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How African American Clergy Perceive the Cultural Relevance and Usefulness of the Mental Health Guide for Faith Leaders

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Abstract

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Abstract

African Americans experience mental illness at a rate similar to White individuals but are less likely to seek professional mental health care. African Americans have traditionally turned to the Black church for mental health assistance. Various organizations have created mental health resources for clergy members, with varying levels of comprehensiveness. The purpose of this basic qualitative study was to explore how African American clergy perceived the cultural relevance and usefulness of the American Psychiatric Association Foundation's *Mental Health Guide for Faith Leaders*. The study was conducted using critical race theory as its theoretical framework. Four experienced clergy participated in two focus groups with open-ended questions as a guide. Participants' comments were coded and analyzed for emerging themes, which included (a) trauma, (b) challenges to addressing mental health, (c) help-seeking behavior, (d) definition of culture, (e) cultural relevance, (f) clergy suggestions, and (g) clergy mental health. Findings may be used for positive social change by creating culturally relevant training and resources to support African American clergy in addressing unmet mental health needs within the African American community.

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Acknowledgments

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Dedication

I dedicate this to so many people who have influenced and impacted my life. To my husband, James (Jay) Harris, you are my greatest supporter, best friend, and the love of my life. Without you this could not have been possible. I love you from the heart, "true love always." To my son, Jaquar, and my daughter, Nyri, I thank God for you both. You are two of His greatest gifts to me. I love you and I am so proud of you. Thank you for the humor, support, and love you continue to give me. To my beautiful grandchildren, Aniya, and Camrin, you truly make my heart smile. Thank you for always being a much needed and pleasant distraction. Thank you all for understanding and extending me grace when my time was limited. To my mother, Zonetta, your life, strength, and love for God continue to inspire me. To my mother-in-love, Barbara, thank you for being an amazing part of my life and always encouraging me to take time to relax. To Christina Michelle Richardson, thank you for always being there to celebrate my ups and pray me through my downs. One could only hope to have such a wonderful friend and sister in Christ. This was yet another adventure of Lisa and Christina!

To my father, the late Robert Lee McDougald, whom I lovingly called "D'Bear," I am sorry. I wish you were here so I could tell you in person. I would tell you that your racial trauma was real. Had I known then what I know now, I would have fought for you and would not have laughed in childhood amusement the many times I witnessed you become anxious at the sight of a police car behind us on our way to church. I would have hugged you and told you that by the grace of God, everything would be all right. Today, with God's help I will be there for all of the "D'Bears" who due to a history of racism,

discrimination, and stigma live with a trauma that many never see. I dedicate this to you, my father, and to so many nameless men, women, boys, and girls who have experienced racial trauma. To those who are just trying to get to church, I see you and I pray that others will see you as well.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

The Black church holds great significance as a prominent institution established by African Americans in the United States (R. Campbell & Winchester, 2020). Due to slavery and segregation under Jim Crow, the religious system was the only institution capable of maturing into a secure, cohesive, and autonomous social institution (Lincoln & Mamiya, 2003). The Black church still holds a powerful position in the African American community with African American clergy having the role of "gatekeepers of the community (VanderWaal et al., 2012). African Americans experience mental health issues at a similar rate as their White counterparts but are less likely than their White counterparts to seek professional mental health care (Neighbors et al., 1998). As a result of their respect and reverence in the African American community, African American clergy may be influential and beneficial in addressing issues of mental health in the African American community (Hankerson et al, 2021).

The purpose of the current study was to explore how African American clergy perceived the cultural relevance and usefulness of the mental health guide for faith leaders, which was developed by the American Psychiatric Association Foundation (APAF) in 2018. Although there are other guides geared toward faith leaders to address mental health, the guide examined in the current study is the most comprehensive. This chapter provides an overview of the relevant literature, a description of the problem, the research question, the study's purpose, the theoretical framework, the nature of the study, definitions, assumptions, scope and delimitations, limitations, and the significance of this study.

Background

Although the prevalence of mental health issues among African Americans is comparable to that of their White counterparts (Neighbors et al., 1998), a historical context characterized by racial prejudice, stigmatization, microaggressions, negative experiences with the mental health profession, discriminatory practices, cultural norms, and cultural skepticism causes many African Americans to seek help from African American clergy rather than formal mental health care services (Bolger & Prickett, 2021; Taylor & Kuo, 2019). Using pooled data from the 2011–2015 National Survey on Drug Use and Health and qualitative data from two focus groups to create an analytical sample of African American adults' unmet mental health needs, Alang (2019) found that 10.2% of African Americans did not seek mental health care, compared to 5.1% of the general population. Approximately 40% of African Americans seeking mental health support refer to African American clergy as their primary source of support (Anthony et al, 2015). Although Alang and Anthony et al. (2015) offered valuable insights regarding the percentages associated with unmet mental health needs among African Americans and clergy preference, data in this area were scarce.

Numerous studies pointed out the need for culturally relevant mental health training and resources; however, they did not consider how African American clergy perceive the cultural relevance and usefulness of those resources. The mental health guide for faith leaders was created for clergy. It recognizes the influence of culture on mental health expression, acknowledging that individuals from diverse cultures may exhibit mental health conditions differently (APAF, 2018). It also acknowledges that

certain cultures have distinct views and descriptions of mental health conditions that differ from mainstream medical perspectives in the United States (APAF, 2018). However, the guide does not elaborate on these cultural aspects or equip faith leaders with the knowledge and skills to address mental health issues from a cultural standpoint. To develop an understanding of African American clergy, it was essential to examine key concepts related to the Black church and the African American community. In doing so, it was necessary to start with the Black church.

The Black church, founded in the late 1700s, holds significant historical and social importance within the African American community (R. Campbell & Winchester, 2020). The Black church became the primary institution for African Americans in the United States following years of enslavement and the implementation of Jim Crow laws (Lincoln & Mamiya, 2003). Serving as a social institution in the African American community, the Black church provided religious guidance and spiritual support. The Black church also functioned as a comprehensive institution that addressed the educational, social, economic, and psychological needs of the African American community (Plunkett, 2014). The Black church, through its provision of social support and fostering a sense of belonging, contributes to psychological well-being and acts as a protective factor against the onset of depression and related disorders (Davenport & McClintock, 2021).

The Black church serves as a cultural and community support system, as well as an extension of the African American family. This phenomenon demonstrates the interconnectedness and reciprocal connections within the community, while also acting

as a mediator between familial dynamics and societal expectations (Caldwell et al., 1992). The use of quasi-family terminology such as “church family,” “brother or sister,” and “church mother” demonstrates the Black church’s resemblance to a family (Chatters et al., 2002).

An essential part of this family is the African American clergy, who are seen as the gatekeeper due to their prominence in the community and the services and support they provide (Anthony et al., 2015). Although these men and women may not be equipped or skilled, they are depended on as personal counselors, particularly in concerns of mental health (Allen et al., 2010). African American clergy have played a significant role in addressing mental health issues in the African American community, even without formal support or training from mental health professionals (Burse et al., 2021). African American clergy remain the primary choice for African Americans seeking mental health support (Burse et al., 2021).

One significant factor contributing to the underutilization of professional mental health services among African Americans is their lack of trust of providers, which stems from historical instances of exploitation in research (Guthrie, 1976). The African American community’s mistrust of mental health professionals stems from historical racism, discriminatory practices, and inadequate health care in the field of psychology (Alang, 2019). The American Psychological Association (APA) issued an apology in 2021, recognizing its role in perpetuating systemic inequalities, racism, discrimination, denigration of people of color, and promotion of White supremacy.

The skepticism toward the professional mental health field among African Americans has been interpreted by some as a manifestation of paranoia. Cultural paranoia, as defined by Grier and Cobbs (1968, as cited in Whaley, 2001), refers to a paranoid-like behavior observed among African Americans, which is believed to stem from a legacy of discriminatory practices. Cultural paranoia is a defensive response to perceived racism and discrimination from the dominant White society, including in the field of mental health (Dixon et al., 2023).

Culture plays a significant role in shaping an individual's perception, beliefs about mental health, and their likelihood of seeking professional mental health services, as stated by the U.S. Department of Health and Human Services (2001). The cultural beliefs of African Americans have been influenced by history, which in turn has influenced their help-seeking behavior (R. Campbell & Long, 2014). African Americans' cultural perspectives on mental health often result in a strong reliance on their faith and a tendency to distance themselves from individuals experiencing mental health challenges (Taylor & Kou, 2019).

Recognizing the influence of culture on beliefs and help-seeking behavior, it is crucial to acknowledge the potential advantages of utilizing African American culture to address mental health concerns. Hagen et al. (2020) found that culturally specific mental health programs enhance participants' mental health knowledge, as well as their confidence in identifying and assisting individuals facing mental health issues. Hankerson et al. (2021) argued that the cultural influences of the Black church and the

historical role of African American clergy in addressing mental health position them to promote and deliver evidence-based and culturally relevant mental health services.

Despite the recommendation of training clergy as a means of addressing mental illness in the African American community, these recommendations have been overlooked (Hooley et al., 2020). A mental health guide for faith leaders has been developed by the APAF (2018); however, it was unclear how African American clergy perceive the cultural relevance and usefulness of this guide. Although the guide was not peer reviewed, the APAF (date, as cited in Psychiatric News, 2020) reported that the guide was used to teach 40 African American faith leaders representing over 15 congregations in Wichita, Kansas in 2019. However, the workshop did not address the cultural relevance and usefulness of the guide. The purpose of the workshop was to raise community awareness of mental health services through the dissemination of general information about mental illnesses. There was little or no research that addressed the cultural relevance of the guide for use with African American clergy. Given their cultural experiences and insight of cultural norms addressing issues of mental health and their access to the African American community, it was crucial to address this gap. Understanding African American clergy's perceptions of a mental health guide may contribute to the body of knowledge on issues of mental health in the African American community and may provide firsthand knowledge from the individual and cultural experience of African American clergy.

Problem Statement

African American clergy's perception of the relevance and usefulness of the mental health guide for faith leaders was unknown. African American clergy members have played a significant role in addressing mental health challenges within the African American community (Burse et al., 2021). This is still the case despite the lack of adequate professional support and training.

Research suggested that culturally adapted psychological interventions and the delegation of mental health services for minor issues to nonprofessionals holds promise in addressing unmet mental health needs in the African American community (Mabunda et al., 2022). Furthermore, culturally tailored training could enhance the mental health literacy of these clergy members and their self-assurance in supporting others who may be experiencing mental health challenges (Hagen et al., 2020). Implementation of a culturally sensitive program tailored to religious and racial/ethnic communities may also facilitate the widespread dissemination of mental health education (Williams et al., 2014). Although a mental health guide intended for the use by faith leaders has been created (APAF, 2018), the cultural relevance and usefulness of the guide among African American clergy was unknown. The current study explored how African American clergy perceive the cultural relevance and usefulness of the APAF's (2018) Mental Health Guide for Faith Leaders to understanding the significant and unique cultural and reverential role the Black church and African American clergy play in addressing mental health in the African American community.

Purpose of the Study

The purpose of this basic qualitative study was to explore how African American clergy perceive the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (APAF, 2018) to address mental health concerns within the African American community. The tenets of critical race theory (CRT) were used as a lens to explore African American clergy's perception of the cultural relevance and usefulness of the mental health guide. CRT provides an opportunity to conduct research founded on the experiences and knowledge of people of color (Solorzano et al., 2000). Adult, self-identified, African American clergy with at least 10 years of experience and who had been at a recent or current church for at least 5 years were considered for participation in this study. Obtaining an understanding of African American clergy's perception of the cultural relevance and usefulness of an existing mental health guide designed for use by faith leaders may provide insight into how to develop future trainings and resources that are culturally relevant and useful.

Research Question

The research question for this study was the following: How do African American clergy perceive the cultural relevance and usefulness of the APAF's Mental Health Guide for Faith Leaders?

Theoretical Framework

The theoretical lens that was used to the conduct this study was CRT (see Lynn et al., 2013). Derrick Bell is hailed as the founder of CRT (Lynn et al., 2013). Additional early contributors to CRT include Richard Delgado and Jean Stefancic, as well as

Mildred Ravenell, Cruz Renoso, Leo Romero, and Ralph Smith (Delgado & Stefancic, 2007). Kimberle Crenshaw, who emerged from the CRT movement and is considered a key contributor, is credited with being the one who initiated the construction of CRT by establishing the first CRT workshop in 1989 (Delgado & Stefancic, 2007). CRT has been used to describe how a history of institutionalized racism, stigma, microaggression, and negative mental health experiences have resulted in barriers to formal mental health treatment use by African Americans (Stansbury et al., 2018). In addition to an expanded scope beyond CRT's original purpose of addressing legal issues pertaining to emerging forms of institutional racism following the Civil Rights Movement's decline in activity, CRT has been adopted by other ethnic groups forming their own extension group such as LatCrit, Asian Crit, and TribalCrit, all of whom have taken some of CRT's tenets (Capper, 2015). Critical race theorists posit that racism is not limited but extends beyond individual actions and encompasses systemic, structural, and multilevel aspects (Lopez et al., 2018).

The professional mental health field's failure to capture mental health status across racial groups and its limited focus on racial stratification highlight the importance of conducting research on mental health using a theory that incorporates race (Brown, 2003). A more detailed description of CRT is provided in Chapter 2.

Nature of the Study

Qualitative methodology was chosen due to its naturalistic purpose, which is to obtain insights into phenomena through the exploration of participants' authentic experiences and perceptions within particular contextual environments (Crouch &

McKenzie, 2006). This stands in contrast to a quantitative investigation that prioritizes the measurement and analysis of relationships between variables to test hypotheses (Golafshani, 2003). In accordance with qualitative methodology, I analyzed the data for codes, themes, and subthemes (see Patton, 2015). Merriam and Tisdell (2016) identified six qualitative research designs. The phenomenological design centers on the essential aspects of a given phenomenon. The central emphasis of ethnography lies in the examination of the culture of participants. Grounded theory emphasizes the construction of theory. The narrative design centers on the narratives provided by participants. Case studies are significant because they are bounded. In the current study, the basic qualitative design was most suitable for investigating the perceptions of African American clergy regarding the cultural relevance and usefulness of a mental health guide for faith leaders (see Merriam & Tisdell, 2016).

I conducted semistructured focus groups with open-ended questions to explore how African American clergy perceive the cultural relevance and usefulness of the mental health guide. Referral sampling was used to recruit African American clergy who met the criteria of having a minimum of 10 years of experience as clergy and recently or currently serving as a member of clergy in a predominantly African American congregation for at least 5 years. I used Braun and Clarke's (2006) thematic analysis method to analyze collected data. Coding was employed to condense the transcript data into smaller segments that were pertinent to the aspects of the research (see Maguire & Delahunt, 2017). These codes were examined to identify themes and were reexamined to determine whether any subthemes emerged (seee Maguire & Delahunt, 2017).

