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The Perception of African American Clergy Regarding Mental Health Services

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The rise in diagnosable mental illness disorders in the United States is a major concern. However, researchers indicate that African Americans are far less likely to seek mental health treatment than Caucasian Americans. This qualitative, phenomenological study addressed a research gap regarding the beliefs, perceptions, stigmas, and practices of African American clergy regarding their promotion of mental health services. Two conceptual frameworks consisting of the sociocultural theory and the social learning theory guided the study. There were two research questions used to guide the exploration of the purposive sampling of 6 African American clergy from major African American denominations across the southeastern United States. Responses from the in-depth, semistructured interviews, after being analyzed, coded, and categorized, were grouped into 3 main themes: (a) stigmas African American clergy have regarding mental illness, (b) African American clergy's promotion of secular counseling for mental health treatment, and (c) clergy's personal experiences with mental illness and secular counseling. The results were that African American clergy had stigmas regarding the use and promotion of mental health services and relied more on prayer as the first line of defense. Social change implications include bringing awareness to African American clergy at large and how their perceptions, beliefs, stigmas, and practices affect their congregations and communities. An increased knowledge of mental illness and interventions, with sensitivity to African Americans culturally and spiritually, may improve the rates of African Americans help-seeking behaviors and minimize the risk of stigmatization.

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Dedication

I dedicate this dissertation to my family. This simple paragraph could never summarize my level of gratitude to my parents for all the love, support, and encouragement that have been the foundation of my life. To my best friends (Mommy and Big Sis), your countless hours of reading, proofreading, and discussion about my dissertation journey and subject matter were priceless. Our three-way conference calls gave me moments to breathe, catch my breath, and laugh. Mommy, even when cancer tried to sideline you, you never complained and never stopped cheering me on. You are a living example of grace, and I honor you. To my sister and brother for understanding the struggle from which our passion for service comes, I treasure our bond and appreciate the undying support that could only come from a sibling. And Daddy, I am still singing because it's in my heart. To Uncle Walter, who loved me for who I am totally—until your last breath. You were proud of my educational accomplishments, talents, and gifts, and I know that you would be proud of this one too.

I am not sure if it is appropriate to liken this process to the seven last words (more like phrases) of Jesus Christ, but certainly throughout this process, I found myself talking to God and talking to others who were on the same journey. I discussed this process with my mother and sister on various occasions trying to gain confirmation that the decision to do this was right; I found myself depleted and thirsty during the process, but remained committed to completing the task. And so now, I say, "It is finished" and all things are in your hands God—including this dissertation. Thank you!

To my three lovely nieces and adorable nephew who hugged, kissed, and showered me with love just because I am "Auntie." There is no substitute for the level of love I feel from you or the level of love I give back. Each one of you gives me a real reason to live. To my father, brother, and sister-in-law for being the loving, caring, and concerned spirits that God made you. I love you all with everything that is in me.

With that said, I have to thank God for blessing me with a supportive and loving family. Thank you Joy (my sister), for listening to my weariness when the process became tough. Your strength and encouragement goes unmeasured. When I didn't have the strength to jump the hurdles—you pulled me over each one. You were a constant cheerleader and witness to the journey, and I could not have done this without you. To my mother, I am blessed beyond measure to have your love, prayers, and support. I am forever thankful for your willingness to read every paper throughout my educational career. Even through your illness, you never wavered in your support for me, and I can only pray that I learn how to live with the grace that you display daily.

Without a doubt, the quiet blessing that God blessed me with—Tyga. You have been my strength, protection, confidant, love, and friend. Thanks for holding my hand, making me laugh, catching my tears, and reminding me of my priceless worth. Now we can prepare for the next chapter of our book.

At the end of all of this, I owe this accomplishment to my maternal grandparents (Lonnie and Ada Talley), affectionately known as Granddaddy and Nana, for ingraining love and the spirit of service into the fabric of my family. I wish that you both were still with us. I know that you would be proud of me. Thank you!

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To the president and staff for allowing me to use the student body to conduct my research, I appreciate you. I am grateful for the experience to have walked the halls of

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To my dissertation chair, Dr. Gregory Hickman, it has been a pleasure traveling down this road with your support. Thank you for your understanding and belief in my study. To Dr. Jaeckle, I appreciate your generosity of spirit for agreeing to serve on the committee despite your workload and other obligations.

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Chapter 1: Introduction to the Study

Introduction

Approximately one half of the population in the United States will suffer from a mental disorder over the course of their lifetime (Gamm, Stone, & Pittman, 2010), which translates into one in every 10 children and one in every four adults suffering from mental illness at any one time (Leong & Kalibatseva, 2011). Analysts for the World Health Organization reported mental illness was a major public health issue in the 1990s and put it in the same category with other serious illnesses such as cancer and heart disease (Keyes, 2014). Mental illness is a term that encompasses all diagnosable mental disorders, which are schizophrenia, affective disorders, and anxiety disorders (U.S. Department of Health and Human Services, 2010). Out of the three diagnosable mental disorders, Neighbors, Hudson, and Bullard (2012) estimated that affective disorders such as depression affect 14 million Americans in a given year.

Mental health issues exist among all races of people, including Hispanic, Asian, Caucasian, African American, American Indian, and Native Hawaiian (U.S. Department of Health and Human Services, 2013). However, Aten, Topping, Denney, and Bayne (2010) concluded that African Americans' beliefs regarding mental health and stigmas associated with mental health issues face may be heightened by their social stresses. For example, while Payne (2009) asserted that African Americans seek assistance with coping with depression and distress from family, spiritual leaders, and professionals, Holt, Wang, Clark, Williams, and Schulz (2013**)** found cultural beliefs and stigmas

associated with seeking counseling equated to being angry or weak and carried a negative burden of shame.

I will use the terms *African American* and *Black*, as well as *Caucasian American* and *White*, interchangeably throughout this study. Cook (2013) described the terms Black and African American as common and used interchangeably across the United States. Smith (2014) noted the distinction between people of color in terms of difference helps to validate the centering of the Caucasian population.

Background

Various reasons exist regarding why people seek and do not seek aid for mental illness (National Institutes of Mental Health, 2014). For instance, lack of money, lack of insurance, lack of access to affordable and effective services, and severe mistrust are reasons African Americans do not seek mental health services or underuse mental health services (Masuda, Anderson, & Edmonds, 2012). Corrigan (2005) claimed stigmas are the most critical hurdle that African Americans need to overcome regarding their use of mental health services.

Defining stigmas can be challenging, as a variety of definitions exist (Clement, Jarrett, Henderson, & Thornicroft, 2010). Goffman (as cited in Katz, 2014) discussed three types of stigmas: (a) *abominations of the body*, which include physical deformities, disabilities, and chronic diseases; (b) *blemishes of individual character*, inferred from a recorded or known history of socially deviant behavior; and (c) *tribal stigmas of race, nation, and religion* (p. 4). Corrigan (2005) noted that stigmas relate to individuals' negative perceptions about mental illness and mental illness treatment options.

Owen, Thomas, and Rodolfa (2012) asserted that higher perceptions of stigmas are found in men and racial and ethnic minorities than in women and Euro-American or White individuals. Three types of stigmas are public stigma, self-imposed stigma, and social stigma (Katz, 2014). Public stigma is associated with how society reacts to individuals who suffer from and seek help for mental illness (Corrigan, Morris, Michael, Rafacz, & Rusch, 2012). Self-imposed stigma refers to the internalization of how society and social networks react to an individual's mental illness (Bathe & Pryor, 2011). Vogel, Wade, and Hackler (2007) noted the fear of what others think about an individual who seeks counseling becomes a self-stigma.

A number of professional mental health options for people in the United States dealing with psychological and emotional issues include family therapies, social workers, counselors, and psychiatrists (Taylor, Chatters, & Levin, 2004). Conner et al. (2010) determined that only one third of the population with diagnosable mood disorders seeks treatment. Roberts, Gilman, Breslau, Breslau, and Koenen (2011) found that minorities, including African Americans, were far less likely to seek mental health treatment than Caucasian Americans. Barksdale and Molock (2009) asserted that the comparison between the rate at which African Americans and Caucasian Americans seek mental health services directly relates to family traditions.

For African Americans, family traditions include connections to the church and clergy and represent a primary option for coping with mental health issues (Gardner, 2013). Payne (2009) noted that clergy are a vital part of the African American community because they are often present during milestones (e.g., weddings, childbirths,

baby dedication services, deaths, funerals). With the church and clergy playing such a major role in the lives of African American families, the church and clergy became a natural mental health resource for the African American community.

The juxtaposition of counseling, stigmas, and African American clergy is unique and understudied (Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011). In a recent study, the levels of trust and mistrust in the U.S. health care system are high, particularly among African Americans (Scharff et al., 2010). Studies about how tradition and cultural values affect African Americans (Abdullah & Brown, 2011) can be useful to highlight the perceptions, controversy, and distrust African American clergy have about secular mental health services labeled as intricate (Stansbury, Harley, King, Nelson, & Speight, 2012).

Cultural beliefs and practices, such as faith, language, social norms, and political understanding, are a confirmation of the idea that perceptions, beliefs, and stigmas aid in the decision-making practices of African Americans to seek or not seek assistance for mental illness (Paniagua & Yamada, 2013). Added to the issue of mental illness and ways to address stigmas related to beliefs and perceptions associated with seeking help is the ability to diagnose mental disorders efficiently due to cultural and religious beliefs that influence the expression and discussion of issues (Paniagua & Yamada, 2013). For instance, conditions such as fibromyalgia and other unknown or unlabeled conditions affect specific populations (Teo & Gaw, 2010). Such conditions, along with other cultural factors, can lead to issues such as stigmas that then lead to a reluctant attitude toward seeking and using mental health services (Paniagua & Yamada, 2013).

African American clergy hold positions of prominence and trust and serve as providers of information within the African American community (Gardner, 2013). What African American clergy think and say about mental health and counseling and the way they characterize mental illness is key to how members of their churches and community view mental health and counseling (Hankerson, Watson, Lukachko, Fullilove, & Weismann, 2013). However, research studies about the beliefs, perceptions, stigmas, and practices held by African American clergy regarding promoting the use of mental health services (Patterson, 2013) are few.

Problem Statement

African American clergy are a source of power in the African American community and have perceptions, beliefs, stigmas, and practices regarding mental health services. African American clergy may promote seeking mental health services among African Americans either directly or indirectly (Gardner, 2013). However, how clergy's perceptions, beliefs, stigmas, and practices contribute to African Americans not seeking mental health services remains unclear. Developing such an understanding may partly explain why African Americans seek mental health services less often than other ethnic groups, despite the continual and persistent mental health problems among the African American community (Gonzalez et al., 2011).

Purpose of the Study

The purpose of this qualitative case study was to discover the perceptions, beliefs, stigmas, and practices of African American clergy regarding the use of mental health services and the ways such variables directly or indirectly promote members of the

African American community to seek or not seek mental health services in an effort to reduce mental health problems. The particular perceptions, beliefs, stigmas, and practices of African American clergy active in ministry in urban areas were the primary focus. This group was representative of the diversity of African American churches in urban cities. The data collected from the study may be useful to inform clergy about how their perceptions, beliefs, stigmas, and practices related to mental health influenced their willingness to promote or not promote the use of mental health services. These results could also be useful in helping African American clergy to recognize how their perceptions, beliefs, stigmas, and practices affect their African American community. As such, the following research questions (RQ) guided the study.

Research Questions

RQ1: What stigmas did African American clergy have regarding mental illness?

RQ2: Did African American clergy promote secular counseling for mental health treatment?

Conceptual Framework

The two conceptual frameworks of this study were sociocultural theory and social learning theory. Social and cultural contexts serve as the foundation for sociocultural theory (Willis, 2009). Social and cultural contexts influence individual behavior and productivity while sociocultural theory examines this. Most relevant to this study was the ability to understand a group's environment. Many social learning theories derive from the work of Bandura, who promoted the idea that the behavior of humans is *observational learning* derived from the actors and the surrounding environment

(McLeod, 2011). Bandura (1977) noted that social learning theory (also known as social-cognitive theory) includes reciprocal interactions between the environment, personal factors, and individual behavior.

Social and cultural contexts reinforce the sociocultural theory and influence individual behavior and productivity (Willis, 2009). Understanding African American clergy's environment and context was relevant to this study. A number of social learning theories were useful in expanding the idea that observing the surrounding environment leads to learning and adaptations in human behaviors. The term used for this dynamic interactive process is observational learning (McLeod, 2011).

Corey (2013) noted that social learning theory or social-cognitive theory is a combination of interactions between environment, personal factors, and individual behaviors exchanged and reciprocated between members of a group and the environment. These theoretical frameworks were appropriate because they facilitated engagement with African American clergy. Furthermore, the results of this study were useful in providing an understanding of this subject and in forging collaborative efforts between counseling professionals and Christian leaders and educators to promote the use of counseling to address mental health issues.

Nature of Study

I focused on interviewing six African American clergy from the major African American denominations (Church of God in Christ [COGIC], Baptist, African Methodist Episcopal [AME], United Methodist, Christian Methodist Episcopal, or African Methodist Episcopal Zion). Respondents in the purposive sample received an e-mail

request to participate. Twenty-five invitations went to African American clergy. The invitation included details of the study and a request for their participation. The participants had 2 weeks to respond to the invitation.

When the invitation response deadline expired, I selected all the respondents to participate. Researchers who wish to narrow the pool of participants can select participants based on age, years of service, and availability to participate in an interview (Creswell, 2009). This qualitative case study is suitable for exploring the lived experiences and perceptions of participants (Marshall & Rossman, 2010), including African American clergy and the African American community inside and outside of churches, as they relate to mental health services.

The study collected data using in-depth interviews with 6 African American clergy from churches located within urban metropolitan areas in the southeast United States. These participants represented the COGIC, Baptist, and AME church and were the only participants out of 25 that responded to the invitation to participate in the study. Participants were selected through purposive sampling and I sought participants who could provide information on lived experiences of the African American community through the perspective of African American clergy.

Definition of Key Terms

African American: A person having origins in any of the Black racial groups of Africa (Centers for Disease Control and Prevention [CDC], 2014).

African American Church: Members of the seven to eight largest African American denominations, including the AME, the African Methodist Episcopal Zion

Church, the Christian Methodist Episcopal Church, the COGIC, Baptist (National Baptist Convention of America, the National Baptist Convention, USA, Inc., and the Progressive National Baptist Association), the United Methodist Church, and the Presbyterian Church USA (African American Registry, 2014).

African American community: An African-originated population of Black racial groups who live in the same areas and share a common cultural, ethnic, or historical formation (CDC, 2014; Oxford University Press, 2014**)**.

Beliefs: Another word for faith, which holds a high regard for the perceived truth or nature of God (Harvey, 1992).

Clergy: Christian ministers, elders, pastors, bishops, and lay leaders (Harvey, 1992).

Culture: A socially learned behavior, including behavior and thought, influenced by society (Zimmermann, 2012).

Faith: An observance regarded as a belief of some truth about the nature of God (Harvey, 1992).

Mental illness: A syndrome characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning (American Psychiatric Association, 2013).

Perception: The act of becoming aware of something; a spiritual awareness or understanding of something considered general in nature (Kalderon, 2015).

Public stigma: Public stigma is a set of negative attitudes and beliefs that influence individuals to reject, fear, avoid, and show prejudice toward people with mental illness (Corrigan et al., 2012).

Stigma: The term, stigma, has been difficult to define, but Goffman described stigma as an "attribute that is deeply discrediting, and reduces the bearer from a whole and usual person to a tainted, discounted one" (as cited in Link & Phelan, 2013, p. 526).

Tribal stigma: Different forms of stigma that people experience and categorize mainly as public stigma or self-stigma. Physical stigma, as noted in Goffman's Greek example, is not the main source of stigma. More specifically, tribal stigma in the 21st century is social and cultural (Shin, Dovidio, & Napier, 2013) and can be the result of social disapproval (Bos, Pryor, Reeder, & Stutterheim, 2013) with a global reach in an era of technology in which information spreads in minutes. For this study, the unit of analysis was African American clergy's perceptions regarding mental illness and the self-stigmas and tribal stigmas that inform their perceptions about mental health services.

Assumptions

Assumptions included basic ideas outside of the researcher's control and considered true (Simon, 2011). For this study, I assumed that all participants participated of their own volition, without any coercion, promise, or benefit of any kind for their participation. Another assumption was that the consistency with which I handled data added to the content validity of the study because the content came from clergy participating in the study.

Scope of the Study

Simon (2011) indicated that delimitations are characteristics that limit the scope and define the parameters of a study and are in a researcher's control. Delimitations include research questions, theoretical perspectives, and the population investigated. Participants were clergy practicing in one of the major African American Christian denominations. African Americans of other faiths (such as Muslims, Jews, and Buddhists), or those who were agnostic or atheist, could and should be included in a larger or future derivative research project. The participants had the option to participate in the interview via telephone, Skype, or in person at a mutually convenient location.

Time and participants' timeliness and willingness to be honest and transparent in their responses limited the scope of this research. By relying on interview responses, I had no way to guarantee or verify the truthfulness or accuracy of participant responses. To mitigate the risk of dishonest responses, I called upon the participants' responsibilities as leaders to be open and to help discover viable solutions to mental health issues in the African American community.

