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Strong Black Women, Depression, and the Pentecostal Church

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Walden University
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Abstract

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MEd, Cambridge College, 2000

BS, Utica College of Syracuse University, 1990

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

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Abstract

Depression is a global health concern and among the top two causes of disability and disease. African-Americans often seek help from the Black church, but Pentecostal churches may fail to provide effective support due to doctrinal beliefs. African-American women with depression struggle due to psychosocial implications of the diagnosis. This research study used social constructionism and the biopsychosocial model of health to explore the lived experiences of African-American women suffering from self-reported depression while attending Pentecostal churches in the Northeast United States. Fourteen women, ages 20 to 76, participated in this qualitative, phenomenological study. Data obtained from the semistructured, face-to-face interviews was analyzed with Moustakas' modified Stevick-Colaizzi-Keen method. Findings included the following main themes: the Pentecostal church was ineffective in dealing with depression, participants drew comfort from personal faith in God, participants emoted through their behavior, most felt they had to wear a mask, traditional supports were used to deal with depression, strength was expected of them, they were blamed by the church for their depression, traumatic experiences were related to depression, and psychological harm was suffered because of Pentecostal church membership. Social change implications included the personal liberation of research participants who shared their experiences. Other implications include the potential for clergy to adopt more supportive practices for their members based on these findings and for mental health professionals to develop treatment options that are more culturally attuned and sensitive.

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Dedication

My Savior, my Daddy, my Papa, and my friend. This journey would not have been possible without you. On good days, on bad days, on happy, and on sad days, you never left my side. With you I found the courage to fight and conquer my anxieties, my depression, my insecurities, and my fears. Because of you, I will forever know that I am accepted. I am healed. I am loved. I AM ENOUGH.

> "He has made everything beautiful and appropriate in its time. He has also planted eternity [a sense of divine purpose] in the human heart [a mysterious longing which nothing under the sun can satisfy, except God]--yet man cannot find out (comprehend, grasp) what God has done (His overall plan) from the beginning to the end." (Ecc. 3:11, Amplified Version)

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Chapter 1: Introduction to the Study

Depression, sometimes referred to as Major Depression or Major Depressive Disorder, is recognized globally as a serious, sometimes fatal medical condition (Ferrari et al., 2013). Classified as a mood disorder, depression causes chronic feelings of melancholy and leads to anhedonia, inhibiting participation in all aspects of life (World Health Organization [WHO], 2012). At diagnosis, African-American women report greater severity in symptomatology and debilitation (National Alliance on Mental Illness [NAMI], 2009/2019). Yet, cultural and social role expectations limit the ways in which African-American women can cope with symptoms when experienced (Abrams, Maxwell, Pope, & Belgrave, 2014). Many have used immersion in the church community through membership and participation as a safe haven and as a coping strategy (Pew Research Center, 2009). However, church leaders often fail to support individuals with the diagnosis of depression (Payne, 2014). This is particularly true in some Pentecostal churches where depression is viewed as a moral failing or spiritual condition (Sorenson, 2013).

The lived experiences of African-American women dealing with self-reported depression or depressive symptoms as they attended Pentecostal churches are explored in this study. Using a qualitative phenomenological research method and design was the most effective way to identify the beliefs and perceptions of the participants as they navigated their church lives, personal lives, and cultural lives while coping with the disease of depression. The study findings have beneficial social change implications in that the data gathered produced information that can positively influence mental health

treatment through the provision of more culturally sensitive care. This effect may in turn reduce the economic and social burden of disease as it relates to health care costs and costs related to disability.

The information in this chapter provides the backdrop of this study, explaining the problem as related to both the general population and the study population. This chapter includes the explanation of the study's purpose, significance, and outlined the research question. This chapter also provides a brief explanation of the theoretical and conceptual frameworks of the study, its nature, and design, and provided definitions of study terms. Finally, study assumptions, scope, limitations, and delimitating factors are identified.

Background of the Problem

At the close of the 20th century, depression was becoming a global problem. Characterized by persistent melancholy, anhedonia, suicidal ideation, somatization, fatigue, anorexia or overeating, insomnia or hypersomnia, and feelings of hopelessness, worthlessness, helplessness, and guilt, depression was in the top five disease burden category (WHO, 2001). Women reportedly had a greater expectation of years lived with disability (YLDs) (14% women vs. 9% men). Moreover, in disability-adjusted life years (DALYs), which related to their years of life lost and YLDs combined, women were doubly affected (i.e., 6% women versus 3% men) (WHO, 2001). Over a decade later, depression rates had not eased with women still affected more so than men, substantiating earlier findings (Ferrari et al., 2013).

Depression is a significant problem for African-American women. Although African-American women are diagnosed less frequently than Caucasian-American

women, when diagnosed their depression is reported to be more debilitating (NAMI, 2009/2019). African-American women cite physical and emotional symptoms that impede engagement in normal routines like work especially when coupled with a comorbid condition (e.g., hypertension) (NAMI, 2009/2019). Bhattacharya, Shen, and Sambamoorthi (2014) found that similar to Caucasian-Americans, African-Americans in the study were at risk for co-occurring conditions like arthritis, asthma, or diabetes. Unfortunately, disparities in health care treatment make it likely that depressed African-American women will be misdiagnosed or under-treated for their condition (NIMH, 2011a).

African-American women feel they have fewer resources to cope with depression, as there is a great deal of social stigma associated with seeking traditional medical treatment for any mental health conditions (Black & Woods-Giscombe, 2012). These women are under a great deal of social pressure to behave and perform in certain ways: they are expected to be strong Black women (SBW) (Beauboeuf-Lafontant, 2009). SBWs are to be depended on, but never dependent; selfless and giving to others, yet expected to suppress their own needs (Woods-Giscombe, 2010). This gendered identity influences the physical, emotional, and psychological health of the women expected to live it out and its pressures are manifested in interpersonal and intrapersonal difficulties, (e.g., relational strife, obesity, and depression) (Woods-Giscombe, 2010). As a result, African-American women seek out culturally acceptable ways to cope with depression, one of which may be attending church.

In the *Black church*, women have historically played an important role in the building and expansion of the church membership and financial accounts (Townsend Gilkes, 2001). In terms of personal benefit, African-American women find spirituality to be a great help in their psychological health (Townsend-Gilkes, 2001). Studies conducted by the Pew Research Center (2009) confirmed that 80% of African-American women believed religion to be important in their lives and 60% attended church regularly. Prayer and Bible reading were noted to be common stress relieving activities (Pew Research Center, 2009). Additionally, African-American women were more likely to seek out pastoral counseling when dealing with life crisis (Chatters et al., 2011). Those who belonged to the Pentecostal denomination most specifically sought out this type of support (Chatters et al., 2011).

Pentecostalism ,as a movement and identified denomination, is rapidly growing. Pentecostals, sometimes referred to as *holy rollers* or *Bible thumpers* are set apart from other denominations because of the belief that the Holy Spirit is an active presence at work in the life of believers upon conversion (Pew Research Center, 2006a). Because of this abiding presence, Pentecostals live in adherence to the Bible, believe in moral and righteous living, and foster an active and loving spiritual community (Synan, 1997; Trice & Bjork, 2206). Consistent attendance at worship services and participation in church events is both encouraged and expected (Sanders, 1996; Townsend Gilkes, 2001). In many cases, church leaders, commonly referred to as clergy, are reverenced as representatives of God, and are often sought out for counsel in activities of daily living and times of difficulty (Sanders, 1996; Townsend Gilkes, 2001). The moral and spiritual

code by which Pentecostals live can be considered unique and somewhat out of step with mainstream culture. These factors aid in fostering the closeness of the community and reliance upon clergy for support.

There is ample research to suggest that African-American women find spirituality and involvement in the church community to be a great help to their psychological health. In addition, church attendance is considered foremost as a mechanism for social support and spiritual health (Pew Research Center, 2009). Yet African-American women who are depressed or exhibit depressive symptoms often experience difficulty when participating in denominations (e.g., Pentecostalism) that demonize or moralize the condition (Asamoah, 2013; Hardwick, 2013). Because so little was known about the experiences of these women, research was needed to understand their collective experience.

Problem Statement

The general problem is that depression is an insidious, chronic, and deadly disease. In 2012, the WHO reported depression as " the leading cause of disability worldwide" (para. 1). The Centers for Disease Control and Prevention (CDC, 2015) reported that close to 400,000 patients leave the hospital with depression as their primary diagnoses and almost 10 million people annually receive some form of medical care related to depression. The CDC further reported that another 40,000 people diagnosed with depressive disorder commit suicide (CDC, 2015). Depression is diagnosed in women twice as often as men (WHO, 2012).

African-American women are more likely to experience severe symptoms from depression than Caucasian-American women (Carr et al., 2013) reporting greater physical

and emotional impairments. African-American women are often chronically debilitated because depression substantially influences their work, home, and social lives (Shim et al., 2013). Social stigma (Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014), cultural pressure (Abrams et al., 2014), and gendered role expectations (Woods-Giscombe, 2010) limit the ways that African-American women can acceptably cope with their depression. Support from spiritual sources is still one of the preferred methods for African-American women (Hwang & Meyers, 2013).

The specific problem is that church leaders often fail to support those with depression diagnoses despite the integral role church organizations have in the African-American community. Payne (2014) reported that pastors surveyed lacked the necessary training to treat mental health issues with few possessing formal pastoral counseling training. Despite admitted deficits in counseling training, over 90% of these pastors believed they were equipped and qualified to treat depression; perhaps bolstered by some participation in postsecondary secular education. This is concerning given that Pentecostal pastors were more likely to attribute mental health issues like depression to the moral or spiritual failure of the person diagnosed (Mercer, 2013). Sorenson (2013) expressed concerns that such intransigent views can exacerbate symptomatology for depressed congregants and increase the risk of further episodes or suicidal ideations. Perhaps that is why African-American Christians reported they would discuss all other life issues with their pastors except depression (Hardy, 2014).

Such mixed messages create conflict for African-American women suffering from depression who attend Pentecostal churches. They live under the constant pressure of

competing demands from culturally engendered role expectations and the expectations from their religious communities (Townsend-Gilkes, 2001; Woods-Giscombe, 2010). On the one hand, African-American women deal with the emotional, physical, psychological, and social effects of depression daily (Carr et al., 2013; Shim et al., 2013). Yet, they are exposed to cultural (Abrams et al., 2014) and religious ideologies (Payne, 2008; 2009) about depression that seem to negate or question the legitimacy of the condition and their experiences. These multiple expectations may affect the emotional, physical, and psychological health of these women.

Purpose of the Study

The purpose of this qualitative phenomenological study was to identify the lived experiences of 14 African-American females who suffered from self-reported depression or experienced self-reported depressive symptoms and attended Pentecostal churches in the Northeast United States. The intention was to ask open-ended questions within semistructured interviews with 14 women or until data saturation was achieved (see Robinson, 2014). Through these interviews, I explored the phenomenon of depression as it related to the women's personal and religious beliefs, perceptions of the disease itself, cultural pressure, gendered identity, and gendered-role expectations from both an ethnic and religious perspective.

The Significance of the Study

African-American Pentecostal women who suffer from depression could be significantly impacted. The research findings brought their struggle out of obscurity and enlightened readers about cultural and religious dogma associated with SBW and the

disease of depression that caused African-American women to hide their experiences due to embarrassment or shame. The willingness of the sample population to share their lived-experiences was a significant step in reducing the social stigma associated with the condition. Moreover, their participation in the study could encourage other women of similar experience to come forward and thereby generate social support networks for African-American Pentecostal women with depression.

The study findings offer support to pastors in their work with congregants, as they are often the first resource sought by African-Americans in times of crisis. The data gathered provides informational insights into the physical, physiological, and psychological effects of depression and enhances pastors' knowledge about how these issues affect social and interpersonal relationships. The information gleaned can inform their counseling practices and open doors for collaborations between religious and secular service providers. Moreover, the understanding garnered might also encourage information sharing between pastors, who through their social capital, may influence change within their networks.

Health professionals can benefit from the research findings as it provides additional understanding about the unique needs of these women. As internists and gynecologists are more likely to provide primary treatment for African-American women (Keller, Valdez, Schwei, & Jacobs, 2016), the study results inform their practice by encouraging discussions between providers and patients about depression and traditional and complementary treatment methods more in line with patient belief systems. Adding

these tools to practice conceivably encourage the provision of more culturally sensitive services.

The findings of the study contributed to the field of health psychology and the literature on depression as it provided insight into the experiences of a group of women who have been in relative obscurity in the literature. There have been many studies published that explore the topic of spirituality and depression as they relate to African-American women, yet there appears to be few that examined a specific segment of the more conservative religious community.

This findings of this study have the potential to significantly influence social change in that it may reduce the economic and social burden associated with depression for African-American women. If these women feel more supported by their pastors and church communities, it could enhance functioning and may reduce the impact on their activities of daily living. This may result in a lessening of the chronicity of their conditions, may reduce, or eliminate missed time from work or the need to collect government or private benefits for disabling conditions. It may also reduce the use of health care and social services.

Research Question

RQ1 – What are the lived-experiences of African-American women with self-reported depression who attend Pentecostal churches in the Northeast United States?

Nature of the Study

The qualitative research methodology was appropriate for this study due to its unique ability to allow for focus on perspectives and illustrate participant experiences in

rich detail (see Malagon-Maldonado, 2014). Qualitative research is applied to understand the meaning of the essential nature or essence of a phenomenon (Kemparaj & Chavan, 2013). Health research specifically has used qualitative methodology more frequently in recent years due to its focus on the beliefs, ideas, and perceptions of participants, an aspect often missing for underrepresented groups (Kemparaj & Chavan, 2013). Qualitative research adds insights where a dearth of knowledge exists (Kemparaj & Chavan, 2013).

Contrariwise, quantitative research methods are directed at developing hypotheses, testing and confirming assumptions or theories, and determining cause-effect relationships or correlations in the data (Malagon-Maldonado, 2014). Historically, health research has used the instruments employed by quantitative methods (e.g., surveys, questionnaires) to quickly gather data and measure outcomes for large sample sizes (Malagon-Maldonado, 2014). A quantitative method has been effective in providing statistical data for health outcomes and allowing for generalizability of findings to the wider population (Malagon-Maldonado, 2014). However, the rigidity of quantitative methodologies makes it impossible to ascertain the assumptions, beliefs, and perceptions of study participants. These aspects are important to consider when the desire is to influence changes in health behaviors.

Phenomenology was selected for the study research design. The design provided for a focus on the exploration of identifying lived experiences, specifically seeking to understand the meaning from experiences of the study participants (Kemparaj & Chavan, 2013). Study participants not only provided the sequential history of events, but also

offered the context of events describing their feelings, thoughts, beliefs, and perceptions. Patton (2015) referred to this process as intentionality. Phenomenology was appropriate to describe the phenomenon of depression, gain insight into the experiences of these women with self-reported depression as it related to their religious beliefs and church participation, and ascribe meaning to those experiences through their collective voice.

Although Chapter 3 provides more detail into the nature of the study, a brief synopsis is offered here. I sought to identify the lived experiences of African-American females, ages 20 and older, who suffered from self-reported depression or experienced self-reported depressive symptoms and attended Pentecostal churches in the Northeast United States. Semistructured interviews using open-ended questions were conducted with 14 women at which point data saturation was reached. A demographic questionnaire was administered to collect descriptive data. Moustakas' (1994) method of data analysis and interpretation was used in conjunction with the NVivo qualitative software program.

Theoretical Framework of the Study

This research study was grounded in the biopsychosocial model of health. Proposed by Engel in 1977, the biopsychosocial model of health asserts that, in addition to biological factors, psychological and social factors should be considered equally important when assessing or evaluating disease, health, and illness (Engel, 1977/1992). Engel posited this new approach to medical care, evaluation, and practice due to the observed limitations of the biomedical model, the principal paradigm of that time. The biomedical model focused solely on physical and physiological symptoms to provide evidence of active pathology (Engel, 1977/1992). Biomedicine ignored cultural,

economic, environmental, interpersonal, and other relevant psychosocial factors that could contribute to compromised health, disease manifestation, or illness onset (Engel, 1977/1992).

The biopsychosocial model of health, explained more thoroughly in Chapter 2, is designed to be a holistic system of appraisal, diagnosis, and treatment. The model is considered holistic as it not only investigates the biological, but also the psychological and social etiologies of disease, health, or illness (Engel, 1980; 1977/1992). The biopsychosocial model provides the framework to methodically analyze each of these domains to determine how they interface, emphasizing the interconnectedness of all domains (Engel, 1980). A strong doctor-patient relationship is considered vital for the viability of this model. Engel stressed that the social capital inherent in the relationship could be appropriately leveraged to affect health behavior change (Borrell-Carrio, Suchman, & Epstein, 2004).

The biopsychosocial model was useful in this qualitative, phenomenological study as it helped to frame the examination of depression on both the macro and micro levels. Research (Carr et al., 2014; Shim et al., 2014) suggested that African-American women experience depression on multiple levels. African-American women who attended Pentecostal churches experienced conflict between competing domains while trying to reconcile the spiritual ideology of the church as it related to depression, the cultural and gendered expectations to be strong, and their own beliefs and perception about their mental illness. Such conflicts affected emotional, physical, and psychological health (Black & Peacock,2011; Woods-Giscombe, 2010). It was assumed that the exploration of

the lived experiences of the research participants would encompass all of the domains previously mentioned providing a description of the phenomenon under examination.

Conceptual Framework of the Study

Social constructionism is a social psychological theory introduced by Berger and Luckmann in 1966. This theory was the conceptual framework through which this research study was aligned. Researchers explain that the theory of social constructionism asserts that realities are developed or constructed out of intrapersonal and interpersonal experiences (Berger & Luckmann, 1966; Gergen, 2009). An individual's ideas and thoughts about experiences are perpetuated through collective societal acceptance and endorsement, effectively becoming the truth of a thing (Berger & Luckmann, 1966; Gergen, 2009). Therefore, lived reality, or the world as it is known, does not exist independently of that which is shared by a given group (Gergen, 2009).

It has been asserted that in the theory of social construction, explained briefly here and with more detail in Chapter 2, constructions (e.g., cultural images) arise from individuals attributing them meaning (Berger & Luckmann, 1966). This attribution is achieved through primary socialization (microlevel) and secondary socialization (macrolevel) (Berger & Luckmann, 1966). That is to say, it starts first on an individual level, and then shared in-group, endorsed, shared out-group, endorsed, and the cycle continues. These socially constructed realities become credible through what the researchers (Berger & Luckmann, 1966) call "maintenance" (p.166) by groups, usually those with influence. This mechanism is how constructions spread well beyond their initially intended audience (Gergen, 2009).

Social constructionism is related to the research method, design, and the research question. Social constructionism is similar to phenomenology in that there is recognition that individual and collective realities exist (Patton, 2015). The lived experience is explored in phenomenological inquiry, specifically the assumptions, beliefs, and perceptions of those who have experienced a particular phenomenon. One of the primary assumptions in social constructionism is that realities are based in personal and shared worldviews (i.e., assumptions, beliefs, perceptions) (Patton, 2015). Researchers (Porter & Pacquiao, 2011) have also suggested that depression is socially constructed particularly for African-American women. There is a culturally constructed ideology related to identifying with a mental health issue or a mental illness. Moreover, depression has been negatively constructed in Pentecostal circles (Payne, 2009). The research study allowed for the gaining of meaning from the research study participants who experienced the phenomenon.

Definitions

Clergy – For the purposes of this study, clergy was identified as individuals who are charged with officiating over the business of the church as well as liturgy services (Avent & Cashwell, 2015). The term clergy was used interchangeably with the terms evangelist, minister, and pastor (Avent & Cashwell, 2015).

Members – For the purposes of this study, a member was identified as an individual who regularly attended a specific church or was an individual who was formally documented on the church membership roster (Dupree, 1996). The term

member was used interchangeably with the words congregant and parishioner (Lincoln & Miyma, 1990).

