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African American Clergy's Attitude Toward Professional Mental Health Services

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Abstract

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MD, Xavier School of Medicine, 2009

MBA, Gardner-Webb University, 2006

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Dissertation Submitted in Partial Fulfillment

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Abstract

Evaluating the attitude of African American clergy toward parishioners seeking professional mental health services for mental illness has important treatment implications. Religion and spirituality are equally important determinants of mental health and can affect African American clergy's attitudes toward professional care for mental illness. Utilizing the health belief model (HBM), this quantitative study examined the role of theological beliefs, education, and personal experience with mental illness as they correlated with clergy's attitudes toward seeking professional mental illness services. Approximately 98 African American Protestant Clergy in the states of Georgia and South Carolina participated in this study. Data were collected using self-administered surveys via e-mail and mailings using the religious attitude scale (RAS) and the attitude toward seeking professional psychological help scale (ATSPPHS). A multiple linear regression analysis was used to examine the correlation of independent variables. The results of this study indicated that theological beliefs ($p = 0.025$) but not education ($p = 0.084$) or personal experience with mental illness ($p = 0.078$) had a direct effect on the African American clergy attitudes toward parishioners seeking professional mental health services. This research supports the idea that conservative African American pastors' attitudes toward congregants seeking professional mental health services are positive. The results of this study can influence social change by increasing access through clergy's pivotal role as the gatekeeper for parishioners who seek help for mental illness.

African American Clergy's Perception of Mental Illness

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Dedication

I would like to dedicate this dissertation to my family for their encouragement and support through this journey. From the beginning you were there and now at the end I solute you for hanging in there with me. I am so grateful for my husband's help with life's balance and 'grind' when I wanted to give up. To my fellow believers in the ministry, may this be a testament on how God can utilize EVERY aspect of your life, if you let him.

Acknowledgments

I would like to acknowledge all who have played a major and minor part in making this happen. There are too many names to name, but most of all GOD! Thank you for the strength, wisdom, and knowledge to put it on paper. May my sacrifices bring you glory in the Kingdom.

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Chapter 1: Introduction

Introduction

The attitudes of African American clergy concerning professional mental health services is based on different schools of thought (Moran et al., 2005; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). With the diverse backgrounds of African American clergy, their treatment recommendations are most likely based on their attitude or perspective of mental illness. Attitudes are considered one-dimensional yet powerful in that they can influence how a person perceives information and then act on that information (Petty & Krosnick, 2014). In particular, there appear to be no consistent treatment recommendations for mental illness amongst African American clergy, which can either hinder or help congregants in psychological distress who are seeking professional mental health services (Lewis, Turton, & Francis, 2007; Stansbury, Beecher, & Clute, 2011). For example, while African American Baptist clergy share denomination and doctrine, they are still diverse in their education, theological beliefs, and personal experiences with mental illness, factors that could influence their attitude toward congregants seeking professional mental health counseling. Understanding these influences could benefit the practices of psychology, psychiatry, and religion by spurring improved resources for congregants and enhancing the referral process between clergy and mental health professionals (Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). This can also improve treatment outcome for the patient (congregant) by generating a more holistic treatment approach. This information can create opportunities for more engagement in mental health services for members of the African American faith

community by reducing the stigma associated with seeking professional mental health services and thereby mitigating help seeking disparities in mental health (race, socio-demographics, and culture competency) (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009; Payne, 2008).

Current literature states that those of faith receive more help for their psychological distress from their faith based community than from medical professionals (Corrigan, 2004). It is also known that individuals who attend churches with a positive attitude toward mental health services have more favorable attitudes toward seeking treatment; this is particularly true within the African American community (Chapman & Steger, 2010). In the African American community there is a general aversion to professional mental health services, turning instead to friends, family, and their religious beliefs for support (Hardy, 2012). It is not clear if this is due to a specific religion or other factors. Barriers to seeking mental health services for the African American community include but are not limited to stigma, shame or embarrassment, cultural mistrust, lack of knowledge, inadequate transportation, and lack of insurance or financial resources (Hardy, 2012; Taylor et al., 2000). While this reluctance can lead to seeking services elsewhere (e.g., friends, family, and the church), these alternate resources can also be considered a barrier to effective treatment. Friends and family may offer a sense of comfort, but that can delay professional services and reinforce a lack of understanding and fear of the mental illness (Mattis et al., 2007). Religious beliefs, while also comforting from a spiritual perspective, can also hinder believers from seeking professional services due to a concern of being perceived as weak or lacking in faith. A study by Obasi and Leong (2009) reports an inverse relationship between strong religious

faith and trust in professional mental health services. Obasi and Long also used the survey attitudes toward seeking professional psychological help scale (ATSPPHS) developed by Fischer et al. (1970) to assess help seeking attitudes of African Americans when they are faced with psychological distress. The results of their study supported the general census of research that psychological distress does affect the attitude of help seeking behavior but adversely (Constantine, Wilton, & Caldwell, 2003). As psychological stress increased, the participants' attitudes toward seeking professional mental health services were more negative. This was also one of the few studies that adequately represented the African American community while looking at the direct relationship of psychological distress versus behavior through service utilization (Vogel & Wei, 2005). A weakness of the Obasi and Leong (2009) study was that it was not able to determine other factors (other than religion) of influence within the African American community to predict their behavior. It is difficult to study the reasons why a person who considers themselves religious or spiritual would seek professional mental health services when they don't believe that the psychological distress they are experiencing is a medical problem (Boehnlein, 2006; Seybold & Hill, 2001).

Meanwhile, the African American church continues to be an avenue or gateway to at risk populations (African Americans, Latinos, African immigrants) faced with healthcare disparities (utilization, culture, access, education) in different areas of medicine (diabetes, obesity, breast cancer) (Allen, Davey, & Davey, 2009; Belin, Greene, & Washington, 2006; Hanmaker, 1998). Over the years, African American communities have faced a variety of influences such as crime and poverty that have caused fluctuations for the need of medical and mental health services. These influences go beyond the

influences of the African American church directly; however, despite the fluctuation, the church continues to be the dominant leader in providing diverse services and support when needed for the community and congregants alike (Baker et al., 2006; Belin et al., 2006). Considering the African American church is made up of different denominations that incorporate varying belief systems concerning mental illness. This can send conflicting messages to the communities in which they serve. Therefore, attitudes regarding help seeking behavior, especially those of African American clergy, may have an impact on the underutilization of professional mental health services and "on the duration, course, and outcome for treatment of those who actually seek professional psychological services" (Obasi & Leong, 2009, p. 227).

Background

Religion and spirituality are now considered part of the treatment plan for recovery due to its effect on mental illness (Brade, 2009). The effects of utilizing religion and spirituality in the treatment plan has shown predominately positive outcomes, with improved coping skills during psychological distress, particularly an increase in communication, and a general reduction of mental health symptoms such as depressed mood and anxiety (Hill & Pargament, 2008). However, causation has not been established between the two (Seybold & Hill, 2001). The literature does confirm that help seeking behavior toward clergy increases during psychological distress (Chapman & Steger, 2010; Corrigan, 2004). It is also noted that help seeking behavior can also be affected by an individual's theological beliefs, church attendance, and certain religious practices (Spriggs & Sloter, 2003). These interactions are known to have both negative and positive effects in regard to mental illness amelioration. For example, untreated

mental illness has led to suicide attempts as well as treated mental illness aiding relapse prevention for alcoholism (Hackney & Sanders, 2003). It is also apparent that high levels of religious or spiritual beliefs can lead to less discussion of mental health issues within the faith based community due to stigma (Phillips, Paukert, Stanley, & Kunik, 2009). Less discussion can further lead to denial or rejection of the existence of mental illness within the African American community due to a religious undertone of denial perceived by congregants as emanating from clergy. Payne (2008) did a qualitative study regarding statements made from the pulpit by African American Pentecostal preachers about depression. The study found that three out of 10 sermons substituted descriptive terms and phrases, such as "bottom falling out" or "cloudy or rainy days" instead of the words mental illness or depression (p. 222). The analyses showed that the term "depression" was associated with having a weak faith and being viewed as having a negative attitude concerning God. The sermons were also clear that using medication for mental illness instead of God was considered a poor substitute to reliance on the Holy Spirit. The study did not determine if clergy actually believe that mental illness existed in general, just that they did not believe it existed among those of the Christian faith. Therefore, it is evident that African American clergy have the opportunity to represent their religious beliefs from the pulpit concerning mental illness (Stansbury & Schumacher, 2008).

The role of African American churches in decreasing mental health disparity and stigma within the African American community is important to acknowledge (Belin et al., 2006). Studies show that mental health is essential in the ministry of African American clergy (Spriggs & Sloter, 2003; Vassol, 2005; Young, Griffith, & Williams, 2003). Clergy attempt to address the complex needs of their congregants, whether they

are social, psychological, spiritual, or physical. Their role could also include linking congregants with mental health professionals in order to provide the best treatment options, just as they would with physical health providers. Kramer et al. (2006) presents an interventional model demonstrating an integration of trust between clergy and mental health professionals. This intervention development model could provide opportunities to build trust between African American clergy and mental health professionals, decrease the stigma and increase awareness of mental illness, and improve treatment outcomes. The model begins with the recognition of the illness at its onset followed by determination of the cause, whether biological, psychological, cultural, or spiritual. This model suggests that clergy can intervene at this stage by being open to talking about mental illness from the pulpit to lessen the stigma. Another way for clergy to intervene is to encourage congregants to follow through with their outpatient treatment. The purpose of the study was to "develop a preliminary model of depression and depression care from the perspective of pastors of Southern Christian churches with predominantly African-American or Caucasian membership" (Kramer et al., 2006, p. 125). This study presented different perspectives based on race regarding how to handle depression in their congregants, but the model showed a consensus to address it from an institutional religious approach.

Personal experience with mental illness can offer different perceptions of mental illness versus those who have no experience at all. Different perceptions include favoring mental health treatment from secular counselors, treating mentally ill congregants versus referring or resistant behavior to what is not understood (Angermeyer & Matschinger, 1996). Darling, Hill, and McWeyl (2004) and Hills, Francis, and Rutledge (2004)

discussed the effects of stress on clergy and how that may influence the perceptions of clergy regarding mental illness. Moran et al. (2005) further evaluated the confidence of clergy based on their personal experience to refer congregants with mental illness to hospitals with pastoral care. The study found that clergy referred congregants to hospitals with pastoral care 8.5% more times than to hospitals without pastoral care. This was due to clergy perception of the importance of having a pastoral care department to take care of the congregant's spiritual needs during their illness. This finding was relative to the 54.7% that stated that they are more likely to refer to a hospital with a pastoral care department versus 16.2% who were not.

The literature does address the positive effects of religion and spirituality on mental illness as a whole (Hartog & Gow, 2005; Wachholtz & Sambamoorthi, 2011); however, there is limited research literature regarding African American clergy's attitude toward professional mental health services and the influences thereof. African American clergy are diverse in character and culture, which may influence their beliefs regarding mental illness. In the study by Kramer et al. (2006), clergy were not uniform in determining the etiology of depression, whether biological, psychological, spiritual, cultural, or social, which may be the cause of inconsistencies in their attitudes toward seeking professional mental health services. It would be expected that these etiologies could be affected by theological beliefs, level of education, and personal experience with mental illness, which in turn could impact their attitude regarding professional mental health services. Literature supports that the level of clergy's education influences their decisions to refer congregants to mental health services (Rumberger & Rogers, 1982);

however, the literature is limited on the effects of education toward the attitudes of African American clergy as it relates to professional mental health services.

Additionally, African American clergy are susceptible to experiencing mental illness whether personally or within their immediate family (Darling, Hill, & McWey, 2004). Clergy may offer themselves as a resource for their congregants without considering the personal consequences. Holaday, Lackey, Boucher, and Glidewell (2001) identified three consequences in a qualitative study of clergy's experience in counseling congregants: 1) burnout, 2) vicarious traumatization, and 3) secondary stress or compassion fatigue. Fewer than half of the participants received supervision when they began to counsel, with counseling amounting on average to 25% of their duties. Having supervision is essential to the training for and practice of psychotherapy or counseling services for mental health. It helps the practitioner maintain boundaries and identifies areas of concern (Hess, Hess, & Hess, 2008). Participants reported that the congregant's issues affected their personal trust of others, their decision-making process, their levels of intimacy with their spouses, and their confidence in solving congregants problems (Holaday et al., 2001). The participants were open about the lack of education, support, and collaboration with mental health professionals concerning mental illness for themselves. These consequences are the same experienced by mental health professionals; however, the clergy in this study spent less time counseling than do mental health professionals. The experiences of a clergyperson can be equivocal; with rewards of seeing others prosper and succeed balanced against concerns about their own personal challenges such as finances and marital issues (Lewis et al., 2007). In summary, the clergyperson tends to be exposed to insurmountable expectations, which can result in

self-defeating behaviors and can lead to mental illness manifesting as burn out, depression, or even suicide if not properly managed (Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). In another qualitative study, Darling et al. (2004), found that clergy reported quality of life satisfaction was inversely related to the psychological and physiological stress they experienced while in their role as clergy. Literature is also limited on how the views of African American clergy are affected by their personal experience with mental illness. This study sought to determine if personal experience with mental illness influences their attitudes on professional mental health services.

Problem Statement

The research problem to be investigated in this study focused on African American clergy as gatekeepers for mental illness for their congregants during psychological distress. While some African American clergy are comfortable with this position, others are not (Stansbury, Beecher, & Clute, 2011). Due to the flexible role of clergy, the chance of treatment error or misdirection of care increases as they are confronted with mental illness cases with only limited information or education (Stansbury et al., 2011b). The literature is clear that religion and spirituality are important in the African American community, with over 70% being members of a church and 84% considering themselves religious based on the National Survey of Black Americans (Hankerson & Weissman, 2012). Due to the significant role of the African American church in the life of the community and the availability of clergy for counseling services in times of psychological distress, parishioners are less likely to seek professional mental health service (Allen, Davey, & Davey, 2010). The literature does present inconsistencies among African American clergy regarding beliefs about mental illness that could affect

their attitude regarding professional mental health services (Leavey, 2010; Stanford & Philpott, 2011). These inconsistencies are related to the diverse backgrounds of African American pastors from which emerge a plethora of beliefs and attitudes regarding congregants seeking professional mental health services (Earl, Williams, & Anglade, 2011; McMinn, Staley, Webb, & Seegobin, 2010). While clergy do provide counseling care, it is not clear what their attitudes are about help seeking behavior and how their education, theological beliefs, and own personal experience with mental illness, impact their attitude. This particular study examined the degree of influence of African American pastors' theology, education, and personal experience with mental illness on their attitude toward congregants seeking professional mental health services. Mental health disparities will be substantial within the African American community if mental healthcare is delayed or not accessed, which affects the public health of all (Earl et al., 2011). In particular cultural competency that includes: community context, cultural characteristics of local populations, organizational infrastructure, and direct service support (Hernandez et al., 2009). The congregants' responses to mental health services are within the context of the community (the church). African American clergy have to reiterate their understanding of mental illness and appropriate response in a positive manner that will encourage the congregants to view and respond the same way (influence by the culture in which that person is in.