Limitations of the Study

The purpose of this study was to explore clergy perceptions regarding mental health services. This study, as with all research, had many limitations that need acknowledgment. The first limitation was that the study only included African American Christians. Thus, no one can make any inferences about how other racial or ethnic clergy group perceptions, beliefs, stigmas, and practices influence their decision making regarding mental health services based on the results of this study. Further, the sample

size for the study was small. Though 25 invitations went out to clergy to request their participation in the study, the number of responses received was six.

Other limitations in this study were time, geography or location, race, and religious affiliation. Qualitative research includes the potential for personal bias, especially when analyzing individuals within the same culture or with similar backgrounds. For this reason, I kept a reflective journal to minimize personal bias. After the interview transcriptions were complete, I sent copies to all the participants to ensure the information and experiences that they shared were accurate and as described.

I share the same cultural background as the participants. Some participants had an affiliation with the same denomination of which I am a part. However, I had no direct links to any participants interviewed for the study. In an effort to protect the ethical integrity of the study, I shared my denominational status prior to conducting the interviews. My knowledge and cultural ties to the African American community provided a deeper understanding and passion for the participants' experiences.

Significance of the Study

The significance of this qualitative case study was to understand how African American clergy promote the use of mental health services in African American communities. The participants from a target group of African American clergy were a population invested in the well-being of the African American community in general. Clergy in the African American community are often the first line of defense when members face various issues. As a result, clergy can play a useful role in formulating

solutions for eliminating the negative perceptions, beliefs, stigmas, and practices associated with African Americans seeking counseling or mental health services.

The further significance of this study was in the prospect of profound social change presented through this research. A change in how African American clergy become aware of their own perceptions, beliefs, stigmas, and practices (Hays & Aranda, 2015) is significant and worthwhile. This study could be useful in generating a reassessment of the responsibility African American clergy have to their constituents regarding mental health services, which could positively affect the greater community.

Summary

This study on the perceptions of African American clergy regarding stigmas of the African American community seeking mental health services was an opportunity for further research about changing the perceptions of mental illness in the African American community. The themes found from existing literature included the following:

1. Stigmas in the African American community are more likely to be self-imposed by the tribe or group (Masuda et al., 2012).
2. Stigmas in the African American community are a result of traditional beliefs that seeking treatment for mental illness is a sign of weakness (Gardner, 2013).
3. The African American community has fears associated with what others think about individuals who seek counseling (Vogel et al., 2007).
4. Clergy influence decision making in the African American community (Gardner, 2013; Payne, 2009).

These existing themes are highlights in the discussion that clinicians, counselors, psychologists, therapists, and other human services professionals might have and conversations that might emerge as a result of this research. This approach could be instrumental in realizing the connections African American clergy have to stigmas about mental health services. More so, this qualitative approach could lead to ways for African American clergy to use their power to combat stigmas of African Americans seeking counseling and mental health services in their churches and communities.

To conduct this study, I focused on African American clergy in urban areas who were serving in the six major African American denominations in the United States. I purposively selected participants through e-mailed requests to participate in the study. The e-mail requests went to African American clergy with the goal of interviewing a sample of 6 to 10 participants.

For the purposes of this research, the term, *clergy,* included African American Christian pastors and ordained ministers in leadership positions who offered services such as spiritual counseling in the absence of the pastor as a part of their clergy or ministerial responsibilities. The clergy group who participated had access to congregations and communities influenced by the attitudes of clergy and their beliefs regarding mental health service. Understanding this phenomenon is an opportunity to lend experience and understanding to (a) the African American community and (b) mental health professionals regarding how to provide services more effectively. The review of the literature will include the gaps that exist in existing literature and the importance of the study in addressing those gaps.

Chapter 1 included background information on the rationale for exploring the perceptions, beliefs, stigmas, and practices of African American clergy regarding mental health. Like cancer and heart disease, mental illness is a major public health issue (Keyes, 2014). Mental health issues exist among all races, including Hispanic, Asian, Caucasian, African American, American Indian, and Native Hawaiian (U.S. Department of Health and Human Services, 2013).

Aten et al. (2010) noted that the societal stresses that African Americans face might heighten their beliefs regarding mental health and stigmas associated with mental health issues. Payne (2009) asserted that African Americans seek assistance in coping with depression and distress from family, spiritual leaders, and professionals. Cultural beliefs and stigmas associated with seeking counseling translate into being angry or weak and carry a burden of shame (Holt et al., 2014).

These conceptual frameworks facilitated and framed my engagement with participating African American clergy. Specifically, my interview questions were developed from the components of social learning and sociocultural theory. The findings from this study may be a helpful resource to counseling professionals and Christian educators. For instance, understanding the history and relationship between religion and mental health is essential for addressing the commonality, conflict, controversy, and distrust religious communities had with the mental health community (Sullivan et al., 2014). Having an awareness of this relationship is critical to clergy and mental health professionals who seek to meet the needs of people in the church, mental health facilities, and communities.

Chapter 2 includes an in-depth synthesis of the literature to uncover the challenges related to mental illness that I explored in this study. The research methods selected for the study appear in Chapter 3. Chapter 4 includes results of the study, and Chapter 5 includes a summary, conclusion, and recommendations for future research.

Chapter 2: Literature Review

Introduction

The purpose of this study was to gain an understanding of mental health issues among African Americans and the influence that African American clergy may have on decisions to seek or not seek counseling outside of clergy. The focus was on the perceptions of African American clergy regarding stigmas of the African American community seeking mental health services. The literature review search spanned several areas of study, including general mental health issues, mental health issues as they relate to African Americans, stigmas related to African Americans' perception of mental health service and counseling, the influence of African American clergy in the African American community, the influence and perceptions of African American clergy regarding mental health services and professional counseling, and how African American clergy promote or discourage the use of mental health services.

Search Strategies

Several databases and keyword searches revealed relevant and recent peer-reviewed articles on the topic. Resources used included Google Scholar and databases such as ProQuest Central and Academic Search Complete, available through the Walden University library, Candler Theological Seminary, and Pitts Theology Library at Emory University. Examining the existing body of literature using an exhaustive list of keywords and phrases led to the basis for this study. The keywords and phrases were as follows: *African Americans, African American clergy, mental health stigmas, counseling stigmas, depression, pastoral counseling, professional counseling, faith, weak faith,*

strong faith, mental health services, church counseling, pastoral advice, clergy certification, distrust of mental health system, cultural bias, fear of counseling, distrust of counseling, mental illness, mental illness among African Americans, mental illness among African American clergy, African American clergy promoting mental health services, and *promoting the use of mental health*.

Following an introductory overview of sources related to the conceptual frameworks, this chapter included a review of studies on African American cultural beliefs, African American stigmas, and distrust of mental health services. The first part of this literature review is background on African American cultural beliefs, African American stigmas, and distrust of mental health services. The second is an examination of the types and rates of mental health issues that affect the African American community, as well as the rates of use and effectiveness of mental health or counseling treatments on African Americans who use them. The final is a presentation of the status and influence of African American clergy perceptions of mental health services. I conclude the chapter with additional information regarding how their perceptions result in the promotion or nonpromotion of mental health services to the people they serve.

Conceptual Frameworks

The two conceptual frameworks used for this study were sociocultural theory and social learning theory. These theories were the basis for the research inquiry and interview questions. Components of these two theories were compatible with the process of exploring the lived experiences and reasoning of African American clergy regarding mental health stigmas and counseling services.

Sociocultural Theory

Much of the prevailing understanding and application of sociocultural theory is from the Russian psychologist, Vygotsky (Mahn, 2013), whose work emphasized educational assessment. The basis of sociocultural theory, also known as the cultural historical theory, was Vygotsky's objective of confirming behavior and cognition through genetic analysis (DeValenzuela, 2013). Mercer and Howe (2012) noted that sociocultural theory is an explanatory framework used in the process of learning and cognitive development.

Willis (2009) indicated that the perspective of sociocultural theory is a communal perspective developed in both social and cognitive ways through learning from other members of the same cultural group. Murphy, Sharp, and Whitelegg (2006) posited that sociocultural theory is a part of a social structure and a relational system instead of solely referring to a lack of learning or instruction. Therefore, social learning theory occurs by participating in the community (Willis, 2009). Over time, researchers (Ahn & Ettner, 2013; Kaptelinin, 2013) have expanded the application and usefulness of the theory in areas not limited to the field of education.

Sociocultural theory, when applied to African Americans, is derived from their heritage of the cultural and learning practices brought to this country from Africa through slavery (Murrell, 2012). For African Americans, sociocultural learning includes the interconnectedness of identity and learning (Nasir & Shah, 2011). Sociocultural learning becomes normal practice and influences community members' decision making based on cultural beliefs and support (Dickson, McCarthy, Howe, Schipper, & Katz, 2013). The

sociocultural approach is an active bidirectional relationship between individuals and their environment and their adaptation to changes within the environment over periods of time (DeValenzuela, 2013).

Social Learning Theory

Bandura explained the social learning theory as learning focused on one's environment, behavior, and psychological process (Adnan & Tasir, 2014). According to the social learning theory, role models influence the understanding and practice of moral and other behavioral patterns (Brown & Trevino, 2014). Social learning involves engagement in activities, discussions, and considerations for what social life is and how individuals should experience it (Wenger, 2010).

In conjunction with the social learning theory as learning, participants in the community create words, concepts, resources, stories, and other documents to display a shared experience (Wenger, 2010). Corey (2013) suggested that social learning theory included interactions among the environment, personal factors, and individual behaviors reciprocated among individuals. Social learning systems include communities that practice learning through the lens of community characteristics (Wenger, 2010). With this type of learning, individuals are able to negotiate their own identity and cultural meaning.

According to a new understanding of social learning theory, social learning had a social change element where people learned from one another in a manner that benefitted a broader and wider system (Reed et al., 2010). Previous researchers expanded on Bandura's conceptualization of the individualization of social learning and that social

learning occurred in a social context informed and influenced by social norms (Bandura, 1977; Reed et al., 2010). Other researchers believed that power dynamics being responsible for bridging knowledge and influencing learning outcomes and leading to social learning was a simplistic theory (Cundill, 2010; Wildemeersch, 2007).

While much research exists on Bandura's social learning theory, some have taken issue with the theory and its offshoots, including the theory of planned behavior (Ajzen, 1985). Sniehotta, Presseau, and Araújo-Soares (2014) questioned the utility and validity issues of the theory of planned behavior in ways that may also apply to Bandura's social learning theory, such as whether the theory of social learning provided a completely accurate or comprehensive picture of human behavior and learning. Bandura's social learning theory (Rodela, 2013) added focus on the environment and psychological processes, along with observations of behavior, coupled well with sociocultural theory to anchor this study.

The view of social learning theory is that behaviors are learned through interactions with a series of socializing agents to which one is disclosed. As a result, it is through these interactions where behaviors are either adapted or quenched (Brown et al., 2005). Similarly McHale, Dotterer, and Ji-Yeon (2009) found that children learn from what they do in their everyday lives. This directly relates to the participants in this study as the objective was to explore the everyday experiences of African American clergy and their perceptions, beliefs, stigmas, and/or practices regarding mental health services. Social learning theory suggests that it is the everyday activities and practices of individuals, including African American clergy that influence their identity development,

social relationships and understanding at an early age. It is during these activities and practices where children start to see and develop their own understanding and begin to identify with the leaders of the activities and practices. The extent to which one is influenced and emulates the behavior of a role model or leader is imitation (Sellers, Cochran, & Branch, 2005). Furthermore, in order for imitation to happen there has to be a recognized personal relationship and an explicit observation of the role model's behavior.

Thus, using social learning theory will provide the opportunity to learn how perceptions, beliefs, stigmas, and/or practices of African American clergy regarding mental health services were learned from their parents, role models, and/or cultural leaders (including clergy). More so, the study will explore how the perceptions, beliefs, stigmas, and/or practices of the African American clergy participants are interjected onto the church membership and community that they serve. The in-depth interviews allowed the interviewees to disclose how they learned about mental illness, mental health services and stigmas related to both. The exploration of this connection shed light on the decision making process of African American clergy and thus how members of the church and community take on these same practices as normal.

On the other hand, sociocultural theory includes both human interaction and shared practices (Vygotsky, 1978). These human interactions and shared practices can occur as traditions, customs, practices, values, roles, and norms inflicted on by society and culture that influence an individual's behaviors, attitudes, and beliefs (Boundless, 2014). The basis for using sociocultural theory along with social learning theory is

because it explained how learning is greatly impacted by social interaction and cultural beliefs (Vygotsky, 1978). Specifically, sociocultural theory would place the participants of this study in the context of the African American experience (Hunter & Schmidt, 201).

This theory provided a conceptual framework to assist in exploring the perceptions, beliefs, stigmas, and/or practices of African American clergy regarding the use mental health services. Pamental (2010) suggested that the sociocultural framework included the process of internalization and how humans interact with their environments influences their development of identity and patterns of behavior. More importantly, using sociocultural theory infused Vygotsky's conceptualization of how African American clergy's perceptions reflect their physiological, psychological, and sociological experiences (Pamental, 2010).

History of African Americans

Importing Africans from Western Africa to the southeastern United States over a 200-year period resulted in 4.5 million Africans being in the United States by the time of the Emancipation Proclamation (Asante, 2011). African Americans share a common origin in Africa and a long-standing struggle of racial oppression. African American populations are vast, but have a greater concentration in particular cities and states. According to a 1990 census, Asante (2011) reported that the greatest concentration of African Americans was in New York, with a population of more than 2.1 million. Table 1 includes other cities with high concentrations of African Americans.

Table 1

Concentration of African Americans

Cities (Demographic areas)	% of African Americans in this area
East St. Louis, Illinois	96
Washington, DC	70
Atlanta, Georgia	67
Detroit, Michigan	65
New Orleans, Louisiana	55
Memphis, Tennessee	49

American history has different meanings between various races. In particular, the African American experience of America began as slaves and later turned into a life of struggle (Marble, 2011), even after gaining their freedom. Slavery and racism caused trust issues between African Americans and Caucasian Americans. Researchers at Mental Health America (2010) provided statements that reflected some common misconceptions about African Americans and mental health (depression):

- "Why are you depressed? If our people could make it through slavery, we can make it through anything."
- "When a black woman suffers from a mental disorder, the opinion is that she is weak. And weakness in Black women is intolerable."
- "You should take your troubles to Jesus, not some stranger/psychiatrist" (Hastings, Jones, & Martin, 2015, pg. 6).

For African Americans, the unfair juxtaposition of race, class, and culture played out in many ways. Feagin (2010) posited that negative images and stereotypes displayed on television, movies, videos, and other media caused individuals from other races to view African Americans as self-destructive, ignorant, criminal-minded, violent, dirty, and

even ugly but to worship them as athletes. African Americans suffered more from the internalization of stigma, which was a major cause for African Americans' negative attitudes toward treatment for mental illness (Brown et al., 2010). Ennis et al. (2004) found that the African American community suffered from depression in large numbers.

Many major societal issues face African Americans. Harris (2010) noted that the societal issues that led to depression for African Americans included rates of unemployment, education, earning and wage disparities, health, and the constant underlying issue of racism. After seeing the results of a 1986 Gallup poll, Putman, Campbell, and Garrett (2012) indicated that religious observance in general had declined due to young people losing interest in formal religion.

Slavery and Mental Illness

African Americans have a long history of relying on the Black church and clergy as a resource for overcoming challenges (Lincoln & Mamiya, 2001). Billingsley (2003) indicated that the Black church has been directly involved in helping African Americans for hundreds of years. For instance, African American clergy and leaders in the Black church helped free Blacks establish a colony in Sierra Leone in the 1790s, helped ex-slaves during and after the Civil War, and continue to promote social change by being a pillar in the community (Billingsley, 2003).

Researchers at the National Institutes of Health (NIH) reported that the majority of African Americans could trace their ancestry back to slavery in Africa (Salas, Carracedo, Richards, & Macaulay, 2005). For 200 years or more, Africans were chattel and the personal property of their owners. Although most Northern states had started the

process to end slavery in the early 1800s, slavery remained strong in the South until 1863 with the Emancipation Proclamation and the Thirteenth Amendment to the U.S. Constitution in 1865 (Healy, 1995).

In 1868, African Americans became citizens and gained the protection of their civil rights in the Fourteenth Amendment (NIH, 2001). The Fifteenth Amendment of 1870 prohibited disenfranchisement based on race (Solomon, 2016). Although victories occurred in the fight against slavery and civil rights, the efforts did not eliminate the subjugation of African Americans. Many people in the Southern states created ways to mitigate the Fifteenth Amendment by implementing exclusionary practices to prevent Blacks from voting and receiving a formal education (NIH, 2001). These practices led to Jim Crow laws or Black codes, which reinforced the public separation of races and bolstered African Americans status as inferior to that of Caucasian Americans (NIH, 2001).

The inferior status of African Americans in the South lasted until the early 1950s (Thernstrom & Thernstrom, 1997). This condition included being at the bottom of the economic ladder as sharecroppers with low incomes lacked education and had no opportunities that led to living above the poverty line (Thernstrom & Thernstorm, 1997). The challenges and hurdles that African Americans endured were vast, but the African American community survived because of its commitment to religion and family (Broman, 1996).