Pentecostal – For the purposes of this study, Pentecostal referred to all religious denominations that believe in the necessity of repentance for sin, the indwelling of the Holy Spirit through spirit baptism evidenced by glossolalia, and living a sanctified lifestyle for salvation (Johnson, 2009).

Strong Black Woman (SBW) A socially constructed image representative of all African-American women who selflessly care for the needs of family and community while enduring unending hardships associated with gender, race, and socioeconomic bias (Beauboeuf-Lafontant, 2009).

The Black church – This term historically references the collective community of churches and religious organizations, of any denomination or ideology, with predominately African-American memberships that serve as the spiritual and social support core of the African-American community (Wiggins, 2005).

Scope of the Study

The scope of this study was on identifying the lived experiences of 14 African-American females who suffered from self-reported depression or experienced self-reported depressive symptoms and attended Pentecostal churches in the Northeast United States. Moreover, the focus of this research study was on the participants' assumptions, beliefs, and perceptions about the phenomenon of depression within their life contexts. Open-ended questions within a semistructured interview approach with face-to-face interviews were conducted with 14 females at which point data saturation was achieved.

Interviews were planned to be conducted within an approximate 60 to 90-minute timeframe in the a church building or a neutral community space like a public library. Research participants completed a demographic questionnaire (Appendix B) so I could collect descriptive data.

Assumptions of the Study

The first assumption was that the participants in this study were truthful and provided authentic accounts of their lived experiences as they related to depression, their specific church, and culture as it was personally understood. It was assumed that the information they provided was an accurate reflections of their assumptions, beliefs, and perceptions of the phenomenon. Given the sensitive nature of the phenomenon explored, participants may have unintentionally subverted the truth in instances where providing candid responses may have reflected on them poorly. At its core, phenomenology focuses on the meaning or essence of a phenomenon through the examination of lived experiences (Patton, 2015). As such, this design relies heavily on the accuracy of personal accounts. To foster a sense of trust and safety, participants were reminded that all responses were confidential, identities were protected through coding and anonymity, and participation in the study was voluntary and consent could be withdrawn at any time. All research participants signed a consent form to participate.

The second assumption was that all research participants could identify what depression was, that they could identify if they did or did not have depression or depressive symptoms or that they could identify if they were at some point depressed. No proof of diagnosis was sought, nor was a valid measure for depression used during the

collection of data. Therefore, the true status of each research participants psychological state was unknown; all participants provided a self-report of depression.

The third assumption was that church attendance was reflective of the participants' acceptance or belief in the religious ideology taught. Pentecostals subscribe to distinct religious doctrine (Payne, 2008) and as Pattison, Lapins, and Doerr (1973) suggested are a distinct "socioreligious " (p. 398) culture or, as Yinger (1960) further stated, a "contraculture" (p. 629). Those who willingly attend these churches on a regular basis are assumed to adhere to the system of beliefs espoused. It was further assumed that the experiences shared by the study population were in the context of organizational and personal religious belief systems. Consequently, another related assumption was that participants identified themselves as being of the Christian faith.

The fourth assumption was that the process to be used in the selection of study participants was purposeful. This type of criterion sampling is used when looking for the most salient and relevant cases (Patton, 2015). Using this process facilitated the likelihood that the sample of participants was representative of the larger population and that their lived experiences were reflective of those with similar backgrounds. This allowed for transferability of the study findings.

Limitations of the Study

An unavoidable limitation found when electing to conduct a qualitative phenomenological study has to do with sample size. Sample sizes in phenomenological qualitative research are normally small when compared to those used in quantitative designs (Robinson, 2014). As a result, the generalizability of the findings are limited as

they relate to participant demographics (e.g., socioeconomic status, educational level, age, or marital status). To help enhance the potential usefulness of the study findings, interviews were continued until data saturation was reached.

The study was also limited in that participants were self-selected and participated of their own volition. An interconnected issue related to the information research participants may have disclosed. Individuals may have been concerned about expressing negative statements about their church or church leadership (e.g., clergy) for fear of reprisal or retribution. These fears may have resulted in self-censorship limiting the extent to which participants fully communicated their lived experiences. Participants may have vacillated in their decision to participate without the consent of their pastors, the gatekeepers of the church community, and by extension, church members. To acknowledge and demonstrate sensitivity to this cultural norm, information about the study objectives was provided to church leadership and verbal permission sought to engage prospective participants as necessary.

A potential bias that may have influenced study outcomes was my personal background as the researcher. Possessing similar demographics as the study sample (i.e., race, ethnicity, religious and denominational affiliation) might have affected neutrality. Despite the potential benefits to having a common background with the sample population (e.g., quicker development of rapport and trust and enhanced sensitivity to shared experiences), such intimacy could make it difficult to set aside personal biases, ideas, and opinions. This potential obstacle could have led to misinterpretation or misrepresentation of the research data. To guard against this possibility, peer debriefing

and researcher journaling was used to bolster credibility and enhance trustworthiness of the data. Overall, familiarity with the ideologies, practices, and traditions associated with the denomination clarified the in-group contextual data shared (see Seidman, 2005).

Delimitations of the Study

The primary delimitation of this study was related to the study participants. This study focused on African-American women who self-reported as suffering from depression or depressive symptoms (i.e., past or present), identified themselves as being of the Christian faith, and past or present attendance at Pentecostal churches. African-American women were the selected population due to the multifaceted issues that arise from being identified as (a) depressed (Shim et al., 2013), (b) Christian Pentecostal (Mercer, 2013), (c) an African-American, and (d) a female (Abrams et al., 2014). Although literature has been published in each of these categories or even with two or more combined factors (e.g., depressed, African-American, and female), there is little or no data on all of these variables collectively. African-American women experience more physical and emotional debilitation resulting from depression (Shim et al., 2013). Moreover, for African-American women religious faith is deemed essential as a coping mechanism (Pew Research Center, 2009). With a reported 82% of African-American women identifying themselves as Protestant, and with Pentecostalism (a denomination categorized under the Protestant faith) experiencing a furious pace in its global expansion (Pew Research Center, 2006b; Syan, 1997), it seemed most logical to focus on a growing, but understudied population. Consequently, no other racial groups were considered and non-Christian religions were excluded. Finally, given that postpartum depression is a

specific illness related to childbirth, individuals identified with this condition either through inquiry or self-report were excluded from this study.

The study was also geographically delimited to the Northeast United States. More specifically, recruitment of study participants was limited to participants that lived or worked in the Commonwealth of Massachusetts and the State of Connecticut. Although the study may have been enriched greatly by interviewing participants from various parts of the United States, financial resources and time constraints did not allow for such an expansion to the study.

This study was delimited to using a qualitative research method and design instead of using a mixed-methods or purely quantitative research model. The goal of this study was to understand the lived experiences of the participants themselves. Making meaning from the exploration of their assumptions, beliefs, and perceptions was the focus. Therefore, the use of published data collection instruments used in measuring depression, religiosity, and the like was not considered appropriate. With respect to conceptual framework, feminism and Black feminism, although relevant on an intellectual basis, were not studied because the ideologies associated with these beliefs are divergent from the ideologies associated with Pentecostalism specifically, and I believed them to be incongruent with principles of Christianity generally. Therefore, these frameworks were considered inappropriate in the context of this study.

Summary

This chapter provided an overview of the disease burden of depression, its symptomology, its adverse physical, emotional, and economic effects on individuals, and

more specifically its devastating effects on African-American women. There was also examination of a specific coping strategy used by African-American women dealing with depression and an explanation of how churches have failed, perhaps inadvertently, to provide adequate support for individuals diagnosed with depression. Moreover, this chapter outlined the benefits of utilizing a qualitative, phenomenological study to identify the lived experiences of African-American women suffering from self-reported depression or depressive symptoms while attending Pentecostal churches. There was also clarification of the study's contributions to the literature. Chapter 2 provides an in-depth look into the current literature, discussing what has been learned, what is yet to be studied, and how the this study filled in the gap. This chapter includes discussions about the theoretical and conceptual frameworks of this study and offer analysis of the current literature as it relates to this topic.

Chapter 2: Literature Review

Depression is an insidious disease and a chronic mental health condition. Depression affects over 300 million people worldwide and is the disability leader (WHO, 2012). Women are disproportionately affected by this disease, and African-American women specifically experience more debilitating effects from depression (Carr et al., 2013; Shim et al., 2013). African-American women also have culturally engendered scripts (i.e., SBW) through which they operate that limit their coping strategies (Beauboeuf-Lafontant, 2005b; 2007; Black & Peacock, 2011). One regularly used coping mechanism is religion (Pew Research Center, 2009; Chatters et al., 2011).

Clergy may fail to effectively support African-American women who experience depression and attend Pentecostal churches as a result of beliefs and practices that attribute the disease to moral or spiritual failures. Researchers suggest that clergy in Pentecostal denominations, particularly those of African descent, believe depression results from demonic forces or spiritual sin (Bryant et al., 2013; Leavey, 2010; Payne, 2009). These clergy also seem to advance what can be construed as negative messages about depression from the pulpit (Payne, 2008). Yet, African-American women and Pentecostals repeatedly report preferring to speak to clergy when dealing with a serious problem (Chatters et al., 2011; Mattis et al., 2007). There is, however, a disconnect when it comes to talking about depression; Hardy (2014) found that clergy were not the first choice as treatment providers when talking about this issue. Perhaps, intuitively, African-American Christians are reserved when it comes to discussing depression for the aforementioned reasons.

One area in which the literature is notably silent relates to the experiences of African-American women who experience depression or depressive symptoms and attend Pentecostal churches. Conducting a qualitative, phenomenological study provided an opportunity to identify the lived experiences of these women and bring their stories out of obscurity. Moreover, it added to the literature by providing insight into a segment of the religious community that had been to some degree understudied. This literature review (a) details the literature search strategy; (b) explains the theoretical foundation and conceptual framework that grounded and structured the research study; (c) discusses key concepts and studies related to the topic; and (d) outlines the rationale for the study, research method, and design based on what has been studied to date and what remains to be understood.

Literature Review Search Strategy

The literature search was conducted on an ongoing basis between September 2012 to November 2015, mainly using databases available through Elms College Library, Springfield College Library, University of Massachusetts Amherst libraries, and Walden University Library. The primary databases used were EBSCO Host (multiple databases including all major medical, psychology, and social science related databases), ProQuest, Sage All Access & Premier, and WorldCat. The following databases were used to obtain reference materials that focused specifically on culture, ethnicity, and religion: Arts and Humanities Citation Index, ATLA Religion, Brill Online Discovery Black Studies Center, Black Thought and Culture, Black Women Writers, Brill Online Discovery (general), Humanities International Complete, JSTOR, Religion and Philosophy

Collection. Google Scholar was also used during the literature search, as well as two public libraries. A final search of the databases was conducted between October 2018 and November 2018 in an attempt to find any new literature published related to this topic since November 2015. Relevant articles were incorporated in Chapter 5 when discussing study findings and implications.

Search terms included various combinations of the terms *African-American, Apostolic, assumptions, beliefs, biopsychosocial model, Black, Christian, church, clergy, costs, cultural script, depression, disease burden, gender, life script, mental health, mental illness, minister, pastor, Pentecostal, perceptions, phenomenology, Protestant, religion, research methodology, social construction, spiritual, strength, strong Black woman, superwoman, theory,* and *woman*. In the search process, asterisks were added at the end of some search terms so that all potential suffixes of the word to which it is attached would come up in the search. Resources referenced or used, as presented in Table 1, included foundational books related to subject matter, dissertations, monographs, peer-reviewed articles, and theses. Magazine and newspaper articles along with several popular books were also included in the search to provide both primary and anecdotal information. No time parameters were used during the literature search to capture materials that could assist with developing the historical content of the research study.

Table 1

Sources of Literature

Research Concepts	Books	Dissertations/ Theses	Peer Reviewed Articles	Web Publications	Total
African-American women	4	1	13	0	18
Biopsychosocial model	0	0	7	0	7
Depression	0	0	22	0	22
Mental health/ illness	0	0	2	2	4
Methodology/Qualitative	9	0	18	0	27
Pentecostalism	6	3	7	2	18
Phenomenology	1	0	2	0	3
Religion/Clergy	2	0	29	0	31
Social constructionism	3	0	5	0	8
Strong Black woman	2	1	14	0	17

Note. Information included reflects the resources used in this study; therefore, it does not include total hits from databases listed.

Theoretical Foundation

The biopsychosocial model was the theoretical framework for this research. Popularized by Engel in 1977, with the earliest reference of the term attributed to Grinker (1964, as cited in Ghaemi, 2009), the primary concept of the biopsychosocial model is that biological, psychological, and social factors are equally relevant in the diagnosis and treatment of illness (Engel, 1977/1992). Engel (1977/1992) recognized the deficits of the biomedical model which approached illness from a purely pathological perspective, using physical and physiological symptoms as evidence of disease. On the other hand, the biopsychosocial model included all pertinent psychosocial factors (e.g., cultural, economic, environmental, interpersonal) that could potentially contribute to disease (Fava & Sonino, 2008). To some degree, this model allowed for the integration of the nature

versus nurture argument, in that it acknowledges there are biological roots to illness or disease which can be scientifically explained or summed to pathological deviance from the norm (Engel, 1977/1992). Yet and still, it also encompassed the nurture argument suggesting that psychological injuries such as experiences of gendered racism or exposure to a traumatic event and social conditions like poverty or homelessness, should also be evaluated to determine their effect on biological conditions.

The biopsychosocial model was explained as a systems-oriented model that views the person not only as an individual, but also as part of a hierarchy that was interconnected (Engel, 1980). The focus of the model was on understanding the person in the context of the systems (e.g., cultural, linguistic, social) in which he or she lives. The belief was that healing or treatment of an illness cannot be effective unless all important factors are evaluated and weighted according to their contribution to the condition or disease (Engel, 1980). Theorists of the biomedical model excluded all other considerations and focused solely on physical manifestations.

Silent prohibition of the inquisition of illness etiology from all perspectives was in some respects, ushered in by early church ideology (Engel, 1977/1992). The ideology of the time considered the physical part of man's being (i.e., the body) to be the domain of medicine and the remaining parts (i.e., soul and spirit) the domain of the church (Engel, 1977/1992). As the former was considered a "weak and imperfect vessel", autopsies were allowed by the church (Engel, 1977/1992, p. 320). Subsequently, practitioners in the field of medicine derived a physiological understanding of the development and progression of disease. Yet, as indicated, this new practice came at the concession of the medical field to

willfully direct its attention away from examination of the other factors considered the church's responsibility (Engel, 1977/1992). It can be speculated, that the influence of the church in the practice of medicine, changed the direction of medical discourse on the topic of illness etiology.

The biopsychosocial model has its detractors. Van Oudenhove and Cuypers (2014) argued that the model does not adequately operate as such given its bidirectional continuum without clear explanation or justification. Ghaemi (2009) posited that the model lacks appropriate guidance on the prioritization of the three spheres. Moreover, he decried the fact that it does not seem to allow for the elimination from consideration any of the three areas, arguing that one or more may lack relevance when considered case to case (Ghaemi, 2009). Hatala (2012) effectively quelled these concerns suggesting that the biopsychosocial model holds up to scrutiny when the interactive systemic approach and outlined areas are merited with equal validity. Discussing the model in a health psychology context, Hatala urged appropriate attention be paid to culture when using this model. Specifically, Hatala proposed culture be explored at the individual level, noting that personal experience and worldview determine significantly the way in which culture is interpreted.

Researchers examining depression seem to readily acknowledge the probability that factors in addition to those originating from the biological sphere are contributing factors in depression. For example, Beaboeuf-Lafontant (2009) argued that cultural restrictions contribute to the somatized expression of depression in African-American women. Frieri, O'Connor, and Nassef (2015) suggested that the physiological changes

that occur during life stress episodes induce comparative physiological reactions (e.g., cortisol stimulation, reduction in protective immune response) making individuals more susceptible to asthma and depression reciprocally. Koenig (2014) concluded that despite many positive correlations between decreased depressive symptoms with increase religious involvement, there were biological and environmental factors that could contribute to depression via psychological distress.

The biopsychosocial model was selected for the present study as it allowed for the examination of all factors (i.e., biological, psychological, social) that contributed to the self-reported depression for these African-American women who attended Pentecostal churches. Moreover, the model informed this exploration of depression from the viewpoint of the SBW identity, a pertinent sociocultural component for African-American women. It also enhanced the discussion of psychological and social implications of religious dogma. Engel (1977/1992; 1980) generated the understanding that the manifestation of disease may vary greatly when viewed in the context of a patient's unique life experience. He accurately assessed the need to look at cultural, linguistic, and all germane differences when assessing information related to disease (Engel, 1980). As African-American women come with various issues and it is sometimes difficult for practitioners to determine if depression is present, it would be helpful to understand the condition from the perspective of the women to understand their experience with the illness .

Conceptual Framework

Social constructionism was the conceptual framework that grounded this research study. Posited by Berger and Luckmann (1966), social constructionism theorists assert that lived realities arise out of a collective societal agreement to ascribe a certain meaning to a person, place, or thing. More specifically, the theorist of social construction asserts that constructs (e.g., gender, race) develop from attribution of meaning on the intimate individual level on up to the broad societal level (Berger & Luckmann, 1966). This process happens as a result of primary and secondary socialization (Berger & Luckmann, 1966). Occurring through interpersonal (i.e., external exchange of information between and among individuals) and intrapersonal (i.e., internal processes within the self through which information is evaluated, interpreted, synthesized, then accepted or rejected based on sociomental filters) experiences, beliefs and ideas are shared, accepted, and endorsed collectively (Berger & Luckmann, 1966; Friedman, 2011; Patton, 2015) thus assigning it a lived reality. Credibility of constructed realities is attained through maintenance, defined as the cyclical perpetuation of a reality by influential groups to its original audience and beyond (Berger & Luckmann, 1966; Gergen, 2009).

Social constructionism was the most suitable conceptual framework for this research as it corresponded with the research question, method, and design. Both African-American femininity (i.e., SBW) and depression are posited to be socially constructed realities (Hacking, 2000; Harris-Perry, 2011; Porter & Pacquiao, 2011). The SBW identity, explained more thoroughly later in this chapter, is believed to be a culturally derived construct used to attenuate the negative images long perpetuated by the dominant

social group (Abrams et al., 2014; Beauboeuf-Lafontant, 2003; 2005a; 2005b; 2007; 2008; 2009). Similarly, depression, discussed later, has a unique social construction in the African-American and Pentecostal communities (Mercer, 2013; ; Payne, 2008; Porter & Pacquiao, 2011 2009; Sorenson, 2013).

Phenomenological qualitative inquiry was appropriate for coupling my study with social constructionism. There is an overt acknowledgment and acceptance of the idea that all individual perspectives are to that individual reality (Patton, 2015). Therefore, they should be equally weighted and given voice. Moreover, there is an expectation that when examining a phenomenon, there will be similarities, which can be taken collectively, ascribing meaning for a particular group. Yet, at the same time, a said phenomenon maintains its' multiple and unique meanings for everyone experiencing it (Patton, 2015).

Depression

Major depressive disorder or major depression, heretofore referred to as depression, is a medical condition that adversely affects mood and by extension the lives of individuals who have the disorder (WHO, 2001; 2012). The general identifying symptoms of depression include feelings of sadness and hopelessness, loss of interest in formerly pleasurable activities, changes in sleep habits or appetite, and noticeably depressed mood or affect (WHO, 2012). Depression, in its myriad forms, is a common, often chronic condition that affects individuals by interfering with their daily activities and quality of life (NIMH, 2011a). The disorder is often associated with other health conditions, exacerbating symptoms or disrupting disease maintenance (CDC, 2011).

Depression is a condition with global impact affecting individuals all over the world, often cited as one of the leading causes of disease burden (CDC, 2011).