Definitions

African American: A term used to describe individuals with distant African ancestry who identify themselves or are identified by others as African American. This identification is based on their descent from individuals who were brought to America as slaves between the 17th and 19th centuries. The term distinguishes them from individuals from Africa or the Caribbean who have more recent ancestry in the 20th and 21st centuries, and who have different languages, cultures, migration, and health backgrounds (Agyemang et al., 2005). Although there is support for the use of the term "Black," the preference for African American indicates a move toward highlighting cultural or ethnic aspects rather than race for group identification (Sigelman et al., 2005). For this reason, the term African American was used in the current study.

American Psychiatric Association Foundation Mental Health Guide for Faith Leaders: This resource was developed in an effort to produce a partnership between those in the field of psychiatry and faith leaders who "share a common goal of promoting health, healing and wholeness" (APAF, 2018, p. 2). The idea behind the development of this resource was so that each entity could learn from the other. Faith leaders could learn more about the best treatments for mental illnesses that are evidence based. In the same way, psychiatrists and people who work in mental health could learn from spiritual leaders about how spirituality can help with healing and how faith leaders can help. The guide indicates that people who are having problems with their mental health often talk to a faith leader because it is known that religion and spirituality can play an important role in helping people experiencing mental health challenges heal. The guide aims to provide

religious leaders with information to assist members of their congregation and their families' experiencing difficulties with mental health.

Black church: The African American church was born out of racial segregation within the Protestant church. In keeping with the language of the African American community, the term "Black church" was used and included the seven major African American denominations: African Methodist Episcopal Church, The African Methodist Episcopal Zion Church, The Christian Methodist Episcopal Church, The National Baptist Convention, U.S.A., Incorporated, The National Baptist Convention of America, Unincorporated, The Progressive National Baptist Convention, and the Church of God in Christ (Lincoln & Mamiya, 2003). Additional churches covered under classification of African American Churches are the Southern Missionary Baptist and nondenominational churches (FEMA Religious and Cultural Literacy and Competency Tip Sheet: Black Protestant Leaders, 2010).

Clergy: Various honorific titles are held by African American church leaders. Pastor, minister, bishop, reverend, prophet, and prophetess are common terms used to identify faith leaders (FEMA Religious and Cultural Literacy and Competence Tip Sheet: Black Protestant Leaders, 2010). Webster's Unabridged Dictionary of the English Language (2001) defined clergy as a group or body of ordained individuals in a religion who differ from the laity. I used the term clergy to refer to all ordained members of the religious organizations.

Cultural competence: The delivery of care that is both effective and respectful, aligning with the cultural norms, practices, and languages of individuals seeking mental

health services (Conner & Grote, 2008). Cultural competency involves the integration and transformation of cultural knowledge pertaining to a particular population into clinical standards, skills, and approaches (Conner & Grote, 2008). Cultural competence is a noteworthy objective in the realm of mental health and in the fight for social justice. However, its approach neglects contemporary and historical challenges that have affected cultural groups. Furthermore, it adopts a value-neutral stance and fails to involve those receiving treatment, focusing instead on the provider's capacity to deliver services that are culturally appropriate (Gopalkrishnan, 2018).

Cultural relevance: The modification of therapeutic interventions to align with the cultural context of an individual's or group's race/ethnicity (Conner & Grote, 2008). Connor and Grote (2008) defined eight culturally relevant features of a mental health treatment or resource:

- –Language, which encompasses cultural and emotional experiences, is of utmost importance. Insufficient knowledge of cultural norms regarding language expression and verbal style can result in misinterpretation of the intended message, potentially affecting the treatment process.
- The racial/ethnic similarities and differences of the persons giving and receiving the service or resources are also important in being culturally relevant. Individuals working with racial/ethnic minority groups should have extensive experience working with the population while also receiving ongoing training.

- Professionals providing services and resources to racial/ethnic groups should possess a solid understanding of the cultural metaphors, which are symbolic representations and shared concepts within the groups.
- Professionals providing services and resources should have an understanding of specific concepts. These concepts refer to the conceptualization and dissemination of information about a specific problem in a way that takes into account the individual's perspective of the problem from the scope of their racial/ethnic background.
- To be considered culturally relevant, there must be a collaboration of goals between the individual providing the service or resource and the racial/ethnic group receiving the services or resources. These goals must consider and encompass the racial/ethnic group's cultural norms.
- The approaches and procedures used must be consistent with the cultural norms of the racial/ethnic group receiving the service or resource.
- Context requires considering the socioeconomic and political context of the racial/ethnic group's environment. Recognition of group dynamics, including acculturation, immigration, and connection to and identification with countries of origin, is necessary. Professionals working with a population should possess the ability to recognize stress-inducing factors that may arise from socioeconomic circumstances.

Mental disorders (mental illness):

> A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activity. (APAF, 2022, p. 14)

Mental disorders or mental illness can be separated by any mental disorder or severe mental disorders (National Institute of Mental Health, 2009) with any mental illness constituting any mental, behavioral, or emotional disorder ranging from no impairment to minimal, moderate, or severe impairment. Serious mental illness refers to a mental, behavioral, or emotional disorder that causes significant impairment in functioning and substantially hinders or restricts one or more major life activities (National Institute of Mental Health, 2009). In the current study, the terms mental health, mental disorders, and mental illness referred to conditions with nonsevere impairment.

Assumptions

Determining whether to conduct research using a qualitative or quantitative approach must be based on an understanding of the epistemological differences between the two (Hathaway, 1995). Research conducted from a qualitative approach is interpretive in nature and conducted in a natural setting, whereas quantitative research is empirical and analytic in nature and detached from the setting under study (Hathaway, 1995). Both qualitative and quantitative approaches involve a set of assumptions about the nature of knowledge and reality, as well as how knowledge and reality are understood and acquired (Hathaway, 1995). These assumptions are identified as a paradigm. In its

simplest form, a paradigm is defined as a set of beliefs or a worldview that serves as a lens through which the researcher observes the world (Davies & Fisher, 2018). A paradigm is a framework that provides a set of philosophical assumptions for qualitative or quantitative research (Mingers, 2003). The paradigm for either approach includes ontology, epistemology, and axiology (Mingers, 2003).

Ontology assumptions focus on reality. Ontology assumptions, from a quantitative or empirical-analytic approach, view reality as being singular, necessitating an objective and impartial approach (Davies & Fisher, 2018). Researchers following the quantitative paradigm assume the existence of an independent reality and examine how participants are connected to that reality and how they can acquire knowledge about it (Hathaway, 1995). In contrast, a qualitative approach posits that reality is not a singular entity but rather a multifaceted and subjective concept that is constructed by the research participants (Hathaway, 1995). Participants' understanding and construction of reality vary. According to Hathaway (1995), comprehending the reality experienced by the participants aids the researcher who employs the qualitative method.

Epistemology assumptions focus on different types of knowledge. Researchers using the quantitative method seek to develop universal knowledge that is dissociated from human interest (Hathaway, 1995). In contrast, researchers from a qualitative perspective assume that knowledge is imbued with human thought and human interest, exemplified by the situation that is being studied; therefore, knowledge can only be comprehended within the framework of the social environment in which it is enacted (Hathaway, 1995).

Axiology assumptions, according to Mingers (2003), focus on what is valued. Values form the foundation of knowledge-generating systems and social initiatives. Axiology assumptions also have to do with intrinsic moral rightness; fundamental moral principles include the obligation to fulfill promises, demonstrate loyalty, tell the truth, uphold justice, and avoid causing harm (Hart, 1971).

The methodological assumptions of a quantitative approach involve the isolation and definition of preselected categories prior to conducting the study. The hypotheses are formulated based on predetermined categories, and only data relevant to those categories are collected (Hathaway, 1995). The researchers may derive these predetermined categories from their personal beliefs or experiences, their theoretical framework, or from interpretive research conducted by themselves or others (Hathaway, 1995). On the other hand, the researcher who is conducting a qualitative study is looking for emerging themes that are derived from the knowledge and experiences of the participants (Hathaway, 1995).

Although qualitative and quantitative research methods have valuable and essential applications in research, the current study was better suited for a qualitative method to provide rich, detailed data from participants' knowledge and experience. This decision was based on the understanding of quantitative and qualitative methods. In addition, I assumed that participants would have the capacity to comprehend the questions and explain their opinions inside the group with comments that were honest and rich. The purpose of this study was to explore the perceptions of African American clergy regarding the cultural relevance and usefulness of the mental health guide for faith

leaders (APAF, 2018) in relation to its use in addressing mental health concerns within the African American community. These assumptions were essential for individuals who met the selection criteria for this research.

Scope and Delimitations

The purpose of this study was to explore how African American clergy perceive the cultural relevance and usefulness of the mental health guide for faith leaders. Although the study was not denomination specific, the scope was limited by the need to sample African American clergy who had been ordained for at least 10 years and who were serving or had recently been serving a church for at least 5 years. The delimitation of the study was related to the focus on African American clergy as opposed to clergy from diverse cultural and ethnic backgrounds. The purpose of this research was to explore how African American clergy perceived the cultural relevance and usefulness of the mental health guide for faith leaders in addressing mental health concerns in the African American community.

For this study, referral samples were obtained from the professional contacts of African American clergy. This procedure was used to minimize or avoid power imbalances and biases. Participants were placed in one of two focus groups that included at least two participants The inclusion criteria were self-identified Black clergy of predominately African American congregations of any denomination. The clergy must have served or were currently serving a church for at least 5 years and had been ordained as a member of clergy for at least 10 years. Recruitment was denomination neutral. Non-African American clergy of primarily African American congregants and self-identified

African American clergy of non-African American congregants were excluded. Clergy not affiliated with a church were likewise excluded.

Delegating mental health services to minor nonprofessionals such as African American clergy, as well as offering culturally relevant training and resources, may be helpful in addressing unmet mental health care needs in the African American community (Mabunda et al., 2022). Transferability, as defined by Cope (2014), pertains to the capacity to apply research findings to various settings or populations. The current study explored the perceived cultural relevance and usefulness of the mental health guide for faith leaders among African American clergy. However, the findings of this study may be applied to develop culturally relevant training and resources for other ethnic groups.

Limitations

A limitation of this study was the small sample size and the reliance on subjective data obtained from participants regarding their thoughts and lived experiences (see Crouch & McKenzie, 2006). There are limitations in conducting qualitative research due to the fact that the focus is on meaning rather than the generalizability of the findings (Mason, 2010). The current study included use of a focus group, which had its own set of limitations starting with being influenced by my interests (see Morgan, 1997). One of the limitations of focus groups is when people dominate the discussion to the point that their opinion is the only one that is sufficiently articulated (Smithson, 2000). The unwillingness of participants to express their opinions and experiences, particularly when there is a dominating person present, has the potential to result in group conformity

(Morgan, 1998). Polarization within focus groups, where participants may express more extreme views in a group setting compared to private discussions, can also be seen as a potential weakness (Morgan, 1998).

In the current study, an additional potential constraint may have arisen from the impact of clergy perceptions of mental health and cultural norms. Limitations may arise when investigating sensitive or controversial topics that participants are confronted with, especially in contexts in which attitudes, behaviors, or norms are widely accepted (Bergen & Labonté, 2020). Smithson (2000) proposed that the attributes of the moderator, both actual and perceived, can influence group behavior. This raises the question of whether the moderator should share a similar cultural background with the participants. A potential limitation of conducting a focus group with African American clergy was the participants' perception of my expectations regarding appropriate behavior for clergy. This perception may have influenced participants' behavior during the focus group.

Significance

According to Gopalkrishnan (2018), when it comes to mental health and help-seeking behavior, culture influences what is deemed a problem, how the problem is conceptualized, and which solutions are permissible. A history of cultural norms, institutional and cultural mistrust, racism, discrimination, stigma, and microaggressions experienced by African Americans have impacted their help-seeking behavior (Bolger & Prickett, 2021; Taylor & Kuo, 2019). When considering matters related to mental health, it is crucial to understand the desires and values of individuals within a specific location

or community (Gopalkrishnan, 2018). The African American community continues to have a preference for the Black church and African American clergy when it comes to issues of mental health (Burse et al., 2021).

The current study is significant because I aimed to comprehend the perceptions of African American clergy regarding the APAF (2018) mental health guide developed for faith leaders. Gopalkrishnan (2018) suggested the possibility of integrating positive mental health resources within communities. One potential contribution of the current study could be to provide support for the idea that African Americans may find community-based mental health care to be more accessible, acceptable, and appropriate in terms of holistically addressing their mental and spiritual needs. This research may also be beneficial in supporting the idea of moving from a cultural competence framework to a cultural partnership. Gopalkrishnan (2018) noted that cultural competence often fails to acknowledge the power dynamics and historical oppressions faced by different cultural groups because it attempts to approach culture from a value-neutral standpoint. Furthermore, cultural competence requires the provider and their institution to offer culturally appropriate services while overlooking the involvement of the client and their communities (Gopalkrishnan, 2018). The results of the current study have the potential to provide valuable insights into working with clergy and other community stakeholders. Partnerships between researchers and mental health providers have the potential to improve mental health training and resources through the incorporation of the historical context and current realities of African American culture.

The findings in this study may also be used in future research addressing the cultural significance and efficacy of the mental health guide's use by clergy of different racial and ethnic communities. Moreover, the findings may have significant implications for positive social change. By revealing the wealth of knowledge possessed by African American clergy, findings may be used to create trainings and resources that are culturally relevant and sensitive, aiding clergy in their efforts to address mental health concerns among African Americans.

Summary

I sought to understand how African American clergy perceive the cultural relevance and usefulness of APAF (2018) mental health guide for faith leaders. In a review of literature related to this topic, I found a variety of studies that provided the context for the current study, beginning with general studies on African American use of mental health services. African Americans are less likely to seek formal mental health services due to cultural norms and negative interactions with mental health professionals (Neighbors et al., 1998). However, the African American church, a significant institution in the United States, has played a significant role in addressing mental health concerns within the African American community (Burse et al., 2021). Culture plays a significant role in shaping an individual's perception of mental health and whether they will seek professional mental health care (U.S. Department of Health and Human Services, 2001). The significance of the cultural and communal bond within the Black church can be seen in their formation of quasi-families. Within these families are African American clergy

who are viewed as the gatekeeper. These clergy are often called on to address mental health needs within the community despite their lack of training.

A generic qualitative approach including focus groups was used to obtain rich, descriptive data. CRT was used as the theoretical framework for this study. CRT has been used to describe how a history of institutionalized racism, stigma, microaggression, and negative mental health experiences have resulted in barriers to formal mental health treatment use by African Americans (Stansbury et al., 2018).

To improve understanding of the terminology used, I provided definitions with reference to the population being studied, which in this case was African American clergy. I clarified the use of pertinent terminology by characterizing African Americans as individuals who possess distant ancestral connections to Africa. I opted to highlight cultural or ethnic dimensions instead of race, thereby refraining from employing the term Black despite support for its use.