From slavery to vindication by the *Brown v. Board of Education* ruling that racially segregated education was unconstitutional to prominent activists such as Martin

Luther King, Jr. advocating for civil rights, African Americans have developed beliefs and practices that strengthen their abilities to survive despite seemingly insurmountable odds (Taylor & Chatters, 1991). Crocker and Major (1998) indicated that African Americans developed the ability to overcome negative stereotypes and focus on positive African American influences as a reference point for what to believe and how to behave. As a result, African Americans believe most African Americans do not suffer from issues such as low self-esteem (Gray-Little & Hafdahl, 2000).

Understanding or finding the link between slavery and mental illness among African Americans was challenging because researchers have not focused on this element. However, researchers have described how negative treatment and subjugation of African Americans has led to a mistrust of authorities (NIH, 2001). Specifically, the efforts to sterilize American Indians and Blacks, known as the Tuskegee Experiment, were examples of the mistreatment of African Americans, even in the health care and medical research industry (Davis & Reid, 1999; George, Duran, & Norris, 2014). As a result of this type of abuse, research participation remains a barrier among African Americans and other minorities.

Prior to 1868, legislators in Virginia determined whether individuals were mentally ill based on whether they owned property (Foltz, 2015). The establishment of the Central State Lunatic Asylum for Colored Insane occurred in Petersburg, Virginia, in 1868 (Foltz, 2015). Since Blacks did not own property, they were at maximum risk of mental illness. The authors of the article expressed how diagnosing mental illness among slaves changed during the post-Civil War era until the civil rights era. For instance,

medical professionals could deem African Americans mentally ill and confine them to a facility for the insane for not following the laws of Jim Crow.

The significance and value of these historical records were considerable and remained safe after removing a threat to destroy them (Institute for Urban Policy Research & Analysis, 2014). Analysis of the records provided valuable discoveries regarding African Americans' mental health state (Metzl, 2011). Researchers believed that understanding why African Americans seek help from pastors and not mental health services were in these records, as well. Degruy (2005) credited African Americans as being strong and resilient, but noted they suffered from posttraumatic slave syndrome (PTSS).

PTSS is a condition that existed as a result of the multigenerational oppression of Africans and their descendants, deemed as chattel and genetically inferior to Caucasian Americans (Degruy, 2005). Degruy (2005) posited that slavery, Jim Crow laws, civil rights, and the prison industrial complex affect the psyche of the African American community even in the 21st century. Moreover, African Americans have passed down the ability to adapt and compensate as a form of survival across generations. African Americans with PTSS were unable to address their mental health issues outside of the trusted resources of family, friends, and clergy.

Another link to mental illness and slavery is the concept of drapetomania. During slavery, drapetomania emerged as a condition that caused Black slaves to flee from captivity (Cartwright, 1851; Summerfield, 2015). Thus, a Black slave's desire to be free resulted in a diagnosis of a mental illness or a disease that caused African Americans to

flee. Physician S. A. Cartwright coined the term, drapetomania, in 1851. Since that time, the term has undergone various modifications in meaning by various researchers studying the link between race, slavery, and mental illness (Kaba et al., 2015).

Kaba et al. (2015) conducted a study using inmates in the New York City jail system. Caucasian inmates had higher diagnosis rates of major affective and depressive disorder, as well as higher suicide rates, than their African American counterparts. African Americans had higher rates of schizophrenia and nonschizophrenic psychotic disorder diagnoses. Kaba et al. pointed out that similar disparities existed in the communities that the patients represented. Even though mentally evaluating all inmates was a practice in the jail system, a mistrust of medical professionals existed among inmates.

Kaba et al. (2005) also noted a correlation between mental illness and solitary confinement. Inmates' race and ethnicity determine whether an inmate with mental illness receives treatment or punishment (Baillargeon et al., 2009; Hetey & Eberhardt, 2014; Kaba et al., 2015). Kaba et al. found that 38.8% of African Americans and 25.6% of Hispanics with a mental health diagnosis went to solitary confinement, compared to only 8.8% of Caucasian inmates. Jail security and medical staff may be more likely to believe that behavioral problems with Caucasian inmates is a manifestation of mental illness and recommend treatment, whereas they believe non-Caucasians need punishment. Such disparities are evidence of the drapetomania theory, because prison officials and medical staff use race to determine whether a person is mentally ill, and African Americans received punishment instead of treatment.

In 1869, lawmakers in the Commonwealth of Virginia passed legislation that led to the establishment of the first asylum to care exclusively for African Americans in the United States (Foltz, 2015). The Central Lunatic Asylum for the Colored Insane was in Richmond, Virginia, and started accepting patients in 1870. Caucasian physicians believed that freed Blacks were not mentally, emotionally, and physically fit to be free.

During the last decade of the 19th century, some doctors in the South argued that freedom was the contributing factor that led to the increased admission rates of Blacks into insane asylums and diagnoses of mental illness (Foltz, 2015). North Carolina physicians Roberts and Murphy claimed the emancipation was the reason for the increased insanity rates among African Americans (Foltz, 2015; Roberts, 1883). Roberts (1883) also claimed that insanity in African Americans occurred as a result of freed Blacks lacking the mental stability to live as a free person. Furthermore, Roberts indicated that African Americans lacked the ability to control their emotions and were prone to become more superstitious and experience an emotionally charged religious experience than Caucasian Americans were.

To quell this inability to control their emotions, Roberts (1883) believed that slaves needed to be under the subjugation of a master. Georgia physician and president of the American Medico-Psychological Association, T. O. Powell, considered insanity the penalty that freed slaves paid for their freedom (Murphy, 1883; Powell, 1897). Foltz (2015) noted the patients at the Central Lunatic Asylum for the Colored Insane had a double stigmatization because they were both colored and insane.

African American Cultural Beliefs

African Americans have traditional values rooted in West African cultures. Embedded traits related to religion, family structure, moral values, faith, and so forth are intergenerational and influence contemporary African Americans (Brisbane, 2011). Asante and Asante, as well as Lincoln and Mamiya (as cited in Lumpkins et al., 2013), asserted (a) the Black church is a trusted organization in the African American community and (b) African Americans seek help from clergy for spiritual counseling and counseling for issues related to social, financial, educational, health, and other personal needs outside of spiritual ones. Although no direct research was available to confirm depression as the cause of mental illness, Jimenez, Bartels, Cardenas, Dhalivual, and Alegria (2012) noted that a number of perceptions exist about why African Americans experience depression and possible causes include the loss of family, friends, lack of money, and worry. Aside from depression and other mental health issues occurring among all races of people, Das, Olfson, McCurtis, and Weismann (2006) concluded that African Americans' beliefs about mental health and stigmas they associate with mental health issues might heighten and exacerbate the societal stresses that African Americans face.

Lindsey et al. (2006) found that African American boys between the ages of 14 and 18 consulted with family first about issues and would not share if they received assistance for mental illness. African Americans' level of mistrust of the American health system is a mindset that dates back to events such as the Tuskegee syphilis experiment (Scharff et al., 2010). Underlying financial issues, limited accessibility to health care,

inability to afford health care, shame and guilt, a fear of clinicians not properly diagnosing issues, and a lack of trust for the U.S. mental health care system add up to stigmas and unaddressed mental illness (Allen, Davey, & Davey, 2010).

History of Religion in the African American Community

Schilbrack (2010) asserted that before the 17th century, the notion of religion was nonexistent. In non-Christian religions, there was no term for religion. The modern concept of religion derived from European Christians who developed the word based on certain activities. At best, the concept of religion is not a universal term. Although some researchers have argued that there was no such thing as religion, other researchers have indicated that American religious history includes four categories or eras (Hunt, 2012). The first era was the exploration and encounter era (1492 to 1676), the second era was the Atlantic world (1676 to1802), the third era was the American empire (1803 to 1898), and the fourth era is global reach (1898 to present).

Religion in the lives of African Americans survived enslavement and transportation from Africa to the Americas (Murphy, Melton, & Ward, 2013). The survival rate was higher in Latin America and the Caribbean than in the United States. The sense of identity and belonging that slavery tried to destroy emerged in various forms of religion and later denominations.

History of the Black Church

Due to slavery almost destroying the Africa American family structure, the Black church leaders and members worked to restore the family structure and even acted as a surrogate family for many (Erskine, 1991). Wilmore (2006) posited that during African

American enslavement, pastors provided hope and encouragement by sharing stories and sermons about a promised land that would give them freedom and rewards for their suffering. Many civil rights leaders, including Martin Luther King, Jr., were pastors and active in organizations through which they promoted civil rights and advancement for people of color (Erskine, 1991).

The history of the Black church is an intricate part of contemporary cultural life (Eliade, 2013). One of the primary religions in West Africa was based on orishas (Johnson, 2010). Lum (2013) noted that the Orisha religion, also referred to as Orisha Work, consists mainly of Black working-class members. The Orisha religion includes African, Christian, and Roman Catholic aspects, with the main component being spirit manifestation and spirit possession (Lum, 2013). Spirits and orishas engaged in warfare to liberate individuals enslaved in problematic situations (Beliso-De Jesus, 2014). Orisha Work also has links to Creole and Caribbean religions, such as voodoo and Santeria (Olmos & Paravisini-Gebert, 2011), which all share a common theme of transcendence (Sager, 2012). Transcendence directly relates to a change in religious believers' physiological or psychological state that heightens their awareness by spiritually experiencing a time, place, or being different from their normal state.

The Black Church

The Black Church as Monolithic

The findings in a recent study of religious practices, beliefs, and mental health indicated that meaning and forgiveness led to effective mental health outcomes among African Americans, Caucasians, and Hispanics, but results among each group were

different and depended on the level of religiosity (Sternthal, Williams, Musick, & Buck, 2012). African Americans and Hispanics had higher levels of religiosity across various planes, but did not experience greater mental health results than their Caucasian counterparts. According to the theory of *semi-involuntary institutions*, African Americans in the South viewed attending church as a normal and regular behavior (Ellison & Sherkat, 1995; Sternthal et al., 2012). Also based on the semi-involuntary institutions theory, the community norm of attending church led African Americans to attend church at least moderately out of a fear of stigmatization rather than for sincere spiritual factors.

Black Church Versus White Church

Caucasian Americans correlated church attendance and self-forgiveness with anxiety, and African Americans reported feeling positive anxiety with congregational criticism (Sternthal et al., 2012). The reduced symptoms of anxiety and depression occurred only in Caucasian Americans who attended church services. Payne (2009) noted that significant differences existed in how African American clergy and Caucasian clergy perceived mental health. In addition, Caucasian clergy considered depression to be a biological mood disorder, whereas African American clergy believed it to be a sign of weakness that resulted from difficult situations.

Black Church Versus Hispanic Church

Hispanics who did not attend church were four times as likely to receive a diagnosis of depression as Hispanics who attended church at least marginally (Sternthal et al., 2012). Individuals who rejected the use of, or association with, religion had more detrimental mental health outcomes than their counterparts who attended church.

Abraido-Lanza, Vasquez, and Echeverria (2004) reported that church attendance of Hispanic Americans exhibiting symptoms of depression had no bearing on their outcome. Thus, Kessler et al. (2008) posited that since mental illnesses were conceptually different among varying groups, service attendance could improve the quality of life for Hispanics, while at the same time neglect the issue of mental illness or psychological issues.

Black Church Versus Asian Church

In a recent study conducted among Asian Americans, Yamada, Lee, and Kim (2012) noted that Asian American clergy provided assistance for various services, but little information was available about how Asian clergy responded to mental health issues within the community or with members. Asians and Latino Americans shared the same risk factors regarding mental health services and their underutilization (Abe-Kim et al., 2007). Cummings, Ponce, and Mays (2010) noted that researchers had identified a reduction in racial and ethnic disparities in specific areas of unmet needs, such as suicide and depression in schools, compared to other contexts.

Black Clergy

Role of Black Clergy

Taylor, Ellison, Chatters, Levin, and Lincoln (2000) noted that a growing number of researchers focused on understanding the role that clergy played with regard to addressing mental health needs in the African American community. Clergy in the African American community were often the first point of contact for addressing issues, such as personal problems, physical health concerns, grief and loss, divorce or broken family systems, and more (Taylor et al., 2000). In addition, one important finding was

that African Americans who identified with or were a member of a fundamentalist denomination used clergy at high rates and did not use psychologists or psychiatrists.

Lumpkins et al. (2013) described African American clergy as vital to affecting behavior patterns of the African American community. More specifically, the clergy were vital because of their role as a communicator of God's word and because they served as a moral compass for how believers should live their lives. African American community members consider African American clergy to have specific roles (Anshel, 2010). For example, African American clergy are responsible for providing faith-based incentives accompanied by resources that promote healthy behaviors and make healthy behaviors possible.

In the African American community, the general perception of African American clergy is that they are emotionally stable and balanced individuals (Patterson, 2013). African American clergy act in various capacities for members of the church and community, including helping to identify and address psychological issues (Chatters, Mattis, Woodard, Taylor, Neighbors, & Grayman, 2011). Although Americans have a high faith belief, and approximately 80 million Americans attend at least one church service a week, the United States still has the highest rates of crime, violence, and addiction of all Western industrialized nations (Kosmin, 2011).

Power of the Black Church

The Black church has a significant impact on social and health-related issues in the African American community (Stewart, Sommers, & Brawner, 2013). The African American church represents a belief system that directly affects followers and often

influences the reception and processing of information about health (Lumpkins, 2010). Anshel and Smith (2014) offered ideas for African American churches to be effective in implementing healthy initiatives and interventions. Puhl and Heuer (2010) focused on the issue of obesity and failed to mention the correlation between obesity and mental health. Negative stereotypes of obese individuals in U.S. society have led to stigmas, prejudice, discrimination, and negative effects on emotional health.

Anshel (2010) reported a link between being in good mental health and practicing religion. At the same time, the relationship between religious practices did not translate into practicing good physical health. Anshel credited African American clergy with having the power to create environments that are healthy through preaching topics and delivery, along with activities and programs.

Influence of the Black Church

African American clergy's influence extends to a number of health causes and interventions, such as cancer prevention programs, healthy eating for the body and soul, and preventative collaborations with the American Heart Association called Power Sundays (American Heart Association, 2011; Lumpkins et al., 2013). The Lumpkins et al. (2013) study included an examination of the perceptions African American urban pastors' ability to communicate healthy behavior and the ways this information resulted in health promotion and prevention. Programs, such as Church-Based Health Promotion Interventions and Wellness for African Americans Through Churches, led to significant improvements in health practices among African Americans, but included no mention of

promoting mental health as a component in either program (Campbell, Hudson, Resnicow, Blakeney, Paxton, & Baskin, 2007; Lumpkins et al., 2013).

African American clergy promoted the use of small groups to support members coping with life-threatening diseases (Lumpkins et al., 2013). Affecting positive change in the area of healthy behaviors within the African American community requires involvement from respected individuals, such as the clergy, who have information and serve as credible members of the church and the community (Anshel & Smith, 2014). The promotion of health initiatives and programs in the Black church is common, and understanding and effectively addressing these other comorbid medical conditions may give way to treatment options that lead to better mental health for African Americans (Agyemang, Mezuk, Perrin, & Rybarczyk, 2014). Understanding that the role of African American clergy involves being role models as well as leaders may help to recognize their influence with regard to their followers' behavioral practices (Brown & Trevino, 2014).

Responsibility of the Black Church

One of the responsibilities of the Black church is to effect change with the church membership and the members of the community at large (Lumpkins et al., 2013). Relationships between illness and sin appear in all books of the Bible except the Old Testament book of Job (Harris, 2010). Thus, the correlation between sickness and sin determined views of illness and ways to address it (Harris, 2010). In terms of direct responsibility, aside from the historical responsibility of the African American church and clergy caring for the bodies and souls of members of the church and community, an

emerging responsibility has been the importance of the African American church and clergy in increasing the costs of services related to mental illness (Samuels, 2011).

No articles included a focus on African American clergy promoting the use of mental health services. Campbell et al. (2007) revealed that churches were prime resources for health promotions because of the buildings, kitchens, meeting rooms, and ability to reach a vast number of individuals in and outside of the church. Government-funded churches promoted health programs related to improving nutrition, exercise and physical activity, cancer or cancer-related diseases, and hypertension. Although a positive correlation existed between church attendance and physical and psychological health among various religious populations, the promotion of health excluded mental health and counseling. The only mention of counseling related to substance abuse counseling initiatives.

Mental Illness

History of Mental Illness

Fourteen to 17% of Americans will receive a diagnosis of major depressive disorder at least once during the course of their lifetime (Hankerson et al., 2013). Although African Americans had lower or similar rates of major depressive disorder to Caucasian Americans, African Americans had more ongoing mental illness issues than Caucasian Americans (Hankerson, et al., 2013). One of the main historical threads of mental illness was that information needed to understand the mind and brain fully was elusive (Adam, 2014).

With substantial victories in the fight for mental illness, some researchers and mental illness victims disagreed with the Freudian psychoanalysis that the cause is everything (Adam, 2014). Although mental illness had biological roots, the primary concern of mental illness sufferers was how to address the disease. Thus, the question became whether people can address mental illness with prayer and spiritual counseling, secular counseling, or a combination of both.

Mental Illness in the African American Community

Challenges exist with regard to determining accurate mental health prevalence data among African Americans and their formal help-seeking behaviors (Buser, 2009). The African American community has for many years provided church-based health programs to address dietary issues, weight loss, smoking, and diabetes management, but literature on programs addressing mental illness is lacking (Hankerson et al., 2013). A review of African American church-based programs with a focus on mental illness yielded only eight studies.