Purpose of the Study

The goal of this quantitative study is to correlate theological beliefs, education, and personal experience with mental illness (independent variables) with African American clergy's attitudes (dependent variable) regarding help seeking behavior of their

congregants for professional mental health services. The purpose of the study was to understand the influence of the African American clergy on help seeking behavior for mental illness or psychological distress. The study looked at the influences of theology, education, and personal experiences with mental illness regarding clergy attitudes toward seeking professional psychological help. The significance is that African American clergy and the church are considered gatekeepers for mental health issues in their community (Allen et al., 2009). The clergy and church serve as gatekeeper for many aspects of community life. Their role as first responders specifically for mental illness has yet to be identified or exposed. Clergy's overall attitude regarding mental illness in general can affect the level of utilization of psychological services, which can affect the prognosis and treatment efficacy for those who do use professional mental health services (Vogel & Wei, 2005). Bringing greater cultural awareness to the role of clergy and church in helping to provide access to formal mental health services may lead to increased referrals, which could better serve the mental health needs of the African American faith based community (Parrill & Kennedy, 2011; Allen, Davey, & Davey, 2010). This includes improving alliance and collaboration between the leaders of the African American church and the mental health system.

Research Question

The overarching research question for this study was: Is there a correlation between theological beliefs, education, and personal experience with mental illness and African American pastors' attitudes toward seeking professional psychological help? The independent variables were theological beliefs, education, and personal experience with mental illness, and the dependent variable was the pastor's attitude toward seeking

professional psychological help. I hypothesized that theological beliefs, education, and personal experience with mental illness do influence African American pastors' attitudes toward seeking professional psychological help.

RQ1: Is there an association between theological beliefs and African American pastors' attitudes toward seeking professional psychological help?

$H_0$1: There is no association between theological beliefs and African American pastors' attitudes toward seeking professional psychological help?

H_a1: There is an association between theological beliefs and African American pastors' attitudes toward seeking professional psychological help.

RQ2: Is there an association between education and African American pastors' attitudes toward seeking professional psychological help?

$H_0$2: There is no association between education and African American pastors' attitudes toward seeking professional psychological help.

H_a2: There is an association between education and African American pastors' attitudes toward seeking professional psychological help.

RQ3: Is there an association between African American pastors' personal experience with mental illness and their attitude toward seeking professional psychological help?

$H_0$3: There is no association between African American pastors' personal experience with mental illness and their attitudes toward seeking professional psychological help.

H_a3: There is an association between African American pastors' personal experience with mental illness and their attitudes toward seeking professional psychological help.

Definitions of Terms

African American (Black) church: For this study it represents a group of individuals attending a Christian based church of a historically African American denomination and/or predominately African American congregation, for example, African Methodist Episcopal Church (AME), The National Baptist Convention (Baptist) or Pentecostal (Church of God in Christ). The African American church has been a cultural sustainer in the African American community for a range of issues including social, political, health, and economic. The African American church has been defined as a mixture of common beliefs, rituals, and experiences that can determine processes and plans to address pressing social problems in the African American community (Barnes, 2005). Barnes (2005) further clarifies the characteristics of the church:

> (1) Common belief and unwavering confidence in a just, impartial God; (2) reminders of the inherent value of people of African descent and their right to equality in all its forms; (3) biblical examples and themes of victory over seemingly insurmountable odds and individuals who act as they anticipate deliverance; (4) shared communication with the Deity during corporate prayer; and (5) singing to fortify courage and provide meaning during challenging times—all spur continued commitment, provide a common, reassuring language, and frame pending events. (p. 967)

Clergy: Designated or appointed leaders of a faith based organization or religious group who help individuals come together under one faith as a group (Chalfant et al., 1990). Clergy are represented in many denominations in diverse forms. In this study, I looked specifically at African American clergy who represent leadership in the African American church with a predominately black congregation. For the purposes of this study, clergy was considered synonymous with the terms pastor, minister, bishop, or preacher.

Mental illness: Mental health becomes an illness or disorder when an individual's daily function is affected by an imbalance of emotions and behavior, ultimately leading to psychological distress such as depression, anxiety, stress, and so on. (Hackney & Sanders, 2003). According to the American Psychological Association DSMIV (1994), a mental disorder is defined as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important area of functioning) or significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. XXI).

*Mental health professionals***:** According to Harris, Edlund, & Larson (2006) mental health professionals are trained individuals who "refer, assess, and treat" individuals who are psychologically distressed (p. 396). This is a formal system that utilizes many types of professionals in different settings, for example, psychiatrists, psychologists, counselors, social workers, physicians, and nurses. The role and perception of *mental health professionals* by African American clergy is the question to be answered in regard to the extended role of clergy as religious counselors (Duhl, 2001)

Theological beliefs: Christian beliefs and views that are measured by the religious attitude scale (Poppleton & Pilkington, 1963). In this particular study, the survey measured African American pastors' theological beliefs from being either liberal or conservative. Studies have shown that clergy who are more liberal seem to be more accepting of congregants seeking mental health services versus the more conservative pastors who are more rigid in their theological beliefs (less open) (Barnes, 2005; Koenig, 2009).

Theoretical Foundation

The theoretical foundation for this research was the health belief model (HBM) originated by Rosenstock (1966). It is based on the influence of health behavior by personal beliefs (experiences) and perception of a disease (Janz & Becker, 1984; Rosenstock, Strecher, & Becker, 1988). This model utilizes four basic constructs to predict an individual's behavior to the threat and risk of having a certain disease: the perceived seriousness of the disease, the perceived susceptibility of the disease, and the perceived benefits and barriers to taking action (Janz & Becker, 1984). It has been predominately used for physical health education and promotion (mammogram screening for breast cancer, exercise program for obesity, condom use for sexually transmitted disease, etc.) to decrease the risk and incidence of a disease in a community through interventions. The HBM was relevant to this study because African American clergy attitudes regarding professional mental health services affects the perceptions of congregants regarding susceptibility, seriousness, barriers to action, and benefits of treatment for mental illness (Kramer et al., 2006). Those clergy who hold a conservative view tend to have a view of mental illness in contrast to that of mainstream American

society and are often unwilling to work with professional mental health providers (McMinn & Runner, 2005). This contrast is projected from the perspective of the religious–spiritual framework of the clergy that may create suspicions of mental health professionals lacking an understanding of the God-concept (Meissner, 2009). The religious–spiritual framework is fluid in nature and difficult to measure; however, we do know that it encompasses several theories and assumptions that are too complex for this study (Hill & Pargament, 2008). Meissner (2009) referenced the contrast between theology and psychology as an intellectualization conversation regarding the God-concept. He reports that theologians regard the meaning of God from a religious–spiritual perspective that relies on a revelation through faith that God exists, creates, and acts in the world on behalf of the individual. The reflection of the philosophical view is stated as, " God as known or knowable only by the inherent subjective capacity of the human mind as opposed to the concept of the Godhead as known objectively through revelation and faith as really existing, creating, revealing, and saving" (p. 211).

Utilizing the HBM, African American clergy attitudes toward mental health professionals are expected to be positive if clergy perceive that the congregants are experiencing a mental illness. Predicting the threat and risk of having a mental illness from the perspective of the clergy would be based on several factors. For this study we looked at theological beliefs, education, and personal experience with mental illness. The perception of seriousness with a congregant's psychological distress is a question clergy would have to ask themselves to determine the next course of action, to personally counsel or to refer (Stanford & Philpott, 2011). The primary objective of the clergy in the role of counselor is to offer understanding and support to congregants who are faced with

a mental illness, which may lead clergy to underestimate the seriousness of the condition (McMinn & Runner, 2005; Stanford & Philpott, 2011). The second part of the HBM is for clergy to determine how susceptible the congregant is to having the mental illness that would warrant a referral. This stage of the model would rest on the education of the clergy to be able to take appropriate history and determine the congregant's risk (Moran et al., 2005). Lastly, clergy must determine if the congregant accessing mental health professionals is in keeping with their shared religious–spiritual beliefs and therefore could be presumed beneficial. Recommending reliance on nonreligious persons to manage a condition that is considered spiritual would create internal conflict for the clergy (Leavey, Loewenthal, & King, 2007; Vespie, 2007). Their attitudes toward mental illness may therefore determine their attitudes toward professional mental health services for their congregants.

Nature of Study

This quantitative correlational study used a multiple linear regression design to examine the correlation of theological beliefs of Protestant African American clergy, their education, and their personal experience with mental illness as it relates to their attitudes toward seeking professional mental health services (Creswell, 2009). The statistical package for the social sciences (SPSS) was used for all analyses. This study surveyed African American adult clergy between the ages of 25 and 65with active ministries in African American churches of the Protestant religion in the state of Georgia and South Carolina within the last year. The study utilized the religious attitude scale (Poppleton & Pilkington, 1963) to evaluate the theological views and the attitude toward

seeking psychological professional help scale to examine clergy attitudes toward congregants seeking help from mental health professionals (Fischer et al., 1970).

Assumptions

In this study it was assumed that African American clergy (the respondents) have addressed mental illness in their ministry and would therefore should have an opinion of their congregants seeking treatment from mental health professionals (MHPs) versus counseling the congregants themselves. This assumption is necessary because clergy are considered first responders for the needs of their congregates in general and if they are faced with a mental illness, it highly likely they will be the first to know or respond (Allen et al., 2009; Creswell, 2009). This would therefore make the assumption true.

Currently clergy are in a dilemma in addressing mental health treatment because their personal ministry can be viewed as either positive or negative (McMinn, Ruiz, Marx, Wright, & Gilbert, 2006; Payne, 2008a). Positive if it is in line with their current religious-spiritual beliefs and negatively if it appears too secular (the referral). This assumption is meaningful because this study directly measured the attitudes of African American clergy regarding MHPs in relation to their theological beliefs, which plays a major role. The theoretical framework (HBM) used in this study also suggested the clergy's attitude regarding professional mental health treatment is grounded in their religious–spiritual perspective. This is based upon the assumption that most African American clergy use the religious-spiritual framework as the foundation for the decision in counsel regarding congregants in search of psychological counseling. Rather than relying on influences from their educations or personal experiences concerning

professional mental health services (Mattis & Jagers, 2001), using their theological beliefs appears easier.

Limitations

Religious–spiritual beliefs can be fluid in nature and therefore a difficult subject for a study of this nature. Each pastor comes from different religious experiences and different schools of thought. Circumstances within or outside the church could influence the pastors' attitudes regarding professional psychological services. Due to these variations, it would be difficult to generalize and categorize pastors according to their specific religious beliefs (Vespie, 2007).

Because this study used a self-reported survey measuring theological beliefs of clergy, it would be safe to assume that there would be a religious bias affecting their responses. Clergy may reveal only what they wish even if it is contrary to what they personally believe in order to stay in concordance with their theological beliefs (Creswell, 2009). Therefore the responses may be limited or less truthful due to this potential bias.

This study was limited to churches listed on the Internet *Yellow Pages* or registered with a solicitation service as a predominately African American church in the states of Georgia and South Carolina. This was due to my inability to get permission to use a database of addresses for the National Baptist Convention of Georgia, USA, Inc., which is a large, predominately African American organization of Baptist clergy in the south. An inability to draw broad conclusions about all African American clergy based on the survey distributed in two states is a limitation of this study.

Scope and Delimitations

The study population was African American clergy of predominately black churches or of historically African American denominations located in the states of Georgia and South Carolina. African American clergy of non-African American congregants were not included in this study. Race can be a limiting factor if the clergy and congregants are non-African American. Thus, this study was void of non-African American denominations and other races with regard to clergy's attitudes' regarding congregants seeking professional mental health services. These differences in denomination and race are difficult to control for in the study (Creswell, 2009). Future research may be indicated to determine the effects of different denominations by not factoring in race as it relates to clergy's attitudes toward professional mental health services. The perspectives of other races, especially European American clergyman were excluded from this study because it is unlikely that they lead congregations that are predominately African American, which is the focus of this study.

The methodology chosen was intended to be a representative sample. It was assumed that those who choose to respond were representative of African American pastors who led African American churches. It is possible, however, that those who chose to participate were not representative of all African American pastors in the south (Creswell, 2009).

Significance of the Study

The goal of this study was to determine if theological beliefs, education, and personal experience with mental illness influenced African American clergy attitudes regarding professional mental health services. The purpose was to understand the role of

the African American church and clergy regarding mental illness in the African American community by understanding the influences of African American clergy. This is significant because African American clergy and the church are considered gatekeepers for mental health issues in their community, and there may be a need for more culturally diverse interventions within the community (Allen, Davey, & Davey, 2010). In response to such a need, formal mental health services could potentially be better aligned with the needs of the African American faith based community, manifesting in increased culture awareness and greater access to services (Allen, Davey, & Davey, 2010; Parrill & Kennedy, 2011). In addition to assessing the attitudes of clergy to determine the effects of those attitudes on the outcome of mental illness interventions for their congregants, and a strategy for improving alliance and collaboration between the leaders of the African American churches with mental health professionals could potentially lead to more evidence based mental illness treatment practices.

Summary

This study looked at the role of African American clergy in the life of congregants with mental illness and the effects of seeking help from professional mental health services (Allen et al., 2009; Taylor et al., 2000; Vassol, 2005). A study that examines African American clergy perspective of congregants seeking mental illness treatment from mental health professionals was needed. Previous studies (Corrigan, McCorkle, Schell, & Kidder, 2003; Payne, 2008; Segal, Coolidge, Mincic, & O'Riley, 2005) have primarily focused on congregants' view of utilizing mental health professionals for mental illness. Due to the leadership of the African American church taking on the role as first responders to mental illness, it is important to determine their attitude regarding

congregants seeking services from mental health professionals. Recent research shows that African American clergy referral decisions are less favorable compared to referrals from mental health professionals to clergy (Lish, Fitzsimmons, McMinn, & Root, 2003; MR McMinn & Runner, 2005). Among the variables that influence the perceptions of African American clergy in regard to mental illness are their theological beliefs (Kramer et al., 2006; Phillips et al., 2009), level of education (Shabezz, 2002), and personal experience with mental illness (Doolittle, 2007; Lewis et al., 2007). While these variables affect clergy's perception of mental illness in general, there is little known about how they affect clergy's attitudes toward professional mental health services. This is important because congregants' perceptions of religious–spiritual directives and confidence in professional treatment could be affected (Young et al., 2003) by what they hear from the pulpit and in counseling with clergy. Doolittle (2007) examined the burnout of clergy but did not determine if burnout affected their role as first responders to mental illness. Again, this supports the need to conduct this research among African American clergy to determine if these three variables correlate to the clergy's attitudes toward professional mental health services.

Chapter two addresses a review of the existing literature comparing the relationship of African American clergy and professional mental health services. The chapter begins by examining the role of the African American church in dealing with mental illness. Chapter two will also describe the role of pastors in mental health counseling and their attitudes toward professional mental health counseling. The different approaches of pastors toward counseling will also be reviewed. Finally, there is a

discussion of health beliefs regarding mental illness that are specific to the African American community.