Statistically, the numbers associated with depression are staggering. In the United States, 15 million adults are affected annually by depression (NIMH, 2011b). The use of antidepressant medications has more than tripled since 1988 for all age groups (i.e., 12 to 74); starting at a low of 2% between 1988 and 1994, increasing to 9% between 2009 and 2012. The CDC (2015) reported depression as a primary diagnosis in 8 million medical cases during a 1-year span. Those hospitalized with depression were close to 400,000 in 2010, with the length of stay averaging seven days (CDC, 2015). Moreover, in 2013, over 40,000 individuals committed suicide whose deaths were in some way related to depression. The sheer numerical volume of individuals affected by depression highlights the magnitude of the problem. The financial impact of depression is also substantial.

The costs associated with depression are equally alarming. Depression is ranked first among disabilities worldwide (Ferrari et al., 2013). Depression accounted for 3% of the 3 billion DALYs in 2010 (Ferrari et al., 2013). With depression expected to be the leading cause of global disease burden in 2030 (Lepine & Briley, 2011), it is likely this number is higher now. Depression affects role performance with individuals missing an average of 5 days annually as a result of the condition (Kessler, 2012). Depression also affects work productivity, estimated to cost employers an average of $41 billion annually (Kessler, 2012). These numbers quantify the economic effects of depression. The two factors combined demonstrate why this disease is a global concern. Through conducting

my study, I sought to add to discourse as it relates to a specific cohort of African-American women.

Health Risks Associated with Depression

Depression increases the health risks for individuals with the condition, either making them more susceptible to comorbid conditions or intensifying the symptoms of pre-existing conditions (Bhattacharya et al., 2014). The study (Bhattacharya et al., 2014) was conducted to ascertain the association of co-occurring depression and anxiety with chronic physical condition risks such as arthritis, asthma, chronic obstructive pulmonary disorder, diabetes, heart disease, hypertension, and osteoporosis. The authors concluded that there was a positive correlation between diagnoses of both depression and anxiety as they related to risks of developing chronic physical conditions (Bhattacharya et al., 2014). Researchers (Frieri et al., 2015; Hicken et al., 2013) associated with other studies corroborated Bhattacharya et al., findings, linking depression to poor asthma control and obesity. In both studies (Frieri et al., 2015; Hicken et al., 2013) biopsychosocial factors were acknowledged as contributing factors to the development of depression and other conditions substantiating the selection of the biopsychosocial model of health as the theoretical framework for this study.

Depression in African-American Women

Depression is a significant problem for African-American women. The CDC (2011) reported that women and African-Americans are more likely to experience depression at some point within their lifespan. Although incidents of depression for African-American women are reported to be less prevalent than for their Caucasian-

American counterparts, when it does occur, depression symptoms are recurring and severe (NAMI, 2009/2019). Shim et al. (2013) validated the latter part of this finding when conducting a study to examine the links between depression and other conditions for African-American women. When compared with diabetes and hypertension, women who presented with depression were more impaired, which impeded engagement in normal routines (Shim et al., 2013). The researchers (Shim et al., 2013) reported women who were dually diagnosed (i.e., having both depression and hypertension) were more likely than women solely diagnosed with hypertension to be impaired citing similar areas of functional loss to the other group. This finding supports research mentioned earlier (Ferrari et al., 2013) related to the debilitating nature of depression.

Medical professionals often miss depression in African-American women delaying, sometimes outright obstructing, treatment (NAMI, 2009/2019). This oversight occurs for the fact that depression in African-Americans usually presents through the somatization of symptoms (Beauboeuf-Lafontant, 2005a). African-American women cite physical symptoms like pain and general malaise as interfering with participation in life roles (Shim et al., 2013). NAMI (2009/2019) reported that African-Americans were 6% more likely than Caucasian-Americans to present with physical illnesses when it related to mental health diagnoses. In a more recent study, Hwang and Myers (2013) found similar reports from African-American and Latin-American women in which 81% and 88% respectively indicated physical symptoms contrasting with 65% of Caucasian-American women when characterizing depression. Twenty-three research participants in another study (Poleshuck, Cerrito, Leshoure, Finocan-Kaag, & Kearney, 2013) reported

gastrointestinal problems and bodily pain along with emotional symptoms to describe depression. Somatization, a culturally acceptable presentation of depression, may be easily overlooked by the medical community (Shafi & Shafi, 2014). Medical professionals may also miss depression in African-American women because these women are more likely to discuss these problems with their primary care physicians or their gynecologists (Poleshuck et al.; Shim et al., 2013) rather than seeking psychiatric care. The combination of these factors demonstrate the importance in understanding the lived experiences of some of these African-American women so that care and treatment can be better informed.

African-American women with depression are at greater risk for developing other diseases. As indicated earlier, Bhattacharya et al. (2014) established a positive correlation between depression and risk for developing other chronic conditions, like arthritis, asthma, diabetes, and heart disease to name a few. Participants solely diagnosed with depression were ranked second in terms of their related risk (Bhattacharya et al., 2014). The sample in Bhattacharya et al.'s study was predominately Caucasian-American; however, similar results were found for the small number of African-Americans in the study. There is some dispute about the linear positive association between depression and obesity for African-American women specifically (Hicken et al., 2013). At the same time, there was recognition by researchers (Beauboeuf-Lafontant, 2009; Hicken et al., 2013) that psychosocial factors could establish a plausible link not only for obesity, but other conditions and those factors should be seriously considered when working with this population. The potential risks associated with depression in African-American women is

noteworthy. Therefore, obtaining a clearer understanding of contributing factors seems prudent.

Contributing Factors to Depression in African-American Women

Beliefs and Perceptions

Many of the beliefs and perceptions that African-Americans hold about depression are a hindrance to the recognition of the condition and a deterrent to help-seeking (Doornbos, Zandee, & DeGroot, 2012; Holden, Belton, & Hall, 2015). Several qualitative studies were conducted (Black, Gitlin, & Burke, 2011; Borum, 2012; Doornbos et al., 2012; Holden et al., 2015), predominately in the Northeastern United States, exploring the beliefs and perceptions of African-American adults, ages ranging across the lifespan. Depression was categorized by research participants (the majority of whom were in focus groups) as an external enemy (Black et al., 2011) that endangered both the physical (Doornbos et al., 2012) and spiritual (Black et al., 2011; Borum, 2012; Holden et al., 2015) well-being of individuals affected. Exhibiting depressive symptoms was viewed as a lack of faith (Black et al., 2012; Holden et al., 2015) or abandonment by God (Borum, 2012; Doornbos et al., 2012). Participants did not endorse medication as an acceptable method of treatment, but rather referred to church, God, or spirituality as appropriate coping resources (Holden et al., 2015). It should be noted that the use of religion and spirituality as a coping strategy was acknowledged as important across all studies referenced (Black, Gitlin, & Burke, 2011; Borum, 2012; Doornbos et al., 2012; Holden et al., 2015). However, specifics with regards to how it was important was only obtained through the study which conducted face-to-face interviews with research

participants (Black et al., 2012) as opposed to the focus group format of the others (Borum, 2012; Doornbos et al., 2012; Holden et al., 2015). The latter findings suggest that face-to-face interviews, as those conducted in my study, produced rich data, enabling a clearer understanding of the phenomenon.

Life Stressors

African-American women are exposed to unique life stressors that are a contributing factor in depression or depressive symptoms. Gendered racism, sometimes called double jeopardy, refers to experiences of discrimination and prejudice based on negative assumptions or stereotypes related to one's gender, race, and sex (Harris-Perry, 2011). Although it is possible for other minority women to experience this phenomenon, it seems to occur most prevalently with African-American women (Harris-Perry, 2011). Some researchers (Beaboeuf-Lafontant, 2008; Harris-Perry, 2011; West, 2008) attributed reported experiences of economic inequality, professional disparity, and social injustice, to the perpetuation of negative socially constructed images (explained in greater depth later in this chapter) that relegate African-American women to a lower social status. For instance, Beaboeuf-Lafontant (2008) asserted that the Mammy image is regularly used to subjugate Black women to an inferior status in the workplace. Through the clever maintenance of this image as selfless and deferent, Black female participants felt their voices were effectively muted through the expectations of complicit acceptance of racialized gender discrimination (Beaboeuf-Lafontant, 2008). These images "normalized" the inequitable treatment they experienced (Beaboeuf-Lafontant, 2008, p. 3). Moreover, Black women felt forced, as a protective measure, to self-contain, internalizing all the

emotional angst and pain associated with the burdensome expectations and "disempowerment" they lived through (Beaboeuf-Lafontant, 2008, p. 17). These beliefs seem to hold true as more recent research suggests.

Carr, Szymanski, Taha, West, and Kaslow (2014) corroborated these assertions reporting that in a 144-research participant sample population, all of which were African-American females, participants were more likely to suffer from depression resulting from the internalization of experiences of gendered racism and sexual objectification. Porter and Pacquiao (2011) referenced the Sojourner syndrome and the SBW construct, stating that these schemas encouraged self-silencing relegating African-American women to emote in physiological ways. A study conducted by Pieterse, Carter, and Ray (2011/2013) seemed to contradict these conclusions; they found that 118 research participants, 76% of which identified themselves as African-American, did not experience psychological distress as a result of racists incidents, neither did any distress result from racism-related stress (Pieterse, Carter, and Ray, 2011/2013). Poor psychological well-being was only negatively associated with general life stress. However, the researchers (Pieterse et al., 2011/2013) cautioned that learned self-silencing practices might have inhibited the women in this study from being able to discern the subtle distinctions between general and racism related stress. This lack of awareness might be an unconsciously activated coping mechanism in and of itself. The literature suggests that African-American women, by internalizing these issues, create for themselves chronic dis-ease with limited ways through which to cope.

Psychosocial Factors

Depression in some African-American women is attributed to their economic, environmental, and social conditions. Studies (Doornbos et al., 2012; Starkey, Keane, Terry, Marx, & Ricci, 2013) have associated poor economic conditions with depressive symptoms. For example, Starkey et al.(2013) demonstrated a positive relationship between negative beliefs about one's financial condition and experiencing depressive symptoms. Research participants in Doornbos et al.'s (2012) study believed that issues like high debt-to-income ratios and unemployment were contributing factors to poor mental health. In addition, ruptures in the family system due to divorce or domestic violence as well as caregiving concerns like elder parent care or single-parenting created acute or chronic stressors that contributed to depression (Doornbos et al., 2012).

This type of evidence suggests that the intersectionality between the aforementioned factors and race make their collective effects unique to African-American women, even though many of these same factors are commonly cited contributors for women of diverse ethnic backgrounds (Doornbos et al. 2012). For example, Hudson, Neighbors, Geronimus, and Jackson, (2012) reported that the odds of experiencing a major depression episode or lifetime depression were decreased for African-American women who were financially stable. Yet, Watson, Roberts, & Saunders (2012) found that despite higher educational attainment and personal income, African-American women were less likely to be married which led to lower overall family income, more likely to live below the federal poverty level, and more likely to live in a poor neighborhood with higher crime rates. These results would seem to suggest that although African-American

women seemed to be highly functioning, issues in the psychosocial arenas have adverse effects.

Other researchers (Holden et al., 2012; Holden, Bradford, Hall, & Belton, 2013) have provided data that seems to support this assertion. Despite African-American women scoring high in spiritual well-being, moderately high in resiliency and normal in self-esteem measurements (Holden et al., 2012) more than half of the women in the sample (65%) reported mild depression, with the remainder reporting moderate to severe depression (35%). Sixty-two percent reported energy loss and pessimism as main symptoms of depression, with over half (51%) reporting feelings of guilt (Holden et al., 2012). Holden et al. (2013) similarly reported even though African-American women scored relatively high on resiliency scales which resulted in lower scores on depression measures, exactly half of the study research participants (145) reported experiencing mild to severe levels of depressive symptoms. In each of these studies (Holden et al., 2012; 2013) it was not uncommon for women to also report having physical conditions in addition to depression symptoms which again have been associated (Bhattacharya et al., 2014) with exacerbated mental health symptomatology. Thus, suggesting that biopsychosocial elements of health are too great to ignore.

Stigma

Mental illness stigma in the African-American community contributes to the reticence of African-American women to acknowledge experiences of depression or depressive symptoms (Sirey et al., 204). Studies conducted by Okeke, (2013), Sirey et al. (2014), and Ward, Witshire, Detry, and Brown (2013) reported that African-American

men and women were more likely than Caucasian-Americans to cite ostracism and rejection concerns if mental health issues were known. Mental illness is viewed as a personal weakness or failure by many in the African-American community especially given the historical violence generations lived through and maintained sanity (Okeke, 2013). Oakley, Kanter, Taylor, and Duguid (2011) challenged the magnitude of stigma noting that African-American women in their study were less likely than Caucasian-American women to express shame or self-stigmatization. However, the researchers (Oakley et al., 2011) acknowledged that self-stigma did occur for African-American women on some level and that they were on par with both Caucasian and Latin American women when it came to maintaining secrecy about personal mental illness. These conclusions by Oakley et al. (2011) seem to neutralize the stigma argument. At the same time, such discrepancies can be accounted for by differences in cultural presentation of depression (Shafi & Shafi, 2014). Moreover, discrepancies can be explained by the inherent limitations of quantitative measures which do not speak to the lived experience through which the essence of a phenomenon can be derived.

The Strong Black Woman

The SBW is a socially constructed identity which epitomizes the core of femininity and womanhood in the African-American community (Beauboeuf-Lafontant, 2009). The SBW identity is an amalgamation of all the characteristics (for example, independence, perseverance, resilience) that have enabled African-American women to weather the hardships, misfortunes, and tragedies experienced resulting from societal oppression (Abrams et al., 2014). Strength is the core characteristic of the SBW which

makes possible the selflessness that is usually exhibited (Beauboeuf-Lafontant, 2009; Woods-Giscombe, 2010). However, it is not based on dictionary definitions of strength; rather, it is based on the construct narrative of the African-American community which is further explained (Beauboeuf-Lafontant, 2005b).

Beauboeuf-Lafontant (2005b) explained that African-American women categorize strength in two ways, descriptive and prescriptive. Descriptive strength engendered autonomy and allowed each woman to define herself according to terms that she could live with and function within (Beauboeuf-Lafontant, 2005b). It enabled her to set parameters on her strength, and for who her strength would be used (Beauboeuf-Lafontant, 2005b). In short, it allowed healthy selfishness. Prescriptive strength, on the other hand, was characterized by deferential concern for others at a woman's personal expense (Beauboeuf-Lafontant, 2009). African-American women who exhibited this form of strength focused on ensuring that collective needs were met even when to do so would be personally detrimental (Beauboeuf-Lafontant, 2009). Prescriptive strength encouraged the acquiescence of personal autonomy and Beauboeuf-Lafontant (2007) asserted that it is this type of strength that most African-American women are socialized to demonstrate. Yet, despite its potential harm, the SBW identity is sacrosanct to the African-American community. In order to understand why the SBW identity is thus, one must understand the context from which it came to be.

Historical context of the SBW. The SBW was a counter-offensive identity to three Eurocentric, socially constructed images of African-American females; the deferential Mammy, the sensual Jezebel, and the angry Sapphire (Beauboeuf-Lafontant,

2003, 2008; West, 2008). Birthed during slavery times, African-American women were depicted in derogatory personas in attempts to sanction the horrific treatment they received (Harris-Perry, 2011; West, 2008). These images controlled the narrative about African-American women effectively subverting their righteous cries for justice (West, 2008). These cries, related to the selling of their sons, the murdering of their husbands, and the sodomizing of their daughters, often went unheard, drowned by the negative images of their personhood (Harris-Perry, 2011; West, 2008).

Jezebel. African-American women suffered much sexual brutality during slavery and in the times thereafter (West, 2008). Treated like chattel, these women were displayed and used in any manner deemed appropriate which was more often than not, sexually for the maintenance of the slave trade (West, 2008). In an effort to desensitize the public, a controlling image (i.e., Jezebel) was manufactured that in effect, sanctioned the cruelty (Collins, 2000). Jezebel was characterized as a hypersexual African-American slave girl who encouraged the advances of the White man and any other man for that matter (Collins, 2000). Jezebel reportedly enjoyed rough sexual encounters and was "open" to anyone and anything; a subliminal suggestion that the sexual violence encountered by African-American women resulted from insatiable, licentious beckoning (Harris-Perry, 2011). Although this construct was useful initially, another construct was developed when the moral and political climate in the United States change.

Mammy. Mammy, depicted as a smiling, deferential, rotund house servant, was a concoction of the slavery establishment, created to appease those who might question the practice (Beauboeuf-Lafontant, 2003). Mammy nurtured the slave owner's (i.e.,

'Massa's) children, catered to his wife, and cared for his home lovingly (Beauboeuf-Lafontant, 2003). Mammy's grateful image suggested that African-American women were happy to be grounded and shackled on plantations (West, 2008). Yet in truth, this grounding and shackling was sometimes literal as female slaves tried to escape the abuse through flights for freedom (Collins, 2000). Mammy was in many ways an alter ego to Jezebel; adiposity marring her physical appearance, rendering her unattractive and asexual. This negative image stripped African-American women of their femininity and more importantly, their womanhood (Collins, 2000). Still, yet another construct emerged, equally damaging to the image of the African-American woman, if not more so, as its likeness can still be seen in today's society.

Sapphire. Another humiliating alter ego, Sapphire was characterized as an angry, dominant, emasculating African-American woman (Harris-Perry, 2011). Initially, the Sapphire persona was a real radio and television character in the early 20th century (Harris-Perry, 2011). However, the image of African-American women as defensive, vulgar male circumcisers was skillfully propagated by sociopolitical forces to discredit the rage African-American women expressed over the injustices suffered (Harris-Perry, 2011; West, 2008). Sapphire was one to be dreaded or mocked, but never one to be taken seriously (Harris-Perry, 2011; West, 2008). As a result, concerns raised by African-American women regarding experiences of institutionalized gendered racism and oppression were discounted and nullified by the majority (Collins, 2000; Harris-Perry, 2011).

These varied, negative depictions of African-American women were routinely disseminated through social media (i.e., movies, radio, and television) so as to transform the socially constructed stereotypes into accepted true-life representations (Harris-Perry, 2011). In 2008, West found similar images in commercials, sitcoms, and most notoriously through entertainment mediums like music videos and song lyrics. The author suggested that these images dehumanize African-American women and at times overtly suggest that treatment received is treatment deserved (West, 2008). As recently as 2013, Smith affirmed West's (2008) findings when she examined episodic and scene content of College Hill, A Black Entertainment Network (BET) reality television show that portrayed the daily lives of African-American students attending historically Black colleges and universities. Smith studied scenes from two full seasons (i.e., 2006 & 2007) to see if the character portrayals perpetuated negative stereotypes of African-Americans. Smith found that the women were portrayed negatively and similarly to the angry Sapphire persona (2013). The images of the females in the show were also more sexualized, characteristically similar to that of the Jezebel image revealing that character portrayals on College Hill, extended, and reinforced the constructed stereotypes society holds about African-American women. The Black community could not allow these images to infiltrate the psyches of their young girls, therefore, a counter image was constructed.

a Counter image. African-American women were compelled to assume community and familial leadership roles in the absence of their brothers, husbands, and sons (Abrams et al., 2014). Such headship began during slavery when husbands and male

children were sold (Abrams et al., 2014). African-American women were forced to take on roles traditionally associated with men to keep their families afloat (Collins, 2000). As heads of households and pillars in church communities, African-American women did not fit the image of the ideal (i.e., White) woman (Collins, 2000). When viewed through the dominant, European paternalistic lens, African-American women's' behaviors, or role switching, was seen as pathological, further distorting their images and characteristics (Office of Policy Planning and Research [OPPR], 1965). Despite the fact that much of this role switching was necessitated by circumstance, African-American women were belittled and ridiculed, classified as "misandrists" and "verbal dominatrixes", a veiled reference to the Sapphire construct (Robinson, 1983, p.137). Constant subjection to classism, racism, and sexism did not allow for weakness, as showing signs of frailty was psychically unsafe (Collins, 2000).