The findings of this study may contribute to positive social change by supporting the development of community-based mental health services that are more accessible, acceptable, and appropriate in addressing the mental and spiritual needs of the African American community in a holistic manner. This research could support the notion of transitioning from a cultural competence framework to a cultural partnership that incorporates the insights and experiences of African American clergy. Chapter 2 presents information on the literary search strategies employed, the theoretical framework used, and the literature reviewed.

Chapter 2: Literature Review

As a result of a history of racial biases, stigmatization, microaggressions, negative experiences with the mental health profession, discriminatory practices, cultural norms, and cultural skepticism, many African Americans prefer to seek help from African American clergy over formal mental health services (Bolger & Prickett, 2021; Taylor & Kuo, 2019). However, many clergy may not possess the necessary training and resources needed (Burse, et al., 2020). A mental health guide intended for use by faith leaders has been created by the APAF (2018); however, the perceived cultural relevance and usefulness of the Mental Health Guide for Faith Leaders among African American clergy in their congregation and community was unclear.

In Chapter 2, four main sections are included. These sections are the literature search strategy, the basic qualitative approach, CRT as the conceptual framework, and a review of recent literature. These sections are followed by a summary of the chapter.

Literature Search Strategy

The inquiry was limited to peer-reviewed articles, websites, and books pertaining to the African American church, African American clergy, factors influencing help-seeking behaviors in the African American community, the importance of training clergy to address nonsevere mental illness, and the advantages of incorporating culturally relevant services and resources for African American clergy. The Walden University Library, Google Scholar, and relevant websites were used to search the literature. Sage, ProQuest, ERIC, Springer, Taylor & Francis, EBSCOhost, Behavioral Science, and MDPI databases were searched. Websites that were searched were Nami.com, and

psychiatry.org. Ulrich was used to ensure articles were peer reviewed. Words, terms, and combination of terms were searched. The key terms that were utilized were *African American, Black, African American community, Black community, Black church, congregant, pastor, clergy, minister, gatekeeper, mental health, community mental health, religion, counseling, faith-based intervention, African American clergy perception of mental health, mental health in the African American community, attitudes towards mental health, African American help-seeking behavior, African American mental health stigmas, culture, mental health training for clergy,* and *mental health training for African American clergy*.

The search strategy for this study began with searching Walden University's library for literature reviews pertaining to African American clergy's perception of mental health, which guided the search to the role of the African American church in the African American community and mental health in the African American community. This led to additional terms and term combinations. Over 200 sources dating from 1851 to the present were identified with relevant material. Most of the material in this review was published within the last 5 years. Older sources were included to provide a perspective and foundation of the history and longevity of this problem.

Theoretical Framework

Considering the historical context of the African American community and the contribution to scientific inquiry and methods of the APA (2021) that perpetuated systemic racial oppression, I employed CRT as a theoretical framework to explore how African American clergy perceive the cultural relevance and usefulness of the Mental

Health Guide for Faith Leaders (see APAF, 2016). The founders of the APA were White men who, among other things, promoted eugenics and other concepts in the early 20th century that contributed to a system of racial discrimination. The economic gap in wealth and discrepancies experienced by many people of color can be attributed to the APA's development, research, and interpretation of racial difference, and psychologists produced, supported, and disseminated conceptions of human hierarchy (APA, 2023). The APA has recognized the existence of racial discrimination in the field of counseling. However, most counseling faculty are White, and the training provided in this field reflects a predominantly Eurocentric perspectives (Branco & Bayne, 2020). Although the problem has been defined and supported with historical data, there is a need for a viable solution to a long-standing problem. For these reasons, the use of CRT as a theoretical framework was appropriate.

The founder of CRT Derrick Bell did a significant portion of CRT's foundational work (Lynn et al., 2013). The formal development of CRT evolved out of the concern of lawyers and law professors who felt the need for theories to address emergent forms of institutional racism after the Civil Rights Movement stagnated (Delgado & Stefancic, 2007). In addition to Bell, other notable contributors to the development of CRT were Alan Freeman, Kimberlé Crenshaw, and Richard Delgado (Crenshaw et al., 1995; Delgado & Stefancic, 2017). CRT has undergone a significant expansion beyond its initial legal context and has found applications in various fields including but not limited to law, politics, sociology, religion, education, and medicine (Delgado & Stefancic, 2017.) Critical race theorists maintained that racism comprises four fundamental factors

including micro and macro components manifesting in institutional and individual forms. Furthermore, racism encompasses both conscious and unconscious elements, and its cumulative impact is experienced by individuals and groups (Solorzano, 1997).

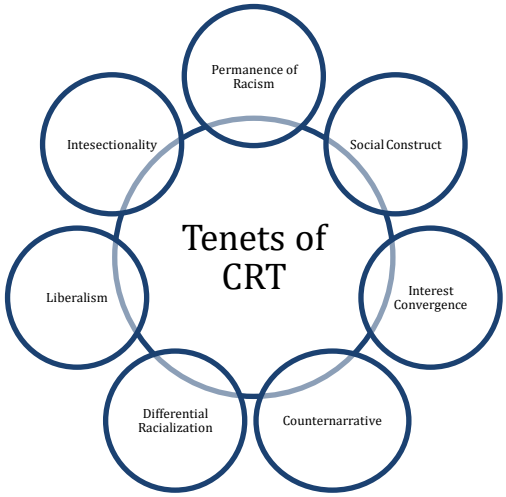
There are several tenets of CRT (Delgado & Stefancic, 2017). One of the primary tenets is the permanence of racism, which suggests that racism is an inherent aspect of American culture, exerting significant influence on the political, economic, and social landscape (Bedford & Shaffer, 2023). The revelation of the APA (2021) racist and discriminatory history demonstrates the permanence of racism deeply imbedded presence in American society, including the field of mental health. Another key tenet is that race is a social construct devoid of genetic or biological basis, intended to classify individuals based on physical traits such as skin color, hair texture, and facial features (Ballentine, 2019). This construct was created with the purpose of legitimizing practices such as enslavement, genocide, Jim Crow laws, and the exclusion of certain individuals from citizenship, all under the ideology of White supremacy (Christian et al., 2021).

The tenet of interest convergence suggests that, within the framework of White supremacy, progress in civil rights is only made when it aligns with the interests of White Americans or when the continuation of oppression poses a threat to White American interests (Ballentine, 2019). Capper (2015) proposed that African Americans, due to their lived experiences within the White culture, are more aware of the pervasiveness and consequences of racism, which is the tenet of counternarrative. Individuals who have personally experienced oppression are more qualified to articulate their experiences and perspectives on race and racism (Delgado & Stefancic, 2017). The tenet of differential

racialization of individuals belonging to ethnic groups has been observed to occur at various points in time in response to the needs and demands of the dominant White culture (Abrams & Moio, 2009). The tenet of liberalism critique focuses on the concept of colorblindness as a way to conceal the privilege and power of the dominant White society (Bedford & Shaffer, 2023). The tenet of intersectionality's central idea is that no person or group can be reduced to a single, easy-to-understand identity because each person has other identities and differences (Capper, 2015; see Figure 1).

Figure 1

Tenets of Critical Race Theory



CRT was chosen as the theoretical framework for the current study because it enables researchers to explore how the impact of social phenomena, cultural practice, and the intersection of race and power impacts African Americans' help-seeking behavior (see Stansbury et al., 2018). The influence of a racist past on African cultural norms, views, and help-seeking behavior is significant. It is important to recognize the role

played by the APA (2021) in shaping this history. Additionally, the APAF's (2016) Mental Health Guide for Faith Leaders briefly acknowledges the significance of culture. CRT allowed for the analysis of this guide from the standpoint of African American clergy who work to address the mental health concerns of the African American community. The use of CRT in the current study was appropriate because it could reinforce the notion that researchers and mental health professionals should refrain from developing or providing training and resources from a colorblind perspective.

Researchers have employed CRT to examine the effects of race and racial stratification on the African American community. Stansbury et al. (2018) used CRT to investigate the effects of institutional racism, stigma, microaggressions, and adverse mental health encounters on the help-seeking patterns of African Americans, which impeded their access to formal mental health interventions. Ballentine (2019) applied CRT to explain the overrepresentation of African American children diagnosed with oppositional defiant disorder compared to attention deficit hyperactivity disorder in real-world diagnostic settings. This discrepancy persists despite epidemiological studies indicating that African American and White children engage in similar behaviors. Ballentine argued that a theory focused on race is essential for comprehending the significant role played by race and inequality.

In studying the sociology of mental health's approach to studying race, Brown (2003) employed CRT to conceptualize five mental health issues that may arise because of racial stratification. Brown characterized the first mental health concern as nihilistic tendencies, which are a tendency to destroy and harm oneself as a result of fatalism

related with the permanence of racial inequality. This propensity is thought to be a result of self-defeating attempts to survive in a culture that systematically thwarts normal attempts at natural human growth. Brown described anti-self-issues as another tendency in which an individual may desire to escape their Blackness and, as a result, any connection with other African Americans. Instead, these individuals engage in deracination in which they seek to assimilate to the majority White society's norms and practices. Brown identified suppressed anger expression as an additional mental health issue. This problem arises from the normalization of denying anger, resulting in "false affability, passivity, resignation, and ultimately withdrawal or self-destructive behavior" (Brown, 2003, p. 297). Brown identified delusional denial tendencies as a mental health issue that arises from individuals attempting to reconcile conflicting public and private thoughts, indicating a belief in the enduring nature or resolvability of racial hierarchy. Brown identified extreme racial paranoia as the fifth mental health disorder that manifests itself in White people who are actively or passively committed to maintaining racial stratification.

Abrams and Moio (2009) used CRT to challenge the tendency of cultural competency to mistakenly foster colorblindness, which overshadows the significance of institutional racism. According to Abrams and Moio, the cultural competency paradigm does not go far enough to confront systemic and institutionalized discrimination. Abrams and Moio concluded that although CRT does not offer an exhaustive guide for teaching about all types of oppression, it does enable an examination of how the intersectionality of oppressed statuses is evident in the lives of individuals, communities, and social

environments. CRT, according to Abrams and Moio, can contribute to the expansion of antiracist education.

Critical race theory enables researchers to examine the influence of race-related factors on the mental health and health-seeking behavior of African Americans. Alang (2019) asserted that four interconnected racism-related themes persistently contributed to the unaddressed mental health needs of African Americans. According to Alang, African Americans are affected by ongoing systems of oppression. To minimize exposure to institutionalized racism, some African Americans may avoid seeking mental health services (Alang, 2019). Double discrimination, another interconnected theme is a significant aspect of interconnected racism. Alang suggested that not only do African Americans with mental health issues encounter devaluation in a predominantly white society, they may also experience stigmatization within their own community, where mental health is often perceived as a sign of weakness. Alang suggested that African Americans may be reluctant to seek mental health services due to their concerns about potential experimental procedures, dehumanization, and excessive diagnosis, which can be attributed to institutionalized mistrust. Another theme identified by Alang was racial microaggressions that exist within the mental health field and can lead to inadequate treatment and pressure to conform to dominant cultural norms.

Although a significant portion of research that utilizes CRT are qualitative in nature, there is a growing emergence in the field known as QuantCrit (Lopez et al., 2018). Lopez et al. (2018) argued that because of the historical association of statistics use of eugenicist principles and practices, researchers must use racial statistics to promote

social justice and eradicate racial biases from statistical analysis. However, to gain and understanding of how African American clergy perceive the cultural relevance and usefulness of the mental health guide for faith leaders, a qualitative approach is appropriate.

Literature Review Related to Key Concepts

In this literature review, previous research relevant to the understanding of the need to explore how African American clergy perceive the cultural relevance and usefulness of the mental health guide for faith leaders were reviewed. The historical role of the Black church is the starting point of this section. This section is followed by African American clergy addressing mental health, the field of psychology's racist past, the cultural advantages of culturally relevant resources and services. This section ends with a review of mental health resources for faith leaders.

Historical Role of the Black Church

Formed in the late 1700s (Campbell & Winchester, 2020), the Black church is widely regarded as the most historical and consequential establishment within the African American community. It is commonly acknowledged as the cultural genesis of the African American community (Lincoln & Mamiya, 2003). Following years of enslavement and subsequent Jim Crow segregation, the Black church emerged as the only resilient, unified, and autonomous institution for the African American community in the United States (Lincoln & Mamiya, 2003). According to scholarly sources such as Lincoln and Mamiya (2003) and Ruiz (1990), the Black church has been instrumental in providing support for various facets of the African American community, including but

not limited to spiritual, political, economic, educational, musical, psychological, and cultural aspects. The Black church provided African Americans with solace and support as they navigated the difficulties of living in a society characterized by systemic racism (Campbell & Littleton, 2018).

The Black church, as a cultural and community stronghold (Blank et al., 2002), has been woven into the fabric of the lives of African American individuals, providing a place of refuge and healing from the oppression and marginalization from broader society (Brewer & Williams, 2019). The Black church has been a cultural resource in the African American community, preserving the history, narratives, rituals, and ceremonies that are important to the African American experience (Hays, 2015). The Black church serves as a social institution in the community (Brunson et al., 2015) with clergy fulfilling multiple roles as the spiritual leader and the primary source for addressing community needs. According to Plunkett (2014), members of the Black church work to provide a variety of community needs, including religious, spiritual, educational, social, economic, and psychological. Previous research suggests that the social support and sense of belonging provided by members of the Black church can contribute to psychological well-being and serve as a protective factor against the development of depression and related disorders (Davenport & McClintock, 2021).

As the center of cultural and community, the black church served as a conduit between families and established social structures (Caldwell et al., 1992). This intimate relationship between the church and the family unit highlighted their interdependence and mutual reinforcing relationship, supporting family values, stability, loyalty, and

functioning (Caldwell et al., 1992). The Black church has been seen as a mediator between the family and formal social norms (Caldwell et al., 1992). Some members of the African American community see the Black church not just as a place for the observance of religious practices, but also as a place for the maintenance of familial and communal ties. In this context, one may refer to the church as one's "church home," and the congregation may be referred to as one's "church family." The phrase "church home" refers to a place of worship that has been frequented by numerous generations, and where the worshippers are believed to be part of a familial community known as the "church family" (Boyd-Franklin & Lockwood, 1999). According to Chatters et al. (2002), the phrase "church family" alluded to the near resemblance of the Black church to a quasi-family. This close resemblance is indicated by the use of terminology such as brother, sister, and church mother in the African American church. The church family frequently fills the role of a surrogate family for members of the congregation whose interactions with members of their biological families are limited or nonexistent (Chatters et al., 2002). These surrogate family members are an essential source of informal aid to the church members who are in need (Taylor et al., 2013). The clergy as part of the extended family frequently offer emotional support and resources during times of need (Boyd-Franklin & Lockwood, 1999).

