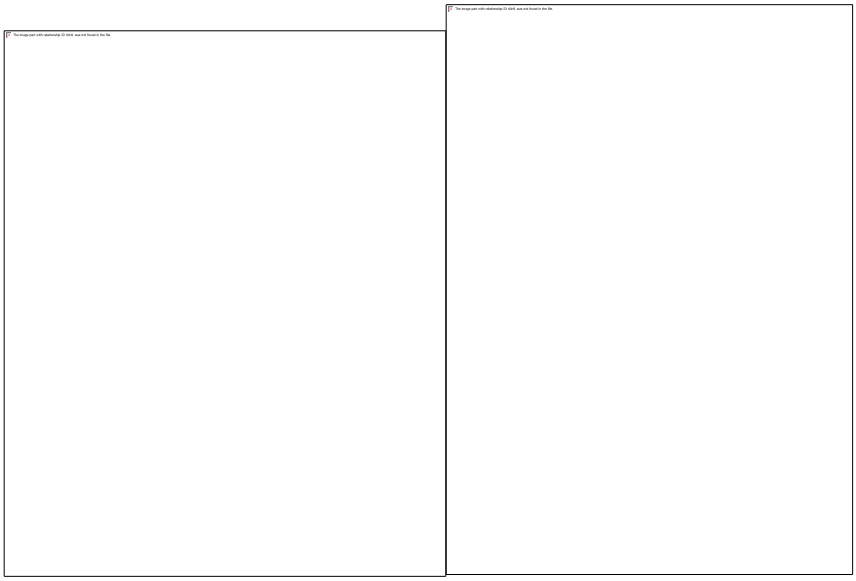
If you are interested in participating in this study, please reply to this email. If you have any questions, please contact me at phyllis.foye@waldenu.edu.

Thank you for your consideration to participate in this study.

Appendix B: Flyer

Are You a Pastor?
Do you provide counseling for members of your congregation?

If so, I would appreciate the opportunity to talk with you.



1. Are you African American?

2. Are you part of the Pentecostal Movement?

3. Are you the senior pastor of your church?

There is a new study call "Exploring the lived experiences of African American Pentecostal clergy perceptions of Scripture teachings and beliefs regarding mental illness and secular mental healthcare".

About the Study: One 45–90-minute interview. To protect your privacy, no names will be collected

This interview is a part of a doctoral study for Phyllis Bethea Foye a Ph.D. student at Walden University. If you are interested in participating please contact me at phyllis.foye@waldenu.edu.

Appendix C: Demographic Questionnaire

I***nstructions***: Eligible participants for this study will be African American Senior Pastors who are part of the Pentecostal Movement Please do not include any information that could be used to locate or identify you when returning any information.

Please provide a response to each of the following questions by filling in the appropriate bubble:

1. What is your gender?
   Female O
   Male O

2. What is your ethnicity?
   Hispanic/Latino O
   Or Not O

3. What is your age?
   35 - 40 years old O
   45 - 50 years old O
   50+ O

4. How long have you pastored?
   1 – 5 years O
   5– 10 years O
   15 – 20 years O
   20+ O

5. What is your highest level of education?

   GED or high school graduate O
   Associates of Arts (AA) or Associates of Science (AS) O
   Bachelor's Degree or Beyond Bachelor's Degree O

6. Where is your home located (Country)?
   United States O
   Other O

Appendix D: Semi-Structured Interview Guide

The following questions are semi-structured open-ended questions that will be asked to clergy of the African American Pentecostal churches regarding the Scripture teachings, beliefs, and practices by which they address mental health issues among members of their congregations:

1. What are your lived experiences of integrating your religious beliefs and beliefs about mental healthcare?
2. What do you feel are the Biblical Scriptures, teachings, beliefs, references, and interpretations of clergy specific to mental illness that influence fear of stigma and the avoidance of secular mental health treatment among AAPs?
3. What are the specific Biblical Scriptures, texts, beliefs, references, and interpretations you teach that support your congregants seeking mental healthcare from clergy?
4. What type of training have you had in mental health counseling?
5. What do you believe causes mental illness?
6. What do you believe is the role of the clergy in treating congregants suffering with mental illness?
7. What types of mental health problems have you encountered with members of your congregation? Please share some of the ways in which you addressed the issues.
8. What types of interventions, methods or practices do you use to address the mental problems of congregants?