Chapter 2: Literature Review

Introduction

While the literature currently shows positive effects of religion and spirituality on mental health, the relationship is unclear, as there are numerous factors to consider (Hartog & Gow, 2005; Wachholtz & Sambamoorthi, 2011). Clergy or pastors who serve as spiritual leaders in the African American community are considered the gatekeepers to this relationship. The literature offers limited information about the influences of African American clergy in guiding their congregants who are faced with a mental illness (Vespie, 2007). The literature is also limited in understanding African American clergy's attitudes toward mental health professional services in general. The purpose of this study was to determine the effects of theological beliefs, education, and personal experience with mental illness as influences on the attitudes of African American clergy regarding professional mental health services.

The purpose of this literature review was to examine the role of African American pastors as counselors to congregants with a mental illness. Specifically, the review will look at how this role influences their attitudes toward congregants seeking professional mental health services. The review also examines if African American clergy favored mental health professional counseling for congregants who have a mental illness.

The review discusses the tension that exists in religion between spiritual and medical views of mental health as it relates to the attitudes of African American pastors toward seeking professional mental health counseling. The review will also consider the effects of education on African American clergy attitudes. A thorough review of the psychology and theology literature related to this topic is presented for further

understanding. The review discusses the different approaches African American clergy use for counseling, the extent of religious–spiritual beliefs on their attitudes toward mental illness, and the beliefs of African American clergy regarding mental health. Finally, the literature review establishes the groundwork from which to measure the perceptions of African American clergy attitudes toward seeking professional mental health counseling for their congregants.

Literature Search Strategy

This critical literature review of the relationship between mental health and religion utilized electronic databases include Google Scholar, PsycINFO, PubMED, Academic Search Primer, PsycArticles, Dissertation Abstracts International, and Psychology: A SAGE full text collection. The articles published since 1990 were critically reviewed, along with any relevant material prior to 1990 in order to better understand the association between mental health and religion. The search terms used were *religion, spirituality, African American pastor/clergy, African American mental health, psychological counseling, African American clergy education, and African American church*.

Themes from the literature were the role of the African American pastor as counselor, the African American pastor's approach to counseling, the religious–spiritual influence on mental health, and the relationship between theological beliefs, education, and personal experience with mental illness on the attitudes' of African American clergy regarding professional mental health services. The literature was reviewed under these themes.

Theoretical Framework

The HBM originated by Rosenstock (1966) is based on how health behavior is influenced by personal beliefs and perception of a disease, a sociocognitive perspective (Rosenstock, Strecher, & Becker, 1988; Janz & Becker, 1984). It was developed by a social psychologist to better understand why individuals choose not to utilize preventive behaviors to detect early signs of disease, and their response to symptoms as well as compliance to treatment (Janz & Becker, 1984). This model utilizes four basic constructs to predict an individual's behavior response to the threat and risk of having a certain disease: (a) the perceived seriousness of the disease, (b) the perceived susceptibility of the disease, (c) and the perceived benefits to taking action or making a change, and (d) the perceived barriers to taking action or making a change (Janz & Becker, 1984). The theory is based on the personal beliefs—interpersonal factors—that explain or justify behavior. Over the years it has been expanded to include cues of action, motivating factors, and self-efficacy (Stretcher & Rosenstock, 1997).

The perceived seriousness of a disease is based on medical knowledge, information, or expected difficulties the disease would cause if contracted. The perception of susceptibility is considered the most powerful component that motivates behavior, the intention being to decrease behavior that potentiates risk. The behavior can be positive or negative depending on the risk of getting or having the disease. There is an inverse relationship between susceptibility and risky behavior (Stretcher & Rosenstock, 1997), but not in all settings. That is, the higher the perception of susceptibility, the less likely the individual is to engage in risky behavior. On occasions, the perception of the benefits of the behavior outweighs the risk and the behavior does not change. An

example of this is college students who continue to have unprotected sex and are consequently at risk for HIV, but do so because their perception of the chances of contracting the disease is low. Another scenario is that the combination of the perception of seriousness and susceptibility creates a perception of threat, which is a greater opportunity for change (Henshaw, Freedman-Doan, & Michigan, 2009). In addition, an individual may determine the benefits of adopting a certain behavior in order to avoid risk. The rational thought would be that the benefit is in not getting the disease, however people tend to look for additional positive rewards before considering a change in behavior (Henshaw & Freedman-Doan, 2009). The perception of the benefit of avoiding a disease encourages preventative screenings such as breast self-exam for breast cancer or colonoscopy for colon cancer. Janz & Becker (1984) stated, however, that the perception of barrier is the deciding factor for change. For this construct the individual must consider what would hinder change and then decide that the benefits would outweigh the barriers. The identified barrier in this case is no longer a possibility that can affect behavior.

These four constructs are important in determining behavior change, but there are additional external and internal modifying factors, personal characteristics, that can also influence the behavior (Stretcher & Rosenstock, 1997). Level of education, personal experience, and cultural beliefs and practices are a few examples. An additional influence on change in the HBM are cues to action (Carpenter, 2010). Cues to action is a fifth factor recommended by Henshaw et al. (2009) to the HBM. Cues to action are awareness of signs, symptoms, and potentiating factors of the disease, whether personal, such as an individual's awareness of a family history of mental illness, or from an external source

such as a pamphlet seen in a church bulletin or an anti-drunk driving billboard with a picture ofsomeone being arrested. These are factors that help an individual initiate change.

Another component added to the HBM model in 1988 is self-efficacy (Rosenstock, Stretcher, & Becker, 1988). Change behaviors require that individuals believe that they are capable of adopting the desired behavior. An individual might believe the change is beneficial—a perceived benefit—yet lack confidence in the ability to actually do it (Stretcher & Rosenstock, 1997). Due to a lack of research on cues to action and self-efficacy in the literature (Carpenter, 2010), however, this study focused on the original four constructs with modifying factors. The HBM can be used in many settings to determine the motivation behind behavior such as utilization of public health programs, screening, and other prevention opportunities and policies.

The HBM has been predominately used in research for physical health education and promotion, such as mammogram screening for breast cancer, exercise programs for obesity, condom use for sexually transmitted disease, and so on, to determine why individuals do what they do regarding health issues. A meta-analysis reviewing 18 out 94 articles that directly measured all four constructs of HBM with behavior as outcome confirmed that the perception of benefits and barriers were the two key factors for promoting a change in behavior (Carpenter, 2010). Specifically, the meta-analysis showed that these two constructs (benefits and barriers) had greater effect in changing prevention behavior than in treating an existing disease. The perception of severity was found to be a weak change agent. The perception of susceptibility was always unrelated to behavior. Carpenter (2010) concluded that because those with existing diseases have

some level of resignation over their condition that they believe their susceptibility to a worse outcome is low. It appears that separately these two (the perception of severity and susceptibility) are weak in determining behavior, however together they only have a perception of threat (Janz & Becker, 1984)

In this study, African American clergy's attitude toward [congregants] seeking professional mental health services was explored by using the theoretical framework, HBM. This is in addition to examining the effects of African American clergy's education, theology beliefs, and personal experience with mental illness regarding their attitudes (modifying factors). Based on the HBM, African American clergy would most likely have a positive attitude toward mental health professionals if that were congruent with their religious–spiritual beliefs. Because of their gatekeeper role for congregants in psychological distress, African American pastors have to consider the seriousness of the mental illness that affect their congregants' spiritual life. Clergy serve as a personal resource for their congregants during this time, which is most likely affected by the level of education. Similarily clergy's personal experience with mental illness may influence their attitudes toward seeking professional mental health services which needs to be further expored. Finally, African American clergy have to evaluate the barriers to congregants accessing mental health professionals based on clergy's knowledge and personal experience. Initially, African American clergy will assess the seriousness of a congregant's mental illness based on a combination of the clergy's theological perspective and education, which will set the foundation for their attitude toward mental health professionals.

Limitations to the HBM include an inability to predict long-term health-related behaviors (Henshaw et al., 2009). For example, a positive African American clergy attitude toward mental health professional does not predict a referral. It also does not determine if clergy are more inclined to counsel patients themselves or consider referral to professional mental health services. The HBM considers personal attitudes regarding beliefs about a system that affect a personal behavior, in this case, a mental health system. It does not determine the validity of the beliefs; in other words, no matter how much education is obtained on a subject matter, it may not change the underlying beliefs regarding the same subject matter.

Conceptual Framework

The religious–spiritual framework can be regarded as a perceived closeness to God that overshadows life in general (Hill & Pargament, 2008). It has been used as a coping skill throughout life's trials, especially through times of distress for African Americans (Mattis & Jagers, 2001). The religious–spiritual framework is centered on maintaining a close relationship with God, which limits certain behaviors (drinking, smoking, promiscuous behavior, etc.) due to the possibility of inhibiting this relationship (Hill & Pargament, 2008; Mattis & Jagers, 2001). These negative behaviors will most likely contribute to physical and mental distress, but if limited or avoided, the distress is expected to be less (Payne, 2008). Clergy would be a prime example of one perceived to have a close relationship with God and therefore less likely to have experienced mental health distress. In addition, clergy are most likely to conceptualize mental illness through a spiritual lens viewed as a weak spiritual relationship with God (Payne, 2008; Schnittker, Freese, & Powell, 2000). Due to this view, mental illness is likely to be

spiritualized by clergy when congregants who are faced with a mental illness (Corrigan et al., 2003; Hill & Pargament, 2008). This is an important treatment response, because clergy are considered first line responders when congregants are faced with physiological distress (Hanmaker, 1998). Using the religious–spiritual framework explored African American clergy perception of mental illness, as it related to their attitude toward professional mental health services.

Literature Review

The Pastors' Role in Mental Health Counseling

Utilization of the traditional mental health system offers several options for treatment of mental illness from the clinician. The number of options are often limited due to either lack health insurance coverage, inability to pay, or skewed by the view of the clinician (Haas & Cummings, 1991; Lish et al., 2003). One particular option not usually highlighted in the traditional mental health system is the option of pastoral counseling and the resources offered within the black church or any church (Farris, 2007). Pastoral counseling are clergy and others who have been educated in psychological and theological theories to counsel laypersons (Jordan, 1997). Training in both allows for integration of services to the patient. Pastoral counseling has been utilized for decades in the African American community, yet it has been given little credit for providing these resources within the community. Due to the history of the African American church and the role of African American pastors, they both coexist to provide support to the African American community for mental health services. This may contribute to the underutilization of the traditional mental health system by African Americans (Taylor et al., 2000). To better understand the factors that influence the

African American church toward mental health services, Davey & Watson (2007) suggested an integrative model to determine how African Americans enter the mental health system (Allen et al., 2009). While the model depicts the church as a local resource option, the church may be over looked because of the other local options (family, friends, and employers) or the fear of religious stigma. Very religious congregants avoid seeking mental health services from clergy or mental health services because of being perceived of having no faith or the potential of loosing their faith (Davey & Watson, 2007). It is also found that African American congregants report shame, the character of the minister, authenticity of the minister, and their ability to help as reasons to consult clergy for support (Mattis et al., 2007). African Americans also consider access and stigma as factors that inhibit them from seeking professional mental health services (Corrigan & Kleinlein, 2005).

In comparison to other races, studies suggest equal prevalence of mental illness in African Americans compared to European Americans. In fact the National Comorbidity Survey (NCS) of over 8,000 participants showed that African Americans have a lower lifetime prevalence of mental illness compared to European Americans (Kessler et al., 2005). Looking closer at the study design of the NCS, the African American cohorts were not obtained from strata like psychiatric hospitals, prisons, or poor rural (most likely due to poor accessibility); therefore the results of this study may not accurately represent the overall mental health status of the African American community as a whole.

The pastors' role in counseling is broad and diverse which can be affected by stigma and attitude of mental illness from both sides of the table. The need for African Americans congregants to seek professional mental health treatment lies in their

understanding of what is considered a "mental illness" (Farris, 2007). A quantitative study done by Schnittker, Freese, and Powell (2000) using the General social survey noted that African Americans are most likely to seek pastoral care secondary to their religious beliefs and practices compared to European Americans. This was the first study of its kind to use a nationally represented sample that directly looked at racial influences regarding attitudes toward professional mental health treatment. In another quantitative study, African Americans were also found to contribute their psychological distress to being spiritually based, therefore seeking pastoral counseling in times of psychological distress seemed reasonable (Taylor et al., 2000). This particular study is in contradictory to other studies that show that religious beliefs does not play a significant role in pursuing clergy for mental health services (Chalfant et al., 1990; Mattis et al., 2007). Chalfant et al. (1990) showed that religion affiliation was not a significant factor in seeking counseling from clergy amongst all the religions represented (Roman Catholic, Liberal Protestant, Conservative Protestant). Less than a third (28%) chose clergy as first choice of seeking help if needed based on their religious affiliations. This study does report that help seeking behavior for clergy counseling was affected by ethnicity, church attendance, and socioeconomic status (Chalfant, et al., 1990). The respondents in this study were predominately of Mexican descent from El Paso, Texas. Due to this being a traditional culture, Mexicans respondents were more likely than the Anglo and Mexican-Americans respondents to seek clergy for psychological help. The study results determined that mental health professionals were least preferred compared to clergy among the respondent. While religious affiliation did not play a leading role, it confirms that clergy continue to be first responders for mental illness. A drawback in this study was that it was

unable to determine why the participants chose certain resources. Mattis et al., (2007) conducted 13 focus groups that confirmed that African American congregants seek clergy for counseling when it pertains to spiritual enrichment (83%) and general unspecified counseling (83%). Interestingly, this study showed over 90% (N=9) never using clergy [for counseling], while 50% (N= 6) reports not using them for "particular issues", but would not clarify in the group that looked at the things they would not take to their ministers (p. 253).

Out of a 40 plus hour workweek, clergy reported over 15% of their time devoted to counseling congregants (Weaver et al., 1997). The clergy's objective in counseling is to "provide care, counseling, compassion, or advice mainly in relation to emotional, psychological, or moral problems" (Young et al., 2003, p. 689). While a little over 6 hours a week may not seem comparable to a typical mental health professional workweek, clergy are on 24-hour call 365 days a week for the needs of their congregants (Chatters et al., 2011; Taylor et al., 2000) and there are over 300,000 active clergy, Jewish and Christian, currently providing counseling services. This in turn places clergy in a position to decide the trajectory of mental health services for their congregants (Allen et al., 2009). The care that they are providing is not much different than that of the psychologist and psychiatrist, just in a different context or frame. For example, African American congregants are known to solicit help for their psychological distress from their clergy when they are looking for more than medications to solve their situation (Young et al., 2003). The similarities between the two professions lie in how the illness is perceived and the ability to provide the service for the illness. The differences include the approach to the perceived illness and treatment recommendations. Clergy reports referencing

scriptures and prayer over 50% of the counseling sessions (Young et al., 2003). Literature is congruent with themes from congregants reporting clergy as a first line of contact for mental health services because of availability, accessibility (Farris, 2007), and high trust (Weaver et al., 1997). They also report interpersonal skills that include warmth, caring, stability, and professionalism (Chalfant et al., 1990) as an advantage to utilizing clergy. The advantage here is for psychologist and mental health professionals to take advantage of this resource in order to better serve the African American community through referrals and collaboration. .