Black Clergy Addressing Mental Health

African American clergy remain the primary choice for mental health assistance, some may have limited knowledge and training in this area (Burse et al., 2021). Approximately 40% of African Americans turn to clergy members as their main support

system for addressing mental disorders such as depression (Anthony et al., 2015). African American clergy have a favorable position as gatekeepers to professional services in the African American community due to their prominence, perceived credibility, and absence of stigma (VanderWaal et al., 2012). They often serve as the primary and sometimes sole source of support for members of the African American community. They are frequently relied upon as personal counselors and spiritual advisors, particularly in matters related to the mental well-being of the congregation (Allen et al., 2010). Some members of clergy may perceive mental health disorders as indications of spiritual weakness, a lack of faith, or the influence of demonic forces (Anthony et al., 2015). Others have expressed concerns about their limited ability to effectively assist individuals seeking help (Bolger & Prickett, 2021). Anthony et al., (2015) suggested that those who sought to improve their understanding of mental illness and treatment found limited resources and a lack of opportunities to receive training from mental health professionals.

The Field of Psychology's Racist Past

Due to a legacy of racism, discriminatory practices, and inadequate healthcare, African Americans harbor a sense of distrust towards mental health professionals (Alang, 2019). Guthrie (1976) highlights the historical focus of early psychologists on studying African Americans through sensory measurement devices. These devices allowed them to generate numerous statistical tables, curves, ranges, and distributions, which supported their belief in the inferiority of African Americans (Guthrie, 1976). Assessments and research conducted by White psychologists, using White individuals as the standard, have led to the characterization of African Americans as inferior and feeble-minded, thereby

reinforcing the concept of White racial superiority (APA, 2023). The APA admits that these feelings of institutional mistrust are not unwarranted, admitting and apologizing for their role of contributing to systemic inequalities, acts of racism, discrimination, the denigration of people of color, and the promotion of White supremacy (APA, 2021). To comprehend the extent and detrimental consequences of these actions, it is imperative to examine the historical occurrences within the field, politics, education, and society.

In 1851, Dr. Samuel Cartwright, a prominent Louisiana physician, proposed the existence of a mental disorder called drapetomania which caused slaves to run away (Meerai et al., 2016). According to Cartwright (1851 as cited in Meerai et al., 2016), although not known by the medical community, the symptoms of drapetomania were well-known among planters and overseers. In addition to drapetomania, Cartwright also identified what he called dysaethesia aethiopica, a mental disease which affected both the mind and the physical body resulting in laziness and insensibility to pain (Cartwright, 1851). According to Cartwright, symptoms of this supposed mental disorder suggest that:

> From the careless movements of the individuals affected with the complaint, they are apt to do much mischief, which appears as if intentional, but is mostly owing to the stupidness of mind and insensibility of the nerves induced by the disease. Thus, they break, waste, and destroy everything they handle,-abuse horses and cattle,--tear, burn or rend their own clothing, and, paying no attention to the rights of property, steal others, to replace what they have destroyed. They wander about at night and keep in a half nodding sleep during the day. They slight their work,-cut up corn, cane, cotton or tobacco when hoeing it, as if for pure mischief. They

> raise disturbances with their overseers and fellow servants without cause or motive and seem to be insensible to pain when subjected to punishment.

In the late 1800s, prominent figures in psychology, including Galton, Stanley, and Stetson, introduced concepts of racial inferiority, and introduced and advocated for eugenics (APA, 2023). According to the APA, (2023), 31 of its presidents held prominent positions within eugenics organizations that advocated for the sterilization of individuals deemed “unfit” or belonging to inferior races. This association persisted from 1892 to 1947. In an effort to preserve “the blood of American people”, or the White race, a eugenics committee enlisted the expertise of psychologists to establish an assessment to identify individuals they classified as “mental degenerates and defectives” who were then recommended for sterilization (APA, 2023). The initiative led to 35,000 individuals being sterilized by 1930, a significant proportion of whom were African Americans (APA, 2023).

Ferguson's (1916) research findings on the psychology of the Negro, indicated that individuals he classified as pure negro demonstrated intellectual inferiority in comparison to the dominant White population. According to Ferguson, African Americans experienced significant emotional shifts that were expressed in a volatile manner. Ferguson suggested that the deficiency in the intellectual capacity and development of African Americans were considered responsible for their perceived shortcomings, including a lack of foresight, improvidence, limited capacity for serious initiatives, contentment with instant gratification, propensity toward immoral conduct, and lack of ambition. According to Ferguson, African Americans were deemed suitable

primarily for manual labor, given their perceived strengths in sensory and motor abilities, rather than abstract thinking. Consequently, Ferguson cited the economy and social conditions as the primary reasons for increasing industrial-focused education. This type of education, as proposed by Ferguson was believed to be the only form of education that would not result in wasted resources for educating African Americans.

Psychologist Raymond Cattell in his argument of the mixing of blood between races expressed that the purpose of this strict division was to allow science to determine which races were suitable for continuation and which ones need extinction (Tucker, 2004). Tucker (2004 as cited by Cattell 1938, p.94):

> a race "such as the negro," for instance, "which hardly seems to compensate for its lack of mental capacity by endearing qualities of humour and religiosity," had "served [its] turn" and "must... be brought to euthanasia by gradual restriction of births, and by life in adapted reserves and asylums.

The early psychologists' eugenic and intelligence-based racial bias contributed greatly to the fight against desegregation. Henry Garret, a former president of the APA, who as the in-house psychologist for state’s rights and segregationalists, was influential in promoting the belief that African American children were intellectually inferior to White children in terms of learning (Guthrie, 1976). The belief in White children's intellectual superiority was not new. In the "Mixed Relations Test II," it was suggested that individuals with a higher degree of African ancestry were deemed less intelligent, while those with mixed racial backgrounds were believed to possess higher levels of intelligence (Ferguson, 1916). However, it was believed that these “mixed raced”

children's intellectual ability would never be equivalent to White children due to their African ancestry.

Over time, the APA has persistently demonstrated a lack of concern regarding its history of White supremacy and cultural insensitivity. A study revealed that 50% of minority individuals, including African Americans, who sought professional therapy discontinued treatment prematurely due to negative experiences and a perceived lack of cultural sensitivity from their therapists (APA, 2023). Supporting their concerns, research conducted in 2007 indicated that the therapeutic alliance between White therapist and African Americans was severely impacted as a result of microaggressions by the therapist (APA, 2023). The APA (2021) has apologized for its historical promotion and perpetuation of racist ideology, racism, and discrimination. However, this apology alone may not be sufficient, as further efforts are needed to address the lasting harm inflicted upon African Americans.

From Cultural Paranoia to Cultural Mistrust

The concept cultural paranoia, a paranoid like behavior resulting from a history of discriminatory practices and African American experiences was first coined in 1968 by African American psychiatrists Grier and Cobbs (Whaley, 2001). The term "healthy cultural paranoia" was used to imply that it serves as an adaptive behavioral response (Whaley, 2001). According to Whaley (2001), the behavioral response of African Americans to a history of White dominance should be viewed as cultural mistrust rather than the psychopathology of clinical paranoia, even though it may fall in the middle or end of the paranoia continuum. Dixon et al (2023) further defined cultural mistrust as "an

attitudinal stance, or cultural coping response, characterized by reality-based expressions of lack of trust, suspiciousness, and heightened sense of self-consciousness." This response is used as a defense mechanism against potential racism and discrimination from the dominant White society including those in the field of mental health.

African American's Cultural Beliefs

African American's beliefs about issues of mental health have been shaped by a history of racism, discrimination, and their personal experiences. These cultural shaped beliefs may be a deterrent to African American's help-seeking behavior. In their study on depression and the beliefs held within the African American culture, Campbell and Long (2014) identified some deeply held beliefs that impact the help-seeking behavior within the African American community such as the notion that although African Americans may experience long-term sadness, depression is not something they are affected by. When the idea of depression is discussed, it is often met with the idea of it being a mental disorder germane to White America (R. Campbell & Long, 2014). Reluctance towards medication was identified as a contributing factor to the underutilization of mental health services within the African American community (R. Campbell & Long, 2014). Double stigma, racial stigma and the stigma of mental illness pose a significant obstacle for African Americans when it comes to seeking mental health care (Yu et al., 2022). According to R. Campbell and Long (2014), individuals often perceive depression as a matter of faith and seek solace through prayer and dependence on God, as well as support from family and friends. While reliance on supportive family and friends is said to be beneficial, the stigma surrounding mental illness in the African American community can

also result in the alienation of individuals diagnosed with such conditions, causing their family and friends to distance themselves from them (Taylor & Kuo, 2019). Additionally, to seek help outside of God can demonstrate a lack of faith in His ability to heal (Taylor & Kuo, 2019). The belief that African Americans must always display and uphold the image of being a strong Black woman or strong Black man is also prevalent in African American community (Taylor & Kuo, 2019). Cultural beliefs and institutional mistrust contribute to the underutilization of mental health services. However, adopting an attitude of openness and acceptance towards cultural can help to mitigate these issues (Taylor & Kuo, 2019).

Cultural and Advantages of Culturally Relevant Resources and Services

The history of slavery, racism, and stigmas, combined with the African American culture's unique worldview, have likely contributed to the African American culture's unique approach to the concept of mental health (Campbell, 2021). In the context of research, it is imperative to distinguish culture from race and ethnicity.

Race

According to the APA (2003), the concept of race lacks a universally agreed-upon definition and clear biological or phenotypical markers. Rather, it can be broadly understood as a socially constructed categorization based on physical attributes such as skin color or hair type, often accompanied by the application of stereotypical assumptions.

Ethnicity

The concept of ethnicity, which lacks a precise and unambiguous definition, has been defined by the APA (2003) as the acceptance and adoption of the customary beliefs and behaviors of one's native culture, along with a corresponding feeling of affiliation.

Culture

Culture, according to the APA (2003), encompasses a collection of beliefs and values that influence customs, norms, practices, and social institutions, such as language, caretaking practices, media, and educational systems. Arshad and Chung (2021) further define culture as a system of meanings, including shared beliefs and values, that is acquired through shared activities and subject to change over time. It is a construct formed by individuals in order to interpret and define the world in which they exist. These cultural aspects exert a profound influence on psychological processes.

Every individual embodies cultural, ethnic, and racial heritage. Furthermore, individual and group culture are comprised of religious and spiritual traditions, history, socioeconomic status, political forces, and demographic location, as stated by the APA in 2003. To mitigate ongoing disparities, it is imperative to engage trusted community stakeholders, including clinicians and African American clergy members, who are widely acknowledged as credible sources of information. Engagement in this endeavor is crucial for advancing a more informed and established standard of care (Coombs et al., 2022) and aligning with the APA’s (2021) efforts to address and eliminate racism within the field of psychology.

The Mental Health Resources for Faith Leaders

The need for mental health resources and training for clergy is not a new phenomenon. The National Institute of Mental Health and the Academy of Religion and Mental Health awarded grants to Harvard, Loyola, and Yeshiva Universities for developing mental health training courses for clergy in 1956 (Hollander, 1962) . The teaching materials were to be drawn from various mental health disciplines, including psychology, psychiatry, general medicine, sociology, anthropology, and religion. The Yeshiva University Project as it was called, faced a major task in developing teaching materials, as all disciplines provided valuable mental health knowledge for clergy. This study aimed to examine several key aspects related to the role of clergy in mental health. These aspects included understanding the scope of clergy's function in mental health, the nature of the mental health assistance provided by clergy, the value that clergy derived from their knowledge of mental health, the importance of religion in the healing process, and the specific form and content of teaching materials required for this subject matter (Hollander, 1962).

Continued education of clergy in the field of mental health is imperative given their pivotal role in addressing mental health issues (Hollander, 1962). Numerous organizations have made efforts to tackle this problem by providing mental health resources to clergy. Approximately 23% of congregations in the United States have implemented programs to support individuals with mental illness (Wong et al., 2018). Despite being commendable, there remains a lack of adequate coverage or complete absence of culturally relevant material for African American clergy.

Substance Abuse and Mental Health Service Administration

The SAMHSA website section titled "For Community and Faith Leaders" (SAMHSA, 2023) discusses mental health but does not offer explicit guidance on how faith leaders should address mental health concerns among their congregations. The SAMHSA website provided information on the impact of COVID-19 on communities of color but lacked comprehensive guidance on addressing this issue. Furthermore, no specific race was emphasized.

Interfaith Network on Mental Illness

The Interfaith Network on Mental Illness (n.d.) website offered readers a resource guide for congregations and provided a concise introduction on initiating a spiritual support group. The website did not include African American clergy representation in its visuals and did not address mental health from a cultural perspective in its video or resource section for clergy.

American Psychological Association

The APA's website provides an article discussing the collaboration between psychologists and the religious community to address mental health issues and reduce the stigma associated with seeking help (Weir, 2020). Although the article briefly addressed the issue of stigma within the African American community, it did not offer any specific culturally relevant materials for clergy to utilize.

American Psychiatric Association

The America Psychological Association (2021) Mental Health Guide for Faith Leaders (2018) provided focused and comprehensive content tailored specifically for

clergy. The guide consisted of two main sections. The first section of the guide provided a definition of mental illness and an overview of prevalent mental disorders. It also addresses suicide risk factors, mental health diagnosis and treatments, the relationship between mental and physical health, recovery, wellness, and strategies for promoting and sustaining wellness. Part two focused on providing targeted assistance to faith leaders in supporting individuals with mental illness. This resource provided guidance on the appropriate timing and method for referring individuals to mental health professionals. Strategies for addressing resistance to accepting mental health treatment were also covered. This section also addressed the assessment of an individual's needs to differentiate between religious or spiritual issues and mental illness. The guide addressed strategies for effectively approaching individuals in urgent mental health crises. A helpful resource section is provided. One of the provided links in the guide is to the product section for the Center for Cultural and Structural Equity (Center for Cultural and Structural, 2016). While CCASE places a strong emphasis on cultural competence, it did not provide specific guidance for African American clergy regarding the culturally relevant approach to addressing mental health concerns. This guide's online accessibility did not provide any information regarding its usage among African American clergy. To resolve the existing gap, it would be necessary to investigate how African American clergy perceive the cultural relevance and usefulness of the mental health guide for faith leaders. The mental health guide for faith leaders (American Psychiatric Association Foundation, 2016) is the most comprehensive resource for clergy. This mental health guide serves as an initial resource for researchers to investigate the cultural relevance and

usefulness from the perspective of African American clergy. This research has the potential to contribute to existing research and provide a culturally relevant resource for African American clergy to address mental health concerns in their community.

Summary and Conclusion

The Black church is widely recognized as the cultural origin of the African American community, owing to the historical events such as the enslavement and the subsequent era of Jim Crow (Lincoln & Mamiya, 1990). Historically, the Black church has been instrumental in providing spiritual, political, economic, educational, and psychological support to the African American community (Lincoln & Mamiya, 2003; Ruiz, 1990). Moreover, African Americans have found comfort and assistance from the Black church as they have attempted to navigate a systemically racist society (Campbell & Littleton, 2018). According to Hays (2015), the Black church is a cultural resource in the African American community. These resources encompass significant artifacts, rituals, symbols that preserve history, narratives, rituals, and ceremonies central to the African American experience (Hays, 2015). According to VanderWaal et al., (2012), African American clergy occupy a significant position as "gatekeepers" within the Black church, which functions as a pseudo-familial institution. Historically, African American clergy have played a crucial role in addressing the mental health needs of the community (Boyd-Franklin & Lockwood, 1999).