In an effort to negate the destructive images perpetuated by the dominant society, the Black community concurrently began to construct new, positive images of African-American women (Harris-Perry, 2011). In their new roles, African-American women forged paths not previously trod by women and called attention to issues that were taboo (Harris-Perry, 2011). African-American women were appraised as self-reliant, self-sacrificing; judged to possess a grace and serenity that endowed them with an endless capacity to take it (it being whatever atrocity or injustice came their way) (Hill, 2009). Maintaining a facade of stoic determination and resiliency regardless of the challenges or oppression faced was not only a form of self- protection, but of ethnic preservation and

pride (Beauboeuf-Lafontant, 2005; Abrams et al., 2014). To survive, these women were socialized to be 'fearless', invincible', 'strong' (Black & Peacock, 2011).

the SBW identity activated. This socialization developed generationally with daughters, extended family, and sister-friends and quickly became the standard for African-American femininity and womanhood. Researchers (Abrams et al., 2014; Beauboeuf-Lafontant, 2003, 2005, 2007, 2008; Romero, 2000; Shambley-Ebron & Boyle, 2006; Woods-Giscombe, 2010) have concluded that the SBW construct (one of boundless selflessness, indestructible hope, and unyielding resiliency while meeting the demands of community, family, and society) is an affirmed identity in the African-American community. Romero (2000) discovered that the SBW was essentially a cultural mandate, and not a personal choice. Most, if not all, African-American women were born into and groomed to assume the SBW identity, in a continued attempt to refute the negative, while propagating these traits as the ideal (Beauboeuf-Lafontant, 2003; Woods-Giscombe, 2010). As such, community expectations dictated adherence to these scripts (Woods-Giscombe, 2010).

African-American women seem to understand that they cannot escape the SBW identity. Jones and Shorter-Gooden (2003) discovered the presence of the SBW script even in the lives of younger African-American women. Research study participants described lessons learned while observing their mothers' emotional responses, or more likely the lack thereof, to circumstances (e.g., death, job loss) potentially devastating to others (Jones & Shorter-Gooden, 2003). Shambley-Ebron and Boyle (2006) corroborated this observational learning while exploring how African-American women diagnosed

with HIV/AIDS, caring for themselves and for children who have HIV/AIDS defined and lived out the SBW ideology. The authors (Shambley-Ebron & Boyle, 2006) explained that the women in their study (who consciously categorized themselves as strong) believed they were living out the cultural heritage endowed to them at birth, and passed down generationally through a legacy of slavery, struggle, and perseverance. The women viewed SBWs as having "extraordinary courage" despite living lives filled with sickness, dogged by poverty, and gendered powerlessness (Shambley-Ebron and Boyle, 2006, p. 200). Studies like those aforementioned laid the foundation for a clearer picture of the SBW construct.

Woods-Giscombe (2010) ascertained what study participants believed to be the characteristics of the SBW (known in her work as the superwoman schema). The author (Woods-Giscombe, 2010) was trying to assess if previously identified characteristics were endorsed as construct components. Woods-Giscombe compiled a list of main characteristics associated with the SBW identity based on responses from research study participants. The characteristics were benevolence, control, independence, perseverance, stoicism, and strength (Woods-Giscombe, 2010). The research study participants also attributed the leading factors in the development of the SBW as the social construction of negative images of African-American women, the corresponding cultural response, along with nurture, racism, and sexism (Woods-Giscombe, 2010).

Abrams et al. (2014) improved upon previous studies establishing a primary representation of the SBW construct (referred to as the SBW schema) which combined and expanded findings from previous research (Beauboeuf-Lafontant, 2003, 2005, 2007,

2008; Jones & Shorter-Gooden, 2003; Romero, 2000; Woods-Giscombe, 2010). Multi-generational focus groups were used to gain insight and understanding into constructs espoused by research study participants as it related to the SBW identity (Abrams et al., 2014). Abrams et al. found that strength, in its various manifestations (that is, independence, resilience, and matriarchal leadership) was believed to be part of the ancestral heritage of African-American women and endorsed by over 60% of research study participants. Strength was viewed positively by the sample and believed to be the exemplification of Black womanhood (Abrams et al., 2014). However, maintenance of such a rigid identity is not without consequence as many have found.

Consequences of Living out SBW Expectations

African-American women pay both a physical and psychological cost for living out the SBW identity. Romero (2000) concluded that many African-American women might not easily recognize how the SBW identity influences their actions or behaviors. The research participants in another study (Beaboeuf-Lafontant, 2005a) reported that SBWs are expected to be all things to all people regardless of the personal costs. Any sidestepping of this role provoked criticism and rejection, which often forced these women to suffer in silence (Beaboeuf-Lafontant, 2005a) . The research participants in Beauboeuf-Lafontant's (2005a) study also hinted at the stresses associated with maintaining the role, suggesting there was an ongoing internal struggle felt from stuffing the negative emotions.

Black and Peacock (2011) learned that African-American women felt suffocated by the expectation that they were to assume multiple roles and manage multiple stressors

silently and sacrificially. In blogs and magazine articles, African-American women discussed the burden of others' expectations, the pressure of having to keep it all together, and the tendency to neglect self-care as a result (Black & Peacock, 2011). Voices of the women communicating through the print and social media examined, believed that living out the SBW identity negatively influenced physical and psychological health (Black & Peacock, 2011). This belief has been supported in the literature (Beauboeuf-Lafontant, 2005a; 2007; Black & Woods-Giscombe, 2012; Harrington, Crowther, & Shipherd, 2010) as the following research indicates.

Adiposity. The mandates from the SBW identity contribute to obesity in African-American women. Beauboeuf-Lafontant (2003; 2005) posited that the lofty expectations of the SBW identity have caused some African-American women to internalize and emote these pressures through their bodies. The author (Beauboeuf-Lafontant, 2003; 2005) posited a correlation between overweight, obesity, and the SBW construct. Beauboeuf-Lafontant (2003; 2005) suggested that African-American women were using their bodies as their voices, using weight to protest the unrealistic expectations placed on them to be strong, selfless, deferent, yet, defiant (Beauboeuf-Lafontant, 2003; 2005). She (Beauboeuf-Lafontant, 2003; 2005) surmised that the African-American vision of womanhood (i.e., SBW) was distorted from its inception as it perpetuated unrealistic expectations, similar to Mammy and her obliging deference to White-Americans throughout slavery and subsequent emancipation. These outcomes suggest that African-American women, although silence in physical voice, have found a way to speak through their bodies.

Overeating is used to cope with the pressures associated with the SBW identity. Harrington et al. (2010) established that for African-American women who internalized the SBW identity and experienced trauma, binge eating was a culturally acceptable coping strategy. Harrington et al. posited a specific model for how binge eating occurred, suggesting that traumas suffered would be filter through the SBW script for those who espoused it, which would then trigger coping strategies perceived to be acceptably lined up with the SBW script. Harrington et al's (2010) study results supported this hypothesis, noting that similar to White women, African-American women used binge eating as a coping mechanism, but their reasons were related to internalized cultural scripts (mainly, the SBW) (Harrington et al.,2010). From this information, it seems that adherence to the SBW script captivates women, pigeonholing them into limited coping responses.

Additional study findings (Black & Peacock, 2011; Woods-Giscombe, 2011) supported those of Harrington et al. (2010) discovering that African-American women used food and overeating as a coping mechanism. Mutinda (2009) found that it was often done in isolation. This seems counterintuitive as the concept of negative body image is rarely associated with African-American women (Hill, 2009). Studies have often shown that young girls and women of African-American descent demonstrate positive self-concept and self-esteem, more so than other ethnic groups (e.g., Caucasian-Americans or Latinas) (e.g., Mutinda, 2009). Hill (2009) corroborated this, reporting that the beauty mandate espoused by some African-American women suggests that these women have rejected the Eurocentrically based norms associated with beauty, instead espousing the 'big beautiful Black woman' as the ideal despite the documented effects of obesity on

health. The research study participants in Mutinda's (2009) study echoed these sentiments adding that weight was equated with SBWs. Societal tolerances, even expectations of the larger weights of African-American women through the social construction of the asexual Mammy image, encourages larger sizes and ignores the possible personal psychic distress associated with perceived non-conformity to societal standards of physical appearance and beauty and suppress opportunities for these same women to express concerns with their sizes (Harrington et al., 2010; Mutinda, 2009). Combined, this data suggest that the SBW script limits coping responses to physical or psychological manifestations of distress.

Avoidance. Social scripts for African-American women hinder their intellectual, psychological, and physical health. West (2008) stated that the strength narrative of the African-American woman is ever present, referring to it directly as the *"strongblackwoman"* whose "spelling implies that strong, Black, and woman, are inseparable parts of a seemingly cohesive identity" (West, 2008, p. 209). She (West 2008) stated that the burden of the SBW role was appropriately associated with depression, self-hatred, and overeating echoing the underlying theme of pain and stress shared by study participants in the work of Beauboeuf-Lafontant (2003; 2005). Hill (2009) also explored how the health of African-American women was impacted by living out or taking on the imposed cultural images surrounding strength, motherhood, and beauty, further endorsing it. She suggested that race, gender, and SES intersectionally influenced these images; mostly affecting poor African-American women because they were more likely to live out the cultural scripts put upon them by society (Hill, 2009).

Hill explored three mandates, strength, motherhood, and beauty, positing that attitudes and beliefs associated with each contributed to poor health outcomes for African-American women. The strength mandate ignores the plight of African-American women of limited resources, in effect silencing their voices and shading their lived experiences, which were far from ideal (Hill, 2009). Hill went on to state that the motherhood mandate encouraged childbearing regardless of or even in spite of marital status for its own sake. Its' perpetuation has most negatively affected poor, vulnerable, African-American youth who either embraced the ideology, ignoring the difficulties associated with it or were forced into it (Hill, 2009). It can be postulated that these various biopsychosocial factors create an emotionally charged environment for African-American women with little ability to maneuver aside from separating from cultural norms.

Finally, the strength mandate is likely to cause treatment avoidance or delay. Black and Woods-Giscombe (2012) recognized this probability when they combined and analyzed data from previous studies (Black & Peacock, 2011; Woods-Giscombe, 2010) which explored African-American women's attitudes, beliefs, and perceptions as they related to the SBW identity and personal health. Examining print media and transcripts from focus groups, the researchers sought to ascertain the impact of the SBW identity on health seeking behaviors, specifically breast screenings (Black & Woods-Giscombe, 2012). Respondents reported that they carried much responsibility whether it was attending to a single parent home, elderly parents, or working in their communities with some poignantly stated that they felt as though they carried the weight of the world on their shoulders (Black & Woods-Giscombe, 2012). From various responses, the

researchers determined that it was probable that African-American women would defer dealing with personal health concerns to attend to the demands of multiple roles, effectively putting themselves in jeopardy. It would be beneficial to see how these factors would interplay with religion introduced as a variable.

Depression. Depression is associated with the SBW construct. Qualitative studies (Abrams et al., 2014; Black & Peacock, 2011; Jones & Shorter-Gooden, 2009; Woods-Giscombe, 2010) and quantitative studies (Donovan & West, 2015; Watson & Hunter, 2015) have examined the association and found that adherence to the SBW construct was negatively related to health, specifically emotional health. Research study participants in Abrams et al.'s study associated emotional and physical fatigue and social isolation with perpetual strength demonstrations. Those in Black and Peacock's (2011) study believed the constant internal and external pressure to meet the constant barrage of expectations was the cause of feeling depressed, frustrated, and stuck; emotional distress like depression was usually emoted through physical symptoms. African-American women in both Jones and Shorter-Gooden's (2009) and Woods-Giscombe's (2010) work had atypical presentations of depression, which often led to inaccurate assumptions about emotional well-being. Adherence to the SBW construct, referred to by Jones & Shorter-Gooden as the Sisterella complex and by Woods-Giscombe as the Superwoman schema, was credited by research study participants with causing emotional and physical health to plummet and intimate relationships to suffer.

Maladaptive coping strategies (for example, overeating and smoking) were often cited and depression displayed through psychoneuroimmunological responses and

somatization. Recent quantitative studies (Donovan & West, 2015; Watson & Hunter, 2015) corroborated these qualitative studies' findings. Donovan and West (2015) found that research study participants who strongly related to the SBW construct were more likely to have a robust link to depression, stress, or both. Similarly, when the SBW construct and its correlation to anxiety and depression were examined by Watson and Hunter (2015), construct endorsement was positively correlated to both conditions. It can be ascertained from these findings that adherence to this cultural narrative has adverse effects on the health of African-American women. More specifically, it seems that the strength narrative, encapsulated in the SBW construct, is associated with depression.

African-American Women, Depression, and Religion

The recurring theme in the depression literature as it pertains to African-Americans is the importance of religion (Pew Research Center, 2009). Faith and strength, or coping with Jesus has been cited as a tool enabling elder African-Americans to deal with depression (Black et al., 2011). Ward et al., (2013) found this same effect with her research participants noting that both men and women endorsed religious coping. Moreover, according to women in Okeke's (2013) study, religion and spirituality were effective coping strategies. This information is not surprising when one understands the role that religion has played in the preservation of the African-American community.

Since times of slavery, the Black church has served as a primary source of support for the African-American community (Avent & Cashwell, 2015). The church has been a place of escape and refuge, albeit temporarily, from the harsh realities of an 'ism'-filled world. Viewed as a venue for self-help, the Black church provided African-Americans

with both camaraderie and a sense of community (Barber, 2015). Moreover, in many instances, the church has been a vehicle through which social change has been wrought (Barber, 2015). The Black church was prominent in the Civil Rights movement and also played a role in the provision of social services throughout the 1980s (Barber, 2015).

Recent studies on religion and spirituality in America demonstrate that religion remains vitally important for African-Americans. Pew Research Center (2009) reported that almost 80% of African-Americans believe religion is important and almost 90% believe in the existence of God. When reporting religious practices, over 50% of African-Americans attend weekly church services and over 75% pray regularly (Pew Research Center, 2009). Eighty-three percent of African-Americans identify themselves with the Christian faith, with nearly 60% of those attending predominately Black churches (Pew Research Center, 2009).

Similar to the general African-American community, the majority of African-American women identified themselves as Christian; more specifically with the Protestant faith (82%) (Pew Research Center, 2009). As much as 80% of African-American women consider religion central to their lives (Pew Research Center, 2009) with 60% consistently attending church services. African-American women are more likely to engage in religious practices like Bible reading and prayer than their male counterparts. Moreover, African-American women prefer utilizing spiritual resources in times of crises as opposed to secular options (Chatters et al., 2011). These numbers reveal the significant role that faith has in the life of African-American women. Given the importance of ecclesiastical participation as a coping mechanism for African-American

women, it would seem prudent then to gain more insight into how depression and religion interconnect.

Beneficial or Harmful?

The effects of religion on depression are mixed. Bonelli, Dew, Koenig, Rosmarin, and Vasegh (2012) conducted a meta-analysis on 444 quantitative studies to examine if there has been a demonstrated efficacious relationship between religion, spirituality, and depression. Studies analyzed cover almost 50 years of research on the subject. More than half of the 272 studies showed favorable results, that is, less depressive symptomology (Bonelli et al., 2012). Less than 10% of the studies (*n*=28) showed religion and spirituality to be correlated with an increase in depression. According to Koenig (2014) depression has decreased with more involvement that is religious and physiological responses have also improved such as lowered chemical stress response while using religiously-based psychotherapy and pharmacotherapy. Koenig (2014) does acknowledge, however that there is literature to suggest that biopsychosocial factors may increase religious persons' likelihood of developing depression.

This assertion seems to be supported to some degree by Ahles, Mezulis, and Hudson (2015) as well as Leurent et al. (2013). Ahles et al. did not find positive religious coping to be a moderator between stress and depression over time, despite encouraging readings at study baseline. However, the use of negative religious coping did interact with depression when religious coping was high suggesting that when religious coping is the primary coping mechanism for individuals and there is a propensity towards the negative, greater depressive symptoms can be expected (Ahles et al., 2013). Similarly,

Leurent et al. discovered that research participants who possessed a religious understanding of life (10.3%) were more likely than those who possessed a secular view (7.0%) to exhibit depression within a 12-month period. Individuals in this category who also scored high in the strength of their beliefs were at greater risk for major depressive disorder within that same time period (Leurent et al., 2013). More specifically, Leurent et al. found that those participants with strongly held beliefs were twice more likely to develop a major depressive episode than those with weakly held beliefs. Yet, despite contradictory evidence relating to the efficacy of religion in coping with depression, African-American women view it as such. This response is demonstrated in their help-seeking behaviors.

Help Seeking Through Religion

African-American women seek ministerial support to deal with depression or depressive symptoms. According to Mattis et al. (2007), women in this qualitative study were just as likely as men to contact a minister with problems including, but not limited to bereavement, health or sickness, and intimate relationship matters. Yet in a later quantitative study, Chatters et al. (2011) found that African-American women were twice as likely as African-American men (26% vs. 16%) to turn to pastoral support in times of crisis or difficulty. This help-seeking pattern was particularly important for regular church attendees, and for Pentecostals (discussed in greater detail later in this chapter), a category in which African-American women are anecdotally and statistically found (Chatters et al.,2011). Surprisingly, higher education and income was significantly and positively associated with use of ministers (Chatters et al.,2011). Important to note given

that African-American women at higher levels of the socioeconomic strata are demonstrated to experience mild to moderate depression (Holden et al., 2012) with greater odds of experiencing it over a lifetime (Hudson et al., 2012). From the data, it can be concluded that African-American women regardless of socioeconomic status, find value in their relationship with the church, more specifically clergy.

In a more recent quantitative study of 725 research participants, Hardy (2014) reported that African-American Christians, 72% of which were female, preferred pastoral counseling above secular forms of counseling. More specifically, when averaging the two administrations of the survey, research participants preferred to utilize a pastoral counselor to address 17 out of the 22 issues presented; translating into close to 80% (Hardy, 2014). Interestingly, in the second administration of the same survey, which contained the largest portion of the sample population (*N*=609), Hardy discovered that a pastoral counselor was the principal provider selected for all but one of the 22 issues. In that one instance, African-American Christians indicated they would choose a psychologist or psychiatrist first when dealing with symptoms of depression. The selection is thought-provoking given the reliance of African-American women on religious coping and help-seeking. Perhaps this outcome is related to clergy attributions and treatment of depression.

Depression and the Clergy

Clergy are often in the forefront when dealing with depression among members (Chatters et al., 2011). This activity might be partly due to the demands of congregants. For example, African-Americans, especially women, wanted to talk first to a minister

when dealing with a life issue (Chatters et al., 2011). African-American elders elected to speak with pastors second only to a family doctor (Woodward, Chatters, Taylor, & Taylor, 2015). Moreover, according to Hardy (2014), 28% of research study participants chose pastoral counselors (often clergy) to assist them in handling symptoms of depression. However, seeking help does not necessarily translate into receiving help. As ministers are held in high regard by the African-American communities (Avent & Cashwell, 2015), their opinions and thoughts on issues like depression have much influence. It is important therefore to ascertain the assumptions, beliefs, and perceptions clergy hold about depression. But first, it is important to explore what clergy are currently doing to address depression in their congregations.

Helping Patterns of Clergy

Clergy aspire to provide support to their members suffering from depression. Generally speaking, clergy, regardless of denomination, ethnicity, or race, indicated that they provide some level of care for depression (Asamoah, Osafo, & Agyapong, 2014; Montesano, Layton, Johnson, & Kranke, 2011; Wood, Watson, & Hayter, 2011). Most reported dealing with mild to moderate cases of depression. Ministers believed their primary role was to provide spiritual guidance and support to parishioners (Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013) whether through specific faith practices like healing, prayer, or scripture reading, or short-term counseling sessions. It was noteworthy that in the majority of studies examined (Asamoah et al., 2014; Graham, 2013; Montesano et al., 2011 Payne, 2014; Wood et al., 2011) ministers recognized that they were deficient with regards to their knowledge about depression and mental illness

(MI). In addition, many acknowledged they were not adequately trained to deal with mental health issues (Graham, 2013; Payne, 2014). Therefore, clergy desire to help their parishioners, yet recognized their need for training in this area despite some having obtained higher education.