There is little known about the utilization of referrals, mental health treatment options, and counseling options among African American clergy due to many variables (Taylor, Chatters, & Levin 2000). African American pastors' attitude toward mental health counseling is affected by education, the number of congregants, ministerial training (theology school), and even geographical locations of clergyman (Vassol, 2005; Young et al., 2003). It is assumed that the education of clergy (including psychological training) makes them better equipped to handle certain levels of psychological distress (Stansbury & Schumacher, 2008). Contrast to this study, educated clergy were found to be unaware of the severity of the mental illness and often spiritualize the symptoms, and usually only refer when they feel it is outside their scope (hallucinations or suicide) (Taylor et al., 2000).

The Different Approaches to Pastoral Counseling

A theory postulated by Kevin (1976) as stated in Stansbury and Schumacher (2008) on the role of pastoral counseling to congregants who are faced with a mental illness consisted of three typologies: Conservative-Theological (C-T), Theological-

Psychological (T-P), and Religious-Community (R-C). The C-T model is identified as the least applicable when dealing with someone who has a mental illness, secondary to the believing that is due to the framework of having some form of discord with their religious beliefs and believing that religious practices as the only remedy for emotional instability. If clergy predominately used the C-T model, this would decrease the likelihood of referring to a mental health professional for treatment of a mental illness due to belief that it would not be beneficial because of the spiritual/religious origin. The T-P model is a combination of theology and psychology approach used to address mental illness in its congregants. As noted by Dittes (1970) in Stansbury and Schumacher (2008), this approach helped to bridge the gap of where one currently is (in life) and where one is expected to be based on a religious underpinning (in life). This approach offers a diversity of counseling secondary to its integration of psychology with theology, which encompasses more than "applied theology". The R-C model approaches the treatment of mental illness based on the clergy's comfort zone of counseling and views the counseling sessions as supportive versus treatment for their emotional instability or mental illness (Stansbury & Schumacher, 2008). This approach from clergy is most likely to form a relationship with mental health professionals as the depth of intervention from the clergy perspective is supportive and in the form of crisis management while maintaining a positive environment for the congregant to return to. To date no studies have been conducted to test this theory, however many articles cite this article.

The Religious–Spiritual Influence

The different approaches of pastors in counseling are based on a religious or theological framework that provides the congregants with a sense of hope, external

support, and understanding (Weaver et al., 1997; Stansbury & Schumacher, 2008). This approach is mostly utilized by clergy, versus mental health professionals whose primary approach is based on science and research (Lish et al., 2003). These technical differences of approach can make a difference when it comes to mental health treatment outcomes according to the most recent studies (Stansbury & Schumacher, 2008). The pastor's role is invested in the spirituality of the person with understanding that it affects the entire person (body, mind, and soul). Pastors, as well as the congregants drive the incorporation of religion and spirituality into the counseling session. This is expected from clergy, but for mental health professionals discussion of religion and spirituality can be uncomfortable (Plante, 2009). Due to the minimization of religion and spirituality in training, social workers are left to depend on evidence-based research to incorporate spiritual interventions (Hodge, 2011). There are four approaches suggested by David (2011): 1) following the lead of the client, 2) approach the situation based on research specific to the presenting illness (for best outcome), 3) clinical competency to practice services within their scope of training, and 4) competency in the context of the culture of the client. The availability of religion and spirituality within counseling sessions are slowly increasing due to the request of the client and improved training of the staff. It has integrated the field of surgery where surgeons find themselves praying with their patients before procedures (Wachholtz & Sambamoorthi, 2011). In general, the research does show that religion and spirituality has improved times of psychological distress or even lessoned the severity (Hill & Pargament, 2008; Koenig, 2009; Plante, 2009).

Protestant congregations make up at least 48% of the U.S. population and there are over 600,000 available clergy in multidisciplinary settings (hospital, prison,

universities, military, etc.) according to the U. S. Religion Census 2010 (Kosmin, Mayer, & Keysar, 2001) and the *Yearbook of American and Canadian* churches, respectively ("Fast Facts about American Religion," 2006). It would be important to understand this impact on the clergy's role in providing counseling and services (mental health) to their congregants. These resources reach far beyond faith, extending into economics, health, politics, and even social (Taylor et al., 2000). According to the APA's Center for Workforce Studies, the number of employed psychologists compared to clergy, (approximately 84,000) is disproportionate compared to the availability of clergy ("Center for Workforce Studies," 2014). Therefore understanding the approach of African American clergy's attitude could help bridge the gap for resources for the community. In addition, this may explain the help seeking behavior to clergy secondary to limited availability of mental health professionals.

Theological Beliefs

The care for mental health patients can be traced back to the early church, as primary care givers for the mentally ill (Billingsley & Caldwell, 1991). This role continues to evolve within the African American church and clergy as a resource to understand mental illness. Mental illness can be challenging to understand which often place African American clergy in a difficult position (Allen, Davey, & Davey, 2009; Taylor, et al., 2000). Clergy are often conflicted with religious traditions, personal beliefs, and understanding of mental illness (Leavey, Loewenthal, & King, 2007; Leavey, 2008). The range of theological beliefs can stem from ritual focused to charismatic depending on personal experience, and understanding of mental illness from the viewpoint of the clergy (Leavey, 2008).

In the qualitative study by Leavey, Loewenthal, and King (2007) different pastors of faith were interviewed to determine if their view of mental illness was based on personal beliefs or their overall religious beliefs/institutions. While the study was based in London, the results correlated with majority of the U.S. studies noting that African American pastors view mental illness from a spiritual lens and rely most often on their personal understanding of mental illness in their approach. This study also correlates with Kevin's (1976) typologies as stated in Stansbury and Schumacher (2008) in key factors (ethnicity, theological variation, literal interpretation of sacred text, culture, and secularism) that influence the views of clergy regarding mental illness which supports why there is such variation of attitudes regarding mental illness among clergy overall.

Protestant Christians believe in the Bible and that the Holy Trinity directs their Christian faith: The Father, The Son, & the Holy Spirit (Loewenthal, 2000). Due to these core beliefs, the Christian's perception of professional counseling and mental health has been lessoned. Stereotypically defined as less spiritually aware of what their congregants need, which would make them reluctant to resource out to mental health professionals (Lish et al., 2003; McMinn & Runner, 2005). At least 35% of the Protestant Christians believed that a demonic spirit caused depression and schizophrenia (Hartog & Gow, 2005). Leavey (2008), report that main stream Christians are more likely to consider counseling private and is based on skills, interests, and the energy needed versus Pentecostal clergy who were more inclined to approach mental illness in the form of exorcism, display of gifting's, and healing ceremonies. The study also found that the pathway to counseling was variable and each religion considered certain aspects of mental illness challenging (mainstream Christians) and welcoming (Pentecostal).

Level of Education

In addition to using Kevin's (1976) typology to categorize the approach of clergy (R-C model) in dealing with mental illness in older adults; Stansbury and Schumacher (2008) found that the level of education played no role in the mental health literacy of clergy regarding mental illness. This is a qualitative study of 9 African American Baptist ministers from urban and rural areas with education ranging from 12th grade education to doctorate level. The effect of education could have been overshadowed by the size of their congregation and availability of resources for mental health services within the community. In other words, it did not matter the educational level, the pastors responded to the needs of their congregants based on their personal limitations (availability based on size of congregation or outside the scope of their practice) and resources beyond what they could provide (community contacts).

On the other hand, Unger (2011) found that Baptist clergy who had higher levels of education (masters level) had a moderately favorable attitude toward seeking psychological help (M = 56.36). This was a quantitative study of randomly selected Baptist clergyman assessing their attitude toward help seeking behavior for psychological help and their depression rates. It can be assumed that if Baptist clergy favored professional mental health counseling for them, its highly likely they would recommend it to their congregants (which could potentially increase referrals). Unfortunately, the study was not able to quantify the levels of education to determine if mental health or psychological training was included. This information would be helpful to determine if additional education is needed for clergy to understand mental illness as a whole and if

this training or education affected their attitude toward professional mental health services. This gap was explored in this study.

Personal Experience With Mental Illness

An older study done by Angermeyer & Matschinger (1996) in Germany looked at the effects of personal experience of mental illness on the attitudes toward individuals with mental illness. The surveys were distributed at two different times, 1990 with response rate of 68.9% (2045) and 1993 with a response rate of 67.8% (4237) (p. 322). While this study was not directly targeting Clergyman's attitude, it does support that the more exposure one has to mental illness, they are less likely to have anxiety when encountered, more likely to enter into a relationship, and less aggressive emotions toward mental illness.

In support of this study, Roth, Antony, Kerr, & Downie (2000) confirmed through analysis of variance that medical students who had contact with persons with mental illness displayed a more positive attitude toward patients with mental illness. These two studies support the need to determine how personal experience may affect African American clergy.

A more recent study done by Igbinomwanhia, James, & Omoaregba (2013), surveyed clergy located in sub-Saharan Africa about their attitude toward mental illness. The overall opinions of laypersons in Nigeria believe that over 50% of mental illness is due to some form of spiritual problem. This quantitative study found over 80% of clergy reported feeling uncomfortable addressing the mentally ill. This study also reports "over two thirds of participants (69.2%) had not received any form of mental health training. Sixty four (59.8%) were willing to provide care for the mentally ill while 23.4% were

unsure" (p. 197). The aim of the study was to determine the influences of attitudes toward mental illness because of the basic stigma of mental illness and dependence on clergy in Nigeria. It was clear that the pathway of decisions from clergy would be based on personal experience and beliefs in how they handled the situations.

Overview of Previous Research Literature and Methodology

The review of literature present some concerns that were addressed in this study: (a) African American clergy are approached by congregants in times of psychological distress; however African American clergy attitude tend to be variable, especially among African American Protestant clergy. This research addressed this dilemma among Protestant African American clergy: (b) Clergy base their counseling strategy on the religious–spiritual framework, which can spiritualize the symptoms or underestimate the symptoms that may actually need professional mental health services. It is therefore important to understand the attitudes of Protestant African American pastors because of it being a large denomination in the south (Pew Research Center, 2013). The literature currently presents a lack of information about African American Protestant clergy's attitudes regarding professional mental health services: (c) The research that does address African American clergy's attitudes toward professional mental health services are outdated to draw conclusions, inconsistent in methodology, and statistical analysis in order to replicate. These deficiencies create opportunities to gather more information regarding clergy's attitudes regarding professional mental health services.

This study encompasses over 60 supporting data/literature overall. The research literature presented in this study can be summarized with at least 4 Meta analysis, 29 qualitative, 15 quantitative, and 8 other methods (N= 60). There were only a few who

specifically looked at African American clergy as respondents, N= 20. The primary questions answered in these studies were about their attitude toward mental health or illness in general. The discussion of seeking mental health services was intertwined with studies that focused on referrals and collaborations with psychologists. There were at least 20 that did not identify race as factor, but mostly focused on congregants regarding seeking mental health services from faith-based organizations or other (at what point or stage in their decision making process). After careful review, the theoretical frameworks appeared to be inconsistent throughout, however there were suggestions of religious under tones through out. Due to these inconsistences, it would be difficult to duplicate the theory and or study to determine similar results among the same population.

The Inferential Method of Research

Sixty percent (60%) of historically African American churches are located in the south (Pew Research Center, 2013); valid statistical conclusions is needed for the method of study in order to make predictions of data collected of the general population (Creswell, 2009). It was not possible to capture every historical African American church; therefore a sample of the population will be recruited for a self-administered survey. Random sampling was done to allow Protestant African American clergy located in Georgia and South Carolina, to allow for equal opportunity to participate in the study (Creswell, 2009).

Summary and Conclusions

In summary, African American clergy play an important role in helping congregants seek professional mental health services. Previous studies have focused on the influences of help seeking behavior from the perspective of the congregant (Barksdale

& Molock, 2009), which has provided valuable information on how congregants consider clergy, however limited on the attitudes of clergy when approached with a mental illness (Hardy, 2012). Learning more about African American clergy's attitude toward professional mental health services for their congregants is important for utilization, accessibility, and reliability (Roth et al., 2000; Snowden, 1999). Since church leaders are the gatekeepers, a better understanding of their attitudes toward professional mental health services "could help African Americans seek and receive more equitable and culturally sensitive outside professional mental health care" (Allen et al., 2009, p. 119). The African American church in of itself has served as a pillar of help for centuries regarding the health of their followers (Farris, 2007). Recent research presents challenges between African American clergy and professional mental health services in the form of resourcefulness (McMinn & Runner, 2005), collaboration (Lish et al., 2003), referrals, and trust(McMinn, Aikins, & Lish, 2003). It is not clear how clergy's attitude regarding professional mental health services is affected by their theological beliefs (Leavey et al., 2007), educational level (Young et al., 2003) and their personal experience with mental illness (Lewis et al., 2007; Unger, 2011).

McMinn & Runner (2005) provides the basis for the methodology adopted in this research study due to choosing pastors of the Southern Baptist Convention because of their conservative Christian beliefs (Vespie, 2007). In addition, Roberts (1994) successfully used The religious attitude survey and attitudes toward seeking professional psychological help scale to determine the effect of conservatism in relation to help seeking behavior. This proposed research therefore sought to extend the research of McMinn et al. and Roberts. Chapter 3 details the methodology of the study.

Chapter 3: Research Method

Introduction

The purpose of the study was to understand the influences of African American clergy's attitudes toward help seeking behavior for mental illness/psychological distress. The study was designed to determine if theological beliefs, education, and personal experience with mental illness affected African American clergy's attitudes toward professional mental health services.

This chapter includes a description of the study's research design and rationale, a description of the study sample, data analysis, and ethical considerations. A discussion of practical implications that promote social change is provided as well as suggestions for future research and a summary of the chapter.

Research Design and Rationale

The research question was: Is there a correlation between theological beliefs, education, and personal experience with mental illness and African American pastors' attitudes toward seeking professional mental health services? The independent variables were theological beliefs, education, and personal experience with mental illness. The dependent variable was the pastor's attitude toward seeking professional mental health services. This study was intended to be conclusive; therefore, an inferential study was appropriate to define the attitudes of African American pastors. The research design was a nonexperimental cross-sectional descriptive survey analyzing variables in one particular population. This design was used to determine the prevalence of African American pastors who were either conservative or liberal, had attained certain levels of education,

and had or had no personal experience with mental illness and to correlate these factors with their attitudes toward professional mental health services. According to Crosby, Diclemente, & Salazar (2006), a cross-sectional survey design would allow for assessment of these relationships among variables for the African American pastors; it is often referred to as a correlational study. According to Creswell (2009), the advantages of using a self-administered survey for this study would be cost efficiency and quick data collection. A disadvantage to using a cross-sectional survey study is that it does not allow the researcher to infer causation. Due to the sensitivity of the subject, the participants required a sense of privacy while taking the survey; however, that creates the disadvantage of negating the opportunity to ask follow-up questions from the survey (Crosby, Diclemente, & Salazar, 2006). To adjust for problems inherited in utilizing a survey such as survey bias and nonresponse bias, the questions were appropriately sequenced and constructed to enhance the validity and reliability of the study (Babbie, 1990).