9. Would you refer a member of your congregation to a mental healthcare professional for treatment? If so, what do you feel is important for a mental health clinician to understand about working with AAPs? If not, what would be the apprehension?
10. What do you feel are the characteristics necessary for clinicians to successfully service members of AAP churches in need of mental healthcare?
11. What type of mental health education do you believe may impact the acceptance of mental healthcare in the AAP communities?
12. Have you encouraged AAPs to seek secular mental healthcare through sermons, bible class or during counseling session?
13. Would you be willing to collaborate with a mental health clinician to help meet the mental health needs of congregants within your church?

Appendix E: Participant Consent Form

You are invited to take part in a research study about the lived experiences of African American Pentecostal clergy perceptions of Scripture teachings regarding mental illness and treatment. The researcher is inviting senior pastors of Pentecostal churches, ages 35 and older, with a minimum of 3 years pastoral experience and who provides counseling to congregants to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Phyllis Bethea Foye, who is a doctoral candidate in Clinical Psychology at Walden University.

Background Information:

The purpose of this study is to gather information which will assist mental health professionals in understanding the beliefs associated with African American Pentecostals and mental illness. It will also help clinicians understand the religious barriers.

Procedures:

This study involves the following steps:

- You will be asked to participate in an interview that will be conducted at a time and method that is convenient for you. Interviews will last approximately 45-90 minutes.
- You will be asked your perceptions of Scriptures regarding mental illness and treatment.
- You will be asked for permission to audiotape the conversation.
- Prior to the completion of the study, the researcher will share a summary of your interview with you to confirm what you said is accurately represented. It will take about 30 minutes to read this summary.

Here are some sample questions:

- What are AAPs' lived experiences of integrating their religious beliefs with beliefs about mental healthcare?

- What are the Biblical Scriptures, teachings, beliefs, references, and interpretations specific to mental illness that influence stigmatization and avoidance of secular mental health treatment among AAPs?

- What are the Biblical Scriptures, texts, beliefs, references, and interpretations specific to AAPs seeking mental health support from clergy?

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer, so everyone involved will respect your decision to join or not. You will be treated the same at __Walden University__ whether or not you join the study. If you decide to join the study now, you can still change your mind later. You may stop at any time. The researcher seeks 15 volunteers for this study. The researcher will follow up with all volunteers to let them know whether or not they were selected for the study.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life, such as the exploring of religious beliefs and practices which may be sensitive to other leaders within the Pentecostal Movements Also, the interview is likely to trigger memories of difficult counseling sessions or experiences with congregants, or struggles pertaining to your own mental health. It is important that as a volunteer, you are aware that at any time during this study, you have the option to skip questions, or stop the interview without being penalize. With the protections in place, this study would pose minimal risk to your wellbeing.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by:

- Inform psychologists and other mental health professions of the fundamental teachings which influence mental healthcare decisions.
- Gather information that will provide psychologists and other mental healthcare professions assistance in understanding how mental health is addressed in the AAP churches.
- Contribute to information that will help foster collaborative efforts between mental health professionals and African American Pentecostal clergy to assist with mental health issues within the AAP communities.
- Assist in gathering information for further training of mental healthcare professionals in multicultural competence.
- Providing information that will fill a gap which exists in research, contributing to a new generation of knowledge in the area of mental health.

Payment:

No compensation will be provided for your participation in this study.

Privacy:
The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. The researcher is only allowed to share your identity or contact info as needed with Walden University supervisors (who are also required to protect your privacy) or with authorities if court-ordered (very rare). The researcher will

not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Codes will be used in place of names during the research process unless you specify in writing otherwise and storing of names will be kept separate from data. If the researcher were to share this dataset with another researcher in the future, the researcher is required to remove all names and identifying details before sharing; this would not involve another round of obtaining informed consent. Data will be kept secure by lock in a file cabinet located in the researcher's office throughout the duration of this study. Data gathered and recorded via media devices will be password protected. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You can ask questions of the researcher by email at phyllis.foye@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is 11-25-20-0559560 and it expires on November 24, 2021.

Please print or save this consent form for your records.

Obtaining Your Consent:

If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, "I consent." _____

Printed Name of Participant _____

Date of consent _____

List of Tables