Most clergy acknowledge having some type of educational training. Graham (2013), Bryant, Haynes, Yeary, Greer-Williams, and Hartwig (2014) along with Hankerson et al. (2013) and Payne (2014) concluded that pastors had some secular education varying in degree from a few college courses on up to post-graduate, doctoral degrees. Some clergy had theological training (Asamoah et al., 2014; Payne, 2014) and others, pastoral counseling training (Payne, 2014). Those with specific vocational training reported that their educational programs did not focus on mental health issues sufficiently and as a result clergy felt ill-equipped to deal with these problems (Asamoah et al., Payne. 2014). Clergy in Asamoah et al.'s study conceded that there was little to no focus on mental health during training, which resulted in lack of preparedness in the field.

Clergy also expressed concern about their lack of knowledge with regards to community resources (Graham, 2013). More specifically, clergy lacked the knowledge in how to effectively and efficiently locate mental health professionals who were competent and trustworthy to provide culturally sensitive services (Bryant et al., 2014; Graham, 2013; Hankerson et al., 2013; Montesano et al., 2011). There was reticence in making referrals to mental health professionals as many pastors argued that they did not receive respect from secular providers (Asamoah et al, 2014; Hankerson et al., 2013; Wood et al., 2011). For example, Payne (2014) found that almost 40% of the clergy expressed

ambivalence about making referrals to mental health providers noting it would take place situationally, with another 11% rejecting the idea of referring to a secular mental health provider outright. In another study, (Graham, 2013), clergy expressed concern about mental health providers turning congregants away from the church and their faith. While those in Montesano et al.'s (2011) study preferred making referrals only to mental health providers who shared Christian beliefs or demonstrated respect for Christian values.

At the same time, clergy seemed to recognize the emotional damage that could be done if mental health concerns were not handled properly (Bryant et al., 2014; Hankerson et al., 2013). According to both Bryant (2014) and Hankerson et al. (2013), clergy in their studies expressed concern about doing harm to parishioners, recognizing that words proceeding from the pulpit carried considerable weight. In light of this expressed concern, it was surprising to learn that among ministers with a few secular college classes, 92% felt strongly that pastors were the best providers to treat depression (Payne, 2014). Whereas those with no education or a bachelor's degree or higher, were noticeably more cautious (70 to 80%) (Payne, 2014). This practice suggests that clergy with some education may develop a false sense of competency creating situations were harm can be done.

Noteworthy differences along denominational, gender, and racial lines were established upon analysis of study results. In studies with research participants of African descent (Asamoah et al., 2014; Bryant, Greer-Williams, Willis, & Hartwig., 2013; Hankerson et al., 2013), stigma was of great concern. In these cases, clergy requested that programs or services not be referred to as 'depression related' for fear of alienating

potential members (Bryant et al., 2013). In study samples composed largely of African-American female clergy (Allen, Davey, & Davey, 2010; Hankerson et al., 2013), transmission of the message regarding depression was diluted for what seemed to be fears of stigmatization. A plausible explanation being that any association with depression, is an association with weakness; a narrative contrary to the SBW schema as established earlier. Finally, in studies with Pentecostal research participants (Asamoah et al., 2014; Bryant et al., 2014; Graham. 2013; Payne, 2014) found that attributions of mental health etiology inclined toward a demonic or supernatural explanatory model, skepticism about the effectiveness or usefulness of mental health services increased; and treatment recommendations were clearly aligned with faith-based practices.

There were also observable limitations among the literature reviewed. Payne (2014) determined that clergy with limited training were more likely to treat depressed congregants themselves. Yet the denominational affiliation and race of pastors in this category were not clearly delineated (Payne, 2014). This information is particularly vital given that clergy of both African descent and Pentecostal denomination acknowledge that depression is more likely to be stigmatize and categorized along moral or spiritual lines (Asamoah et al., 2014; Payne, 2009). Moreover, given that clergy recognize the harm that can be done to parishioners struggling with mental health issues if handled improperly, additional information that could explain these differences would be critical (Bryant et al., 2014; Hankerson et al., 2013).

In Graham's (2013) study, the sample population were not at all racially diverse. Ninety-seven percent of the research study participants were Caucasian (Graham, 2013).

Given that this study (Graham, 2013) was designed to measure the competency of Pentecostal clergy in assessing depression accurately, it would have been helpful to learn how African-American pastors performed. Another limitation is related to gender. Gender may have influenced outcomes in Hankerson's et al. (2013) study given that 86% of research study participants were African-American females. Although depression was in many instances attributed to non-spiritual causes, coping mechanisms and treatment suggested were those that seemed most culturally acceptable (e.g., faith healing, prayer, and quoting scriptures) (Hankerson et al., 2013). It has been established earlier that most, if not all African-American females are socialized to assume the SBW constructed identity. Therefore, the care and treatment of these clergy may have been consciously or unconsciously filtered along these socially ascribed parameters. This particular study is also unique in that clergy were predominately female; a practice not common in African-American churches overall (Hankerson et al., 2013). The majority of African-American church clergy are male; a fact especially true in Pentecostal denominations (Alexander, 2011). Cumulatively, inference from the data is that parishioners may be receiving mixed messages from clergy. Those individuals struggling with issues like depression may discern judgement as well as timidity from clergy as it relates to their concerns. When such perceptions are coupled with cultural constructs which discourage help seeking, church members, especially African-American women may feel isolated in their circumstances.

Beliefs and Perceptions

Clergy have varying assumptions, beliefs, and perceptions about depression. Depression is acknowledged by some as an illness of biological etiology singularly (Payne, 2009). Yet, it is also considered to be the result of biopsychosocial factors, including those of cultural, spiritual, and social origins (Kramer et al., 2007; Leavey, 2010). Depression is thought to result from feelings of guilt or poor behavior or choices (Leavey). This illness is also believed to be the result of spiritual or moral causes (Payne, 2009).

Many assumptions, beliefs, and perceptions fall along both denominational and racial lines. For example, African and African-American pastors are more likely to attribute depression to demonic activity or a lack of faith or trust in God (Kramer et al., 2007; Payne, 2009). Whereas, Caucasian clergy were more likely to favor biological explanations for depression (Payne, 2009). Moreover, African-American pastors specifically are more likely to express concerns about community and societal stigma related to a diagnosis of mental illness. In terms of denominational differences, clergy from churches with liberal or mainstream doctrine and practices are more likely to attribute depression to the biopsychosocial arena and less likely to attribute it to sin or Satan (Kramer et al., 2007; Leavey, 2010; Payne, 2009). Pentecostal clergy attributed depression to more malevolent causes (Leavey, 2010; Payne, 2009). Given that the focus of this this study is on African-American Pentecostal women with self-reported depression, it seems prudent to gain greater understanding of Pentecostalism and Pentecostal views on depression.

Pentecostalism and Depression

Understanding the Denomination

Pentecostalism is a rapidly growing denomination worldwide (Pew Research Center, 2006). In 2006, Pew Research Center indicated that there were almost 500 million followers on a global scale. Allan Heaton Anderson, (2011) one of the foremost experts on the Charismatic and Pentecostal movements concluded that this number is well over 800 million worldwide. In the United States, the number of Pentecostals is estimated to be almost 300 million (Pew Research Center, 2014). Almost 70% of African-Americans reported affiliation with Evangelical Protestant or historically Black Protestant traditions, the root faith of Pentecostalism (Pew Research Center, 2006). African-American Pentecostal organizations (e.g., Church of God in Christ, Pentecostal Assemblies of the World, Incorporated) are numerous in the United States, some having well over 500 churches or more within the organizations (DuPree, 1996; Pew Research Center, 2006a).

Pentecostalism, in the United States has its origins in the Protestant renewal which arose out of believers' rejection of the Catholic Church's negative teachings around the operation of the supernatural and their desire to reconnect with the God of the early church (Johnson, 2009; Hardwick, 2013). Charles F. Parham, an American evangelist in Topeka, Kansas, is credited with reconnecting Christendom with the early church experience of spiritual conversion known as Pentecost (Lincoln & Mamiya, 1990; Seymour, 2011). Pentecostalism is called such for its direct biblical reference to the day of Pentecost where the Holy Spirit was tangibly manifest through the outward

manifestation of glossolalia (explained in detail shortly hereafter) and a converted lifestyle (Lincoln & Mamiya, 1990). Pentecostalism also has some connections to Methodism and John Wesley's Holiness movement in that Pentecostals embraced the exhortation towards clean living and purity as well as the invitation to intimate, personal relationship to God (Anderson, 2011). However, William J. Seymour, is credited with bringing Pentecostalism to African-Americans (Lincoln & Mamiya, 1990).

African-Americans and Pentecostalism

The African-American Pentecostal movement gained traction in 1906 with the Azusa Street revival (Lincoln & Mamiya, 1990). William J. Seymour, an African-American preacher from Texas, heard about the Pentecost teachings of Charles F. Parham and traveled to Kansas to study under Parham (Alexander, 2011). Even though segregation, and sadly Parham himself, did not allow for him to take part in the official classroom, Seymour accepted these radical teachings and was soon ready to share with others, believers and non-believers alike (Alexander, 2011). At a revival meeting, on Azusa Street in Los Angeles, California, the Holy Spirit manifested itself through several converts' experiencing spirit baptism evidenced by speaking in tongues (Seymour, 2011). From that moment, the Holiness community was set afire and Pentecostalism spread rapidly (Alexander, 2011).

For African-Americans, the Holiness-Pentecostal tradition was attractive because it seemed to rehearse the saga of their collective experiences, as slaves brought from their home (i.e., Africa) to a land not their own (Sanders, 1996). Pentecostal values called for separation from the worldly system, a value that rehearsed their rejection from White

America and in many ways mirrored the struggle of God's chosen people, Israel in Egypt and through to the exodus (Sanders, 1996). This feeling was further cemented when Caucasian Christians became concerned that people would not come to their churches if Negros were present (Sanders, 1996; Alexander, 2011). This racial split was painful to African-Americans, as they believed the Gospel should have been a way to unify the body of Christ not divide it further.

African-American Women and Pentecostalism

Pentecostalism is a denomination that holds particular salience for African-American women (Alexander, 2011;Townsend-Gilkes, 2001). It is true that women of all races have played an important role in the spreading of the gospel in the Pentecostal movement since its beginning stages (Alexander, 2011). According to Tangenberg (2007), women in Pentecostalism around the globe, make up much of the church structure in terms of carrying out the daily activities of Pentecostal congregations. However, the Pentecostal church has long been a socially affirming haven for African-American women (Townsend Gilkes, 2001). African-American women have historically been vital to the churches in their communities with Townsend Gilkes (2001) specifically noting that churches which maintained vibrant women's ministries, kept their doors open. Although, the demographics on the exact numbers of women who participate in the Pentecostal movement are currently unknown, anecdotal evidence suggests 75% to 85% of the average membership in African-American Pentecostal churches is female.

Pentecostal Worldview

Beliefs and doctrine. Like other Christian denominations, Pentecostals believe in the existence of an omniscient, omnipresent, omnipotent God and accept him as the creator of the universe (Trice & Bjorck, 2006). Pentecostal Christians believe that Jesus Christ is the incarnate son of the living God (Pew Research Center, 2006a; Trice & Bjorck, 2006). Pentecostals believe that Jesus' death, burial, and resurrection are actual occurrences and establish salvation through him as the only way of redemption back to God (Trice& Bjorck, 2006). That is to say, Christians believe humans are born into a sin state defined as separation from God due to the inherited sin nature of Adam and are in need of restoration to their original sin free state, a state that can only be gained through acceptance of Jesus Christ (Alexander, 2011; Trice & Bjorck, 2006). Moreover, Pentecostals accept the Holy Bible as the sacred, divine revelation of God (Trice & Bjorck, 2006). Pentecostals also believe in the second coming of Jesus Christ, commonly referred to as the Rapture; an event expected to occur prior to the end of the world (Johnson, 2009).

Salvation (Repentance, water baptism, baptism of the Holy Spirit). Pentecostals believe that the process of salvation can only occur through symbolic death, symbolic burial, and spiritual resurrection. Symbolic death occurs as a result of repentance which seeking forgiveness through confession of sin and acknowledgement of Jesus Christ as Lord (Trice & Bjorck, 2006). Burial is symbolized through water baptism (i.e., complete immersion in water in the name of Jesus Christ) (Alexander, 2011). Finally, spiritual

resurrection occurs through the indwelling of the Holy Spirit which is provides initial tangible evidence through glossolalia. (Anderson, 2011; Johnson, 2009).

Glossolalia. Glossolalia, also referred to as speaking in tongues, is considered to be the essential evidence of baptism in the Holy Spirit (Anderson, 2011). The belief in the necessity of this practice sets Pentecostals apart from other Christian denominations. Glossolalia is reported to occur when a believer begins to utter words in a language not previously known to the believer (Alexander, 2011; Anderson, 2011). This event occurs under the influence of the Holy Spirit. In addition, the language spoken is not recognized as a known earthly language (e.g., Latin or Spanish) (Alexander, 2011; Anderson, 2011). The requirement of this evidence sets Pentecostals apart from other denominations (Johnson, 2009).

Holy lifestyle. Pentecostal Christians believe that genuine spiritual conversion is also evidenced by the way in which life is lived post-conversion (Payne, 2008). Pentecostals are expected to live a "holy and sanctified life" (Payne, 2008, p. 218). This change is demonstrated by adherences to modest forms of dress, avoidance of sexual activity outside of marriage, clean language (i.e., no swearing or cursing) clean, moral living devoid of alcohol, tobacco or other illicit substance consumption and a rejection of "worldly influences" (Payne, p.218; Sanders, 1996; Trice Bjorck, 2006). The Pentecostal worldview can be classified as unique and its differences make members distinguishable from other denominations.

Important Religious Practices

Divine healing. Miraculous healing is another hallmark of Pentecostalism. Healing is loosely defined as an immediate resolution of a condition through supernatural means (Anderson, 2011). Healing can take place instantaneously by of the "laying on of hands" (James 5:14-15, King James Version) by clergy or through "effectual fervent prayer" (James 5:16, King James Version) by clergy or other believers. Healing can also take place over the process of time (Trice & Bjorck,2006). Many Pentecostal Christians believe that healing is the will of God (Anderson, 2011; Trice & Bjorck, 2006). As a result, individuals who do not receive healing for conditions are sometimes thought to have 'sin' in their lives (a transgression that temporarily or permanently hinders one's relationship with God) or thought to lack faith (Payne, 2008; Trice & Bjorck, 2006). It can be posited that individuals with depression, an oft times persistent and chronic condition, could be viewed negatively by those within their church community.

Church Service and Worship. Pentecostals are distinctly known for their lively liturgies. During Pentecostal church services one can expect to hear upbeat music upon various instruments (e.g., drums, organ) (Sanders, 1996). Congregants participate with hand-clapping or foot-stomping in musical rhythms (Sanders, 1996). There will also likely be expressions of ecstatic worship, also referred to as 'shouting 'or 'dancing in the spirit', and dramatic, enthusiastic preaching with audible encouragement from the congregation (Sanders, 1996).

Pentecostal Views on Depression

Pentecostals have definitive views on depression (e.g., Harley, 2006). The prevailing view among Pentecostals is that depression is caused by biopsychosocial factors (Harley, 2006; Hardwick, 2013; Leavey, 2010; Payne, 2009; Trice & Bjorck, 2006). According to Harley (2006), when compared to the general population, Pentecostal Christians were just as likely to believe major depressive disorder was caused by a chemical imbalance. Hardwick (2013) established similar results with his small sample of Apostolic Pentecostal clergy who attributed mental health disorders to a variety of causes of which biology was one. Research participants in Leavey's (2010) study concluded that personal choice as well as biopsychosocial factors were responsible for mental illnesses like depression. Caucasian pastors in Payne's (2009) study were more likely to consider depression as a biological mood disorder. Finally, according to Trice and Bjorck (2006), for Pentecostal students enrolled in Bible College, biological etiology was noted as the sixth cause of depression out of seven. However, demonic forces were ranked as a significant potential cause of depression (Trice & Bjorck, 2006).

Demonic oppression and possession was concluded to be one main cause of depression by 230 research study participants (Trice & Bjorck, 2006) who believed that depressed individuals were victims and likely encountered this type of demonic activity as a result of a weak point in their spiritual lives. Pentecostals in Leavey's (2010) study were more likely to believe demonic, spiritual forces were at work in cases of mental illness. These beliefs were similar to pastors in Payne's (2009) study who attributed depression to a moral or spiritual cause. Hardwick (2013) reported that pastors

acknowledged the recent history of Apostolic Pentecostals demonizing mental health disorders. In addition, although these pastors believe that demonic possession is rare, they do believe it can occur (Hardwick, 2013). A much milder view than clergy interviewed by Asamoah et al. (2014). The clergy stoutly attributed mental illnesses including depression to demonic forces and believed their responsibility as clergy was to conduct exorcisms as a primary form of treatment (Asamoah et al., 20140. It is interesting to note that clergy in the aforementioned study are from Ghana and those in Leavey's study from the UK, whereas the latter studies were conducted in the United States, thus demonstrating the universality of these types of beliefs among Pentecostals on a global scale.

Other observations made by both Harley (2006) and Payne (2008) important to consider are Pentecostal beliefs about divine healing and ecstatic expression in worship services. Regarding divine healing, the former, it is likely disconcerting to clergy or members themselves if they receive prayer for a particular issue, feel better momentarily and then experience a subsequent reoccurrence (Harley, 2006). Trice and Brjock (2006) also recognized that sincerity of faith might be questioned if depression were chronic. In terms of expressiveness in worship services, Payne (2008) expressed concern for a Pentecostal believer's self-image if he or she were unable to live up to an unspoken standard of worship. In these instances, clergy attributions of depression have the potential to adversely affect members if their experiences are not understood (Payne, 2008).

Study results also revealed differences across ethnicity. African-American pastors were more likely to have negative beliefs about the etiology of depression (Payne, 2009). African-American clergy attributed depression to a moral cause, a spiritual failure, or a weakness more often than their Caucasian counterparts (Payne, 2009). Moreover, they were more skeptical of depression having biological roots. Caucasian Pentecostal clergy generally accepted that depression resulted from a chemical imbalance, life circumstances (e.g., bereavement, divorce), or substance abuse (Payne, 2009). It is unclear what variables contribute to these belief differences by race.

Methodological Literature Review

For this literature review by methodology, the focus was on studies that examined depression and religion and depression and religion in the African-American community. The methodological perspective yielded interesting results. In the qualitative studies, men participated more often than women and in almost all of the studies (Asamoah et al., 2014; Bryant et al., 2013; Bryant et al., 2014; Hankerson et al., 2013; Kramer et al., 2007) research participants were African-American or of African descent. In the quantitative studies (Ahles et al., 2015; Bellinger et al., 2014; Graham, 2013; Hankerson et al., 2015; Harley, 2006; Leurent et al., 2013; Payne, 2009; 2014; Trice & Bjorck, 2006), the opposite was true with respect to gender with women participating more often than men. Also, in this category, most studies were slightly more racially diverse. No mixed methods studies were discovered specifically related to the variables aforementioned. Out of all the studies examined, there was only one qualitative study in

which the researcher (Mengesha, 2013) focused exclusively on religious African-American women with depression.

Quantitative Research

In this research category, researchers in eight studies assessed religion and depression (Ahles et al., 2015; Bellinger et al., 2014; Graham, 2013; Harley, 2006; Leurent et al., 2013; Payne, 2009; 2014; Trice & Bjorck, 2006) and only one study (Hankerson et al., 2015) specifically focused on depression and religion in the African-American community. Out of the nine studies, the quantitative research conducted included an experimental design (Bellinger et al., 2014), several descriptive, cross-sectional designs (Graham, 2013; Harley, 2006; Payne, 2009; 2013), two longitudinal, prospective designs (Ahles et al., 2015; Leurent et al., 2013), and one participatory action research design (Hankerson et al., 2015). Most of the quantitative studies reviewed examined the physical and psychological benefits of religious involvement on depression (e.g., Bellinger et al., 2014), and clergy involvement related to depression (e.g., Graham, 2013; Hankerson et al., 2015).