Methodology

Population

The participants of this study were African American clergy over the age of 25 currently residing in the states of Georgia and South Carolina and representing the Protestant faith. The Protestant faith comprises different denominations including Baptist, Lutheran, Calvinist (Presbyterian), Pentecostal, and Restoration (Atwood, Mead, & Hill, 2005). The basic construct is based on Christianity with different theological beliefs per denomination. Protestantism represents social constructs that are in constant change over the course of hundreds of years (Maffly-Kipp, 2001). Protestant clergy were chosen for

this study because they hold the largest predominately African American Christian organization (Baptist) to date (Pew Research Center, 2013). Several denominations of the Protestant faith were represented in this study.

The research design required the participants to be African American pastors. The information was self-reported under the demographics section of the survey. Recruitment was done through the online Yellow Pages with search term *African American Church, Protestant* and via the *Official Email Marketing* service. There were over 2,500 listings of Protestant churches located in Georgia and South Carolina in the online *Yellow Pages* directory (Yellow Pages, 2014) and approximately 10,000 listings of African American churches located in the states of South Carolina and Georgia located provided by *Official Email Marketing* service.

Sampling and Sampling Procedures

Participating churches were randomly selected from the online *Yellow Pages* directory (Yellow Pages, 2014) and the *Official Email Marketing* service list. Randomization of participants allowed for generalization of the population (Crosby et al., 2006). This study was only interested in African Americans and therefore both of these databases were useful because they had listings specifically for African American Protestant churches located in Georgia and South Carolina. A sampling size of 98 would make the statistical power of the study significant. The online *Yellow Pages* displayed approximately 30 African American churches per page and every 5th church listed was invited to participate in the study. The *Official Email Marketing* service provided a spreadsheet listing 10,000 Protestant African American churches located in the states of Georgia and South Carolina, and every other listing was invited via e-mail (*Survey*

Monkey) to participate in the study. That allowed each listing an equal opportunity to participate in the study. The limitation to one religious category was decided because there are fundamental theological differences between religious groups (e.g., Christians and Muslims) that would overshadow or conflict with central discussions regarding the role of religion and religious leaders in addressing mental illness (Mattis & Jagers, 2001). Participating churches were required to have at least 80% of their congregation African American in order to participate in the study, which was also defined under the demographics section of the survey. Historically, African American Protestant churches have predominately African American congregants; however, the culture of religion and spirituality has changed over the years and the possibility of other races in attendance as members was high. While all participants were listed as Protestant, there was likely a difference between the Pastors' theological beliefs (conservative versus liberal) and their attitude toward professional mental health services. This study attempted to capture these differences as each participant received a packet via mail or e-mail that contained the following information: (a) introductory letter of the study; (b) an informed consent form; (c) demographic questionnaire that included their church demographics, educational level/training, and status of personal experience with mental illness; and (d) two questionnaires: The religious attitude scale (Poppleton and Pinkleton, 1963) and the attitudes toward seeking professional psychological help scale (Fisher & Turner, 1970).

Inclusion Criteria

All pastors in this study were over the age 25, African American, male and female. Traditional African American denominations were of the Protestant faith included, i.e. Baptist, AME, CME, AME Zion and COGIC. Despite their specific

denominations, all would be considered Christian or Protestant, which is the focus of this study. Any level of education is expected to influence the clergy's attitude of professional mental health; therefore a specific level of education was not a factor in determining the inclusion criteria. All participants were not expected to have had a personal experience with mental illness; therefore not having any experience will not be excluded from the study. All pastors were considered Protestant, have an African American congregation, and currently hold the position of pastor of the church located in the states of Georgia and South Carolina.

Exclusion Criteria

All other races were excluded from this study secondary to the frame of this study focusing on the attitudes of African American clergy and the African American church directly impacting the behavior of the African American community (Marks & Chaney, 2006; Taylor et al., 2000) and mental health. This study targeted primary leadership (Pastor's, Reverends, Co-Pastor) of the congregations; therefore other leadership of the church (chaplains, ministry leaders, etc.) will be excluded from the study. This was identified within the demographics.

Power Analysis

The sampling size and power analysis was determined by using the G*Power Calculator (Faul, Erdfelder, Lang, & Buchner, 2007). The statistical analysis used for this study was multiple linear regression. The a priori power analysis was used to calculate the sample size (N=98), with an effect size of $f^2 = 0.15$, alpha of .05, and the power (1-B err probability) being 0.80. This model has 5 predictors (independent variables: theology, education, and personal experience with mental illness and dependent variable: African

American clergy attitude). The effect size will affect the power of the study and on average researchers are looking for a moderate effect in the results. The output numbers include a critical f as 2.1999052, denominator df = 91, N=98, and actual power at 0.80. The participants had an equal opportunity to be selected for the research because of randomization, which allowed for a diverse selection of African American clergy with various educational levels, theological beliefs, and connection with mental health.

Procedure

Participants were recruited via the *Yellow Pages* on the World Wide Web and an *Official Email Marketing* service. The *Yellow Pages* has over 2500 churches listed in the state of Georgia and South Carolina. Every 5th listing was chosen to participate in the study per page. To increase the likelihood of 98 participants, at least 200 surveys were mailed to the leadership of each church listed and then another 100 surveys were mailed to another group of identified participants 2 weeks later for the state of Georgia. Four to six weeks later another 200 surveys were mailed to the state of South Carolina using the online *Yellow Pages.* The church listings in the *Official Email marketing* service were sent surveys via e-mail using Survey Monkey. The company provided 10K listings of African American churches located in the states of Georgia and South Carolina. Every other listing was chosen to receive a survey that totaled 5,000.

Included in the packet or e-mail was a brief introductory letter describing the study, informed consent, a one-page questionnaire for the demographics, and two surveys. A self addressed, stamped envelope was provided within the packet. The informed consent explained the inclusion and exclusion criteria, risk and benefits to participating, emergency contact information if they have questions about or during the

study, and the withdrawal procedure if they decide to withdraw from the study at any time. Participants do not have to sign the informed consent, as returning the survey packet or completing the online survey will note their consent and keep it anonymous. Participants were able to withdraw without penalty and no questions asked. Participants could request a copy of the study results once completed if they choose by noting it on the demographic sheet with address only (no name). Demographic information gathered would include an identification number that will consist of the first two letters of first and last name (four letters), and year of birth (2 digits). This will be used to help with duplicate submissions and if participants choose to withdraw from the study, their survey can be identified and destroyed. Race, age, education, race of congregation, denomination affiliation, and if participant has had personal experience with mental illness (defined and nominal values of yes and no) were asked. Participants were enrolled until the number required is met. Any surveys received after the required participants are collected will be shredded and disposed of appropriately. Surveys without the demographics filled out correctly or completely will be discarded, as this identifies exclusion and inclusion criteria. The participant generated ID number will only identify participants as a participant once the surveys are returned.

Instrumentation & Operationalization of Construct

Demographics

A demographic questionnaire was given to collect the study identification number per participant (self generated), the Pastors' age, education, race, percentage of congregation, denomination affiliation, and their personal experience with mental illness (Appendix A).

Religious Attitude Scale

To measure the religious–spiritual attitude of Pastors the religious attitude scale (Poppleton & Pilkington, 1963) was used. The religious attitude scale (Appendix B) categorized pastors as either conservative or liberal (less conservative) based on score ranges (Luckow, 2000). It was originally designed to measure attitudes toward Christian religion in college students. It assesses Christian tenets with the necessity of religion through a series of statements (Luckow, 2000). It contains 21 statements regarding religious characteristics on a 5 point Likert scale (1=strongly disagree to 5 = strongly agree) describing them. Poppleton and Pinkleton (1963) measured the reliability of the instrument by dividing the scale into three sections that were then correlated. It showed good internal consistency by correlations above .95 and good reliability using Cronbach's formula (coefficient alpha = .97) (Poppleton & Pilkington, 1963; Luckow, 2000). This instrument has not been used specifically on clergy, however this instrument is appropriate for this study because it allowed the religious attitudes to be categorized (high score correlates with conservative thoughts versus liberal is correlated with a low score). The median will determine the cut off for high or low. Due to the intricacies of religion and spirituality, categorizing Christian beliefs make it easier to correlate in a study of this type of study. Due to this study not focusing on one specifically denomination, but religious–spiritual beliefs, African American clergy of traditional African American denominations were able to identify with the questions. Studies have shown that clergy who are more liberal (low score) seem to be "open" to congregants seeking mental health services versus the more conservative (high score) who are less "open" (Vespie, 2011). The religious attitude scale scores can range from liberal (40) to

conservative (130), using the Thurston scale giving each question a weighted value. To validate the original scale, participants were placed into two groups (pro-religious and anti-religious) based on religious behavior (Poppleton & Pilkington, 1963). The study found that the two groups differed significantly with $p < .01$, using t-test between the mean scores. Those who considered pro-religious were a member of a church, prayed daily, and attended church services at least 3 times a week scores were considered having a conservative attitude (median score = 116). In addition, 50% of those who were considered them selves pro-religious (prayed daily and a member of a religious group) had even higher scores of median = 122. Those who were part of the anti-religious group (atheist and agnostic) scored a median = 60. "It is evident that the scores obtained on the scale corresponded in a consistent way with other indices of religious behavior and belief" (Poppleton & Pilkington, 1963, p. 24).

The Attitude Toward Seeking Professional Help Scale

The Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fisher & Turner, 1970) (Appendix C) is another scale using statements (N=29) on a continuously scored scale. This scale originally looked at the effects of social class, educational level, religion, and college major regarding the attitudes toward seeking professional psychological help scale. In this study it was used to assess African American Pastor's attitudes toward seeking professional psychological help. The scale is broken down into four subscales: recognition of need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in mental health practitioners (Fischer & Turner, 1970, p. 86;). These four factors help distinguish who would favor seeking psychological help and who would not. The subscores were combined for one attitudinal

score for this study. The items are rated on a 4-point scale (0 = disagree to 3 = agree), with 18 negative items reversed for scoring (0 = agree to 3 = disagree). The scores can range between 0-87 with a high score delineating a positive attitude. The internal reliability is reposted as 0.86 and .83 for standardized sample of 212 and 406 respectively (Fischer & Turner, 1970). Fischer and Turner (1970) reported test-retest correlations at different time intervals, i.e. .73 (6 weeks) to .89 (2 weeks). Obasi & Leong (2009) had adequate reliability by using the scale on Africa/African American descents with alpha = .74. The study survey measured African American clergy's attitude toward professional mental health counseling in relation to their theological beliefs (RAS), education (measured in the demographics), and personal experience with mental illness (measured in the demographics).

Operationalization

This study had three variables of possible influence on African American pastors' attitude toward congregants seeking professional mental health services. The independent variables included a) theological beliefs, b) education, and c) personal experience with mental illness. Theological beliefs will be ordinal based on a total score. The religious attitude scale provided this data. The responses from the clergy were scored from low (40) to high (130). Typically the higher scores represent a conservative few and a low score is considered to have more liberal thoughts (Poppleton & Pilkington, 1963). A median score was determined from the data received to determine the cut off of high and low. Each question is scored according to the Thurston scale. A key was used to translate for analysis and it will not be provided on the participants survey form. For example, question number two states, "Jesus Christ was an important and interesting historical

figure, but in no way divine, ” has a score of 9.84, which would be considered an antireligious statement (0-11). Unlike question number seven that states, “The miracles recorded in the Bible really happened,” has a score of 1.22, which would be considered a pro-religious statement. The clergy determined to what degree they agree with the statements using a different Likert-scale per question (see Appendix A). Using question seven as an example (pro-religious statement), the Likert-scale is represented by strongly agree = 6, agree = 6, undecided = 4, disagree = 2, and strongly disagree = 2. If a person strongly agreed with question numbers seven (pro-religious statement), a score of 6 would represent a person to be considered conservative. Question two (antireligious statement) is the opposite with Likert scoring of strongly agree = 2, agree = 2, undecided = 2, disagree = 5, and strongly disagree = 7. If a pastor strongly disagreed with this statement, he/she would score a 7, which would mean they are more conservative due to a higher Likert score. Due to this format, this scale will appropriately distinguish if the pastor is either more conservative or liberal.

The second variable is the level of education attained. The clergy were asked to designate their educational level under demographics. The participants were given a choice between high school diploma or GED, some college/college degree, masters/doctorate, and other category to capture those are outside these choices e.g., courses/classes administered by the organization. The final independent variable presented in this study was if the clergy has had personal experience with mental illness or not. This information was placed on the demographic questionnaire. This question was dichotomized with a choice of either “yes” or “no”. Participating pastors must answer either one. Personal experience is defined as either them personally or knowing someone

who has dealt with mental illness (having some form of contact). It would not be expected for this study to determine whom and to what extent of the experience.

The dependent variable is the attitude of African American clergy toward seeking professional mental health services. This attitude was analyzed using the Attitude Toward Seeking Professional Help Scale (ATSPHS) (Fischer & Turner, 1970). Scores can range from 0 to 87, with high scores indicate a positive attitude toward seeking help. This scale uses a 4 point Likert-scale of agree = 1, probably agree = 2, disagree = 4, and probably disagree = 3. The 18 negative statements will have reversal scoring (1, 3, 4, 5, 6, 8, 10, 13, 14, 15, 17, 19. 20, 21, 22, 24, 26, & 29) using agree = 4, probably agree = 3, disagree = 1, and probably disagree = 2. Statement number one states, "Although there are clinics for people with mental troubles, I would not have much faith in them," is considered a negative statement in which the scale would be reversed and "If I thought I needed psychiatric help, I would get it no matter who knew about it" (statement # 28) would be considered a positive statement. Final scoring was based on a summation of all the questions.

Research Question

The research question is: Is there a correlation between theological beliefs, education, personal experience with mental illness and African American pastors' attitude regarding seeking professional psychological help. The independent variables are theological beliefs, education, and personal experience with mental illness and the dependent variable is the pastor's attitude toward professional psychological help. The hypothesis is that theological beliefs, education, and personal experience with mental

illness do influence African American pastors' attitude regarding seeking professional psychological help.

RQ1: Is there an association between theological beliefs and African American pastors' attitude toward seeking professional psychological help?

$H_0$1: There is no association between theological beliefs and African American pastors' attitude toward seeking professional psychological help.

H_a1: There is an association between theological beliefs and African American pastors' attitude toward seeking professional psychological help.

RQ2: Is there an association between education and African American pastors' attitude toward seeking professional psychological help?

$H_0$2: There is no association between education and African American pastors' attitude toward seeking professional psychological help.

H_a2: There is an association between education and African American pastors' attitude toward seeking professional psychological help.

RQ3: Is there an association between African American pastors' personal experience with mental illness and their attitude toward seeking professional psychological help?

