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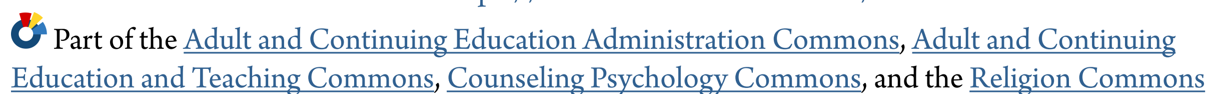
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Walden University

College of Counselor Education & Supervision

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Trinaa' L. Copeland

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Walden University
2018

Abstract

African American Christian Senior Pastor's Beliefs About Mental Health Treatment

by

Trinaa' L. Copeland

MA, Western Michigan University, 2001

BS, Western Michigan University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2019

Abstract

In the African American community, the Black Church and its clergy have served as gatekeepers to formal mental health treatment. Little is known about the beliefs of African American Christian senior pastors about mental health treatment and their personal views influencing their counsel to congregants seeking support through the church. This transcendental phenomenological study explored the lived experiences of African American Christian senior pastors in relation to how they understand mental health treatment and provide it to their congregants. The research questions explored three areas: (a) the senior pastors' experiences in rendering mental health treatment, (b) the senior pastors' personal experiences with mental health treatment, and (c) the senior pastors' views on their effectiveness in rendering mental health treatment to congregants. An emergent hand coding analysis of participant narratives collected from 6 participant semi-structured interviews generated 3 main themes and 14 sub-themes related to participant experiences. The results showed the senior pastors not wanting to do harm when congregants sought mental health support through the church; hence, the pastors referred congregants to formal treatment when issues were beyond their scope. Also most of the senior pastors felt comfortable participating in formal mental treatment as needed because it was beneficial for addressing personal and professional challenges. This study can assist the mental health community in making positive social change via the development of relationships and/or partnerships with African American Christian senior pastors looking to refer congregants to formal mental health treatment.

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Dedication

I am dedicating this to my loving, supportive husband and two sons. Each of them gave me the strength needed for completing this milestone in my life. It was challenging and came with many ups, downs, and setbacks; however, they did not lose faith in me and my ability to complete this task in my life. I love each you and appreciate your love and encouragement. I am officially a "doctor that doesn't give shots."

Acknowledgments

It took a village for me to begin and complete this process. My village was made up of my biological and spiritual family, friends, classmates and faculty. First, I want to thank my Heavenly Father for giving me the ability, strength, and will to return to school and complete this monumental goal in my life. I truly thank God for the guidance, direction, and spiritual connections made with people during my educational journey. Without God, I could do nothing.

I would also like to thank my dissertation committee Dr. Kristi B. Cannon and Dr. Katarzyna Peoples for supporting and guiding me through the dissertation process. It was quite humbling to have them critique my work, but worth it because I am a scholar because of them. You both were the best things to happen to me when my dissertation journey began. I have learned that people come into your life for different reasons and during different seasons. I know that you were both here for specific reasons and will remain throughout upcoming seasons. I would also like to thank Dr. Geneva M. Gray for her guidance, support, and openness as my third committee member when reviewing my research during the proposal and final dissertation stages. You played a valuable and significant role in my work.

To my family I want to say thank you for loving and supporting me through this process. Thanks for your concern and always checking on me. Special thanks to the best little sister a girl could have. Our many talks, tears, and words of encouragement helped me to get through this process. Whenever I was down and out, you were there cheering me on and telling me to not give up and keep going. Thank you sis, from the bottom of

my heart. To my besties, thank you for loving me and also encouraging me to finish the task set before me. I love you both dearly and would not trade you for the world. And my MA'AMS, I appreciate each one of you.

Lastly, I want to thank Bishop Kenneth Anthony and Pastor Sylvia Anthony for being there every step of the way with me. I thank you for supporting my vision and entrusting me with expanding the ministry of Redeemed Christian Center to the counseling field. I would also like to thank my church family for never giving up on me and encouraging me in the pursuit of higher education. I love each one of you.

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Chapter 1: Introduction to the Study

Introduction

Mental health professionals need to understand the lived experiences of African American Christian senior pastors because of the influence this group has in the African American community regarding African Americans' participation in formal mental health treatment. The senior pastor is the first level of leadership in the Black Church (Allen, Davey, & Davey, 2010), and the senior pastor has significant influence upon his or her congregants (Brown & McCreary, 2014) as well as the friends and family of those connected to their church. The Black Church and the senior pastor play significant roles in assisting congregants with life problems, challenges, and serious physical or mental health problems (Chatters et al., 2011).

In relation to mental health issues, senior pastors provide support for grief and bereavement, substance abuse, medical issues, relational and situational conflict, and serious mental health problems (Chatters et al, 2011). Allen et al. (2010) found that for most African Americans, a clergy member is the first counselor and usually the doorway to mental health treatment. For many African Americans, the Black Church and its clergy serve as alternatives to formal mental health services (Mattis et al., 2007). According to Avent, Cashwell, and Brown-Jeffy (2015) senior pastors are valued as credible sources of mental health care in the African American community because of their role, regardless of the individual's educational background, knowledge, or awareness of mental health issues and previous experience. In the African American community, over 50% of church participants have sought advice from the senior pastor in a "crisis situation" (Payne,

2008, p. 217). According to Collins (2015), congregants expect the senior pastor to be able to render guidance and insight on issues ranging from spiritual development and growth to personal challenges. Therefore, many African Americans seek support from senior pastors on a variety of mental health issues when experiencing personal distress (Avent et al., 2015).

Congregational members and individuals in the African American community view the Black Church and the senior pastor as alternative resources to formal mental health treatment; therefore, the messages regarding treatment disseminated to African American congregants by the senior pastor influence individuals' inclination to seek or participate in formal mental health treatment (Avent et al., 2015). According to Payne (2008), the messages expressed by the senior pastor may unintentionally lead to the delay of treatment by the individual experiencing distress, thereby increasing the risk of significant mental health issues going unaddressed in the African American community. Because senior pastors have the ability to influence the help-seeking behaviors of their congregants, it is important to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment (Broman, 2012). In this study, I explored the lived experiences of African American Christian senior pastors in relation to mental health treatment and sought to understand how these experiences influence the assistance pastors provide to congregants when they seek mental health support through the church.

Major Sections

In the remainder of this chapter, I discuss several areas related to the background of the problem and the purpose of this study. The background section will offer a brief overview of the literature on the Black Church and African American Christian senior pastors, exploring the gap in the literature and the need for this study. In the section on the study's purpose, I outline the research questions for this study, identify the philosophical framework, and provide operational definitions of key concepts and constructs discussed in the study. In the chapter, I also review the limitations and significance of this study, outlining potential contributions for the counseling community. The chapter concludes with a summary of major points from the chapter, followed by a brief introduction to Chapter 2.

Background

African Americans will seek support from the church even though this specific population has a lower frequency of seeking and accessing mental health services (Brown & McCreary, 2014). African Americans are known for seeking initial support from a spiritual leader; however, some African Americans may not view this as counseling because the services are not rendered in a formal setting (Lee, Oh, & Mountcastle, 1992). Cultural mistrust (Whaley, 2001) or general distrust (Redmond, Galea, & Delva, 2009) of formal treatment services is a factor influencing the help-seeking behaviors of African Americans that may result in the senior pastors' lack of advocacy for formal mental health treatment. In the African American, community there are deep-rooted cultural beliefs and a mistrust of people from different ethnic groups. Therefore, it is

understandable how the Black Church is viewed as a safe haven, hence making many spiritual leaders fulfill dual roles in the church because they are addressing the mental health issues and concerns of members and nonmembers (Briggs, Briggs, Miller, & Paulson, 2011; Mulvaney-Day et al., 2011).

Fulfilling the role of spiritual advisor and counselor could be a challenge for clergy if they have not received training and are limited on resources for addressing serious mental health issues (Allen et al., 2010). Allen et al. (2010) explained how senior pastors offer scripture and prayer as tools for coping, and the belief in God for healing as tools of assistance for persons seeking guidance in this informal setting. This leads to questions regarding whether the individual seeking aid needs additional tools for coping: Would that individual benefit further from a referral to a mental health agency given the gravity of the issue being presented? If African Americans do participate in treatment, is it important for senior pastors and mental health clinicians to understand what participants need to begin and continue in treatment?

The senior pastor has influence in the lives of African American congregants and the larger community because 68% of African Americans belong to a church and 92% of these individuals participate regularly in membership (Allen et al., 2010). This statistic shows that active engagement in a faith community is significant in the African American population. Despite the clear influence of the senior pastor in this community, it is unclear how senior pastors' experiences with mental health treatment influence how they offer assistance to congregants seeking counsel from them. There is limited scholarly information on senior pastors' lived experiences with mental health treatment.

According to Chaney (2013), the current research focus has been on the relationship between the Black Church and the mental health of African Americans. In this study, I explored the senior pastor's role in the Black Church and mental health treatment for the purpose of understanding the lived experiences of African American Christian senior pastors with mental health treatment, specifically regarding (a) their views about mental health treatment, (b) the messages conveyed to congregants, (c) the services rendered when counseling, and (d) how these factors may influence how services are rendered to congregants when assistance is sought through the church. Further exploration of this area could assist the mental health community in developing strategies, education, and programs for reaching members of the African American population, the Black Church, and senior pastors and ministerial leaders.

Problem Statement

In the African American community, the Black Church and its leaders are viewed as reliable resources and support for African American families and individuals (Adksion- Bradley et al., 2005). Both the church and its leadership have fulfilled historical roles in the African American community when individuals were seeking support for personal or professional issues. Often times, the leaders of the church serve as the gateway to formal mental treatment outside of the church (Allen et al., 2010). It is because of the church's role in the African American community that many African Americans seek counseling services from clergy and do not seek additional care from physicians or mental health clinicians (Stansbury, Harley, King, Nelson, & Speight, 2012).

For many African Americans, the Black Church is a safe place to seek support, guidance, and fellowship, to create friendships, and to identify moral support (Adksion-Bradley et al., 2005). However, mental health professionals are concerned about how effective services in the church are when it comes to mental health treatment. According to Allen et al. (2010) and Mattis et al. (2007), counseling professionals have concern over a pastors' competence because of the potential for limited education, skill, and training on mental health issues. A combination of these factors could create situations where a congregant's needs go unmet because of the pastor's lack of awareness or formulated beliefs about mental health treatment from personal or professional lived experiences. Mattis et al. (2007) found that there is limited scholarly knowledge on the referral behaviors of pastors. Therefore, I sought to further exploring this area to increase the counseling community's understanding of African American congregants and assist counselors with identifying strategies for aiding senior pastors' in referring congregants to formal mental health treatment when it is warranted.

According to Chatters et al. (2011), individuals genuinely connected to their church are more likely to seek support from their pastor. Given the senior pastor's influential role, I determined that it was important to understand the senior pastors' lived experiences with mental health treatment because they are a critical component in determining if a congregant should seek formal mental health treatment to address personal issues and challenges (see Allen et. al, 2010). According to Rowland and Isaac-Savage (2014), the Black Church and the senior pastor play a significant role in educating, informing, advocating, and promoting health in the lives of African American

congregants and the larger community. However, if the information disseminated to congregants is "pray about it," and "give it to God" (Plunket, 2014, p. 216), or mental illness and mental health are viewed as one being "crazy" (Payne, 2008, p. 224) because mental health treatment is opposed, then it is important to understand how such counsel impacts the mental wellbeing of the person with the mental health concern. Thus, I sought to explore the lived experiences of African American Christian senior pastors in relation to mental health treatment in order to understand the level of influence these pastors have on the help-seeking behaviors of congregants.

Lumpkins et al. (2013) explained that pastors' communication is influential because of their leadership role and what it represents in the church. The senior pastor is considered both a "spiritual guide" and a "conduit of information" connected directly to God (Lumpkins, 2013, p.1097). Given the senior pastor's vital role in the church, he or she has the ability to promote health issues and concerns (Lumpkins, 2013). It is because of this positioning that the senior pastor has the opportunity to address the needs of congregants who seek support through the church. In this study, I thus worked to understand how senior pastors' experiences and beliefs on mental health related issues affected and/or influenced the guidance given to congregants seeking support through the church.

According to Allen et al. (2010), there is limited research information on the beliefs of African American Christian senior pastors on mental health treatment and how their personal views influence how they provide counsel to congregants. The mental health community needs a greater understanding of the lived experiences of African

American Christian senior pastors for understanding how counsels given to congregants regarding formal mental health treatment, especially if the pastor is the first and only professional the individual sees for advice and counsel (Allen et al., 2010). Allen et al. (2010) explained that many African Americans initially seek support from pastors during a personal challenge, who at times is the only counseling professional an individual will encounter. In smaller African American churches where the senior pastor is the primary and sometimes only resource for an individual, the senior pastor's views about mental health treatment, based upon personal and professional experience, may be particularly consequential for if and how they refer congregants to formal treatment when it was necessary.

Further exploring the lived experiences of the senior pastor in relation to mental health treatment could assist the mental health community in understanding how pastors' views affect how they render counseling and thus influence the treatment seeking behaviors of congregants. When senior pastors do not understand their own beliefs about mental health treatment, it may create situations where a congregant's needs are unaddressed when seeking support through the church. Such lack of advocacy or referral to treatment by clergy could lead to serious mental health issues going untreated within the African American community. These are some of the issues I sought to understand in this study.

Purpose

The purpose of this qualitative study was to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment and how

these experiences influenced the assistance they provided to congregants who sought support through the church. It was important to understand the lived experiences and messages of senior pastors regarding formal mental health treatment because these experiences and messages could influence the mental health treatment seeking behaviors of their African American congregants. Lumpkins et al. (2013) explained how African Americans used the church not only for spiritual guidance, but also for assistance on finances, education, health, social and civic management, and personal needs. The senior pastor fulfills a significant role in the lives of congregants, and it was because of this role that I sought to understand the lived experiences of this influential person. In order to effectively serve African American clients connected to a faith community, it is important for members of the counseling community to understand a key member in the African American community who provides mental health services to individuals in the church and community.

In this phenomenological study, I used a main question and three sub-questions to guide data collection from African American Christian senior pastors. The information gained from this study could offer mental health counselors the opportunity to establish collaborative relationships with church leaders when rendering treatment services to African American clients connected to faith communities. The information gained from this qualitative study could also offer mental health counselors the opportunity to increase their multicultural competence when working with the African American faith-based community.

In this qualitative study, I explored three areas related to African American Christian senior pastors. First I explored senior pastors' experiences in rendering mental health counseling to congregants in order to understand how they counseled. Then I explored senior pastors' personal experiences with mental health treatment to better understand the pastor. Last, I explored senior pastors' views on how effective they believed they were when offering mental health support to their congregants. This exploration was needed because of the church's role and that of senior pastors.

Research Questions

For this qualitative study, I developed a main question addressing the purpose of the study and three sub-questions for further analyzing the main question of the study. The sub-questions allowed me to subdivide the main question into several parts (see Creswell, 2013). The sub-questions allowed me to explore different components of the senior pastors' lived experiences in relation to mental health treatment. Listed below is the main question and the sub-questions of this phenomenological study.

Research Question and Sub-Questions

I developed the following research question to guide this study: What are the lived experiences of the African American Christian senior pastor in relation to providing mental health treatment to congregants?

From this question, I developed the following sub-questions:

a. How do senior pastors make meaning of experiences helping congregants seeking counseling through the church?

b. What are the senior pastor's personal experiences with mental health treatment?

c. What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?

Conceptual Framework

Edmund Husserl (1900) developed phenomenological philosophy for understanding the meaning individuals associated with factual experiences (Giorgi, 2010; Moustakas, 1994). The phenomenological approach "involves a detailed examination of a participant's lifeworld" and "attempts to explore personal experiences" while also being "concerned with an individual's personal perception" of an event (Giorgi, 2010, p. 5). In this study, I sought to explore firsthand the lived experiences of African American Christian senior pastors in relation to mental health treatment. I have included a more detailed discussion of phenomenology and its concepts in Chapter 2; however, I offer an overview of the phenomenological approach in the following pages.

A phenomenological approach allows the researcher to understand a participant in the context of the research questions when seeking to understand the meanings associated with an experience (see Van Manen, 1990). According to Giorgi (2010), phenomenology is about understanding the "essence" (p. 12) or meaning associated with a phenomenon. In its simplest terms, "everything is experienced as something" (Giorgi, 2010, p. 18). A phenomenological approach was appropriate for this study because I sought to understand the meaning made from senior pastors' experiences with mental health treatment. Exploring the meanings participants associated with their experiences is the

core idea of phenomenological research (see Dahlberg, 2006). It was the "essence" of senior pastors' experiences with mental health treatment that I was seeking to understand in this study (see Giorgi, 2010).

According to Van Manen (1990) phenomenology involves the researcher finding a sense of balance, being open-minded to the information shared by the participant, and being able to identify personal biases regarding the data collected from participants. This awareness assisted me in remaining true to self throughout the study. This meant reporting the participants' experiences and meanings with a phenomenon while also presenting the insight gained from the information collected from the participants. To demonstrate objectivity, I positioned myself in the beginning, middle, and end of the study (see Creswell, 2009). Positioning allowed me to gain internal awareness of personal cultural values and biases related to the phenomenon while conducting research. This awareness encouraged sensitivity to differences and possible bias during the research process. It was this awareness that allowed me to refrain from judgement of the information that stood before me. This is also known as the epoché (Husserl, 2002). The epoché process involves the researcher removing themselves from their personal thoughts, biases, and preconceptions while examining the first person stories of life experiences (Husserl, 2002; Moustakas, 1994). I was only seeking to understand the participants' experiences and meanings associated with the phenomenon; therefore, the epoché process encouraged me to take a fresh look at the phenomenon being studied for understanding what was being heard (see Creswell, 2009). According to Moustakas

(1994), this involves asking one to refrain from judgement by staying away from the ordinary way of perceiving things.

For this study, I examined my awareness throughout the research process from beginning to end while studying African American Christian senior pastors' lived experiences with mental health treatment. My personal experiences as a Christian and mental health counselor have led me to form thoughts and beliefs about senior pastors based upon my experiences and encounters with this population in relation to mental health treatment. It was from these experiences that personal biases have formed; therefore, personal awareness was significant to the research process because I was the instrument for data collection.

Even though I have personal thoughts and beliefs about the phenomenon, what I think, feel, and perceive were not enough to understand this specific group; therefore, the epoché process assisted me in remaining "open, receptive, and naïve" (Moustakas, 1994, p. 22) when listening to participants' stories describing their experiences with the phenomenon (Giorgi, 2010). I was to take what was expressed by the participants as what it was without including personal assumptions, beliefs, and theories (Dahlberg, 2006). It was crucial for me to focus on the details of the phenomenon for each participant and the context for how the phenomenon was presented. This kept me open and receptive to identifying the emotions and themes presented by the participants. There was a continuous need for me to keep an open attitude and mind by refraining from judgements (see Finlay, 2009).

According to Moustakas (1994) the epoché is the starting point when utilizing a phenomenological approach, but I also needed “valid determinations” (p. 26) for verifying the phenomenon experienced by the senior pastors regarding mental health treatment. I sought to understand the participants’ personal experiences and accounts surrounding the phenomenon and was not seeking an objective account about an event (see Giorgi, 2010). In order to understand the participants’ experiences, I worked to set aside bias by being clear about the intent of the study, and by remaining attentive to the meanings the participants associated with the phenomenon (see Creswell, 2013). I clarified the study’s expectations and maintained and open-minded stance to set aside bias during this phenomenological study.

I was seeking to understand the meanings African American Christian senior pastor associated with their experiences in relation to mental health treatment, which could only be explained by the senior pastors themselves. Specifically, I sought to understand how senior pastors had formed messages about mental health treatment based upon what they had learned from their experiences. Moustakas (1994) explained that Husserl identified this as ideation. Ideation is the relationship that has formed between the conscious awareness and what exists in the world (Moustakas, 1994). Therefore, the messages and behaviors of the senior pastor is what was presented to congregants based upon what the senior pastor had learned from experiences. The phenomenological approach allowed me to understand the experiences of the participant and meanings associated with the experiences. The phenomenological approach allowed me to “capture and describe” the African American Christian senior pastor’s experiences in relation to

mental health treatment (Patton, 2002, p. 104). In interviews, the participants had the opportunity to describe their experiences with mental health treatment, share their judgements about mental health treatment, make sense of what mental health treatment was, and have the opportunity to freely discuss these experiences. The firsthand accounts of the participant's lived experiences offered me a deeper understanding of the meaning associated with the experiences (see Patton, 2002).

Nature of the Study

In this study, I focused on a single phenomenon by exploring the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance they provided to congregants seeking mental health support through the church. A transcendental phenomenological approach allowed me to (a) explore the human experience by focusing on the whole experience and not singular parts, (b) identify the meaning and essences associated with an experience, (c) obtain first hand descriptions of experiences with the use of interviews, (d) recognize that the data of the experience was vital for understanding human behavior, (e) consider my commitment as the researcher because I formulated questions and problems reflective of personal or professional interest or involvement, and (f) view the experience and behavior of an individual as inseparable (see Moustakas, 1994). These actions were necessary for studying the lived experiences of African American Christian senior pastors in relation to mental health treatment. The senior pastors' life experiences, cultural beliefs, and faith informed how they understood mental health treatment.

I focused on senior pastors because, while an abundance of research had been conducted on the behaviors and attitudes of African Americans seeking mental health treatment who are connected to and/or influenced by the Black Church (Plunkett, 2014), the research emphasis had not been on the senior pastor. According to Allen et al. (2010), researchers have gained limited knowledge on the African American senior pastor, who is viewed as a gatekeeper in the community. Researchers thus know little about the lived experiences of African American Christian senior pastors in relation to mental health treatment and how they advise congregants about mental health treatment (Allen et al., 2010; Snowden, 1999). In understanding the senior pastors' "perceptions, beliefs, motivations, and barriers" (Rowland & Isaac-Savage, 2014, p. 1099) in relation to mental health treatment, the counseling community has the opportunity to understand how mental health education and issues are addressed and promoted in the Black Church. Given the senior pastor's role as a gatekeeper in the African American community, counselors need to understand pastors' experiences because congregants value their thoughts and opinions (Lumpkins et al., 2013). In this study, I sought to gain knowledge about senior pastors and a general knowledge on the phenomenon of mental health in these individuals' lives. According to Giorgi (2010), phenomenological researchers seek to gain a "general knowledge about a phenomenon" (p. 14), hence my use of this method for this study.

Organizational Data Source

I selected the participant population from a ministerial organization in a northern county in Michigan. This is large faith-based organization made up of diverse

denominations of African American pastors in the community. I considered this organization an appropriate group for selection because of the variation in gender, denominational affiliation, age, and educational levels of the pastors associated with it. I purposefully selected participants from a pool of volunteers internal and external of the ministerial organization for interviews to collect data on the phenomenon until the point of saturation was met. Three to 10 participants is the recommended sample size when focusing on one phenomenon, even though a sample size can range from one to 325 participants when conducting phenomenological research (Creswell, 2013). One participant from the ministerial organization participated in the study. The other five participants were enlisted in this study from word of mouth about the study from members and affiliates of the organization.

When soliciting participants, I posed four questions to identify if potential participants were appropriate for this study.

1. Are you African American?
2. Are you Christian?
3. Are you the senior pastor of your church?
4. Have you ever provided mental health counseling to congregants?

These four questions were useful for identifying participants with information-rich cases. The purposeful questions assisted me in selecting participants who had meaningful experiences related to the phenomenon, and who could thus provide rich data when answering the interview questions (see Patton, 2002).

Phenomenological studies primarily involve in-depth interviews as sources for data collection because the participants are describing their experiences surrounding the phenomenon (Creswell, 2013). Therefore, I used 30-60 minute face-to-face semi-structured, recorded interviews with follow-up interviews, as needed, for this qualitative study because I sought detailed descriptions to explore the phenomenon (Van Manen, 1990). The interview questions for this study are listed in Appendix A. I developed the questions and arranged them in hierarchical order for personal reflection and depth. The questions assisted me in understanding the participants' beliefs and attitudes, experiences, understandings of mental health treatment, and faith; therefore, a variety of interview questions were used. Not all the questions were asked due to the type and level of information each participant shared during the interview. In addition to face-to-face interviews, I used an interview protocol form for data collection with each participant (see Creswell, 2013). I used the interview protocol form to record the participants' responses and comments to questions, and to take reflective notes (Creswell, 2009, 2013). For this study, the data I collected involved beliefs, experiences, personal and professional treatment services, and knowledge about mental health issues.

The data collection phase ended once saturation occurred (see Creswell, 2013; Patton, 2002). Saturation is an indicator that enough information has been collected because no new information is offered by participants, allowing the researcher to progress to the stage of data analysis (Patton, 2002). Saturation assists researchers in determining if adequate and quality data has been collected from participants (Walker, 2012). The point of data saturation had been met when no new information was seen or

heard. I planned to use a minimum of three participants because it was the recommended number from my committee for studying one phenomenon; however, I did not determine the maximum number prior to the study because the point of saturation could be met with a small or greater number. There are no rules for sample size in qualitative research (Patton, 2002); hence, the use of a data saturation point for ending the data collection phase of this study.

Data Analysis

During the data analysis and interpretation phase of this study, I used trustworthiness techniques to increase the reliability and validity of the data. Trustworthiness techniques aid researchers in establishing the quality and credibility of their qualitative studies (Patton, 2002). Creswell (2009) identified eight strategies for establishing trustworthiness which are commonly used by qualitative researchers. The eight strategies are: (a) prolonged engagement and persistent observation, (b) triangulation, (c) peer review or debriefing, (d) negative case analysis, (e) clarifying researcher bias, (f) member checking, (g) rich, thick descriptions, and (h) external audits (Creswell, 2009, p. 250-251).

Trustworthiness was important because it added value to the data analysis process. The implementation of different trustworthiness techniques identified my understanding of the information given by the participants in their interviews (Creswell, 2009). More specifically, trustworthiness techniques demonstrates a researcher’s competence because procedures are established for verifying and validating the process utilized during a qualitative study (Patton, 2002). In simplest terms, trustworthiness

techniques allow other researchers to replicate a study. I implemented procedural steps to establish credibility, trustworthiness, and cohesion in this study. This involved three steps: preparing and organizing data, classifying data to develop themes, and representing the data (Creswell, 2013).

To organize the data, I transcribed the interviews and uploaded them into a folder named Senior Pastor. Each participant was identified as SP followed by a numeric value for tracking the data of each participant (SP 1, SP 2, SP 3, etc.). I also transcribed the data collected from the interview protocol form and compiled them into the folders for each correlating senior pastor participant. After the transcription, all data collected during the study was stored on a password protected computer. Once the interviews were transcribed, I reviewed the larger text several times to gain a sense of what the participant was describing. This was the first step in the application of a Husserlian transcendental phenomenological approach (see Giorgi, 2009).

The second step involved the identification of significant statements made by the participants for the development of themes or meaning units. This step was completed by breaking the larger text into smaller parts. Giorgi (2009) explained that the researcher is to reread the text slowly and line by line to create the units. I developed the units using the themes identified during the initial review of recording and interview notes. The last step involved representing the data. Representing the data involved obtaining feedback form the participants on the transcripts for ensuring credibility and accuracy of the descriptions given by the participants (Creswell, 2013). The participant’s responses were

reflected back to them throughout the interview for verifying the accuracy of the data collected.

Operational Definitions

The terms related to this phenomenological study are outlined in this section to assist the reader in understanding how I have used the terms throughout the study.

African American: An American of African and especially black African descent (Merriam-Webster, 2016). For the purpose of this study the traditional definition was not encompassing of the term of reference for African Americans; hence, the use of a non-academic source for a comprehensive description of African American. The ethnic identity of a black person who is the descendent of (Black) African slaves whom were brought to the United States. This individual identifies as a person of African descent born in America after their ancestors of African heritage were brought to America. The designation *African American* excludes Black Jamaicans, Nigerians, Kenyans, Black Dominicans, and others of Caribbean descent (Urban Dictionary, 2017).

Black Church: An institution, which emerged from slavery, that is unrivaled in its historical influence in Black culture and among black people in the areas of education, economics, politics, art, music, counseling and therapy, and community outreach (Floyd-Thomas et al., 2007). A predominately African American congregation that follows predominately African American Christian traditions with distinct meanings, beliefs, and practices involving social activism with the church, community, and American society (Adksion-Bradley et al., 2005; Morris & Robinson, 1996).

Congregant: An individual who attends religious services regularly. A person who is part of a congregation (Merriam-Webster, 2016).

Senior pastor: The first level of Black church leadership that ensures that church leaders under his/her leadership effectively meet their parishioners and family's needs (Allen et al., 2010). The interpreter of life for Black people in light of God's revelation in Jesus Christ who thereby provides for, teaches, and inspires the moral dynamics needed for everyday living, as well as the theological ideals and cultural wisdom needed for commonsense survival and sanity; the primary teacher of the congregation (Floyd et al., 2007).

Assumptions

For this study, all participants volunteered without compensation. I assumed that the participants would provide information on their lived experiences with mental health treatment. I assumed the participants would speak to how they rendered mental health services when support was sought through the church. Last, I assumed that each participant would be able to comprehend the questions being asked of them and not need assistance or interpretation from a third party.

Scope

This study included African American Christian senior pastors from a ministerial organization in a northern county in Michigan. I selected this ministerial organization because it was made up of a diverse group of African American Christian senior pastors. The study followed the guidelines of qualitative research in selecting a few individuals for the study (Creswell, 2013); however, the ministerial organization offered a large

sampling pool of participants. The selection in focusing on senior pastors instead of other forms of church leadership was because of the results and recommendations of the Allen et al. (2010) study. In the Allen et al. study the church leadership was the focus for identifying if the messages or views of the senior pastor were transmitted to congregants by the leadership; however, the attitudes and views of the senior pastor were not addressed directly in the study.

In addition to the findings of the Allen et al. (2010) study, Payne (2008) explored the messages in African American Pentecostal pastor's sermons surrounding depression and mental health treatment. Payne did not interview the pastors, but identified through sermons, the messages given to congregants about mental health treatment from the pulpit. The Payne study reinforced the important role pastors play in the lives of congregants from the messages delivered without direct individual contact with congregants. Each study indirectly engaged the pastors for learning their views and attitudes about mental health treatment; as a result, identifying a population of limited focus in research. Payne implicated how members of the counseling community should approach clergy for understanding and assisting these individuals with mental health related concerns presenting in the church.

The results of the Payne (2008) and Allen et al. (2010) studies, combined with the findings of this study, could assist in bridging a gap between the mental health community and the Black Church. The findings from this study could begin the exploration for identifying if these experiences are similar for other African American Christian senior pastors regardless of denomination affiliation and church size. The

findings could assist the counseling community in gaining a better understanding of this specific population within the Black Church leadership. For increasing the validity and/or credibility of this study's findings triangulation methods were used for establishing trustworthiness. According to Creswell (2013) there are different terms used for describing validation; such as, verification, trustworthiness, or authenticity. However, for this study the term trustworthiness is used for discussing the standards of validation.

Delimitations

This study focused on the African American Christian senior pastor. I chose this specific group because Allen et al. (2010) discussed the limited focus on the senior pastor and their lived experiences with mental health treatment; whereas, Payne (2008) and Lumpkins et al. (2013) identified the influential impact the senior pastor has in the church regarding messages and communication surrounding mental health for influencing the help-seeking behaviors of congregants. My interest in the African American Christian senior pastor began because of the literature reviewed and because of personal experience as an African American female Christian and a licensed professional counselor in the mental health field. I was intrigued because the literature confirmed some of my personal beliefs surrounding faith and mental health in the African American community. The exclusion of other forms of church leadership is purposeful because the senior pastor is seen as the most influential person in the church (Allen et al., 2010; Payne, 2008; Taylor et al., 2000); hence, the focus of this group for this study.

Limitations

A limitation of this study involved the sampling population. The participants were self-reporting their experiences surrounding the phenomenon of study. If the participant did not have a clear understanding of the phenomenon, had limited experience with the phenomenon, or was unwilling to participate in this study then the study would need to expand the sampling to include other African American Christian senior pastors unaffiliated with the ministerial group. One participant was unclear with certain terminology; therefore, I reviewed the different terms with the participant and future participants for ensuring a clear understanding of the terms used for this study in the interview questions. I identified this early during the interview process with member and prepared accordingly with future participants. I believe if this was not addressed with each participant, the study would have rendered different results. I recommend future researchers and participants have a clear understanding of the terms used if this study is duplicated.

The sole focus on a single ministerial group for participants created a limitation with sampling size because the participants represented one county in a specific area of Michigan. Initially this was a limitation; but, the sampling changed because participants outside of the ministerial organization contacted me after learning of the study. If participants outside of the ministerial organization had not shown an interest, I would have implemented a different recruitment approach for this study. Before the sampling population expanded, one participant from the ministerial organization contacted me with an interest in this study. This is a factor future researchers should consider when utilizing

a single organization for participant recruitment instead of several organizations. I recommend future researchers utilize several entities for participant recruitment for increasing sampling size.

The second limitation is this study's sole interest in African American Christian senior pastors. The results of this study could limit its generalizability to other Christian senior pastors who are not African American; as well as, other African American Christian church leaders rendering mental health services or support to congregants. The senior pastor is the first hierarchy in church leadership which is the focus of this study; hence eliminating church leaders serving under the senior pastor within the church. This study is seeking to understand the lived experiences, associated meanings, and beliefs held by the participants surrounding mental health treatment identifying as African American Christian senior pastors.