Qualitative Research

For qualitative studies, researchers in only one study (Kramer et al., 2007) explored religion and depression and those in five studies (Bryant et al., 2013; Bryant et al., 2014; Mengesha, 2013; Payne, 2008) explored all three variables. The qualitative research designs used were community-based participatory research (Bryant et al., 2013; Bryant et al., 2014), consensual research (Hankerson, et al., 2013), grounded theory (Kramer et al.), and phenomenology (Mengesha, 2013). Payne (2008) conducted a study

which was exploratory using qualitative interpretive analysis. In most studies identified, researchers focused on the perspectives of clergy specifically exploring assumptions, beliefs and perceptions about depression as it relates to religion (e.g., Asamoah et al., 2014; Hardwick, 2013).

Methods of Data Collection

In the literature reviewed specifically related to depression and religion or depression, religion, and the African-American community, the most common data collection methods used were focus groups and surveys. Surveys were by far the most popular form of data collection used in seven (Ahles et al., 2015; Graham et al., 2013; Hankerson et al., 2015; Harley, 2006; Leurent et al., 2013; Payne, 2009; 2013; Trice & Bjorck, 2006) out of the 15 studies examined and this popularity is justified. Survey instruments can be quickly disseminated to large numbers of research participants (Creswell, 2009). Surveys can also be easily administered whether in the traditional fashion (i.e., with pen and paper) or electronically (Creswell, 2009). The rapid dissemination and collection of survey materials keep administration costs low and any interval between start to finish of a project relatively short (Creswell, 2009). For the seven studies previously mentioned, surveys were conducted via face-to-face meetings, the internet, or US mail. In one study (Hankerson et al. 2015), researchers had a face-to-face interview and workshop component as preparation for the survey administration. One of the disadvantages of survey use is that participants might give into social desirability bias and not answer truthfully, but in a manner that would present them in a more favorable view (Creswell, 2009).

Focus groups were used in four (Bryant et al., 2013; 2014, Hankerson et al., 2013; Kramer et al., 2007) out of the 15 studies examining the two or three variables. Focus groups are also cost effective and allow for the voices of multiple participants to be heard (Patton, 2015). The synergy of focus groups also encourages lively conversation making for richer data. Data collection through focus groups also presents challenges. Some research participants may monopolize the conversation silencing quieter members (Patton, 2015). Moreover, the size of the focus group may impede the amount of data collected allotting less time for all participants to be heard (Patton, 2015).

Surprisingly, face-to-face interviews were only used in one (Mengesha, 2013) of the 15 research studies examined. This method of data collection provides much opportunity to gather detailed information related to the topic being studied (Creswell, 2009). Interviews also allow for the researcher to direct the discussion using a guide or protocol. Face-to-face interviews allow for the researcher to observe behavior and body language which are important when analyzing or contextualizing data gathered (Creswell, 2009; Patton, 2015). Face-to-face interviews can be particularly difficult if rapport is not quickly established (Creswell, 2009). Buffers against this potential obstacle are the authenticity of the interviewer and the interviewer's comfort with the process. (summary)

Research on Depression, Religion, and the African-American Community

Studies that focused on depression in the African-American religious community are presented in Table 2. Studies using a community-based participatory (CBPR) research (Bryant et al., 2013; 2014) or participatory action research (PAR) (Hankerson et al., 2015) designs were most prominent. Researchers that use these types of research designs

seek to engage civic and private partners in addressing problems affecting their communities. The CBPR studies were both qualitative, focusing on diagnosis and

Table 2

Studies on Depression, Religion, and the African-American Community

Publication	Qualitative	Quantitative	Research Design	Collection Method	Gender
Bryant et al., 2013	X		CBPR	Focus groups	Mostly male
Bryant et al., 2014	X		CBPR	Focus groups	Mostly male
Hankerson et al., 2013	X		Consensual	Focus groups	Mostly male
Hankerson et al., 2015		X	PAR	Interviews/surveys	Mostly female
Mengesha, 2013	X		Phenomenology	Interviews	Female
Payne, 2008	X		Exploratory	Secondary (audio tapes)	Mostly male

Note. CBPR = Community-based participatory research; PAR = Participatory action research.

treatment barriers (Bryant et al., 2013) and health disparity solutions in the treatment of depression (Bryant et al., 2014). Researchers in quantitative PAR study (Hankerson et al., 2015) examined the feasibility of conducting depression screenings in churches. Study strengths for Bryant et al. (2013; 2015) were related to the representativeness of the church denominations (i.e., Baptist, Pentecostal, Non-denominational) and the diversity in the age range of the participants by focus group (between 18 to 70 years of age). Strengths in Hankerson et al.'s study were related to it being the first of its kind, the level of African-American male participation than general research average. However, one significant limitation was the small sample size for a quantitative study.

In the study (Hankerson et al., 2013) using a qualitative, consensual research design (i.e., a blending of grounded theory and phenomenology) researchers explored ministers' perspectives on the potential success of and the most appropriate type of church-based depression intervention for their community or congregation. Although stigma was a major concern across all themes, research participants believed that group

interpersonal psychotherapy might be a beneficial intervention (Hankerson et al., 2013). A major strength of the study was the gaining of the female perspective on ministry. African-American churches are historically male dominant in positions of authority (Townsend Gilkes, 2001). Limitations are related to the study's focus on one specific denomination (i.e., Methodist) and one specific church; restricting generalizability.

Payne (2008) conducted an exploratory qualitative study using secondary data consisting of audio recordings of sermons was discovered. This study focused exclusively on the Pentecostal denomination, exploring the direct and indirect messages clergy conveyed about depression and treatment (Payne, 2008). Analysis and interpretation of the data suggested that communications about depression were generally negative, viewing the disease as a moral failing or spiritual weakness (Payne, 2008). This study was important in that it provided insight into how depression and mental health treatment were viewed in the Pentecostal church. More specifically, it provided some understanding of how clergy communicated to congregants about the topic.

Finally, the qualitative, phenomenological study Mengesha (2013) completed explored the lived experiences of nine African-American women dealing with depression and their coping strategies. Out of the studies examining the three variables (i.e., depression, religion, and the African-American community), Mengesha's study was the only one that focused specifically on women. Participants admitted to struggling with being depressed and calling themselves Christians (Mengesha, 2013). Others referred to the stereotypes and by extension, expectations from those around them (Mengesha, 2013). The content of the quotations cited seemed to suggest some participants living

with conflicted identities. Research participants also expressed concerns related to seeking help from the medical community (Mengesha, 2013). These concerns were primarily related to providers' lack of cultural sensitivity. These participants seemed to accept medical interventions when their belief systems were validated by health care professionals (Mengesha, 2013). This finding suggested that cultural sensitivity in care provision increased the perception of its benefits.

A key strength of this study was that it provided insight into the difficulties that African-American women face dealing with depression while juggling expectations of their identities as Christian women and as SBW. However, Mengesha's (2013) study did not give clear indication as to the experiences that caused the conflicted feelings. The study also did not focus on a specific denomination; therefore, it was unclear if the uneasiness experienced was related to specific church doctrine or messages that arose out of the African-American community. Notwithstanding, the women clearly communicated the conflict between the two identities.

The cumulative take away from all the studies discussed in this literature review is the recognition that some ideas about depression, its etiology, manifestations, and treatment are deeply rooted in culture, whether it be ethnic or religious. This is important to consider when thinking about the relationships some African-Americans have with their church communities. Most notable is the fact that clergy are held in high regard in the African-American community. As a result, they have considerable psychological and social influence within their churches and with their parishioners. Therefore, it is expected that congregants through doctrinal teaching hold ideas similar to their leaders.

This expectation likely also extends to denominational doctrine. An important notion to consider in light of the ascription of demonic or malevolent roots to depression. Although, there is some evolution in ideology, for there are many who no longer believe such, there are still many who do. This knowledge is particularly disconcerting when thinking about African-American women suffering from depression or depressive symptoms who attend Pentecostal churches. Yet, in a review of all the related literature, no studies were located that focused on African-American women dealing with depression or depressive symptoms who attended Pentecostal churches. This research study filled this gap in the literature.

Summary and Conclusions

Depression in African-American women has many contributing biopsychological factors. Although, African-American women tend to score lower on depression scales than their Caucasian and Hispanic-American counterparts, when in-group comparisons are made, the effects of depression are generally more debilitating. Cultural scripts related to the SBW constructed identity and stigmatization about mental illness force African-American women into limited and narrow coping strategies. Thankfully, African-American women find great solace in religion and religious participation. However, for African-American Pentecostal women dealing with depression, religion may actually do more harm than good. African-American clergy views on depression were discovered to be negative and their treatment of depression concerning. Yet the views of African-American Pentecostal women dealing with depression remain unknown. Therefore, the exploration of lived experiences where these three variables, that is race

(specifically African-American), gender (female), and denomination (Pentecostal) converge, specifically from the viewpoint of congregants was a significant addition to the literature. Chapter Three provides a detailed outline of the research method and design, research methodology, ethical procedures, and data analysis. The chapter also includes information explaining the role of the researcher in this study and discusses issues of trustworthiness.

Chapter 3: Research Method

The purpose of this research study was to identify the lived experiences of African-American women who self-reported suffering from depression or depressive symptoms and attended Pentecostal churches in the Northeast United States. It was hoped that information gathered from this research study would give insight into the essence of the phenomenon of depression, through understanding the assumptions, beliefs, and perceptions of the women interviewed, as it related to the disease itself, cultural pressure, gendered identity, and gendered-role expectations from both an ethnic and religious perspective. The information in this chapter includes a discussion of the selection of the qualitative method for the research study and reviews the reasoning behind the selection of a phenomenological research design specifically. The chapter contains detailed information about the targeted study population, the sampling strategy selected, and instrumentation used in data collection. The role of the researcher is also included. Outlined is the recruitment process used from participant identification to the initial contact of potential research participants, informed consent, interviewing, through to the debriefing. Finally, trustworthiness issues, ethical procedures, and data analysis have been provided.

Research Method

The qualitative research methodology is grounded in the objective of ascribing meaning to the participant experience. Researchers seek to understand phenomena where little, if any, information is known through the exploration of participant accounts of their own lived experiences (Kemparaj & Chavan, 2013). Interactions with multiple research

participants enable researchers to discover common themes and patterns emerging from the data gathered (Kemparaj & Chavan, 2013). In phenomenological studies, such interactions provide explanation of and insight into the phenomenon's essence (Malagon-Maldonado, 2014). Purposive sampling methods, rather than random methods are used as researchers seek study participants who have lived the phenomena under inquiry (Kemparaj & Chavan, 2013). Use of qualitative methodology has become salient in health research as its use allows for insight into the social encounter with individuals, environments, or systems as experienced by study participants (Malagon-Maldonado, 2014). Underrepresented populations benefit much from this method of research, as its primary focus is to gather data in areas where little is known.

Qualitative inquiry is distinct in its processes. In this approach, the researcher is the primary instrument used to gather data (Malagon-Maldonado, 2014). The human connection between the researcher and study participants encourages the sharing of experiences. Another distinction in qualitative inquiry is the lack of expectation (Kemparaj & Chavan, 2013). There are no predictions or hypotheses made with respect to research outcomes. Proposing nothing, researchers allow themes to arise out of the data gathered (Kemparaj & Chavan, 2013). Therefore, it is not the researcher imposing meaning, but insight is derived out of the echoing voices of study participants.

A qualitative methodology was ideal for this study in that the central characteristic of the method enabled me to collect the data necessary to answer the research question. The foundation of qualitative methodology is to derive meaning from the events, experiences, and viewpoints shared by research study participants (Malagon-

Maldonado, 2014). Much of the time, the focus is on a singular phenomenon, exploring the assumptions, beliefs, and perceptions of study participants (Kemparaj & Chavan, 2013). Deriving meaning and gaining understanding are the primary goals. As the research question was designed to gain an understanding of lived experiences, a qualitative method was most suitable to obtain the desired data.

Quantitative research methods are focused on hypotheses testing and outcome predictions. This approach's primary intent is to generate numerical data (Turner, Balmer, & Coverdale, 2013). Researchers use specific instruments (e.g., surveys, questionnaires, experiments) to collect and analyze statistical data which may confirm assumptions, suggest correlations, or determine cause-effect relationships as they relate to the area studied (Campbell, 2012). Health research has traditionally embraced quantitative methodology because instrumentation used to gather data can be generalized to large sample populations, strengthening the statistical power of findings, and thereby improving generalizability of those findings to the general population (Malagon-Maldonado, 2014). Tests and measurement tools can be constructed in such a way to bolster the integrity of the data (i.e., reliability and validity) (Campbell, 2012).

Health behavior is very much driven by individual ideology. There remains a lack of knowledge as to the intrinsic nature of the phenomenon that quantitative research methods cannot answer (Kemparaj & Chavan, 2013). The social aspect of health research cannot be ascertained using quantitative methods considering its fail-safe mechanisms increase its rigidity, limiting, if not eliminating, its capacity to capture assumptions, beliefs, and perceptions (Malagon-Maldonado, 2014). Gathering information about study

participants' views does not only increase the likelihood of the potential to positively influence health behaviors. It also improves that potential of creating systemic changes in the healthcare industry for patients who are disenfranchised (Malagon-Maldonado, 2014).

A quantitative methodology was not ideal for this study as this type of methodology would not produce data that could effectively answer the research question or ascertain the essence of the phenomenon. The focus of quantitative methodology is on accepting or rejecting hypotheses (Holt, 2009). Researchers predict outcomes and use objective measures (e.g. surveys) to see if the data does or does not support them. A quantitative method would provide descriptive statistics about the research population. It should be mentioned that there were quantitative tools specifically focused on measuring depression or depressive symptoms (e.g., Beck Depression Inventory II, Reynolds Depression Screening Inventory) available for use. However, the use of a quantitative method or its tools would not allow for information about experiences to be obtained (Turner et al., 2013) or provide the data needed to understand the lived experiences of the sample population in this study. Also, given the potential reticent of African-American women in discussing depression (Okeke, 2013; Sirey et al., 2014; Ward et al., 2013), there was concern that the use of formal diagnostic tools would deter participation. Therefore, inviting self-reports of depression or depressive symptoms seemed the most viable way to engage research participants.

Research Design

Phenomenology is the exploration of lived experiences. This qualitative research design focuses on understanding phenomena from the perspective of research study

participants specifically looking to uncover the essence perceived by those who share the experience (Patton, 2015). In some ways similar to the conceptual framework of social construction, phenomenology is based on the idea that there are commonalities endorsed by those who experience a particular phenomenon. Husserl believed the world is shaped by the psychic encounters of people (Groenewald, 2004). In phenomenological inquiry, researchers want to know how study participants perceive the phenomenon. Research study participants relate their experiences reflexively so that they are reflecting on what has occurred; remembering their desires, fears, emotions, ideas, and thoughts about the incident being explored. Researchers seek to gather detailed, descriptive information to authenticate the phenomenon (Groenewald, 2004).

The primary focus of phenomenological inquiry is to understand the subjective reality of research study participants (Patton, 2015). Maintaining the integrity of the intentionality or consciousness associated with study participants' lived experiences is critical in communicating accounts accurately (Reiners, 2012). Therefore, researchers focus on *epoche* (i.e., bracketing) to reduce or eliminate the potential of tainting data with their own interpretations (Moustakas, 1994). Bracketing is achieved by systematically acknowledging and rejecting preconceived ideas followed by authenticating study participants' experiences as they are relayed (Moustakas, 1994). When researchers have prior personal knowledge of a particular phenomenon, it seems most appropriate to use a method of inquiry that lessens the potential for bias so that study participants' accounts are not distorted.

A phenomenological research design was ideal for this study. Considering the data to be gathered were lived experiences as psychically encountered by study participants. A heuristic, phenomenological design was ideal as it allowed me to reflect on the phenomenon as a participant (Moustakas, 1994). The suggestion of the researcher as a study participant may cause skepticism, but such an inclusion increased the trustworthiness of the data, specifically the credibility. Inclusion acknowledged my experience honestly and provided opportunity to see how or even if my experience interacted or shaped the data.

An ethnographic research design was considered for this study. The goal of ethnography is to understand cultures through examination of beliefs, practices, and rituals (Turner et al., 2013). Similar to other qualitative designs, the researcher is the primary instrument for data gathering. However, ethnography is different in that the researcher is immersed in the culture of the research study participants, usually through direct observation although other means of data collection are also used (e.g., interviews) (LeCompte & Schensul, 1999). As the sample population for this study could be categorized into several distinct cultural or social groups, it is possible to examine participant experiences of depression in the context of Pentecostal church culture or African-American culture. That was not the focus of this research.

Ethnography was not an appropriate research design for this study as lived experiences of study participants are being explored. Ethnography focuses on identifying cultural patterns and making meaning on a macro-level, eliminating the individual perspective (Turner et al., 2013). Use of an ethnographic design would have been useful

if this study were examining systemic issues as they relate to the Pentecostal church and individuals with depression. However, the study goal was to understand the essence of the phenomenon from personal accounts. This research design would not provide the data necessary to answer the research question asked.

Similarly, a qualitative case study research design was not appropriate for this research study. Like ethnography, the design requires prolonged exposure and focuses on a holistic, rather than individual perspective (Patton, 2015). Case study research occurs over a period of time so that sufficient depth and breadth can be captured (Patton, 2015). In addition, a case study critically explores an activity, an intervention, an organization, or a program from various viewpoints and through multiple sources to generate understanding of the whole (Creswell, 2012). It is possible that African-American women who suffer from depression and attend Pentecostal churches could be considered a unit of analysis, and by extension presumed case study worthy. However, the research study looked to explore lived experiences and a case study by virtue of its purpose did not effectively address the research question.

Community-based participatory research (CBPR) was not an appropriate research design for this study. It is discussed here because several of the key studies (Bryant et al., 2013; 2014; Hankerson et al., 2015) focused on depression, religion, and the African-American community demonstrated its efficacy with the target population of the research study. To ignore this point would be a demonstration of researcher presumptuousness. CBPR, historically rooted in participatory action research, brings the community, organizations, and researchers together to study an issue or phenomenon to address it for

the betterment of the community and those who live therein (Roberts, 2013). All parties are equal stakeholders and work cooperatively to design and implement interventions or programs to address social issues on both micro- and macro levels (Roberts, 2013). CBPR did not address the research question which focused on the lived experiences of African-American women with self-reported depression attending Pentecostal churches. With that said, it is possible that future research using this design might be beneficial for church communities and organizations.

Grounded theory, which focuses on theoretical development based on data acquired from field research, was not considered for this study. The principal idea in grounded theory is to develop an explanatory model through which to view and understand events or experiences (Turner et al., 2013). Data is usually collected from multiple sources (e.g., documents, interviews, or observations) and theories emerge through the process of comparative analysis (Glaser & Strauss, 2010). Grounded theory would have been appropriate as a method of inquiry if the focus of this study were understanding the behavior of African-American women with self-reported depression who attend Pentecostal churches. However, the research study focused specifically on the lived experiences of these women. Therefore, the use of grounded theory as a research design was dismissed as it would not yield the data to answer the research question.

A narrative research design was a possibility for this research study because like other qualitative approaches, narrative research focuses on life experiences. However, narrative research is unique in that the design uses stories or storytelling to organize personal life experiences and make meaning out of the stories shared (Creswell, 2012).

Whether through oral history or written memoir, the stories shared are the personal events experienced and interpreted by the individual storyteller (Turner et al., 2013). A narrative qualitative research design was not appropriate for this research study because the focus was the lived experiences of this study population. More specifically, the intent was to understand the essence of the phenomenon of depression for African-American women who attend Pentecostal churches. As so little is known, it seemed premature to focus on personal narratives, although such a study may be appropriate to consider when thinking of potential future research.

Research Question

RQ1 – What are the lived-experiences of African-American women with self-reported depression who attend Pentecostal churches in the Northeast United States?