In comparison to non-Hispanic Caucasian Americans, African Americans suffer more chronic and severe symptoms and have medical conditions such as diabetes and hypertension that exacerbate depression (Agyemang et al., 2014). Some researchers (e.g., Ani et al., 2009) reported less than hopeful rates for reducing mental illness in African Americans with comorbid medical issues. Others (i.e., Agyemang et al., 2014) found positive and successful rates for treating depression, regardless of other medical conditions.

Diabetes is a major public health issue in the United States (Li, Ford, Strine, & Mokdad, 2008). Understanding the link between comorbid medical issues such as diabetes and hypertension and depression is important in the fight against mental illness among African Americans (Osborn, Kozak, & Wagner, 2010). Li, Ford, Strine, and Mokdad (2008) noted that 18 to 31% of diabetes patients also suffered from depression. In addition, approximately half of all Americans with depression remain undiagnosed or undertreated (Li, Ford, Strine, & Mokdad, 2008).

The relationship between depression and diabetes exists in both Blacks and Whites equally (Wagner, Abbott, Heapy, & Yong, 2009). Being able to address issues of depression directly correlates to lifestyle factors and adherence (Holt, de Groot, & Golden, 2014). Individuals suffering with depression tend to be sedentary, follow an unhealthy diet full of fats and refined sugars, and avoid foods that lead to a better quality of health.

Bryant, Haynes, Greer-Williams, and Hartwig (2014) asserted that African American men are less likely to seek help for depression than African American women are, if at all. African American men who experience depression face psychosocial stressors, such as racial discrimination, close proximity to or involvement with violence, extreme levels of poverty, and more. Although African American men receive a diagnosis of depression significantly less frequently than males in other ethnic groups (Williams et al., 2007), the factors relate not to differences in prevalence rates but misdiagnosing African Americans or not diagnosing them at all (Bryant, Haynes, Greer-Williams, et al., 2014).

Sanchez and King disclosed that some research resulted in negative attitudes toward mental health treatment and directly linked to ethnicity and race (as cited in Gonzalez et al., 2011). In contrast, Diala et al. (2001) noted that some studies had no differences or more positive attitudes linked to ethnicity or race. The fear of institutionalization was one reason African Americans decided not to seek mental health treatment (Gonzalez et al., 2011; Takeuchi, Bui, & Kim, 1993). Das et al. (2006) also noted the misdiagnosis and under-diagnosis of African Americans because they feared labels or stigmatization. Ward and Besson (2009) posited that African American men underreported symptoms of depression because they feared institutionalization or incarceration or they experienced discrimination, including job discrimination, due to mental illness.

African Americans have strong religious beliefs, and they often view mental illness such as depression as a sign of weakness that they should manage through faith and prayer, not counseling and medicine (Martin & Martin, 2005; Shellman, Mokel, & Wright, 2007). Ward and Besson (2013) used the common sense model to examine African American men's beliefs about mental health. The African American men studied did not perceive a mental health stigma and thus did not identify the stigma as an issue or barrier to seeking help. The male African American participants welcomed the assistance of professional help and indicated they would encourage others to seek help from a mental health professional. How Ward and Besson arrived at such conclusions in the face of opposing evidence remains unclear.

Socioeconomic Costs of Mental Illness

Underlying all the research and data is the common yet unresolved thread of the socioeconomic impact of mental illness. According to analysts at the National Alliance on Mental Illness (NAMI; 2016), the statistics are staggering (see Figure 1).

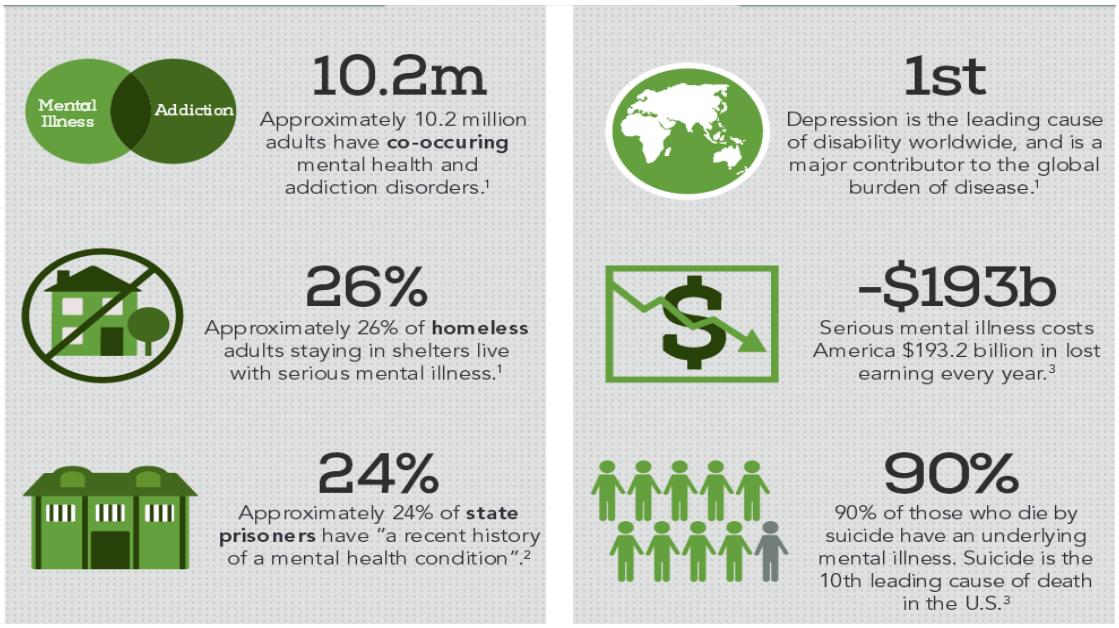

Figure 1. Prevalence and consequences of mental illness. Adapted from "*National Alliance on Mental Health Issues: Mental Health by the Numbers*, by National Alliance on Mental Illness" by National Alliance on Mental Illness. Retrieved from http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers.aspx. Copyright 2016 by NAMI. Figure is in public domain.

Within a given year, nearly 44 million adults (1 in 5, or 18%) will experience a mental illness, 4.2% of Americans experience a serious mental illness that substantially interferes with major life activities, and more than 18% of American adults experience anxiety disorders such as posttraumatic stress disorder or obsessive-compulsive disorder (NAMI, 2016). The pervasiveness of mental illness among the homeless include statistics such as 26% of homeless adults in shelters suffer from serious mental disorders and both

African American and Hispanic Americans use mental health services at about half the rate of White Americans (Algeria et al., 2015). The economic and financial cost of mental illness is almost $200 billion in lost earnings per year in the United States (Algeria et al., 2015).

In April 2015, researchers at the NIH examined differences in mental health service use by race and ethnicity (Substance Abuse and Mental Health Services Administration, 2015). The results indicated some increases in African Americans seeking mental health services outside of their religious or faith-based culture. The researchers did not specify whether practitioners could verify the self-reported increase in seeking mental health services by participants (Substance Abuse and Mental Health Services Administration, 2015).

Researchers at the CDC produced several studies on the state of mental health in the United States. One report by Weissman, Pratt, Miller, and Parker (2015) included data about serious psychological distress (SPD), which refers to mental health problems severe enough to cause moderate-to-serious impairment in social, occupational, or school functioning and that require treatment to resolve. The findings indicated that (a) regardless of the age group, women were more likely to suffer from SPD than men; (b) adults 18–64 with SPD were more likely to be uninsured than adults without SPD; and (c) the age group with the highest rates of SPD was adults between ages 45 and 64 (see Figure 2).

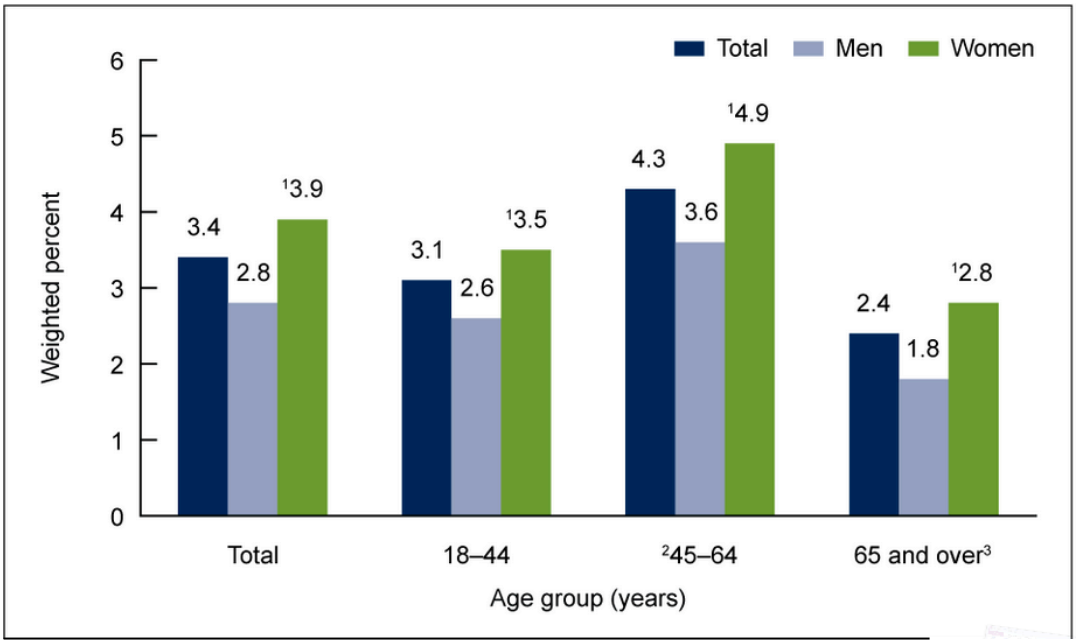

Figure 2. Percentage of adults aged 18 and over at interview with serious psychological distress, by sex and age. Adapted from "Psychological Distress Among Adults: United States, 2009-2013" by Eric A. Miller, Jennifer D. Parker, Laura A. Pratt, and Judith Weissman 2015, NCHS Data Brief, 203, p. 1. Copyright by public domain.

Pratt and Brody (2014) conducted another CDC report and focused on depression in U.S. homes between 2009 and 2012. Americans ages 12 through adult had a range of depressive symptoms from mild to severe with difficulties at work, home, and social activities related to their symptoms of depression. Individuals with depression had more functional limitations than those without depression.

In addition, a combination of medication and therapy was most effective for all types of depression, including severe depression (Pratt & Brody, 2014). Although a primary care physician could prescribe medication, a mental health professional generally provided therapy. Highlighted was the need for mental health services, as well as the importance of all stakeholders (e.g., African American clergy) being aware of the impact of their own stigmas, perceptions, and beliefs regarding mental health services.

A study funded by the National Institute of Mental Health (NIMH) had a focus on the concept of *adult role disability*. More than 50% of adults have a condition that interferes with their work or conducting their usual duties (roles) for several days each year, and many of the conditions relate to mental disorders (Ames et al., 2007). Also found was that *role disability* has gained increasing recognition as a major source of the societal costs of illness, and major depression resulted in the second greatest number of disability days (387 million), second only to musculoskeletal disorders, such as back and neck pain, accounting for 1.2 billion days of disability. The findings of these and other research studies revealed the cumulative toll of mental illness. Societal responses and perceptions about mental health services had human, physiological, environmental, and financial implications and consequences.

Stigmas

History of Mental Health Stigmas

The origins of stigmas related to mental illness were difficult to narrow down because the extent of stigmas and influence of stigmas are obscure and evasive due to specific studies in different categories (Hatzenbuehler, Phelan, & Link, 2013). For instance, a stigma related to mental illness had negative impacts on self-esteem and overall mental health of individuals suffering from and affected by mental illness (Ilic et al., 2012). This finding led to other studies on self-stigma and stereotypes related to mental illness. Corrigan, Powell, and Rusch (2012) noted that addressing stigmas requires individuals to be aware of their prejudices by recognizing that stigmas exist, applying stigmas to themselves, and experiencing the negative effects to their self-esteem.

Hatzenbuehler et al. (2013) noted that to understand the effects and wide reach of mental illness stigmas, it is important to understand that stigmas can affect multiple areas of individuals' lives.

Some people have deemed mental illness to be the ultimate stigma (Nee & Witt, 2012). The compartmentalization of research on stigma has led to a focus on stigmas related to HIV, mental illness, and sexual orientation (Hatzenbuehler et al., 2013). Stigma has a toxic impact on the health of individuals and links to overwhelming stress and disease. Abdullah and Brown (2011) posited that cultural groups experienced stigma differently, but how differently remains unknown because research on this subject is scarce.

History of Stigmas in the African American Community

Awosan, Sandberg, and Hall (2011) noted that barriers to African American help-seeking behaviors included stigma, shame, and a concern for how family members and friends might react to experiencing and seeking help for mental health issues. The African American community has a history of being strong and prone to suffering and difficulties; thus, African Americans may see no need to seek help (Chandler, 2010). For instance, in a recent study of Black women suffering from anxiety, many opted not to seek counseling services because of the expectation that Black women need to be strong (Neal-Barnett et al., 2011).

Alvidrez et al. (2008) found that messages received by family, implicitly and explicitly, inferred that discussing mental health issues was inappropriate. This fear of familial stigma can delay using treatment as well (Kane & Green, 2009). Furthermore,

Awosan et al. (2011) noted that because of the complexity and internalization of these messages, African Americans believe that there would have to be a reorientation of culture to minimize stigma.

African American clergy associate depression with vast suffering as a result of financial hardships and unstable housing (Hankerson et al., 2013). In addition, African American clergy defined depression as a feeling of hopelessness and believed that individuals dealing with depression were trapped or stagnant. Abdullah and Brown (2011) noted that researchers needed to study mental illness in the United States from a cultural perspective because of a connection between values and mental illness. The assumption was that stigma was the same across cultures, but stigma perception is a unique situation.

Being able to address taboo issues in the African American community has always been difficult (Harris, 2010). One of the most difficult issues to address in the African American community is sexuality and the AIDS epidemic. Even though programs exist to decrease racial disparities regarding obtaining access to effective mental health services, African Americans with depression underutilized professional mental health services while dealing with depression and stigmas that hindered seeking help (U.S. Department of Health and Human Services, 2010).

Counseling

Use and Effectiveness of Professional Counseling

The mental health community must function within the African American community as a social, political, and other institutional force to which the population has

adapted to address mental health issues effectively (Gary & Jones, as cited in Dozier & Jackson-White, 2011). Leaders of agencies and organizations who understand collaboration and leverage with regard to providing services and resources needed in the community aid in the ability to meet the increased demands despite decreased service funds and depleted reserves (Sinha, 2013). Fukuyama, Puig, Wolf, and Baggs (2014) noted that it was imperative to consider religious and spiritual diversity in the context of multicultural counseling, because it helps mental health professionals become more aware and open to religious and spiritual themes that clients need addressed.

Church attendance had an impact on whether African Americans sought professional help from clergy or professionals (Taylor et al., 2000). African Americans who attended church regularly were more likely to seek help from clergy, whereas African Americans who did not attend church regularly were more likely to seek help from mental health professionals. African Americans have strong concerns about working with non-Black counselors, because they fear a leak of confidential information (Nadeem, Lange, & Miranda, 2008). Even though some researchers indicated that African Americans underused mental health services, Chandler (2010) reported that the underuse could relate to years of institutional oppression and maltreatment that led African Americans to develop a distrust of health care services and therefore chose not to use them.

Spiritual Counseling Versus Professional Mental Health Counseling

Researchers for the U.S. Department of Health and Human Services (2010) reported that African Americans tend to choose their pastors and spiritual leaders to

address mental health concerns. For example, in a study by Newhill and Harris (2007), African Americans believed that religion was the answer to mental health issues, which could explain some of the disparity in African Americans' help-seeking behavior. African Americans also believed that professional mental health service providers could damage the therapeutic relationship by assuming that religious coping methods were maladaptive or ignoring spiritual connections during treatment process (Brown, Elkonin & Naicker, 2011; Entwistle, 2009). Moreover, African Americans veered away from the use of counseling services because they felt that counseling made the situation worse and caused more negative or depressive feelings (Cooper et al., 2012).

Most people believe in God or a deity of some kind and would consider themselves to be spiritual, religious, or both (Plante & Thoresen, 2012). In contrast, mental health professionals tend to view themselves as nonreligious and are spiritually or religiously diverse. These differences may cause problems when serving clients with mental illness. Furthermore, the term spirituality is not exclusive to religious institutions or religious traditions. For example, a link exists between spirituality and various situations and experiences independent of traditional religions (Miller, 2012). Kosmin (2011) noted that Americans translate the meaning of religion as a personal affirmation of faith in God and a connection to a particular religious denomination.

Stansbury et al. (2012) described clergy views and definitions of pastoral counseling and pastoral care as nonuniform. Although African American clergy serve as formal gatekeepers in the African American church and community, clergy's assistance does not include formal relationships and help from mental health professionals. Finding

definitive definitions for pastoral care and pastoral counseling was challenging. However, the findings showed that clergy were shepherding the flock, which they considered the most important aspect of being a minister.

Hori, Richards, Kawamoto, and Kanugi (2011) posited that a link exists between the cognitive behavioral aspects of stigma and mental illness. Behavioral ramifications of stigma tend to result in not seeking treatment or terminating treatment early (Pinto-Foltz, Logsdon, & Myers, 2011). Stigmas related to mental illness are slow to see change and media sensationalism tends to exacerbate the stigmas.