Another limitation for this study is the selection of phenomenology as the qualitative approach. A phenomenology utilizes the self-report of individuals within their natural settings allowing participants to tell their story surrounding a phenomenon. My analysis is based upon the textural and structural descriptions given by the participant. If I am unable to understand the participants' experiences and meanings surrounding the phenomenon then my results would be inaccurate. In addition, if the participant is unclear in their understanding of the phenomenon there would be inaccuracies within the sampling population because their self-report would not convey the essence of their experience relative to the intended goals of this study.

The identified limitations led me to create and outline procedures for each phase of this study for establishing trustworthiness. Trustworthiness techniques increase a studies credibility and validity when conducting qualitative research. According to Moustakas (1994) techniques or procedures that demonstrate methods of preparation, methods of data collection, and methods of organizing and analyzing data are necessary when conducting qualitative research because it guides and moves a study into action. I used member checking, researcher notes, and an interview protocol as trustworthiness techniques. The three techniques are reasonable measures for addressing bias, credibility, and validity for demonstrating the careful attention given to the methodological process when producing scholarly material (see Patton, 2002).

Significance

The church has always been a place for counsel and comfort for people of faith (Galloway, 2003) and one of the possible reasons is that the counseling community has not adequately addressed the needs of African American's mental health issues (Briggs et al., 2011). The church has filled the gap where the quality and access to care has been limited due to barriers, environmental stressors, lack of cultural sensitivity, and a lack of minority mental health professionals in the local community (see Briggs et al. 2011). These reasons could be why the counseling community has discussed the need for training and sensitivity of spiritual and religious diversity with the discussion of counselor competency in the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards in counseling programs (Sauerheber, Holeman, Dean, & Haynes, 2014). The findings from this study could assist the

counseling community in implementing social change on how services are rendered to African Americans referred by the church for mental health treatment when addressing spiritual or religious issues during the course of treatment. The findings also have the ability to assist the counseling community in gaining a greater understanding in how mental health and mental health treatment is viewed by African American Christian senior pastors. Finally, the findings from this study could aid members of the mental health community in the development of in-services, trainings, and presentations on issues related to mental health and mental health treatment in relation to African American senior pastors and their congregants.

This study could contribute to furthering the counseling community's knowledge on understanding the African American Christian senior pastor's lived experiences, beliefs, messages, and referral behaviors with mental health treatment. The information could also assist mental health clinicians in better understanding clients referred to treatment by senior pastor or other leaders in the church. The outcomes from this research could assist counselors in multicultural competence on how they approach senior pastors in the community when discussing mental health treatment. The data collected could assist mental health clinicians in developing partnerships between the Black Church and ministerial leaders with members of the mental health community. The information could create social change in how African American Christian senior pastors are educated or re-educated on mental health issues and treatment influencing the African American community on how mental health education/awareness and help-seeking behaviors are viewed.

The information gained from this study has the potential to increase awareness about a marginalized population and offer insight into the thoughts and behaviors of a key resource within the community. Williams, Gorman, and Hankerson (2014) developed programming in the African American community for educating clergy, reducing stigma, and the promotion of treatment for addressing the issue of depression within the community; hence, creating future opportunities for other community-based interventions in the African American community on other mental health related issues. An increase in sensitivity and awareness in the African American community and the demonstration of cultural competence in the mental health community is needed for creating social change.

Summary

I sought to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences have influenced the assistance they provide to congregants seeking mental health support. It is clear that the senior pastor is an influential leader in the Black Church and the lives of congregants (Brown & McCreary, 2014), and viewed as a gatekeeper in the African American community (Chaney, 2013; Lee et al., 1992). It was because of the level of influence this individual has that I sought to explore further from a phenomenological approach, the lived experiences of African American Christian senior pastors in relation to mental health treatment.

The literature reviewed in Chapter 1 identified the senior pastor as a significant and influential person in the African American community and church (Brown & McCreary, 2014) because they offer safety, security, and support to African American

individuals when in need (McRae, Thompson, & Cooper, 1999). Chapter 1 further explained the role of the senior pastor and the challenges encountered within the African American community when support is needed for personal issues and challenges. It is the background information in this chapter that offers a context for how and why the senior pastor has become an important individual in the African American community, and the value in studying this group in the African American community.

Chapter 1 discussed the purpose of this study and outlined the research questions and phenomenological philosophy. In this chapter key terms were introduced and defined for understanding the context of the Black Church, the senior pastor, and other concepts related to mental health. The chapter also presented explanations about the need, significance, and benefit of this study, as well as the limitations and the strategies outlined for establishing credibility and dependability of the information collected from participants. In the Chapter 2, an exhaustive review of the literature is discussed regarding the Black Church, the role of the senior pastor, and mental health in the African American community, and the phenomenological philosophy and methodology selected for this study.

Chapter 2: Literature Review

Introduction

Historically, many African Americans have sought support and assistance with personal and professional issues from the church in lieu of treatment in formal mental health settings because they have viewed the church as a trusted community institution (Floyd-Thomas, Floyd-Thomas, Duncan, Ray, & Westfield, 2007). Allen et al. (2010) stated that the Black Church and its senior pastors have been the initial contact for mental health support in the African American community. The Black Church has fulfilled the role of an informal service provider throughout African American history, and it holds a prominent role in the community due to the community's distrust of mental health services because of poor past experiences in the larger White society (Rowland & Isaac-Savage, 2014; Hays, 2015). These poor experiences have involved an irregularity of referrals, a lack of support and resources, social injustices, and other cultural factors (Redmond et al., 2009). These factors, among others, have increased the crucial role the senior pastor has played when advising congregants on mental health issues (Blank, Mahmood, Fox, & Guterbock, 2002; Lumpkins et al., 2013). The Black Church and pastors fulfill a historical and persistent role in the African American community because of the challenges faced surrounding racism and discrimination (see Rowland & Isaac-Savage, 2014). Given the social role of the Black Church and pastors' critical place in African American communities, I developed this study to understand the lived experiences of African American Christian senior pastors in relation to mental health

treatment and how these experiences have influenced the assistance provided to congregants seeking mental health support.

The Black Church is an anchored institution in the community, and the senior pastor is a trusted source (Rowland & Isaac-Savage, 2014), which has led to them fulfilling a gatekeeper role in the African American community. The gatekeeper role formed because most African American individuals could express themselves freely with the pastors in ways that they could not in the larger White society and culture (Allen et al., 2010). African Americans have felt valued within the church because there they were seen as people and treated humanely.

Anti-black racism and inhumane treatment led African Americans to develop a cultural mistrust of outsiders. This cultural mistrust influenced how the Black Church became a safe haven in the African American community (see Rowland & Isaac-Savage, 2014). The mistrust of persons of different ethnic groups led to the senior pastor fulfilling a dual role of spiritual leader and counselor for addressing the mental health issues of members and nonmembers of the Black Church (Allen et al., 2010; Briggs et al., 2011; Lumpkins et al., 2013; Mulvaney-Day, Diaz-Linhart, & Algeria, 2011). In the informal setting of the Black Church, many African Americans have opened up and shared private issues and concerns that they believed would be misunderstood or forbidden by someone outside of the community (Hays & Change, 2003).

Many African Americans believe that people should not know about one’s circumstances or mental health not only due to the stigma associated with treatment, but also because of judgement and being viewed as incapable of coping with personal

problems and stressors (see Briggs et al., 2011; Conner et al, 2010). Members of the African American community are concerned about the stigma associated with treatment, which could influence their help seeking behaviors and participation in treatment. For some African Americans, mental health and wellness is not a viable option due to the secrecy and stigma associated with seeking help; hence, many hold the belief that one is to cope with problems without the assistance of outsiders (see Broman, 2012).

This deep rooted cultural belief is particularly entrenched amongst many older members of the African American community; therefore, these members do not share private and personal matters because it is viewed as inappropriate and weak (see Broman, 2012). In addition to stigma and secrecy, there are other factors that impact the help seeking behaviors of African Americans. These include a lack of knowledge about mental health issues and treatment, a lack of trust for clinicians from different ethnic groups (Broman, 2012; Hays & Change, 2003; Mulvaney-Day et al., 2011), and inadequate medical and financial resources (Allen et al., 2010; Briggs et al., 2011, Roberts, Robinson, Topp, & Newman, 2008). It is understandable how the identified barriers connected to this systemic problem could impact the help seeking behaviors of African Americans who decide to seek support and assistance from the Black Church and the senior pastor. With the Black Church being viewed as an alternative to support from formal treatment settings, senior pastors have become gatekeepers in the African American community (see Allen et al, 2010). Hays (2015) explained that the senior pastor is viewed as the gatekeeper of social services for church congregants. In the Black

Church, the senior pastor is considered a central figure in the lives of congregants and is intimately connected because of this role (see Hays, 2015).

According to Allen et al. (2010), the Black Church and the senior pastor is the opening to mental health treatment. At times, the pastor can also be the only contact. Thompson et al. (2004) explained that African Americans are less likely to seek support from other mental health professionals if the minister is contacted first. These individuals are less likely to seek subsequent support from a mental health professional because it has been taught that one must cope through God instead (see Hays, 2015). There are high rates of religious coping in the Black Church, often taught by the senior pastor (see Hays, 2015). Due to the high levels of satisfaction reported by individuals seeking counsel from the senior pastor, these individuals are likely to refer friends to the senior pastor for assistance in addressing personal problems (see Hardy, 2014).

Senior pastors of Black Churches serve as counselors because they are central figures in the lives of congregants (see Hays, 2015). Even though there are African Americans who seek support for personal issues, this population is still the least likely ethnic group to participate in mental health treatment (see Broman, 2012). Even with high levels of distress in the environment from poverty, violence, limited resources, and disenfranchisement due to racism, discrimination, and prejudice (Conner et al., 2010), African Americans are still consistently less likely than White Americans to seek services for mental health treatment (see Thompson et al., 2004). African Americans also experience a shorter span and quality of life in comparison to other ethnic groups due to a

lack of resources in the community for healthcare, and unhealthy resources, such as fast food, drugs, and alcohol (Briggs et al., 2011; Broman, 2012; Conner et al., 2010).

Even with increased levels of stress, many African Americans minimize the value of treatment due to the stigma associated with seeking assistance from others. Payne (2008) stated that African Americans use the informal services of physicians and ministers more for emotional assistance than traditional mental health settings with mental health professionals. In an effort to address the lack of research on the views of non-health professionals and the messages given to African Americans when seeking support, Payne conducted a qualitative study to explore how Pentecostal African American ministers discussed depression, grief, and sadness. While the qualitative study focused on the area of depression, it included information about the ministers' views of mental health treatment in general. Payne reviewed sermons on depression and found that the minister participants viewed depression and mental illness unfavorably.

According to Payne (2008), sermons related the term "crazy" (p. 225) to mental illness or mental issues and encouraged congregants to rely upon Jesus for answers to mental illness rather than mental health professionals. Because of the small sample, findings could not be generalized to all pastors; however, Payne did identify the need for further studies of the lived experiences of African American Christian senior pastors and how their beliefs, attitudes, and messages related to mental health treatment developed. According to Payne, further information is needed for counseling professionals on (a) how senior pastors discuss mental health services in their churches, and (b) the messages emphasizing reliance on Jesus and not mental health professionals in treatment facilities.

Allen et al. (2010) found that once an African American individual received assistance from clergy, they were less likely to seek additional support for mental health support and care. According to Hardy (2014), more than 10% of a senior pastor's time is devoted to counseling congregants for personal problems. Congregants' satisfaction with the effectiveness of counseling provided by senior pastors has made it equivalent to treatment by a mental health professional in the eyes of many congregants (see Hardy, 2014). Therefore, the senior pastor is sought after for guidance and direction on spiritual and personal matters in the African American congregant's life. This has resulted in the senior pastor fulfilling a dual role as spiritual advisor and counselor (Lumpkins et al., 2013; Allen et al., 2010). The respected role of the senior pastor in the African American community and the lack of existing research substantiated the need for my exploration of pastors' lived experiences with mental health treatment.

African American senior pastors fulfill an important role as spiritual guide and counselor in the Black Church; however, there is limited research on the experiences of these prominent leaders with mental health treatment (see Stanford & Philpott, 2011). Chaney (2013) explained that quantitative and qualitative research have been conducted on the relationship of the Black Church, the mental health of African Americans; and the help-seeking behaviors of African American senior pastors. Stanford and Philpott (2011) explained that most research conducted on pastors has focused on the leader's education and their frequency of rendering counseling services to church members. According to Stanford and Philpott (2011), even when individuals are diagnosed with a mental

disorder, they are more likely to seek support from a pastor than mental health professional.

Senior pastors have reported feeling inadequate in recognizing mental illness, yet there is a low referral rate of counselees to mental health professionals (Stanford & Philpott, 2011). The dual role of spiritual advisor and counselor is challenging when the senior pastor has not received training or has limited information and awareness on resources for addressing serious mental health issues (Allen et al., 2010). Allen et al. (2010) explained how clergy use scripture, prayer, and the belief in God as tools for congregants coping with distress. However, there may be times where the individual seeking support needs additional tools and resources in a formal mental health setting. Stanford and Philpott (2011) found that further research was needed on the beliefs of the senior pastor about mental health treatment when supporting congregants with personal issues and matters; hence, the purpose of studying the experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences have influenced the assistance provided to congregants when seeking mental health support. The next section will discuss the literature reviewed for conducting this qualitative study.

Major Sections

There are five major sections for Chapter 2. The five sections discuss the literature search strategy, the phenomenological approach, and philosophy of the research method, the review of the current literature, and the summarization of themes. The literature search strategy discusses key words, phrases, and search engines utilized for

identifying literature on the research topic. The second section focuses on the framework of the phenomenological approach. The third section examines the conceptual framework of this study and outlines the phenomenology research method. The fourth section focuses on a review of the current literature in the topical areas of the Black Church, the role of the senior pastor, and the challenges of mental health treatment for African Americans. The last section discusses the summarization of themes identified in the literature.

Literature Search Strategy

Multiple search engines were utilized for identifying peer reviewed scholarly material. Broad searches were conducted for identifying literature available on topics related to African Americans, faith, spirituality, mental health, counseling, senior pastors, and the role of the church. Based upon results on the broader topics, narrower searches were conducted utilizing a combination of key words and phrases for identifying current, comprehensive, and relevant literature. The keyword searches and combination of phrases were *black church and counseling*, *black church and mental health*, *the impact and/or influence of the black church*, *beliefs of senior pastors*, *beliefs of pastors*, *help seeking behaviors of African Americans*, *mental health referrals*, *lived experiences and counseling*, *knowledge/understanding of mental health*, *mental health and/or counseling and African Americans*, *phenomenology and research*, *phenomenology and counseling*, *gatekeeper role and black church*, *gatekeeper role and senior pastor*, *role of black church*, and *spirituality and mental health*. The keyword combinations and phrases were utilized with each database search. The majority of the search engines were accessed

through the Walden University library and included PsycINFO, PsycARTICLES Sage, ERIC, SocIndex, Thoreau, Science Direct and Google Scholar. In addition to the library databases, the references materials within the reviewed articles were utilized for completing a comprehensive and exhaustive search for identifying materials related to the topics on the Black Church, the role of the senior pastor, and the challenges of mental health treatment for African Americans. The literature search concluded once I identified coinciding articles in each database rendering no new information.

Conceptual Framework

According to Van Manen (1990) researchers utilizing a phenomenological approach are seeking to understand a participant, using the research question as the lens for understanding what a phenomenon is like for a participant. I selected a phenomenological approach because I was seeking to understand *what is it like* for the senior pastor and their experiences in relation to mental health treatment and how these experiences influenced the assistance provided to congregants seeking mental health support. A phenomenological approach allows me to gain insight into the participant's experiences from the information shared during the data collection phase (see Van Manen, 1990). It was this concept that solidified the suitability of the use of a phenomenological approach for studying the lived experiences of African American Christian senior pastors in relation to mental health treatment. A phenomenological approach allowed me to understand the meaning made from the senior pastor's life experiences regarding mental health treatment and how these experiences assisted in the development of beliefs, attitudes, and messages about mental health treatment.

As an African American researcher focusing on a specific group within the African American population, I could position myself throughout the study to gain awareness about myself and the participants. A phenomenological approach allowed for positioning to be explored and addressed during the beginning, middle, and end of the study (see Creswell, 2009). Positioning involved increasing my internal awareness of personal values and biases. According to Sue, Ivey, and Pederson (1996) the researcher moves from being culturally unaware to aware for developing sensitivity to the differences in attitudes, beliefs, knowledge, and skills of the participants in the study. My awareness was addressed throughout the research process from beginning to end while studying the experiences of the African American Christian senior pastor in relation to mental health treatment.

I sought to understand the lived experiences of the African American Christian senior pastor in relation to mental health treatment and how these experiences influenced the assistance provided to congregants when mental health support. Understanding this phenomenon was the driving force behind this qualitative study. According to Patton (2002) the purpose is the driving force behind qualitative studies which falls on a continuum from theory to action. The continuum begins with contributing to the knowledge base for addressing a societal issue aimed at addressing a specific problem within the African American population (see Patton, 2002). The action phase involves the use of this study's outcomes for how mental health professionals address this population in future work.

This study will focus on a single phenomenon by exploring the lived experiences of African American Christian senior pastors and their lived experiences in relation to mental health treatment. Creswell (2013) explained that a phenomenological approach allows researchers to explore, describe, and make meaning of the experiences of participants when conducting qualitative research. The participants should have knowledge and/or experience with the phenomenon being studied (see Creswell, 2013); hence, the selection of a phenomenological approach for studying the beliefs and experiences of African American Christian senior pastors in relation to mental health treatment. The senior pastors' life experiences, cultural beliefs, and faith has assisted in the formulation of how they understand mental health treatment. It is the lived experiences of the senior pastor which influenced their "way of being in the world" (Van Manen, 1990, p. 39).

The senior pastor's cultural beliefs, implications, assumptions, and values would assist me in understanding their "way of being in the world" as it relates to decisions about mental health treatment referrals (p. 39). A phenomenological approach was most appropriate because it focused on the concept of a phenomenon and how the lived experiences of the individual was impacted by the phenomenon (Creswell, 2013). I sought to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance provided to congregants seeking mental health support. The Black Church and its role have been researched in several ways and in multiple areas; however, the facets of the role of the senior pastor have primarily focused on pastoral counseling, knowledge of

mental illness, perceptions of mental health, and the role of the pastor for counseling (Brown & McCreary, 2014; Chatters et al., 2011; Mattis et al., 2007; Stanford & Philpott, 2011; Young, Griffith, & Williams, 2003).

In addition, Stanford and Philpott (2011) explained that most research examining clergy commonly focused on the education of pastors, and the frequency of counseling rendered to their congregants. The research conducted did not focus on the lived experiences of this specific group in the African American population which is what this study explored. The African American senior pastor's role has been noted as impactful and influential throughout past and present time due to their integral role in the African American community (Allen et al., 2010; Chatters et al., 2011; Mattis et al., 2007; Payne, 2008; Rowland & Isaac-Savage, 2014; Stanford & Philpott, 2011; Young et al., 2003) allowing this individual to be viewed as a gateway to treatment (see Brown & McCreary, 2014). The senior pastor's role is significant because a minimum of 15% of the pastor's time is devoted to counseling, and this can increase or decrease based upon the social and community resources available in rural or urban areas (Broman, 2012; Brown & McCreary, 2014; Lumpkins et al., 2013). The senior pastor's role and the Black Church are significant in the African American community; however, the limited research on the lived experiences of African American Christian senior pastors in relation to mental health treatment (Allen et al., 2010; Brown & McCreary, 2014) from a phenomenological approach increased the need for this qualitative study.

Allen et al. (2010) utilized an integrative model for conducting a quantitative cross-sectional survey study for examining the role of the church and its leaders as the

gatekeeper for African Americans when seeking formal mental health services. The integrative model utilized a culturally sensitive framework combining 225 items drawn from the National Survey of American Life: Coping with Stress in the twenty-first Century (NSAL) regarding behaviors, and beliefs about mental health, and four transmission questions using a 6-point Likert scale designed for evaluating the church leaders views about advising congregants to seek mental health treatment outside of the church (Allen et al., 2010). The researchers focused on associate pastors/ministers, deacons, deaconesses, and caregivers/deacon aides, but not the senior pastor. Each leadership position reported to the senior pastor, who is the "highest level of church leadership" (Allen et al., 2010, p. 125). It was the senior pastor whom allowed for the study to be conducted with the use of church leaders; however, the senior pastor did not participate in the study. Of the 112 participants, it was determined that support for mental health treatment was influenced by the role of the leader within the church and the individual's contact with the senior pastor. As a result of the study, it was identified that the views or messages of the church leader on mental health treatment were weakened the farther away the individual was from the senior pastor (Allen et al., 2010). It was the outcome of this study which steered the research questions for this qualitative study for understanding the life experiences of African American Christian senior pastors with mental health treatment because of the level of influence they have upon leaders and congregants in the Black Church.

I was interested in collecting data from the African American Christian senior pastor that was reflective and retrospective. Van Manen (1990) explained that

phenomenological research is retrospective and not introspective because it examines the experiences one has lived through. Understanding these experiences allows me to explore how the participants make sense of the world through their lived experiences and how they formulated beliefs about mental health treatment (Patton, 2002).

Literature Review

The Black Church

In order to understand the role of the African American Christian senior pastor providing mental health treatment in the church it is necessary to gain a greater understanding of the Black Church and its inception, the role it played when formed, and its present impact in the African American community. As explained in Chapter 1, the term Black Church is used to describe a predominately African American church, regardless of religious denomination (Floyd-Thomas et al., 2007). The Black Church offers the context for understanding the significance of the senior pastor and their role of leadership fulfilled in the church setting when rendering services for mental health issues to congregants.

The Black Church began as a source of support for African American families and individuals. The Black Church is defined as a predominately African American congregation which follows predominately African American Christian traditions with distinct meanings, beliefs, and practices involving social activism with the church, community, and American society (Adksion-Bradley et al., 2005; Morris & Robinson, 1996). Within the African American community the Black Church is viewed as an anchor because it attends to the social, psychological, and religious needs of African Americans

(see Adksion-Bradley et al., 2005). It is within the Black Church that individuals form friendships, experience fellowship, and find moral support. It was these experiences which lead to the formation and the foundation of the Black Church.

During the times of slavery, the Black Church formed because slaves were unable to fellowship and worship within organized institutions of faith (Floyd-Thomas et al., 2007). According to Floyd-Thomas et al. the Black Church was instrumental in its role as African Americans gained freedom from slavery and during the fight for civil rights. Before physical freedom was experienced, African Americans found religious freedom offering a compass towards morality, personal and communal values while also providing social support for addressing issues of education, insurance, and recreation (see Floyd-Thomas et al., 2007). It was the founding of the Black Church which allowed African Americans to worship and express their cultural and spiritual heritage after being brought to America from Africa. It was the freed slaves who structured the Black Church in response to the opposition of White evangelical ministers for the Christianization of African slaves (see Allen et al., 2010).

For many African Americans the church became a place where individuals were seen as people and not property, because within the larger White American culture basic human rights were denied. The “enslavement, segregation, and persistence of racism” (Floyd-Thomas et al., 2007, p. 3) kept African Americans from being viewed as equal and human. In response to these institutional and societal beliefs, the Black Church became a safe place where African American men, women, and children expressed their culture, heritage, humanness, dignity, and power because personal identity and role

development was formed in the church (see Allen et al., 2010). According to Adksion-Bradley et al., (2005) slavery and racism assisted in the shaping of the Black Church because of the oppression experienced by African Americans. The safety of the church created loyal and attentive relationships from their African American membership, because it created community and connection which could not be experienced in larger White American culture. The church gave a sense of control and power to African Americans because the organization was created, owned, and operated by African Americans (see Morris & Robinson, 1996).

Religious and Spiritual Functions of the Black Church

The Black Church began as a safe haven for worship; however, it has evolved to provide this and other functions to members of its community. The Black Church is viewed as a place of worship, a social support for African American individuals and families, a social activist for addressing social injustices experienced by African Americans, and a financial resource for those in need. Floyd-Thomas et al. (2007) identified the Black Church as a single self-governing institution that began in times of slavery and racial segregations which has evolved and shifted for addressing and meeting the needs of members of the African American community in wider society.

As a worship institution, the Black Church offered prayer, praise, worship, biblical teachings, and sermons for offering hope and healing to those hurt, broken, and in despair (Floyd-Thomas et al., 2007). The worship services gave hope with the use of "singing, dancing, praying, moaning, clapping, and shouting" (Floyd-Thomas et al., 2007, p. 13). These worship characteristics began in the eighteenth and nineteenth

century but are still used today in the Black Church for expressing how they feel about their God, their faith, and hope placed in God. Prayer, music, and teachings are foundational tools used in the Black Church worship experience. Prayer is used for offering "physical, mental, emotional, spiritual relief, and revitalization" (Adksion-Bradley et al., 2005, p. 150). It is taught that prayer relieves pain and suffering of daily stressful encounters experienced in an individual's environment. Whether it is altar or pastoral prayer, it is an important therapeutic tool for offering comfort and support in the Black Church.

Music is another tool used in the Black Church for allowing individuals to express their feelings of anguish and hope to God (Adksion-Bradley et al., 2005). Music allows one to verbally express relief from pain and suffering while also experiencing spiritual wellness through song corporately with one's biological and spiritual family. Allen et al. (2010) identified music as a coping tool passed down from generation to generation in the African American culture for promoting spiritual wellness within the Black Church.

An additional spiritual tool for promoting spiritual wellness is teaching. The teachings offer religious and moral principles for fostering growth, help, stability, and empowerment in the African American community (see Morris & Robinson, 1996). The teachings focus on religion and spirituality. Religion focuses on a set of core beliefs and the practice of those beliefs within a church or faith community; whereas, spirituality focuses on one's belief in God, the Creator, or Higher Power and the power of those beliefs in one's life (p. 978).

Spirituality and religion differ because a spiritual individual believes in a Higher Power but does not participate in a formal religious or church setting; whereas, a religious person formally participates in a formal setting interconnecting spirituality and participation (see Boyd-Franklin, 2010). The religious person experiences spiritual renewal because of the emotional release, rejuvenation, and transformation that occurs through the participation in a formal worship service or ceremony creating closeness and unity with others in the church (see McRae et al., 1999). The spiritual person holds fast to their spiritual beliefs and practices (i.e. prayer, meditation, readings) but chooses not to participate in an organized setting (see Boyd-Franklin, 2010).

Spirituality and religion are similar; however, they are practiced differently. Both teachings are deeply entrenched in the lives of African Americans because they offer comfort and support; hence, creating opportunities for psychological well-being and resilience in daily life (see Boyd-Franklin, 2010). The teachings on religion and spirituality have promoted spiritual wellness for coping with daily life stressors encountered by African Americans when faced with the emotional pain of racism, discrimination, and oppression (see Boyd-Franklin, 2010).

The tools of prayer, music, and teaching in the Black Church have created opportunities for African Americans to fellowship together. It is during these times of fellowship that individuals find social support (see Boyd-Franklin, 2010). As previously mentioned, the Black Church formed out of a need for connection and empowerment during times of disenfranchisement within the larger White American society. It has been the foremost place for African Americans to build social connections (Adksion-Bradley

et al., 2005). Then and now the Black Church is used for establishing social connections, but also serving as a place for learning new skills, development in self-identity and talents or abilities (see Morris & Robinson, 1996). As noted by Adksion-Bradley et al. (2005) the Black Church is the "pulse" (p. 147) in the African American community for addressing the social, psychological, and religious needs of African Americans. The Black Church offers a sense of belonging to individuals disconnected from family and friends, or those seeking to deepen their connections with others. Regardless of the reasoning, the Black Church offers individuals the opportunity to connect with other like-minded persons seeking fellowship, friendship, and support in the local African American community (Adksion-Bradley et al., 2005).

Social Functions of the Black Church

The Black Church and its leaders fulfill a significant role in meeting the needs of members a part of the African American community. The Black Church addresses "psychological, economic, and sociopolitical needs" (Mattis et al., 2007, p. 250) in the African American community. Historically, and currently, the Black Church has offered religious and educational support, academic development with the creation of schools, political activism for increasing awareness on social issues, economic development with the purchasing of property exclusively used for meeting the needs of the community, social and psychological support by offering group meetings and pastoral counseling to the community, medical and psychological care with the use of workshops and trainings, and personal support in times of crisis (p.250). The Black Church began providing "health, social, and educational services" (Williams et al., 2014, p. 416) because it was

needed within the African American community and not offered by White American culture.

With the Black Church offering such resources it became an alternative to conventional healthcare and formal mental health treatment in the African American community. The above mentioned resources increased the role and significance of the Black Church. According to Whaley (2001) cultural mistrust is the terminology used for reflecting the attitudes and beliefs of African Americans about White society and culture (p. 514). Cultural mistrust in the African American community created situations where individuals seek initial support from the Black Church instead of the larger community because of their history of marginalization within society. In many ways, African Americans have not been afforded the same level of care or services as White Americans because of the discrimination and racism experienced throughout history (see Allen et al., 2010). Briggs et al. (2011) explained that African Americans have not reaped some of the benefits of White Americans, which has influenced the cultural mistrust within the African American community.

Cultural mistrust increased the value of the Black Church because it became the primary location for socializing and establishing connection in the African American community (see Allen et al., 2010). The Black Church's social role was significant to its congregants because African Americans experienced "fellowship, developed friendships, and found assistance when in need" (McRae et al., 1999, p. 208). During times of slavery families were separated and it was the Black Church that offered African Americans to connect with a spiritual family and/or create opportunities for biological families to

reconnect. Historically, this connection was needed in order for African Americans to survive, to provide hope during hopeless times, offer spiritual freedom while enslaved, and solace for believing that freedom would be afforded (see Moore-Thomas & Davy-Vines, 2008; Floyd-Thomas et al., 2007). In addition to being a resource for families, the Black Church provided "tradition, moral guidance, and service for adults, children, and the elderly" (p. 208).

For many African Americans today, the Black Church is a trusted institution and highly regarded because of its instrumental historical role in the community (see Lumpkins et al., 2013). Initially the Black Church formed from a need; yet, it still plays a valuable role in the African American community because it fights against social injustices surrounding legal, health, mental health, and community issues plaguing African Americans (see Rowland & Isaac-Savage, 2013). In 2001, the Bush Administration established the White House Office of Faith Based and Community Initiatives, creating opportunities for religious institutions in the African American community to provide additional support to local residents. In 2009 President Obama established the new White House Office of Faith-Based and Neighborhood Partnerships, expanding the initiative to other communities and group committed to improving their community regardless of religious or political beliefs (see Rowland & Isaac-Savage, 2013). Both administrations identified and supported the need for improvement for vulnerable communities and populations (Rowland & Isaac-Savage, 2013); hence, reaffirming the need for the Black Church in current times.

Historically, when African Americans encountered "hostile and debilitating environments" (Adksion-Bradley et al., 2005, p. 49) the Black Church created opportunities where African Americans could "survive and thrive" (p. 49) and it continues today. These opportunities created a sense of interconnectedness consistent with African traditions and values of collectivism and interdependence (Moore-Thomas & Day-Vines, 2008, p. 208). It is because of the social functioning of the Black Church that it became more than a place offering spiritual guidance.

Psychological Functions of the Black Church

The Black Church has offered counsel and comfort to African American persons of faith throughout their challenging history. The Black Church has an extensive history in addressing the life circumstances African Americans face on a daily basis (see McRae et al.,1999). For many African Americans the Black Church is a trusted, accessible, and prominent organization within the community (see Williams et al., 2014). Due to the Black Church's positive influence and respected role within the community, it is understandable how the church has become a safe haven for seeking counsel on personal and professional matters. According to Lumpkins et al. (2013) African American congregants seek counsel on financial matters, education, health, personal needs, and societal or community engagement. In its psychological role the Black Church has offered group therapeutic experiences with the use of mid-week services, bible study, and prayer services. It has also met some of the needs of African American congregants with the use of Sunday school, activities for youth, athletic events, and training and development opportunities for growth (see Boyd-Franklin, 2010). For many African

American congregants the Black Church service is similar to group psychotherapy because of its therapeutic benefit (McRae et al.,1999). The therapeutic nature has served as a "buffer for the pressures" of daily living and is viewed as a "community mental health resource" for African Americans (p. 208). The church is trusted and so is the pastor because of the roles fulfilled in the personal lives of African Americans and the community. Both the Black Church and the pastor are familiar, recognized, and influential resources in the lives of African Americans for addressing life difficulties (see Chatters et al., 2011).

The Role of the Senior Pastor

The senior pastor is the first level of leadership within the Black Church (see Allen et al., 2010). The church size determines the levels of hierarchical leadership; however, the senior pastor is always the first level (Allen et al., 2010). The hierarchical structure of leadership begins with the senior pastor, followed by the associate pastors/ministers (the second level of leadership), the deacons/deaconesses (third level of leadership), and congregation/aids/mothers (fourth level of leadership) (see Allen et al., 2010, p. 118). Each rank of leadership submits to the authority and leadership of the senior pastor of which their title is diverse and determined by denominational affiliation. The primary role of the senior pastor is "tending to the personal needs" of congregants (Hardy, 2014, p. 4). African American congregants seek out assistance from the senior pastor not only for spiritual guidance, but for counseling and direction in other aspects of life. Some of the issues addressed with the pastor are spiritual and religious development, romantic relationships, grief and bereavement, family issues and problems, health

concerns, reproductive problems, substance abuse, situational difficulties, mental health issues, and general counseling matters (see Mattis et al., 2007; Chatters et al., 2011). Regardless of denomination, the Black Church fulfills a need within the African American community for addressing fears, angers, and sadness about needs going unmet in the larger White society (see Hays, 2015).