Role of the Researcher

In the qualitative phenomenological study, my role was that of participant-observer. Kawulich (2005) suggested assuming this role in instances where the researcher is also a member of the group under observation. This role is thought to be the most honest and transparent although study participants understand the researcher's primary goal is to collect data (Kawulich, 2005). The benefit of identification as a group insider was that trust and rapport was more easily established. Assuming the participant-observer role was also a potential liability in that study participants may give into social desirability bias limiting or misrepresenting experiences for fear of vulnerability or retaliation (Kawulich, 2005).

Part of the rationale for assuming the participant-observer role had to do with my religious affiliation. I was an active member in one of the largest, predominately African-American Pentecostal organizations in the United States and around the world. In addition, I had a leadership role in my local church and I regularly participated in regional activities sponsored by the organization. It was possible that I might have known or at least had made the acquaintance of study participants. It was also possible that some of the potential study participants have viewed me as an instructor. This was more likely given the finite geographical location from which research study participants were recruited.

I was the sole researcher for this study. I personally handled the recruitment of study participants, the vetting, the interviewing, and debriefing of study participants. I was responsible for gathering data, the coding of data, and the analysis of data. A third party was responsible for the transcription of the audio digital recordings of participant interviews. Finally, as the sole researcher, I was responsible for writing up the study results.

Steps were taken to preserve the integrity of the research process. I was cognizant of my potential toward bias based on the affiliations previously mentioned. I was also aware that power relationships could have an effect on recruitment, data collection, and study results. In addressing the latter concern, during recruitment, data collection, and debriefing, I reminded potential study participants of confidentiality, informed consent, and the ability to withdraw from the study at any time without reprisal. This information was also outlined in the consent form that each research participant signed. Moreover,

research study participants were informed of the steps taken to protect their identities, secure their data when collected, and how the process of disposal of their data would occur if they chose to participate. Taking such steps engendered participant confidence with the process and the researcher (Kawulich, 2005). To guard against bias, I used journaling to reflect on the process, and to bracket judgments and assumptions (see Koch, 2006). Peer debriefing was also used in which peers reviewed interview transcripts, interview session notes, and researcher journal entries to increase trustworthiness of the data gathered (see Kemparaj & Chavan, 2013). In addition, audio digital transcription was done by a third party and not by the researcher to decrease the possibility of unintentional filtering and omission of data.

Methodology

Sample

The study sample consisted of African-American females who self-reported suffering from depression or depressive symptoms and attended Pentecostal churches. Research participants indicated through self-report that they either have or have had depression, have or have experienced depressive symptoms at some point in their church attendance. In addition, all research participants answered no when asked about recent birth of a child during initial screening (Appendix F), thus eliminating the possibility of postpartum-related depression. Study participants ranged in age from 20 to 69 years old. The research study was geographically located in the Northeast United States, with the target sample population either living or working in the Commonwealth of Massachusetts or the State of Connecticut. It was intended that 12 to 20 African-American females who

met the aforementioned criterion were to be interviewed or until data saturation was achieved (see Robison, 2014).

Sampling Strategy & Saturation

Study participants were recruited primarily through purposive, criterion sampling. This type of sampling method is used when looking for cases that can provide what is often referred to as thick description while at the same time fulfilling the sample population criteria (Patton, 2015). Convenience sampling and snowball sampling were used as parallel methods with the understanding that the sample criteria must be met for research study participants to qualify for inclusion into the study. Samples of convenience occur when potential study participants voluntarily come forth for the study (Kemparaj & Chavan, 2013). All research study participants were obtained through convenience, as their participation was voluntary. Snowball sampling (Robinson, 2014) occurs when current study participants suggest and provide contact information for other individuals to participate who fit the participant profile.

Purposive, criterion sampling also facilitated the probability of data saturation, a suggested goal in qualitative research (see Patton, 2015). Saturation occurs when there is no additional information surfacing that differs from what has already been provided by study participants (Patton, 2015). Researchers suggest that saturation or depth of understanding can be reached in phenomenological inquiry with fewer participant numbers (e.g., 5 to 25) especially when they are somewhat homogenous (Mason, 2010; Trotter, 2012). Maintaining a range of research participants to interview also fostered the process of saturation (Robinson, 2014).

Instrumentation

The primary instrument used for this study was an interview protocol I developed. The interview protocol included open-ended questions and prompts designed to elicit responses related to the research question (Appendix A). The interview protocol was based on the central research question and the data gathered in the literature review. The interview protocol was to be field tested with three to five qualitative methodology experts to insure that the items contain engendered the data needed to answer the research question (Kallio, Pietila, Johnson, & Kangasniemi, n.d.). A demographic questionnaire designed to obtain descriptive data was administered to study participants (Appendix B).

Data Collection Plan

Recruitment. Research participants were recruited using purposeful, criterion sampling parallel to convenience sampling. Assistance in the dissemination of study materials was solicited from women personally known to me from Pentecostal churches in both Massachusetts and Connecticut with which there is current or former affiliation. These women were given a study introduction letter along with a recruitment flyer (Appendices C & D) and asked to submit the written information to church leadership for review and approval. The letter contained a request for permission to announce the research study to congregants during Sunday worship services and also to post the recruitment flyer on the church bulletin board. In addition, letters and flyers were to be mailed to 50 to 100 Pentecostal churches in Connecticut and Massachusetts. These churches were identified in the religious section of local African-American news publications, telephone directories, and geographical internet searches. A reminder

follow-up call was to be made to those female contacts and churches who received the mailings within two weeks of submission.

Recruitment flyers were not placed in select local beauty salons who serve predominately African-American clientele, posts describing the study and requesting participants were not added to social media forums (e.g., Facebook and LinkedIn), nor was study information submitted for publication through Walden University On-Line Research Participation System. The rationale for the plan departure is detailed in chapter four. A short advertisement about the research study was placed (Appendix E) in five local community newspapers that target African-American readers. Advertisements ran concurrent to other recruitment methods and were discontinued when desired sample size was reached and data saturation was achieved.

Upon being contacted by potential research participants, I explained the study using the description outlined on the informed consent form. Each potential research participant was vetted using the study eligibility screening tool (Appendix F) to insure that sample criteria for participation were met. If a candidate expressed interest in participating, a face-to-face interview was scheduled within two weeks of the screening.

Informed Consent and Confidentiality. At the start of the interview session, the study purpose was reiterated to each research participant using the written script at the top of the interview protocol. The potential benefits and risks of the study were provided. The terms of confidentiality were explained along with the voluntary nature of the study and the ability to withdraw participation at any time. Then each participant was asked to read and sign a written informed consent form along with a form giving permission to

audio record the session. If the interview took place in a community church building, written consent was obtained from church leadership to utilize the building for the interview. Each participant was also given a demographic questionnaire to collect descriptive data prior to the interview.

Interview and Debriefing. I conducted face-to-face, semistructured interviews with each research participant. Each interview was audio digitally recorded and lasted approximately 22 to 101 minutes. All interviews were conducted using an interview protocol I developed that included open-ended questions, and prompts as follow-ups to those questions. The interview guide was based on the research questions and information gathered during the literature review. Interviews were conducted in a public library or a community church building. These locations were selected for their "convenience, familiarity, and privacy" (see Seidman, 2006, p. 49). Arrangements were made to use church buildings off peak hours which minimized the possibility of disruptions. As an alternative for participants who did not want to use churches, a neutral community space such as those available in public libraries were used. If needed, a white noise machine was to be used outside of the interview space so that conversations would not be overheard. At the conclusion of the interview session, I reviewed the experience with the research participant, allowing time for feedback, and offered each a list of community mental health resources. I thanked each participant for her time and informed her that she would be contacted within one month to review the session transcript.

Issues of Trustworthiness

Skepticism with regard to qualitative research methodology exists due to the reliance on the researcher as the data collection instrument. Such reticence is understood in the field as researchers often acknowledge the intimate entanglement of the data with the researcher (Houghton, Casey, Shaw, & Murphy, 2013). Yet, the base connection between the researcher and the study participants is the catalyst that stimulates the rich descriptions of the phenomena making qualitative research valuable. With this noted, qualitative research methods possess their own unique measures of trustworthiness which provide evidence of scientific rigor.

Credibility. Credibility is established when the data presented is espoused as an accurate reflection of the study participant accounts and the phenomenon itself (Shenton, 2004). Member checking and peer debriefing were used as the primary methods to address issues of credibility. Member checks helped to insure that the data collected captured the essence of the research participants' lived experiences (Shenton, 2004). The member checking process involved study participants reviewing copies of the interview transcripts, having the opportunity to make corrections or add information as appropriate (see Carlson, 2010). Member checking can also involve study participants evaluating what are usually the researcher's initial findings or interpretations of the data to determine if their viewpoints of the phenomenon have been reflected accurately. Researcher identification as a participant-observer bolstered credibility due to insider knowledge of cultural norms (Schensul, Schensul, & LeCompte, 1999). At the same time, potential towards bias was recognized because of this identification. Peer debriefing addressed this

concern by allowing the researcher to reflexively discuss data collection and data analysis with a knowledgeable, yet uninvolved peer to maintain the integrity of the research process and study participant data (see Houghton et al., 2013).

Transferability. Although not intended for generalization to the larger population, transferability can be established when there is what LeCompte and Preissle (1993) refer to as "translatablilty" of the research findings to similar situations or circumstances (p. 348). To aid in this process, audit trails were used. Audit trailing is the systematic description of the procedures used during the data collection phase and the documentation of the rationale used in data analysis and classification of themes (Ryan-Nicholls & Will, 2009). There may be some limitations to transferability due to the use of purposive; criterion based sampling which characteristically fosters more homogeneous sampling. However, information contained in the audit trails provide the foundation necessary for interested parties to determine circumstantial applicability of the findings.

Dependability. Qualitative researchers (Chenail, 2010; Schensul et al., 1999) define dependability as the degree to which a study can be replicated. This measure of trustworthiness in qualitative research is often likened to the concept of reliability in quantitative research (Ryan-Nicholls & Will, 2009). However assumptions, beliefs, and perceptions, core to understanding phenomenon from the participant perspective, are intrinsically individual and are unlikely replicable in the truest sense. Necessitating data saturation rescues this specific measure of rigor in that its requirement, when done correctly, generates the reverberation of themes from the data (Ryan-Nicholls & Will, 2009). Such findings demonstrate a study’s dependability. Verbatim transcriptions and

audit trails documenting the analysis process provided evidence of data saturation (Chenail, 2010).

Confirmability. Confirmability focuses on the integrity and authenticity of the data collected (Chenail, 2010). Third party transcription of the audio-recorded interviews, member checking of transcript content, audit trailing, and observer journaling are all tools that were used to guard against researcher bias. Doing so allowed for the voices of the study participants to be heard unfettered.

Ethical Procedures

It was important to address the ethical concerns associated with human study participants in any research. To insure that I was up to date with all of the latest practices regarding such, I completed the National Institute of Health training module for Human Research Protections online and submitted a copy of my certificate of completion with my IRB application. I sought approval from Walden University and the Institutional Review Board (IRB) prior to conducting any research. The approval number for this study is 04-08-16-0062339. Much of the recruitment was conducted via purposive, criterion and convenience sampling. With contact, mailing, and advertisement recruitment strategies, the information provided was related to the study purpose and included contact information. All contact with me as the researcher was done through a dedicated, confidential phone line (activated upon receipt of IRB approval) and email address to which no other person had access. No contacts were made regarding the study via social media (e.g., Facebook or LinkedIn).

Research participants were made aware of the potential risks associated with their participation and confidentiality was continually reviewed at all stages of the data collection process (i.e., preliminary contact, interview sessions, and member checks). Informed written consent for participation and audio digital recording was obtained from each participant at the start of the interview session. The potential risks associated with participation in this research project were minimal. There were no foreseeable financial or physical health risks associated with participation. However, study participants may have unintentionally disclosed personal or confidential information about themselves or others not related to the study. To protect the identity of study participants, pseudonyms were used during interviews, during data analysis, and in verbal or written presentation of the data. Because interviews were conducted in a neutral location (e.g., community church building or public library) potential intrusion and unwanted observation risks were minimized. During the interview process, study participants may have experienced some psychological distress relaying sensitive, personal information. Study participants were informed that they could withdraw their participation and information at any time during the process. A list of community resources (e.g., mental health services) were provided in writing to all research participants.

Research participants who were active church members or regularly participated might have hesitated to do so without the consent of church authority (e.g., pastor) who are viewed as key stakeholders in these communities (see Avent & Cashwell, 2015). It was important to acknowledge and demonstrate sensitivity to this cultural norm. In such instances, information about the study objectives would have been provided to church

leadership and permission to engage prospective study participants sought verbally or in writing.

During the data collection process, all research participants were assigned a pseudonym and a study number; that number was associated with their data. Each digital audio digital recording was packaged individually with that identifying number; all digital recordings were stored collectively. The transcription information was stored on an external hard drive and external flash drive with password protection. All forms of data were stored in a locked file cabinet or safe. All electronic correspondence (e.g., emails) were encrypted. When destruction of data is allowed, a company will be hired that specializes in the destruction of sensitive material and a certification obtained when it is completed. Since digital audio recordings was contracted out for transcription, the transcriptionist signed a confidentiality agreement (Appendix H) with regards to the handling, storing, and destruction of materials.

My final ethical consideration was my affiliation with the Pentecostal community from where I recruited participants for the study. It was possible that I may have known some of the study participants from church conventions or meetings. To insure the trustworthiness of the data, I recruited research participants from churches or regions of the states where I was less likely to have had any personal interactions other than on a casual level.

Data Analysis Plan

Moustakas (1994) provides two methods with which to analyze research data; modified methods from Van Kaam and Stevick-Colaizzi-Keen. As the researcher, I used

the modified Stevick-Colaizzi-Keen method to analyze and code verbatim interview transcripts to discover themes and eventually the essence of the phenomenon being studied (see Moustakas, 1994). I selected this specific method as it encouraged the inclusion of researcher data. This addition acknowledged the inherent potential for unconscious influence and neutralized possible influence via epoche (Moustakas, 1994). The data analysis occurred as follows:

1. I conducted a self-audio digital interview so that I could document my personal experience with the phenomenon.
2. After receiving the verbatim transcription of that self-interview, I systematically categorized each original statement related to the phenomenon into meaning units. This action was repeated until no new meaning units were discovered. Moustakas (1994) referred to this process as *horizontalization*.
3. The meaning units discovered were then re-categorized and classified (i.e., *delimited* and *clustered*) into relevant themes representative of the phenomenon (Moustakas, 1994).
4. The themes derived were then worked (a) into a *textural description* using verbatim excerpts as illustration of the phenomenon and (b) into a *structural description* which served as personal explanation for the phenomenon (Moustakas, 1994).
5. From both the textural and structural descriptions, a blended description was drafted that encapsulated the personal experience and ultimately captured the essence of the phenomenon from my perspective as a participant-observer.

6. The previous steps were then repeated for each of the research study participants through a process Moustakas (1994) referred to as *phenomenological reduction*, while practicing epoche.
7. All the data gathered was then synthesized into a comprehensive description of the phenomenon representing the collective voice of the research participants (Moustakas, 1994).

The qualitative software program NVivo was used to aid in the categorization, analysis, and interpretation of data (Moustakas, 1994). Discrepant or disconfirming cases, referred to as additional findings, were included even though such cases challenged the information gathered and provided alternative discourses for the topic being studied (see Patton, 2015). The inclusion of these cases lent authenticity to the data collection process.

Summary

This chapter reflected the research methodology that was used to explore the lived experiences of African-American women who have self-reported depression or suffered from self-reported depressive symptoms and attended Pentecostal churches. The information contained in the chapter explained the phenomenological method of qualitative inquiry and defended the rationale for the design selected. The target sample, participant recruitment process, and instruments used were described. The role of the researcher as a participant-observer was explained and the potential influence this role had on the research project. The potential for bias and the strategies used to protect the trustworthiness of the data were described. Finally, ethical considerations were reviewed with the steps taken to insure confidentiality of participant identity and information

outlined. In chapter four, the results of the study are discussed, including the study setting, demographics, the data collection and analysis process, and the trustworthiness of the study findings.

Chapter 4: Results

Introduction

The purpose of this research study was to explore the lived experiences of African-American women residing in the Northeast United States who self-reported experiencing depression or depressive symptoms while attending a Pentecostal church. The study had one research question: What are the lived experiences of African-American women with self-reported depression who attend Pentecostal churches in the Northeast United States?

This chapter provides information about the research conducted. The settings of the interviews are discussed, and research participant demographics are presented. The process of data collection is explained in detail including changes made during the data collection process. Data analysis is outlined, and evidence of data trustworthiness is offered. An in-depth discussion of the results is presented, and a summary concludes the chapter.

Interview Settings

A total of 14 interviews were conducted. Eleven out of the 14 interviews were conducted in public libraries. I offered to meet all participants at a local library in their communities. Each participant identified a library and I made the appropriate calls to locate space. A private study or meeting room was reserved in each of the public libraries to insure confidentiality and the privacy of the research participant. Most of the rooms were in areas of the library away from foot traffic. There was only one instance where the room was located close to the reference desk. One interview was conducted in the public

community room of the participant's apartment complex, and one interview was conducted in the pastor's office of a local church. My interview was conducted in my home.

In two of the interviews, interruptions during the session caused some distractions to the research participant. When conducting Zipporah's interview in the public community room, we were interrupted by a resident coming in to watch a football game. We quickly moved our meeting to the computer room which was vacant and were able to complete the interview with minimal interruption. When conducting Jael's interview, we were in a private room near the reference desk. At one point, the reference librarian knocked on the door to indicate he could hear raised voices. Jael has a deep speaking voice and she talked boisterously when she became animated during the interview. He assured us that he could not hear the content of what we were discussing, but only the louder tones. We continued the interview being mindful of keeping our voice volume low, but audible.

These two interruptions might have influenced the research participants' flow of dialogue, thought processes, and comfortability thereby potentially affecting the data. However, there was no indication that either of the two research participants were affected by these interruptions as they continued the interviews with no difficulties.

Demographics

The research population consisted of 14 African-American females between the ages of 20 to 76. Each of the participants selected a name from the women in the Bible to use as her pseudonym for the interview. The selection process is explained more fully in data

collection. Demographic information about the research participants is presented in Table 3 and Table 4. Most research participants were 41 years of age and up (*n* =12). The remaining participants (*n*=2) were below the age of 40. Most participants had children (*n*=11) and lived in Massachusetts (*n*=9). Most of the research participants learned about the study either through an advertisement in the local newspaper (*n*=7) or from an email listserv (*n*=4). All research participants identified their denomination as Pentecostal with most (*n=6*) identifying themselves as Pentecostal-Apostolic and two (*n=2*) identifying themselves as Pentecostal-Holiness. Most participants (*n*=7) worked full-time, and most of the rest (*n*=6) were not working either due to unemployment or retirement. Only one participant indicated that she was unable to work. Almost all (*n*=13) research participants had some form of college training and one earned her high school diploma. Roughly half of the participants (*n*=6) had an income of less than $30,000. The remaining (*n*=7) earned between $30,000 and $99,999. Only one participant earned over $100,000 per year.