$H_0$3: There is no association between African American pastors' personal experience with mental illness and their attitude toward seeking professional psychological help.

H_a3: There is an association between African American pastors' personal experience with mental illness and their attitude toward seeking professional psychological help.

Data Analysis

This study attempted to correlate relationships and multiple linear regression is the most appropriate way to analyze this data (Munro, 2005). In order to use multiple linear regression appropriately the following assumptions must be made 1) the sample must be representative of the population being inquired, 2) the variables must have a normal distribution, 3) the assumption of homoscedasticity (for every value of X, the distribution of Y scores must have approximately equal variability), and 4) the relationship between X and Y must be linear (Munro, 2005). Advantages for using multiple linear regression is that it allows for prediction of outcome and determine an interrelationship among variables (Munro, 2005). In addition, if all the assumptions are met, it will allow the data to be generalized beyond numbers. The independent variables were categorized as the following 1) theological beliefs using the religious attitude scale (Poppleton & Pilkington, 1963) (numerical), 2) educational level was provided on the demographic form (high school diploma/GED, some college/college degree, masters, doctorate/biblical courses, and other category to capture those outside these choices e.g., religious courses/classes), and 3) personal experience of mental illness was captured on the demographic survey designated as either 'yes' or 'no'. The dependent variable (pastors' attitude toward seeking mental health services) provided numerical data by using the Attitude Toward Seeking Professional Help Scale (Fisher & Turner, 1970).

Examination of the descriptive techniques will be easily viewed via tables. It will include statistics of pastors' theological beliefs, their educational level, and personal experience with mental illness. This will also include the other basic demographic information provided in the questionnaire. The SPSS for Windows was used analyze the

data. Surveys incomplete or ineligible were discarded and not included in the data analysis.

Results were interpreted using SPSS (the latest version) showing significance between and within the variables. The descriptive statistics will be displayed via charts and graph.

Threats to Validity

It is important to control for the validity of the study in order to validate the likelihood of truth within the study (Creswell, 2009). Clergy have a natural instinct to counsel congregants that may be diverted to seeking a mental health professional due to fear being exposed from the survey. This may affect the responses to the survey in direct opposition of what they would naturally do (Harris, Edlund, & Larson, 2006; Parrill & Kennedy, 2011). While it does not negate their theological approach in supporting their congregants in times of psychological distress, this survey may influence their attitude toward professional mental health services while participating. In order to strengthen the validity of the study the participants randomized "so that characteristics have the probability of being equally distributed among the experimental groups" (Creswell, 2009, p. 163)

Another threat to validity included the limitation on the study participants to being all African American pastors of churches who consider themselves Protestant listed in the online *Yellow Pages*. While this is broad it does not speak to the general population of all African American pastors, because not all of them use the online *Yellow Pages* and may not be listed under Protestant. While this is difficult to control for, different denomination

of the traditional African American faith were included, i.e. Baptist, AME, CME, AME Zion and COGIC.

While this study determined if African American pastors either were conservative or liberal religious in their beliefs, it correlated with their attitudes toward professional mental health services to be negative or positive. The study may predict a correlation; but it will not determine causation, which is a limitation of this study.

Ethical Procedures

The perception of this study will reflect on upon an important role model in the African American community (clergy), therefore assumptions and perceptions will be handled carefully. Participants were randomly chosen from the online listing of the *Yellow Pages* and the *Official Email Marketing* service. Participants were provided with an informed consent. In the informed consent participants were provided with information about withdrawal from this study even after they have completed and returned the surveys. The informed consent also provided the contact information for the research if there is an emergency or questions need to be asked. The participants created a study identification code (6 digits) to remain anonymous and to identify which survey is theirs if they wish to withdraw from the study. The demographic data did not include the participants name for confidentiality. Files and data will remain confidential and access limited to the researcher only. The data files were kept in a locked cabinet (only the researcher has a key) and will be kept for 3 years (Services, 2006). Any electronic files will be placed on a jump drive and also retained in the locked cabinet with the other data. After 3 years the information will be shredded.

Summary

The goal of this study was to determine if theological beliefs, education, and personal experience with mental illness influence African American clergy attitude regarding seeking professional mental health counseling. This chapter detailed out the specific methods, including sampling procedures, inclusion/exclusion criteria, data collection procedures, description of the population, and data analysis. This correlational study of relationships between the independent and dependent variables will use multiple regression for statistical testing. The data will be analyzed using SPSS 16.0 showing any significance within and between groups.

Chapter 4 will report the results and summarization of the data obtained from the study.

Chapter 4

Introduction

The purpose of the study was to understand African American clergy attitudes toward help seeking behavior for mental illness/psychological distress. The study also looked at the influences of theology, education, and personal experiences with mental illness with African American clergy regarding their attitudes toward seeking professional psychological help. The research question was: Is there a correlation between theological beliefs, education, and personal experience with mental illness and African American pastors' attitudes toward seeking professional psychological help. Three hypotheses were tested using multiple linear regression analysis. The overall hypothesis was that theological beliefs, education, and personal experience with mental illness do influence African American pastors' attitudes toward seeking professional psychological help. Chapter 4 summarizes the data collection process with gross results followed by a summary.

Data Collection

Starting in March 2015, the data collection phase lasted approximately six months. Approximately 5,500 African American Protestant pastors serving in the states of Georgia and South Carolina were invited in four waves to participate via individual mailings and e-mails. Of the 5,500 clergy contacted, only 98 responses were received. Table 1 summarizes the four waves of recruitment via e-mail and individual mailings.

Table 1

Participants Contacted by Mail and E-mail

Correspondences	N	Respondents	% of response
Wave 1			
Mailings	300	13	4.0
Wave 2			
Mailings	200	12	6
Wave 3			
E-mails	2500	56	2.2
Wave 4			
E-mails	2500	19	.76
Overall Total	5500	100*	1.8

*Note. N = 5,500. 98 participants met criteria to participate in study.

Originally, the study was approved for 300 survey mailings through random selection of African American churches in the state of Georgia using the online *Yellow Pages* in two waves. After 12 weeks of waiting for responses, only 13 have come in. Due to this, IRB was petitioned for an additional 200 mailings and to add South Carolina's African American Protestant pastors to the list in order to gain participants, as the original list for Georgia was exhausted in the first wave based on the original protocol. In addition, each church receiving a mailed survey received a reminder phone call to respond to the survey. The telephone numbers were listed with the addresses using the online *Yellow Pages*. Phone solicitation is governed by the Federal Communications Commission (FCC) under the Telephone Consumer Protection Act and currently the regulations would not allow random calls to churches due to violation of privacy; permission was therefore needed to call (Federal Communications Commission,2014).

While this was approved by IRB, I was unable to comply due to federal guidelines. Over the next 8 weeks, 12 more participants responded. There were a total of 25 returned envelopes from the initial 500 mailings due to a wrong address or the church no longer existing at the address provided on the online *Yellow Pages*. Due to the continued slow rate of responses from mailings, IRB was petitioned again to send e-mails to African American protestant churches in the states of Georgia and South Carolina. I obtained a listing of 10,000 churches from *Official Email Marketing* service and was able to select every other listing. I submitted 5,000 e-mail survey requests through survey monkey. This was done in 2 waves (2,500 each wave) and an e-mail reminder 2 weeks after of original e-mail. All survey documents remained in their original state except for minor verbiage changes needed in the consent form to reflect the online version versus hardcopy mailings. Overall, the better response was via e-mail.

Description of the Sample

As shown in Table 2, close to half of the participants were between the ages 56 and 65 (40.8%), followed by age range 36 and 45 at 29.6%. In this study over 77.6% African American pastors served a congregation that was 90 to 100 % African American. The respondents were well educated with almost half with some college, masters and or doctorate degrees (43.9% and 42.9% respectively). This study targeted Protestant pastors and at least 50% of the respondents were of the Baptist religion followed by African Methodist Episcopal (AME) at 27.6%. A great percentage of respondents noted to have some experience with mental illness at 71.4%. Religious attitude scale (RAS) scores ranged from 55 to 87, with the median being 83. Pastors that scored 83 or lower were considered less conservative; those that scored between 84 and 87 were considered to be

conservative. As shown in Table 2, 53.1% were categorized into the less conservative group.

Table 2

Frequencies and Percentages for the Study Variables ()

Variables	*n*	%
Age (in years) group*		
25 to 35	11	11.2
36 to 45	29	29.6
46 to 55	18	18.4
56 to 65	40	40.8
Percentage of African Americans in congregation*		
Less than 30%	4	4.1
30 to 50%	2	2.0
50 to 70%	2	2.0
70 to 90%	14	14.3
90 to 100%	76	77.6
Highest level of education		
High school/GED	11	11.2
Some college/college degree	43	43.9
Post-graduate degree	42	42.9
Other	2	2.0
Denomination*		
AME	27	27.6
Baptist	49	50.0
Other	22	22.4
Experience with mental illness		
Yes	70	71.4
No	28	28.6
Religious conservatism (RAS)		
Less conservative (83 or lower)	52	53.1
More conservative (84 to 87)	46	46.9

Note. $N = 98$.
*Inclusion criteria only

Univariate Normality

The ATSPPHS items were summed to create an ATSPPHS variable. Kline (2011) states that a variable is normally distributed if its skewness index (i.e., skewness statistic/standard error) is less than three and if its kurtosis index (i.e., kurtosis statistic/standard error) is less than 20. The skewness index of this variable (i.e., 2.04) fell below three; thus, its distribution was normal.

Multivariate Normality

Multivariate normality was assessed via the normal probability plot generated by the SPSS regression program. The ATSPPHS total score was regressed on the study variables. Norusis (1991) states that when the plots fall close to the diagonal, multivariate normality is fulfilled. Therefore, the assumption of multivariate normality was met.

Results

Characterization of the Sample

The study sample (n= 98) was representative of the African American clergy population over the age of 25 located in the states of Georgia and South Carolina (male and female) who currently preside over a predominately African American church. All represented clergy African American churches were listed in the online *Yellow Pages* or with the *E-Mail Marketing Service.* There were several denominations (n = 9) represented, all of the Protestant faith, which met the inclusion criteria. The majority of the clergy who responded were educated beyond high school, with at least some college.

Description of the Study Variables

Cronbach's alpha for the 29-item ATSPPHS was acceptable at .90. According to Nunnally & Bernstein (1994), a scale is reliable if alpha is .70 or higher. However, two

items, 9 and 27, had negative item-total correlations. Therefore, these two items were deleted. As shown in Table 3, alpha for the 27-item scale increased to .92. ATSPPHS total scores ranged from 28 to 105; the mean total ATSPPHS score was 56.77 (*SD* = 16.20). Given that the highest possible score was 108, the sample of pastors had somewhat lukewarm attitudes towards seeking professional psychological help.

Cronbach's alpha for the 21-item RAS scale was unacceptable at .54. Seven items, 5, 6, 8, 10, 11, 17, and 20, had item-total correlations that were negative or less than .10 and were thus deleted. Thereafter, alpha increased to an acceptable .70. RAS total scores ranged from 55 to 87; the mean RAS score was 81.31 (*SD* = 6.26). Given that the highest possible score was 98 and higher scores indicated more conservative attitudes, the sample of African American pastors was quite conservative.

Table 3

Descriptive Statistics for the Study Variables

Variable	Alpha	Range	*M*	*SD*
ATSPPHS total score	.92	28 to 105	56.77	16.20
RAS total score	.70	55 to 87	81.31	6.26

Note. *N* = 98.

Checking the Regression Assumptions

As noted above, the assumption of multivariate normality was fulfilled. To check whether the assumptions of linearity and homoscedasticity were fulfilled, the scatterplot of the standardized predicted values by the studentized deleted residuals was examined (Norusis, 1991). Per Norusis (1991), linearity and homoscedasticity are fulfilled if the

plot results in a random scatter. The plot did result in a random scatter; therefore, the assumptions of linearity and homoscedasticity were fulfilled. Multi-collinearity was assessed via the Tolerance values of the model predictors. Per Tabachnick and Fidell (2007), multi-collinearity is not a problem when the Tolerance values are above .20. The Tolerance values ranged from .89 to .95; therefore, multi-collinearity was not a problem.

Pearson Correlations Between the RAS and the ATSPPHS Scores

A two-tailed Pearson correlation was conducted to assess the degree to which the RAS and the ATSPPHS were associated with one another. The results indicated that there was a statistically significant correlation between the RAS and ATSPPHS total score (r = .28, p = .005). As scores on the RAS increased, scores on the ATSPPHS total score also increased.

Results for the First Hypothesis

It was hypothesized that there would be an association between theological beliefs and African American pastors' attitudes toward seeking professional psychological help. In the first regression model, only theological beliefs was entered as the independent variable. The findings in Table 4 reveal that theological beliefs significantly predicted attitudes toward seeking professional psychological help, β = .26, p = .010. The more conservative pastors had significantly more positive attitudes toward seeking professional psychological help (M = 61.22, SD = 15.60) than the less conservative pastors (M = 52.83, SD = 15.85). Therefore, the first hypothesis was supported.

Table 4

Linear Regression Results for Theological Beliefs and Attitudes toward Seeking Professional Psychological Help

Variable	*B*	*SE*	β	*F*
Less conservative vs. more conservative	8.39	3.18	.26	6.94**

Note. Tolerance values ranged from 1.00 to 1.00. Overall model $F(1, 96) = 6.94$, $p = .010$, $R^2 = .067$.
* $p < .05$. ** $p < .01$. *** $p < .001$.

In the next regression model, theological beliefs, personal experience with mental illness, and education were entered as the independent variables. The findings in Table 5 reveal that theological beliefs significantly predicted attitudes toward seeking professional psychological help, β = .22, $p = .025$. As previously indicated, the more conservative pastors had significantly more positive attitudes toward seeking for help ($M = 61.22$, $SD = 15.60$) than the less conservative pastors ($M = 52.83$, $SD = 15.85$). Therefore, the first hypothesis was supported.

Table 5

Multiple Linear Regression Results for Attitudes Toward Seeking Professional Psychological Help

Variables	*B*	*SE*	β	*F*
Less conservative vs. more conservative	7.16	3.26	.22	4.84 *
None vs. has experience with mentally ill	-3.89	3.72	-.11	1.09
College or less vs. post-graduate	-3.17	3.41	-.10	0.87

Note. Tolerance values ranged from .88 to .95. Overall model $F(3, 94) = 3.26$, $p = .025$, $R^2 = .094$.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Results for the Second Hypothesis

It was hypothesized that there would be an association between education and African American pastors' attitudes toward seeking professional psychological help. In the linear regression model, only education was entered as the independent variable in the model. The findings in Table 6 reveal that education did not significantly predict attitudes toward seeking professional psychological help, $\beta = -.17$, $p = .084$. Therefore, the second hypothesis was not supported.

Table 6

Linear Regression Results for Education and Attitudes toward Seeking Professional Psychological Help

Variable	*B*	*SE*	β	*F*
College or less vs. post-graduate	-5.71	3.27	-.17	3.04

Note. Tolerance values ranged from 1.00 to 1.00. Overall model $F(1, 96) = 3.04$, $p = .084$, $R^2 = .031$.