There are several historically Black denominations: African Methodist Episcopal (AME), African Methodist Episcopal Zion (AMEZ), Christian Methodologist Episcopal (CME), National Baptist Convention, National Baptist Convention of America, National Missionary Baptist Convention of America, Progressive National Baptist Convention (PNBC), Church of God in Christ (COGIC), and Full Gospel Baptist Church Fellowship (Floyd-Thomas et al., 2007; Plunkett, 2014; Hays, 2015). Different denominations have different titles for the senior pastor; however, the duties and hierarchical structure remain the same (see Floyd-Thomas et al., 2007). For example, in the COGIC a senior pastor's tile is Bishop or Apostle, but still holds the office of senior pastor. Likewise, in the Full Gospel Baptist Church denomination the senior pastor's title could be Apostle, Prophet, Pastor, or Evangelist, yet holds the office of senior pastor (see Floyd-Thomas et al., 2007). It is necessary to understand that the title of the person can be interchanged, but the duties associated with the office remain the same.

Mattis et al. (2007) conducted a focus group, study which examined the use of ministerial support by African Americans and utilized the words "clergy", "pastor", and "minister" interchangeable for representing the leadership utilized for support (p. 249). The researchers interchanged the three terms because the study selected Christian African

American participants, regardless of denomination for the focus groups for exploring the use of ministerial support for issues discussed with leaders (Mattis et al., 2007). Based upon the studies conducted by Mattis et al. (2007), Allen et al. (2010), Plunkett (2014), Rowland and Isaac-Savage (2014), Brown and McCreary (2014), Stanford and Philpott (2011), and Payne (2008) I found the duties associated with the office of senior pastor was the same regardless of denomination or church size.

African American senior pastors, regardless of church size or denomination fulfill a significant role within the community for addressing a variety of life issues and challenges faced by African Americans (see Chatters et al., 2011). Due to the role and impact of the senior pastor, congregants tend to seek initial support from the senior pastor when facing personal crises (see Allen et al., 2010). In the church, the senior pastor is a key player in the provision of support and care to African American congregants addressing life problems and challenges because more than half of active African American congregants seek advice from the senior pastor when faced with a "crisis situation" (Payne, 2008, p. 216).

One of the main reasons the senior pastor is a significant figure within the African American community is because they are "called to ministry by God" (Floyd-Thomas et al., 2007, p. 158). For some, the senior pastor is acting on behalf of God. The senior pastor is viewed as an interpreter of God's word because they offer congregants hope, wisdom, and inspiration for everyday living with biblical principles and teachings. They teach congregants how to thrive and survive the human life experience with the use of

divine narratives on healing, guidance, and reconciliation (Floyd-Thomas et al., 2007, p. 158).

Senior Pastor as Counselor

In addition to the role of teacher, the senior pastor fulfills the role of counselor. In the African American community counseling from the senior pastor is an alternative to formal mental health treatment due to an assortment of reasons (see Allen et al., 2010; Mattis et al., 2007). African Americans seek counsel from the senior pastor instead of formal mental health services because of the stigma associated with treatment, a lack of access to care, a lack of education on mental illness, and cultural mistrust (see Allen et al., 2010). Senior pastors are heavily involved in the lives of congregants; thus, reinforcing the benefit in seeking counsel from a trusted person when addressing personal or professional challenges. As previously mentioned, a wide spectrum of issues is brought to the senior pastor for counsel; hence, the need for mental health professionals to understand the level of influence the senior pastor has with an individual or family seeking counsel.

Hardy (2014) noted that African American senior pastors dedicate more than 10% of their time to counseling congregants. This demonstrates how senior pastors play dual roles of spiritual advisor and mental health counselor (see Allen et al., 2010). Traditionally, the senior pastor is the person to offer counsel because of the cultural history of African Americans (see Boyd-Franklin, 2010); hence, offering explanation on how or why the senior pastor is the initial contact when in distress. When answers,

guidance, or direction is needed the Black Church and the senior pastor are the initial point of contact for counsel and assistance (see Dempsey, Butler, & Gaither, 2016).

Senior Pastor as Gatekeeper

The Black Church and senior pastor are viewed as gatekeepers to mental health treatment and social services in the African American community (see Hays, 2015; Jackson, 2015; Dempsey et al., 2016). This is related to the history of the Black Church and the confidence placed in the senior pastor when advice or guidance is sought on issues related to spirituality, finances, physical and mental well-being (see Adksion-Bradley, 2005; Lumpkins et al., 2013). What the senior pastor communicates to congregants is important because of the level of influence this person has in the African American community and is represented in the Black Church (see Lumpkins et al., 2013). Senior pastors are in a position to assist with preventative care because they provide counsel, have access to community resources, and are socially connected to the community. Payne (2008) stated that the National Alliance for Mental Illness (NAMI) identified religious communities as a source of support and strength to many African Americans dealing with mental illness. With the Black Church and the senior pastor being viewed as trustworthy sources in the African American community the messages conveyed to congregants regarding social and political issues locally and nationally are respected by the congregants and trusted (see Lumpkins et al., 2013).

Payne (2008) conducted a qualitative analysis on the sermons given by ten African American senior pastors associated with the Pentecostal faith. The study identified how messages from the pulpit of African American Pentecostal senior pastors

have the ability to impact, influence, or delay the treatment seeking behaviors of congregants inadvertently. For example Payne identified “don’t” messages within the context of the senior pastor’s sermons. It was stated that “there are don’ts in regard to handling depression; don’t trust psychiatrists wholeheartedly, don’t be counted amongst those called “crazy”, don’t be weak, don’t cry. If you do need to take medications, that is something to be done in hiding. It is embarrassing and stigmatizing” (Payne, 2008, p. 226). The Payne study utilized a small sampling with the purpose of not generalizing; however, it illustrates the necessity for research in understanding the lived experiences and beliefs of African American Christian senior pastors in relation to mental health treatment and how these experiences have influenced the assistance they provide to congregants seeking mental health support. The identified messages of the study infers further the level of influence and impact the Black Church and senior pastor have in the lives of congregants.

As gatekeepers to formal treatment services in the African American community it is important for members of the counseling profession to know how and when to assist the Black Church and the senior pastor when necessary (see Payne, 2008). As gatekeepers African American senior pastors have the ability to refer congregants to formal mental health treatment services when they are ill-equipped or have insufficient training to address the issues being brought to them from congregants (see Adksion-Bradley et al., 2005; Allen et al., 2010; Lumpkins et al.,2013). Allen et al. (2010) explained that despite the role of gatekeeper, some African American senior pastors are uncomfortable with referring congregants to treatment services outside of the church. At

times the message of reliance or support from God and the church family is reinforced instead of trust or dependence on external resources outside of the church (see Payne, 2008).

The influential and impactful role of the senior pastor prompts the need for further studies to be conducted on the lived experiences of African American Christian senior pastors in relation to mental health treatment. According to Allen et al. (2010) limited information is available on the beliefs, attitudes, and values of African American clergy and its leaders on how formal mental health treatment is viewed. When studies have been conducted they have focused on the roles of clergy in the delivery of supportive services (see Mattis et al., 2007). Mattis et al. (2007) identified eight areas examined in literature when studying the role of clergy: (a) the factors which impact who is more likely to seek assistance from a minister, (b) the minister's role in detecting mental illness, (c) the type of assistance and approaches offered by ministers, (d) the likelihood of persons seeking assistance from a minister also seeking help from other professional resources, (e) the gatekeeping role of the clergy and the services they refer, (f) the ministers attitudes toward the discussion of social and mental health issues, (g) the characteristics of clergy that influence the church goer's decision to seek assistance, and (i) the types of problems taken to ministers reported by the clergy. The beliefs of senior pastors were not directly explored for understanding their lived experiences in relation to mental health treatment. A better understanding of this population could assist with the treatment practices of faith-based African American patients and the church they are affiliated with in the African American community.

Mental Health Treatment in the African American Community

Mental illness is a significant factor in the health and well-being of all persons throughout the world; however, there is a higher tendency for African Americans more than any other ethnic group to avoid seeking mental health treatment even though mental health issues are prevalent in the community (see Broman, 2012; Roberts et al., 2008). Broman (2012) stated “Blacks are significantly less likely to receive services than all other race-ethnic groups” (p. 41). However, when treatment is sought they attend fewer sessions and are more likely to terminate treatment prematurely (see Conner et al., 2010). The poor participation of African Americans in treatment could be related to the lack of benefit experienced by African Americans when seeking treatment due to culturally inadequate services and care (see Briggs et all, 2011). Historically, there has been a lack of consideration for African Americans in the treatment and care of emotional and personal needs in comparison to other ethnic groups (see Briggs et al., 2011). Additional barriers or factors; such as, ageism, a lack of information, and transportation could influence the participatory behaviors of African American clients (Conner et al., 2010, p. 972). When treatment has been terminated or interrupted it was because African American participants identified alternate strategies for coping with challenges and distress. Alternate strategies involved: (a) engaging in other activities that were viewed culturally acceptable, (b) focus on self-reliance in overcoming the difficulty because the individual believed they were strong enough to cope, (c) the avoidance or denial of an issue/feeling, and (d) the belief in God for healing (see Conner et al., 2010). The alternate strategies allowed African Americans to find support from family, friends, the church,

and other social groups. Of the four groups, family and the church are the most influential (see Chatters et al., 2002). In the African American community the church and family have been the primary groups to promote and sustain “Black” community life (Chatters et al., 2002, p. 67). Chatters et al. explained it was the church and family which endured during the period of slavery and after its end. It is also the church and family which provides support in the African American community with various issues related to poverty, the loss of loved ones, disability and illness, the care and supervision of grandchildren, and the caring of children to teen parents (see Chatters et al., 2002). The findings were based upon an analysis of the National Survey of Black Americans (NSBA) data set collected by the Program for Research on Black Americans, Institute for Social Research at the University of Michigan (Chatters et al., 2002). The data consisted of 2,107 completed interviews completed by African Americans with a response rate close to 70%. A multinomial logistic regression analysis was used for examining sociodemographic information, and family and church factors for predicting specific patterns and sources of support. The Chatters et al. findings indicated the majority of respondents utilized informal support from family and church members as resources for personal support. The historical role of the church and family offers an explanation of why these areas are most influential in the African American community; hence, increasing the need for further study on understanding the beliefs of African Americans Christian senior pastors about mental health treatment and its impact upon referral behaviors when congregants seek support through the Black Church for mental health issues.

Historically, there have been barriers in the African American community when seeking services for treatment of mental health issues. Allen et al. (2010) explained that the cost of treatment, a lack of insurance, feelings of shame or guilt, fears of being misdiagnosed and misunderstood, and a cultural mistrust of the system have been identified as barriers to treatment for African Americans (p. 118). It is because of these barriers African Americans have sought assistance from primary care physicians, clergy, and the Black Church for addressing mental health issues (see Payne, 2008). The historical challenges have created an environment in the African American community where the primary source for help for mental health and other related services begin with the Black Church and the senior pastor. Even though the church and senior pastor are the primary source, there is little known on the referral behaviors and treatment outcomes for congregants when assistance is sought through the church (see Allen et al., 2010).

Some African Americans eliminate the option of external support or resources beyond the church due to feeling vulnerable for seeking assistance with personal problems/issues (see Whaley, 2001). The feeling of vulnerability experienced by African Americans elicits a further sense of mistrust for mental health treatment or therapy when working with someone from a different ethnic background (p. 517). According to Whaley one of the reasons African Americans avoid treatment is due to bias in the delivery of services by the provider. The avoidance is based upon the fear of treatment, fear of hospitalization, or misdiagnosis by the provider (see Whaley, 2001). Due to experiences of discrimination, oppression, and prejudice in the larger White society African American individuals have developed a “health cultural paranoia” of culturally different providers

in mental health treatment settings (p. 514). Healthy cultural paranoia is “an African American cultural response style resulting from experience with racism and oppression in White American society” (Whaley, 2001, p. 514). This cultural response combined with cultural mistrust increases the need for receiving assistance from someone where an established relationship or rapport has been proven. It is within the Black Church that the senior pastor has an established relationship and rapport which influences the African American individual’s initial contact for support. The Black Church and the senior pastor are special connections to congregants; hence, influencing their view or label of reference to these entities as familial relationships (see McRae et al., 1999; Roberts et al., 2008).

Hardy (2014) conducted a study surveying the preferred sources of help for African Americans. A three-section instrument was used for exploring the attitudes of African American Christians toward religious help-seeking. Hardy utilized a Likert-style scale called the Attitudes Toward Religious Help-Seeking Scale (ATRHSS) for data collection. The ATRHSS was developed and piloted for the two-part administration study because there was not a pre-existing instrument designed for examining the attitudes of African American Christians toward religious help-seeking. The first administration was to self-identify 18 or older African American members of a Christian church with the use of SurveyMonkey with purposive and snowball sampling techniques. The second administration consisted of eight African American churches with a system random sampling size of 609 participants completing a paper-pencil survey. The first administration findings indicated the respondent’s preference for a pastoral counselor over a social worker, psychologist/psychiatrist, and counselor for twelve of the twenty-

two issues sought for treatment. The second administration identified pastoral counselors as the preference for treatment over a social worker, psychologist/psychiatrist, and counselor.

According to Hardy (2014) the increase in preference for pastoral counselors increases the benefit of collaborative relationships between mental health workers and senior pastors. The research discussed not only the historical context for why African Americans sought assistance through the church but outlined additional reasons. According to Hardy economics, proximity, convenience, and relationship context were factors for why treatment was sought through the church. For example, older and less educated African American persons preferred support from the senior pastor; hence, identifying age and socioeconomic factors of influence in preference of care provider during times of distress. The second administration of participants displayed an overwhelming preference of participants in finding support and guidance for a variety of issues (Hardy 2014). Therefore, if the church and the senior pastor are viewed as primary resources in the African American community then further information is needed in the mental health community about the lived experiences and beliefs of African American senior pastors in relation to mental health treatment.

In the African American community mental health treatment is viewed by some negatively. There is a negative association with seeking treatment because it may be seen as “anti-spiritual,” or viewed as being for “sick or crazy” people because “therapy is not believed in” (Boyd-Franklin, 2010, p. 985). An additional consideration for the negative connotation in the African American community is that treatment could undermine one’s

faith or religious beliefs (see Boyd-Franklin, 2010). These beliefs could be related to the history of African Americans surrounding racism and discrimination, the messages and experiences handed down from generation to generation, and personal experience. Regardless of the belief ascribed to by the individual it is important to consider each factor as reasoning for the avoidance of mental health treatment and the acceptance for support from the Black Church and the senior pastor. A better understanding is needed in the mental health community about the beliefs of African American Christian senior pastors if the trend of African Americans seeking support through the church continues to increase. This study sought to understand the experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance they provide to congregants seeking mental health support.

Methodology

For exploring the lived experiences of African American Christian senior pastors in relation to mental health treatment a qualitative method is selected with a phenomenological approach. The qualitative method is most appropriate for this study because I sought to understand how the lived experiences of African American Christian senior pastors in relation to mental health treatment influenced the assistance they provided to congregants seeking mental health support. Moustakas (1994) explained phenomenology seeks to understand the meaning a person associates with an experience; hence, the appropriateness of this qualitative approach for this study. According to Van Manen (1990) when one wants to understand a person the researcher asks the individual about "his or her world, profession, interests, background, place of birth and childhood,

etc." (p. 102). This study sought to understand the senior pastor's worldview and experiences with mental health treatment and the possible meanings created from these experiences.

In order to understand the senior pastors experiences I needed to understand the history of the participants related to the area of mental health. It is the history which adds to the meaning of an experience (Moustakas,1994). It is the understanding of the senior pastors' lived experiences and beliefs in relation to mental health treatment which allows me to identify the meaning associated with the experiences, enabling me to understand the essence of the experiences for the participants (Moustakas, 1994). As the history and lived experiences of the senior pastor is understood, I have a greater opportunity for completely understanding the participant's lived experiences and beliefs in relation to mental health treatment.

Moustakas (1994) identified phenomenology as an appropriate approach for understanding an individual's meaning connected with an experience. It is the researcher that interprets information from open-ended questions and dialogue from the interviews conducted with the participants for understanding the participant's "way of being in the world" (Van Manen, 1990, p. 39; Moustakas, 1994). The phenomenological approach was selected because I sought to understand the meanings the senior pastor had associated with mental health treatment based upon their lived experiences in their leadership role in the church. A phenomenological approach is most appropriate for understanding the common or shared experiences of this group while focusing on a specific phenomenon (see Creswell, 2013). The phenomenon for this study involved

understanding the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance they provided to congregants seeking mental health support. Previous qualitative studies were conducted by Lumpkins et al. (2013), Brown and McCreary (2014), Stanford and Philpott (2009), Rowland and Isaac-Savage (2014), and Mattis et al. (2007) focusing on African American pastors; however, none of the aforementioned studies focused on the lived experiences of the senior pastor in relation to mental health treatment. The focus of the previously stated studies left a gap for exploring the lived experiences of African American Christian senior pastors in relation to mental health treatment for this study.

Lumpkins et al. (2013) conducted open-ended, semi-structured interviews with six pastors exploring the perceptions of communication from the pulpit to congregants on healthy behavior utilizing a grounded theory for conceptualizing a framework on how to utilize clergy for promoting health behavior from the pulpit. The study focused on five major areas: (a) biographical information, (b) church demographics, (c) health screening knowledge, (d) beliefs about cancer screening, and (e) the pastor and church as health promoters (Lumpkins et al., 2013, p. 1098). The study identified six major themes related to how pastors view their leadership role in the church and how they impact positive health behavior among congregants and the community. The six themes were pastor's personalization of health, pastor's assessment of the congregation's health, pastor's usage of authority, linkage of spirituality, religion and health, participation in health ministries, and the church as an agent for healthcare equity and access (see Lumpkins et al., 2013).

The Lumpkins et al. (2013) findings suggest that pastors see and understand their influential leadership role in promoting health behaviors amongst congregants and the surrounding community. The Lumpkins et al. study supports the influential role the African American senior pastor has in the lives of congregants when conveying messages about health; however, its goal was to conceptualize a framework for pastors to promote healthy behaviors from the pulpit. Whereas, I am exploring the beliefs of African American senior pastors about mental health treatment from a phenomenological approach for understanding the meanings associated with their experiences. The Lumpkins et al. study focus supports the reasoning for this study's focus on the senior pastor population in the Black Church.

The studies conducted by Brown and McCreary (2014), Stanford and Philpott (2011), and Rowland and Isaac-Savage (2014) explored the perceptions, knowledge, and views of African American senior pastors on mental health. Each study utilized a survey or questionnaire for data collection with the use of mailings or online services. Brown and McCreary surveyed 39 pastors utilizing both qualitative and quantitative methods for exploring the pastor's attitudes toward mental health service seeking. The online survey utilized a combination of quantitative and qualitative questions for investigating the pastors training, counseling practices, and perceived needs for training or assisting parishioners (Brown & McCreary, 2014). The exploratory investigation hypothesized that the pastor's attitudes would predict the pastor's counseling practices and referral behaviors.

The pastors were recruited from various ministerial council organizations in the state of Virginia and email invitations. Forty-nine pastors completed the online survey, but a final number of 48 participant surveys were utilized because data was incomplete for one survey. Thirty males and 18 females completed surveys. Thirty-nine identified as African American which resulted in the sample size for the study. According to Brown and McCreary (2014) the study found that pastors with positive attitudes toward mental health services conducted counseling with parishioners on a larger spectrum of topics and issues and rendered more counseling services to parishioners in a month. Even though the hypothesis predicted a positive correlation between attitudes and counseling behaviors and referral practices, it did not explore the process of how referrals were handled.

The Brown and McCreary (2014) study found pastors continually rendering services to congregants because of the positioning they had in their members lives; however, it did not explore how the senior pastor's attitudes or experiences with mental health treatment developed and shaped their involvement in counseling practices. Brown and McCreary used the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) for assessing the senior pastor's attitudes toward mental healthcare. The 5-point rating scale identified the pastors having moderate attitudes toward mental health services in general due to responses falling in the mid-range of scoring. Even though most pastors (88%) stated congregants came to them for assistance, they were more likely to refer their congregants to other sources of care (Brown & McCreary, 2014). The Brown and McCreary study further acknowledged the significant role pastors played in the lives of congregants and people in the community due to referrals for help; however,

there is still limited information on the lived experiences of this population for understanding their personal affiliation and background in relation to mental health treatment.

Stanford and Philpott (2011) utilized an online questionnaire to anonymously survey senior pastors affiliated with the Baptist General Convention of Texas (BGCT). Stanford and Philpott wanted to learn about the beliefs of senior pastors within the BGCT group about the causes and treatment of mental illness. The senior pastors were contacted via email and directed to a hyperlink for completing the online questionnaire with a likert-type scale with a range from 1 to 10 developed by the authors. One hundred sixty-eight senior pastors of 999 active members completed the online questionnaire collecting information on demographics and church profile, the individuals level of contact with the mentally ill, factors influencing mental health referrals, causes of mental disorders, the perceptions of treatment efficacy, and the senior pastor's personal account of congregants suffering with mental illness (Stanford & Philpott, 2011).

In addition to the six areas outlined participants were asked to describe in writing their personal account of congregants suffering with mental illness and their responses; hence, featuring a qualitative component for the study. The data identified a moderate level of contact for senior persons with the mentally ill, even though a number of congregants were rarely diagnosed with mental illness (see Stanford & Philpott, 2011). Two possible explanations from this result. The first being that congregants were referred to local providers which removed them from the pastors counseling practice, and second that due to the pastors limited training this individual may not be sensitive in recognizing

the symptoms of mental disorders (Stanford & Philpott, 2011). In addition to this, the senior pastors were likely to refer their congregants to mental health professionals they knew were Christian. This factor could be related to the responses of the senior pastors on causes of mental illness.

According to Stanford and Philpott (2011) three factors were identified in this area on causes for mental illness: (a) biological (genes, chemical imbalance), (b) psychosocial (parenting, social pressure), and (c) spiritual (demonic oppression, sin, lack of faith). Each area was identified by the senior pastors as aspects for treatment with a possible combination of medication with different treatment approaches; such as, medical, pastoral counseling, psychotherapy, and spiritual deliverance. According to Stanford and Philpott the notion of formal treatment suggest the senior pastor's value on the well-being of a congregant being provided therapeutic services in a faith filled supportive environment when referred to formal treatment. The Stanford and Philpott study was effective in its process for gaining results regarding learning about the Baptist senior pastors knowledge and perception of mental illness; however, its sample is non-representative because it eliminated individuals incapable of being contacted via email or unable to access the survey for online completion; as well as, senior pastors from other Christian denominations.

The study also utilized a sample population of predominately Caucasian Baptist senior pastors (89.9%). Only 3% of the study included African American senior pastors (Stanford & Philpott, 2011). The study indicated from the sample that the senior pastor's perceptions of mental illness was based upon biomedical knowledge; however, the

individual's religious beliefs influenced their views on some mental health disorders (Stanford & Philpott, 2011). This leads to question how much of the senior pastors' religious views influence how counseling is approached; as well as, their referral practices. This aspect of the Stanford and Philpott study supports this study's focus on the African American Christian senior pastor without denomination limitations for learning about the individuals lived experiences in relation to mental health treatment.

Rowland and Isaac-Savage (2014) also conducted a study on the views of African American senior pastors on health and health education in the Black Church. The quantitative study utilized a questionnaire developed by the authors. Rowland and Isaac-Savage wanted to explore the senior pastors' perceptions of the role of the church in providing healthcare, education, and wellness opportunities to congregants. The questionnaire consisted of 32 questions and was mailed to 500 pastors in two Midwestern states (Rowland & Isaac-Savage, 2014). Random selection was used from a list of African American churches in the two states, and of the 500 mailed questionnaires 100 were completed for the study.

Rowland and Isaac-Savage (2014) did not focus solely on mental health; however, the study did reveal how often the senior pastor's perceptions are not heard. The study revealed most pastors felt that medical issues were plaguing the African American community and their congregants; therefore, 62% of the pastors made health care materials available for congregants, and 59% reported having a health ministry program within their church for educating, supporting, and empowering congregants (Rowland & Isaac-Savage, 2014). Most of the senior pastors were knowledgeable about most of the

health issues; however, believed that the Black Church's response to these concerns were slow because of their heavy focus on spiritual or emotional solutions instead of practical applications for improving health (Rowland & Isaac-Savage, 2014).

The Black Church and the senior pastor have played an influential role in the African American community with the education and promotion of health issues plaguing African Americans; however, it is important for Black Churches to establish partnerships with health professionals and organizations for further advancement in the African American community (Rowland & Isaac-Savage, 2014). Due to the slow response on health issues and a lack of partnerships with health organizations, it is important to explore the senior pastor population further for gaining a better understanding of the experiences influencing their decision-making process surrounding treatment and referral practices in relation to mental health treatment. Because of their influence it is important for the counseling community to gain a better understanding their perceptions and attitudes and how it influences their ability to respond to the mental health needs of their congregants.

For further understanding the African American senior pastor, Mattis et al. (2007) conducted a qualitative study utilizing a focus group for exploring the uses of ministerial support among African Americans. Mattis et al. focused on the issues taken to the minister by congregants, the issues not taken to ministers by congregants, and the factors which inform the decision-making process for whether or not to seek support from the minister. The study utilized 13 focus groups with group size ranging between 5 to 12 persons for a total of 78 participants comprised of 39 men and 39 women (Mattis et al.,

2007). An audio-taped semi-structured interview protocol was utilized for data collection with the focus groups. Several themes were identified in the three areas of focus for the study. The themes related to issues taken to ministers were: (a) religion and spiritual development, (b) general/unspecified counseling, (c) romantic relationship counseling, (d) grief-bereavement, (e) family problems and issues, (f) health/sickness/hospitalization, (g) reproductive issues, and (h) financial/work related issues. The themes identified for not taking issues to the minister were: (a) never go to minister, (b) general unspecified issue, (c) family and marital problems/conflicts, (d) sex, (e) reproductive/gender specific issues, (f) financial/work related issues, (g) health/sickness, (h) sexual violence, (i) domestic violence/spousal abuse, and (j) substance abuse. The last set of themes identified as factors for not seeking ministerial support were: (a) direct relationship with God, (b) ministerial character, (c) uneasiness, (d) availability of alternative support, (e) shame, (f) ministerial competence, and (g) availability of pastor and seriousness of issue (Mattis et al., 2007, p. 253-255).

Mattis et al. (2007) found overlap between what the congregants shared with the minister and what the ministers reported encountering when rendering counseling services. It is clear that senior pastors and other ministerial staff fulfill a supportive function in the lives of congregants; however, there is limited information discussing the senior pastor and how they respond to the mental health needs of their congregants. According to Mattis et al. “few studies have explored the particular roles by ministers in providing for members of their communities” (p. 255). This factor combined with the lack of information on the lived experiences of African American Christian senior pastors

in relation to mental health treatment is what I sought to understand for filling a gap within the literature; hence, expanding the knowledge base in the counseling community on this specific population.

Phenomenological Philosophy

There are various philosophical and theoretical perspectives which have influenced qualitative research (see Patton, 2002). Lincoln and Guba, Schwandt, Crotty, Creswell, and Denzin and Lincoln have each identified different types of qualitative inquiry (Patton, 2002); however, for this phenomenological study Edmund Husserl's philosophical focus is used. Husserl developed a philosophical system which is embedded in subjective openness (Moustakas, 1994). It is the subjective openness which allows researchers to acknowledge and place value upon the returning to self for discovering the nature and meaning of experiences as they appear in their essence (Moustakas, 1994). Van Manen (1994) explained that phenomenology seeks a deeper understanding of the nature and meaning associated with everyday experiences which is what this study sought by focusing on the lived experiences of African American Christian senior pastors in relation to mental health treatment.

Husserl believed that scientific knowledge could be gained when the information collected was viewed from a fresh and unbiased perspective by the researcher (see Wertz, 2005). The *what it is* is understood by the researcher when the individual abstains from assumptions about the phenomenon being studied (see Wertz, 2005). It is the essence of the *what it is* that drove the phenomenological research conducted by Husserl. Husserl believed that in order to understand the true essence of an experience one is to put all

preconceived ideas aside (see McConnell-Henry, Chapman, & Francis, 2009). The research data is viewed as valid when the researcher is able to place experiences and presuppositions aside because these factors are not relevant to the data collected during the research (see McConnell-Henry et al., 2009). Transcendental phenomenological research is about understanding your own experiences but understanding the lived experiences of others. Understanding the senior pastors lived experiences allows for a potential uncovering and description of the internal meanings associated with the events surrounding mental health treatment. It is the uncovering, interpretations, and descriptions of the experiences which identify the meaning associated with the lived experiences of the senior pastor (see Van Manen, 1990).

Phenomenological studies seek to understand the meaning derived from the factual experiences of participants experiencing the phenomenon. As meanings are explored the researcher is to be aware of what they personally, think, feel, and perceive by remaining consciously mindful; however, the individual is to abstain from judgement for experiencing new knowledge (see Moustakas, 1994). Husserl's philosophy identified this as the epoché . The epoché involves an individual setting aside judgements, perceptions, thoughts, and feelings while investigating a phenomenon (see Moustakas, 1994). This standard is necessary for a qualitative researcher to fulfill when conducting a phenomenological study because it allows for the discovery of new meanings, interpretations, and knowing to present based upon what is presented by the participant. The epoché keeps the researcher from being influenced by bias (see Wertz, 2005) allowing the implementation of bracketing. Bracketing assists the researcher in

identifying personal experiences which could be introduced when deemed necessary and appropriate for the study (see Creswell, 2013).

It is the epoché principle which causes researchers to examine biases for remaining open to the information presented by participants when utilizing a phenomenological approach (see Moustakas, 1994). As previously stated, qualitative researchers are to remain conscious of perceptions, experiences, and judgements because it leads them to being intentional when analyzing the data collected on the phenomenon (see Moustakas, 1994; Wertz, 2005). The act of being intentional correlates to the ideas of noema and noesis. Noema is that "which is experienced" or the "what of the experience" (Moustakas, 1994, p. 69); whereas, the noesis awakens the researcher to "recognizing and drawing out" (Moustakas, 1994, p. 69) the meaning of whatever is perceived, thought, felt, or judged. It is intentionally, the noema and noesis which assist the researcher during the data analysis phase because it challenges the individual to "look and reflect" and "look and reflect again" (Moustakas, 1994, p.70) for discovering the hidden meanings surrounding a phenomenon.

According to Cleary, Escott, Horsfall, Walter, and Jackson (2014) researchers are given the opportunity to understand a participant's lived experiences and how they are different from others whom experience the phenomenon, yet similar. The experiences are authentic to the participant because of the meaning associated with the phenomenon. A phenomenological approach was selected for this study because it was more meaningful to me to gain information form a participant's stories and personal accounts than the measuring of facts. I wanted to understand the participant's view of the world in which

they “live and work” (Creswell, 2013, p. 24). I wanted to understand the participant’s views in relation to mental health treatment. It was personally believed what I sought to understand about the senior pastor could be achieved through meaningful, personal exchanges throughout the interviewing process. Cleary et al. (2014) explained this as the reasoning for researchers conducting qualitative research. For supporting this reasoning studies conducted by Henfeld, Woo, and Washington (2013), Ward, Mengesha, and Issa (2014), and Dupre, Echterling, Meixner, Anderson, and Keilty (2014) are discussed for explaining how a phenomenological approach is used for learning the meanings associated with lived experiences. Each of the studies focused on different topics and populations; however, their studies utilized phenomenological approaches for research.

Henfeld et al. (2013) conducted a phenomenological study exploring the perceptions of challenges of African American doctoral students enrolled in counselor education programs. The purpose of the Henfeld et al. study was to explore the African American students self-identified challenges and any program structural practices that affect successful retention and matriculation (p. 123). Henfeld et al. wanted to answer two questions. The first research question wanted students to discuss the challenges they confronted in the program, and the second question wanted students to share how the programs structural and cultural practices contributed to their challenges. The two research questions guided the phenomenological study.

Purposeful sampling was used for recruiting eleven African American participants attending predominately White institutions (PWI) through the CESNET and COUNSGRADS listservs for the phenomenological study (Henfeld et al., 2013). Selected

participants completed a demographic questionnaire and informed consent form delivered to participants through standard mail, while email follow-up was utilized for scheduling interview with participants (Henfeld et al., 2013). Two rounds of interviews were conducted with participants for data collection. The first round of interviews utilized email for sending structured interview questions asking participants to describe their experiences regarding the institution, the department, the classrooms, and encounters with their advisor (Henfeld et al., 2013). The information collected in the initial interview was utilized in the second interview offering students the opportunity to expound upon their responses to the initial interview questions.

Three themes were identified from the interviews during the data analysis phase of the study. The three themes were feelings of isolation, disconnected peers, and faculty misunderstandings and disrespect (Henfeld et al., 2013). The first theme was a reflection of how the students did not feel like they were accepted into the culture of the “majority” (Henfeld et al., 2013, p. 127), and how the individual’s previous educational experiences intensified the feelings of isolation. The second theme of disconnection from peers also had two subcategories: (a) quality of program orientations, and (b) classroom interaction. The participants reported a lack of cohesiveness in general and as a cohort between students. The participants also reported preferential treatment from faculty toward White students, and insufficient information from the department during the orientation phase of the program. These experiences increased the challenges experienced by the participants in the counselor education program (Henfeld et al., 2013). The third theme involving faculty misunderstandings and disrespect was identified because of the staff’s lack of

cultural understanding for the participants' needs, cultural style and norms. Each of the themes utilized the direct quotes of participants for offering a textural and structural descriptive of the experience. The themes identified from the interviews allowed the researchers to understand the participants' views and personal experiences with their counselor education program.