According to Anthony et al., (2015), approximately 40% of African American's primary source of support for mental disorders such as depression comes from African American clergy. Albeit the primary source for addressing spiritual and mental health

needs, African American clergy have expressed their concerns about their limited mental health knowledge and training (Bolger & Prickett, 2021; Burse et al., 2021). African Americans and White individuals experience similar rates of mental health challenges (Neighbors, 1998). However, African Americans encounter a distinct set of barriers stemming from a history characterized by racial prejudice, stigma, microaggressions, negative experiences with the mental health field, discriminatory practices, cultural norms, and skepticism. As a result, African American clergy often serve as their preferred source of support (Bolger & Prickett; Taylor & Kuo, 2019).

The APA acknowledges its historical involvement in perpetuating racism, discrimination, and the marginalization of people of color, which has contributed to the African American community's cultural mistrust, leading to the reliance on African American clergy for their mental health needs (APA, 2021; Dixon et al., 2023; Allen et al., 2010). Resources such as the APAF Mental Health Guide for Faith Leaders (2016) have been developed to assist clergy in addressing mental health challenges within the church. Nevertheless, despite the evidence from research indicating the influence of culture on perception and beliefs regarding mental health and help-seeking behavior, as well as the positive impact of culturally specific mental health resources on knowledge and confidence (U.S. Department of Health and Human Service, 2001; Hagen et al., 2020), there has been a lack of focus on understanding the perspectives of African American clergy regarding the cultural relevance and usefulness of these resources. According to Psychiatric News (2020), the guide was used teach 40 African American faith leaders representing over 15 congregations in Wichita, Kansas in 2019. However,

the cultural relevance and usefulness of the guide was not addressed. Exploring the viewpoints of African American clergy, who have historically been engaged in addressing mental health issues within the African American community, is an attempt to fill this gap in understanding. In addition, the use of focus groups to gather clergy perceptions is a method that has not been utilized in most of the studies reviewed and offers the possibility of significant insights.

The methodology employed to investigate this current research question is discussed in the following chapter. The research design and rational, the role of the researcher, the technique, issues of trustworthiness, and ethical considerations will be the primary topic of discussion in chapter three.

Chapter 3: Research Method

The purpose of this qualitative study was to explore how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (APAF, 2016) to address mental health concerns within the African American community. This chapter provides an overview of the reasons for employing the basic qualitative design, the responsibilities of the researcher, and a description of the methodology used in this study. This section covers the instrumentation, study procedures, data analysis, interview questions from a CRT perspective, and issues of trustworthiness including credibility, transferability, dependability, and confirmability. This chapter concludes with a discussion of ethical considerations and the treatment of participants and collected data.

Research Design and Rationale

The research question for this study was the following: How do African American clergy perceive the cultural relevance and usefulness of the APAF's Mental Health Guide for Faith Leaders? A qualitative design was selected to investigate the perspectives of African American clergy on the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders. The basic qualitative design was selected due to its ability to gather detailed descriptive data from a limited number of participants in a familiar environment (see Tavakoli, 2012). The qualitative approach facilitated the examination of the authentic experiences and knowledge of African American clergy (see Crouch & McKenzie, 2006). The data's authenticity may enhance existing research and contribute to the advancement of culturally relevant training and resources.

The decision not to pursue a quantitative approach for this study was based on the lack of perceived benefits in obtaining empirical-analytic data. Another reason for not selecting a quantitative approach was the decision to adopt CRT as the theoretical framework. The primary phenomenon of interest was cultural relevance and usefulness. Interviews were used to collect data, which were analyzed to uncover recurrent patterns or themes that represented the findings of the research (see Merriam & Tisdell, 2016).

Three qualitative designs were considered: ethnography, case study, and basic. A basic qualitative design was chosen because ethnography and case study designs were deemed unsuitable for this research, which aimed to explore the perception of African American clergy. The focus of ethnographic research is to understand what is happening in the lives of a people from a cultural perspective (Singer, 2009).The most common methods of data collection are interviews and field observations made in the natural environment of the cultural group being studied (Creswell & Creswell, 2018). Due to my inability to directly observe the natural setting of a private counseling sessions between African American clergy and individuals seeking support, the ethnographic approach was not feasible.

Although case studies may focus on one or more events, phenomena, or units of analysis, this does not imply that they are restricted to a solitary observation (Creswell & Creswell, 2018). One advantage of conducting a case study is that it provides the researcher with the opportunity to conduct an in-depth examination of a specific case. However, one disadvantage is that case boundaries can be challenging to define (Givens, 2008). An additional issue associated with the use of case studies is the prolonged period

over which data are gathered using a variety of data collection methods (Creswell & Creswell, 2018). I aimed to explore African American clergy's perceptions of the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders. The qualitative approach in a focus group setting was deemed most suitable for obtaining detailed and descriptive data.

The most common kind of qualitative research is the basic qualitative approach. In this kind of qualitative research, the researcher strives to recognize and understand the meaning that a phenomenon has for the group that is being researched (Merriam & Tisdell, 2016). Interviews were used to collect data, which were analyzed to uncover recurrent patterns or themes that represented the findings of the research (see Merriam & Tisdell, 2016). Similar to Hankerson et al.'s (2013) study, the current study was conducted using a basic qualitative design and a focus group format. The basic qualitative approach was chosen for its ability to obtain rich descriptive data from a limited number of participants in a setting that was familiar to them (see Tavakoli, 2012). The COVID-19 pandemic led to an increase in the use of technology, specifically Zoom, by clergy members to conduct church services (Fletcher et al., 2020). Therefore, I anticipated that the Zoom setting would be familiar to participants.

Role of the Researcher

In qualitative research, the researcher's role is to explore and understand the thoughts and emotions of the participants (Sutton & Zubin, 2015). In the current study, I aimed to explore the perceptions of African American clergy regarding the relevance and usefulness of the Mental Health Guide for Faith Leaders. The clergy's perspectives were

based on their experiences and insights gained from addressing the mental health concerns of individuals within the African American community. During the focus group, I served as an observer-participant facilitating the focus group and collecting data through participant interviews. In the Zoom session, participants respond to open-ended questions and provided valuable descriptive data for this study.

Although it was impossible to fully eliminate personal bias, I acknowledged and addressed my biases through the practice of reflexivity (see Sutton & Zubin, 2015). I incorporated reflexivity into every stage of my research, including question formulation, data collection and analysis, and reporting of findings. As an African American member of the clergy and a licensed professional counselor, I needed to maintain my role as a researcher and strive to gather detailed descriptive data from the participants while acknowledging my personal perspectives, biases, and opinions.

To avoid creating an imbalance of power, I abstained from selecting members of the clergy with whom I was familiar on a personal level. Because I and the participants were member of the clergy, there were no further issues of a power differential. Given the historical context of institutional racism, stigma, microaggressions, and negative mental health experiences in the African American community, it was important to acknowledge the challenges in discussing mental health in this population. In addition to protecting the data, I sought to ensure the well-being of the participants (see Sutton & Zubin, 2015).

Methodology

Participant Selection Logic

The population of interest for this study included self-identified African American clergy. Participants were recruited via referral sampling using emails sent to known African American clergy. The criteria for participation in this study were (a) African American clergy, (b) at least 10 years of experience in the role of clergy, and (c) currently or recently served 5 years or more at a predominantly African American church.

The anticipated sample size for this study was two focus groups with four to six participants in each. This homogeneous sample was chosen because of their relevant and extensive experience, which assisted in addressing the research question (see Patton, 2015). Hennink and Kaiser (2022) proposed that conducting four to six focus groups is sufficient to achieve data saturation. Hennink et al. (2017) also argued that conducting limited interviews may be sufficient for researchers seeking to identify broad thematic issues or to develop survey items. Qualitative samples are often smaller than quantitative samples because qualitative research focuses on meaning rather than generalization (Mason, 2010). According to Mason (2010), saturation should be sought until it becomes counterproductive because new information discovery may not add significantly to the data set. Mason suggested that rather than attempting to define a process that spans disciplines, a small study with modest claims may achieve saturation sooner.

Instrumentation

A crucial aspect of qualitative research is the role of the researcher as the primary instrument (Chenail, 2011). The most common methods of data collection for qualitative

research include interviewing, field observation, and document analysis (Chenail, 2011). Another strategy that can be used as the primary source of data collection is the self-contained focus group (Morgan, 1997). For the current study, the primary instruments were focus groups and the interview questions asked during each focus group session.

Focus Groups

According to Smithson (2000), focus groups are in-depth group interviews that involve relatively homogeneous groups. Focus groups are used to gather data on specific topics identified by the researcher. In the current study, the focus group was preferred over individual interviews due to its capacity to obtain more comprehensive insight from the collective group. Data were collected during each 60–90-minute audio recorded and transcribed focus group session via a secure Zoom platform.

Interview Questions

To investigate how participants perceived the Mental Health Guide for Faith Leaders in terms of its cultural relevance and usefulness, I formulated interview questions with CRT as the theoretical framework (see Appendix).

Procedures For Recruitment, Participation, and Data Collection

I used referral sampling from my professional contact list as the primary sampling strategy. I sent an email invitation to clergy members with whom I was acquainted, asking them to refer other clergy members who met the selection criteria by forwarding the invitation. The email invitation provided a brief description of the study and its criteria.

In the event that the primary recruitment method failed to yield a sufficient number of participants, social media flyers served as an alternative recruitment strategy. The flyer was posted on private social media sites asking that it be forwarded to individuals meeting the criteria. The flyer contained a concise description of the study, its criteria, and steps to express interest.

Participants

Participants who met the requirements and were referred by known clergy received an email notification containing a comprehensive explanation of the study, including its objectives and the procedures for data collection and analysis. Participants who responded to the social media referral and met the criteria were asked to express their interest by sending a private message via social media. Eligible participants were emailed and provided a detailed explanation of the study, including its objectives and the procedures for data collection and analysis.

All participants were informed via email that their personal information, including their names, church names, and any other identifiable data, would not be included in any part of the study. The email included an informed consent form for participants interested in participating in the study. The informed consent form contained information regarding the secure Zoom platform and the necessary time commitment of 60–90 minutes. Participants were required to thoroughly review the email and informed consent document. They were to then respond to the consent request by sending an email stating “I consent” along with the date of consent. In recognition and gratitude for the

participants' time, I presented a $20 digital gift card to each individual as a token of appreciation.

Data Collection

Morgan (1998) suggested using an interview guide with open-ended questions and follow-up questions to facilitate a conversation among participants centered around the research question. Krueger (1998b) proposed classifying questions into three-time intervals: 5, 10, or 15 minutes. To introduce the topic, Krueger recommended initiating 5-minute questioning at the outset of the focus group. Ten-minute questions were used to guide the main focus of the current study. According to Krueger, 15-minute questions were significant and required a substantial time commitment. The questions in the current focus group were arranged in a sequential manner, as is customary in focus group interviews. This approach enabled participants to establish their opinions and further develop their perspectives (see Krueger, 1998).

The Zoom focus group was audio recorded and transcribed using transcript-based data analysis (Onwuegbuzie et al., 2009). As a result of the Covid-19 pandemic, clergy members have become proficient at utilizing technology for conducting diverse church services (Fletcher et al., 2020) which aided in the elimination of technology and geographical barriers. As the only data collector and researcher, I thoroughly examine each recorded focus group session, comparing the audio recordings with the transcribed data to ensure content validity and accuracy. Participants did not have to be contacted for clarification on any ambiguous comments.

Data Analysis

According to Braun and Clarke (2006), thematic analysis is a technique that can be used to recognize, investigate, and report on recurring themes and patterns within data. Through coding, categorization, and analytical thought, a theme can emerge (Saldana, 2021). In contrast, codes are usually used to represent a word or short phrase that symbolically assigns a clear and significant attribute to a portion of language-based information. On the other hand, themes are longer phrases or sentences that provide a description of what a unit of data is about and/or what it signifies (Saldana, 2021). This study adhered to the six specific stages for conducting thematic analysis outlined by Braun and Clarke (2006):

1. Familiarizing yourself with the data: immersion of the data through repeated reading, the transcription of verbal data, checking transcripts against original audio or video recording for accuracy
2. Generate initial codes: generate initial codes from the data in a systematic manner while simultaneously identifying intriguing attributes of the data items that could potentially form the basis of recurring patterns.
3. Searching for themes: directing the analysis in a more general direction toward themes derived from the various codes and compiling all pertinent coded data into themes that have been identified.
4. Reviewing themes: the process involves scrutinizing and improving upon themes through a review of coded data extracts. This entails assessing the

validity of each theme in relation to the data sets and determining whether the thematic map faithfully represents the meanings inherent in the entire data set.

5. Defining and naming themes: the process of defining and refining themes in preparation for their analysis and examining the data contained within them.
6. Producing the report begins once a comprehensive collection of themes has been established. This stage involves the final analysis and composition of the report.

According to Onwuegbuzie et al. (2009), there are three stages of analysis. The preliminary phase entails the identification of codes present in the data. The transcribed data is then analyzed alongside the transcribed data collected during participant debriefings. Examining focus groups presents its own set of challenges, as two participants may express the same idea using different words or phrases (Krueger, 1998). To address and resolve inconsistencies, member checking may be implemented (Connelly, 2016).

I used a MAXQDA data analysis software to analyze the audio and transcribed data. Participants did not need to be contacted to clarify data. There was a three-stage analysis (Onwuegbuzie et al., 2009). The initial stage consisted of identifying codes within the data. In the second stage codes were organized into groups. Finally, in the third stage I used the content of each group to extrapolate themes (Onwuegbuzie et al., 2009). I maintained an audio journal documenting my reflections following each session of the focus group. As a result, I was able to consciously identify and confront any biases that

arose. This enabled me to maintain reflexivity during the research process (Sutton & Zubin, 2015).

Issues of Trustworthiness

The degree to which confidence in the data, interpretation, and methodologies used ensures the quality of this study is referred to as its trustworthiness. Stahl and King (2020) argue that the trustworthiness of research is influenced by the mutual understanding and constructive interaction between the reader and the writer. It is characterized by readers' confidence in the reported findings. The essential elements for establishing trustworthiness in this qualitative research were credibility, transferability, dependability, and confirmability.

Credibility

Credibility is the term used to denote the truthfulness of data (Cope, 2014). Credibility seeks to ask how congruent are the findings with reality (Stahl & King, 2020). Cope (2014) suggest that a qualitative study is considered credible if the descriptions of human experience are immediately recognized by individuals that share the same experience. Credibility was established through reflexivity self-analysis through reflective journaling. While member checking, the process where researchers seek the assistance of participants to verify their interpretation of the facts (Stahl & King, 2020) was considered, it was not needed. I thoroughly examine the transcripts. As a result of having audio and transcribed data, contacting participants to address any required clarifications and modifications was not needed.