As shown in Table 5, when level of education was in the regression model with theological beliefs and personal experience with mental illness, it did not significantly predict attitudes toward seeking professional psychological help. Therefore, the second hypothesis was not supported.

Results for the Third Hypothesis

It was hypothesized that there would be an association between African American pastors' personal experience with mental illness and their attitudes toward seeking professional psychological help. In the linear regression model, only personal experience with mental illness was entered as the independent variable in the model. The findings in Table 7 indicate that personal experience with mental illness did not significantly predict attitudes toward seeking professional psychological help, $\beta = -.17$, $p = .078$. Accordingly, the third hypothesis was not supported.

Table 7

Linear Regression Results for Personal Experience with Mental Illness and Attitudes Toward Seeking Professional Psychological Help

Variable	*B*	*SE*	β	*F*
None vs. has experience with mentally ill	-6.37	3.58	-.17	3.16

Note. Tolerance values ranged from 1.00 to 1.00. Overall model $F(1, 96) = 3.16$, $p = .078$, $R^2 = .032$.

As shown in Table 5, when experience with mental illness was in the regression model with theological beliefs and level of education, it did not significantly predict attitudes toward seeking professional psychological help. Therefore, the third hypothesis was not supported.

Summary

The statistical analysis of this study data supported hypothesis I that theological beliefs has a direct impact on pastor's attitudes toward seeking professional psychological counseling. This study failed to support hypothesis 2 and 3 that education and personal experience with mental illness had an effect on pastors' attitude toward seeking professional psychological counseling.

Chapter 5 will summarize the study with conclusions about the findings. This will include limitations, recommendations, and implications of the study.

Chapter 5

Introduction

This study was conducted to measure the attitudes of Protestant African American pastors located in the states of Georgia and South Carolina regarding their attitude toward seeking behavior for professional psychological help. Specifically, I examined education, theological beliefs, and personal experience with mental illness against pastors attitudes as measured by the ATSPPHS (Fischer et al., 1970). Due to African American pastors' roles as leaders of the church, they assume a range of responsibilities including those of counselor and advisor (Vespie, 2011; Young et al., 2003). They are usually the first paraprofessional that congregants turn to for direction when faced with a mental health issue (Farris, 2007), hence the focus of this study on African American clergy attitudes toward seeking professional psychological help.

This study found that theological beliefs affected African American pastors' attitudes toward seeking professional psychological counseling. The study did not support the hypothesis that education and personal experience with mental illness had an effect on pastors' attitudes toward professional psychological help

Interpretations of Findings

African American clergy are considered to be first line responders to mental illness for their parishioners, and little is known about how they view mental health treatment. African American churches are considered safe havens for their community and serve as an important resource in the community for mental health also (Taylor et al., 2000). It is important to understand pastors' impact on the mental health community due to their direct or indirect influences with mental illness. It would therefore be useful to

understand their attitude toward mental health seeking behavior regarding their congregants (Stanford & Philpott, 2011).

Theological Beliefs

Hypothesis 1 was that African American pastors' theological beliefs (conservative versus less conservative) had an effect on their attitudes toward seeking professional psychological help. Clergy participants completed the RAS (Poppleton & Pilkington, 1963) to assess their theological view (Luckow, 2000). The findings revealed that theological beliefs significantly correlated with African American clergy's attitudes toward seeking professional psychological help. African American clergy in this study who scored above the mean (81.3%) were considered theologically conservative. In a study by Vespie (2011), who used, the RAS (Poppleton & Pilkington, 1963), and the mean score was about the same at 81.5% (conservative view). However, that study determined that African American clergy respondents who scored closer to perfect (125 of 130) on the RAS had a negative attitude regarding help seeking behavior. The true difference between these studies was that Vespie (2011) participants were Southern Baptist pastors; which are known to have conservative religious views (Vespie, 2011); therefore the results are expected. This study presented a positive correlation showing that conservative pastors had positive attitudes regarding seeking professional psychological help using the RAS and ATSPPHS. This could be due to the randomization of Protestant pastors in this study selected from two southern states versus focusing on one denomination. The expectation for this study was that clergy would be theologically conservative due to the location of these states in the "Bible belt." The Protestant pastors included a variety of denominations, beliefs, and practices, which could affect their

overall view of mental illness seeking behavior or the role they(clergy) play in help seeking behavior for mental illness.

Education

Stansbury and Schumacher (2008) found that the level of education played no role in the mental health literacy of clergy regarding mental illness. Their study showed the pastors responded to the needs of their congregants based on resources in the community versus reliance on education. That confirmed the finding of this study regarding the correlation between attitudes toward mental illness treatment and education. There is a range of education levels among pastors, and those with higher levels of education tend to have a more favorable attitude toward seeking psychological services (Unger, 2011).

Hypothesis 2 was used to test the association between education and African American pastors' attitudes toward seeking professional psychological help. This study found that the education of African American clergy did not significantly correlate with such attitudes. This was contrary to other studies that showed clergy with a higher education (above high school) were more likely to refer parishioners to professional mental health services (Moran et al., 2005; Stanford & Philpott, 2011), which is indicative of having a positive attitude. The participants in this study regarded education as important as evidenced by the number of respondents with higher levels of education (85%). The educational requirements of clergy can vary from denomination to denomination. This study did not directly look at the attitude of African American clergy regarding actual referral to mental health professionals but their attitudes toward congregants actually seeking mental health care. This is an important area to understand considering 43% had at least a college degree and 42% had a post graduate degree. In a

study done by Vespie (2011), looking at African American clergy attitudes toward referrals, he found that there was a correlation of referrals with a higher level of education. The referral process appears to be unidirectional from the perspective of the clergy and limited in innovative ways to collaborate between both parties (mental health professionals) (McMinn, Aikins, & Lish, 2003). Many barriers hinder the collaboration between psychologists and clergy including interest in and ideology regarding mental illness (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). Obviously education is an important asset for anyone who desires to help address mental illness; however, this study did not find a statistical correlation between education among African American clergy and their attitudes toward seeking psychological help.

Personal Experience with Mental Illness

Hypothesis 3 was used to test association between African American pastors' personal experience with mental illness and their attitude toward seeking professional psychological help. Research has supported that the more exposure one has with mental illness, the anxiety associated with addressing it lessens (Corrigan, 2004). In addition they are more likely to enter into collaborative care with mental health providers and are less intimidated regarding their approach to mental illness (Angermeyer & Matschinger, 1996; Roth et al., 2000). This study found that personal experience with mental illness did not significantly predict or affect attitudes toward seeking professional psychological help. It is likely those African American clergy who have experience with mental illness causes them a decrease in anxiety when they are around it (less affected), which could have affected their responses to the survey.

There is limited research regarding clergy's personal experience with mental illness and its effect on how they manage mental illness with their parishioners. A most recent study done by Sullivan et al., (2014) recognized clergy's view of mental illness from the view of the parishioners can take several approaches 1) spiritual problem, spiritual solution, 2) mental problem, spiritual solution, and 3) mental illness, spiritual and mental solution. Understanding clergy's view of mental illness in their congregants allows for appropriate care for congregants. The expectation is that clergy who are considered conservative would most likely have the first approach of spiritual problem, spiritual solutions which means that mental illness is due to a spiritual problem and can only be fixed by a spiritual solution (Vespie, 2011). The effect of this can lead to less collaboration with MHP, limited conversations with parishioners, and limited understanding overall regarding mental illness (Sullivan et al., 2014). For this particular study the conservative clergy were found to have a positive attitude toward seeking psychological help, therefore the third approach is most likely from the "experience" of the clergy. This approach allows the parishioners to seek spiritual and secular treatment (of their choice), but most importantly with the support of church and mental health professionals (Johnson, 2010). This approach lessons the stigma associated with mental illness from the pew and create opportunities for clergy to engage in appropriate treatment/care for their parishioners (Leavey, 2010; Stansbury et al., 2011).

Theoretical Framework

The theoretical framework used in this study was the HBM (Stretcher & Rosenstock, 1997) that is based on the perception of a disease process to promote change in behavior (socio-cognitive approach). It is essentially based on ones personal beliefs to

explain behavior according to risk. Particularly in this study, perception and attitude are the same, and was measured by using the ATSPPHS (Fischer et al., 1970) of Protestant African American pastors. In addition theological beliefs are considered personal beliefs as noted by using the RAS (Poppleton & Pilkington, 1963). Education, theological beliefs, and personal experience with mental illness are all modifying factors that can influence ones perception that affect attitude. This study found that African American pastors' attitude was affected by their theological beliefs, but not their education or personal experience with mental illness, even when controlling for all other variables. According to this study, positive attitude toward mental health professional is congruent with conservative theological beliefs. Therefore a conservative protestant African American pastor of Georgia or South Carolina would perceive the seriousness of mental illness as substantial and consider the risk or probability of their congregant(s) having a psychological disorder. Due to the impact of theological beliefs on African American clergy attitudes of help seeking behavior; clergy would see the benefit of reaching out to professional psychological counseling while minimizing the barriers to increase the chances of recovery or appropriate treatment (Henshaw & Freedman-Doan, 2009; Johnson, 2010). The HBM promotes mental health awareness by evaluating and developing structured systems. HBM is practical in determining mental health utilization due to (1) believing that there is a problem, (2) believing that the consequences are significant and can impact daily living (or is);(3)trust the intervention being offered with less barriers in order to take action (referral). Benefits of this study include limited research of using HBM for mental health utilization, which can drive future research on health seeking behaviors. It offers a "systemic approach to intervention" by assessing

ones health beliefs (Henshaw et al., 2009, p. 434). Mental health utilization is complex and offers many variables that influence its domain.

Limitations of the Study

Religious–spiritual beliefs can be fluid in nature and difficult to conduct a study of this nature due to the different schools of thoughts of religion. The same way personal beliefs can be influenced by "the church", different schools of thought can vary even within the same denomination. Due to the randomization of this study it would be difficult to generalize this study to all African American pastors despite them all being of the protestant faith (Vespie, 2007).

This study would most likely have a religious bias due to it being a self-reported survey. One would assume that clergy would like to reflect their theological beliefs positively when answering a survey. They may only reveal what they would like for us to know, which makes the responses limited or less truthful (Creswell, 2009).

Another limitation of this study was limiting the participants to only one state initially (Georgia). This was later expanded to South Carolina due to exhausting the initial procedure of using the online *Yellow Pages* for the state of Georgia that resulted in a limited number of responses. All participants of this study had to either list their church in the online *Yellow Pages* or the *Official E-mail Marketing* firm. Those who chose alternative routes of advertisement the opportunity to participate were not given; therefore their view was not compared. In addition, the researcher had to believe that all resources were up to date with the information provided (trustworthiness). Therefore this study is unable to draw broad conclusions regarding conservatism about all African

American clergy in the states of Georgia and South Carolina of the protestant faith, which continue to be a limitation of this study.

The primary focus of this study was on African American pastors, which prevented people of other races to participate in the study. This may not have been a direct limitation, but indirectly through the theoretical framework (HBM). Race is considered a factor of effectiveness in using the HBM to explain mental health utilization (Henshaw et al., 2009). Engaging other races would have allowed for more of a comparison study looking at referral behavior using the HBM (Barksdale & Molock, 2009).

This study sought to determine if African American pastors theological beliefs (conservative versus less conservative) correlated with attitudes toward seeking professional mental health services to be negative or positive. This is limitation of doing a correlational study due to its inability to determine causation (Creswell, 2009). It is only able to provide the correlation between the two.

Validity

The study did not seek to expose what the African American pastors were actually doing (behavior) and why, but their attitude toward (congregants) seeking professional psychological counseling. Due to clergy's natural instinct to counsel first, this will most likely affect the responses to the survey by providing answers that are in opposition of what they would naturally do (Parrill & Kennedy, 2011). Although the resources utilized to obtain participants were limited in responses, the participants were randomly selected. For the online *Yellow Pages* every 5th listing was invited (N = 500) and for the *Official E-mail Marketing* listings, with every other listing selected (N = 5000).

The validity of the religious attitude scale (RAS) (Poppleton & Pilkington, 1963) is in question due to eliminating 7 questions due to the item-correlation being negative. The tools original validity was based on determining if the group of college students had conservative religious views versus liberal religious views. The conservative median score was 116 and the median score of anti- religious/liberal was below 60. Taking out the seven questions for this study changed the score range (55 – 87 vs. 1 - 130) and offered lower median scores (81.31 vs. 112) which if compared, participants would still be considered conservative; however, the study sample is not the same (Poppleton & Pilkington, 1963). All the participants in this study (African American clergy) would be expected to have strong religious views, but to what degree toward mental illness is the question.

Recommendations

The Pastors Role in Mental Health Counseling

Traditionally people of faith utilize the church clergy to help them make decisions in their life (Chatters et al., 2011; Sullivan et al., 2014). This can either be directly from Christian counseling or either from the Sunday morning messages. We also know that clergy come in contact with congregants who are under psychological distress regularly, but we do not know how clergy feel about how they should address psychological issue/mental illness (Farris, 2007; Stansbury et al., 2011). This study suggested that African American clergy attitudes were affected by their theological beliefs. Their conservative views suggested a positive attitude toward seeking professional psychological counseling. One would assume that those who scored lower than average (83%) on the religious attitude scale were considered less conservative or almost liberal;

however clarity is needed to determine their perception of mental health help seeking behavior. Due to this correlation, it is recommended that the barrier of access and stigma be addressed from the theological (spiritual) aspect to help congregants seek out mental health services that they are comfortable with (Hankerson & Weissman, 2012). Which means African American clergy should take the leading role to education and promote this positive perception to the congregants. Addressing mental illness or how to seek mental illness can be done either by pulpit, education, outreach services, and or direct counseling (to name a few). It would also benefit the church to offer resources that not only promote mental health utilization within the community, but services and resources that are in alignment with their theological beliefs (Hanmaker, 1998). This will most likely enhance the faith-based community in which they serve to hopefully see mental health comparable and or equal to physical health care (Sullivan et al., 2014). Promoting further research in the area of African American clergy's counseling (i.e. pilot studies) would be important in order to provide evidence based education and support for the parishioners.

The Different Approaches of Pastors' and Counseling

While this study did not find education and personal experience with mental illness as factors contributing to African American pastors attitudes toward seeking professional psychological counseling. This study did support one of the theories postulated by Kevin (1976) as stated in Stansbury and Schumacher (2008) in how to approach mental illness from the view of the church/clergy. The theories suggested different ways to approach mental illness and since this study did find theological beliefs to have a positive affect, the theological – psychological (T – P) typology versus

Conservative-Theological (C-T) and Religious-Community (R-C) would be best. This particular typology suggests that there is a balance between theological beliefs and psychology as it relates to the person. This is in contrast to being either all theological or psychological. This study suggests that there should be a balance between the two in order to appropriately approach mental illness and meet the congregant where they are. This is also supported about a more recent study appreciating similar approaches (Sullivan et al., 2014). Understanding these approaches from the perception of African American clergy would help bridge the gap within the African American community without being "torn" between religious beliefs and seeking appropriate mental health treatment. Furthering research in this area would include actual utilization of these theories and testing if the approach is helpful from the view the parishioner and accepting from the view of the clergy. They may not be realistic in practice.