The results of the Henfeld et al. (2013) study revealed the challenges African American doctoral students experienced in a counselor education program and the need for counselor education programs to make changes for creating and providing an "atmosphere of inclusion and acceptance" (p. 132). The study revealed specific experiences of African American doctoral students in counselor education programs for outlining the limitations of the current study, but also the implication for future research in this area because it utilized a phenomenological approach. According to Henfeld et al. a level of knowledge was gained on the topic because of a phenomenological approach. The information gained from the study could be utilized for evaluating the success of counseling programs for recruiting and retaining African American faculty and students because now there are specific detailed experiences of students and their challenges in a PWI counselor education program. The phenomenological approach allowed participants to describe their lived experiences; which in turn, allowed researchers to understand the essence of the lived experiences of participants (see Creswell, 2013).

Qualitative research allows researchers to utilize thick descriptions; such as, "details, context, emotions, and social relationships" (Ward et al., 2013, p. 50) for identifying the meaning in experienced phenomenon. Qualitative research from a

phenomenological approach allowed Ward et al. to understand the lived experiences of older African American women with depression and their coping behaviors. According to Ward et al. the purpose of the study was to examine age 60 years and older African American women on their lived experiences with depression and their coping behaviors in response to depression. The study sampled 13 older African American women with face-to-face 60-75 minute semi-structured interview for collecting data on their experiences with depression.

The Ward et al. (2013) study wanted to know what depression meant, and what they were doing about their depression. The identified group was selected for the study because little was known about this population in relation to their life experiences with depression (see Ward et al., 2013). The Ward et al. study utilized the common sense model as its theoretical framework for the phenomenological study. According to Ward et al. the "common sense model is based in the self-regulation theory, which suggest that illness representation or beliefs about an illness determine an individual's appraisal of the illness as well as health behaviors including behaviors used to cope with illness" (p. 47). This theoretical model combined with the interview questions allowed participants to share their experiences and perception of depression offering the researchers a narrative of the participant's life surrounding depression. In addition to the conceptual framework and interview process for data collection, Ward et al. utilized a transcendental phenomenology for the approach. A transcendental approach allows researchers to focus on a participants' descriptions of the experience with less focus on the researcher's interpretations (see Ward et al., 2013). This approach allows for the researcher to focus

more on what it is like for the participant experiencing the phenomenon (see Wertz, 2005). For understanding the essence of the depression for the participants, interviews were audio recorded and transcribed. The transcripts accuracy was verified by the audio recording, and then all identifying information was removed from the transcripts prior to the data analysis phase (Ward et al, 2013).

The phenomenological approach allowed Ward et al. (2013) to identify the different experiences and circumstances causing the participants depression. The Ward et al. study concluded that women associated their depression to challenging life events, as far back as early childhood. According to the participant's descriptions, experiences related to trauma and turmoil caused their depression (Ward et al., 2013). The rich textural and structural descriptions collected from the phenomenological approach allowed the researchers to establish the significance of the women's life experiences associated with depression identifying the participant's beliefs, causal factors, and coping behaviors for managing depression. The Ward et al. study revealed that the majority of the women did not utilize professional mental health services for their depression; however, they did utilize religious and culturally sanctioned strategies for coping with their depression.

The women utilized their belief in God, prayer, bible readings, bible study, worship services, activities related to the church, and consultations with clergy for coping with depression (Ward et al., 2013). The coping strategies combined with the participant's lack of awareness about depression led to years of non-professional treatment, but used alternative culturally appropriate options for coping with depression

(Ward et al., 2013). The Ward et al. study sought to understand the lived experiences of older African American women with depression and coping behaviors, which was accomplished according to the researchers with the use of a phenomenological approach.

Thus far the studies conducted by Henfeld et al. (2013) and Ward et al. (2014) utilized a phenomenological approach for engaging and not observing the participants (Creswell, 2009). This form of qualitative research allows for participants to convey information directly in natural settings to the researchers (see Creswell, 2009). Dupre et al. (2014) utilized this same approach for exploring the supervision experiences of professional counselors providing crisis counseling. The Dupre et al. study interviewed 13 licensed professional counselors for understanding the counselor's perspective and experiences with crisis supervision. Dupre et al. wanted to understand the experiences of counselors involved in supervision working in the area of crisis counseling in different treatment sites. The goal of the study was understanding the meaning of crisis supervision for licensed professional counselors (Dupre et al., 2014). A phenomenological approach was deemed most appropriate for the study because it allowed participants to reflect on their involvements with the phenomenon by describing the "depth and meaning" associated with the experience to the researcher (Dupre et al., 2014, p. 85).

The participants completed two rounds of 60 minute semi-structured open-ended interviews, which were recorded and transcribed during the data collection and data analysis phase of the study (Dupre et al., 2014). According to Dupre et al. 12 open-ended questions guided the first interview; whereas, the second interview utilized 10 open-ended questions developed from the tentative themes which emerged from the first round

of interviews. This method allowed further reflection by the participants on the crisis supervision phenomenon (Dupre et al., 2014). The data collected from participants rendered five major themes related to crisis counseling and crisis supervision. The themes were: (a) counselors confronting types of crisis situations, (b) complex crisis situations (clinically, systemically, and culturally), (c) the positive and negative outcomes of crisis counseling, (d) the benefits and potential harms of crisis counseling, and (e) the want and need for post licensure clinical supervision for crisis counseling (Dupre et al., 2014). According to Dupre et al. the study's results provided a framework for crisis counseling, crisis supervision, and post licensure clinical supervision.

The study's findings rendered several implications for licensed professional counselor. Dupre et al. (2014) identified the narratives as "powerful evidence" in portraying how inadequately current literature depicted the "complexity and dynamics" of crises (p. 91). The data identified risks for clients, their family members, first responders, other service providers, and counselors which were not accurately captured in previous literature (Dupre et al. 2014). According to Dupre et al. previous literature focused on crisis strategies or protocols based on certain incidents; whereas, the study's findings indicated that crisis counseling cannot be deduced to a set of procedures because it is "multifaceted, systemic, and a cultural phenomenon" (p. 91). The findings displayed how the participants placed themselves in demanding situations which required them to be knowledgeable in multiple areas ranging from mental health disorders to community resources.

Due to the range of information crisis counselors and supervisors must know for being effective as clinicians, professional development is a necessity (Dupre et al., 2014). In addition to professional development, supervision is important because it serves as protection for the counselor regarding client welfare, and restorative because it creates a safe space for counselors. A significant level of emotional trauma is experienced by counselors rendering crisis counseling which is why a significant value is placed upon supervision. It was because of these findings that Dupre et al. noted the need for counselors to have supervision for processing and addressing crisis situations experienced with clients. The participants lived experiences increased the necessity in crisis counselors utilizing supervision for support, self-reflection, and a safe space for being vulnerable (Dupre et al., 2014). The narratives of the participants allowed researchers to hear personal accounts of how crisis counseling is experienced and what the counselor's needs are in relation to supervision.

Qualitative research conducted from a phenomenological approach allows researcher to understand what occurs for participants when studying a phenomenon (see Wertz, 2005). In order to gain a greater understanding, the researcher is to "actively do it" (Van Manen, 1990, p.8) by being retrospective and introspective when collecting and analyzing data from participants whom have experienced the phenomenon. As introspection and retrospection occurred I was able to deduce the meanings associated with the lived experiences of the African American Christian senior pastor in relation to mental health treatment; however, this could not have occurred without implementing the phenomenological philosophy of Husserl. The concepts and ideas of Husserl assisted me

in going deeper for determining meaning, and identifying themes related to the phenomenon being studied. As this study was conducted the teachings, philosophy, and methods of Husserl were implemented for understanding the lived experiences of the African American Christian senior pastor in relation to mental health treatment. The phenomenological philosophy allowed me to understand how the senior pastors developed messages, attitudes, and beliefs about mental health treatment based upon their experiences.

Summary

This qualitative study sought to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences have influenced the assistance they provide to congregants seeking mental health support. This aspect of research is limited; therefore, understanding the lived experiences of African American Christian senior pastors has the potential to increase the counseling communities understanding on how to better to serve this population and the individual referred to formal treatment settings. Snowden (1999) explained how understanding the beliefs and views of this population would assist in understanding how congregants may or may not be referred to formal treatment settings for addressing personal issues. Allen et al. (2010) further reiterated this need; therefore, the gap was identified for this study from a qualitative approach utilizing phenomenology for understanding the experiences framing the African American Christian senior pastors lived experiences in relation to mental health treatment. For some African Americans the Black Church and the senior pastor are the entry points to informal and formal treatment

(see Allen et al., 2010); hence, the need for understanding how the life experiences of the senior pastor with mental health treatment influence referral behaviors, messages given to congregants about treatment when seeking assistance, and their leadership. Based upon the literature there was a need for further exploring the lived experiences of African American Christian senior pastors with mental health treatment and how it has influenced their ability to respond to the mental health needs of their congregants.

In Chapter 2 five major sections were discussed. The chapter reviewed in the first section the literature search strategy conducted for identifying literature related to the Black Church and its history, the purpose of the Black Church in the areas of religion, spirituality, social, and psychological functioning. The chapter also reviewed the role of the senior pastor and their influence in the lives of congregants as spiritual leader and how they fulfill the role of gatekeeper when referring to formal mental health treatment or social services; as well as, counselor when congregants are in need of guidance and support with personal issues. Also, this chapter identified the help-seeking behaviors and treatment of African Americans for understanding how faith and the Black Church are viewed as supports and coping strategies when in distress. The final section discussed the phenomenological approach and philosophy for this study.

The next chapter outlines the qualitative research design and rational for its selection. A detailed explanation is offered on how a phenomenological approach is utilized for this study. The limitations and significance of this are discussed outlining the weaknesses, biases, and measures used to address these limitations. The final section of

Chapter 3 reviews the contributions and potential implications for the methodological approach selected for this study, followed by a summary of the chapters main points.

Chapter 3: Research Method

Introduction

Researchers select designs based on the nature of the research problem and what they are seeking to understand or explore (see Van Manen, 1990). For this study, I was seeking to understand the lived experiences of African American Christian senior pastors and how these experiences influenced the assistance they provided to congregants seeking mental health support through the church. A qualitative method and phenomenological approach allowed me to understand the shared experiences of senior pastors, thereby offering me a deeper understanding of their involvements surrounding mental health treatment. In this chapter, I offer specific details of this phenomenological study exploring the lived experiences of African American Christian senior pastors in relation to mental health treatment.

Major Sections

There are five major sections in this chapter. The five sections address the research design and rationale, the role of the researcher, the research methodology, the trustworthiness and transferability of the study, and a summary of the chapter. In the research design section, I discuss key concepts of the study, offer a review of the research questions, and provide a rationale for the research design. In the second section, I define and explain my role as the researcher, review my personal and professional relationships with participants, and explore biases and ethical issues that could have caused a conflict of interest during this study. In the next section, I review the methodology for participant selection, instrumentation, procedures, and data analysis. The fourth section is dedicated

to issues of trustworthiness, credibility, transferability, dependability, reliability of the strategies I used, and the ethical procedures I used throughout this study. The last section includes a summary of the main points of Chapter 3, as well as a brief introduction to Chapter 4.

Research Design and Rationale

In this phenomenological study, I sought to understand the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influence the assistance they provide to congregants who sought mental health support through the church. I used four questions to guide this study of the lived experiences of African American Christian senior pastors. The main question identified the focus of this study and the three sub-questions explored further the main research question. The sub-questions allowed me to divide the main research question into several parts (see Creswell, 2013). The sub-questions for this study allowed me to explore different aspects of the African American Christian senior pastors lived experiences in relation to mental health treatment. The main question and three sub-questions of this phenomenological study are listed below.

Research Question: What are the lived experiences of the African American Christian senior pastor in relation to mental health treatment?

Sub-Question 1: How do the senior pastor's make meaning of the experiences of helping congregants seeking counseling through the church?

Sub-Question 2: What are the senior pastor's personal experiences with mental health treatment?

Sub-Question 3: What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?

To understand the lived experiences of African American Christian senior pastors, I determined that a phenomenological approach was most appropriate. Creswell (2013) explained that there are five major qualitative approaches researchers can choose from. These are narrative research, phenomenology, grounded theory, ethnography, and case study. Four of the qualitative approaches were not selected because their focuses did not align with this study. Narrative research explores the biographic information narrated by a participant whom has lived through the event being studied while focusing on the meaning made of this experiences (Rudestam & Newton, 2007). A grounded theory approach allows a researcher to develop a theory based upon the similarities experienced by a group of individuals (Rudestam & Newton, 2007). Moustakas (1994) explained that grounded theory is used for understanding the "nature and meaning of an experience for a particular group of people in a particular setting" (p. 4). Ethnographers utilize direct observations of groups in a variety of settings for an extended period of time (Moustakas, 1994). According to Rudestam and Newton (2007) ethnography is used for "capturing and understanding specific aspects of life of a particular group by observing their patterns of behavior, customs, and lifestyles" (p. 41). And last, a case study is used for "understanding a single unit of study within a complex context" (Rudestam & Newton, 2007, p. 50). Case studies can focus on a single person, an organization, a specific event, program, or process for developing an in-depth description (Rudestam & Newton, 2007; Creswell, 2013). None of the aforementioned approaches would have allowed me to elicit

rich, thick descriptions or the personal meanings associated with experiences related to mental health treatment; hence, the selection of a phenomenological approach for this study.

According to Moustakas (1994) qualitative research allows for the exploration and understanding of the meaning an individual or a group associates with a social or human problem. In this study, I sought to understand participants' lived experiences and identify themes from their interview data. In its simplest form, I worked keep in mind the participant's lifeworld throughout the research process (see Giorgi, 2009). A phenomenological approach was most appropriate because it involved an inductive inquiry for understanding the meaning a participant associated with a phenomenon. Giorgi (2009) explained that this approach allows for researchers to focus on the meaning related to the phenomenon, which is what I sought to do.

By using a phenomenological approach, I gave participants the opportunity to give details on how they experienced the phenomenon personally and professionally. A phenomenological approach allowed me to clearly capture and describe how the participants encountered the phenomenon. According to Van Manen (1990), participants in phenomenological studies are given the opportunity to share their perceptions, descriptions, feelings, judgements, and reflections for making sense of a phenomenon. This form of in-depth exploration allowed me to understand the range and depth of emotions experienced by the participants when the phenomenon was encountered. I was able to clearly understand the participants' views of their experiences. A quantitative approach would not have allowed me to gain in-depth explanations from participants

about the phenomenon because it focuses more on the examination of relationships among variables (Van Manen, 1990). Quantitative strategies are often used for testing predictions or hypothesis, whereas, qualitative strategies are used for discovering emerging themes (see Teddlie & Tashakkori, 2009).

Research Tradition

Phenomenology began as a philosophy in the social sciences and evolved into a method because of its examination of an individual's lived experiences and its study of a small number of participants with similar backgrounds for identifying patterns, relationships, and meanings surrounding a phenomenon (see Moustakas, 1994). Phenomenological research allows researchers to explore a single concept or idea, or a specific instance experienced by the participant (see Giorgi, 2009). In this study I examined the lived experiences of African American Christian senior pastors in relation to mental health treatment. I also sought to understand how these experiences influenced the assistance senior pastors provided to congregants seeking mental health support through the church. I explored participants' stories regarding their personal experiences, beliefs, and attitudes towards mental health treatment.

According to Van Manen (1990) the phenomenological researcher wants to know "what it is like" for the participant (p. 42); therefore, I was seeking to understand what the participants experienced and how they experienced it. Little is known in the counseling community about the lived experiences, beliefs, and attitudes of African American Christian senior pastors in relation to mental health treatment, or about how the senior pastors' experiences effect how mental health services are rendered to

congregants. Therefore, I explored the lived experiences and messages senior pastors had learned throughout life in their family, community, and church in relation to mental health treatment. If any of the senior pastors had participated in treatment, it was important that I understood the factors which influenced their decision for participation. Likewise, if they had not participated in treatment, it was necessary to understand if there were factors which swayed their decision to not pursue treatment. The lived experiences were defined and given meaning by the senior pastors and it was necessary to understand their experiences in order to identify patterns or themes in this population. Based upon what I sought to understand, a phenomenological approach was most appropriate.

Phenomenology formed from a philosophical practice developed by Edmund Husserl in the twentieth century (see Giorgi, 2009). Husserl was seeking to understand how individuals defined things and experienced them in everyday experiences (see Van Manen, 1990). For Husserl it was about the perceptions and meanings individuals associated with a particular phenomenon when utilizing a phenomenological approach. According to Van Manen (1990) a phenomenological approach is retrospective because participants are asked to recall past experiences related to a phenomenon they have lived through. I sought to understand collectively, the lived experiences of African American Christian senior pastors in relation to mental health treatment and the meanings associated with these experiences. Of the five qualitative approaches, phenomenology was most appropriate because of its focuses on the human experience and how an individual senses the world (see Van Manen, 1990). Previous studies (Broman, 2012; Allen et al., 2010) identified African Americans not fitting into the majority of persons

utilizing mental health services because of personal history and experience; therefore, a phenomenological approach allows me to explore the personal and subject encounters of African American Christian senior pastors in relation to mental health treatment and how support is given to congregants when support is sought through the church. An exploratory approach was needed for listening to the senior pastors and their lived experiences. A phenomenological approach allows for researchers to "describe and reveal the meanings of the human experience" (Rudestam & Newton, 2007, p. 39). utilizing the language and knowledge of the participant.

The phenomenological approach gave me the opportunity to gain a clear, comprehensive description of the phenomenon from the senior pastor's perspective. According to Moustakas (1994) experiences can be explored and interpreted with the use of a phenomenology for understanding the meaning or essences of a phenomenon, which is why this approach is appropriate. The five qualitative approaches utilize similar strategies and processes for data collection and analysis (see Creswell, 2013), but only a phenomenological approach gives me an in-depth explanation from the participant on their lived experience. I sought to understand the meanings and essences associated to a specific phenomenon; therefore, a phenomenological approach was most suitable for this qualitative study. I had the opportunity to collect thick rich descriptions for understanding the senior pastors' personal meanings associated with mental health treatment. Each of the qualitative approaches are effective when conducting qualitative research; however, for my study a phenomenological approach was best suited for answering the research questions.

Role of the Researcher

As the researcher, it was important I understood my role during the research process. According to Van Manen (1990) there is a fine balance between objectivity and subjectivity when conducting research from a qualitative perspective. As an objective researcher I remained true to what was presented by the participant; whereas, being subjective meant I was insightful in my perceptions when creating rich, textural meanings from the data collected from the participants during data analysis. In this section I explain further my role as the researcher.

My Role

In qualitative research the researcher is instrumental to a study because they collect data, examine documents, observe behavior, and interview participants (Creswell, 2013, p. 45). For this study I was a key instrument because I collected data with the use of interviews, observed the behavior of participants during interviews, transcribed interview notes, and analyzed data. As an instrument in data collection, I was to suspend my biases in order to decrease my level of impact on data analysis. For managing my bias, I utilized bracketing for remaining focused on the data. Bracketing is used for phenomenological reduction when searching for commonalities in meanings and experiences between the participants surrounding the phenomenon of study (see Moustakas, 1994). When bracketing one is to consciously or deliberately focus on the phenomenon being experienced by the participant for understanding what the phenomenon is like for them (Moustakas, 1994). The intentional focus on the phenomenon allowed me to see how participants experienced and associated meaning

(Moustakas, 1994). I was continuously "looking and noticing" (Moustakas, 1994, p. 93) what the experiences were for the participant for understanding the full meaning of the phenomenon for the participant.

My direct contact with participants and the data allowed me to grasp the meaning of the phenomenon and what it was like for the participants. It was from this reduction that I had the opportunity to suspend or set aside my thoughts or beliefs for focusing on the reality of the participant's world surrounding the phenomenon (see Van Manen, 1990). While on the data, I did not allow my past knowledge to engage in the process of analysis for influencing the present information collected from the participants (see Giorgi, 2009). The process of bracketing allowed me to focus on what was in front of me for understanding the experiences of participants, and not what I had experienced for understanding the experiences of participants. I did not use my experiences for understanding the participants' experiences (see Giorgi, 2009). My perceptions, descriptions, and meanings developed from the data collected from the participant (see Moustakas, 1994). This is how I balanced being objective and subjective during data analysis for discovering the meanings and essences of the experience (see Moustakas, 1994). My goal was to identify and understand the senior pastors' meanings individually and collectively for the experienced phenomenon. It was about understanding how the senior pastors made meaning of these experiences. Ultimately this happened by existing in the world of the participant for understanding the experiences and meanings associated with the phenomenon (see Van Manen, 1990).

As an instrument, I fulfilled the role of observer while collecting data from the participants during the interview process with the use of recording equipment and an interview protocol form. Van Manen (1990) explained observation is crucial to qualitative studies because the researcher is observing the verbal and nonverbal behaviors of participants, as well as their own behavior during the research process. As observer, I used the Speaker/Listener technique for keeping the interview on topic. I completed researcher notes on the interview protocol form. My advanced counseling skills allowed me to follow-up participant statements with clarifying questions for ensuring the participants were answering the interview questions. If more information was needed, or if the participant did not fully understand the question I asked follow-up questions. An example of a few of the follow-up questions are listed below.

- Can you tell me more?
- Can you give me an example?
- Is there more you would like to share?

Good interviewers are to be good listeners for giving participants the opportunity to speak without frequent interruption from the researcher (see Creswell, 2013).

As the observer and instrument for data collection I revealed any personal and professional relationships with participants for addressing issues of conflict. I informed participants as needed that I was a member of the gatekeeper's church and the role they fulfilled for this study. This study utilized African American Christian senior pastors from a ministerial organization, and I was introduced to this group by the gatekeeper. The

gatekeeper was a member of the ministerial organization; therefore, they did not participate in the study. The gatekeeper explained their during an open meeting.

with the senior pastors affiliated with the ministerial organization.

After identifying participants from the ministerial organization and outside of the organization, I began conducting 30 to 60 minute face-to-face semi-structured interviews with participants at an agreed upon location with the participant, such as their church office for increasing levels of comfort while participating in this study. Follow-up interviews or phone calls were scheduled as needed with participants during the data collection and analysis stage of this study. For avoiding bias and power relationships I was: (a) clear about my intentions for this study, (b) informed participants about this study, (c) did not have participants remain on site for the interviews longer than required, and (d) offered participants the opportunity to express any concerns they had about me, this study, or the interview site. If there were any senior pastors who were a part of the group that I had personal relationships with, I excluded them from the study for avoiding a conflict of interest or power differentials during the interview process. According to Van Manen (1990) qualitative research hinges on credibility; therefore, my skill, competence, and rigor were efficient and effective as the instrument of research.

Ethical Issues

Patton (2002) discussed the use of an ethical issues checklist outlining areas related to research design, data collection, and analysis. I utilized the 10 item checklist outlined by Patton for ensuring credibility and minimizing ethical issues. A checklist is the starting point for researchers for addressing concerns related to qualitative studies.

The 10 checklist areas are: (a) explaining the purpose, (b) addressing promises and reciprocity to participants, (c) evaluating the risks for participants, (d) establishing confidentiality and/or anonymity, (e) types of informed consent, (f) data access and ownership of data, (g) interviewer mental health, (h) advice or researcher's confidant, (i) the boundaries of data collection, and (j) ethical versus legal issues (Patton, 2002, p. 408-409). The issues were reviewed with participants at the beginning of the interview prior to the completion of the informed consent form. The ten areas addressed any ethical issues during this qualitative study. The ethical issues checklist is in Appendix C.

A flyer was sent to the ministerial organization briefly discussing this study's purpose. The flyer included the four criterion questions and my contact information for interested participants. During an open meeting the gatekeeper shared additional copies of the flyer with the ministerial group meeting for recruitment; hence, the need for disclosure of our relationship and their nonparticipation in the study. The gatekeeper reviewed the details on the flyer with the ministerial group but directed all questions to me regarding this study with the contact information listed on the flyer. When interested participants contacted me I reviewed the four criterion questions, discussed the purpose of this study and the interview process. I made participants aware of my role as the researcher for collecting and analyzing data, the role of Walden's Institutional Review Board (IRB) when working with human subjects during a study, and the role of my dissertation committee for peer debriefing for establishing informed consent. Each of these items addressed the ethical issues identified for this qualitative study in Appendix C.

Methodology

Several factors were examined in the development of the methodology. The four factors are participants, instrumentation, data collection, and data analysis. Each area was given considerable thought during research plan development because every aspect of the methodology is to align with the research questions. The specifics of each area is outlined in this section.

Participants

This study focused on the African American Christian senior pastor. This specific group in the Black Church was identified because of their leadership role as gatekeeper in the church and the African American community, referral behaviors, and their lived experiences with mental health treatment. There are no specific rules regarding sample size when conducting qualitative research (see Moustakas, 1994); however, because this is a phenomenology it was important to identify participants with thick rich experiences surrounding the phenomenon. Studying a small number of participants for a period of time surrounding the phenomenon of interest allowed me to understand the experiences of participants because they are the expert on the phenomenon (see Rudestam & Newton, 2007). The selection of participants was based upon their lived experiences with mental health treatment and how their experiences influenced the assistance provided to congregants seeking mental health support through the church. The Christian senior pastor population is large; however, the focus was narrowed to the African American Christian senior pastor for understanding a specific group within the community and church leadership. For further narrowing the identified population, I chose a specific

group within a northern county located in the state of Michigan for accessing participants. The ministerial organization was made up of over 150 African American Christian senior pastors. The ministerial group was well-suited for the study because of the diversity of the group regarding age, gender, and denomination affiliation. The ministerial organization consisted of clergy from local predominately African American churches within the northern county.

Sampling Strategy

First a flyer was sent to the ministerial organization with a brief overview of this study. The gatekeeper reviewed the flyer with the senior pastors and clarified their role as the gatekeeper for recruiting participants for this study. The gatekeeper disclosed the nature of our relationship because I was a congregant of the church. The gatekeeper explained to the senior pastors that they were not participating in this study or have access to any of the information related to this study. The gatekeeper reviewed my contact information for interested participants for speaking with me directly regarding questions related to this study. If senior pastors were interested in participating in this study, they were to contact me directly with the information listed on the flyer.

The flyer included four criterion questions for participants to self-identify as appropriate participants for this study. Each volunteer participant was asked the same four criterion questions by me before scheduling the initial interview for identifying appropriateness for participating in this study. A brief overview was given of the interview process and how I could be contacted if there were concerns or questions. Once appropriateness of participation was determined I scheduled the initial interview at a

location convenient for the participant (i.e. the senior pastor's office). All participants were informed that all information collected during the interview process remained anonymous for preserving the participant's identity.

Participants were purposefully selected based upon the four criterion questions for data collection until the point of saturation was met. The four criterion selection questions used are as follows:

- Are you African American?
- Are you Christian?
- Are you the senior pastor of the church?
- Have you ever provided counseling to congregants?

The participants should have knowledge and/or experiences with the phenomenon being studied (see Moustakas, 1994); hence, the use of selection criteria questions for identifying suitable participants for this study. After volunteers were purposefully selected data collection began. Purposeful selection allowed me to collect information rich cases for this study. I wanted cases which were able to answer my research questions; hence, increasing the studies credibility (see Van Manen, 1990; Moustakas, 1994). Before the interview began, participants completed informed consent forms permitting the use of handwritten notes, and digital recording of the interviews for data collection. Informed consent took place after I briefly reviewed the purpose of this study. The completion of informed consent forms by the participants established an explicit acknowledgement of what the study was, my role as researcher, their role as participant, and the requirements for this study. The informed consent established full disclosure and

demonstrated my ethical principles and practices for this study while working with human participants (see Moustakas, 1994). The informed consent form is listed in Appendix D.

Once the informed consent was completed, the data collection phase began with face-to-face interviews with participants. The interviews were informal and interactive for creating a comfortable environment for the participant (see Moustakas, 1994). The maximum number of participants was identified at 10, but this number could change based upon the point of saturation being met during the data collection phase. It was explained by Rudestam and Newton (2007) a heterogenous group consisting of a small number of participants (10 or fewer) was appropriate for phenomenological studies. For this study there was a range of 3 to 10 participants because the study could reach the point of saturation with a small or large number of participants. When no new information is collected from the sample and redundancy occurs, then the study has reached the point of saturation allowing for the data collection phase to conclude (see Rudestam & Newton, 2007). Data collection ended when the point of saturation was met with 6 participants.

Eleven interview questions were developed from the main research question and three sub-questions. Interview questions 1 and 2 were designed for answering the main research question. Interview questions 4, 5, and 8 were designed for answering sub-question 1. Interview questions 3, 9, 10, and 11 were designed for answering sub-question 2. Lastly, interview questions 6 and 7 were designed for answering sub-question 3. The research questions guided this study and the interview questions were aligned for

collecting thick rich descriptions for answering the research questions. I interviewed participants until saturation was met with 6 participants. No new information was collected from the 6 participants and redundancy occurred with the information shared by participants. I concluded the data collection phase and moved on to data analysis once saturation was met.

Open-ended questions focusing on the experiences, attitudes, and beliefs in relation to mental health were used with the senior pastors during semi-structured 30 to 60 minute face-to-face interview sessions. The level of information shared by the participant determined if a larger number of participants was needed for data collection in order to reach the point of saturation. As previously stated, saturation involves reaching the point where no further information is needed for fully developing a study (see Rudestam & Newton, 2007). I met saturation with 6 participants.

Instrumentation

Phenomenological studies primarily utilize in-depth interviews as sources for data collection because participants are describing their experiences surrounding the phenomenon (see Moustakas, 1994). For this study, I was exploring the senior pastors experiences in participating and/or rendering treatment, their perceptions of what mental health treatment was, and how or if they referred congregants to formal treatment. Each interview utilized a combination of three instruments for data collection: (a) the interview protocol form, (b) researcher notes, and (c) a recording device. I was the instrument conducting 30 to 60 minute face-to-face semi-structured interviews for exploring these areas with the participants. As the instrument for data collection, information was

included about me for increasing credibility; hence, the use of researcher notes. The researcher notes increased my awareness of personal and professional areas that could affect data collection and data analysis. Utilizing researcher notes during data collection allowed me to generate early insights when data analysis began. The researcher notes assisted me when there were any recording malfunctions during the interview.

A greater understanding was being sought about African American Christian senior pastors' lived experiences with mental health treatment, beliefs, attitudes, messages, referral behaviors, and ability to assist congregants. The semi-structured interviews allowed for data to be collected on the beliefs, experiences, opinions, feelings, and knowledge about mental health treatment and how these elements influenced their ability to respond to the mental health needs of congregants seeking counseling through the church. Telephone, face-to-face, and focus groups are the different types of interviews a researcher can utilize, and it is the researcher that selects the most appropriate form of interview based upon the forum which will render the most useful information for answering the research question (see Rudestam & Newton, 2007).

Face-to-face interviews were selected for this study for several reasons. First, interviews allowed data collection to occur in the field where the participant experienced the phenomenon (see Moustakas, 1994). This approach allowed participants to be understood through engagement in their natural settings during the interview process (see Moustakas, 1994); therefore, the interviews took place at a convenient location for the participant. Secondly, with face-to-face interviews I had the opportunity to collect data directly from the participant through engagement, which is advantageous when

conducting qualitative research because researchers can control the line of questioning for eliciting responses related to the participants' personal views and opinions on the phenomenon (see Giorgi, 2009). I collected data utilizing an interview protocol form for ensuring each participant was asked the same question in the same order. And last, the use of semi-structured face-to-face interviews allowed me to build a repoire with the participants for establishing trust and credibility because I was engaging and not only observing the participants in their natural setting.

Face-to-face meetings allowed me to review informed consent with the participant for creating a safe and comfortable space for them to feel relaxed with sharing their story with me because of the use of recording equipment and note taking. I utilized a portable digital voice recorder for recording interviews with participants. The Philips Digital Voice Tracer DVT 2710 recording device had the capability of recording the interviewer and the interviewee through different microphones for easily deciphering the individuals speaking. This recording feature was tested before data collection for gauging the adequacy of the devices capabilities for voice recordings. Interviews allowed for interaction, engagement, and observation of the participants surrounding the phenomenon; hence, the selection of this form of data collection for this study.

Interviews are just one of three ways researchers collect data when conducting qualitative research. Patton (2002) explained that the three forms of data collection involve the use of "in-depth open interviews, direct observation, and written documents" (p. 4). The purpose of this study was best suited with the use of interviews because I sought to identify themes, patterns, understandings, and insights of the senior pastors'

lived experiences surrounding mental health treatment and how it has prompted their actions when counseling congregants. The data collected from the semi-structured interviews assisted me in developing themes, patterns, understandings, and insights of the senior pastor in relation to mental health treatment. I obtained "concrete descriptions" (Giorgi, 2009, p.96) of the experiences directly from participants. With the use of interviews, I was able to engage and interact with the senior pastor for exploring and understanding the meanings associated with experiences surrounding mental health treatment.

I used an interview protocol form for collecting data during the semi-structured interview. I utilized the interview protocol form for recording participant responses and comments to interview questions and recording researcher notes of (see Creswell, 2013). The sample interview protocol form listed by Creswell (2013) was utilized for this study. The interview protocol form included the date, time, location, interviewee's initials, and interview questions. The interview protocol form assisted me in keeping the interview focused on the participant and their lived experiences with mental health treatment. The interview protocol form for this study can be found in Appendix B.

The interview protocol form listed questions explored with the participant during the interview. Each participant had the same standard of questions because the questions were designed for answering the research questions. Open-ended interview questions were created based upon the concepts being studied. The goal was to align the research questions, sub-questions, and interview questions with the research design; hence, increasing the credibility of this study. The same questions given to participants in the

same order allowed me to easily locate each participant's responses to the same question for quickly organizing questions and answers that were similar during the analysis phase (Patton, 2002, p. 346). The interview questions were designed to align with the research questions for understanding the phenomenon allowing me to gain a deeper understanding of the African American Christian senior pastors experiences, perceptions, and behaviors related to mental health treatment. The alignment of questions is listed below in Table 1. This method allows others to precisely review my steps for verifying findings from this study.