In a recent study, research participants admitted that church leaders had addressed the issues of depression for years but refrained from labeling it depression (Bryant, Haynes, Yeary, et al., 2014). African Americans suffering with depression indicated that church leaders should address the issues. Many of the participants had a greater sense of concern regarding confidentiality than addressing or treating the depression.

The Faith Factor (Prayer Versus Counseling)

Help seeking through prayer or a higher power is reportedly more culturally acceptable than other help-seeking behaviors within the African American community. Some members of the community do not attend or associate with a church. However, despite all the different religious affiliations, there is a cultural thread that is the same, which is the general lack of trust for mental health services help (Chandler, 2010). Avalon and Young (2005) found that African Americans who had God as the core of their external locus of control were less likely to seek mental health help from professional sources. Bowman (2012) noted that African Americans who received mental

health treatment previously were less likely to seek or receive treatment again for another issue.

Asante (2011) noted that Christianity is the predominant faith that African Americans practice. Asante also indicated that some African Americans practice ancestral African religions, such as Vodun, Santeria, and Myal, and the remainder follow the teachings of Islam. Religion and spirituality have the capacity to inform, empower, and influence African Americans in many aspects of their lives (Brisbane, 2011). More critical within the African American community is clergy's influence. Clergy serve as gatekeepers for the most part and do not use or collaborating with professional mental health services (Stansbury et al., 2012).

Brey and Clark (2012) noted that environment, occupational, emotional, social, mental, and spiritual factors can be stressors. Mochon, Norton, and Ariely (2011) indicated that churchgoers with a high level of religiosity appeared to be happier than churchgoers with a lower religiosity, but the churchgoers with a lower level of religiosity may benefit more from not believing or associating with a faith or denomination group. Noted was a trend of individuals deciding between religion or no religion to maximize their well being, including mental health, which could lead to a severe membership decline in proportion to the increase of low-level (weak) believers.

Anshel and Smith (2014) discussed the use of the God Locus of Control Scale (GLCS). Although it did not have a mental health component, the GLCS measured the extent to which faith believers perceived a God as the sole determinant of their quality of health and life (Anshel & Smith, 2014; Watson et al., 1999). Participants with a strong

GLCS felt less likely to hold themselves accountable for their own actions, including unhealthy eating practices.

Anshel and Smith (2014) noted that various faiths have a set of tenets and moral codes established to ensure physical, mental, emotional, and spiritual health because these moral codes are a part of their own devotion to God. Other researchers pointed the blame of unhealthy living toward the individual by noting that living an unhealthy life is in direct opposition to the New Testament (Omartian, 1996). In I Corinthians 3:16 (King James Version), "Know ye not that ye are the temple of God, and that the Spirit of God dwelleth in you? Walters and Byl (2008) examined how Christians intertwined exercise, nutrition, and ways to maintain a healthy life with scriptures taken from the Bible.

Reports about mindfulness-based cognitive therapy indicated that teaching decentering and mindfulness techniques led to fewer episodes of depression (Knabb, 2012). Monroe (2010) indicated that individuals who suffered from major depressive disorder were at a high risk to experience a relapse within 6 months of the initial diagnosis. In a study on the spiritual coping methods of foster care children (Cruz et al., 2010), 59% of the foster care children reported that they used prayer. Coping strategies vary in form but indicate that religious beliefs are one of the main coping practices in the United States for individuals dealing with life stresses.

Cruz et al. (2010) studied the relationship between religious involvement and bipolar disease and offered elements and frameworks for future research into relationships between other mental illness issues and religious involvement, including prayer and meditation as coping mechanisms. Mental health counselors providing care

for religious bipolar disorder sufferers carefully assessed their religious beliefs and the ways these beliefs influence their willingness to seek and receive treatment. Contrary to much of the literature reported about African Americans seeking help for mental illness from the church was the notion that African Americans sought assistance for mental health services from their primary care providers instead of treatment specific to mental illness (Agyemang et al., 2014).

Promoting Mental Health

Although documented research confirmed that clergy and the church were mental health resources, studies on interventions in mental illness are few (Payne, 2009). Mental illness negatively affects marriages, parenting ability, financial status, employment, and other aspects of life that link to issues that affect the African American community (Kessler, 2012). Waites, Kaiser, and Martin (2014) confirmed that church is an effective place for promoting health. Waites et al. focused on the health of the aging population and determined the church was a safe environment that fostered a sense of belonging for older adults. Again, the focus was on issues related to exercise, nutrition, affordable food, and transportation. The focus of the healthy promotion program Waites et al. highlighted was spiritual, emotional, and social support for members of the congregation and community, but Waites et al. failed to address mental health. Most important to the goal of current study was the lack of information regarding the African American clergy's promotion or non-promotion of mental health utilization.

Recent partnerships between leaders in the faith community and mental health service providers involved 40 leaders from both faith-based organizations and mental

health fields who agreed to partner with clergy, psychiatrists, and advocacy groups (Moran, 2014). The goal was to reduce the issue of stigma and foster understanding with effective measures related to individuals' spirituality and faith when in need of mental health services. Addressing stigma was important but clergy, psychiatrists, and advocacy groups struggled with how stigma associated with mental illness could be addressed without clergy promoting the use of mental health services.

Hankerson and Weismann (2012) posited that church members widely underused church-based health programs as a mental health resource, even though they boast about health promotion programs. Research about church-based programs for mental health issues in the Black church was scarce. The exploratory study involved studying African American clergy's willingness to offer depression screenings and assessments to church members, but not whether the clergy promoted the use of mental health services.

African American clergy viewed their work as being more than just spiritual leaders, but health promoters as well (Lumpkins et al., 2013). However, the limited information available did not include promoting or communicating support for seeking help for mental illness. Future researchers need to focus on one health issue instead of multiple health issues. Researchers can use this and other studies as a springboard to examine how African American clergy promote the use of mental health services.

Researchers have proposed using basic components to help clergy promote healthy living (Anshel & Smith, 2014). The three components include an intrapersonal component to influence behavior by educating and improving attitudes, beliefs, and impacts of past actions; the interpersonal or social interaction component, including the

use of formal and informal support systems, such as family, friends, and fellow church members; and the organizational policies and resources component involving organizational ideas on health and positive expressions of promoting healthy living within the church (Anshel & Smith, 2014; Campbell et al., 2007).

While many authors reported that African American clergy promoted healthy living habits, Anshel (2010) pointed out that African American clergy preach about healthy living, but fail to practice a healthy lifestyle. The term, *surrendering style,* reflects a disconnection between healthy living and practicing one's religion. Surrendering style involves giving control of one's life and its circumstances over to God (Anshel, 2010).

Summary

Many African Americans do not seek help for issues related to mental health concerns and exhibit negative feelings toward using professional resources (Connor, Koeske, & Brown, 2009) rather than seeking counsel from a pastor or religious leader. The focus of the research presented was mental health and the influence of African American clergy on African Americans' help-seeking behaviors. Compared to other ethnic groups, especially Caucasian Americans, African Americans are less likely to seek professional help for mental health issues (Woodard, 2011). In this empirical investigation of help seeking, one of four African Americans reported that they relied solely on informal resources for mental health assistance.

Since the literature in the area of African American clergy stigma and their influence on help-seeking behavior was lacking, I used an exploratory qualitative

methodology to identify themes. The existing research did not have correlations of stigma to mental health seeking behavior. Existing research also lacked any indication of a connection between cultural values and mental illness among ethnic groups (Abdullah & Brown, 2011), including African Americans. For instance, the connection between African American clergy who are affected by stigma and in turn influence help-seeking behaviors among the clergy's congregants and community is not known. Researchers have not studied stigmas of African American clergy extensively. Researchers have also not studied how African American clergy promote or do not promote the use of mental health services.

In conclusion, the literature review indicated how clergy address practical, emotional, and spiritual problems (Stansbury et al., 2012). How African American clergy's stigmas, perceptions, beliefs, and practices promote or do not promote the use of mental health services remains unknown. Addressing stigma requires individuals to be aware of their prejudices and recognize that a stigma exists (Corrigan et al., 2012). If African American clergy's stigmas, perceptions, beliefs, and practices regarding mental health remain unrecognized, then African Americans may continue to apply stigmas to themselves and fail to seek help.

A consistent theme was of clergy being a trusted resource for spiritual and practical counseling (Lumpkins et al., 2013). Thus, a broader understanding remains of how clergy recognize, identify, and address stigmas related to mental health. The study fills a gap in the literature by providing insight into how African American clergy cope with stigmas related to mental illness and provide effective ways to address mental health

concerns. Qualitative case study was the method used to explore and acquire data from clergy in the African American community. The interview process involved individuals from different African American denominations.

This study was conducted to address the lack in current research about African American clergy's perceptions, beliefs, stigmas, and/or practices regarding mental health services. Chapter 3 provides the methodology for the research study. In addition, this chapter outlines the research design and rationale, role of the researcher, participant selection, sample size, instrument, data collection methods, and the procedures for recruitment. The chapter concluded with the data analysis plan, issues of trustworthiness, and ethical procedures that may have impacted the integrity of the research.

Chapter 3: Research Method

Introduction

Due to the low rates of African Americans seeking assistance for mental health issues in America (Gonzalez et al., 2011), a study to determine what factors contributed to the phenomenon was relevant. Specifically, exploring how African American clergy's beliefs, perceptions, and stigmas contributed to the African American community's help-seeking behavior related to the use of mental health services. The literature review, although extensive, did not reveal the perceptions, beliefs, stigmas, and practices of African American clergy. The literature review also did not indicate whether these factors affect members of Black churches and the Black community adopting mental health counseling.

The purpose of this qualitative case study was twofold to: (a) discover the perceptions, beliefs, stigmas, and practices of African American clergy regarding the use of mental health services and (b) explore the direct or indirect promotion of such beliefs, perceptions, stigmas, and practices among the African American community. The particular perceptions, beliefs, or practices of African American clergy in the greater metropolitan Atlanta, Georgia area were the primary focus and unit of analysis. The reasons for selecting this group and location were their accessibility and proximity and the diversity of African American denominations represented in the city that attend the Interdenominational Theological Center.

Research Design and Rationale

My methodology of choice to investigate the research questions was a qualitative case study. The focus of the philosophical assumptions and interpretive approaches was to understand and give meaning to one's personal experience (Rossman & Rallis, 2012). Through qualitative case study, I discovered the perceptions, beliefs, stigmas, and practices held by African American clergy regarding the use of mental health services. I was also able to discover how clergy directly and indirectly promote the beliefs, perceptions, stigmas, and practices among the African American community to seek mental health services. More specific to this study, conducting in-depth interviews to gain insight into the perceptions, beliefs, stigmas, and practices African American clergy provided me with evidence of the validity of the findings as the data collected remained consistent with each interview.

The population for this research included clergy acting in a ministerial capacity at urban Baptist, COGIC, and AME, churches. Christian Methodist Episcopal, United Methodist, or African American Episcopal Zion Church. I sent e-mails detailing the nature of the study and requesting interviews to a group of potential participants after the Institutional Review Board approved the research. Participants from Baptist, COGIC, and AME churches in the southeast United States responded to the request for interviews.

Role of the Researcher

Patton (2002) noted that the role of a qualitative researcher is as the instrument of the study. The role of the researcher is to identify and describe any personal biases, assumptions, expectations, or experiences that can hinder the ability to conduct research

(Greenbank, 2003). I used the beliefs, perceptions, stigmas, and practices of African American clergy derived from the questionnaires and interviews to build a picture of the exploration and discovery. I established and maintained boundaries during each phase to build rapport with the participants and to remain focused on the purpose of the research.

I am the daughter of a bishop in one of the largest African American denominations. I have been around ministers, preachers, and church leadership all my life. Due to my history and legacy in ministry, I have served in quiet (and sometimes secret) as a church administrator, consultant, and spiritual counselor. As I prepared for this dissertation topic and process, I reflected on my role as a researcher and felt passionate about this limited and understudied topic. To mitigate researcher bias, I maintained a reflective journal to keep track of and describe my feelings about conducting this research. I also used the reflective journal to record my personal assumptions, expectations, and biases related to this research.

Methodology

Using qualitative methods for this type of research was valuable because of its purpose to explore issues (Ritchie, Lewis, Nicholls, & Ormston, 2013) that could hinder or promote African Americans' use of mental health services. I chose the purposive sampling strategy (Bryman, 2012) to identify the participants. In this case, African American clergy contributed their relevant perspectives on the topic (Ritchie et al., 2013). Critical case sampling is useful in exploratory studies where resources and literature are scarce (Yin, 2014).

The potential threats to the validity of the research were in the area of interpretive validity. As the data collected in the study included the participants' own words and beliefs, it was important to pay attention to interpreting the information from the perspective of the participants. To enhance the validity of the study, I created a standardized system that included detailed documentation of the time, day, and place of interviews.

In tandem with conducting an ethical study, the study involved an attempt to minimize or mitigate researcher bias by seeking out contrary or rebuttal opinions and evidence (Yin, 2014) from the larger population of African American religious leaders. As the researcher, I left myself open to possible evidence that was contrary to my own beliefs, expectations, or experiences. I shared full disclosure of the research project with the participants. In conjunction with the details of the research, the participants signed an informed consent form. Participants who sign the informed consent form acknowledged that they received detailed information regarding the research and understood what their participation would entail and that their participation was voluntary.

Participant Selection

The participants were all African Americans from various cities throughout the southeastern United States. Criteria for selection of the sample were as follows: Participants must have been (a) at least 25 years of age at the time of research, (b) currently serving in the capacity of pastor, clergyperson, or Christian education director for a minimum of 3 years, and (c) available to participate in an interview lasting up to 1

hour. The participants were given consent forms and returned them signed to the researcher prior to the start of the interviews.

Sample Size

Pickard (2013) posited that the sample sizes should be large enough to ensure the perception of the sample is sufficiently comprehensive. Patton (2009) asserted that rules for sample size in qualitative inquiry did not exist and suggested that a researcher take into account available time, credibility, and the quality of the information gathered. In a study used to explore the perspectives of clergy and lay leaders from a diverse urban sample regarding barriers to HIV, Mendel et al. (2015) used purposive sampling from 14 congregations in the Los Angeles, California area.

A purposive sampling is useful for adding credibility to smaller sample sizes, while also reducing opportunities for biases (Patton, 2002). This type of sampling enabled me to find those clergy who met the specific criteria I needed. Thus, the participants were representative of multiple African American churches and denominations throughout the United States.

Instrumentation

Patton (2002) noted that interviews can be structured, semistructured, or informal. In informal interviews, also known as conversational interviews, researchers do not predetermine the questions (McNamara, 1999; Spaulding & Rockinson-Szapkiw, 2012). The structured interview approach ensures the use of the same questions as a guide for collecting data, and this more focused approach leaves room for adaptability. During the structured or fixed response portion of an interview, all interviewees respond to the same

question with the same set of alternative responses (Spaulding & Rockinson-Szapkiw, 2012).

Smith et al. (2009) noted that semistructured interviews should be broad and should prompt participants to provide a narrative of their experiences. Semistructured or open-ended interview questions tend to be faster and more easily analyzed. In this study, I asked participants to provide a narrative (Shepherd, Reynolds, & Moran, 2010) of their perceptions, beliefs, stigmas, or practices regarding mental health. I designed a semistructured interview guide that I followed for each interview.

Cohen and Arieli (2011) reported that face-to-face interviews were the most effective because respondents could provide detailed responses. However in this study, providing interviewing options allowed participants to select the interview method best suited for them. Each participant opted to conduct the interview over the telephone. Prior to the start of the interview, I informed the participant that I would record and transcribe the interview. At any time prior to the start of the interview or during the interview, the participants had the option of ending the interview.

Procedures for Recruitment, Participation, and Data Collection

Prior to the data collection process, I submitted the required documents necessary to conduct research within the parameters set by Walden University and the Institutional Review Board (IRB). The data collection process began after receiving an IRB approval number (11-18-15-0230255). The participants received consent forms that included my IRB approval, and I collected signed consent forms from each participant prior to the start of each interview.

I ensured the anonymity and confidentiality of participants by assigning pseudonyms to all participants. The pseudonyms assigned to the participants were as follows: Lisa (Participant 1), Michael (Participant 2), Jacob (Participant 3), Christopher (Participant 4), Isaac (Participant 5), and Gavin (Participant 6). I stored the consent forms and confidential data in a locked file cabinet in my private office and will destroy all data 5 years after the study is complete, according to IRB regulations.

Twenty-five African American clergy received invitations that included a description of the study. Six participants responded by or before the 2-week deadline. After confirming the six participants were able to participate, the interviewees chose whether to participate in the interview in-person, by telephone, or on Skype. All interviews took place on the phone, and I recorded them with the permission of the participants. Each interview took less than 1 hour to complete, and the overall interview data collection window lasted for a 3-week period.

The interviews began with an introduction, followed the protocol, and included space for any questions the interviewees had. Each participant received the same description of the study and an identical set of instructions prior to the interview beginning. I also informed the participants I would audio record the interviews to ensure accuracy.

After I completed and transcribed the interviews, the participants received a copy of the transcripts to ensure the responses were accurate and free from researcher bias. I used an open coding system to identify emergent themes. Pereira (2012) asserted that open coding is a preliminary step in the pursuit of identifying emergent categories. As

suggested by Creswell (2010), I (a) read the data, (b) divided information into segments, (c) labeled the segments of information with codes, (d) reduced overlapping and redundant codes, and (e) collapsed the codes into themes.