Reflexivity is a continuous process that spans the entire duration of a research project. Reflexivity involves critically examining personal, interpersonal, methodological, and contextual factors that impact research (Olmos-Vega et al., 2023). To generate thick descriptions (Stahl & King, 2020), I maintained a journal where I recorded my thoughts, emotions, observations, and reflections throughout the research endeavor. I utilized journaling to reflect on participant interactions, data collection and analysis decisions, findings interpretations, and emotional responses during the research process.

Transferability

Transferability refers to the capability of applying the findings of research to new groups or settings (Cope, 2014). Although qualitative research does strive to seek replicability, patterns, and descriptions from one context may be transferable to another with the purpose of extending understanding by transferring findings from one context to another (Stahl & King, 2020). Transferability of a study is determined by its ability to be understood and related to by individuals who are not part of the study (Cope, 2014).

I was specific in narrowing down the population of study to African American clergy. The use of the theoretical framework of CRT to explore the perception of the mental health guide for faith leaders' cultural relevance and usefulness laid a foundation for replication of this study with participants from diverse racial/ethnic groups.

The study's specificity enhanced its transferability. The study focused on African American clergy as participants and used Critical Race Theory as the theoretical framework. It aimed to determine whether a mental health guide for faith leaders was

seen as culturally relevant and useful to this specific population. The study aimed to gather detailed and descriptive data that could applied to other contexts.

Dependability

The concept of dependability, according to Cope (2014), pertains to the consistency of data observed in similar contexts. Dependability is said to be the trust in the trustworthiness of the research (Stahl & King, 2020). Dependable research provides clear insights into the study's objectives and allows for replication of findings under similar conditions and with similar participants (Cope, 2014). To ensure research dependability, it was important to maintain audit trails of detailed research notes throughout the research process. Additionally, member checking and peer-debriefing could be utilized as methods to enhance the dependability of the research (Connelly, 2016; Enworo, 2023). However, having recorded audio and transcribed data made this unnecessary. To ensure the dependability of the research process, a reflexive journal was maintained throughout the entire study. This journal included a detailed audit trail that transparently describes each step taken, from the initiation of the research project to the development and reporting of the findings. Another method that could be used to assure dependability is the usage of member checks to validate my understanding of the participant by validating both the accuracy of their statements and my interpretations of their statements (Enworo, 2023). However, having recorded audio and transcribed data made this unnecessary.

Confirmability

Confirmability in a study is established when the researcher demonstrates that the findings accurately represent the perspectives of the participants, rather than the researcher's own biases (Cope, 2014). According to Stahl and King (2020), confirmability is the process of doing a qualitative investigation with the goal of achieving the highest feasible level of objective reality. To ensure confirmability, I aimed to interpret and establish the research findings strictly based on the data collected. I engaged in reflexivity self-analysis by using reflective journaling, which included an audit trail of rich descriptions.

Ethical Considerations

As I began this scholarly research, I was acutely cognizant of my obligation to conduct it ethically. I promptly attended to any ethical concerns that arose. Understanding that by conducting focus group studies I could not promise complete confidentiality, my primary focus was to protect each participant to the best of my ability within the confines of focus group sessions. Participants were strongly encouraged to avoid discussing the content and persons within their focus groups although, I could not confirm that they would adhere to this request. I intended to comply with the requirements and ethical guidelines established by the Institutional Review Board (IRB) of Walden University.

Treatment of Participants

I acknowledged the requirement to obtain approval from Walden University's Institutional Review Board (IRB) prior to beginning any research. The IRB number for this study is 03-05-24-1156274. My utmost priority was to safeguard participants from

bias, coercion, intimidation, personal obligations, or any other factors that could compel their participation in the study. To avoid power differential, I excluded individuals with whom I had personal or professional connections.

Participants were notified at the beginning of the focus group sessions that they have the option to withdraw from the study at any point. The information was included in the informed consent document as well. Participants received a contact number for Substance Abuse and Mental Health Services (SAMHSA) during the focus group sessions, which provides mental health services and referrals.

Treatment of Data

The data was obtained from the two-focus group session via a secure Zoom. The two Zoom session were both audios recorded and transcribed. Clarification and confirmation of data through member checking was not needed. During the data analysis process all identifiable data was removed. Participants were not identified by name, state, or church affiliation. All written data will be securely stored in a locked file cabinet located in my home office. The Zoom audio was saved on a jump drive and securely stored in a locked file cabinet within my home office. All data will be destroyed after a period of five years, in accordance with the guidelines set by the IRB and Walden University.

Summary

Chapter three of this study discussed the rational for the research, the researcher's role in this research, which is to understand and explore the perspective of the participants, based on their experiences and insights gained from addressing mental

health concerns within the African American community. The methodology which included participant selection, instrumentation, procedures for recruitment, data collection and analysis have also been covered in this chapter. Establishing trustworthiness through credibility, transferability, dependability, and confirmability were covered in detail within this chapter as well.

This qualitative study aimed to investigate the perceptions of African American clergy regarding the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (APA, 2016). The research question developed using tenets of CRT were designed for this basic qualitative research study. The recognition of the need to conduct ethical research and promptly address any concerns were acknowledged. Ensuring the safety and well-being of participants in focus group sessions was given top priority. I adhered to Walden University's IRB guidelines throughout the research process.

Chapter four presents' details on the study's setting, data collection, and data analysis. Evidence of trustworthiness, potential adjustments to the strategies used to establish trustworthiness and the results of the study are also covered in the following chapter. Despite the initial mention of the specific time zone, adjustments had to be made to the scheduled time of the Zoom focus group to accommodate participants from various time zones. Due to time zone discrepancies, a participant was absent. The adjustment was made for the second focus group to accommodate all participants.

Chapter 4: Results

The purpose of this basic qualitative study was to explore how African American clergy perceived the cultural relevance and usefulness of the APAF's (2016) Mental Health Guide for Faith Leaders. The data were collected using two focus groups conducted via secured Zoom. This chapter discusses the study setting, demographics, data collection, and data analysis process. The trustworthiness and the study results are also included, followed by a summary of the chapter.

Setting

I aimed to enable African American clergy to discuss the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (see APAF, 2016). By drawing on their personal knowledge and experiences, the clergy could determine how culturally relevant and useful the guide was in addressing mental health issues within the African American community. Due to the impact of the COVID-19 pandemic, numerous religious leaders turned to online communication platforms such as Zoom to maintain church services. I decided to use this communication platform due to the expertise and experience of the clergy in using it. Additionally, Zoom allowed for the inclusion of participants from multiple locations.

Demographics

The criteria for participation in this study were (a) African American clergy, (b) at least 10 years of experience in the role of clergy, and (c) currently or recently served 5 years or more at a predominantly African American church. The participants were from several states across the United States. To broaden the pool of participants, I needed to

modify the selection criteria. The initial criteria were that participants must have served in their current church for 5 years. This was changed allowing for the recruitment of participants who had recently been appointed to a new church but had served at a previous church for over 5 years.

Each of the two focus groups had four confirmed participants scheduled. However, in each of the two scheduled focus groups, two participants participated. I chose to continue because I believed that the rich data obtained from this underrepresented population in these first focus group would be significant to the field of research and the African American community. Despite the small number of participants, the very small focus group (VSFG) led to a focus on more structural analysis while offering rich data (Toner, 2009). I found this to be true during my VSFGs.

Data Collection

At the start of the data collection process, I emailed members of clergy whom I knew asking for referrals for individuals who met the criteria. Two referral sources stated that they wished to take part in the focus group themselves. I explained that due to the closeness of our relationship, they would not be able to participate. My second method of obtaining participants was to post on my social media platforms. I posted a flyer on Facebook and Instagram for 2 weeks. The flyer contained a concise description of the study, its criteria, and steps to express interest. I shared the flyer with members of clergy who I knew via these social media outlets. Individuals who also knew clergy shared the flyer on their social media platforms. Modification to criteria had to be made to broaden the participant pool.

The primary instruments for data collection were the two focus groups and the interview questions that were asked during each focus group session. The first focus group was scheduled to have four participants. Of the four, two were present. Of the two who did not participate, one logged in at the wrong time zone. This participant attended the second focus group. The first focus group lasted 44 minutes. The second focus group was scheduled to have four participants, but only two were present. The second focus group lasted 90 minutes.

The audio recordings of each Zoom focus group were transcribed and analyzed using transcript-based data analysis. As the sole data collector and researcher, I conducted a comprehensive analysis of each recorded focus group session. This involved comparing the audio recordings with the transcribed data to ensure the validity and accuracy of the content. I made edits to the transcribed data in a Word document, including the inclusion of phrases such as "umm" that were not accurately transcribed by the transcription program. The language employed by each participant in each focus group was classified by color. In the first focus group, the moderator had a purple color, Participant 1 was orange, and Participant 2 was blue. The second focus group was also color coded. The color for the moderator remained purple, Participant 1 was red, and Participant 2 was green. Two different methods were employed to preserve the data. The audio and transcribed data were securely stored in a password-protected file on my computer. The transcribed data were also securely stored in a locked file cabinet in my home offices. Additional communication with participants was unnecessary.

Data Analysis

After reviewing the audio multiple times to cross-check the transcribed data and make necessary corrections, I familiarized myself with the data by repeatedly reading the transcribed data. I color coded each participant's statement. I followed the six stages for conducting thematic analysis outlined by Braun and Clarke (2006). Additionally, I uploaded the transcribed data into MAXQDA data analysis software to analyze and code each line. The process was repeated three times. Codes were given a specific color. Memos were included to offer additional information about the codes. After identifying the initial codes, I organized them into more focused codes. The codes were analyzed thematically through content analysis to identify emerging patterns and themes. A map was created to represent these themes. Next, the themes were defined, refined, and named, as proposed by Braun and Clarke. I used a combination of personal phrasing and direct citations to clarify the observed patterns derived from the data, which effectively addressed the research question.

The patterns were identified based on 15 codes that were observed in the data. These codes included the following: "is it spiritual," "don't see color," "suggested changes to the mental health guide for faith leaders," "the pandemic," "determining culturally relevant resources," "culture," "how do you tell a person they need to seek mental health help," "Black church neglects mental health," "trauma," "stigma and discrimination," "clergy on people with mental health issues," "people don't know where to get help," "mental health education," "clergy on mental health," and "clergy mental health." The point of data saturation was considered to have been reached when no

additional information could be extracted from the codes. I carefully examined the codes and categorized them into distinct groups. Next, themes were derived from the code groups. I was able to identify seven themes: (a) trauma, (b) challenges to addressing mental health, (c) help-seeking behavior, (d) definition of culture, (e) cultural relevance, (f) clergy suggestions, and (g) clergy mental health.

The theme of trauma was examined through five subthemes, each revealing different aspects of its impact on the African American community. The emergence of the Black church from historical trauma highlighted the community's resilience and the need for self-sustainability. Systemic inequality and segregation contributed to the neglect of mental health within the Black church, emphasizing the importance of addressing this issue. Specific experiences of trauma shaped behavioral patterns and responses within the African American community. The psychological impact of racism and discrimination was explored, revealing how it could lead to mental health difficulties. During societal crises such as the COVID-19 pandemic, existing mental health challenges were exacerbated, underscoring the need for increased support and resources. Together, these subthemes provided a comprehensive analysis of trauma's complex effects on the African American community, addressing its historical roots, societal consequences, and implications for mental well-being and resilience.

The subthemes that emerged from the broader theme of challenges in addressing mental health encompassed a range of significant obstacles. I found that many individuals hesitated to share their mental health struggles due to concerns about trust and confidentiality, leading to a reluctance to seek help. Moreover, the pervasive stigma

surrounding mental health issues often resulted in individuals choosing to remain silent about their problems, further exacerbating the issue. Ongoing prejudice targeting marginalized communities such as African Americans added another layer of complexity, perpetuating systemic inequalities in society and hindering access to appropriate care. Another challenge identified was that both the church and the community faced a deficiency in formal education regarding mental health, which further compounded the challenge. Additionally, the spiritualization of mental health problems within these contexts may impede awareness and proper treatment, emphasizing the need for greater education and destigmatization efforts within these communities.

The theme of help-seeking behavior encompassed various subthemes, one of which involved a tendency to seek support within religious communities, particularly from clergy members. This preference was compounded by an avoidance of traditional mental health services due to cultural norms and pervasive stigmas, resulting in the underutilization of professional mental health services. Social stigma surrounding mental health also emerged, which further exacerbated the reluctance to seek help and perpetuated the cycle of silence and isolation. Additionally, there was resistance to being categorized or stereotyped based on mental health conditions, adding another layer of apprehension toward seeking mental health care. Moreover, the prevailing belief within the community suggested that faith alone was sufficient to address mental health challenges, diminishing the perceived need for professional mental health care. The relationship between cultural, social, and religious factors emphasized the intricate nature

of help-seeking behavior within the African American community, highlighting the urgent need for culturally relevant and accessible mental health resources and support.

The definition of culture was also a theme that resulted in several subthemes. Culture was said to be a dynamic and integral aspect of human existence that was characterized by a continuous interaction with cultural elements within daily life. Culture was said to represent a lifelong process of adaptation and integration of values and practices that shaped a person's development and personality. Through engagement with cultural norms and traditions, a person's personal identity was formed and reflected the richness of cultural heritage. Culture was found in the expression of the outward manifestation of language, clothing, and customs. Rituals, ceremonies, and symbols were observable manifestations that pertained to a specific community. In addition, culture was expressed through various forms of artistic expression, such as art, architecture, and craftsmanship, which reflected the creativity and resourcefulness of a particular cultural community. In the face of external influences and the impact of globalization, cultural identity demonstrated remarkable resilience, adjusting to evolving circumstances while preserving its inherent strength and significance.

Determining cultural relevance also emerged as a theme offering multiple subthemes. Cultural relevance was said to involve careful consideration of various factors to ensure that a resource effectively met the needs of the African American community. The content and delivery of the resource must be considerate of cultural nuances and sensitivities. The resource must recognize the diverse and rich experiences, perspectives, and identities within the African American community while authentically portraying

their experiences and contributions to society. To be culturally relevant, a resource should also align with cultural norms, values, and practices to foster a sense of connection and understanding. Additionally, language and terminology should be respectful and inclusive, devoid of stereotypes and derogatory language, and a positive representation of the dignity of the people and the culture. By incorporating this theme as well as these subthemes, cultural relevance can be effectively assessed, ensuring that resources are relevant and useful to African American clergy.