Table 1

Interview Question Sequence

Interview question	Research question
1, 2	Primary research question
4,5,8	Sub-question 1
3,9,10,11	Sub-question 2
6,7	Sub-question 3

The interview protocol form allowed me to sequence the questions for collecting in-depth meaningful responses as the interview progressed for encouraging the participant to talk and share their experiences, feelings, opinions, and knowledge in relation to mental health treatment (see Patton, 2002). The interview questions were open-ended allowing for large amounts of data to be collected; however, follow-up questions were used by me for clarifying information. Follow-up questions were used

when more information was needed, or if the participant did not fully understand the question. A few of the follow-up questions included:

- Can you give me more?
- Can you give me an example?
- Is there more you would like to share?

Follow-up questions have been found to be effective and a useful technique when interviewing participants (Laureate Education, Inc., 2010c). The interview questions and probing follow-up questions allowed me to gain a better understanding of the senior pastor's lived experiences in relation to mental health treatment. The interview questions allowed me to see how the participant's experiences were similar yet different.

The interview questions were developed based upon my personal interest in understanding African American Christian senior pastors, and the need for understanding their lived experiences with mental health treatment. Based upon the information gained from the literature reviewed it was my goal to develop questions which aligned with the research question I was seeking to answer. The interview questions were developed from the research questions for providing the data needed for identifying themes and patterns from the senior pastors lived experiences. According to Moustakas (1994) the research questions for phenomenological research are formulated by an "intense interest in a particular problem or topic" and "the researcher's excitement and curiosity" (p. 104). Since I was conducting my first research study the use of the interview protocol form combined with my counseling skills allowed me to gain meaningful information on the

participant's lived experiences in relation to mental health treatment, while also remaining clear, concise, focused and on task in my intentions for this study.

The interview questions were a combination of what and how questions for eliciting in-depth responses from participants for sharing their lived experiences with mental health treatment. The open-ended questions used non-directional exploratory verbs for increasing depth in the responses elicited from the participant (see Creswell, 2009). The questions were developed and arranged in a hierarchical order for personal reflection and depth. The questions were created for understanding the experiences of the participant regarding their beliefs and attitudes, experiences, understanding of mental health treatment, and faith; therefore, a variety of interview questions were used. The questions were made up of basic, descriptive, big-picture questions, and follow-up questions as needed for clarifying the participant's responses (see Janesick, 2011). All of the questions were not asked depending upon the type and level of information the participant shared during the interview. When the participant answered a question without prompting then the question was not asked; however, a follow-up question was used for increasing depth or for clarification purposes to previously answered questions. According to Janesick (2011) the different types of interview questions allowed me to gain various responses from participants while also allowing them to share their stories with me during the interview. Phenomenological studies primarily utilize in-depth interviews as sources for data collection because participants are describing their experiences surrounding the phenomenon; hence, its selection for this study.

The Philips Digital Voice Tracer DVT 2710 recording device was used for audiotaping the interviews for ensuring accuracy of transcripts during the data analysis phase. Audiotaping allows researchers to have an alternate form of recording in the event the researcher notes or interview protocol forms are incomplete due to the difficulty of writing the participant's answers quickly and remaining a good listener during the interview (see Rudestam & Newton, 2007). Additionally, recordings allow for an increase in accuracy of transcripts when participants are given the option to review the transcripts.

The interviews took place until the point of saturation was met. Two interviews per week were scheduled for permitting time for transcription between interviews. I scheduled all interviews in groups of two throughout the data collection phase. Participants were made aware at the initial interview of possible follow-up interviews during the data collection phase if further clarification was needed on interview responses. Participants understood and were willing to meet for follow-ups or phone calls as needed. The interview process during the data collection phase ended when no new information was collected from participants. Data collection ended after three weeks because the point of saturation was met with 6 participants. At the conclusion of the interview participants were given a referral list of local mental health agencies if any mental health related issues or concerns presented at the conclusion of the study. Participants were reminded at the end of each interview additional follow-up interviews would be scheduled as needed if further information was needed during data analysis .

For this study follow-up interviews were scheduled as needed during data analysis. Step two of data analysis involved classifying the data as themes or meaning units. It was during the data analysis stage that follow-up interviews would be scheduled with participants for one of three reasons. First, follow-up interviews were scheduled if more information was needed from the participant; secondly, if clarification was needed on the information collected from the participant; or lastly, if the participant needed to confirm the accuracy of the meaning or theme I identified. I called the participants as needed for follow-up meetings for completing step two for classifying the data. The interview question(s) needing more information for classifying the data were used for guiding the follow-up meeting. I utilized member checking by reflecting the participant's response for ensuring accuracy of the information shared during the call. The interview protocol form was used for note taking, an all information was hand recorded, and filed in the correlating participant's folder. At the end of the follow-up call I reminded the participant that additional interviews would be needed if additional information was needed for completing the data analysis process. For this study, I followed up with 3 participants on the phone for reviewing and collecting demographic information.

Data Analysis

The analysis of data can be challenging when conducting qualitative research; therefore, researchers need to have outlined steps for analyzing multiple sources of data (see Giorgi, 2009). The data analysis process utilized the senior pastor's direct quotes, personal experiences, opinions, feelings, and knowledge collected from the interview for extrapolating the meaning associated with the participant's history and experiences with

mental health because concrete and detailed descriptions were needed for understanding the phenomenon (see Giorgi, 2009). I discussed with participants their lived experiences, beliefs, and perceptions about mental health treatment and the influence it had upon their ability to respond to the mental health needs of congregants seeking counsel through the church. For this study three strategies were implemented for outlining the data analysis process: (a) the preparation and organization of data, (b) classifying data for developing themes, and (c) representing the data (see Creswell, 2013).

Preparation and Organization

The preparation and organization step began with the transcription of audio recordings from the interviews, then transcription of the interview protocol form and researcher notes. I placed transcripts placed into the designated Senior Pastor folder. Each participant had a folder which included the transcripts of each of the previously noted items. For example, participant one was identified as SP 1 and notes related to SP 1 were placed into this folder. This process took place with each participant after the interview concluded. The numerical classification assisted me with identifying data collected for each participant. All documents were stored on a password protected personal computer and backed up on a flash drive. After completing this process, I moved to classifying the data.

Classification of Data

The second step in the data analysis process is the classification of data for the development of themes or meaning units. The data analysis during this stage followed the steps outlined by Giorgi (2009). This process began with me reading and then rereading

the transcripts 1-2 more times for gaining a sense of the phenomenon described by the participant. After thoroughly reviewing the transcripts I broke down the larger descriptions into smaller parts for identifying themes or meaning units. I reviewed the transcript line by line for identifying significant statements for classifying themes or meanings. All information was relevant during this process and given equal value during the coding process because it assisted me in identifying detailed descriptions for developing themes (see Moustakas, 1994). Next, I looked for descriptions which were similar and made a mark too keep the meaning unit together. Each time I identified a new meaning I marked it separately from the previous meaning unit. The markings allowed me to create large and small categories for identifying meaning units which were used as a step for developing themes (see Moustakas, 1994; Giorgi, 2009). Once the document was read completely through the full descriptions were broken into smaller meaning units or themes. As the units were identified I utilized color coding and memo writing in the margins of the transcript for outlining initial thoughts and themes. The researcher notes and interview protocol form notes were incorporated into this process for assisting with the organization of data. After reviewing the document multiple times for the identification of non-repeating non-overlapping statements, and verbatim quotes of the participants I began clustering statements for emerging themes. The themes were made up of broad categories consisting of several smaller groupings for forming a shared idea (see Giorgi, 2009).

Next a grid was made which consisted of three columns for classifying the data. Column 1 consisted of the participants exact words written in 3rd person. The third person

account allowed me to see my analysis of the participant's description (see Giorgi, 2009). Column 2 gave a more specific meaning or theme of the phenomenon based upon the participant's description. Column 3 reflected an initial meaning unit or theme related to the phenomenon being studied. This was a general meaning associated with the description given by the participant. The third column allowed me to identify common points experienced by the participants. The third column referenced similarities in text between the participants. Again, the meaning was based upon the participant's description, but written from my perspective. The columns were used in the grid for discerning my perspective from the participant's perspective when completing the data analysis (Giorgi, 2009). See Table 2 below for the grid example for participants.

Table 2

SP Meaning Unit

Meaning Unit (MU)	Theme/Meaning	General Description
Participant's exact description written in 3rd person for MU 1	Specific meaning unit/theme of the phenomenon related to participant(s)	A broad/general meaning theme of the description given by the participant
MU 2 Participant's exact description written in 3rd person for MU 2	Specific meaning unit/theme of the phenomenon related to participant(s)	A broad/general meaning theme of the description given by the participant
MU 3 Participant's exact description written in 3rd person for MU 3	Specific meaning unit/theme of the phenomenon related to participant(s)	A broad/general meaning theme of the description given by the participant

The themes or units assisted me in focusing on parts in order to complete a detailed analysis on the entire description (see Giorgi, 2009). It was my job to understand how participants experienced the phenomenon based upon the descriptions given during the

interview. The meaning mattered most and not only the words used to express the experience (see Giorgi, 2009). This process allowed me to examine things in a new way causing me to see what was presented before me without allowing my experiences to hinder the analysis process. This in its simplest terms is known as the Epoché .

As themes and sub-themes formed I created categories supporting correlating statements from the data collected from participants. I utilized written descriptions of what the participants experienced for identifying textural descriptions. This involved the use of verbatim examples from the participants for offering textural descriptions of the participant's experiences and meanings associated with the phenomenon. The textural descriptions were details of *what happened* when the participant experienced the phenomenon. Structural descriptions were used for sharing how the experience happened offering a context in how the phenomenon was experienced in different settings. The participant's experiences and the framework of those experiences were grouped together in the identified theme area offering descriptions of the essence of the phenomenon (see Moustakas, 1994; Giorgi, 2009). The textural and structural descriptions assisted me in identifying the essence of the experiences and meanings made of the experiences by the participants.

Representing the Data

I used member checking for representing the data. I reviewed participant responses during the interview for accuracy in understanding their responses to the interview question. The accuracy of what was shared by the participant was "critical for establishing credibility" (Creswell, 2013, p. 252) for this qualitative study. Member

checking assisted me in ensuring that the participant was focused on the experience related to the phenomenon (see Giorgi, 2009). Member checking also assisted me in keeping the interview on track. If there were inaccuracies, I allowed participants to clarify their response, and then followed-up by reflecting what I heard for ensuring accuracy in the information shared by the participant. After member checking each response given by the participant I proceeded to the next interview question until all of the questions had been answered on the interview protocol form. Once I completed the three strategies: (a) the preparation and organization of data, (b) classifying data for developing themes, and (c) representing the data I concluded the data analysis phase of the study. I then began writing Chapter 4 for sharing the results of the study.

Trustworthiness

In qualitative research trustworthiness is the process for validating the research. The validity of qualitative research involved me checking for accuracy of the findings, as well as my research approach for this study with the usage of specific strategies, techniques, or procedures (see Moustakas, 1994). According to Creswell (2013) trustworthiness is validated when credibility, transferability, dependability, and confirmability are established. For this study the term trustworthiness is used for establishing the validity of this study. The application of specific methods and strategies allows for this study to be duplicated and its findings verified (see Giorgi, 2009).

The use of multiple strategies is recommended when checking for internal and external accuracy of a study; hence, the selection of several strategies, techniques, or procedures for guiding this study (see Moustakas, 1994). The internal accuracy of the

findings was established with the use of member checking and the use of researcher notes. The member checking established the study's credibility because participant interview responses were reviewed during the interview for ensuring accuracy in what the participant was stating about the phenomenon. This assisted in establishing a relationship between the researcher, the participant, and the data collected. The internal accuracy was established with memo notes. My memo notes allowed me to share initial thoughts, experiences, biases, and assumptions related to the phenomenon, while member checking offered participants the opportunity to expand their description of the experience if I was unclear in what was stated by the participant (see Giorgi, 2009). The interview protocol form is related to the internal accuracy of this study because the transcripts were transcribed from the responses and comments given by the participants during the semi-structured interviews and follow-up calls. The transcripts, notes, and interview protocol form contained rick, thick descriptions for demonstrating the similar yet different experiences of the participants for establishing transferability.

The external accuracy of this study was established with the usage of IRB guidelines and the Counselor Education and Supervision (CES) dissertation guidelines. Dr. K. Cannon the committee chair, Dr. K. Peoples the methodologist, and Dr. G. Gray the university assigned reviewer were the individuals to ask me difficult questions about the methodology, findings, meanings, and interpretations made from the lived experiences of the participants in relation to the phenomenon. In addition to the dissertation committee and the URR, I utilized an external auditor for reviewing the accuracy of the procedures, methods, and data analysis for establishing trustworthiness.

The external auditor reviewed the procedures for clear, consistent practices with each participant for establishing credibility and validity of the research. The auditor reviewed the preliminary findings, asked questions about participant summary information, and gave feedback after reviewing the results of the study. The procedures, methods, and findings are all connected for this study because I was checking and rechecking with self, the participants, and my peers for accuracy of the data collected. The checking and rechecking of materials established confirmability. The use of multiple and different sources allowed me to establish the trustworthiness of this study in its procedures and findings.

Ethical Procedures

Ethical procedures are necessary for qualitative studies because human subjects are used for data collection. According to Rudestam and Newton (2007) ethical procedures and guidelines are intricate details, norms, and values the researcher is to consider prior to conducting qualitative research. The ethical considerations for participants and data for this qualitative study are outlined in this section.

Participants

Prior to conducting this study approval was needed by the URR before submitting an application of research with the IRB of Walden University. The IRB's purpose is to ensure ethical practices and protection of participants in research studies. The IRB evaluates risks to participants by evaluating proposed data collection methods of research studies. If proposed studies comply with ethical practices for human subjects, approval is given for research to be conducted. After gaining approval for research with human

subjects from the IRB, approval number 10-12-17-0316714 I began the data collection process of this study. It was assumed all participants volunteered to participate in this study with no compensation from me.

There was an expectation that no harm or undue risk would come to the participants during this study. If any mental health concerns presented for participants, they were to use the referral list of local mental health agencies given to them at the conclusion of the interview. Due to the nature of my relationship with the gatekeeper, and the use of participants from a local ministerial group, anonymity was given to participants for ensuring confidentiality. I utilized pseudonyms when analyzing the data or directly quoting participants for protecting their identity. Ensuring confidentiality protects the participant's identity and offers them the opportunity to fully disclose their experiences with me regarding the phenomenon (see Rudestam & Newton, 2007) as well as, not feel pressured to participate in this study by me, the gatekeeper, or fellow pastors. I discussed the risks and benefits with each participant at the beginning of the interview, and offered a referral list to local mental health agencies if follow-up was needed for participants concerning mental health issues. All statements were "simple, straightforward, and understandable" (Patton, 2002, p. 407) because participants needed to have a clear understanding of this study. It was important that all participants understood the purpose of this study and its risks (see Rudestam & Newton, 2007).

Five specific items were utilized in addition to the above mentioned information. They are listed below:

- I will do no harm by adhering to the American Counseling Association (ACA) ethical codes as a practicing counselor.
- I will comply with Walden's IRB policies and procedures.
- For safeguarding the participant's well-being, I will protect the identity of participants with the use of pseudonyms when reporting the data collected from participants during the interview process.
- Participants will complete informed consent forms prior to beginning the interview with the understanding that they have the right to continue or discontinue participation in this study if a conflict arises leading to the withdrawal of the participant from this study. If a conflict does arise I will discuss the event with the dissertation committee members for advisement on the steps for stabilizing the situation before the participant withdraws from this study. In the event the conflict is serious I will remove the participant from this study.
- For ensuring a balance of power during this study participants will be made aware during our initial phone call of my relationship with the gatekeeper for understanding their role and the nature of our relationship, my role as researcher, and the individual's role as participant. This allows the participant to choose of their own free will their participation in this study after full disclosure.

Data

I used a locked file cabinet for storing and protecting participant recordings and documents. All recordings and documents utilized pseudonyms for participants for preserving their identity. No other persons had access to the confidential documents or recordings stored in the locked file cabinet. After transcription, all files were uploaded and stored on a password protected computer with back-ups stored on a flash drive and external hard drive which was also password protected and secured in a locked file. No other persons had access to the password protected computer. All data is maintained for five years after the completion of this study, and then destroyed. I believe based upon the research questions, philosophical framework, recruitment strategies, research methodology, and ethical practices this phenomenological study is sound in practice for ensuring the protection of the data and the safety of the participants.

Summary

Chapter 3 discussed the qualitative methods employed for this phenomenological study. The chapter began with discussing the research design and rationale in its selection for this study. The purpose of the study was restated followed by a discussion of the research tradition and the research questions. The chapter also discussed my role as the researcher and instrument for data collection, and the ethical considerations I was to be aware of as an instrument. The next section outlined the specifics of the methodology focusing on the participants and site, the sampling strategy and sample size, the use of semi-structured interviews for data collection, and the strategies employed during the data analysis process. The fourth section discussed the strategies implemented for

establishing trustworthiness and the strategies employed for establishing internal and external accuracy for this qualitative study. The last section discussed the ethical considerations related to the safety of participants and the storage of data for this study.

In the next chapter I will discuss the findings of this study. Chapter 4 offers a description on the purpose of this study, the demographics of the participants, the data collected from the interviews, the analysis of the data, demonstrate evidence of trustworthiness, and the results of this study.

Chapter 4: Results

Introduction

The purpose of this transcendental phenomenological study was to explore the lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance they provide to congregants seeking mental health support. This approach allowed me to explore the human experiences of senior pastors by focusing on whole experiences and not singular parts, which permitted me to identify the meanings and essences associated with their experiences (see Moustakas, 1994). In the data from this phenomenological study, I identified three main themes with 14 sub-themes after collecting information from six African American Christian senior pastors. The following main research question and three sub-questions guided the qualitative study.

Research Question and Sub-Questions

I developed the following research question to guide this study: What are the lived experiences of the African American Christian senior pastor in relation to providing mental health treatment to congregants?

From this question, I developed the following sub-questions:

a. How do senior pastors make meaning of experiences helping congregants seeking counseling through the church?
b. What are the senior pastor's personal experiences with mental health treatment?

c. What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?

In this chapter, I discuss the strategies used for recruiting participants, the interview settings, data collection and analysis, and the results of the study.

Recruitment

I recruited participants from a ministerial organization in a city in a northern county in Michigan after receiving approval from Walden University's Institutional Review Board (IRB) to conduct the study (IRB approval number 10-12-17-0316714). After receiving this notification from Walden's IRB, I contacted a local minister who served as gatekeeper to the ministerial organization. I submitted participant flyers to this minister for distribution at a ministerial meeting. The gatekeeper agreed to share the flyers with the senior pastors at the appropriate stage of recruitment. The flyer included a brief introduction to the study, the four criteria questions for the study, and my contact information so that participants could speak with me regarding any interest or questions about the phenomenological study.

The flyer information was shared with the ministerial organization on the second Tuesday in November 2017 during their scheduled monthly meeting. The data collection phase began in December 2017 with semi-structured face-to-face recorded interviews. One participant from the ministerial organization participated in the study. The other five participants were enlisted in the study because of word of mouth about the study from members of the organization and affiliates of the organization. The participants contacted me using the information listed on the flyer and stated who they

were and how they learned of the study. After the interested participant shared their information with me, I then used the four criteria questions to determine their appropriateness for participating in the study. After determining the participant was appropriate for the study, I scheduled a face-to-face interview. Five of the 6 participants scheduled interviews in their church offices. This allowed each participant to feel comfortable in their setting during the interview process. The participants reported no levels of distress before, during, or after our times of contact; therefore, I assumed the participants' comfort levels in their personal surroundings allowed me to collect thick, rich descriptions of their lived experiences. The sixth participant spoke with me over the phone during a time that was convenient for them.

Demographics

The study consisted of six participants, 5 men and 1 woman. The ages of participants ranged from 28 to 68 years old. Each participant served as the senior pastor of their church with pastoral leadership experience ranging from 8 months to 40 years. Five of the participants resided in Michigan and one participant lived in Virginia. Four of the senior pastors led churches in the Baptist denomination, and two led churches in the Church of God in Christ (COGIC) denomination. The membership size of their churches ranged from 60 to 1,100 congregants. Each of the pastors rendered counseling to their congregants ranging from 2 to 10 hours per week (See Table 3 for individual participant demographics with pseudonyms).

Table 3

Participant Demographics

Participant	Age	Years of Experience	Denomination	Membership	Counseling/Wk
SP 1	40	14	Baptist	1100	7
SP 2	28	8 months	Baptist	60	10
SP 3	62	10	Baptist	300	2
SP 4	68	40	Baptist	300	4-6
SP 5	59	23	COGIC	150	10
SP 6	59	17	COGIC	100	4

Note. SP = Senior pastor.

Data Collection

I conducted face-to-face semi-structured recorded interviews with five participants. Due to the location of one participant, I used a recorded phone interview for data collection. This phone interview took place from my home office during a time when the participant was available to speak in a quiet space to minimize background noise. The five face-to-face interviews were held in each of the senior pastors' offices based upon their availability and level of comfort. Participant recruitment was modified because five of the 6 participants interested in the study were identified through word of mouth about the study from members of the organization and affiliates of the organization. One participant from the ministerial organization participated in this study; hence, the modification in the recruitment process. The semi-structured interviews with each participant ranged from 45 to 90 minutes with the average interview time being 60 minutes.

I recorded all interviews using a Phillips Digital VoiceTracer DVT 2710 audio recorder. I transcribed each interview using Dragon speech recognition software. After each automatic transcription was created, I listened to the recorded interview to correct

grammatical errors in each transcript. Microsoft Word folders were created for each participant with a SP (senior pastor) pseudonym and a number correlating to the participant's interview order during the data collection process. Each SP folder contains the interview transcript, demographics information, informed consent form, interview protocol form, and the participants' themes document with direct quotes. I utilized the interview protocol form (Appendix B) during the interviews to collect data from the participants and to take researcher notes. I developed the interview questions to answer the main research questions and three sub-questions of the phenomenological study. I took minimal notes during the interview in order to focus on the experiences shared by the participant. If clarification was needed on a participant's response, I made a notation underneath the correlating interview question; however, my focus was on listening and reflecting the messages heard from the participant about their experience. I took other minor notes on the interview protocol form related to the participant's initial presentation, non-verbal gestures, and personal observations of the participant. All notes, transcripts, and recordings were backed up and stored on my personal password protected laptop, and a USB drive stored in a locked file cabinet.

Participants contacted me expressing interest in the qualitative study. The initial contact took place over the phone, where I collected the participant's name, contact phone number, email address, and best available days and times for scheduling the interview. During the initial phone call, I reviewed the four criteria questions for the study and then scheduled the interview if the participant was appropriate for participating in the study. After scheduling the interview, I informed the participant that I would email

them two documents for their review prior to the interview meeting. The first document was the informed consent form and the second document was the demographics form. I explained to each participant that I would review the informed consent document before conducting the interview and we would then sign and date the form. I brought an extra copy of the informed consent form to each interview in the event the participant lost or misplaced the copy emailed to them prior to our meeting. I reviewed the demographics form for my clarification before beginning the interview.

The informed consent, demographics, and interview protocol forms were kept in a paper clipped file for keeping the participants' documents together until scanned and uploaded to my laptop. The out of state participant's informed consent and demographics forms were mailed and returned to me with their signature prior to the interview. I also reviewed the informed consent and demographics forms with the out of state participant prior to starting the interview to ensure their understanding and my accuracy in the information collected. During the initial phone call, I made all participants aware that I would use an interview protocol form for taking notes and a digital recorder for recording the interview. Each participant was comfortable with the instruments used and agreed to participate in the study.

I conducted the interviews over a 3-week period. I scheduled two interviews per week, allowing time for transcription between interviews. Each participant was made aware that a quiet environment was needed during the interview to decrease background noise on the interview recordings. Each participant selected a day and time to meet at their office which would allow for no interruption or background noise during the

interview. All participants were flexible with scheduling interviews; therefore, I met with participants during a variety of times from morning until evening, including weekdays and weekends. At the end of each interview, I explained that follow-up interviews would be necessary if I needed more information or if further explanation was needed on information shared during the interview process. Each participant agreed to this request and was willing to meet via face-to-face or telephone based upon the information needed for the follow-up interview. Three follow-up conversations were needed for background information only.

In-depth follow-up interviews were not required because the participants gave very thoughtful, reflective, and detailed responses to the interview questions. However, because basic background information was needed from three participants, I conducted brief follow-up phone conversations after the initial interview. I also used follow-up probing questions during the interview if more information was needed from the participant. In addition, I utilized member checking to ensure accuracy in the information collected from the participant. Before ending each interview, I gave each participant the opportunity to share any thoughts or feelings about the topic they felt were necessary for me to know that was not addressed during the interview. At the conclusion of each interview I offered the participant the opportunity to review their transcript once transcribed, but each participant declined reviewing the transcript. I also thanked each participant for their interest and willingness to participate in the study prior to concluding the interview.

Data Analysis

For understanding the essence of the experiences of the African American senior pastor semi-structured interviews were conducted for collecting data. Face-to-face semi-structured interviews allowed me to obtain concrete descriptions of the lived experiences of the participants (see Giorgi, 2009). I employed the phenomenological method by Giorgi during data analysis for identifying the themes and sub-themes related to the phenomenon being explored for this study.

Data analysis consisted of three strategies: (a) the preparation and organization of data, (b) classifying data for developing themes, and (c) representing the data (see Creswell, 2013). Strategy one was the preparation and organization of the data. For this step I transcribed the interviews and placed the transcripts into the correlating folder named Senior Pastor with designated participant order. The transcripts, demographics, and notes were organized and placed into the correlating folder named SP. Each participants' documents were placed into the folder associated with their given code of SP 1, SP 2, SP 3, SP 4, SP 5, and SP 6.

The second strategy involved classifying the data for developing themes and meaning units. For classifying the data, I read each transcript line by line, and then reread each transcript for identifying large themes and meaning units related to the phenomenon. After reviewing each transcript line by line, I wrote memos in the margins for identifying larger developing themes next to significant statements made by the participant. I marked significant statements in each transcript for identifying meaning units, then underlined and highlighted statements throughout the document with different color markers

correlating to the developing theme or meaning unit. Each marker color was associated to a specific theme or meaning unit of the phenomenon. The same process was utilized for each participant's transcript for ensuring trustworthiness of the study. This strategy of classification allowed me to sort and arrange the data for keeping the data organized.

Next, a grid was created for classifying the data. The grid was made up of three columns. In column 1 the participant's exact words were placed. In column 2 the specific theme or meaning unit of the phenomenon was placed in relation to the participant's words. In column 3 the general description or a broad general theme or meaning unit was placed in relation to the description given by the participant. The grid allowed me to separate my perspective from the participant's perspective while completing the data analysis (see Giorgi, 2009). This entire process allowed me to examine the data in a new way, permitting me to see what was presented without allowing my experiences to hinder the analysis process. I also utilized textural and structural descriptions for offering a context in how the phenomenon was experienced by the participants in different settings. The textural descriptions and structural descriptions were summaries formulated by me based upon the participants' lived experiences as senior pastor for developing themes and sub-themes. The summaries were reinforced by the exact words of the participant describing their lived experiences as senior pastors. The descriptions allowed me to identify the essence and meaning of the experiences by the participants.

Representing the data was the final strategy in the data analysis process. I represented the data with member checking. During the semi-structured interviews, I utilized follow-up questions, probing questions, and reflected the participants' responses

in my own words after answering each interview question for ensuring accuracy in understanding the participant's response. The accuracy of the participant's response was "critical for establishing credibility" (Creswell, 2013, p. 252) for the qualitative study. The combination of questions and reflective listening allowed me to complete two research tasks. The first task helped me remain focused on the experiences shared by the participants, and the second task kept the interview on track for focusing on the phenomenon.

I conducted six semi-structured interviews to explore the lived experiences of African American Christian senior pastors in relation to providing mental health treatment to congregants. I transcribed each recording with Dragon speech recognition software for each interview identifying three main themes and 14 sub-themes (See Table 4 for a summary of themes and sub-themes). A detailed discussion of each theme and sub-theme is in the results section of this chapter. Following the summary of themes and sub-themes is the general participant narrative and the general description. The general description is a collective summary based upon the information collected from the interviews conducted with the 6 participants. The general participant narratives were developed into a shared description of the 6 participant accounts of their lived experiences. The narratives were combined into one description for highlighting the meanings of the 6 participants' lived experiences as senior pastors providing mental health treatment to congregants. Whereas, the general description was developed for merging the three major phenomenological themes into a unified portrayal of the six

participants experiences. The summary of the general descriptions was based upon all or most of the participants' descriptions of their lived experiences (Peoples, 2016).

Evidence of Trustworthiness

As discussed in Chapter 3, trustworthiness was the process used for validating the research while conducting this qualitative study. The application of specific methods and strategies allows for the study to be duplicated and its findings verified (see Giorgi, 2009). This phenomenological study developed specific strategies, techniques, and procedures for checking the accuracy of the findings (see Moustakas, 1994). The trustworthiness of a qualitative study consists of four parts: credibility, transferability, dependability, and confirmability (Creswell, 2013). For this study multiple strategies were used for checking the internal and external accuracy of the study for establishing trustworthiness.

For establishing the internal accuracy of the study an interview protocol form, researcher notes, and member checking were used. The interview protocol form allowed me to present the same set of interview questions to each participant in the same order for ensuring consistency in the questions asked of each participant for collecting data. The interview protocol form served as a tentative script for guiding the semi-structured interviews for keeping the focus on the lived experiences of the participant. The interview protocol form also gave me the opportunity to document researcher notes during and after the interview. While listening to the interview transcripts when transcribing, I was able to recall information observed during the interview for noting on the protocol form for

upcoming interviews. All the notes taken from the data collected were important; therefore, nothing shared by the participant was taken for granted (Peoples, 2017).

The interview protocol form and the researcher notes allowed me to purposely and objectively examine the participant's experience. The researcher notes consisted of my preliminary thoughts, participant observations, experiences, preconceptions, and assumptions related to the phenomenon of study. According to Creswell (2013) researchers are to understand their position, biases, or assumptions because these factors can have an impact on a qualitative study. The researcher notes allowed me to remain focused on the participant and their experiences and not my personal experiences if the information shared was relatable.

The final strategy for establishing internal accuracy was member checking. Member checking was used after the participant answered each interview question. I reflected the messages shared by the participant with the Speaker/Listener technique for demonstrating my understanding of their experience. This was an intentional strategy for focusing on the participant's experience and the meaning they associated with the experience.

This form of intentionality signified my effort in being conscious of the participant and their lived experience with the phenomenon (see Moustakas, 1994). The accuracy and thoroughness for understanding the participant's response was based upon their direct quotes, which served as raw data for revealing their lived experiences and the meanings associated with these experiences. Each strategy established the credibility and transferability of this study by demonstrating a relationship between the researcher, the

participant, and the data collected. Transferability was demonstrated with participant descriptions, demographics, and background information on the sample population. The interview questions adhered to the focus of this study; therefore, the data was reflective of the scope of inquiry. Last, transferability was demonstrated through the strategies and equipment I used for data collection and analysis. Each area serves as a guide for future duplication of this study because each area is transparent in explanation.

The external accuracy used as evidence for establishing the trustworthiness of this study is the Institutional Review Board (IRB) and the Counselor Education and Supervision (CES) guidelines, my dissertation committee, the Utilization Research Reviewer (URR), and an external auditor. The IRB and CES guidelines establish trustworthiness because a study is not given approval until established objectives are achieved or met according to university standards. The study was deemed ethical, legal, and of sound practice when approved by the IRB and CES Dissertation Committee.

The dissertation committee was comprised of a committee chair and committee member. One of these persons served as the expert methodologist while fulfilling one of the two roles on the dissertation committee. Throughout this qualitative study I was in communication with both committee members for guidance, support, and clarity while completing data collection and analysis. Both committee persons offered support and feedback throughout the data collection and data analysis process. Upon completion of data collection and analysis, both committee persons evaluated the results of this study prior to submission to the university for review and approval.

Finally, the committee persons were the individuals to ask me questions about the methodology, findings, meanings, results, interpretations, and implications of this phenomenological study. The external auditor was a colleague whom reviewed the accuracy of the procedures, methods, and data analysis for establishing trustworthiness of the study. The external auditor had no connection to the study and this was essential because they were examining the study's process and the accuracy of the results (see Creswell, 2013). Each factor outlined for the internal and external accuracy of this study established the credibility, transferability, dependability, and confirmability offering future researchers the methodology strategies for duplicating this phenomenological study.

Results

Six participants volunteered for this phenomenological study. The sampling was made up of 5 men and 1 woman. Each participant came from different backgrounds and experiences in relation to pastoral leadership, professional and educational training, and mental health experience and treatment. Even though the participants were from diverse backgrounds, there were similarities in beliefs, faith, awareness, and experiences. Each participant shared strong convictions in their faith and role as the senior pastor of their church. The participants were candid and open in sharing their lived experiences in relation to mental health treatment personally, spiritually, and professionally. The participants were given pseudonyms for guaranteeing confidentiality in their interview responses.

Participants

SP 1. SP 1 was a married 40-year-old African American male pastoring a Baptist church. He had been a full-time senior pastor for 14 years appointed by the 1,110 church membership. SP 1 was relaxed and comfortable during our interview. His responses were open and candid and mixed with moments of humor when sharing his experiences as a senior pastor. He was trained in pastoral counseling and completed this process before being appointed as the senior pastor of the church. He was the only individual rendering counseling to the congregants of the church. SP 1 earned his doctoral degree while completing his formal training for fulfilling the role of senior pastor.

One of the requirements for SP 1 before becoming a senior pastor was participation in counseling. He explained it was introduced to him by his senior pastor.