Data Analysis

Data analysis involved using NVivo qualitative software. The program was useful in sorting, categorizing, linking, and charting patterns of choices, strategies, outcomes, and suggestions for future research and investigation. As Morales and Ladhari (2011) asserted, culture is an important consideration for researchers in terms of data collection and analysis. Categorizing and sorting data collected from the study participants in this church setting and context yielded some applicable and specifically relevant trends, patterns, and outcomes. Qualitative research involves identifying themes and patterns. Being able to organize and manage the data is vital to the qualitative data collection process (Creswell, 2012). Data collection included gathering information through a series of structured and unstructured observations, interviews, documents, and audiovisual materials.

Transcription of Interviews

The demographic characteristics created for data obtained from the interview responses included age, gender, education, and length of clergy service. Study participant solicitation occurred through e-mail. I typed and uploaded the verbatim transcripts into NVivo qualitative software for data analysis. The transcripts were from the audio tape-recorded interview sessions with the participants.

Developing Themes

NVivo was a suitable tool for coding the data. Coding the data led to themes, ideas, and key terms categorized for analysis. Gibbs and Taylor (2010) suggested that the advantages of coding are meaningful because coding helped to identify what was going on with the subject matter, what the participants were doing and saying, and how structure and context played into the participants' behavior. Analyzing the qualitative data using NVivo led to identifiable themes categorized to translate and articulate the data.

The coding process led to six primary themes and five subthemes. The themes fit into three categories. The first category of themes included stigmas African American clergy have regarding mental illness. The second category of themes was African American clergy's promotion of secular counseling for mental health treatment. The third category included the clergy's personal experiences with mental illness and secular counseling. The findings for each research question include examples from the interviews to illustrate the themes and subthemes.

Issues of Trustworthiness

Although the options for conducting interviews included telephone, in-person, and Skype, telephone interviews were the most appealing and feasible based on participants' comfort level, physical location, and access to technology. I recorded each interview using a digital recorder and transcribed the interviews using web-based transcription software. I also maintained a journal for personal reflections and notes.

Transferability

Researchers use descriptive and detailed explanations to describe participants' individual and collective experiences (Rossman & Marshall, 2010). The goal in this study was to ensure the descriptions were realistic and reflected what the participants shared and believed. Using exact quotes from the participants ensured external validity.

Credibility

Using interviews to collect data served to establish credibility. Interviews support and maintain the consistency and accuracy of research (Marshall & Rossman, 2010). Recording and transcribing the interviews also established credibility. Recording and transcribing interviews ensures researchers do not eliminate or misinterpret information (Tracy, 2010).

Ethical Procedures

The IRB has specific guidelines for research, especially research that includes human subjects. Protecting human subjects in this study was an important ethical consideration. The process set forth by the IRB was to ensure the protection of participants' rights. The first step in collecting data included obtaining written informed consent from each of the participants. The informed consent form included a full description of the research and the participants' rights. All participants were aware of the confidentiality of the study and that I was the only person who would have access to the research data. The participants were also aware that the study would include pseudonyms rather than their names.

Summary

This chapter included a detailed description of the research design, sample population, instrument, and data collection and analysis procedures. This qualitative case study involved researching stigmas held by African American clergy and the ways they promoted or discouraged the use of mental health services. The case study involved exploring this phenomenon with the understanding that literature related to this topic was lacking. Interviewing six African American clergy from various African American denominations led to insights and perspectives about the phenomenon.

What African American clergy think and say about mental health and counseling is important. How they characterize mental illness is the key to how members of their churches and community view issues of mental health and counseling (Hankerson et al., 2013). In Chapter 3, I discussed the data collection process, provided an interview protocol, and offered a rationale for using a semistructured interview guide with open-ended questions. I shared how I created the interview protocol to prompt participants to discuss their perceptions, beliefs, stigmas, and practices regarding mental health. Finally, I described how I based the research process on trustworthiness and validated the study by employing methods used by leading qualitative researchers to analyze the data. In Chapter 4, I further discussed the methodology, research setting, demographics of participants, and data collection methods. The chapter concluded with a complete analysis of the data and a description of the themes.

Chapter 4: Research Findings

Introduction

The purpose of this qualitative case study was to discover the perceptions, beliefs, stigmas, and practices of African American clergy regarding the use of mental health services. This chapter includes themes and findings that reflect how these factors influenced the way African American clergy directly or indirectly promoted the use of mental health services in the African American community. The chapter also includes data to substantiate African American clergy's influence as being beneficial or detrimental to African Americans' decisions to seek or not seek mental health assistance outside of the church.

In this study, I investigated African American clergy's attitudes regarding mental illness and determined whether they promoted or did not promote the use of mental health services for addressing mental health issues. The discovery process included identifying some of the clergy's (a) personal feelings regarding mental health, (b) mental health interpretations or understandings included in or omitted from the Bible, (c) denominational feelings regarding mental health, (d) personal reflections regarding depression and coping strategies, (e) how socialization and upbringing frame opinions about using mental health services, and (f) the effectiveness of prayer versus mental health services. The leading research questions that supported this effort were as follows:

1. What stigmas did African American clergy have regarding mental illness?
2. Did African American clergy promote the use of secular counseling for mental health treatment?

My rationale as the researcher was to design interview questions to support the exploration of the perceptions, beliefs, stigmas, and practices of African American clergy regarding the use of mental health services. This rationale entailed discovering African American clergy's feelings regarding mental health. References to participants in this chapter refer to the pseudonyms chosen to ensure their confidentiality. Lisa said:

> It is something that I think a lot of people do not acknowledge, or deal with, or include in their overall health. When they consider health, it (mental health) doesn't really get included. I think that it's something that is lacking maybe as far as something to be addressed.

Michael said, "I definitely believe that mental health [stigma] exists. I believe a lot of people don't give it as much attention as they possibly could, especially in the Black church." Jacob responded, "Mental health is actually a growing issue among the congregations in terms of my observation and how it is not as noticeable as physical ailments that we are accustomed to seeing," while Michael replied, "It [mental health] is a necessity but it is a neglected field for clergymen. More of them need to interact with the mental health side of counseling and spiritual development."

Isaac and Gavin each brought up the issue of fear. Isaac said, "There are a lot of people in need who are afraid to admit to themselves that they are in need of professional assistance as it relates to their mental well-being." Similarly, Gavin expressed:

> I believe that mental health [stigma] exists. It is very prevalent in our community today among all groups of people. However, in the African American community,

we ignore mental health and focus only on what issues that can be seen or identified from a surface level.

Three primary objectives follow. First, I will discuss the research study setting, provide a comprehensive description of each of the African American clergy participants in the study using their pseudonyms, and then present a written account of the study. The written accounts of the phenomenon were relevant to the case. The accounts represented the lived experience, perceptions, beliefs, and attitudes of the study participants. I used both paraphrased interview responses and quotations provided by the participants to present a vivid narrative of the participant's perceptions, beliefs, stigmas, and practices regarding the use of mental health services. Second, I present evidence of trustworthiness, which included using transcription and notes. Finally, I will discuss the themes that emerged through the data analysis process.

Setting

The study participants were African American clergy and clergy representatives recruited from various churches across the United States. However, the participants who responded were all from the southeastern United States (Atlanta, Georgia; Savannah, Georgia; New Orleans, Louisiana; Winston Salem, North Carolina; and Florence, South Carolina). The participants called the contact number provided in the e-mail recruitment letter or responded to the e-mail directly. Interested individuals provided their contact information, so that I could follow up with them, answer any questions about the interview process, and set up a time to conduct the interviews. I contacted each

participant to set up a time, date, and location to conduct the interview. Each participant opted to conduct the interviews via telephone.

Demographics of Participants

The study involved gathering basic demographic information for each participant, such as denomination, title, number of years ordained, age, gender, highest level of education, and geographic location. In this section, I also provide a more in-depth description of the clergy participants' experience as a clergyperson and their feelings regarding mental health as a context for their perceptions, beliefs, stigmas, and practices regarding the use of mental health services in the African American community. Six individuals participated in this study. The individuals were all African American and between the ages of 31 and 49. The participants consisted of five males and one female who represented COGIC, AME, or Baptist denominations. The demographic information of the participants appears in Table 2.

Table 2

Participant Demographics

Participant	Denomination	Title	Years ordained	Age/ gender	Education	Location
Lisa	COGIC	Administrator	N/A	44/female	Master's	Atlanta, GA
Michael	COGIC	Pastor	9	37/male	Associate's	Atlanta, GA
Jacob	Baptist	Pastor	21	49/male	Doctorate	Florence, SC
Christopher	COGIC	Minister	3	33/male	Master's	Winston Salem, NC
Isaac	AME	Pastor	5	42/male	Doctorate	Savannah, GA
Gavin	Baptist	Pastor	12	31/male	Bachelor's	New Orleans, LA

Note. COGIC = Church of God in Christ. AME = African Methodist Episcopal.

Lisa

Lisa was a 44-year-old female church administrator at a COGIC church in the Atlanta metropolitan area. Her church was in a predominantly African American

neighborhood that bordered areas populated by Latin Americans and Asian Americans. As the church administrator, she was the gatekeeper between the church or community members and the church leaders, including the pastor. She acted as a buffer and was often the first point of contact or the face of the ministry that was tangible to members and the community. When asked about her feelings regarding mental illness, Lisa talked candidly about personal experiences with depression and having church members and members of the community ask to schedule counseling sessions with the pastor due to extreme moments of stress and grief. She could not recall any time when someone admitted to being depressed or suffering from a mental issue.

When asked to elaborate on her experience with depression, Lisa shared that she suffered with depression after the loss of a family member. The loss, during her freshman year in college, was so devastating that her grades suffered dramatically and as result she went on academic probation. She explained that the church did not assist with her depression. In fact, if she had not been placed on academic probation and required to attend counseling to be reinstated into school, she would have probably never sought help.

Participating in professional counseling sessions to be reinstated into school was somewhat consoling, because she could attend the sessions without the church being aware of her counseling sessions:

> Even in the event that the church learned about my bout with depression and counseling to address the issue, I would still feel comfortable with being able to

> hide behind the fact that the counseling sessions were a requirement from my university.

When asked how she helped others deal with depression or other forms of mental health issues, she replied:

> I am not trained as a counselor, nor am I ordained as a minister. However, I am a supporter of using mental health treatment to address various mental health issues, especially depression. I have on many occasions encouraged individuals during private conversations to seek the assistance of a professional counselor to address issues.

She believed that prayer was always an option, but noted there were times when counseling and prayer should be used to address mental health concerns.

Michael

Michael was a 37-year-old African American male ordained in the COGIC for more than 9 years. He had been pastoring for approximately 7 years in a church located in a suburb of Atlanta, Georgia. He believed that mental illness existed and more people in church suffered than what they might be willing to admit, stating:

> As a pastor, I encounter individuals and families that are suffering from mental health issues that stem from a number of things from spiritual battles to poverty, job loss to the death of a loved one. In most cases, the sufferers are only willing to participate in praying for the situation and being spiritually counseled.

When asked about how he handled issues of mental health with individuals, he explained that he had a strong desire to see people live healthy and balanced lives. With

that said, he believed that it was extremely challenging to incorporate a mental health agenda in the African American church because in general having faith and praying was a strong cultural tradition that had been passed down from generation to generation. In most cases, African Americans were going to pray, talk to a family member, friend or the pastor.

As a young pastor, he advised his members to seek professional counseling, but many of the older members over 55, including the senior pastor, frowned on that way of thinking. He described this as a constant struggle that he hoped would begin to shift. One of the hardest things for him to experience was trying to move forward in ministry while being held back by the embedded theology of the denomination and lack of support from the senior pastor and denominational leaders.

Jacob

Jacob was a 49-year-old African American male pastor ordained for 21 years in the Baptist denomination. He had been pastoring in Florence, South Carolina for 6 years. He had a doctorate degree in ministry and clinical pastoral education training. When asked about his feelings regarding mental health in the African American church, Jacob stated that mental illness was problematic and that being able to address mental health in the African American church, and in particular, the Baptist denomination was difficult because the denomination did not include mental health as part of the denomination's agenda.

Jacob's education and training played a major part in the way that he approached doing ministry at his church. He wanted his members be healthy and whole mentally,

physically, spiritually, and emotionally. When asked to share more on how he achieved or promoted his healthy and whole agenda, he responded:

> It is not easy, but I use a combination of both prayer and spiritual counseling sessions. The church that I pastor is a small church with a steep history in the small Florence, South Carolina town. Interjecting the use of mental health services is something that has to be approached delicately if at all.

Christopher

Christopher was a 33-year-old minister ordained in the COGIC church 3 years ago in the Winston Salem, North Carolina, area. He had a master's of divinity degree, but admitted that no amount of education could have prepared him for the struggle he would encounter regarding moving forward and adapting to change, including the use of technology and mental health services. When asked if he could elaborate on some of his struggles, he shared that he worked with the youth department at his church. To appeal to the younger generation and community, he suggested creating a website so that the church could have an Internet presence. As a result, sermons, bible studies, and other services, including counseling services, were accessible via the Internet, live stream, and podcasts.

Christopher stated:

> Unfortunately, many of the churches have failed to utilize technology in a manner that could reach more individuals. I proposed having a counseling hotline for the youth department to try to address the issue of bullying and depression. But, I was called to the office by the pastor and told that it appeared that I didn't have a

> prayer life and wanted to hide behind the computer screen and professional counseling services. I tried several times to plead my case about how partnering with youth advocacy and counseling services could help our youth address issues, such as depression, bullying, fat shaming, teenage/young unwed mothers, etc. I was told to pray or leave. Well, here I am talking to you, and I can tell you that I left.

Isaac

Isaac was a 42-year-old African American male pastor in the AME church. He had been ordained for 5 years and pastoring in the Savannah, Georgia area for 3 years. His roots were in the Midwest. Isaac said that being involved in the ministry was almost a given since he came from a long line of pastors and ministers:

> My purpose in ministry has evolved over the years, especially after graduating with my PhD in counseling. I have a better understanding of the mental and emotional issues that individuals are experiencing due to education and training, but I also understand the spiritual aspect that guides individuals thinking and decision making.

When asked if he recommended counseling to his members, he replied:

> I recommend counseling, but it's tricky since my denomination does not make any formal stance on mental health. I find myself advocating for mental health on a local level, if not even individually, depending on the situation and person.

Isaac shared that his church was an older church with a rich history in the community. The largest group in the church was over the age of 50. He believed that it

was a difficult challenge to try to impact change and shift when the majority of the congregation believed that the way things were done was fine. To help individuals and families in need of professional help, he recommended counseling (privately) and suggested counselors and agencies to contact for assistance. Thus, he admitted that he did not help as much in the church as he would like but made an impact through his private counseling practice outside of the church.

Gavin

Gavin was a 31-year-old Baptist pastor ordained for 12 years and pastor of two churches in the greater New Orleans, Louisiana, area. When asked to discuss his thoughts about mental health in the African American church, he stated that mental illness was a problem that people often cover up:

> I think that there are a lot of people suffering from some form of mental illness that attend church each week, but their condition never changes. Maybe the "power of prayer" that is pushed each week is not enough, but our culture has long placed all of our burdens on an altar and suggesting that we seek the assistance of professional counselors would disrupt the embedded theology that has moved our faith and lives for hundreds of years.

Gavin worked throughout his pastoral career as a youth pastor, assistant pastor, and now senior pastor. Throughout his journey, he recognized that people were suffering from mental, emotional, spiritual, financial, and physical despair. He noted each issue required a certain component to address it properly, "The problem is, generally speaking, the African American church prescribes a one-size-fits-all, and we call it prayer." Gavin

had been in contact with city leaders and professionals about ways to address many of these problems in a more effective way, including addressing the issue of mental health:

> It is obvious that the New Orleans and gulf region residents, who experienced the devastation of Hurricane Katrina, are suffering mentally and emotionally. I meet with individuals weekly who still feel the effects of the deadly hurricane and feel hopeless that they will never recover. So the issue of mental illness in the Black church and community is real, but how can we fix it when the victims only want prayer and the pastors only offer prayer?

Data Analysis

Data analysis involved using NVivo qualitative software, which was useful for sorting, categorizing, linking, and charting patterns of choices, strategies, outcomes, and suggestions for future research and investigation. Culture is an important consideration for researchers in terms of data collection and analysis (Morales & Ladhari, 2011). Categorizing and sorting data collected from the interviews yielded some applicable and relevant perceptions and practices.

Theme 1: Hidden Mental Illness

Participants provided various accounts in which they described witnessing issues of mental illness in the church. In each case, the participants shared how African American clergy either ignored the issue of mental illness or identified it as a demon or trick of the enemy. Lisa believed that mental illness was prevalent in the church. She identified several instances where individuals requested prayer for stress-related issues. She stated:

> The more prevalent issue with mental illness in the African American church is the issue of African American clergy suffering from depression. We see the statistics of African American clergy committing suicide on the rise but we often do not know about the issue until after they have killed themselves or left the ministry.

Lisa, a church administrator, described an instance where a leader in the church was absent and the bulletin included a request for prayer. The church members were under the impression that the individual was recovering after a procedure. Lisa shared that as the church administrator, she was privileged to certain information and knew that the leader had been admitted into the mental health ward of one of the local hospitals.