The Religious–Spiritual Influence

The pastor's role is invested in the spirituality of the person with understanding that it affects the entire person (body, mind, and soul). Pastors, as well as the congregants drive the incorporation of religion and spirituality into the counseling session. This is expected from clergyman, but for mental health professionals discussion of religion and spirituality can be uncomfortable (Plante, 2009; Sullivan et al., 2014). Therefore it is suggested that the mental health professional clergy become engaged with the faith-based community to appropriately care for the congregant and increase access to mental health care services. Reiterating that understanding the approach of African American clergy's attitudes could help bridge the gap for resources for the community. Due to this study findings, stigma associated with conservative clergy thinking negatively toward seeking

professional mental health care can be decreased through re-education, conflict resolution (barriers), and discussing therapeutic approaches (together) (Leavey, 2010). In a study done by Sullivan (2014), he found that clergy were most likely to refer due to being over loaded versus inhibition. The religious–spiritual influence from the African American clergy is inevitable, however not limited to the promotion of secular treatment for mental illness (Sullivan et al., 2014).

Theological Beliefs

Theological beliefs can range from clergy to clergy, even within the same faith. Due to theological beliefs having a strong foundation in the lives of African American clergy, it makes sense as to why this is such a big influence. Again, this study supported most studies that African American clergy view mental illness from a spiritual lens (Leavey et al., 2007; Stansbury et al., 2011), but contradicted others showing conservative clergy are more likely to have a negative perception of mental health seeking behavior (Hardy, 2012; Roberts, 1994; Vespie, 2011). While this study currently show a positive effect on attitudes, does it suggest that African American clergy will refer to MHP or know which treatment options are available for their congregants. More research is needed to determine the willingness to refer based on theological beliefs and what treatment options do the clergy actually recommend (religious versus secular or both) to their congregants when they are presented with a mental illness. Recommendation of change with theological beliefs can be difficult to address due to most African American clergy being “followers” of a faith, versus originating one. With this in mind, creating opportunities of dialogue among religions and MHP would help gain insight into positive approaches to mental illness without compromising ones faith

(Farrell & Goebert, 2008; MR McMinn & Runner, 2005; Moran et al., 2005; Vassol, 2005).

Level of Education

This study found that education played no role on the attitudes of African American clergy toward seeking professional psychological counseling. This study supports Stansbury and Schumacher (2008) finding that education played no role in the mental health literacy of clergy regarding mental illness. This study did not quantify the educational level. It did not ask specific questions regarding a particular degree, major or studies performed. This information could have provided an explanation of why education did not play a role or which degree level had more of effect on attitudes (engineering versus biblical studies). Almost 50% of African American clergy had at education at the master's level. Other studies found that the higher the education clergy obtained the more of a positive attitude toward seeking professional psychological counseling (McMinn & Runner, 2005) and may actually refer out when needed (Unger, 2011; Vespie, 2011). Education could have been overshadowed by theological beliefs; however it was controlled for and no correlation was found. In addition, some clergy do not place an emphasis on education for risk of de-spiritualizing their faith (Stansbury et al., 2011). Due to no correlation, the education of clergy is important and validated within their own denominations. Literature continue to support the need of mental health education within the faith based community and clergy asking for more information to make an informed decision (Mance, Mendelson, Byrd, Jones, & Tandon, 2010; Stansbury et al., 2011).

Personal Experience With Mental Illness

Two studies supported that experience with mental illness, increased positive behavior toward mental illness (Angermeyer & Matschinger, 1996; Roth et al., 2000). There continues to be conflicting research on the effects of personal experience versus personal beliefs. This could be different or the same, depending on whom you are speaking with. Leavey (2008) noted that theological beliefs could be influenced by personal experiences. This study did not look at the influence of personal experiences on theological beliefs, however this would be an opportunity to do so in the further research.

Implications

Research tell us that the role of religion and spirituality in times of psychological distress can have positive and negative effects on ones lives. The implications of this study de- stigmatizes the current beliefs of conservative pastors due to the study showing a positive correlation of theological beliefs and attitudes of African American clergy regarding mental health seeking behavior. The social impact of African American clergy on their community starts at the pulpit and filters to the doctor's office. Being a voice when someone has none, supporting what others deem taboo, and providing when the resources are limited can lesson the gap of mental illness in the African American faith based community.

Positive Social Change

It is clear that congregants see African American clergy as a resource to their lives, however the impact is much bigger than just faith. One referral or one counseling session impacts the family and the community as a whole. In most cases the church or the pastor is the first to know, however what is done with this information is the question. A

need for more culturally diverse interventions are needed within the community (Allen et al., 2009). Culturally diverse interventions begin within the actual community, versus just from the church. This would include health fairs, community surveys, and collaboration with local health stores/centers.

Social change in mental illness is bringing awareness to the secrets and hidden issues that have been barriers to congregants seeking professional mental health care. The church as well as the leadership (clergy) can expose these implications without shame, blame, ridicule, or stigma. This is due to the trust that is embedded in the church system. This would increase access and awareness within the community (Parrill & Kennedy, 2011). Not finding a correlation with personal experience and attitudes affect seeking psychological counseling does mean that mental illness does not exist in the lives of African American clergy. It just means that it has not affected their view of mental illness regarding their congregation or its effects on their theological beliefs.

For practical reasons, this study allows the mental health providers (MHP) to further understand the importance of religion in the lives of their clients. This study is far from providing clinical recommendations, however it lays a foundation for MHP and clergy to dialogue about mental health utilization. It does not have to be one way or another, but both can exist to take care of the patient. This includes improving alliance and collaboration with clergy and MHP (Lish et al., 2003; Mark McMinn et al., 2003).

Lastly, the HBM provides a theoretical basis for accessing current programs and treatment seeking behavior (Henshaw et al., 2009). Prior research is limited on theoretical frameworks for mental health utilization due to the variation of variables (race, income, education, size of congregation) that have an effect. The HBM allows for programmatic

research that is able to determine which factors provide the best results. Due to its cognitive framework, it also provides an approach for interventions (pre post test). Utilizing systematic research creates opportunities for "public awareness campaigns, collaborative care, and preventive care policies" (Henshaw et al., 2009, p. 435).

Conclusion

This study offers a useful foundation of mental health utilization using the HBM as the theoretical framework to look at African American clergy attitudes toward seeking professional psychological mental health services. The study reviewed African American clergies' theology, education and personal experience with mental illness as factors. The study found that theology had a direct affect on their attitudes toward seeking professional psychological counseling, but not education or personal experience with mental illness. While 2 out of 3 null hypothesis was accepted, it still spoke volumes about the spiritual/religious background of African American clergy when it comes to viewing mental health.

For congregants with mental illness, their first choice of treatment will most likely be their clergy. With this in mind, clergy will have to answer some questions regarding what to do with the mental illness/congregant, i.e. 1) how severe are the symptoms (Do I treat or refer out?) 2) how do these symptoms effect the life of the congregant (Is this spiritually based or is something really wrong?) 3) what are the barriers facing the congregant (stigma, shame, distrust in the church, financial) and 4) what are the benefits (trust, access, accessibility).

Education would be more important from the standpoint of the congregant and the community (public campaigns) to bring awareness and increase accessibility to mental

illness. Personal experiences with mental illness will be variable, as the perspective of clergy can have many influences. In conclusion, this study did not provide answers to all these questions; however it did provide a platform to promote dialogue to get some of these questions answered.

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Appendix A: Demographic Survey

DO NOT PLACE YOUR NAME ON THE SURVEY!

This research requires certain demographic data. Please answer the following questions completely so that certain variables in the research may be understood.

Thank you.

Identification Code First two initials of first and last name followed by 2 digit birth year, ex. JOSM67 for John Smith 1967.

_____

1**. Age Range** (check one)

_____25-35

_____36-45

_____46-55

_____56-65

2. **Race** (check one)

_____ African American

_____ Caucasian

_____ Native American

_____ Other (specify)

3. Percentage of congregation African American (check one)

_____ 0% - 30%

_____ 30% - 50%

_____ 50% - 70%

_____ 70% - 90%

_____ 90% - 100%

4. Educational Level Attained (Please check the highest degree earned)

_____ High school/GED

_____ Some College/College Degree

_____ Masters Degree/Doctorate

_____Other (please specify)

5. What is your denomination?_____

6. Do you have any **personal experience with mental illness**? This is defined as knowing someone (family member or friend) and or you personally have experienced mental illness It does not matter whether treated, untreated, past, or present.

____ Yes ____ No

7. Do you wish to be mailed a brief summary of the results of this study? If so, please place your ADDRESS ONLY below. Do not include your name or church affiliation.

_____

_____

Appendix B: Religious Attitude Scale (Poppleton & Pilkington, 1963)

Below are 21 statements that concern religious beliefs. Please indicate the extent to which you agree or disagree with each of them. On the right-hand side of the page you will find five alternative answers. Place an "X" opposite each statement in the column that best represents your opinion.

Please do not leave any answers blank even if you are unsure or find it difficult to make up your mind. Remember your answers are confidential.

STATEMENT	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
EXAMPLE: More time in broadcasting should be allowed to agnostic speakers			*X*		
1. To lead a good life it is necessary to have some religious belief (3.15)	6	6	5	4	2
2. Jesus Christ was an important and interesting historical figure, but in no way divine (9.84)	2	2	2	5	7
3. I genuinely do not know whether or not God exists (5.59)	2	2	4	6	6
4. People without religious beliefs can lead just as moral and useful lives as people with religious beliefs (6.90)	2	4	5	6	6
5. Religious faith is merely another name for belief which is contrary to reason (10.05)	2	2	4	5	7
6. The existence of disease, famine and strife in the world makes one doubt some religious doctrines (7.43).	2	2	4	6	6

STATEMENT	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
7. The miracles recorded in the Bible really happened (1.22)	6	6	4	2	2
8. It makes no difference to me whether religious beliefs are true or false (6.20)	3	3	3	4	5
9. Christ atoned for our sins by His sacrifice on the cross (0.62).	7	6	4	2	1
10. The truth of the Bible diminishes with the advance in science (9.00).	2	2	3	6	6
11. Without belief in God life is meaningless (0.73).	7	6	4	2	1
12. The more scientific discoveries are made the more the glory of God is revealed (1.47).	6	6	3	2	2
13. Religious education is essential to preserve the morals of our society (2.64).	6	5	4	2	2
14. The proof that Christ was the Son of God lies in the record of the Gospels (1.53).	6	6	3	2	2
15. The best explanation of miracles is an exaggeration of ordinary events into myths and legends (8.71).	2	2	4	6	6
16. International peace depends on the worldwide adoption of Christianity (2.06).	6	6	5	3	2
17. If you lead a good and descent life, it is not necessary to go to church (7.33).	2	3	4	6	6
18. Parents have a duty to teach elementary Christian truths to their children (2.70).	6	5	3	2	2
19. There is no survival of any kind after death (10.37).	1	1	2	5	7
20. The psychiatrist rather than the theologian can best explain the phenomena of religious experience (8.88).	2	2	3	6	6
21. On the whole, religious beliefs make for better and happier living (3.32)	6	5	3	2	2

Appendix C: Attitudes Toward Seeking Professional Psychological Help Scale

(Fischer & Turner, 1970)

Below area a number of statements pertaining to psychological and mental health issues. Read each statement carefully and indicate your response. Please express your frank opinion in your answers. There are no wrong answers. The right answers are your honest feelings and beliefs. It is also very important that you answer each item.

STATEMENT	Agree	Probably Agree	Probably Disagree	Disagree
1. Although there are clinics for people with mental troubles, I would not have much faith in them.				
2. If a good friend asked my advice about a mental problem, I might recommend that he/she see a psychiatrist, psychologist, or counselor.				
3. I would feel uneasy going to a psychiatrist, psychologist, or a counselor because of what some people would think.				
4. A person with strong character can get over mental conflicts by himself or herself, and would have little need of a psychiatrist, psychologist, or counselor.				
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.				
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.				
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.				
8. I would rather live with certain mental conflict than go through the ordeal of getting professional treatment.				
9. Emotional difficulties, like many things, tend to work out by themselves.				

STATEMENT	Agree	Probably Agree	Disagree	Probably Disagree
10. There are certain problems, which should not be discussed outside of one‘s immediate family.				
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.				
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.				
13. Keeping one‘s mind on a job is a good solution for avoiding personal worries and concerns.				
14. Having been a psychiatric patient is a blot on a person‘s life.				
15. I would rather be advised by a close friend than by a psychologist even for an emotional problem.				
16. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.				
17. I resent a person, professionally trained or not, who wants to know about my personal difficulties.				
18. I would want to get professional attention if I was worried or upset for a long period of time.				
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
20. Having been mentally ill carries with it a burden of shame.				
21. There are experiences in my life I would not discuss with anyone.				
22. It is probably best not to know everything about oneself.				
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				

STATEMENT	Agree	Probably Agree	Disagree	Probably Disagree
24. There is something admirable in the attitude if a person who is willing to cope with his or her conflicts and fears without resorting to professional help.				
25. At some future, I might want to have psychological counseling.				
26. A person should work out his own problems; getting psycho- logical counseling would be a last resort.				
27. Had I received treatment in a mental hospital, I would not feel that it ought to be ―covered up.				
28. If I thought I needed professional help, I would get it no matter who knew about it.				
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, clergymen, and counselors.				

From "Orientations to Seeking Professional Help: Development and Research Utility of an Attitude Scale," by E.H. Fischer and J.L. Turner, 1970. *Journal of Consulting and Clinical Psychology, 35,* pp. 82-83.

Appendix D: Brief Introductory Letter

SUBJECT: You are invited to participate in a research survey

Dear Pastors,

You are invited to participate in a research study titled "African American Clergy's Attitude Toward Professional Mental Health Services". This study survey is being conducted by Ebony Gaffney and her research committee from the Department of Public Health at Walden University.

The purpose of this survey is to gain a better understanding on what you do as a clergy for your congregation who ware faced with a mental illness. Particularly, the African American communities depend on the church to provide services for their needs. However, currently there appears to be a gap in mental illness and the church and the goals of the survey are to determine how to best fill that gap by identifying areas of improvement. We will art by finding out how you feel.

The enclosed questionnaire has been designed to collect information on basic demographic information (anonymous), you religious beliefs, and you attitude regarding professional mental health services during psychological distress.

This survey study is approved by the IRB at Walden University and has met all ethical standards. If you agree to participate in this project, please answer the questions on the survey as best you can. It should take approximately30 minutes to complete. Please return the questionnaire as soon as possible in the enclosed business reply envelope.

If you have any questions about this project, feel free to contact Ebony Gaffney (Principal Investigator) @ 912-660-4162 or ebony.gaffney@waldenu.edu.

Thank you for your assistance in this important endeavor.

Sincerely yours,

PRINCIPAL INVESTIGATOR