> I was exposed to pastoral counseling through my senior pastor. My pastor at my home church when I came into ministry in 1996. My sister had passed away in 1986 and he thought that it was imperative that I have some type of counseling going through some type of process to make sure that I had squared away my grief so that I will be in position to minister to others who were in grief and that those/any suppressed feeling that I had would not prohibit me from helping someone else.

His previous experience and current positioning allowed him to have a personal and professional understanding of mental health treatment and the resources available in the community.

SP 1 and his church were well connected to the community mental health resources offered because of the location of the church. He stated that his church was in the "number three richest county in America. There are tons of resources in the county." The church's location had afforded them the opportunity to have organizations present and offer services to the leadership and membership. SP 1 believed the church had benefited greatly because of its location but also because of the make-up of its membership.

> We benefited from some of those opportunities over the years. And then I have people that are a part of our church that are working in these areas. So, it is very easy for us to tap into those main pipelines into county services (SP 1).

Even though SP 1 and his church were connected to valuable resources he believed treatment was viewed as a negative in the African American community and this lead to the community suffering because "we don't take advantage of counseling at any level." With this information SP 1 decided to begin a series in his church on health and spiritual health. He believed that the conversation on mental health was relatively new within the African American community and churches. "I mean this is relatively new for us, in the last five years where the conversation regarding mental health is increasing. Five years ago, we didn't talk about mental health in our community, in our churches. If you had a mental health issue that was between you and your family, or just you." SP 1 was an advocate for mental health treatment because "it don't matter how much prayer, how much fasting, and how much laying on the hands the people do. If you are

chemically imbalanced, you can call it whatever you want to call it, it's still in need of some medicine."

SP 2. SP 2 was a 28-year-old African American male, married senior pastor of a Baptist church. Upon our meeting SP 2 had been pastoring full-time for 8 months. He was appointed to fulfill the role of senior pastor by the 60 congregants which made up the membership. SP 2 was relaxed, engaging, open, and talkative. He was also very polite and respectful when sharing his lived experiences about mental health treatment with me. In all our exchanges he referred to me as "ma'am" and would respond "yes ma'am" when questioned; hence reinforcing my belief in his respect for his elders.

SP 2 shared that he and his wife were the only persons rendering counseling to congregants, but he fulfilled a larger role because of his position. SP 2 believed that transparency was important not only with me, but also in his role as a pastor because he wanted his congregants to know that he was approachable and not "too churchy." He took his role as senior pastor very seriously which is why he was currently enrolled in a masters counseling program. He believed that "you should be trained on just whatever your niche, whatever your calling is. The feeling is one thing, but I think there should always be learning behind what you do."

SP 2 grew up in the church and was introduced to pastoral counseling because of the church. He stated, "I always heard counseling and it was more so the pastoral thing because I grew up in the church." He began ministering at the age of 14 and had only known, practiced, and experienced pastoral counseling until beginning his master's program. SP 2 was currently enrolled as a student at a theological seminary working on

his master's in counseling. He was interested in experiencing the formal or clinical side of treatment. "I never experienced the professional side of it. So that's actually one of my driving forces now, to experience both sides and to be able to give both sides."

SP 2 shared that he felt inspired to become a resource in the community after visiting a church that offered counseling services to the congregants and community. He was a firm believer in building community in his church and in the neighborhood the church resided. "That's a big thing for me, our community. I never want to be just a church on the corner and nobody know that we're here." SP 2 was an advocate for treatment even with his strong convictions of faith. He believed that you could have Jesus but also do the work for gaining healing in your life. Even in his seriousness, he jokingly shared "Jesus and meds, or Jesus and a therapist, or Jesus and…." for the congregant to apply what was needed in addition to their faith. SP 2 believed that counseling or mental health treatment was a practical tool which should be used when it is a readily available resource. SP 2 shared that he wanted to be a resource and to fulfill his spiritual assignment in the earth.

> Yes, that's what we we're here for, that's what we were created for. Whatever assignment God gives, you know, like I said. He can but He's not coming to tap you on your shoulder. He's gonna use somebody else to do it. To say, hey I'm here to help you.

SP 3. SP 3 was a 62-year-old married African American female senior pastor of a Baptist church. She had 10 years of pastoral leadership over 300 congregants. She worked full-time in ministry during her tenure as a senior pastor. During our meeting she

was relaxed and engaging. We spent the first 30 minutes in casual conversation which was quite enjoyable. She was very open in sharing her life experiences with ministry and her role as a woman in ministry. She had a strong faith and hope in God, but also believed in people taking personal responsibility for their lives and seeking help when in need of assistance. SP 3 felt “you’re always supposed to look for solutions, solutions to the problem.”

She eagerly shared her personal experiences for participating in mental health treatment and the reasons for seeking help in the past. She felt that formal mental health treatment and pastoral counseling allowed her to “vent because of dealing with so many issues that the people have. It’s, it’s hard.” She felt that treatment was beneficial, and she believed it was an underutilized resource in the African American community. “People of faith, African Americans. Yes, African Americans we have not as a people relied on that help until it was critical. We haven’t sought those kinds of avenues, to get some counseling, to go talk to somebody.”

SP 3 grew up in the church in the Baptist denomination and under her father’s teachings because “he pastored a church” and “was pretty intuitive, they [her parents] were very common sense and they just said things that just made sense. And I just kind of grew up with common sense notions, you know, thought processes.” Even with these teachings her parents supported treatment because she recalled in her youth her brother being taken to see a psychologist because her parents thought “something gotta be wrong with him” because of behavioral issues.

The "something gotta be wrong with him" terminology was what she grew up hearing spoken about persons who may have needed help, but if there was an identified issue she stated her parents would "explain it to me. Sometimes people need help. You need some help, you need to go and get some help." This was a philosophy she practiced in her role as a senior pastor. She stated that "if help is out there, then you need to go and get some help. If it's a problem and you can do it [resolve the problem] don't let this molehill become a mountain. Because you can do something about it." SP 3 was an advocate for mental health treatment and had resources because she stated "I can connect you" when things are a bit deeper than what she could address through pastoral counseling.

SP 4. SP 4 was a married 68-year-old African American male, senior pastor living in Virginia. He had been a senior pastor for 40 years and currently led a Baptist congregation of 300 individuals. SP 4 was interested in participating in the research study after learning about it from the gatekeeper. Our schedules did not permit for a face to face interview while he was in Michigan for personal matters; therefore, we scheduled a conference call upon his return to his home state of Virginia.

There were minor challenges in the beginning of our phone conversation because the participant's call had to be placed on speaker for recording purposes. There were several attempts to use the web service freeconferencecall.com, a site which specialized in free conference calls for phone or video. Due to the technological issues experienced by SP 4 when calling the conference line, I decided to call the participant's direct cell phone number for conducting the interview. I placed his call on speaker and recorded the

interview with the use of the Phillips Digital VoiceTracer DVT 2710 audio recorder. I also attempted recording the interview with the use of the free conference call app as a back-up recording but learned after the interview ended that the conversation did not record through the app. The technological challenges were a bit frustrating and led to the interview feeling awkward in the beginning; however, the process became more relaxed after reflecting the participant's response to the second interview question. Member checking allowed for me to connect with SP 4 because I was able to grasp an understanding of the participant's responses to the interview questions. The participant's response of "exactly" to my reflection placed me in a comfortable place for continuing the interview without feelings of awkwardness.

SP 4 was candid with his responses regarding African American culture and treatment behaviors, his personal experiences with formal mental health treatment and pastoral counseling. SP 4 was analytical, intellectual, and honest with his responses to the interview questions. Throughout the interview he referenced himself as "being from the streets" and this being his "context for life" and how he responded and interacted with others. He reiterated throughout our interview that personal connection with others was important, and when it was lacking he developed issues of trust. He shared that formal treatment was not comfortable or helpful because it felt like an "academic discussion" because the therapist could not understand his experiences. SP4 found comfort and solace in pastoral counseling because he felt understood.

> There's an ongoing relationship and even dealing with my peers, where I think that they better understand the context of my situation.

> I've dealt with it (counseling) from that perspective and felt a lot more comfortable. Because for me I would need to deal…it's gotta be a personal relationship there for me to open up like that. I just wouldn't do it with a stranger, from a strictly professional context.

Even with SP 4's personal experiences, he reported being an advocate of treatment whether it was pastoral counseling or formal mental health treatment. He was most familiar with pastoral counseling because he completed his master's in divinity in Pastoral Care at Virginia University. He explained he was comfortable with referring and believed there were times where "another pastor can help a young minister better than I can, so I let him go work with him. Or there are times when you have to say that's beyond me, or what you're dealing with I think that you need to go and talk to a professionally trained person. They might be able to help you better in this situation." SP 4 felt that treatment was beneficial even though he grew up hearing negative messages. It was never directly stated, but he would hear others saying that someone had "lost their mind" and if they were a danger "then they had to be institutionalized" and because he grew up "in the streets" there was a greater chance that the "intervention was you went to jail."

SP 4 understood his role as a senior pastor and took his position very seriously. He shared that "pastoring for me, is very personal work" and that you "have to pastor every person differently." This perspective allowed him to build connections and relationships with his congregants and non-members that he taught weekly at the local barber shop. He believed that all pastors have "to be humble when we walk into people's

lives" and "meet them where they are if you really care about them." His approach in pastoring allowed him to teach self-empowerment and African American empowerment through personal responsibility. SP 4 believed "that whatever your environment has dictated to you, that you can use, once you become self-aware, then you can use your own power, your own strength, or choice to override whatever has been imposed upon you."

SP 5. SP 5 was a 59-year-old married, African American male senior pastor. He was the senior pastor of a Church of God in Christ (COGIC) leading a membership of 150 congregants. He had been a pastor for 23 years. SP 5 was comfortable with sharing his personal and professional experiences with mental health treatment. He was comedic at times with his responses and quite relaxed during our interview. He took his role as the senior pastor quite seriously and shared that "my job is to please Him [God]. I please Him whether what anybody else think, it really don't matter to me. And so, I keep that before me at all times." This attitude had given him a deep respect for the office of senior pastor and had allowed him to have "great" experiences in this leadership role.

SP 5 shared that he had counseled congregants from his church and non-members because of referrals from other pastors. He primarily rendered pastoral counseling when assisting others and felt comfortable with referring individuals as needed. He was comfortable with referring because he had personally participated in mental health treatment. Initially SP 5 thought "I would never do that. But after talking with some people and getting a better understanding concerning what a psychiatrist…how they can help, and how it's good for you" his thoughts and feelings changed.

He shared that he grew up hearing negative messages about treatment but learned "it was nothing negative about it" and that "it's good therapy." SP 5 initially believed that "only people that was "nuts" was to see a psychiatrist. To be honest, I came up thinking that you had to be crazy. Or some type of mental breakdown of some sort to be able to go and see the psychiatrist." SP 5 denounced the belief that "just cause you go and see a psychiatrist, you gotta be nuts." He now believed that "a good one [psychiatrist] could really help you get through some things, but you have to be open-minded about it."

SP 5 was an advocate of formal treatment when pastoral counseling was not enough because "you may need to go get some information outside the biblical stuff. I don't have all the answers" and "the Bible even talks about a physician." However, he shared that it was not enough to go to treatment:

> You have to apply it. If you don't apply it, it won't work. I don't care, even if they go outside of my counsel they can go to you or anybody else. If they don't apply it, then it's no good to them.

His personal experiences with treatment allowed him to understand that everything the psychiatrist shared did not benefit him, but when it did he applied to his life for creating the change he needed.

SP 6. SP 6 was a married 59-year-old African American male. He was the senior pastor of a COGIC church where he had been leading 100 congregants for 17 years. He had strong convictions of faith and believed in the "holiness or hell" teachings because it "boils down to what the Bible says." He was quite candid in his thoughts and beliefs about faith, pastoral leadership, and mental health treatment. He was also a strong

believer that senior pastors have biblical standards they are to live by to lead God's people. He began sharing this standard for demonstrating the responsibility of the senior pastor.

> The Bishop being blameless, and having this high standard, and working, and loving his wife, and raising his children in the fear and admonition of the Lord. I mean, there's a whole gamut of things that we are instructed to do, so we can be this Godly example.

This Godly example was important to SP 6 because he felt that one could not render effective counsel without living up to a holy standard that God allowed for you to fulfill through trials and tests for developing life experience. SP 6 felt that senior pastors could not render effective counsel when they had no experience with the matter and if they were living their life beneath God's standard.

> Even if I do incorporate my experience, my experience hopefully, were birthed out of what the Bible told me to do. And I did it, it worked out good or I didn't do it and it didn't work out good. And I say the advice has to come from an experienced person. I think a problem with the church today is they let people give them advice that don't have the experience.

Even with his strong convictions, SP 6 felt that "great men and women of God can give good Godly advice from a clinical standpoint." Therefore, he believed in referring his congregants to formal treatment if they needed more, but only if the individual was a "God-fearing doctor" because he believed that they would give Godly

instruction and not only secular instruction. SP 6 had referred his congregants to other senior pastors for counsel, but also understood that sometimes more was needed.

> God can do anything that He wants to do, but He still gave us doctors. There are some medical things that has to be done along with, uhhhh divine healing. I mean the medical part of it where the doctor comes in at. And that's what I mean when I say, that we pray for some things, and then some things you listen to the advice of the person that God gave to study your body.

SP 6 had not experienced formal treatment personally, but he had a sibling that participated in treatment for a mental health diagnosis her entire life. It was not something that he or his family discussed because it was a "private matter." He believed that "it was a big deal and probably could've been discussed" but in the African American culture it was "somebody's business" and it "wasn't a conversation piece." This information highlighted how he felt that mental illness and treatment is not "something that we as black families, then and as far as I'm concerned today really don't understand a lot about. It's definitely something we don't understand a lot, especially in the church."

SP 6 stated how recently in the COGIC, the church had "been telling the pastors that they need to have resources, more resources." He stated how he "he enjoyed the fact that the church was looking at more resources for the people than just pray for them and then send them on their way." The COGIC conference he attended recently had a "list of psychiatrist and psychologist and different avenues" because the church is beginning to

realize and now "teaching us pastors now have some resources, have some avenues that you can refer the people to in order to give them a complete service, not just the word and just prayer, and let them go." This new discussion has led to SP 6 examining how his church could offer more programming and resources to its congregants that would assist with marital, family, financial issues. It was his desire to "have a system set up where you could refer the people" because "resources are very limited in the Black church."

Themes

There were three main themes with 14 sub-themes that emerged from the data collected from the senior pastor's lived experiences in relation to providing mental health treatment to congregants. The three main themes were pastoral experience, personal mental health experience, and mental health treatment. Pastoral experience was theme one, which rendered seven sub-themes. The seven sub-themes were resources; referral behaviors; role and responsibilities; influence; challenges; pastoral versus secular counseling; and training. Theme two was personal mental health experience. Theme two rendered three sub-themes. The three sub-themes were awareness, messages and beliefs; participation; and African American community. The third theme was mental health treatment, and this theme rendered four sub-themes. The four sub-themes were spiritual versus non-spiritual issues; faith issue versus health issues; referrals, God, and treatment; and personal responsibility. The three main themes and 14 sub-themes are discussed further in detail following Table 4. Participant direct quotes are utilized for explaining the corresponding themes and sub-themes.

Table 4

Summary of Themes

Themes	Sub-Themes
Pastoral Experience	Resources; Referral Behaviors; Roles and Responsibilities; Influence; Challenges; Pastoral verus Secular Counseling; Training
Personal Mental Health Experiences	Awareness, Messages, and Beliefs; Participation; African-American Community
Mental Health Treatment	Spiritual versus Nonspiritual Issues; Faith versus Health Issues; Referrals; God and Treatment; Personal Responsibility

For the main question, *What are the lived experiences of the African American Christian senior pastor in relation to providing mental health treatment to congregants?* All the senior pastors had experience rendering mental health services to congregants; however, it was in the form of pastoral counseling. The participants understood the differences between pastoral counseling and mental health treatment because there was a distinct difference in philosophy, technique, training, and resources utilized. The participants grew up learning negative messages and beliefs about mental health treatment because of a lack of understanding of what mental health treatment represented. It was after personal experiences with treatment or an increase in awareness and information did the senior pastors develop a positive view of mental health treatment and its benefits. The senior pastors had more skilled and personal experience with pastoral counseling but supported mental health treatment for congregants when faced with issues that were beyond their scope. The senior pastors were comfortable with rendering pastoral counseling and referring congregants as needed to gifted and talented mental health professionals.

For the first sub-question, *How do senior pastors make meaning of experiences helping congregants seeking counseling through the church?* The senior pastors utilized their faith and relationship with God for making meaning of experiences, and for understanding their role and position in the lives of congregants. At the core of each senior pastor was their faith and trust in God when counseling or referring congregants. The senior pastors utilized a combination of their personal experiences, understanding of the Bible, and training for identifying with congregants when counsel was sought through the church. The senior pastors felt responsible for the spiritual health and growth of their congregants causing them to be mindful of the influence they had when counseling or referring congregants to mental health professionals. There was a strong sense of responsibility and accountability for the senior pastors when giving information to congregants because their goal was to be pleasing to God in the work they did in the church. The senior pastors did not allow their faith to negate the need for treatment but utilized it as a compass for guiding them in how assistance was given to congregants when support was sought through the church.

For sub-question two, *What are the senior pastor's personal experiences with mental health treatment?* All the senior pastors experienced treatment through pastoral counseling; whereas, four of the six senior pastors participated in formal mental health treatment. The senior pastors shared positive experiences with pastoral counseling; however, of the four senior pastors that participated in formal treatment one did not value the clinical setting for treatment due to personal preferences. Overall, the senior pastors felt that mental health treatment was effective, beneficial and had good experiences that

led to growth and a greater empathy for others when assistance was sought through the church.

For sub-question three, *What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?* The senior pastors had limited training for addressing mental health problems. The training experiences of the senior pastors surrounded pastoral counseling and the application of biblical techniques and scenarios, and personal experiences when addressing the mental health problems of congregants. Each senior pastor understood their limitations and knew their boundaries when the issue being treated was beyond their scope. The senior pastors felt that problems could be addressed with the Bible but knew there were times when more was needed, whether it was with the use of medication or formal mental health treatment with a licensed professional. I personally felt that each senior pastor was comfortable with their training experiences because they understood the levels of appropriate treatment when assisting congregants with mental health problems.

Theme 1

Pastoral Experience.

Resources. All the participants utilized similar resources when counseling congregants. Each participant discussed their use of the Bible, scripture, and prayer as foundational components when rendering counsel to congregants; however, they each utilized additional tools of support in the form of reading materials. SP 3 stated he utilized "scriptures from the Bible, prayer, and reading from recommended books" when counseling. The Bible, scripture, and prayer were viewed as necessary tools; whereas, the

supplemental materials were based upon the participant's style and experience with the resources given to congregants for support. All the participants believed that the Bible could answer all problems when applied correctly, but when the Bible was not enough then additional steps were taken with the use of secular or spiritual readings. SP 1 outlined what he identified as a prescription when counseling congregants.

> Alright, so when one would come to me. They'll be given a prescription that would give and that prescription will be inclusive of…okay, I want you to do this, or I want you to do that. Which may include prayer, may include a reading resource. It may include talking to someone else. Ummm, and then we'll come back at a scheduled time for that person to come back and review where they are, and then that will help us to determine if we keep moving forward in this vein or is this going to be beneficial long term to this person or do we need to do something to go to another level (SP 1).

SP 1, SP 2 and SP 4 incorporated the use of materials, and feedback from respected colleagues when assisting congregants. SP 1 and SP 2 found guidance from colleagues and fellow pastors for gaining a better sense on how to counsel congregants when it came to mental health matters. SP 1 stated "when we get together in our different cohorts for counsels or fellowships, we've had conversations about it. Because we need to know…hey, how you dealing with this, how are you treating this?" Whereas, SP 2 shared "I have notes that I've taken from school, books. Even conversations with my professors. From just

getting their perspective. Conversations with other pastors who've been in this thing way longer than I have, in seeing how they address it." The resources varied from pastor to pastor, but they all utilized resources other than the Bible, scripture, and prayer. SP 4 utilized resources from his pastoral training.

> Sometimes I will have people, depending on what the situation is, I have people do a genogram. I have a book that I give them to understand how to do genograms. So, they can take it and work on it themselves. And then I use the Steven Covey, The 7 Habits of Highly Effective People because I like the way he deals with understanding the difference between what it means to be human and to be self-conscious, to be self-aware. What it means to know how to exercise personal choice. That whatever your environment has dictated to you, that you can use once you become self-aware, then you can use your own power, your own strength, or choice to override whatever has been imposed upon you (SP 4).

Regardless of the type of resource used with congregants, all the participants felt that sometimes more was needed when counseling congregants. Whether this understanding was attained recently or if it had been practiced since the beginning of the pastor's tenure, they all understood the value in having resources for helping congregants. SP 6 expressed

that more needed to be done because congregants needed more from its church and its leadership.

> The Bible and experience. Resources are very limited in the Black Church. The church is teaching us as pastors now to have some resources, have some avenues that you can refer the people to in order to give them a complete service, not just the word and just prayer and let them go (SP 6).

Referral Behaviors. All participants referred their congregants as needed to outside referrals whether it was through the church or a formal clinical setting. The participants believed it was important to use referrals when a counseling issue was beyond their scope and needed more than pastoral counseling. SP 1 felt that referring was important when one was not equipped for counseling.

> At this point, I'm very comfortable with outsourcing. Just for multiple purposes. I don't think that pastors who are not in counseling should be engaging in mental health counseling. I think there are too many avenues available to us that we should be ready to source that out (SP 1).

SP 4 understood that there were times where more treatment was needed for certain issues than he could render and knew that the problem required a mental health professional.

> For example, one young man had dealt with a lot of abuse as a child. And he was passing that abuse on, but that's beyond me. So, I let people know when they come to me, now depending on what I

> discover here, then I might have to stop. Because your situation might require the intervention of a mental health professional (SP 4).

Each of the senior pastors felt comfortable acknowledging their limitations when counseling and were comfortable with referring congregants as needed. SP 3 shared throughout our interview that pastors should:

> Let somebody else do it and you're providing for their livelihood and helping somebody, helping somebody out in the process. So if there is a problem, you gotta look for a solution. You gotta at least look for a solution and what is….what is the end product supposed to be. So, if somebody has mental issues, there's people out there. If this is a little deeper than where I can go, okay? The Bible, I can tell you this is what the Bible says, you need something a little deeper than this you need to go see somebody. I can connect you (SP 3).

The six participants also understood they were not the only resources when they did not have the answers when assisting congregants. The senior pastors understood there were resourceful professionals available with answers when they did not have them. SP 2 felt senior pastors were not "the end all to anything" and SP 5 knew "they didn't have all the answers." SP 4 believed that if they were going to "help people, we have to get over ourselves in order to help them."

Of the six participants SP 4 and SP 6 voiced that they would begin with referrals to other senior pastors before referring to mental health professionals. SP 6 expressed "there were some people that I was too close to, to counsel" so he would utilize "an anonymous pastor" to address the situation with the congregant. SP 6 went on to say that these were mutual relationships because he has had "people [pastors] call me from other churches." SP 6 also acknowledged that some of his pastoral referrals were based upon the financial circumstances of the congregant. If the congregant had limited resources SP 6 felt more comfortable referring to another pastor because they would "counsel with them for free" and the congregant could not avoid counseling with the excuse of "I don't have the money for that." Whereas, SP4 began with the pastoral referral regardless if it was for a member of the leadership team or a layperson apart of the congregation.

> Sometimes another pastor can help a young minister better than I can, so let him go work with him. Or there are times when you have to say that's beyond me, or what you're dealing with I think that you need to go and talk to a professionally trained person. They might be able to help you better in this situation (SP4).

Roles and Responsibilities. Fulfilling the role of senior pastor was important to the six participants and it was not a position taken casually. Even though the pastoral leadership experience varied between the participants, it was understood from the responses that they each valued the office held within the church and the responsibilities associated with this

position. SP 1 specified that "I'm the shepherd. I'm their pastor. 1 Corinthians 16 reminds me that I am the pastor wherever they are, in every area of their life."

The work of the senior pastor was personal to each participant and highly respected. The role was personal because each participant understood the gravity of being responsible for the spiritual growth and maturity of congregants because it was their job "to lead, to guide, to feed, all from a spiritual perspective" (SP 1). The role of senior pastor was also respected because each senior pastor knew they were called by God to lead in this position and "biblically speaking" they were the "spiritual authority for the membership's life" (SP 1). SP 4 specified that his role as pastor was:

> …very personal work. You have to pastor every person differently. Well that depends on the degree to which they give me permission to do so. Or the degree to which they need me to do so. And that as a pastor, your main qualifications…Jesus said to Peter, if you love me feed my sheep. He established first of all that there has to be a personal, loving relationship precede the feeding of the sheep. And if you can't cut it on establishing personal love relationships, you have no business feeding sheep (SP 4).

SP 3 acknowledged her role as being "serious" yet "different" because God and her congregants entrusted her when giving counsel.

> If someone has thought enough about me, have decided to put some trust in me or see me as a positive influence. I'm gonna give'em my best. I think it is to take pride in that. It carries weight. And I believe,

> I just believe that at that particular moment whatever's going on, God gives me whatever this person needs to have. That's my belief because of course, I don't talk to anybody without having prayer and asking for direction because I don't know what to say (SP 3).

Even with eight months of experience, SP 2 came to learn that he played "a huge role" in the lives of his congregants and believed it was because "people are watching leadership in more ways than one." SP 2 shared that his "phone has rung more than normal" since becoming a senior pastor and felt that his congregants believed he had "something to say…whether it is from God or anybody else. Not saying they can't study for themselves, read for themselves or anything like that, but they value our opinion." Because congregants value the opinion of their senior pastor, SP 6 explained his experience as follows:

> The challenge for leaders such as myself is to make sure that my life lines up with the word of God, so that when I do give out I can give the word, but I can use examples. Because I went through it, and a lot of the things I went through God sent me through them just so I could speak concerning the congregants are going through. I'm the type of pastor I don't cut corners, I don't care who you are. My job is to tell you the truth. When issues come to me I deal with them (SP 6).

Influence. The senior pastors understood their leadership roles involved influencing their congregant's behaviors and decision-making in spiritual and secular

issues. With this influence came the notion that senior pastors were to do right by their congregants concerning the things of God.

> Biblically we have the influence, and we're put there to influence and help congregants in decision-making. The way God set it up was according to Jeremiah 3:15, and I'll give you pastors after my own heart and they will feed you and give you wisdom, knowledge, and understanding. They'll take the word and interpret it, and so He's trusting us to do it right (SP 6).

In understanding their influence, the senior pastors shared how they have addressed mental health issues in the church. Some of the participants were direct in their approach to helping congregants understand that mental health treatment was beneficial, and it did not go against one's faith or God. SP 1 stated:

> …if you have a mental health issue you need to get treatment. If you have mental health issues and you have been prescribed medication you need to take your medication. Because it don't matter how much prayer, how much fasting, and how much laying on of hands the people do. If you are chemically imbalanced, you can call it whatever you want to call it, it's still in need of some medicine. And I don't think it's fair for us to be accepting of medicinal treatments in other areas, diabetes or heart issues, what have you, etc. and then not be acceptive of it in this regard (SP 1).

SP 3 was another participant direct in her approach with congregants. She wanted

congregants to understand that she could be trusted with what she shared with them, they could trust God, and they could trust mental health professionals because sometimes extra assistance was needed for addressing certain issues.

> I tell people, I'll tell them in a minute. Look you need to go and talk to somebody. Yeah, I can talk to you spiritually, but you need some help outside of that. Not only should they trust God, they should trust you with the assignment that was given you. Because the people who are in the class including myself, I believe we are people who have influence, and with that influence will help individuals see that this is not anything that is going against what you believe. Matter of fact it might help, you know (SP 3).

The participants knew and understood the level of influence they had with congregants and did not try to overstep their boundaries. However, if a congregant came to them for assistance they would use the opportunity as an invitation to speak into the congregant's life. SP 3 explained it as this:

> It's hands off unless you come to me with it. I'm not going to bombard you with trying to, I'm not going to be in your business. I guess that would be just unless you open the door. If you open the door I walk in, if you don't open that door….I have to have an invitation (SP 3).

SP 5 shared that in his exchanges and interactions with congregants his goal was to always "please Him [God]. I please Him whether what anybody else think." SP 5 went on

to say that his influence with congregants led him to do "a lot of directing and talking, and you know counseling" therefore; he wanted to always be pleasing to God first because "when it is all said and done, my job is to please Him."

Challenges. Most of the senior pastors expressed their greatest challenges with congregants being two things. The first challenge was when or how congregants came to them for assistance. It was the feeling that congregants came to the senior pastor when it was too late compared to speaking with them sooner concerning their issues. The second challenge involved the lack of use in the information given to the congregant for improving their situation or circumstances when they did seek support from the senior pastor. SP 6 stated:

> It's frustrating that they would come, sit and counsel with you and get up and go do the exact thing that you told them not to do, or they knew what they were going to do from the beginning. It's like why did you waste my time. And I find myself being frustrated in that regard as well. But the reality of it is, and not to even sound cliché. Folks in most congregations because I talk with other pastors and what not. It's easier to beg for forgiveness than to ask for permission. Most folks gone do what they want to do first and then when it falls apart then they bring it to the pastor and need some help kind of straightening things out.

SP 1 felt that it could be challenging to help congregants because they wouldn't share the truth due to the risk of exposure. "Most times when people want to see the

pastor it's because of a symptom, they don't necessarily discuss what the main issue is. Because the main issue normally exposes them" (SP 1). SP 3 found it challenging because "As a pastor, it's hard to see people having so many issues in their lives that are self-inflicted or self-caused. You know because of wanting to live selfishly, have your cake and eat it too." Even with these challenges SP 3 has learned from experience that "sometimes there's people and they want to talk, and they don't talk for whatever reason, you know probably out of embarrassment." However, SP 3 tries to let congregants know that "there's nothing that you can say that's going to embarrass me, or that you need to feel embarrassed about. There's a whole lot, there's a whole lot going on, going on in the world."

The participant's expressed that even though they try to offer assurance to congregants there were times that they felt congregants were not "really listening to anything that I'm saying" (SP 5). And it was believed that when the congregant did listen, it would be due to some form of trauma occurring. SP 5 stated that "when trauma hits their lives, like death or sickness. Then they [congregants], at that time they'll be more aimed to listen." SP 4 expressed similar sentiments regarding the lack of receptiveness from congregants. SP 4 shared:

> Some people you can't help because they just ain't ready to be helped. Everybody can be helped, if they have enough time. If they live long enough they'll get to a point of readiness. A lot of people just don't, I mean they run out of time. Cause all of us only have so much time (SP 4).

Pastoral versus Secular Counseling. Each participant had experience in rendering pastoral counseling, even though some had not gone through any formal training. The participants shared that the main difference between pastoral and secular counseling was the biblical and scriptural foundation of pastoral counseling which is not found in secular counseling. SP 1 shared his thoughts about pastoral counseling and what it consisted of:

> …pastoral counseling is biblical counseling. You will counsel from, you want to be guided on what the scripture says pertaining to your issues. That's our gift. That's our skill as pastors we should be amped to give biblical counseling. Anything beyond biblical counseling and unless you are a counselor by trade, you shouldn't be doing. I just think that mental illness is defined and clinically it is supported. Then it has to be a category that we can, you just can't ignore. So, if someone is dealing with a mental issue that they need to be treated professionally. That is not the place for prayer. That does not negate your faith, your walk with God or anything. If you need some medicine, you need some medicine (SP 1).

In addition to the biblical foundation of pastoral counseling and its spiritual nature, it was noted as being less practical than secular counseling. It was believed that secular counseling led one to be practical when creating a plan of action for taking the next step for solving problems. SP 2 shared:

> There is a more spiritual aspect in pastoral counseling, not saying

> that they can't be practical. But I think, I do believe that professional counseling is more practical. It's so funny people have faith, but their faith doesn't lead them to take the next step. That's like the oxymoron of it all. You got faith, but you still not moving. And that's why I say, the practicality of counseling helps you take that next step.

Part of the experience of the senior pastor when addressing the pastoral versus secular aspect was they felt that them being Christian would not be understood in the context of a secular counseling setting, and that it could not be separated from how they viewed themselves. That perhaps them being Christian would be lost in translation because biblical principles and ideologies would not be applied to their circumstance or situation when not in a pastoral setting. SP 4 and SP 6 aligned with this thought process quite significantly. SP 4 stated:

> I think the main difference is that I looked at all of life and all of reality through a Christian lens. And whatever happens in my life, then I want to know, well where is God in this. Why did God allow this to happen, or why did God cause this to happen. Why didn't God stop this from happening? Is it for my good, or is it because I'm being punished? Should I feel guilty, should I be afraid? You know, where is God in this whole thing? And so, I think that's where, pastoral counseling or Christian counseling comes in. When you go to secular counselors, they really don't deal with it from a

> theological lens. They want you to understand yourself, and I have no understanding of myself other than as a creation of God, as a re-creation of God through Jesus Christ. That's my understanding of myself. So, when you ask me to set aside my religion, I might as well leave. Cause how you gone treat me when you asked me to negate me? That's who I am (SP 4).

SP 6 further explained that he believed there was good information in secular counseling, but it was not Godly. He also expressed that a pastor with formal clinical training would still render Godly counsel because it was all connected. This is how SP 6 expressed pastoral and secular counseling:

> I believe that if that pastor, if he hadn't had a psychology degree it's still gone be intertwined with the word of God. Where if I send them to somebody that don't have it they're gonna give them good secular information, but not Godly information. I believe great men and women of God can give good Godly advice from a clinical standpoint, if the people would bear with them or just go see them and listen.