I asked African American clergy what improvements they recommended to make the mental health guide more culturally relevant. Multiple subthemes arose. It was suggested that the guide's content be expanded to address specific mental health issues prevalent within the African American community. The consensus was that guide should reflect the experiences and needs of African Americans, to foster a deeper understanding of mental health challenges. Additionally, cultural understanding and sensitivity were said to be paramount, requiring the authors to demonstrate a profound respect and understanding of African American culture. Integrating cultural insights throughout the guide would also allow for the enhancement of its relevance. Visual representation was said to be important and should authentically portray African American culture and communities, utilizing culturally relevant imagery, terminology, and messaging to engage readers effectively. Furthermore, the guide should strive for balance in spiritual engagement, avoiding excessive focus on spirituality or religion that may alienate certain segments of the community. By incorporating these suggestions to the mental health guide, the participants believed that it could effectively serve the diverse needs of the

African American community, promoting awareness, understanding, and support for mental well-being.

Finally, and unexpectedly, the theme of clergy mental health emerged along with some subthemes. The mental health of African American clergy members is a complex and multifaceted issue, influenced by various factors within their official roles and personal lives. Clergy often face high expectations and demands from congregants and fellow clergy, leading to considerable pressure and stress. These expectations may include providing emotional support, spiritual guidance, and managing the needs of their congregants and the community, all while balancing their own well-being. Additionally, clergy members may experience personal mental health challenges, ranging from anxiety and depression to burnout and compassion fatigue. Despite the time and effort, they expend caring for others, clergy may struggle to prioritize their own mental health needs, leading to a lack of self-care practices. This neglect of self can further exacerbate mental health issues contributing to emotional exhaustion. Further details of the seven themes and the subthemes can be reviewed in table 1. The themes and themes were subsequently viewed through the lens of CRT. CRT provided me the opportunity to explore and publish findings that were deeply rooted in the lived experiences and accumulated knowledge of African American clergy. This approach provided a lens through which to explore the complexities of race, power dynamics, systemic inequalities, and mental health within the context of mental health among African American communities.

Evidence of Trustworthiness

As stated in chapter three, trustworthiness of qualitative research, is the degree to which confidence in the data, interpretation, and methodologies used ensures the quality of a study. Trustworthiness of research is influenced by the mutual understanding and constructive interaction between the reader and the writer. It is characterized by readers' confidence in the reported findings (Stahl & King, 2020). The essential elements for establishing trustworthiness in this qualitative research are credibility, transferability, dependability, and confirmability.

Credibility

The term credibility refers to the truthfulness of data (Cope, 2014). The concept of credibility examines the alignment between the findings and reality (Stahl & King, 2020). According to Cope (2014), a qualitative study is deemed credible when individuals who have had similar experiences can readily identify with the descriptions of human experience. The credibility of the study was established by engaging in self-analysis and reflective journaling, which was maintained throughout the research. I carefully analyze the transcripts. I documented my thoughts, emotions, observations, and reflections through the practice of journaling. Although consulting with participants for clarifications and modifications were not needed, I thoroughly examine the transcripts and audio recording to address any required clarifications and modifications.

Transferability

The transferability of a study is assessed based on its capacity to be comprehended and connected with by individuals who are not involved in the study

(Cope, 2014). Qualitative research aims to achieve replicability, allowing for the transfer of patterns and descriptions from one context to another. This transfer of findings helps to expand understanding across different contexts (Stahl & King, 2020).

I have carefully selected a specific group for my study: African American clergy. This study employs the theoretical framework of CRT to examine the cultural relevance and usefulness of the mental health guide for faith leaders. The findings provide a basis for future replication of this study with participants from various racial and ethnic backgrounds. The study's level of detail and descriptive data increases its applicability to other contexts.

Dependability

Dependability, as defined by Cope (2014), refers to the consistency of data observed in similar contexts. Dependability is often regarded as the belief in the reliability of the research (Stahl & King, 2020). In order to ensure the dependability of research, it is crucial to maintain detailed research notes throughout the entire research process. I utilized reflexive journaling throughout the entire study to ensure the reliability of the research process. I provide a thorough account of each step undertaken, starting from the inception of the research project to the formulation and presentation of my findings. To enhance research reliability, researchers can utilize member checking and peer-debriefing techniques (Connelly, 2016; Enworo, 2023). Member checking was not required as the transcripts could be compared to the audio data.

Confirmability

Confirmability in a study is established when the researcher demonstrates that the findings accurately represent the perspectives of the participants, rather than the researcher's own biases (Cope, 2014). As per Stahl and King (2020), confirmability refers to the process of conducting a qualitative investigation with the aim of attaining the utmost level of objective reality. To ensure confirmability, I interpreted and establish the research findings solely based on the data that I collected. I conducted reflexivity self-analysis through the use of reflective journaling, which involved me maintaining detailed records of my observations and experiences.

Results

In this study, I conducted two very small focus groups (Toner, 2009) via secured Zoom. I asked questions aimed at answering the established research question as it related to the aspects of the critical race theory. The purpose of the study was to explore how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (APAF, 2016). The findings are organized thematically to align with the central research question. The research findings are presented through the identification of key themes and subthemes derived from the research inquiries. The identified themes and subthemes were reviewed through the lens of critical race theory. The themes and subthemes can be found in table 2.

Research Question

The research question for this study is: How do African American clergy perceive the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders

(APAF, 2016). The purpose of this qualitative study was to investigate the perceptions of African American clergy regarding the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (APAF, 2016) in addressing mental health issues within the African American community. The study employed CRT as its theoretical framework. The utilization of CRT as its framework, allowed for the conduct and publication of research that was rooted in the experiences and knowledge of African American clergy (see Table 1).

Table 1

Themes and Subthemes

Theme	Subtheme
Trauma	The Black church's emergence from historical trauma, necessitating self-sustainability and resilience.
	Dynamics of assimilation and the Black church's imitation of mainstream practices contributing to this belief.
	Legacy of systemic inequality and segregation leading to neglect of mental health within the Black church.
	Unique experiences of trauma within the African American community, shaping behavioral patterns and responses.
	Psychological impact of being treated as "less than" or unworthy by others. Exacerbation of mental health challenges during times of societal crisis, such as the COVID-19 pandemic.
Challenges to addressing mental health	Reluctance to disclose mental health challenges due to distrust and concern about confidentiality.
	Stigma surrounding mental health issues leading to secrecy and reluctance to acknowledge them within families and communities.
	Persistent discrimination against marginalized communities throughout history.
	Systemic inequalities perpetuated through policies and societal norms.
	Clergy and community members lacking formal education and understanding of mental health.
	Spiritualization of mental health challenges, hindering recognition and appropriate treatment.
Help-seeking behavior	Preferences for seeking support through religious communities, often turning to the church and clergy for assistance.
	Avoidance of traditional mental health services due to cultural norms and stigma, resulting in underutilization of professional resources.
	Social stigma attached to seeking help for mental health issues.
	Resistance to being categorized or stereotyped based on mental health conditions.
	Belief within the community that reliance of faith negates the need for professional therapy.
Definition of culture	Continuous and dynamic interaction with cultural elements in daily life.
	Lifelong process of adaptation and integration of values and practices.
	Influence of experiences on development and personality.
	Formation of personal identity through engagement of norms and traditions.
	Manifested through outward expression.
	Visible through rituals, ceremonies, and symbols that signify belonging.
	Expressed through art, architecture, and craftsmanship.
	Adapts and stays strong amidst external influences and globalization.
Determining cultural relevance	Considerate of cultural nuances and sensitivities in the content and delivery of the resource.
	Addresses the needs of the African American community.
	Aligns with cultural norms, values, and practices of the African American culture.
	Resource reflects the diversity and richness of African American perspectives and identities.
	Authentically portrays the experiences and contributions of African American people.
	Language and terminology used in the resource to ensure it is respectful and inclusive of African American individuals and communities.
Clergy suggestions	Inclusive topic coverage by expanding the guide's content to include topic specifically relevant to mental health within the African American community.
	Cultural understanding and sensitivity be demonstrating the authors in-depth understanding and respect for African American culture, integrating cultural insight throughout the guide.
	Culturally relevant presentation by incorporating images and visuals that authentically represent African American culture and communities, using culturally relevant terminology and messaging.
	Balance spiritual engagement by avoiding excessive focus on spirituality or religion that may alienate segments of the African American community.
Clergy mental health	High expectations and demands placed on them by congregants and fellow clergy.
	Personal mental health challenges.
	Lack of self-care.

Theme 1: Trauma

This theme emerged from participant's discussion of historical and present-day trauma impacts the Black church and mental well-being of African Americans mental. Existing literature provided insight into the fact that the Black church emerged as a crucial institution for African Americans in the United States after enduring years of enslavement and Jim Crow. It served as a source of psychological support and acted as a protective factor against the development of mental disorders (Lincoln & Mamiya, 2003; Davenport & McClintock, 2021). Participant one from the first group discussed the impact of stigma, prejudice, discrimination, and stereotypes on the mental health of African Americans, specifically highlighting historical and ongoing trauma in relation to the church:

> I think it impacts a great deal. Um, I believe when we even look at the origin of the African American church, no matter if you Baptist, Pentecostal, Church of God in Christ, Methodist or Non-Denomination, we all started from trauma. And once you have trauma um, you gonna have all these things.

The historical legacy of racism, discriminatory practices, and inadequate healthcare has influenced African American's help-seeking behavior (Alang 2019). Participant one in focus group one discussed feelings associated with the knowledge of discriminatory practices and inadequate healthcare due race during the Covid-19 pandemic:

> I think one of those things might be spoken to, especially in a church context having to get past the pandemic, Covid-19. I don't know if that's actually in here,

> but, you know, and us having to feel like we were less, you know, didn't get adequate services and things that we need compared to our counterparts.

Participant one of group two also discussed the impact Covid-19 had of the African American people shared "we as African Americans if you look at it since, say 2020, when the pandemic started, African Americans closed up and shut up everything that was important to them." Considering the historical racist influence of the American Psychiatric Association in perpetuating systemic racial oppression (2021), African Americans are hesitant to seek mental health services. Whaley (2021) suggested that African Americans may experience healthy paranoia. While African Americans have mental health challenges at comparable rates to their White counterparts, this healthy paranoia complicates efforts to address mental health issues.

Theme 2: Challenges to Addressing Mental Health

This theme focused on the challenges clergy face in addressing mental health. Double stigma, the dual challenges of racial stigma and the stigma of mental illness presents a significant challenge to African Americans when seeking mental health support (Yu et al, 2022). Participant one of focus group two addressed these challenges:

> Okay, ah, in my experience dealing with people just in the natural community and the natural habitat in which they live. You tend to get the feel or perception that people are guarded. They are guarded on their personal characteristics, family matters, things that the family chooses not to address.

Dixon et al. (2023) described cultural mistrust as "an attitudinal stance, or cultural coping response, characterized by reality-based expressions of lack of trust, suspiciousness, and

heightened sense of self-consciousness." Participant two of focus group two expounded on how African American's trepidation of seeking mental health stems from their perception mental health and mental health care:

> Because of the way that a lot of African Americans have viewed mental health assistance, that those who are broken sometimes cannot receive the help they need because these people become codependent. What I mean is they cover it up and they turn it back and pretend as though they can't see it or pretend as though it's not there…It is still coming to an understanding that these things can be in my family, right. I still don't wanna know that somebody is depressed. I don't want anybody to know that somebody is schizophrenic, right? I don't wanna be labeled as that.

One participant in group one raised a question about locating professional mental health providers who are culturally relevant and suitable for referral by clergy to individuals in need of mental health services.

> And it's another area that we, a lot of us don't exactly know, unless we are have, have been involved with the situation one on one because you could be dealing with somebody um, and still don't really understand the whole concept of the mental health society. And understand, you could tell somebody, you could tell and understand that somebody's going through something but how, where are you gonna tell them to go get help at you know…and you know, you got families that don't know where to get help at.

When exploring the challenges of addressing mental health, it is critical to spend time gaining an understanding of the help-seeking behavior of African Americans.

Theme 3: Help-Seeking Behavior

Help-seeking behavior is a complex topic, influenced by history and perception of the professional field of mental health. As a result, African American clergy are preferred as the primary source of mental health support for nearly 40% of African Americans (Anthony et al., 2015). This is consistent with the findings of this study. Participant two of focus group two discussed the help-seeking behavior of African Americans, stating, "especially for this African American community you see, the first thing that most still is most prevalent, let me go to the church, right. And so, then you go to the church." Participant one of focus group two further expressed thoughts on help-seek behavior:

> The fact that people in life, people are living in America with some mental deficiency. You can't deny that. And secondly, you can't deny that there's not enough aid for the people. That are able to help everybody. So, you have to incorporate documents. To make them available to people through the medical field, through the psychological field. Whatever the means of disbursement to help people who don't want to see, who don't want to lay on somebody's couch. Don't want to go to somebody's office. You got to have stuff that people are willing at least try.

Help-seeking behavior in the African American community is shaped by historical factors, with African American clergy playing a crucial role in addressing mental health

concerns (Boyd-Franklin & Lockwood, 1999). Therefore, it is important to develop a comprehensive understanding of the definition of culture.

Theme 4: Definition of Culture

According to the American Psychological Association (2003), culture is defined as belief and values that shape customs, norms, practices, and social institutions such as language, caretaking practices, media, and education systems. Arshad and Chung (2021) expounded on this definition of culture defining it as a system of shared meaning, beliefs, and values acquired through shared activities which is subject to change over time. For the purpose of this study, each participant shared their own unique concept of culture, which resulted in a definition that was both rich and comprehensive. Participant one in group one shared, "I think of everything that's in a particular place, that creates a culture." Participant one of group two stated, "I believe culture is the atmosphere, or environment in which one develops a personality." Participant two of group two defined culture by stating,

> Culture is this external thing, but that doesn't come, you know, just simply because that doesn't come, you know, but it comes to exposed, to your exposure of things that you've done and that in the sense governs our conduct…that's why people say you just can't have someone come into your neighborhood and all a sudden they exhibit the culture of that neighborhood. It is taking time, how you are raised and what you think, you know?

Participant two of focus group one summed the definition of culture up in three words, "family, community and values." Based on their definition of culture, the participants

were asked to disclose their method of determining whether are resource was culturally relevant.

Theme 5: Determining Cultural Relevance

Participants readily shared their thoughts on what would need to be present for a document to be deemed culturally relevant. Participant one of focus group two shared:

> It's important that the resources coincide with the action, activities as well as the learning curve within the community. What applies to the environment is based on the need of the people within the community. And the biggest thing that people have, the biggest problem that people have is for a stranger to come in their community and try to tell them what they shou do. This is the biggest negative in any community. I don't care what race you are, what color you are, even nationality you are. You can't go into certain areas and basically want that community to listen, agree and cooperate with your presentation. You have to win people's agreement, understanding and most of all you gotta win their support. So, it's important for us to know the community in which we're operating in and know the people. Something about the people in that community in order to have an effect, a positive effect in that community that they would welcome you.