Michael shared that the church dealt with the issue of mental health in an indirect manner. Addressing or confronting the issue of mental illness head-on was not the typical approach. Michael believed that the African American church covered up the problem of mental illness more than they hid it. For example, someone could be overtly displaying signs of illness, and the African American church and clergy would address it, or cover it up, as demon possession or having a foul spirit. No one tried to hide the person displaying such signs, but using a cover or excuse was more preferable than considering there might be a treatable mental health issue. Michael stated:

> We had a young man in our church who had been diagnosed with cognitive and development issues. However, his parent would not take her son to the counseling sessions, because she believed that taking her son to the counselor was admitting that he was crazy. More so, instead of addressing the issue with available mental

> health and social services, she asked for prayer each week for her son. Instead of the church encouraging the use of mental health services, leaders, ministers, and pastors identify this issue as an attack from the devil and encourage the church to continue praying for the young man.

Michael shared this experience to show why he believed the African American church and clergy cover up the issue and ignore it versus hide it. African American clergy did not hide mental illness in the church, but simply gave it a different name that did not have the stigmatizing and negative implications that mental illness carries in the African American community.

Jacob expressed that mental illness was in the church, but not labeled mental health. He had witnessed instances in church and his family where he recognized that something was not right mentally or emotionally with a person, but no one ever spoke about it. African American clergy and leadership do not formally address many issues in the church because for generations the Black community has been taught to have faith, pray, and trust God. Jacob believed that admitting to the issue of mental health was basically equivalent to admitting to not having faith, not praying enough, and/or not trusting God. So in essence, the mental health issue was somewhat exacerbated because the pressure to live up to great faith and religious belief superseded the need to be honest and transparent with mental health struggles.

In defense of the African American church and tradition, Jacob shared:

> Mental illness is a hidden disease. It cannot be seen. So in the African American community, I believe that it is easier for individuals to grasp the idea of cancer,

> heart disease, a broken leg, et cetera, because those things are tangible, we can see them. Trying to see mental illness is impossible, and so I think that the issue of mental illness in the Black church and community becomes challenging because what can't be touched is not real.

Christopher said his experience in the church with mental illness was what he described as common practice. When individuals are struggling with any issue, including mental issues, in his COGIC church, the clergy/pastors bring the individuals to the front of the church for prayer and casting-out ceremonies. This procedure causes a level of embarrassment for many, so often people suffer in silence because they do not want to go to the front of the church and feel shame due to their condition.

Christopher stated, "I would have to say that mental health being hidden in the church is a result of situations such as this, no one wants to be shamed or embarrassed for a condition or situation that they are in." Ministers and pastors who shared their feelings and concerns about addressing mental health concerns with professionally trained individuals faced an uphill battle that often ended with them leaving the church, because they did not subscribe to the archaic practices of the denomination. Christopher noted:

> I have a real desire to help God's people, and sometimes we have to partner with outside agencies including counseling agencies to help God's people. I refused to be silent or hide behind the pulpit about the issue of mental illness. I, along with other young ministers in our church, am no longer a part of the church because of the issues of mental health, sexual and emotional abuses that continue to be

> covered up and ignored. I have been focused on options that allow me to help in a more effective manner.

Isaac, an AME pastor, said that mental illness in the African American community had been visible but ignored. He explained that the AME heritage was founded on the faith that God is the provider of all things. Thus admitting or allowing mental illness to be visible in the church was silently unacceptable. More specifically, Isaac emphasized that admitting to having mental illness was equivalent to being a nonbeliever. In most instances, his PhD garnered a certain level of respect, but in the church community, in particular the African American church, he described his degree in counseling as making some people uncomfortable:

> I am not in the business of trying to read people's minds. I am in the ministry to try to help offer hope and love to God's people. Sometimes that love comes in the form of identifying and addressing that there is a mental health issue. But as a younger pastor, I was approached by older church members and leadership not to discuss certain topics and events related to mental health over the pulpit. Hidden—no; ignored—yes. That is just how I feel.

Gavin described a specific incident where a family friend who was a pastor had a public breakdown. Once the matter had been addressed professionally, which included medication, the pastor returned to the pulpit and declared that he had won the attack of the enemy. In discussing this experience, Gavin expressed his disappointment with (a) the pastor's missed opportunity to open the discussion about mental illness in his church and denomination and (b) the pastor hiding from his members and followers that he actually

sought and received mental health treatment from professionals. He described the situation as deceptive and as further perpetuating the idea that needing mental health help translates into being weak. Gavin asked, "How many individuals could he have helped if he would have shared his true story and promoted the use of counseling or mental health services instead of hiding?" This scenario confirmed Patterson's (2013) suggestion that the general perception of African Americans is they are emotionally stable and balanced.

Theme 2: Stigmatized by Mental Illness

All the participants believed that admitting to having mental health issues and seeking help for them resulted in being stigmatized and characterized as a person of weak faith. Lisa, a female church administrator at a COGIC church with over 20 years' experience, served as a gatekeeper or buffer between the membership and leadership of the church, including the pastor. She considered this position somewhat intimate and critical to the health and success of the church.

Lisa was often the first point of contact and heard many of the familial, spiritual, physical, psychological, economic and financial, societal, and professional issues of members. Even though some members were clearly suffering mentally and emotionally, they often tried to disguise the problem as being under the attack of the enemy because of the fear of being stigmatized.

Michael stated:

> Admitting to suffering from mental health issues, including depression, is almost always linked to being labeled as crazy or having weak faith. The last thing that someone wants to be identified as is crazy, so instead of dealing with mental

> issues, many of the people that I have encountered stay quiet about the issue. The only time that someone shares the issue is with a trusted friend or family member that they feel is not going to judge them or shame them. Being stigmatized as being weak in any capacity is difficult, but for African Americans being characterized as weak in faith or belief is traumatic.

Jacob shared that African Americans shunned the issue of mental illness because no one wanted to be labeled as being crazy or a lunatic. He stated:

> I know personally of aunts and uncles in my family who, looking back, they had a mental illness, but it was not treated. It was looked upon as that's just how that person was. But now when I think about it, this person had a mental illness and they just weren't getting any treatment because you didn't have the concept or people embracing mental illness like you do now as compared to then.

All the participants shared a belief that many pastors and clergy dealt with mental and emotional issues, but lacked the support to address them because of a belief that clergy should not need mental health services. Christopher admitted mental illness in his church was stigmatizing because the clergy/pastor announced it over the pulpit to the congregation. He said that the "pastors' rationale" was that when a member is suffering, we (the clergy and church leadership) want everyone (the congregation and community) to know so that they know what to pray for. The announcement was like being labeled and coping with that adds to the already sensitive mental health issue. Christopher stated:

> This is a never-ending cycle of mental health trauma that is not going to be resolved until we as African Americans shift our thinking regarding mental health

and effective ways to successfully address them, including sources outside of the church.

Isaac said that mental illness for most is stigmatizing. In the Black community, "We tend to put more emphasis on our faith and appearing to have everything together because you are a Christian than seeking help in times of need for depression and other mental health issues." In his job as a professional counselor, Isaac encountered individuals desperate for help but concerned about their confidentiality. Isaac noted the ability to be counseled in a private and anonymous setting was welcoming for these individuals, but it often took him a few sessions to establish the rapport and confidence for those clients to express themselves and invest in the process to heal.

Gavin said that he never experienced the issue of stigma and did not believe that it really existed in the way discussed. He believed that African Americans are proud people and often kept quiet about a lot of issues that they may be dealing with. As such, Gavin was not sure if mental illness was any different. From his perspective, when he had members who needed help financially, often the church is the last resort that is sought for help, because they are embarrassed that they need help paying rent.
The area in New Orleans that Gavin pastors was different in the sense that many people lived in poverty and experienced myriad health issues, including mental health, that were like the norm. Saying the issue is stigmatizing in Gavin's situation was difficult because people in the area had issues that had existed for generations.

Theme 3: Mental Illness and Lack of Faith

Michael, Jacob, and Gavin each shared the notion that the African American church believed that as long as individuals kept their minds on Jesus, they would be at peace. Michael and Christopher recalled instances growing up in the church when the pastor challenged individuals to increase their faith. Specifically, Jacob said there were members in his church suffering from mental health issues. The pastor told one member to "attend church more, pray, and ask God to forgive their lack of faith," as her challenges and hardships were a result of her lack of faith.

Theme 4: Prayer Versus Counseling

An almost exact consensus occurred among all participants pertaining to mental illness being an ignored issue in the African American church and community. The participants concurred that helping African American clergy identified their perceptions, beliefs, stigmas, and practices regarding mental health were challenging because of the embedded intergenerational traditions of the African American church and family. Each participant described this challenge as the biggest hurdle to promoting the use of mental health services among African Americans.

The general concern for Lisa, Christopher, Isaac, and Gavin was that mental illness was something that many people did not acknowledge, cope with, or include as part of their overall health. A consistent theme was eating right, exercising, getting regular check-ups, and so forth to achieve and maintain good health. This normative repetition becomes a concern because mental health did not appear on the health agenda.

Lisa stated, “In the Black church, we kind of lean heavily on prayer in lieu of dealing with emotional and mental illness.”

Theme 5: Secular Counseling

All participants had been involved in a leadership role in the African American church for a minimum of 5 years. Only one of the participants was not an ordained clergyperson. Each participant shared stories of church members, family members, or friends about some form of mental illness, but the response to the issue was to ignore it or pray. The Black church affected how the Black community receives and processes information about health (Lumpkins, 2010), which is significant if African American clergy are not acknowledging or disseminating information regarding mental health.

Theme 6: Clergy and Secular Counseling

Lisa and Michael were the only participants who admitted to having personal mental health issues that led to seeking professional counseling outside of the church. Isaac shared that a clergy colleague dealt with his mental illness with the help of a licensed professional outside of the church and noted only a few close friends and family were aware of the issue. Isaac’s colleague never admitted to his congregation that he had mental health issues. Isaac stated, “Within the intimate community, there was a lot of support. He was never criticized, stigmatized, or left on an island alone to deal with it by himself.” In terms of promoting secular counseling, every participant indicated that he or she had promoted or would promote the use of secular counseling.

Lisa and Jacob agreed that promoting the use of secular counseling could be beneficial, but it would take a lot of effort and time before African Americans could

overcome the stigmas. As noted previously, the participants believed that not having the help and support for addressing mental illness from denominational leaders made the issue much more challenging than it would be if they had the support. Michael shared that he promoted the use of mental health services with individuals one-on-one. However, "I have been challenged, criticized, and chastised for addressing issues, such as mental illness, over the pulpit. Even to the point where I was accused of giving individuals a reason to not trust in God."

Christopher noted that he tried to address mental health issues by directing his congregation to the scriptures. He reminded his members that if they wanted peace, they had to keep their minds on God. He adamantly believed that when people focused their attention on positive things, they were more apt to have a positive outlook on life. Isaac indicated that secular counseling was beneficial to one of his peers and as such would likely benefit more people within the church community through openly promoting the practice and if church leaders worked intentionally to dispel stigmas. Isaac acknowledged that it was challenging to get church leaders to promote secular counseling publicly or overtly, but also suggested that it might be part of their responsibility to do so.

Evidence of Trustworthiness

I ensured the validity of the analysis in various ways. Qualitative validity, according to Creswell (2009), means that a researcher ensures the accuracy of the findings by employing certain procedures. In Chapter 3, I discussed the use of transcriptions and notes. I also provided copies of the transcribed interviews to the participants to ensure that what they shared was consistent with their voice.

The validation of findings in qualitative research occurred throughout the research process (Creswell, 2009). I conducted a continual check during the coding process to ensure coding did not drift from the original intent as the coding process evolved. I used an electronic codebook within NVivo to code the data. I was the only person responsible for analyzing the data and thus, no need to cross-check for intercoder agreement. I also kept a reflective journal of each interview and e-mailed the transcripts to each participant to ensure the transcriptions were accurate.

I used an open-ended questioning style during the interviews and engaged the participants in conversations that garnered direct responses to questions and often led to an overflow of information, further interactions, and additional understanding about the subject and the participants' experiences. Interview Question 2 was as follows: How are mental health issues addressed in your local church or denomination? The participants provided detailed responses to the question. Lisa stated the following:

> On one hand, the easiest way to say is that they're not. On the other hand, there's the tendency to just say somebody may have a problem and not admit or recognize that its mental illness. It might just be something to be, "Well you got to pray for that." Old-school Church of God in Christ says, "Well that's a spirit, that's a demon that has to be cast out." You don't see quite as much of that in modern times. It's still an undercurrent, but either way the result is the last thing that you'll really hear in churches is that that's a mental health issue. We need a mental health professional, not necessarily the pastor or a ministry to do it—a real

> mental health professional who is probably going to be way, way, way down on the list to hear as an option.

Michael had similar sentiments. He shared that he couldn't say that mental health issues were addressed publicly or even in private. Michael said:

> In the Black church in general, certain topics seem to be taboo and some people don't like to talk about certain things and I believe mental health is one of those things. So, as far as our local assembly a lot of issues that people may deem to be taboo are usually only addressed when the topic is brought up. Usually after some particular issue or some event or something happens that requires that it be addressed.

While Jacob's response invoked how congregants should think, he did not deal directly with how African American clergy cope or do not cope with mental health issues in his local church or denomination. He shared a specific method for addressing mental health. Jacob proposed using Bible lessons about freeing the mind. He believed that the mind was the actual point of contact. Jacob said:

> Most people don't think the Word, they think too much of negative stuff, they think so much of disaster, and all kinds of famine and everything that's negative. Their mind is preoccupied with that and they feed on that—whatever you feed your mind, that's what you become.

Jacob went on to share that he stressed feeding on the Word of God (feeding on what God is saying in the Bible). Furthermore, he explained that his lessons and sermons detail how we should think, how we should see ourselves, how we should see our

circumstances, as well as how we should see others through the Word of God. As a result, using faith and the Word should be the primary source that people should look at when it comes to how they should think.

Christopher's response was similar to Lisa's, as he believed that mental health issues that were addressed at his local church were addressed in different ways. He admitted that he had people with mental health issues that were members and they would just pray for them all the time. In other cases, being that his church was historically Pentecostal, if someone came in with mental illness that was taking over or interrupting the service, the pastor and ministers would start casting out the *"demon"* or enemy (Satan). He felt that it was unfortunate but most of the individuals who had mental illness in his church were told that the devil was attacking their mind and they needed to pray harder.

Both Isaac and Gavin also expressed a void when it came to how their local church or denomination dealt with mental health issues. Isaac said, "It's pretty much ignored or people seek professional help privately on their own." Gavin was emphatic in his response and said, "They do nothing!" Gavin also reported that the way his Baptist denomination was set up, pastors deal with mental illness on a local level or not at all.

Research Results

The results include a brief narrative about the data in relation to each research question, followed by a discussion of the research results by the identified themes. I derived the themes from the answers to the interview questions given by participants. I constructed the interview questions from, and in support of, the research questions for the

study. This study revealed the lack of specific data available regarding the mental health stigmas and perceptions held by African American clergy, and the importance of the influence African American clergy have on their constituents. This section also includes an interpretation of the research findings, with specific emphasis on the identified themes.

Research Question 1

Research Question 1 was as follows: What stigmas do African American clergy have regarding mental illness? I posed this open-ended question to invite the widest possible range of responses. The three primary themes related to this research question are in this section. The section includes tables summarizing the definition of the identified themes and the frequency of occurrence for these identified themes and subthemes, including the number of participants who mentioned a specific theme and subtheme.

The primary themes for the first research question were (a) hidden mental illness, (b) views of individuals suffering from mental illness (with the two subthemes stigmatized by mental illness and mental illness and lack of faith), and (c) you don't want people in your business. Table 3 includes the participants' responses that related to Research Question 1 and shows the frequency with which the primary themes, key terms, participant perceptions, and the number of participants who shared the same information appeared across interviews and across the data.

Table 3

Primary Themes for Research Question 1

Primary themes	Key terms	Participant perceptions	*n*
Mental illness in church	Hidden	Hidden or not addressed explicitly by the church.	6
Mental health sufferers	Stigmatized	Leads to labels and/or being stigmatized.	4
Causes of mental illness	Faith	Not being as connected to God or a lack of faith.	3
Personal or public	Personal	Don't want people in personal affairs, so church is not a source for help with mental illness.	2

Research Question 2

Research Question 2 was as follows: Do African American clergy promote the use of secular counseling for mental health treatment? As reflected in Table 4, the primary themes were (a) clergy feel secular counseling can be useful, (b) prayer versus counseling, (c) secular counseling is not highlighted in the church, and (d) clergy promote secular counseling (with two subthemes clergy and secular counseling to individuals and clergy and secular counseling publicly). Table 4 also shows the frequency with which the themes and subthemes appeared across interviews and across the data.

Table 4

Primary Themes for Research Question 2

Primary themes	Key terms	Participant perceptions	*n*
Secular counseling	Secular, spiritual, counseling	Useful when used with spiritual counseling or prayer	6
Mental health resources	Prayer, faith	Used prayer vs. counseling to address mental health issues	3
Promote **c**ounseling	Privately	Only to individuals privately	6

Summary

This qualitative study revealed that the issue of mental illness in the Black church and community is a hidden but prevalent issue. The data showed African American clergy and the Black church rely more on faith and prayer as the main source for addressing mental health issues. Although the majority indicated they promoted the use of secular counseling, a lack of support for the issue was apparent on denominational levels. The findings indicated that perceptions, stigmas, and practices about mental illness passed down for generations influence African American clergy. In Chapter 5, the discussion, conclusions, and recommendations include a reconciliation of the findings with the components of the theoretical framework governing this study, namely sociocultural learning theory and social learning theory.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

This qualitative case study was about the perceptions, beliefs, stigmas, and practices of African American clergy regarding mental health services. Specifically, this study included an exploration of how the lived and shared experiences of African American clergy regarding mental health services informed their decision to promote or not promote the use of mental health services within their churches and community. The data came from in-depth interviews with clergy. The descriptive data from these interviews included the factors and beliefs, both traditional and religious, that shaped their understanding about how to address mental illness.