Regardless of the senior pastors position each participant expressed that pastoral counseling and secular counseling were capable of helping congregants with their issues or problems. However, there was a greater connection to pastoral counseling for the participants because it is who they were and what they knew. It was also believed that God and the Bible could answer any problem even if the answer was not believed by the

congregant. According to SP 3:

> Most people don't think that the Bible has an answer, but the Bible has an answer if you, if you want it. So often times the answer that the Bible has for you is not what you want. So, you can't say the Bible doesn't have answers, just that it's not the answer that you want. That's just not the answer you wanted.

Along these same beliefs SP 5 shared his thoughts about pastoral and secular counseling and the impact it could have with congregants:

> I try to stay biblical as I possibly can and the only reason I try to stay biblical is because that's where I am, that's where I can relate to, and I can always show my proof of what I say concerning the word on it. The bible even talks about a physician. So, I told you earlier related to them being like doctors. And be able to do prescriptions, maybe not, they don't prescribe it. The have the ability depending on what their degree is, but a lot of times they write a prescription that say if you're prepared to go back to work or not, mentally or so forth. So, I don't have a problem with them going to see a psychiatrist. Because you may say something in a different way and because they carnal, they may be able to pick it up and apply it to where it needs to go. Where I may say it on a spiritual sense, it's the same thing but they hear you better (SP 5).

Training. Of the six participants, two had completed a pastoral counseling

program, and one was currently enrolled in a clinical counseling program. The three participants without formal training had participated in church workshops or conferences addressing mental health issues but mostly relied upon experience and biblical resources when counseling congregants. There was an awareness of mental health issues in the church and the African American community due to the lived experiences of each participant; however, three senior pastors learned more about mental health issues while participating in pastoral counseling programs. SP 1's program required advanced training because the program wanted students to understand what congregants would feel when they came to the senior pastor for counseling support.

> I had to do a Level CPE at Beaumont Hospital. And then I had to do an Adventures in Caregiving course Sinai Hospital. Which was geared toward preparing you to counsel, but you had to go through a process yourself (SP 1).

SP 4 found that his pastoral care program trained him to better connect with congregants on a personal level. SP 4's interest developed initially in college after taking a psychology course. His pastoral classes in his master's seminary program helped him to develop his pastoral counseling skills; therefore, he felt better equipped to focus on the relationship with the individual rather than the clinical aspect of formal mental health treatment.

> In my pastoral classes in seminary, the were focusing on how to observe people, how to care for people. How to listen to people, how to understand where people were in their spiritual growth, and how

> to move cautiously and to ask people for permission before you go barging into certain parts of their life. And then how to go and write down your impressions after you left rather than sitting there with a pad and pencil while talking to them. I just happen to have a very gifted and very sensitive pastoral instructor who taught us how to be humble when we walked into people's lives, when you crossed that threshold. And how to recognize the humanity of all people (SP 4).

For SP 1, SP 4, and SP 2 the focus in training was because of their interest connecting with others, but also because they felt the need to be able to do more for their congregants. SP 2 shared that his decision for enrolling in a masters counseling program was because he had seen firsthand the impact a church could have on its congregants and the community when offering counseling services in the church. SP 2 visited a church with a counseling ministry staffed with clinically trained and licensed mental health professionals offering free counseling services. It was from this experience he selected his masters training in a counseling program. SP 2 explained:

> I don't just want to have a piece of paper and not be able to do anything with it. And I believe that even gaining, when I finish my program my degree in counseling, I'm able to do something with it. But the reason I know I be able to something with it then, is because I'm doing something with it now. I literally take what I learn, and I try my best to implement it in some shape, form, or fashion.

Theme 2

Personal Mental Health Experiences.

Awareness, Message, and Beliefs. The six participants were able to share their level of awareness concerning mental health treatment and how much exposure they had from childhood to adulthood. Collectively, there was limited awareness and encounters with mental health treatment growing up and in adulthood. SP 6 had partial exposure to mental health issues because his older sister participated in treatment, but it was not discussed.

> My sister used to go to a counselor and go through treatment every day, but I didn't talk with her one on one to know any of the details. My mother knew about it and her husband. I was young at the time when she first got started. So, it just wasn't anything they talked with us about. I mean it was a big deal and it probably could've been discussed. You know it wasn't a conversation piece that we talked about, because again, this was somebody's life we were talking about, or if you will it was somebody's business (SP 6).

It was because of this experience that SP 6 believed this was a current issue that African Americans still did not completely understand.

> That was something that we as Black families then, and as far as I'm concerned even today really don't understand a lot about mental issues and what not, or mental health as you call it. It's definitely something we don't understand a lot; especially in the church, don't

> you know (SP 6).

According to SP 4 “treatment was not anything that I had ever heard about. I think it was after high school, in college and taking psychology.” This was also true for SP 2. SP 2 shared that he “didn’t hear much of anything. Until in the past few years.” When treatment was referenced, SP 2 only heard about pastoral counseling. It was in adulthood that SP 2 came to fully understand counseling and mental health treatment.

> Well, I always heard counseling and it was more the pastoral thing because I grew up in the church. But then, as I got older…I’ll hear from the pulpit, stuff like you know you need counseling or whatever like that, but I never really experienced the professional side of it. Growing up I didn’t hear anything about counseling. Again, aside from pastoral counseling (SP 2).

The lack of experiences in relation to awareness or discussions about mental health treatment left the participants learning negative messages or beliefs about this subject matter. SP 5 shared:

> Growing up I thought that only people that was nuts was to see a psychiatrist. To be honest. Yeah, I came up thinking that you had to be crazy or some type of mental breakdown of some sort to be able to see the psychiatrist.

For SP 5 these were the messages learned as a child and believed in adulthood until he participated in mental health treatment. SP 5 went on to share:

> It was just something men heard coming up. You know, they need

> to go and see a psychiatrist. It was a negative, kind of like a negative statement. You crazy, you need to go see somebody. You know, so I assumed coming up, when I got older, that's when you go see them because you had a nervous breakdown or mental breakdown.

For another participant, even if there was an awareness of mental health treatment or counseling it was still believed to be negative.

> Well, I heard about it. I heard about mental illness. But it wasn't a positive kind of thing. It was…. "they lost their mind." That's all I heard. Was that people lose their mind. And dependent on how dangerous they were, whether they had to be institutionalized. But I had heard about it. Yeah, I'd only heard the term "somebody lost their mind (SP 4).

This lack of understanding of what mental health treatment was created situations where it was misconstrued and possibly created negative experiences for the senior pastor when they participated in treatment.

> I thought that it was more about we got a certain amount of time and they were going to listen to me because of the setting, because they were professionals, because I was paying them, because there was a time limit, and all that kind of stuff. I didn't think they really cared about me, and so I didn't feel comfortable really going as deeply into it because I didn't think…I just didn't feel as though there was a personal relationship or that they cared about me. It's gotta be

something personal, a relationship there for me to open up like that.
I just wouldn't do it with a stranger from a strictly professional
context (SP4).

The learned messages and beliefs about mental health treatment also led some participants to feel as though it was a subject that should be discussed. The belief is that mental health issues have been avoided and kept a secret or viewed as a problem with the individual when there were personal issues. For SP 1 it was believed:

…subconsciously, you look at counseling as a negative when counseling is a positive. If there's a natural reality where someone who has been diagnosed with a mental illness. I think that everyone involved should be made aware of that. I buried someone who suffered from mental illness and their family wore it as a negative badge. They almost kept him hidden. Nobody knew who he was. They didn't want others to know that they had this person in their life.

The belief that something was wrong was learned by SP 3 even though her parents attempted to explain things to her from a common-sense viewpoint on life matters.

I can't put my finger on anything growing up other than to say that my mother and pretty much my father. You know he pastored a church. Was pretty intuitive, they were very common sense and they just said things that just made sense. I just kind of grew up with common sense notions, you know, thought processes. My mother

> and father took my brother to see a psychologist because he was always in trouble. Just always in, and I'm not talking big stuff. He was just always doing things. He was a hardheaded child, extremely hardheaded and my parents thought something was wrong with him. My daddy, my daddy said "something wrong with this boy, somethings wrong with him (SP 3).

Regardless of the lived experiences of the participant, each participant shared in some way that the area of mental health and mental health treatment was something "you didn't hear much of anything" about because "it was never like that" (SP 2). It was not an aspect that "Black families…understand a lot" (SP 6).

Participation. Even though there was a lack of awareness and understanding of mental health treatment when growing up, four of the participants had personal experience with treatment in adulthood. SP 1 was required to participate in treatment because of his pastoral education program and found it beneficial for understanding how to help others.

> My sister had passed away in 1986 and he [the senior pastor] thought that it was imperative that I have some type of counseling going through some type of process to make sure that I had squared away my grief so that I will be in position to minister to others who were in grief and that those/any suppressed feelings that I had would not prohibit me from helping someone else. What we did was, well initially it was six weeks. And we decided that we would not only

> go through pastoral counseling skills, but that we would do clinical pastoral education (SP 1).

SP 2 shared that he had participated in pastoral counseling; however, he would complete "25 hours of personal counseling" for his master's program. Even though this was a program requirement, SP 2 felt that "you can't counsel without first going through it."

SP 3, SP 4, and SP 5 all participated in mental treatment voluntarily. Each participant reported experiencing personal challenges that led to them seeking treatment. Each of the participants had experienced pastoral counseling; however, formal treatment was sought out by the participant for personal reasons. SP 3 shared that she had participated in treatment several times throughout adulthood.

> Yes, I have several. I can't tell you how many years ago it was, but I felt a need to have some counseling my own self. And I went to, not to Christian counseling, although I've done that also. I was working at a place where that sort of stuff was covered under employee benefits, and so I went and talked to a lady concerning some things that I was going through (SP 3).

SP 4 also stated he had participated in both forms of counseling for personal issues. SP 4 preferred pastoral counseling because it felt more personable because of the relatability he experienced with his peers.

> I've participated in both (pastoral and secular counseling). In a formal setting with my psychiatrist. I've participated in several of those kinds of sessions. And always felt they were inadequate. I

> didn't feel as though I got enough feedback from the professional. I didn't feel like they really cared. Now dealing with pastoral professionals where there's an ongoing relationship and even dealing with my peers, where I think that they better understand the context of my situation. I've dealt with it from that perspective and felt a lot more comfortable (SP 4).

SP 5 detailed how he worked with a mental health professional a few years ago because of employment issues. He found it to be a positive experience even though he initially viewed mental health treatment negatively.

> I went to a psychiatrist years ago, but it was just for the time I was trying to get out of working. I had to have a reason and so I went, but then I had it again and I was having problems at the job and I needed time off. And I went, and come to find out that a lot of it, the psychiatrist talk to me about I never really grieved over my son's death. It wasn't nothing negative about it. Matter of fact, I would probably say it was positive (SP 5).

African American Community. The participants felt that in the African American community there were challenges for addressing mental health issues and treatment due to the stigma associated with the subject matter; however, the feeling was there had been some progress in the African American community and the church over the last few years due to information and technology. The participants felt it was not an option to "sweep this topic under the rug, it needs to be addressed" (SP 1).

> I think our community suffers because we don’t take advantage of counseling at any level, but specifically mental health. We look at is as a scar or a stigma, or something negative where our counterparts are engaged in these types of activities from childhood well into adulthood just as a part of the process for life. I mean this is relatively new to us, in the last five years where the conversation regarding mental health is increasing. Five years ago, we didn’t talk about mental health in our community, in our churches. If you had a mental health issue that was between you and your family, or just you. But again, in our community people don’t view certain things that are mental health issues. They just don’t view it as that. Probably because we didn’t talk about it, or we didn’t classify it as such. I would just say that mental health is a very serious topic. It deserves or warrants further discussion in our community (SP 1).

SP 2 and SP 5 shared the belief that there had been progress in the African American community because of the information gained from technology. SP 2 shared:

> …we’ve progressed because reading is fundamental. People read more and with all of the worldwide web that’s out there, I think people understand the necessity for counseling. I don’t think it’s frowned upon now, you know as it probably has been in the past and probably the most recent past, but I think we could go further, you know.

SP 5 felt things were changing “for the better only because of today, you got so much information cause the internet, social media.” SP 5 went on to state how he believed that the discussion on mental health treatment was "more acceptable today than it was...I know for a fact that from when I was coming up it’s more acceptable. And the black community we’re becoming more and more aware of different things that we need to see happen.”

Of the six participants, SP 4 felt strongly that part of the reason for African Americans not participating in treatment was due to being “marginalized, penalized, and invalidated by the majority community.” SP 4 stated it would take time for African Americans to progress in normalizing mental health treatment as an option in the community because they needed to feel “validated” and until then it would be a “mental barrier.” In addition to the feelings of invalidation felt by African Americans, there were trust issues that influenced the underutilization of mental health treatment in the community. SP 5 shared that the African American community as a whole “we underutilize a lot, we as black folk. We underutilize because of the way we’ve been programmed. I just think it’s the way we’ve been brought up. We don’t trust really, the way we should.” As well as trust issues, there are also generational issues because older African Americans may not view treatment in the same way as younger African Americans. SP 3 shared:

> People of faith, African American. Yes African Americans, we have not as a people relied on that help until it was critical, okay. We haven’t sought those kinds of avenues to go get some counseling, to

> go talk to somebody. I think that the older population of African Americans would think more like I think, you know. Like no, no that's not right. They wouldn't think like I think because I had a different upbringing. I think that they, a lot more of them are you know…you gotta help yourself, do what's best for yourself.

It was felt that when African Americans did participate in treatment, it was usually with someone that did not look like them working with them through their issues. This was considered as a possible barrier to treatment in the African American community.

> So, you expect us to trust anything that's validated by a majority community that's marginalized us and penalized us for doing the same thing that they do. So when you get credentialed from that community and don't understand that, that becomes a mental barrier as it does anything else. Why should we accept you until you prove that you understand us? So naw we ain't gone participate, and I don't blame them, and I wouldn't either (SP 4).

Theme 3

Mental Health Treatment.

Spiritual versus Nonspiritual Issues. The participants shared that there were spiritual and nonspiritual issues that congregants had to deal with in their lives. However, it was believed by the participants that some issues were nonspiritual issues that should be addressed "in the earth" with a licensed professional (SP2). The participants felt that

sometimes things were over spiritualized when they should be addressed at a practical level. And it could be that because of this mental illness was minimized and went unaddressed.

> If you have a mental illness, I think that we rely so much on the spiritual that we disqualify or, kind of scale down the reality of the mental illness experience. If you need to take your medicine, then you need to take your medicine. Simple as that. I don't care how much prayer you have, if someone needs a prescription then they need to take that prescription (SP 1).

It was believed by participants that spiritual matters and nonspiritual matters had their placement, but both needed to be addressed whether it was through pastoral counseling or formal mental health treatment. Regardless of which issue a congregant was dealing with there was help available if the individual wanted or needed treatment.

> Sometimes people need help. You need some help, you need to go and get some help. So, if you need help there's help out there. And this is the attitude I've taken with dealing with people. Is there help out there, just sometimes people want to take it to God. Okay that's good, that's good. But God has also given that gift to other people. There's help out there. Why not avail yourself of the help, okay? And a lot of people don't want to get help (SP 3).

The understanding was that participants knew and understood the difference between what was viewed as a spiritual matter and nonspiritual matter. The spiritual issues were

referred to as demonic by the participants and this reference was acknowledged based upon the experiences of the senior pastor. For the participants, mental health issues were not demonic; however, it was stated that there were senior pastors whom believed that mental illness was a demonic or spiritual issue. SP 6 shared how he knew the difference between when someone was struggling with a spiritual issue versus nonspiritual issue.

> The Bible talks about the casting out of devils and this and that, and contrary spirits. We don't recognize like we should because we're quick to say, well it's just a demon or it's just a demonic force. I recognize the difference between the two when somebody is having a demonic battle or somebody that is actually dealing with a mental health issue. I've seen the difference between demonic and mental health issues. I've seen the difference between the two and I know the difference between the two. And I've seen it, I know when a person when it's a demonic force as opposed to somebody that's dealing with mental. And again, if you're gonna look at a person you have to look at their history and everything else. So, when you tell me that this boy has been through this trauma, his mother died when he was five. He saw her brutally killed and this and that, we need to deal with those mental things. That's not demonic (SP 6).

SP 1 shared how he also believed that there were demonic or spiritual issues, but he didn't believe that all matters were demonic. He felt that sometimes mental illness was viewed as "demonic," and had seen this stance primarily from older colleagues (SP 1).

He felt that even when older colleagues "ascribe to medicine, it's still called, it's a spiritual issue and it's called the demonic (SP 1). SP 1 shared that he believed demonic or spiritual issues did occur, but one can choose how to address the issue when it presents itself. SP 1 had encountered situations where other senior pastors only believed that one should "pray about it, scripture" and "that's it." However, he stated that he and other "contemporaries" believed that "if it's a mental illness that person needs some medicine. That person needs a treatment program, and we're not afraid to talk about that" (SP 1). He felt that sometimes it was not only a spiritual matter that could be treated biblically, because it required more than scripture and a prayer.

Faith Issue versus Health Issue. The participants felt that mental health issues could lead congregants to question their faith or question God when assistance was needed for addressing personal issues. For the participants, they felt comfortable clarifying with congregants that it wasn't one or the other, and that they were not lacking in faith when challenges were encountered. It was shared by the participants that mental health was a health issue and it was acceptable to view it as such. SP 1 felt that "mental illness is defined and clinically it is supported;" therefore, it was accepted and viewed as a health versus faith issue. It was also expressed by SP1 that "if you need some medicine, you need some medicine" which did not negate your faith in God. It was believed that taking medicine and seeking treatment was an act of faith.

> You can have faith to the third degree, but then it's time to go see the physicians. Cause he made doctors, he made medicine. So now you gone have to use that and apply it with your faith; my faith alone

> ain't gone do this. Because the Bible tells us, it talks about having faith, but it let us know that faith without works is dead. So I'mma have to put some works into play. I'm gone grab this medicine and I'm apply it and believe it's gone work. Now I take both of them, okay. Now God is gone bless it (SP 5).

It was believed that "it's a balance" between one's faith and one's action (SP 5). The participants believed that "God can do all and be all, but he's given you the ability to do the work that's required" (SP 2.)

SP 1, SP 2, SP 3, and SP 5 felt that it took faith to be able to take the next step in being healed. The participants felt that regardless of one's level of faith action had to be taken for change to occur. SP 2 shared:

> It's funny, people have faith, but their faith doesn't lead them to take the next step. That's like the oxymoron of it all. You got faith, but you still not moving. And that's why I say, the practicality of counseling helps you take that next step.

For the participants, prayer was not the only solution to the problem and more could be done for creating the necessary change needed. SP 1 stated "if someone is dealing with a mental illness then they need to be treated professionally. That is not the place for prayer. That does not negate your faith, your walk with God, or anything." SP 3 went on to state that sometimes the congregant would not know what was happening, and felt it was beneficial to seek out assistance for identifying the problem.

> If you know that you are depressed, you know that something not

> going right. You may not be able to apply the word depression, but you know something is going on. You need, you can start with your general practitioner or family doctor. And tell them you are staying tired all the time, you want to sleep all the time, you say you distracted, you got all this stuff that's going on with you. Okay, it could be one of two things. It's a physical problem, or it's a mental problem. Let's find out what it is (SP 3).

For the participants it was about helping congregants understand that there was not only one choice, but it would take multiple options for resolving the problems they were facing. The belief was "you can have Jesus and you can have problems versus you don't have enough faith. If you believe and trust God, or you didn't pray hard enough you know it's not an either or" (SP 2).

Referrals, God, and Treatment. For the participants, seeking God before giving referrals to treatment was a necessary component when assisting congregants. The senior pastors understood that when they were limited in information and resources, referrals to treatment were necessary. The reference used by the participants when discussing referrals to mental health professionals was God given talented or gifted professionals. It was explained that God had "gifted counselors out there that are gifted to handle those circumstances" when congregants needed to be referred to treatment (SP 1). According to SP1:

> There are people in place to do things like that and any time you try to do something that somebody else is gifted, and skilled, and

> qualified to do you put yourself at risk and you prohibit them from doing their job.

The belief was that the senior pastor should utilize outside resources because there were people equipped to do the work they could not do, while also allowing others to have gainful employment in their area of expertise. This belief also substantiated the notion that the senior pastor could "trust God enough to be able to trust somebody else, you know, who He has empowered for those efforts" (SP 2). For SP 6 his referral was based upon the professional's fear in God.

> Everything have to be predicated upon it being a God fearing and that's my thing. Because a non-God-fearing doctor is gonna do what his daddy tell him to do. Well, the God-fearing doctor is gone do what his daddy tell him to do, whatever it is. That would be the difference between a non-God fearing versus a God-fearing doctor. So, if I had anything it would be I would send them towards someone that believe God and believe in God (SP 6).

SP 3 also felt that referrals assisted the congregant and the mental health professional. She believed that mental health professionals had natural giftings to counsel and assist those in need of assistance. SP 3 also believed that God "knew we were going to need psychologists and psychiatrists. He knew there was going to be that need for His people." Therefore, she took the position in allowing "someone else to do it, and you're providing for their livelihood and helping somebody out in the process" (SP 3).

For the participants, congregants could have both God and treatment. The

participants felt that congregants did not have to choose one or the other, but they could have both and experience improvement in their situation. SP 1 explained:

> I think that treatment does not hurt along with my spiritual belief. I believe in God, I believe that God our God can do exceedingly abundantly above all that we can imagine or think. Nothing changes my views on that, okay. I believe that God's hand has been involved in making medicine, okay. So, if I take a high blood pressure pill or if I take something for anything else that I might be dealing with, then does that negate my faith? No not at all.

SP 6 believed "that there is a time when the people actually need the medication because the body is the body, God is the divine healer. God can do anything that He wants to do, but He still gave us doctors." The participants were saying congregants could "do both because whatever medication you gone need God to move it to where and do what it need to be, what needs to be done" (SP 6).

Personal Responsibility. Personal responsibility revolved around the participant's ability to actively engage in the process of change. The participants believed that if the congregant wanted to experience significant change they had to become personally responsible in following through on the recommendations and referrals given by the senior pastor or the mental health professional. The participants felt that one could believe and trust in God, but the individual still had to do work for experiencing change. SP 6 shared that congregants had to be "willing to come in and submit to change. Change

their thinking processes, change the things they doing. It's a life changing experience. That comes from the Bible, but then it transposes into every phase of their lives.

According to SP 3 personal responsibility demonstrated the congregant's commitment to personal growth. The personal growth was a result of learning and experiencing new things because of mental health treatment. Personal responsibility was something that SP 3 shared with congregants in the church.

> I say this in church all the time. There's a personal responsibility. We have a personal responsibility if somebody is telling us something. We have to be personally involved in order to absorb it, to understand it, we gotta make ourselves get to that point. God gave us a choice. There's always a choice, and it's your choice. A lot of people are being content, but God intends for us to grow and growing requires learning. Because life is full of lessons and you have to avail yourself, you got to be personally responsible for learning those lessons (SP 3).

Again, the participants reiterated that the congregant's demonstration of personal responsibility did not negate their faith or their belief in God if they participated in treatment. SP 2 gave an example for demonstrating personal responsibility with the use of a Bible reference.

> Jesus was able in His miracle working time to do anything like that, I believe that. But more often than not, there was responsibility of the person, you know. The guy who was born blind in John chapter

> nine, Jesus made clay, put it on his eyes, anointed him but he still said go wash in the pool. You know there's a responsibility. If you trust me, you'll handle your responsibility. And then at the end, He says go thy way your faith has made you whole. I didn't know you trusted me unless you did what I said. So, you have to handle your responsibility sometimes to get your deliverance (SP 2).

Personal responsibility was the message shared with congregants and felt there was "no harm" when congregants expressed an inability to "comprehend" or "understand" when information was given (SP 3). SP 3 felt there was "no harm in saying I don't know," however, she felt that this lack of understanding would prevent congregants in seeking assistance when needed. It was the wish, hope, and prayer that "people would become more open to seeking help" because "life is a learning experience and we should be learning every day" (SP 3).

General Participant Narrative

Main Question.

What are the lived experiences of the African American Christian senior pastor in relation to providing mental health treatment to congregants?

All the senior pastors provided mental health treatment to congregants in the form of pastoral counseling. Most of the senior pastors were the primary person rendering counseling to congregants; however, there were some that co-counseled with their spouse when addressing marital issues. Each senior pastor utilized a combination of biblical resources and tools when rendering pastoral counseling to congregants for addressing a

range of issues surrounding mental health issues. Most of the senior pastors combined personal experiences when providing counseling with usage of the Bible for scriptural references, prayer, spiritual reading materials,
and outside referrals.

How do senior pastors make meaning of experiences helping congregants seeking counseling through the church?

Many of the senior pastors believed they were important figures in the lives of their congregants due to being a trustworthy and supportive leader. Most found their work with congregants to be personal because it was relationship driven. The senior pastors found their counseling work with congregants meaningful because of the interactive and engaging nature of their role as the senior pastor. The senior pastors were not able to directly verbalize their feelings about their relationships with individual congregants but felt that their feelings were demonstrated through their actions in how they served, guided, and taught biblical lessons to congregants on a weekly basis. Generally, there was a sense of responsibility experienced by most of the senior pastors when counseling was rendered through the church.

What are the senior pastor's experiences with mental health treatment?

Most of the senior pastors had participated in mental health treatment as adults. The reasons varied in why mental health treatment was sought by the senior pastor, but many had a positive experience. Most of the senior pastors were taught negative messages about mental health treatment in childhood and did not understand its purpose or benefit until adulthood. As an alternative to mental health treatment many of the senior

pastors had learned about pastoral counseling because they grew up in the Black Church. The Black Church rendered pastoral counseling as an alternative to mental health treatment because it focused on spiritual growth and development as opposed to mental health issues or concerns. When counseling was recommended, most of the senior pastors were referred to formal mental health treatment by a trusted, respected and influential person or ministry leader in their lives.

What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?

Many of the senior pastors had formal training for addressing the mental health problems of their congregants with pastoral counseling. Many of the senior pastors' trainings was limited to pastoral care; therefore, when issues were beyond their scope congregants were referred to mental health professionals for further treatment. For many of the senior pastors, pastoral counseling involved the use of the Bible; hence, allowing them to use spiritual resources, techniques, and tools as support when counseling congregants. Most of the senior pastors felt competent and proficient in rendering pastoral care to congregants for mental health problems because of their leadership and training experience; however, understood it was necessary to refer when mental health issues were greater than their pastoral training.

General Description

In general, senior pastors have experience rendering mental health treatment to congregants when support is sought through the church because of personal experience or professional training. The form of treatment senior pastors primarily use is pastoral

counseling when offering support for addressing spiritual and non-spiritual issues with congregants. Senior pastors understand the difference between pastoral counseling and mental health treatment and respect the benefits of each form of treatment. This positive view of treatment allows senior pastors to feel comfortable rendering treatment, while also understanding the need for referring congregants to formal mental health treatment.

Senior pastors understand how to use pastoral counseling when assisting congregants with personal matters with the use of prayer, scripture, Bible stories or references, and personal experiences. However, when congregants need further assistance and possible medication management senior pastors know when to refer congregants to licensed mental health clinicians for formal mental health treatment. Senior pastors understand the gravity of their role in the lives of congregants; therefore, when problems are beyond their scope of training or knowledge it is best to refer congregants to licensed mental health professionals. The recommendation to formal treatment is not viewed negatively and does not negate the senior pastor’s or the congregant’s faith when pastoral counseling is not enough for addressing the congregant’s issues.

Senior pastors understand the positioning they have in the lives of their congregants and at their core is the need to please God and to assist God’s people. It is the faith of the senior pastors that assists them in how best to support congregants when pastoral counseling is not enough for addressing personal issues. Regardless of their personal experiences with mental health treatment, senior pastors understand the value, benefit, and necessity of formal mental health treatment. There is the belief that the Bible can answer all the problems presented by the congregant; however, it is understood that

there are times when more is needed because it is beyond the scope of the senior pastor's training, and personal or professional experience. Senior pastors understand how they play a vital role in the lives of their congregants and feel that when they cannot meet the need of congregants with pastoral counseling, there is someone else trained and qualified to render support.

Summary

Data was collected with the use of semi-structured recorded interviews from six African American Christian senior pastors with lived experiences in relation to providing mental health treatment to congregants. Five of the six interviews were conducted face-to-face in the senior pastor's office. One interview took place over the telephone and was recorded. Each interview was recorded with the use of the Phillips Digital VoiceTracer DVT 2710 audio recorder and transcribed with Dragon speech recognition software. I identified three main themes and 14 sub-themes. The three main themes were pastoral experience, personal mental health experience, and mental health treatment. The 14 sub-themes were resources, referral behaviors, roles and responsibilities, influence, challenges, pastoral versus secular counseling, training; awareness, messages and beliefs, participation, African American community; spiritual issues versus nonspiritual issues, faith issue versus health issue, referrals, God and treatment, and personal responsibility.

Three research questions were developed for the study. One main question and three sub-questions were designed for exploring three areas. First, I wanted to explore the senior pastors' experiences in rendering mental health treatment to congregants for understanding how they counsel. Secondly, I wanted to explore the senior pastors'

personal experiences with mental health treatment for understanding the pastor. And last, I wanted to explore the senior pastors' views on how effective they believed they were when offering mental health support to their congregants. The data collected from the participants answered my questions for exploring these three areas.

Chapter 4 described the data collection procedures, data analysis, and summary of themes for this phenomenological study. In Chapter 5 I review the discussion, conclusions and recommendations based upon the findings of Chapter 4. Chapter 5 also discusses the implications for positive social change and the essence of the study based upon the research findings.

Chapter 5: Discussion, Conclusion, and Recommendation

Introduction

I used a qualitative phenomenological approach to explore the lived experiences of African American Christian senior pastors who render mental health treatment to congregants. The purpose of the qualitative study was to understand what lived experiences of African American Christian senior pastors in relation to mental health treatment and how these experiences influenced the assistance they provided to congregants seeking mental health support through the church. I developed the following research question and three sub-questions to guide the study.

Research Question and Sub-Questions

I developed the following research question to guide this study: What are the lived experiences of the African American Christian senior pastor in relation to providing mental health treatment to congregants?

From this question, I developed the following sub-questions:

a. How do senior pastors make meaning of experiences helping congregants seeking counseling through the church?
b. What are the senior pastor's personal experiences with mental health treatment?
c. What are the training experiences of the senior pastor for addressing the mental health problems of their congregants?

The research questions were designed to explore three areas. The first area was senior pastor's experiences with rendering mental health treatment to congregants. This

allowed me to understand how the senior pastors rendered counsel to congregants, and the resources, techniques, and strategies they used when counseling. The second area of exploration was the senior pastors' personal experiences with mental health treatment. This area offered me insight into the senior pastors' backgrounds and personal histories and experiences from childhood to adulthood, which I used to better understand how their experiences influenced treatment and referral behaviors when working with congregants. Last, I explored the senior pastors' views on how effective they believed they were when offering mental health support to congregants. This area allowed me to focus on the effectiveness of services when treatment was sought through the senior pastor and the church.

In exploring these three areas, I gained valuable data for answering the main research question and three sub-questions. I found that each senior pastor had experience providing mental health treatment to congregants who sought support through the church. Data showed how each senior pastor had learned negative messages associated with mental health issues and mental health treatment but did not allow the learned messages to negatively influence mental health treatment, support, or referral behaviors when assisting congregants. Second, the senior pastors believed that mental health treatment did not negate one's faith in God, and when pastoral counseling and biblical resources were not enough for resolving mental health issues, they gave congregants referrals to mental health professionals when further assistance was needed. The senior pastors believed that mental health treatment was effective and beneficial for addressing mental health issues or concerns when needed. Last, the data showed that mental health training

was limited for the senior pastors, and that when an issue was beyond their scope they felt comfortable referring congregants to trained mental health professionals.

This qualitative research allowed me to explore the lived experiences of senior pastors in order to understand how they counseled congregants, their personal experiences with mental health treatment, and their views on their effectiveness when offering mental health support to congregants. Based upon the information collected from the qualitative study, in this chapter I synthesize the findings in the context of literature I reviewed in Chapter 2 to demonstrate the lived experiences of African American Christian senior pastors. In this chapter, I interpret my research findings and discuss limitations of the study, recommendations, and implications, and offer a conclusion.

Interpretation of the Findings

The phenomenological approach allowed me to listen to the detailed accounts of senior pastors' lived experiences rendering mental health services to congregants. This qualitative approach afforded me the opportunity to view the participants "lifeworld" from their perspective (see Giorgi, 2010). Participants discussed their lived experiences as African American Christian senior pastors who render mental health treatment to congregants seeking assistance through the church. The analysis was based upon my interpretations of the participants' descriptions of their lived experiences. For analysis, I used three strategies to obtain tangible descriptions of the participants' lived experiences.

The themes developed from my efforts of summarizing and paraphrasing the participant's descriptions (see Giorgi, 2010). It was my aim to elicit thick, rich descriptions related to the single phenomenon of study in order to understand the

meanings the participants' associated with their lived experiences (see Pietkiewicz & Smith, 2012). From my analysis I identified three main themes and 14 sub-themes. The three main themes were pastoral experiences, personal mental health experiences, and mental health treatment. The 14 sub-themes were resources, referral behaviors, roles and responsibilities, influence, challenges, pastoral versus secular counseling, training, awareness, messages and beliefs, participation, African American community, spiritual versus nonspiritual issues, faith issue versus health issue, referrals, God and treatment, and personal responsibility.