Participant one of focus group two provided a detail explanation of the process they would employ to assess the cultural relevance of a resource:

> First thing, I would do is see who wrote it. That's the first thing or who provided this resource. That's the first thing I would see and the reason why I say that is you know, if you've never been a part of a culture, if you never had experience

> with a culture, how can you speak life to that culture. How can you give resources to that culture?

The final question asked of each participant was suggestions on possible revisions to the guide to make it more culturally relevant and useful for addressing mental health concerns in the African American community. This was critical as literature indicated that culturally tailored resources could potentially enhance mental health literacy among African American clergy while also increasing their self-assurance in supporting those experiencing mental health challenges (Hagen et al., 2020).

Theme 6: Clergy Suggestions

Participants in each focus group had distinct suggestions that they believed would be beneficial in making the present guide more culturally relevant and useful for them. Participant two of focus group two suggested, "if you could come up with some label that would make it more interesting." Participant one of focus two focused on the content of the mental health guide in its present format:

> The biggest thing that I always see when you look at something such as this guide, that you want content. You want something there that would kinda stand out to draw people's attention…That would draw people's attention to want to know more about what's on the inside.

To address the general nature of the present guide and its lack of focus on addressing the specific problems within the African American community, participant one of group one offered these words:

> For in African American health, I mean, right here, just mental health guide for Faith leaders, to me that's general. And I know working on a doctoral degree, general is good, but the finer you can get it or the more pinpoint you can get it the better it is and so, I would share that lens and then look through it. I do think general statements of what is mental illness, common mental illness, suicides, diagnosis, things of that nature, I think those are all general. I also believe that in the African American community, that we also might have traumas that are more, we might also have illnesses or mental illnesses or mental health things that most people might not even think about.

Participant two of focus group one addressed patterns and behaviors within the African American community that may be the result of trauma:

> You see the behaviors, right? And you see certain patterns. But like he said, those certain patterns and certain behaviors, in certain things are caused by trauma that comes from certain things in our communities. So that's where it needs to probably be more targeted at, for direct incidents and situations cause certain communities, you're not, you know, you're not gonna have, I mean, everybody got the same thing pretty much, right? But it's gonna be different. No, so yeah, we probably need to adapt it to our own personal situations in our own communities.

While each of the aforementioned themes was in alignment with the questions asked, clergy mental health was not. The study aimed to explore how African American clergy perceived the cultural relevance and usefulness of the mental health guide for faith leaders. Clergy were also asked to provide suggestions to making it culturally relevant if

needed. However, the final theme that emerged pointed to the significant responsibility African American clergy have in addressing mental health issues, and the impact of this responsibility on their own mental well-being.

Theme 7: Clergy Mental Health

Although not anticipated, the theme of clergy mental health emerged with clergy sharing the impact caring for members and the community had on their own mental well-being. Participant one of focus group one spoke of clergy dealing with emotional issues:

> And so, I always say this, hurt people hurt people and unfortunately, perhaps the most hurt person in the congregation is the pastor and unless the pastor is willing to seek that help, unless that pastor is ready to seek mental health then you gonna spread your trauma on everybody else… I mean, before you help someone else. Well unfortunately, being a pastor, we don't always take care of ourselves right. We don't get a lot of sleep, we don't get a lot of rest. We have meetings that we got to deal with people. We got to deal with the community and things of that nature and all this causes trauma. And so eventually, it is going to leak out. And so now it does not only impact the people in the church but it also impacts your community.

Participant two of group one weighed in on the topic of clergy mental health stated:

> You know, um, on the clergy side, on the side of mental health it's a lot, a lot of weight. A lot of ah, protocol and images that need to uphold, right? And expectations from what the congregation expects from us and what other ministers expect from us. Right? It's sometimes comparable to, a being in the

Armed Forces. You know, you take off, you wear the uniform, you know, you have a certain image to uphold.

While this study utilized very small focus groups, each of the four participants contributed significantly to the discussion, resulting in rich and descriptive data. Every response to the questions asked provided clear and concise data which in turn resulted in the seven themes discussed in this study. Although not initially considered at the onset of this study, clergy mental health is a theme that cannot be overlooked.

Summary

This chapter presented the outcome of the study, showcasing codes, themes and subthemes that addressed the research question. I began by detailing the setting, explaining that the focus groups were conducted over Zoom. Demographics were also provided, indicating a decrease in participant size and the utilization of a very small focus group (Toner, 2006). The duration of each focus group was noted, followed by an explanation of data collection and analysis processes.

Additionally, the chapter discussed trustworthiness, including evidence of credibility, transferability, dependability, and confirmability. This chapter was concluded with results, featuring a table of themes and subthemes followed by direct participant quotes addressing the research questions.

In Chapter 5, the researcher will provide the interpretation of the findings and compare them to the peer-reviewed literature discussed in Chapter 2. The analysis of these findings will be conducted through the lens of critical race theory. Chapter 5 will

also discuss study limitations and provide recommendations and implications for social change.

Chapter 5: Discussion, Conclusion and Recommendations

The purpose of this basic qualitative study was to explore how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (see APAF, 2016) in addressing mental health concerns within the African American community. CRT was used as the theoretical framework for this study, which allowed for findings that were grounded in the experiences and knowledge of people of color. I found that although the guide was useful in providing general information on mental health, it was not culturally relevant and useful for addressing issues specific to the African American experience.

Interpretation of the Findings

In this section, I interpret the findings and compare them to the finding in the recent literature as discussed in Chapter 2. The seven themes found in this study were (a) trauma, (b) challenges to addressing mental health, (c) help-seeking behavior, (d) definition of culture, (e) cultural relevance, (f) clergy suggestions, and (g) clergy mental health. This chapter provides an analysis of the relevant literature and the theoretical framework that was used to guide the study. In this section, the findings are organized based on the research question, highlighting the connections with recent literature. The research question was as follows: How do African American clergy perceive the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders?

The research question was developed to explore African American clergy's perception of the relevance and usefulness of the mental health guide for faith leaders. The focus was to determine whether in its present format the guide was culturally

relevant and useful for African American clergy to address the mental health needs within the African American community. Existing literature pointed to the historical perpetuation of systemic racial oppression by institutions such as the APA (2021) within the African American community. Moreover, the literature highlighted the Black church as a pivotal institution within the African American community, stemming from years of enslavement and Jim Crow segregation. Literature indicated that, over time, the church emerged as a steadfast, unified, and autonomous establishment providing spiritual, political, economic, educational, musical, and psychological guidance and support (Lincoln & Mamiya, 2003; Ruiz, 1990).

The literature also indicated that a significant portion of African Americans rely on African American clergy as their primary support system for addressing mental health disorders (Anthony et al., 2015). This has been attributed to African American clergy holding a favorable position as gatekeeper within the African American community due to their prominence, perceived credibility, and lack of associated stigma (VanderWaal et al., 2012). The clergy members are often sought out as personal counselors and spiritual advisors, particularly regarding issues of mental health challenges. Furthermore, the literature suggested that some clergy may view mental health disorders as a manifestation of spiritual weakness, lack of faith, or the influences of demonic forces (Anthony et al., 2015).

The literature highlighted that assessments and research conducted by White psychologists that used White individuals as the norm resulted in the portrayal of African Americans as inferior and intellectually deficient, which perpetuated the notion of White

superiority (APA, 2023). According to the recent literature, the APA (2021) acknowledged that these feelings of institutional mistrust are justified, admitting to, and apologizing for their contribution to systemic inequalities, acts of racism, discrimination, the marginalization of people of color and the promotion of White supremacy. According to recent literature, African American cultural beliefs regarding mental health are influenced by a legacy of racism, discrimination, and personal experiences that have shaped their help-seeking behavior (R. Campbell & Long, 2014). Of the four participants in the current study, one did not see discrimination as an issue that affects individuals in American society. Instead, the participant noted that the issue is a sin and greed problem.

Previous studies showed that the need for mental health resources and training for clergy is not a recent development. The literature revealed that in 1956, The National Institute of Mental Health and the Academy of Religion and Mental Health awarded grants to Harvard, Loyola, and Yeshiva Universities to develop mental health training courses for clergy (Hollander, 1962). Although there are numerous mental health resources available for clergy, the Mental Health Guide for Faith Leaders developed by the APAF was the most comprehensive. Recent literature emphasized the importance of engaging in trusted stakeholders such as clinicians and African American clergy members who are widely acknowledged as credible sources of information (Hankerson et al., 2021.) Literature also highlighted that involvement in this effort is crucial for advancing a more informed and established standard of care (Coombs et al., 2022) aligning with the APA's (2021) efforts to address and eradicate racism in the field of psychology.

The themes and subthemes were reviewed through the theoretical lens of CRT to explore African American clergy's perception of the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders. The examination of the impact of trauma in African American history using the permanence of racism tenet revealed the lasting effects of racism and its continuous influence on societal dynamics and systemic inequality, resulting in ongoing trauma within the African American community. An examination of how African Americans assimilated into the dominant society was viewed through the lens of CRT's concept of interest convergence, which suggests that progress in civil rights and social justice for marginalized groups such as African Americans is more likely to occur when their interests align with those of the dominant White society. In the current study, the desire for equality may have been motivated by the belief that conforming to White cultural standards would lead to equality.

The analysis of cultural relevance and guide suggestions yielded valuable insights into CRT's tenet of liberalism. These insights revealed how the colorblind ideology often masks the privilege and power of the dominant society. Although current participants recognized that the guide offered valuable insights into general mental health topics, they also noted that it was too vague and lacked cultural relevance and insight to the specific experiences and needs of African Americans.

Finally, the comprehensive data collected from African American clergy support the tenet of the CRT counternarrative, which posits that African Americans, due to their direct experiences with White culture, have a heightened awareness of the pervasive nature and effects of racism. This perspective emphasizes the lived experiences and

narratives of African Americans as valuable sources of knowledge in understanding systemic inequalities. Within the context of mental health and the cultural relevance and usefulness of resources such as the Mental Health Guide for Faith Leaders, this counternarrative underscores the significance of the voices and experiences of African American clergy. Their insights provide a critical lens through which to examine the cultural relevance and effectiveness of such resources, particularly in addressing the mental health needs of African American communities. By acknowledging the unique perspectives and knowledge held by African American clergy, the current study aligns with the core tenets of CRT, which advocate for recognizing and addressing systemic racism and inequality.

Limitations of the Study

The purpose of this study was to explore how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders. This study was not without its limitations. There are limitations when conducting qualitative research because it emphasizes meaning rather than the generalizability of the findings (Mason, 2010). The limitation of the current study was the small sample size, which relied on subjective data derived from participants' thoughts and lived experiences (see Crouch & McKenzie, 2006). Nevertheless, validity was established through VSFGs (see Toner, 2009). These VSFGs could be analyzed based on the characteristics of group development, showing that even with a small size, the typical process of group development still takes place (see Toner, 2009).

Recommendations

This study provided insight into how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (see APAF, 2016). The study filled the gap in the literature regarding African American clergy's perception of the usefulness of the guide for addressing mental health issues in the African American community. Recommendations for future research include conducting multiple focus groups with a larger number of participants. Furthermore, future research could focus on a quantitative or mixed-methods approach to examine whether age, gender, or geographical location have any significant impact on the outcome of the research.

Implications

The study's findings hold promise for promoting positive social change within the African American community, specifically for African American clergy and individuals and families who seek their support in addressing mental health issues. Offering culturally specific psychological interventions such as a resource for African American clergy may be instrumental in addressing the unmet mental health needs within the African American community (Mabunda et al., 2022). Adapting interventions and resources to align with the cultural experiences and needs of African American clergy could help to promote widespread dissemination of mental health education in a manner that could reduce stigma. The extensive data gathered from African American clergy provide strong support for the counternarrative of CRT. This counternarrative suggests that African Americans, due to their firsthand experiences with White culture, possess a

heightened awareness of the pervasive nature and consequences of racism. This perspective highlights the importance of considering the lived experiences and narratives of African Americans as valuable sources of knowledge in comprehending systemic inequalities, the impact on mental health, and what is needed for the development of culturally relevant resources.

Conclusion

The purpose of this basic qualitative study was to explore how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders developed by the APAF (2016). To address the current gap, I explored how African American clergy perceived the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders, which is the most comprehensive resource available to clergy. This guide served as an initial point for me to explore its cultural relevance and usefulness from the perspective of African American clergy. The current study has the potential to augment existing studies and offer culturally relevant mental health resources for African American clergy to address the mental health issues within their community.

Two VSFGs consisting of two African American clergy members were conducted via secure Zoom. The participating clergy had a minimum of 10 years of experience in their role and had currently or recently served for at least 5 years at a predominately African American church. Following the data collection from these focus groups, the data were analyzed, revealing seven themes. These themes included trauma with five subthemes, challenges to addressing mental health with six subthemes, help-seeking behavior with five subthemes, definition of culture with eight subthemes, cultural

relevance with six subthemes, guide suggestions with four subthemes, and clergy mental health with three subthemes.

All participants recognized the guide's value in discussing mental health issues, but they emphasized the need to include content that is specifically relevant and useful for the African American community. Participants highlighted the importance of incorporating culturally specific topics that cater to the needs and experiences of the African American community to ensure cultural relevance of the guide. When addressing the issue of discrimination, one participant did not view discrimination as an issue that affects American society; instead, the participants cited a sin and greed problem in America. Participants expressed the importance of using images that accurately reflect the intended audience. Participants also expressed their concern regarding the availability of mental health professionals who possess knowledge and understanding of the experiences and needs of African American communities. Participants emphasized the importance of professionals who can address mental health issues while also respecting individuals' faith and spirituality.

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Appendix: Focus Group Interview Guide

Hello everyone, I am Lisa Harris and I want to thank you all for your decision to participate in this study. I am a doctoral student at Walden University and this study is the foundation of the dissertation required for completion of the degree. The purpose of this study is to explore how you as African American clergy perceive the cultural relevance and usefulness of the APA Mental health guide for faith leaders that was emailed to you when you consented to participate. I would like to say once again that your personal identity and church affiliation will be kept confidential during and after the research is concluded.

Research Question

How do African American clergy perceive the cultural relevance and usefulness of the Mental Health Guide for Faith Leaders (American Psychiatric Association Foundation, 2016)?

Focus Group Questions

1. I would like to start by discussing challenges that may impact the mental health of individuals in the African American community. Could you please share your thoughts and experiences on this matter?

2. The guide mentions how stigma, prejudice, discrimination, and stereotypes impact individuals belonging to various cultural backgrounds. Based on your experiences and the information you have provided; how do you believe these issues impact the mental health of African Americans?

3. I would like to ask each of you to share your personal definition of culture.

   Based on your definition of culture, please share how you would go about determining if a resource is culturally relevant?

4. In reviewing the guide, would you say that in its present format, it is culturally relevant for your use?

Probe: If so, in what ways does the guide improve your comprehension of mental health from a cultural standpoint?

5. What potential changes to the guide do you believe may be made to ensure its cultural relevance for your use in addressing mental health challenges in the African American community?