I synthesized the information I gathered and created Chapter 5 to provide clarity. The chapter opens with a brief introduction and overview of the conceptual frameworks and transitions to the interpretation of findings, which are detailed according to the six themes that emerged during the study. The six themes were as follows: (a) hidden mental illness, (b) stigmatized by mental illness, (c) mental illness and lack of faith, (d) prayer versus counseling, (e) secular counseling, and (f) clergy and secular counseling. A discussion of the themes is followed by a transition into the limitations of the study and a discussion on data collection and analysis.

After discussing the limitations, I share recommendations for future researchers, African American clergy, and mental health service providers about key perceptions that act as barriers to African Americans seeking mental health services. The chapter includes a commentary on the study's implications on social change and the ways the study

findings are likely to (a) improve how African American clergy perceive mental illness, (b) improve the negative perceptions held by African Americans regarding seeking mental health services, and (c) open communication for building relationships between the African American church and mental health service providers.

The value of this study was that it involved obtaining information from the participants' individual and shared experiences as African American clergy. Even though researchers have studied the issue of mental illness from an African American perspective, African American clergy's voice has been silent due to the lack of research from their perspective. This study identifies how these perceptions hinder African American clergy's ability to acknowledge or address personal mental health issues. As a result, the members of their congregations and communities continue to repeat these behaviors.

Conceptual Frameworks

Sociocultural theory and social learning theory comprised the theoretical framework for this study's research inquiry and the interpretation of findings. Vygotsky used sociocultural theory in the field of education to confirm behavior and cognition through genetic analysis (DeValenzuela, 2013). Mercer and Howe (2012) viewed sociocultural theory as an explanatory framework used in the process of learning and cognitive development. Other researchers have applied sociocultural theory to fields outside of education. Nasir and Shah (2011) asserted that sociocultural learning for African Americans includes the interconnectedness of identity and learning. Similarly,

Dickson et al. (2013) found that sociocultural learning becomes normal practice and influences community members' decision making based on cultural beliefs and support.

Bandura described the social learning theory as learning focused on one's environment, behavior, and psychological process (Adnan & Tasir, 2014). According to the social learning theory, role models influence the understanding and practice of moral and other behavioral patterns (Brown & Trevino, 2014). Social learning involves engagement in activities, discussions, and considerations regarding what social life is and how to experience it (Wenger, 2010).

According to the results of this study, using mental health services in the African American community was characterized as weak. The findings support the social learning theory as decision making behavior patterns of the participants were influenced by their environment. As clergy professionals, the participants admitted that their notion of mental health and mental health services was learned through family and pastors. As such, the participants shared that they developed their perceptions, beliefs, stigmas, and/or practices by considering how pastors lived their lives and pattern their behaviors after what was learned.

Interpretation of the Findings

In this study, I used a phenomenological approach and focused on participants from the same group or culture. Consequently, I was able to identify similar perceptions, beliefs, stigmas, and practices that participants shared regarding the use of mental health services. African American clergy supported the personal use of mental health treatment but were reluctant to admit or deny experiencing mental illness personally, even

depression, to their congregations. All agreed that the promotion of mental health services is important, but the lack of support from the denominations made using the pulpit and clergy platform to promote the use of mental health challenging. The sociocultural and social learning theories, the foundations of this study, involved African Americans being responsive to their clergy persons' influence and patterning their behavior after what they saw or heard from their respective clergy person(s). As a result of this knowledge, what African American clergy learned in their personal education and adapted regarding mental health indirectly affected their decision to promote or not promote the use of mental health services.

The results of this study have the potential to inform and educate African American denominational leaders, clergy, and mental health professionals about potential perceptions, beliefs, stigmas, and practices that African American clergy may have and how they project them onto their congregations. African American clergy need to create and build new constructs to trust and accept mental health options among African Americans. Some European researchers suggested that such new constructs must begin with intentionally building an environment of trust, dignity, confidentiality, and safety (Gaebel et al., 2014). Building new constructs includes cultural sensitivity training for mental health professionals and their staff.

In 2001, researchers in the U.S. Surgeon General's Office suggested that alleviating, mitigating, or at least acknowledging the issues of race and poverty can have a direct and likely positive impact on minority responses to mental health services (Satcher, 2001). New constructs will likely require concerted and coordinated efforts by

mental health professionals to show themselves and their profession as both trustworthy and competent (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). According to social learning theory, many in the African American community learned to distrust the mental health field early in life and passed on those feelings to other generations (Adnan & Tasir, 2014; Dickson et al., 2013). The learned perceptions, beliefs, and practices labeled as stigmas may have prohibited African Americans, including African American clergy, from embracing mental health services. Such stigmas could lead to and support social and economic disparities that negatively impact the African American community at greater rates than the larger society (Pratt & Brody, 2014). To combat the social and economic disparities, African American clergy need to consider and develop new ideas and understandings regarding mental health.

Concerned with the lack of mental health services used in the African American community, my primary inquiry in this study was to explore the perceptions, beliefs, stigmas, and practices that influenced whether African Americans use mental health services. As outlined in the conceptual framework, I explored how social and cultural contexts influenced individual behavior. I acknowledged that African American clergy were trusted figures in the community and relied on for support for various issues and concerns, including mental health concerns. Studies (Gardner, 2013; NAMI, 2004) confirmed that African American clergy were the first point of contact and present for major events, including death, birth of children, baptism, graduation, weddings, and serious physical and mental illness in the African American community.

All the African American clergy participants acknowledged that they understood stigma as not wanting others to label or view them as crazy. For instance, the sociocultural and social learning theories included descriptions of learning and cognitive development processes (Mercer & Howe, 2012). In the African American community, admitting to suffering from mental illness led to characterizations of being weak and having no faith (Neely, 2015; Ward, Wiltshire, Detry, & Brown, 2013). The participants shared that their feelings regarding mental health resulted from family and religious traditions that became normalized and influenced their decision-making practices (Adnan & Tasir, 2014; Dickson et al., 2013).

The findings from the participants' responses included their experiences and understanding of perceptions, beliefs, stigmas, and practices related to mental health services. The participants also described how their religious and traditional beliefs influenced whether they promoted the use of mental health services outside of the church. Although previous investigators had found how well African American church leaders promoted healthy lifestyles and health initiatives in the church, the studies did not include mental health as a part of the health initiative (Campbell et al., 2007; Lumpkins et al., 2013). Another study (Brown & Trevino, 2014) identified the strength of the Black church and African American clergy's influence on followers' behavioral practices. However, no studies existed on African American clergy's promotion of mental health services (Campbell et al., 2007).

The review of the literature that I conducted confirmed that previous researchers had not considered the lived experiences of African American clergy as it related to their

perceptions, beliefs, stigmas, and practices regarding mental health and promoting the use of mental health services. This gap in the literature demonstrated the need to explore this area to determine whether they considered mental health services as beneficial in promoting healthy lifestyles and living. The study was significant in that the outcome was an identification of the factors influencing whether or not African American clergy promote the use of mental health services. What was revealed was that they promoted the use of mental health services at a limited or private level. African American clergy and denominational leaders might choose to include mental health as a part of their overall agenda after learning the findings from this study. This study may inform future intervention efforts and collaborations between the church and mental health agencies that could reduce mental health issues in the African American population.

The research questions explored and answered were as follows:

1. What stigmas did African American clergy have regarding mental illness?

2. Did African American clergy promote the use of secular counseling for mental health treatment?

Recommendations for Future Research

Based on the participants' personal accounts and experiences, the results of this study were that African American clergy's perceptions, beliefs, stigmas, and practices affected how they addressed mental health issues in their congregations. Some participants admitted that they promoted the use of mental health services but failed to address the issue because treating mental health issues in the Black church traditionally occurred in secret, if at all. When the participants shared their experience with any form

of mental illness, all but two admitted that they had personally experienced mental illness. Gavin stated that he was sure that a professional assessment would indicate he was overworked or overwhelmed but not depressed or suffering from a mental issue.

One of the findings of this study was that the African American clergy recognized that mental illness is a crisis in the African American church. Participants noted that they felt stifled about how to approach the issue effectively, especially without the consent or support of the top leadership of the denomination. Jacob stated, "Knowing that there is a problem and addressing the problem are two separate tasks." A consensus existed with regard to feeling powerless or ineffective in the fight against mental illness in the Black church due to the lack of denominational support, but some accounts included that a continued desire exists to help fight mental illness among African Americans, even if it has to occur outside of the church.

After conducting this research and reviewing the data, I have the following recommendations:

- For future studies with African American clergy a larger sample size and age range would help to establish higher validity and reliability than occurred with the small sample.
- Including other racial or ethnic groups may enhance cross-cultural comparisons to determine differences in perceptions, beliefs, stigmas, and practices among the groups. This determination is important, and perhaps critical, to addressing perceptions, beliefs, and stigmas at the cultural *preservation of lineage* (Yang,

Thornicroft, Alvarado, Vega & Link, 2014, p. 3) and "what matters most" (Yang et al., 2014, p. 3) levels.

At a societal level, identifying the culturally based stigmas that inhibit members of different racial and ethnic groups, including African Americans, from seeking mental health services could lead to more comprehensive and effective care and outcomes (Yang et al., 2014). Doing so could lead to a more productive and stable economic outlook for patients and society. Identifying the culturally based stigmas that inhibit members of different racial and ethnic groups, including African Americans, from seeking mental health services could lead to more effective modes of communication with each different racial and ethnic group (Aggarwal, Pieh, Dixon, Guarnaccia, Alegría, & Lewis-Fernández, 2015).

Payne (2009) conducted a research study with Protestant and Pentecostal pastors in California regarding the varying perceptions of the etiology of depression by race and affiliation. African American pastors were more likely to define depression from a spiritual context by linking depression to hopelessness due to lack of faith or trusting in God.

- Studies on African American clergy's mental health aptitude would provide an opportunity for clergy to recognize their areas of strength and areas needing improvement.
- Additional research on pastoral levels of preparation for counseling and knowing when to refer individuals to mental health professionals is necessary. Understanding stigmas is important, but many pastors admitted to conducting

counseling sessions with members of their church and community without formal training. Only one of the six participants had formal training in the counseling field and used both practical counseling techniques and spiritual counseling techniques to address mental health issues in the African American church.

Implications for Social Change

Although efforts to address the issue of mental illness occurred in the African American community, limited progress has taken place, if any. The researchers of multiple studies regarding stigmas in the African American community documented the traditional beliefs and fears of what others think about individuals who seek mental health treatment (Gardner, 2013; Masuda et al., 2012). More importantly, researchers (Gardner, 2013; Payne, 2009) reported that African American clergy influence decision making in the African American community, but continue to exhibit negative feelings toward using professional mental health services (Connor et al., 2009). Based on the research related to mental health stigmas in the African American community, African American clergy stigmas and how these factors affect church members justified exploring this gap.

Implications for social change emerged from this study and fit into four groups:

- African American clergy need to understand about possible perceptions, beliefs, stigmas, and practices they have regarding using mental health services and how these factors erect barriers for the African American population. Increasing African American clergy's awareness and understanding about mental health, including possible stigmas

they may possess, can have a positive impact on how they approach the use of mental health services.

- By accepting the existence of stigma and its ramifications, African American clergy could be advocates who lobby for the inclusion of mental health services as a part of their denomination's overall agenda, especially considering the possible positive socioeconomic impact.

- Mental health service providers who understand the barriers (that prevent seeking mental health services help) could develop effective strategies for implementing counseling methods directed toward cultural and religious beliefs, including denominational beliefs, embedded with the African American population. Understanding how stigmas relate to mental health affects African Americans in a culturally sensitive manner that has promoted the use of prayer and faith (A, Brown, 2012). The goal is to cultivate healthy and productive relationships between African Americans and mental health professionals. This new partnership would be able to help the African American church and community along with mental health professionals to move forward together to address mental health issues effectively.

- Mental health training for African American clergy could lead to collaborations for more effective outreach programs. These programs could (a) provide cross-learning opportunities for mental health professionals and African American clergy and (b) encourage African Americans to seek help for mental health issues without fear of stigmatization. Collaborations between African American clergy and mental health professionals could lead to treatment plans with both spiritual and practical components.

Conclusion

This chapter included a discussion of the conceptual frameworks, interpretation of the findings, recommendations for future research, and implications of social change. In this chapter, I presented key information and experiences that highlighted the existence of negative perceptions, beliefs, stigmas, and practices of African American clergy. I synthesized the participants' responses and experiences with the study's conceptual framework and literature on mental health stigma as they relate to African American clergy.

The main findings of this study were that the African American clergy who participated in the study shared that they either promoted or would promote the use of mental health services for their congregations. However, the variables that conflicted with this promotion included mental illness hidden in the church, the stigmatization of individuals with mental illness, lack of faith caused mental health issues, not promoting secular counseling as a resource in the church, most parishioners relied on prayer and faith, and few clergy promote secular counseling. These themes led to a better understanding of the role that African American clergy played in the decision-making practices of their members.

All the participants provided statements that supported the combined use of mental health services and prayer to address mental health issues. Religion and prayer played a vital part in the lives of the participants, and as a result, the emphasis was on the use prayer as the main source or treatment of mental health issues. This study was similar to previous research on the church and clergy being major sources of trust in the African

American community and fear of what others thought about seeking counseling (Gardner, 2013; Payne, 2009; Vogel et al., 2007). The findings also confirmed that African Americans often self-impose stigmas in the African American community (Gardner, 2013; Masuda et al., 2012).

I found that this self-imposed stigma had a direct link to PTSS and drapetomania. Although drapetomania had various forms and understandings over the years, it was real and prevalent in the everyday life of African Americans. Drapetomania helped to frame why many African Americans still use the church, clergy, family, and friends as trusted resources to deal with issues including mental illness. From the time slaves were captured and shipped to America, they only had their faith and a song to keep them connected to family lost in slavery. They created new families with other slaves on the same boat or on the same plantation.

As I reflected on the literature review, the research, and the findings, I realized the existence of a sinister and toxic mixture of manipulation and control using faith and religion. This research was a partial confirmation that individuals can use what others believe against them. The juggling act for African American clergy who have a genuine concern for addressing the issue of mental health among African Americans is to empower individuals rather than perpetuate an ideology built on falsehood, manipulation, and greed. Ignoring or pretending that mental health does not exist in the African American church and community validates that the church is the new-age plantation with invisible shackles binding the minds of its members.

Members of the African American community have several options for addressing mental health issues. However, when African Americans relied on clergy for counseling, they were not always aware of other options (besides prayer) that could provide relief for mental health issues because clergy were unaware of their own perceptions regarding mental health, or perhaps the impact of their perceptions, even if they were aware of them. In untangling the web of perceptions and stigmas, clergy must consider the whole being of the individuals they are counseling. They might also consider the benefits and positive outcomes possible after comprehensively addressing the issue of mental illness (Masuda et al., 2012; Neely, 2015; Pratt & Brody, 2014). If clergy believed in or accepted the benefits of a mentally healthier congregation and community, as numerous researchers described (NAMI, 2016; Ward et al., 2013), they might embrace mental health services.

As a result of understanding the historical ties linked to mental illness in the African American community, my hope is that African American clergy assess their own mental health. After African American clergy have a personal awareness, they will be able to affect the community in a way that minimizes the fear of stigma regarding mental illness. The idea that clergy should have it all together is another means of robbing an individual from the freedom of being mentally healthy. As more African American clergypersons become open and honest about their mental illness issues and efforts to address them, the community can begin to let go of the perceptions, beliefs, stigmas, and practices preventing them from seeking help from mental health services.

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Appendix A: Interview Questions

The questions are drawn in part from the theoretical frameworks that ground this study. Those frameworks include Vygotsky's sociocultural theory and Bandura's social learning theory.

Interview Questions:

1. What denomination are you affiliated with?
2. Are you an ordained clergy person?
3. (If so, how long have you been ordained? If not, what is your title?)
4. What is your gender and age?
5. What is your highest level of education?
6. What geographic location is the church located that you serve?
7. What are your feelings on mental health?
8. How does the bible address mental health?
9. What does your denomination say (if anything) about mental health?
10. How are mental health issues addressed in your denomination/church?
11. Have you ever experienced depression or another mental health issue?
12. How did/do you cope with the issue?
13. How has your socialization as an African American clergy person shaped your stigmas, beliefs, perceptions, and/or practices about mental illness and mental health services?
14. Is there anything in your upbringing that still frames your opinion about the use of mental health services?
15. Do you believe that prayer alone solves mental health issues or do you believe that prayer coupled with mental health services offers a better solution?

16. Give me an example of a person grounded in ministry who shares your basic religious or spiritual beliefs but who also has benefited from the use professional mental health services outside of the church.

17. Do you promote the use of professional counseling for mental health issues outside of the church? Why or why not?

18. Do you promote the use in sermons, bible study, private spiritual counseling sessions, etc.?