Theme 1: Pastoral Experiences

All the senior pastors were grounded in their spiritual beliefs in serving God and God's people. The senior pastors' identities marked an intermingling of who they were personally, and their spiritual role as the leaders of their churches. The work was viewed as personal and taken seriously by the senior pastors because of the level of influence they had in the lives of their congregants. The senior pastors understood their level of influence because they were the primary person tending to the needs of their congregants. According to Hardy (2014), the senior pastor is the "spiritual shepherd who tends to the personal needs of his or her congregants" (p. 4). This belief was echoed by SP 1 when he stated it was his "responsibility to lead, to guide, to feed, all from a spiritual perspective." This belief aligned with findings from Stansbury et al. (2012) who showed that many senior pastors believe that "shepherding the flock" (p. 964) is their single most important duty as a spiritual leaders.

At the core of the pastoral experience was the need for building connection at a

"human level and not a professional level" because the belief was "the preacher is here for you, you're not here for him" (SP 4). For this connection to occur, the senior pastors felt they had to meet the congregants where they were in relation to the spiritual or nonspiritual problems, challenges, or issues brought to them for assistance. According to Chatters et al. (2011), a lot of the problems, challenges, or issues for congregants are "largely secular in nature" (p. 120). I found this statement to be true for the senior pastors in my study because each reported addressing a lot of issues with congregants that were not related to spiritual growth and development.

To meet the congregants' mental health needs, the senior pastors all began with pastoral counseling. Pastoral counseling was formally described by Young et al. (2003) as the provision of "care, counseling, compassion, or advice mainly in relation to emotional, psychological, or moral problems" (p. 689). Pastoral counseling was the foundational tool for treating mental health issues for each senior pastor. For the senior pastors, pastoral counseling involved addressing the congregants' issues with spiritual principles and resources because of its Christian value and emphasis. For SP 1, "pastoral counseling is biblical counseling" and it is "guided on what the scripture says pertaining to your issues." The use of pastoral counseling was considered a gifting of the senior pastor and it was strongly connected to their role and identity.

The senior pastors' Christian identities were interconnected with how they viewed themselves as leaders; therefore, the Bible and other biblical resources were used when rendering counseling because "the Bible has an answer if you, if you want it" (SP 3). This statement was supported by Young et al. (2003) who found "scripture provides the

answers that people are looking for" (p. 690). Even though three of the senior pastors had formal education and/or training on mental health education, pastoral counseling was always rendered prior to a referral to other forms of treatment. I believe that because the senior pastors felt their leadership role was influential and significant in the church and the African American community, they initially used pastoral counseling when providing mental health treatment to congregants seeking support through the church (SP 1).

I found that the senior pastors' personal and professional experiences influenced how they provided counseling; however, they each understood the value and benefit of formal treatment with a trained mental health professional. More specifically, when an issue was beyond the senior pastors' scope, they gave referrals to congregants for formal mental health treatment. This practice aligned with findings by Stansbury et al. (2012). Stansbury et al. (2012) found that "clergy readily acknowledged their lack of training in counseling and preferred to recommend congregants seek assistance from specialty mental health personnel" (p. 966). Brown and McCreary (2014) also found that a large percentage of senior pastors did not feel equipped to counsel congregants because of limited training. Both studies were reinforced by the statements expressed by the senior pastors participating in the current study. The following statements were made by the senior pastors supporting this idea:

- SP 1: "I don't think that pastors who are not trained in counseling should be engaging in mental health counseling."
- SP 3: "The bible. I can tell you this is what the Bible says, you need something a little deeper than this you need to go see somebody. I can connect

you."

- SP 4: "There are times you have to say that's beyond me, or what you're dealing with I think that you need to go and talk to a professionally trained person."
- SP 5: "I can't remember if I ever told them you need to get more professional help, but I would have no problem saying that. I don't have all the answers."

Senior pastors can assist congregants with mental health issues, promote awareness on mental health issues, and refer when mental health issues are beyond their scope. However, it is up to the senior pastor to practice these behaviors when congregants seek support through the church. I found that each senior pastor assisted congregants with mental health issues, promoted awareness on mental health issues, and referred when appropriate based upon the stories shared with me about their pastoral experiences. I also found that each senior pastor had pastoral experience with leading, teaching, counseling, and referring congregants regardless of their tenure as leader.

Theme 2: Personal Mental Health Experiences

The senior pastors grew up with similar messages and experiences as children surrounding mental health issues and treatment. Each pastoral leader grew up with hopeful lessons about God, faith, and the church, but discouraging or limited messages about mental health treatment. "In the African American community mental health treatment is viewed negatively and we don't take advantage of it in our community" (SP 1). SP 2 stated he "didn't hear anything about counseling or mental health treatment growing up." The messages about God, faith and the church were viewed positively by

the participants because of their experiences and messages learned in their youth; whereas, mental health treatment was taught to be viewed as negative until adult experiences changed their minds. SP 5 grew up thinking that one had to be "crazy" or experiencing a "mental breakdown" for one to seek assistance from a mental health professional. It was because of this negative view and possible lack of awareness that there was little to no personal mental health experiences for the senior pastors prior to adulthood. SP 6 was a senior pastor with no awareness of mental health issues growing up because it "was not anything that I ever heard about." SP 2 also stated that he "didn't hear anything about counseling" when growing up. However, the awareness of mental health increased as the senior pastors grew older because of life experiences. SP 6 learned about mental health "after high school, in college" because of taking psychology courses; whereas, SP 1 indicated "in adulthood is when it was introduced." Even though there were limited mental health experiences and awareness in their youth, the senior pastors did not allow these factors to influence referral behavior. This was contrary to the notion presented by Hays (2015). Hays (2015) stated that negative views about mental health could negatively impact the formal help seeking behaviors of African Americans involved in the church resulting in poor mental health outcomes. I found this contrary to the Hays study because the senior pastors' views and experiences did not hinder them in participating in treatment when needed or assisting congregants with treatment or referrals for treatment of mental health issues.

For some of the senior pastors, the introduction to mental health awareness began in young adulthood. There was an awareness and exposure to pastoral counseling, but a

greater understanding and awareness of mental health began in adulthood. Based upon these experiences, the senior pastors first counselor was their senior pastor. Because of their personal experiences, the senior pastors were possibly the first counselors for their congregants. For the senior pastor's, mental health issues were addressed by the senior pastor in the church with pastoral counseling. "I was exposed to pastoral counseling through my senior pastor" (SP 1). This statement was reflective of most of the experiences of the senior pastors in the study. According to Chaney (2013) African American's help seeking behaviors begin with the church rather than mental health professionals because of their strong relationship with the church, God, and their faith. The experiences of the senior pastors aligned with this research.

It was believed that because of limited awareness and experience the senior pastor's participation in mental health treatment was minimal. Again, if there was participation in mental health treatment it did not occur until adulthood. And the senior pastor's participation in treatment occurred because someone they trusted within the church referred or recommended mental health treatment as an option for support. SP 1 stated he participated in treatment because his senior pastor "thought that it was imperative that I have some type of counseling…to make sure that I had squared away my grief, so that I would be in a position to minister to others." It was after these types of occurrences for the senior pastors that their views on mental health treatment began to shift because there was a greater understanding of what treatment was and how it could be utilized. The removal of the "stigma, shame, and embarrassment" associated with treatment offered the senior pastors the opportunity to view treatment differently

(Thompson et al., 2004, p. 22).

The senior pastors believed that the stigma associated with treatment was changing within the African American community; however, it would take time to further decrease the stigma, embarrassment, and shame associated with mental health treatment because conversations had begun to arise within the cultural group, and its religious community within the last five years. SP 1 stated "five years ago we didn't talk about mental health treatment in our community, in our churches. If you had a mental health issue that was between you and your family, or just you." However, it was now believed that the discussion was increasing because of the church increasing in education and awareness about mental health treatment. "In the COGIC, they've been telling the pastors that they need to have resources, more resources. And as the church gets more educated, they are realizing that we do need those resources" (SP 6).

The participants believed technology and education had assisted in the progression of the conversation within the African American community and the church. SP 2 stated how "people read more and with all of the worldwide web that's out there" mental health issues and treatment could not be ignored. SP 5 felt things had "changed for the better" because "you got so much information cause of the internet and social media." SP 5 went on to state that in the African American community individuals were becoming "more and more aware of different things that we need to see happen" influencing the increase in the utilization of mental health treatment. Jackson (2015) found that even within church-based counseling ministries there was an increase in treatment for African Americans for addressing mental health problems. With a decrease

in the stigma associated with treatment and an increase in mental health treatment, the senior pastors understood their role as gatekeepers to treatment for their congregants. According to Hays (2015) senior pastors serve as “counselors” and as “gatekeepers” of services for congregants because they are the “central figures who set the tone for congregational life” (p. 301). The senior pastors in this study understood their role was important in the mental health well-being of congregants (Jackson, 2015).

Theme 3: Mental Health Treatment

For the senior pastors in this study, mental illness and mental health treatment were real issues needing to be addressed within the African American community and the Black Church. It was believed by the senior pastors that mental health was not an issue that could be categorized into a spiritual versus nonspiritual issue or faith versus health issue. For the senior pastors in this study it was believed that mental health issues were real and should not be overlooked because it was viewed as a spiritual or faith issue. In this study, when pastoral counseling was not enough for treating the congregants’ issues then referrals to formal mental health treatment were given. There were previous studies conducted for exploring if spiritual issues were a cause for mental illness, which is why I explored this aspect in this study with the senior pastors. According to the study conducted by Stanford and Philpot (2011) spiritual issues were considered a cause for mental illness; however, it was listed as the third factor following biological and psychosocial causes. The Stanford and Philpot study’s results assisted me in exploring this area when interviewing the senior pastors for this study. This qualitative study revealed that the senior pastors considered spiritual issues a factor in influencing mental

health challenges, but it was not a significant factor for minimizing the need for mental health treatment when congregants were addressing serious mental health issues.

In this study, the senior pastors offered prayer, Bible scriptures, and other biblical tools when assisting congregants because they felt that was what they needed to offer congregants when support was sought through the church. These resources were viewed as necessary tools when providing pastoral counseling to congregants because of the senior pastor's experience and training, but these were not the only tools used with congregants. Even with the use of spiritual tools for coping, it was personally believed by SP 1 that too much reliance upon mental illness being a spiritual issue led to the dismissiveness of what the congregant was experiencing. "If you have a mental illness, I think that we rely so much on the spiritual that we disqualify, or kind of scale down the reality of the mental illness experience" (SP 1). For SP 6 there was a clear distinction between someone being influenced by demons versus someone needing help with mental health issues, and the necessity for understanding the difference. SP 6 stated that in the church "we don't recognize like we should because we're quick to say, well it's just a demon or it's just a demonic force." He felt that he was able to "recognize the difference between the two, when somebody is having a demonic battle or somebody that is actually dealing with a mental health issue." With SP 1 and SP 6 understanding the distinction between demonic influence and mental illness, would better allow them to identify when a referral was needed for mental health treatment versus pastoral counseling. This supports research by Taylor et al. (2000) who found when clergy can identify and understand a congregant dealing with a serious mental health issue, they are willing to

refer the individual to a mental health professional.

According to Taylor et al. (2000), and Stanford and Philpott (2011) only a small number of clergy refer congregants to mental health treatment because they are unfamiliar with the services and the process for referring, or due to issues of cultural mistrust. However, I found this to be the contrary with the senior pastors participating in the study. Each of the senior pastors had the ability to refer congregants to mental health professionals and understood the necessity for referring to formal treatment. SP 2 shared that when a problem was beyond their scope, they knew it and referred the congregant. "Now if I don't know something, I'm like hey I don't know that information, but I can get it. And if I can't I'm gone literally send you to somebody who can" (SP 2). SP 4 and SP 6 expressed cultural mistrust of mental health professionals due to a combination of personal mental health treatment experience and individual faith. SP 4 and SP 6 preferred to refer congregants to mental health professionals that had experience in working with African Americans and believed in God. SP 4 stated "when you to go to secular counselors, they really don't deal with it from a theological lens." SP 6 felt that if he referred congregants to secular counselors "they're gonna give them good secular information, but not Godly information." However, even though these concerns were expressed it was believed that "good Godly advice" could come from a "clinical standpoint" (SP 6).

Based upon these concerns, the senior pastors felt strongly that there were God given talented professionals available to assist congregants with their problems because that was what they were trained to do. The statements shared by the senior pastors supporting

this thought are listed below.

- SP 1- “There are people that have given their lives in study and preparation and in services to those areas. There are people in place to do things like that and anytime you try to do something that somebody else is gifted, skilled, and qualified to do you put yourself at risk and you prohibit them from doing their job.”
- SP 5- “God knew we were going to need psychologists and psychiatrists. He knew that there was going to be that need for His people. And so, He provided that there are some people that have certain gifts and certain talents that can do stuff. Natural ability, but it’s a gift.”

In relation to mental health treatment, the senior pastors felt that congregants did not have to choose between God and treatment. And that the congregant’s participation in treatment did not negate their faith in God and what He could do for helping them with their issues. SP 1 shared that “treatment does not hurt along with my spiritual belief.” SP 2 had similar feelings because he stated “there are some medical things that have to be done along with divine healing. God can do anything that He wants to do, but He still gave us doctors.” The six senior pastors felt this was an important factor to address with congregants when discussing mental health treatment referrals because it was one of the reasons influencing participation in treatment. According to Allen et al. (2010) “having mental illnesses that might require more professional mental health care services outside the spiritual realm may be viewed as a sign of weakness in congregants or failure to have faith in God” (p. 134). When addressing this aspect with congregants, the senior pastors

explained that it took the congregant being personally responsible for creating change in their life. This was described as “God can do all and be all, but he’s given you the ability to do the work that’s required for the deliverance or the healing” (SP 2). It was also believed that there had to be a “balance” between trusting God and getting help from trained professionals because one must trust God for their healing, but also “put some works into play” (SP 5).

SP 6 shared that “the ones that are willing to come in and submit to change. Change their thinking processes, change the things they’re doing. It’s a life changing experience.” Being personally responsible involved the congregant making choices about what they needed and could benefit from based upon the recommendations of the senior pastor. Sometimes these choices involved accepting the referral to mental health treatment when the issue was greater than what the senior pastor could handle. Allen et al. (2010) explained that sometimes a referral is needed when the senior pastor is ill equipped to evaluate, diagnose, or treat mental illness. The aspect of personal responsibility was one which the congregant and the senior pastor had to understand for determining the next steps of assistance when support was sought through the church.

The senior pastor’s personal responsibility involved the congregants’ problems or symptoms not being viewed only from a religious or spiritual viewpoint (see Taylor et al., 2000). The incorporation of spiritual beliefs is beneficial when addressing mental health concerns for support through the church (Jackson, 2015); however, it cannot be the only option when the congregant seeks support through the church. Due to the senior pastor’s integral role in the congregant’s life, they are faced with the responsibility of how best to

support the congregant when mental health treatment is sought through the church. According to SP 3, “there’s a personal responsibility. We have a personal responsibility if somebody is telling us something. We have to be personally involved in order to absorb it, understand it, we gotta make ourselves get to that point. God gave us a choice. There’s always a choice, and it’s your choice.” The senior pastors understood the important role they played in the lives of their congregants when discussing mental health issues and treatment; hence, increasing the likelihood of referral to formal treatment when pastoral counseling was not enough for addressing the issues plaguing the congregant.

Limitations of the Study

This study provided valuable in-depth data describing the lived experiences of African American Christian senior pastors in relation to providing mental health treatment to congregants when support was sought through the church; however, this study had a few limitations. Given the focus of the phenomenon of study and the inclusion criterion in a marginalized population, there were some challenges with participant recruitment. The specific demographics of the participants selected for this study had a direct bearing on the nature of the lived experiences documented. The focus on African American Christian senior pastors within a specific organization in the faith community created challenges with recruitment within the first month. One participant from the organization expressed interest and qualified as an appropriate participant; however, the other five participants came from word of mouth about the study from members of the ministerial organization and affiliates of the organization. The participants contacted me from the information listed on the flyer and stated who they

were and how they learned of the study. After the interested participant shared their information with me, I then utilized the four criteria questions for determining their appropriateness for participating in the study. After it was determined the participant was appropriate for the study I scheduled a meeting for conducting the face-to-face interview. All the participants self-reported their experiences with the phenomenon after an explanation was given on mental health treatment, pastoral counseling, and mental illness. It was important that each senior pastor had a clear understanding of the phenomenon being explored for this study; therefore, an explanation was given to all participants prior to beginning the interview process.

The generalizability of the findings is limited to the senior pastor which is a specific leader within the church leadership hierarchy. The senior pastor is the first level of Black church leadership that ensures that church leaders under their leadership effectively meet their parishioners' and families' needs. The study did not focus on associate pastors/ministers, deacons/deaconesses, or other church leaders that render support to parishioners and families in the African American church. Therefore, the findings may not apply to other forms of church leaders in the Black Church. For this study the participants were diverse in age, pastoral leadership experience, gender, education, and training in the African American population; hence, the caution in expecting the same or similar themes in future studies with participants from a different level of church leadership than those described in the study. Though I anticipate transferable results based upon the consistency of the findings while exploring the lived experiences of African American Christian senior pastors in relation to providing mental

health treatment to congregants, the factors of age, pastoral leadership experience, gender, education, and training are important considerations for future studies if the leadership level or ethnic group is different.

The last limitation is related to issues of trustworthiness. Member checking, researcher notes, and interview protocol forms were utilized for establishing credibility and validation, but not participant transcript review. Participants were offered the opportunity to review their transcripts after transcribing the recorded interviews; however, each participant declined the review. For future studies I would recommend researchers request participants to review transcripts for further establishing the authenticity of the data collected. The combined trustworthiness techniques implemented for this study were necessary strategies because participants declined transcript review. Based upon the findings of the study, I have a few recommendations for future research studies. The recommendations are discussed in the next section.

Recommendations

Based on the limitations and strengths of this study, I have a few recommendations for future research studies. First, future phenomenological studies should be conducted for exploring the lived experiences of African American Christian senior pastors in relation to providing mental health treatment to congregants. The collecting of thick, rich descriptions on the senior pastors lived experiences will continue to decrease the literature gap on this population. In relation to future phenomenological studies with African American Christian senior pastor participants, the focus of participants over the age of sixty-five is recommended. This study left me wondering if

older participants with different experiences would have rendered different results because of their life experiences with issues surrounding civil rights, Jim Crow, and segregation. Regardless of the other demographics of the participant, it is believed that the age of the participant would vary the themes or sub-themes.

The recommendation on participant age is based upon the interviews with participants from this study. The participant ages ranged from 28 to 68, and the oldest participant referred to the challenges of racial inequality more than the other participants. The reoccurrence of race and inequality in the older participant's interview introduced a factor of why one's faith was important and how mental health illness and treatment was viewed differently. Due to the racial challenges faced by older African Americans a place of belonging was needed, and the Black Church met this need. It was during these times of oppression that one's faith created community amongst African Americans while also offering hope, moral guidance, and support (Thompson & McRae, 2001).

Most of the participants referenced older senior pastors over the age of 65 not believing in mental health issues or treatment because it was taught that these were spiritual issues or demonic forces attacking the individual. Some of the participants shared that African American senior pastors over a certain age would disagree with mental illness being a real issue needing formal treatment because of their spiritual beliefs and teachings. Therefore, future studies surrounding this phenomenon with participants over the age of 65 is recommended. This recommendation would allow for future researchers to explore the same population with specific criteria for identifying similar themes or sub-themes. The literature reviewed in Chapter 2 addressed the need for

future research on the lived experiences of African American senior pastors; hence, the development of this research study. However, the recommendation from this study would allow future researchers to develop a different focus for their study with the same marginalized population. A phenomenology is effective because it focuses on an individuals' lived experiences. This approach allowed me to experience the participant's view in-depth through exploration, observation, and experience creating the opportunity for me to understand the meaning associated with the experiences.

Second, for novice and experienced researchers I recommend a personal introduction when engaging participants for the first time which includes the researcher's background, education and training, and limited personal history, in addition to the purpose of the study. Researchers are asking participants to share personal experiences with them; yet, researchers may not share any details about themselves for remaining objective. One participant wanted to know me and my interest for conducting research after our interview concluded. I felt comfortable engaging the participant, and felt it was important to interact with him as a person and not a "subject" of study. This experience identified the need for researcher introductions when recruiting participants for studies.

Due to the cultural mistrust within the African American community it may be important to share some personal history with the participant for building rapport and establishing trust. African Americans have a history of cultural mistrust because of their marginalization within larger society; therefore, researchers should consider the numerous personal and environmental factors encountered daily within this population (see Briggs et al., 2011). Researchers working with participants in the African American

population should be culturally sensitive in how they engage and interact with participants when conducting research because of the lack of trust felt towards ethnically different individuals. This is a factor future researchers should consider when conducting research with this marginalized population.

Another recommendation involves the recruitment of participants. I recommend future researchers to have an open recruitment of participants meeting the selection criteria established for the study. I focused on a specific group with the assistance of a gatekeeper which initially led to recruitment challenges. I would encourage participants to mail flyers to a list of African American churches and organizations in several areas for recruiting participants. This would increase the sampling pool of participants. For this study, most participants came through word of mouth increasing the variation in sampling. I believe diverse participants were gained for this study because of interested participants sharing information about the study.

Also, I recommend future researchers offer an explanation on the difference between mental health treatment and pastoral counseling. The description of pastoral counseling was based upon the literature of Young et al. (2003) and Power (1990), and the term mental health treatment was based upon the definition of the Merriam-Webster Dictionary (2016). Both terms were discussed in Chapter 1 in the operational definitions section. I learned during my first interview that the participant was unclear in understanding the term mental health treatment. Once this was identified, I explained both terms in subsequent interviews for ensuring participants understood the interview questions; hence, allowing me to gain a detailed description of the participants' lived

experiences in relation to mental health treatment and pastoral counseling. I also reflected the participants' responses with member checking to increase my understanding of their experience and establishing trustworthiness, but also ensuring the participant understood the interview question. Member checking during the interview process increased the reliability of the study because it removed bias and increased credibility and validity during the methodological process (Patton, 2002). In addition to member checking, I recommend future researchers request participants to review transcripts for increasing credibility and validity. Although participants from this study declined transcription review, future studies can strengthen the trustworthiness of their research by having participants their review transcripts for offering feedback on the accuracy of the analysis.

Last, based upon the results it is recommended further research is conducted with church leadership in the Black Church. The results of this study would allow future researchers to use other qualitative approaches for further exploring this phenomenon with African American Christian senior pastors. Data collection in the form of interviews, documents, observations, case studies, or focus groups would allow members of the mental health profession to gain a greater understanding of this cultural group and their shared norms. This study allowed me to identify how long-term research can be conducted with African American senior pastors in various areas for examining their lived experiences surrounding mental health issues and treatment personally and professionally.

Implications

Two implications were derived from the study's findings regarding positive social

change. The first implication involves the increase of information on a marginalized population. This phenomenological study adds to the knowledge base on the lived experiences of African American Christian senior pastors in relation to providing mental health treatment to congregants. The information collected would allow mental health professionals to gain a clearer understanding of the leadership role of the senior pastor. More specifically, the influence the senior pastor has in the lives of congregants, the role of the senior pastor in the Black Church, the type of services the senior pastor renders when counseling congregants, the tools and resources used when counseling congregants, the beliefs and messages learned about mental health treatment by the senior pastor based upon personal experience, and the senior pastors counseling experience when working with congregants when support is sought through the church. The information collected from this study decreases the literature gap and knowledge base on African American Christian senior pastors and their understanding of mental health treatment, their personal experiences with mental health treatment, and their professional role as a provider of treatment when congregants seek support through the church. The current study offers members of the counseling community a point of reference when engaging African American senior pastors about mental health issues and treatment in the Black Church for increasing cultural competency.

Second, the information collected from this study can assist in the development of strategies for establishing relationships with senior pastors and its leaders in the Black Church. If there is an interest in building mutual relationships and/or partnerships with leadership within the Black Church, this study could offer support as a point of reference

for factors of consideration when contacting the senior pastor. These factors are in relation to the senior pastors understanding or meaning of mental health treatment, the type of services offered when treatment is rendered, the senior pastors gatekeeping role in the church and the African American community, and the senior pastors referral behavior for issues beyond their scope.

These factors could assist mental health professionals on how to connect senior pastors in need of nonspiritual resources and referrals within the community for educating and supporting its membership with mental health related issues. The information collected in this study could assist mental health professionals in remaining culturally sensitive when assisting congregants referred to them by the church, if one of their goals is building relationships and/or partnerships with Black Church leadership. The increase in cultural sensitivity in the counseling community would allow mental health professionals to better understand how or why congregants may initially seek support from their senior pastor instead of counseling professionals. The increase in awareness could assist counseling professionals in changing their perceptions of the senior pastor and the Black Church when addressing mental health issues with congregants.

Researcher Reflection

This phenomenological study gave me the opportunity to clearly understand the African American Christian senior pastors lived experiences in relation to providing mental health treatment to congregants. My interest in conducting this study formed because of my own personal experiences as an African American woman identifying as

Christian, a person of faith that works in the mental health professional, and a member of the leadership team in a Black Church. In all of this, I had to set my personal experiences aside for understanding the lived experiences of the senior pastor. I gained a newfound respect for the senior pastor's leadership role, humanity, and struggle for balance in shepherding people looking for answers in their life concerning God and life matters. The role of the senior pastor is significant in the church and community, and it is not taken lightly by those who serve others in this capacity.

The key essence of this study was to learn about senior pastors and how they rendered mental health treatment, their personal experiences with mental health treatment, and their effectiveness when offering support to congregants when treatment was sought through the church. I believe that I gained an in-depth understanding of this population in their personal and ministerial journey concerning mental health issues and treatment. First, I learned that in order to build connection with this group one must see their humanity. It was clear that before all else, the senior pastors cared about taking care of other people. Their positioning afforded them a responsibility that was viewed seriously before man and God. They believed in doing no harm, just as mental health professionals.

Second, senior pastors view mental health professionals as resources because there are times when certain mental health issues are beyond the scope of pastoral counseling. There were concerns about standard of care when referring congregants to non-faith based mental health professionals, but they are still considered trustworthy sources because they are trained professionals. Just as some senior pastors and the church

are beginning to learn about mental health issues and treatment, members of the mental health community are still learning about the Black Church and its leaders. There are perceptions in both groups that are being examined which is why research is needed for creating social change in both communities.

Exploring and understanding this population is important because it gives a voice to those that have been overlooked and marginalized in larger society in relation to many personal and social issues. This form of qualitative research gives members of a marginalized community the opportunity to be heard through the telling of their stories to researchers that can create change within a social context with the creation of programming and training for supporting the mental health needs of members in the African American community. The creation of culturally sensitive dialogue can only begin when an interest is shown by those wanting to know and understand what is needed for effective change to occur. It is my hope that my research will assist in furthering culturally sensitive dialogue for decreasing cultural mistrust within a marginalized community in order to have their mental health needs met when support is sought in the larger community outside of the Black Church.

Conclusion

This phenomenological study explored the lived experiences of six African American Christian senior pastors in relation to how they provided mental health treatment to congregants when support was sought through the church. I wanted to understand the senior pastors' experiences in rendering mental health treatment to congregants, the senior pastors' personal experiences with participation in mental health

treatment, and the senior pastors' views on their effectiveness when offering mental health treatment to congregants. I developed a main research questions and three sub-questions for exploring each area. Face-to-face recorded interviews were used for collecting data from six participants on this phenomenon.

Five men and one woman ranging in ages 28-68 participated in the study with the average interview time being 60 minutes. The participants gave thick rich descriptions on their lived experiences as Christian senior pastors rendering mental health treatment to their congregants. The interviews were transcribed over a 3 week timeframe and data analysis began after the interviews were transcribed. The analysis consisted of three strategies for rendering three main themes and 14 sub-themes. First, the transcripts, demographics information and researcher notes were organized and placed into folders. Then I classified the data by reviewing each transcript line by line multiple times for identifying large themes and meaning units. And last, I classified the data with a three-column grid for placing the participants' words, themes or meaning units, and general descriptions for examining the data from a new perspective. I explored the essence of the participants' lived experiences and the meaning made of the experiences by the participant with this process.

The first theme is pastoral experiences and its 7 sub-themes are resources, referral behaviors, roles and responsibilities, influence, challenges, pastoral versus secular counseling, and training. The second theme is personal mental health challenges and its 3 sub-themes are awareness, messages and beliefs, participation, and the African American community. The last theme is mental health treatment and its four sub-themes are

spiritual versus nonspiritual issues, faith issue versus health issue, referrals, God and treatment, and personal responsibility. From the data analysis I learned that senior pastors primarily render mental health treatment to congregants with pastoral counseling because of their background, experiences, and training. However, when issues are beyond the senior pastor's scope they ae comfortable with referring congregants to a mental health professional for formal mental health treatment. The referrals were used personally and professionally. It was identified that some of the senior pastors had participated in formal mental health treatment and were encouraged to participate by respected clergy when pastoral care was not enough for addressing their personal issues and concerns. The analysis also identified how senior pastors utilized their faith and their relationship with God for understanding their role in the lives of their congregants and their positioning in the church as the leader of God's people. It was because of this that the senior pastors understood the benefit of having faith in God for healing and direction for personal issues and challenges, but also seeking formal mental health treatment did not negate one's faith.

In conclusion, this study allowed me to answer the three areas of exploration surrounding the lived experiences of African American Christian senior pastors providing mental health treatment to congregants when support was sought through the church. In addition to gaining this information, I was able to add to the knowledge base of literature on African American senior pastors in relation to mental health treatment. This study also gave me a greater insight into the role of the senior pastor and the respect and responsibility that comes with shepherding God's people. This insight allowed me to see

the level of discernment needed by the senior pastor for understanding when it was appropriate to counsel congregants on mental health issues and when to refer to formal treatment with a licensed mental health professional. The senior pastor is a significant leader in the Black Church and it is important that the mental health profession understand the level of respect this person fills in the lives of congregants, in the church and its surrounding community.

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Appendix A: Interview Questions

1. Have you or a loved one participated in mental health treatment? If so, would you share this experience?
2. How did you learn about counseling or mental health treatment when growing up?
3. What were some of the messages you learned about counseling or mental health treatment when growing up?
4. How do you define mental health treatment?
5. What type of role do you believe you play in the lives of your congregants?
6. What has been your experience with counseling or mental health treatment with your congregants?
7. What tools or resources do you use when you counsel congregants on personal issues?
8. What are your feelings about referring someone to formal mental health treatment?
9. How has your faith and/or belief in God influenced your referral behaviors to formal mental health treatment?
10. How do you think counseling or mental health treatment is currently viewed in the African American community?
11. Is there anything you wish to share that we did not discuss regarding your thoughts and feelings about mental health issues or treatment?

Appendix B: Interview Protocol Form

Date of Interview:
Time of Interview:
Place of Interview:
Interviewee:
Questions:

1. Have you or a loved one participated in mental health treatment? If so, would you share this experience?

2. How did you learn about counseling or mental health treatment when growing up?

3. What were some of the messages you learned about counseling or mental health treatment when growing up?

4. What type of role do you believe you play in the lives of your congregants?

5. What has been your experience with counseling or mental health treatment with your congregants?

6. What tools or resources do you use when you counsel congregants on personal issues?

7. What are your feelings about referring someone to formal mental health treatment?

8. How has your faith and/or belief in God influenced your referral behaviors to formal mental health treatment?

9. How do you think counseling or mental health treatment is currently viewed in the African American community?

10. Is there anything you wish to share that we did not discuss regarding your thoughts and feelings about mental health issues or treatment?

Appendix C: Ethical Considerations

1. Gain permission through the gatekeeper to recruit at the next scheduled meeting for the ministerial group for soliciting participants
2. Gain informed consent
    a. Build trust and establish rapport
    b. Explain purpose of the study and how data is used
    c. Explain my role as the researcher and my professional background
    d. Explain that participation is voluntary and will not place participants at undue risk
    e. Refer participants to counseling referral (K. Houston) if distress is reported and participant expresses an interest in participating in treatment. Cards will be kept on site for immediate referral, if requested by participant.
    f. Participants made aware of no compensation for participation in study
3. Discuss adherence to American Counseling Association (ACA) ethical guidelines and Walden University's IRB guidelines
4. Anonymity for volunteers participating in the study. Pseudonyms will be given for identifying participants, but I will be the only person to know the identity. The gatekeeper will not be made of aware of volunteers participating in the study. Scheduling of interviews will be made directly with me from listed contact information

5. Data will be stored on a password protected laptop and kept on file for 5 years from the conclusion of the study
6. Advice, guidance, and researcher thoughts/feelings will be processed with dissertation committee members K. Cannon and K. Peoples as needed
7. Participants are encouraged to actively participate in the study with the answering of all interview questions, but made aware of the option to discontinue participation in the study if a conflict arises

Appendix D: Demographics

Participant #:________________________
Interview Date:______________________

1. In what city is your church located? _______________________________________

2. How many congregants do you have at your church? __________________________

3. What is your age? ____

4. How many years of experience do you have as the senior pastor?________________

5. What is your church's denomination?______________________________________

6. How many hours per week do you provide mental health counseling to your

   congregants:____

Appendix E: Flyer

1. Are you African American?

2. Are you Christian?

3. Are you the senior pastor of your church?

4. Do you render mental health counseling to your congregants?

If you answered yes to each question, and you are interested in participating in a research study for exploring the lived experiences of African American Christian senior pastors and how counseling services are rendered to congregants, please contact Trinaa' L. Copeland at

xxx-xxx-xxxx.

I am Trinaa' L. Copeland, a doctoral candidate in Counselor Education at Walden University conducting a qualitative study on the lived experiences of African American Christian senior pastors in relation to mental health treatment. I am conducting 30 to 60 minute face to face interviews with participants. Participants should be African American, the senior pastor of a Christian church, and offer mental health counseling services to congregants. Participation is voluntary with no compensation. All participant responses and identity will remain confidential.