Table 3

Research Participant Demographics

Name	Age Group	Marital Status	No. of Children	Denomination	Referral Source
Dinah	61 - up	Divorced	3-4	Pentecostal	Listserv
Esther	51-60	Single	1-2	Pentecostal H	Website
Eve	41-50	Married	0	Pentecostal	Newspaper
Hagar	61-up (76)	Divorced	5-up	Pentecostal A	Church
Jael	51-60	Widowed	3-4	Pentecostal A	Newspaper
Jezebel	41-50	Divorced	0	Pentecostal	Newspaper
Keturah	51-60 (57)	Single	1-2	Pentecostal	Listserv
Lydia	41-50 (48)	Married	1-2	Pentecostal A	Researcher
Mary	61-up	Widowed	1-2	Pentecostal	Newspaper
Naomi	41-50	Divorced	1-2	Pentecostal	Listserv
Rebekah	20-30	Single	0	Pentecostal A	Newspaper
Ruth	51-60	Divorced	5-up	Pentecostal A	Newspaper
Vashti	31-40	Single	1-2	Pentecostal A	Listserv
Zipporah	61-up	Single	1-2	Pentecostal H	Newspaper

Note. Ages in parentheses () indicate the exact age of the participant. Pentecostal A = Pentecostal Apostolic; Pentecostal H = Pentecostal Holiness

Table 4

Research Participant Socioeconomic Demographics

Name	Ed. Level	Work Status	Income Level	State of Work or Residence
Dinah	Bachelor	Retired	$30,000-$49,999	CT
Esther	Graduate	Full-time	$50,000 -$69,999	MA
Eve	Graduate	Full-time	$100,000 and up	MA
Hagar	Bachelor	Retired	Less than $30,000	CT
Jael	Bachelor	Un-employed	Less than $30,000	MA
Jezebel	Associate	Unable to Work	Less than $30,000	MA
Keturah	Graduate	Full-time	$70,000 - $99,999	CT
Lydia	Graduate	Full-time	$70,000 - $99,999	MA
Mary	HS Diploma	Retired	Less than $30,000	CT
Naomi	Some College	Full-time	$30,000 - $49,999	CT
Rebekah	Some College	Un-employed	Less than $30,000	MA
Ruth	Graduate	Full-time	$50,000 -$69,999	MA
Vashti	Some college	Full-time	$30,000 - $49,999	MA
Zipporah	Some college	Un-employed	Less than $30,000	MA

Note. CT = Connecticut; MA = Massachusetts

Data Collection

For this study, I conducted a total of 14 face-to-face semistructured interviews. All interviews were digitally-audio recorded. In keeping with the Stevick-Coliazzi-Keen method, I was one of the participants. The interviews were conducted over a three-month period, from May 2016 to July 2016. Each interview lasted between 22 to 101 minutes.

All interviews, except mine, were conducted in public locations. Eleven interviews were conducted at public libraries, which included two on university campuses, one interview was conducted at a local church, and one interview was conducted in the community room of a research participant's apartment complex. I completed my interview in my home. Most of the interviews (n=11) took place in a city or town located in Massachusetts, and the remaining interviews (n=3) were completed in a city or town in Connecticut.

Recruitment

All research participants came by way of convenience sampling by responding to advertisements in local newspapers, listservs, church announcement, and a website. Seven participants responded because of a newspaper advertisement. Four came by way of an email listserv. One responded because of an announcement in her church, and one responded to advertisement on a website. All participants were obtained through purposive, criterion sampling. The only data collection instrument used was the interview protocol which I developed.

In April 2016, I purchased and activated a phone to set up a dedicated research phone line. A greeting script which included information about the research study and

researcher contact information was drafted and recorded. The research phone line remains active to date in case any research participants attempt contact regarding the study results.

In anticipation of connecting with various organizations via mailings, I rented a dedicated mailbox at a local UPS Store. In late April 2016, an internet search was conducted to identify print and online media that targeted an African-American audience in Connecticut and Massachusetts. Three newspapers were identified in Connecticut, and three newspapers were identified in Massachusetts. In each state, one organization out of the three was a completely online publication.

Inquiry emails were sent to the Inquiring News, NE News Today, Northend Agents (Hartford, CT), Baystate Banner, BlackBoston.com (Boston, MA), and Point of View (Springfield, MA) regarding advertising in their printed and web-based publications. Emails were also set to NE Informer News (New England online) and FaithBlasts (Listserv) asking information about advertising in their web-based publications. All publications are circulated to and across the Commonwealth of Massachusetts and the State of Connecticut. A transmission failure notification was received from the server for NE Informer News and there was no working phone number by which to follow-up. All other publications responded to the email inquiries and provided information about advertisement costs and duration of publication runs.

In May 2016, a 4-week run in Inquiring News and a weekly run for a 4-week period in Baystate Banner were coordinated. Both venues were printed media. The Baystate Banner also included one month of advertisement on their website.

BlackBoston.com, a minority run website targeting African-Americans in the greater Boston, agreed to a three-month advertisement period. Shortly thereafter, a 2-week advertisement run was started on the FaithBlasts email list serv which targets the African-American faith-based community in both Connecticut and Massachusetts. In mid May 2016, I contacted three female acquaintances to provide information to give to their respective church leaders. The information packet included a research flyer (Appendix D), a letter of introduction (Appendix C) explaining the study, and a self-addressed stamped envelope. The introduction letter had a detachable portion that invited clergy to mail back requests for a summary of the dissertation findings in electronic or print form. The three women hand-delivered materials about the study to seven different churches. Follow-up calls were made to each of the women 2-weeks later. Although I intended to connect with additional women who I targeted for hand-delivery of research materials, I was unable to do so due to time constraints and distance of travel required.

In late May 2016 – early June 2016, searches were conducted using newspaper publications, the internet and telephone directories to identify churches to which information packets could be mailed. Churches were identified either by organization affiliations known to be Pentecostal or identification in directories or newspapers as Pentecostal and geographical location. A list of approximately 70 churches were identified. Through cross-referencing information, duplicates were eliminated. Packets were mailed to 59 churches predominately in Connecticut. This was done to draw more research participants from the State of Connecticut as much of the initial advertising response came from Massachusetts. Six letters were also mailed to churches in

Massachusetts. One additional mailing was sent to a pastor from Massachusetts (not on the mailing list) who called inquiring about the research study. In total, 66 packets were mailed to churches. Due to the staggered mailing of packets, follow-up calls were not made to churches.

One church called in response to the mailing and indicated that it was unable to post or announce the study. Another church called to ensure that they understood what was being requested in terms of announcements and posting. After providing clarification, the church agreed to announce information about the study for 2 months and to post the flyer. Both churches were in Connecticut. A total of five mailings were returned undeliverable (one from Massachusetts and four from Connecticut); three were labeled attempted, not known, one was returned indicating there was no such address, and one was returned as not deliverable as addressed. The postal service was unable to forward these mailings. Three pastors mailed back the detachable portion of the introduction letter requesting a summary of the dissertation findings. All three responses came from female pastors.

Although beauty salons serving African-American clientele in Connecticut and Massachusetts were identified (n=18), they were not contacted. The response from potential research participants via the print and online media methods was overwhelming, therefore this recruitment method was not needed. Nor were postings on social media forums or submission to the Walden University On-Line Research Participation System needed as recruitment tools.

Research participants who responded to the study from newspaper advertisements either contacted me via phone or email. When speaking with potential research participants by phone all were provided information about the study, those who expressed interest were asked to complete the study eligibility screening tool (Appendix A) at that time. Those who met the criteria were again asked if they were interested in participating. If yes, I obtained their contact information including name, email address, phone number and best time to contact along with how they came to learn about the study. I inquired about local libraries in the community and discussed dates and times they might be able to meet for an interview. Each participant was assigned an interviewee identification number at the time of the call. Those individuals who did not meet the criteria for the study were thanked for their interest and I offered to provide a summary of the study results when complete. Individuals who contacted me via email were asked to provide several convenient dates and times at which I could contact them by phone to discuss the study. When phone contact was made, I repeated the steps.

At the start of each interview, I introduced myself to the research participant, thanked her for her participation, reviewed the purpose of the study, along with its risks and benefits, discussed the voluntary nature of the study and confidentiality, and obtained informed consent with signatures for study participation as well as audio recording and transcription. Each participant was also asked to complete a demographic questionnaire (Appendix B). I shared with each research participant that I would be using an interview guide with a list of questions and might occasionally jot notes down to remember important points made during the interview. Prior to the start of the interview, each

research participant was presented with a piece of paper listing the names of women from the Bible. Each participant was encouraged to select a name or woman she liked or most identified with to use as her pseudonym for the study.

Data Analysis

To analyze the data, I used Moustakas' (1994) modified Stevick-Colaizzi-Keen method. This method consisted of constructing a textural-structural description of the researcher's personal experience of the phenomenon first, and then repeating these steps for each research participant. After completing the blended descriptions for each individual participant, I synthesized all the data into a comprehensive textual-structural description of the phenomenon. This overall description encapsulated the voices of all research participants for a corporate understanding of the phenomenon.

To help with this process, in the codes section of NVivo, I set up a file for each research participant, labeled with her pseudonym. I then attached a memo to each file in which I wrote my impressions of research participant, her responses to the questions, and the interview process overall. With each participant file, I set up a separate category or node to represent each of the 14 research questions asked. Under each of the 14 nodes, a child node was created to represent a theme within that question. After doing this for every question, I printed out all the results for that specific research participant. I then started to read through the interview data, deleting any information that was repetitive or completely unrelated to the question or the phenomenon. Once that information was eliminated, I read through the data again trying to condense broader themes, into more concise categories that reflected the experience of depression for that specific research

participant. Once I felt the information left was an accurate reflection of that person's experience, I synthesized that information into a textural description trying to describe what depression is like for her from a sensory, intellectual, spiritual, and emotional perspective.

The structural description was developed out of the historical information derived from the participant's experience. I attempted to share the sequence of events or experiences that led to, caused, or accompanied, the depression so that the research participant's experiences could be understood narratively. These two descriptions were then combined to add the emotional inflection and nuances to what are some stark experiences to vividly portray depression alive in the life of that woman. This process was done for all for the 14 interviews conducted.

Next, all 14 descriptions were analyzed and studied. For the purposes of unifying the collective voice of the research participants, once again repetitive ideas or thoughts were eliminated and information not representative or related to the phenomenon were omitted. From the final emergent themes, the collective description of the phenomenon of self-reported for these women was described. Data that emerged offering alternative discourses for the phenomenon was also included as “additional findings” instead of under the heading “discrepant or disconfirming data”. This information offered a different, albeit sometimes uncommon, perspective on the phenomenon.

Evidence of Trustworthiness

The trustworthiness of the data was verified by third-party transcription, member checking, and reflexive journaling. If appropriate prior to an interview, and directly after

each session, I used reflexive journaling. I noted my feelings about performing the interview prior to each one and what my impressions or feelings about the sessions were at the conclusion. I recorded personal thoughts, feelings, observations, and questions; some of these were related to the research participant and some were related to my performance and techniques as an interviewer. Also, as I wrote the textural and structural descriptions of each participant, I wrote down any feelings or thoughts that came up during the process. I also kept an audit trail of what occurred through the research process. Finally, I also maintained a participant contact journal which primarily contained contacts from participants who inquired about the study whether by phone or email. I tried to catalog my initial contacts and my response dates along with brief contents of the conversations and my replies.

All interviews were transcribed by a transcriptionist hired to provide verbatim transcripts of each audio digital recorded interview. Once I received the transcripts, I listened to each interview a minimum of two times thoroughly, following along on the written transcripts of each, noting any corrections, changes, or omissions that needed to be made. All updates and corrections to transcripts were minor in nature (for example, missed punctuation, missed pronouns or words, a name stated that needed to be omitted to protect confidentiality) and I made them myself. After all the changes were complete, I either met personally or provided a transcript copy to all but two of the research participants to have them check the transcripts for accuracy. At that time, participants were afforded the opportunity to add, correct, clarify, or omit information. Of the two I was unable to contact via email, phone, or in person, I contacted the Walden University

Center for Research Quality during IRB Office hours and discussed my concerns about using the data without this step. I was advised that I could still use this interview data as neither research participant had withdrawn their consent to participate.

Results

In this study, I explored the lived experiences of African-American women with self-reported depression or depressive symptoms who attended Pentecostal churches in the Northeast United States. The nine themes that emerged were (a) church ineffectiveness with depression, (b) comfort from personal faith, (c) emoting through behavior, (d) wearing a mask, (e) use of traditional supports, (f) strength expectations, (g) blaming the survivor, (h) traumatic experiences, and (i) psychological harm done. These themes, presented in Table 5 along with their subthemes, and sub-subthemes, are explored in the remainder of this chapter. When quoting the research participants, words such as “um”, “like”, and “you know” were omitted for message clarity.

Theme 1: Church Ineffectiveness with Depression

All research participants were asked about their experiences attending Pentecostal churches as individuals with self-reported depression. There was an overwhelming consensus that Pentecostal churches are ineffective when it comes to dealing with depression. Thirteen out of 14 participants (Dinah, Esther, Eve, Jael, Jezebel, Keturah, Lydia, Mary, Naomi, Rebekah, Ruth, Vashti, and Zipporah) believed this to be the case. Their reasons varied: 6 believed the church offered simplistic solutions, 5 felt depression was not accepted or taken seriously, 3 felt churches had no resources to offer, 3 felt the

church was completely silent on the topic altogether, and 2 believed the church just cannot deal with depression.

Table 5

Themes and Subthemes

Themes	Subthemes	Sub-subthemes
Church ineffectiveness with depression	Simplistic solutions	Directed to God Just pray Be grateful or joyful
	Depression is not accepted or taken seriously No resources available Silence on the topic Church cannot deal with depression	
Comfort from personal faith	Spiritual practices Ecstatic expression	
Emoting through behavior	Overeating Loss of appetite Drug use	
Wearing a mask	Coping with 'isms' and stereotypes Fear of criticism, judgement, & rejection	
	Self-silencing	Anger
	Stigma	
Use of traditional supports	Therapy	Favorable or neutral Negative Faith-based therapy
	Medication	Beneficial? No meds not ever
Strength expectations		
Blaming the survivor	Church messages Demons	
Traumatic experiences	Domestic violence Sexual trauma	
	Grief and loss	Intimate partner betrayal & heartbreak Death of a loved one
Psychological harm done		

Note. **Additional findings included the following: Emoting through anger and sex, is depression just a word, and sexism in the church**

Subtheme 1: Simplistic solutions. Out of the six participants (Dinah, Esther, Keturah, Naomi, Rebekah, and Zipporah) who believed the church offered simplistic solutions, two were directed to God for help, two were directed to pray, and two were told to be grateful or joyful.

Directed to God. Two of the six participants (Dinah and Naomi) were told to turn to God for help with their depression.

"Oh, yeah, no, we go to God, we don't go to psychologists or therapist and stuff like that. God can handle it". (Dinah)

"But they always talk about hope in God and how God can solve anything, how, bring it to God". (Naomi)

Just pray. Two of the six participants (Keturah and Zipporah) were told that prayer is the solution.

"But again, we have a lot of ministers, they don't have education in this area, and they just think everything is a prayer". (Keturah)

"If you.…whatever it is you're feeling….you need to get on your knees, and you need to pray…and ask Him to help you". (Zipporah)

Be grateful or joyful. Two of the six participants (Rebekah and Zipporah) were told to change their attitude, and to express gratitude or joy.

"I remember the pastor always emphasizing on how you should be joyful.…the joyful spirit of the Lord in spite of what, whatever you go through". (Rebekah)

"You need to have some gratitude; you need to be grateful". (Zipporah)

Subtheme 2: Depression is not Accepted or taken seriously. Five out of 14 participants (Dinah, Lydia, Naomi, Rebekah, and Vashti) did not believe depression was accepted or taken seriously as a legitimate health condition.

For example, Dinah stated, "Well.…mental health is a negative word in a Pentecostal church".

Vashti agreed, and added, "It was okay to have other emotions, but depression was never, it was never something that was like okay to have".

Subtheme 3: No resources available. Three out of the six participants (Jael, Mary, and Ruth) stated that Pentecostal churches do not have any resources for people dealing with depression.

Jael reflected, "It's one thing to have.…a women's conference on depression and have some guest speaker that doesn't talk about depression….get dressed up.…and pay for nothing….You have no resources to go to".

Ruth was more understanding. She explained, "Yeah, they may not have the resources, but they can't be everything and all to people".

Subtheme 4: Silence on the topic. Two out of six participants (Eve and Mary) stated that the church does not talk about the subject of depression.

"Silence. There's silence…and that's not good". (Eve)

"I never received anything from any church….they never strike really depression, you being depressed". (Mary)

Subtheme 5: Church cannot deal with depression. Two out of six participants (Naomi and Zipporah) do not believe that the church or the leadership is equipped to deal

with depression.

"I mean.…they don't really know how to deal with depression.…and they don't want to talk about it…". (Naomi)

"And my pastor.…he cannot handle any talk about depression. His wife suffers from depression.…And the reason why I know is because she told me".(Zipporah)

Theme 2: Comfort from Personal Faith

Ten of the 14 research participants (Esther, Eve, Mary, Ruth, Naomi, Dinah, Hagar, Jezebel, Keturah, and Lydia) derived a great deal of comfort from their personal faith in Jesus Christ. Nine participants obtained comfort through spiritual practices like Bible reading, church attendance, prayer, and singing songs, and two participants enjoyed taking part in the worship services with ecstatic expression.

Subtheme 1: Spiritual practices. Eight of the 10 research participants (Mary, Naomi, Dinah, Esther, Hagar, Jezebel, Keturah, and Lydia) felt comforted by praying to God, reading scriptures from the Bible, or singing hymns or worship songs. For instance, Keturah shared,

> "And I think I forced myself to read my scriptures. A lot of times I was just looking at the pages, I can't tell you, I can't remember what I'm reading, but I just knew I had to have it in front of me. That was the only thing that kept me calm, that brought me some peace".

Hagar demonstrated a different practice from the eight. "But so, I learned to sing. I always was a singer and I still sing, mm-hmm, and it makes me happy, it gets me out of my ruts. And, so I learned, and that's how I did".

Subtheme 2: Ecstatic expression. Two of the 10 research participants (Dinah and Ruth) derived much comfort from participating in their church worship services. As previously explained in chapter 2, ecstatic expression usually refers to dancing in the spirit or shouting under the influence of the Holy Ghost.

> "But I feel good inside, I just feel like I'm not me at that moment, like God has really come in to me and taken over and given me the glory and the blessing to feel his presence". (Ruth)

> "I just get so full, and I'll have a little, a little walk….But they don't know what those, just those words, giving God the praise, that's what we're here for…". (Dinah)

Theme 3: Emoting Through Behavior

Ten of the 14 participants (Dinah, Esther, Jael, Keturah, Lydia, Mary, Naomi, Rebekah, Vashti, and Zipporah) all admitted to either emoting through a specific behavior (e.g., eating or not eating) or openly displaying their anger. Information for two participants (Naomi, and Vashti) is included in the additional findings section because each participants' behavior is unique to them.

Subtheme 1: Overeating. Six of the research participants (Dinah, Esther, Jael, Lydia, Rebekah, and Vashti) eat to cope with their depression. For example, Vashti shared in an exchange between she and I,

> "I would eat, that was my thing then….I would go to McDonald's and order enough food for 4 people and eat it and cry". When I inquired what she was crying about, she replied with a laugh, "I can't believe I just ate all this food".

Esther concurred, revealing, “When I joined that church, I was a size 11-12 (chuckles). When I left, I was a 20”. When I inquired what was going on for her during that time, Esther explained,

> “A lot of eating, a lot of, um, (pauses, sighs) I think just, no, there's no activities outside of that….it was just church, church, church, church, church”. When I inquired why she was eating, Esther stated, “Eating away the pain. Eating away the loneliness. Just that was it, you just, maybe that was, food became my friend, I guess”.

Subtheme 2: Loss of appetite. Contrariwise, two participants (Keturah and Mary) had no desire to eat whatsoever. Keturah exclaimed,

> “I'm a junk-food junkie....potato chips and stuff like that, but I mean I do have a very healthy regimen, I'm the gluten-free cook….It was the opposite….just total loss of appetite. Nothing, nothing, I mean, I just, I literally saw the bones in my legs from just, just laying [*sic*] there, just nothing, just, yeah”.

Mary’s experience was similar, “So, sometimes I could not feel like cooking, not even feel like going to the grocery store, just feeling, not being, not being able to do things like I normally would do”.

Subtheme 3: Drug use. Two participants (Jezebel and Zipporah) indicated that they used drugs to cope with their depression. Jezebel said, “I self-medicated with illegal drugs and alcohol, I did that at first. And once that wasn't working because it made my life spiral even more…”. Zipporah was able to relate revealing,

> "Historically, before I realized I was depressed, because it was a number of years before I really realized that I had a [*sic*] issue, and I used to drink, and, I used to shoot dope, and I used to smoke crack. And, I did a lot of things in order to deal with having to be who I needed to be…".

Theme 4: Wearing a Mask

All participants were asked about their experiences as African-American women living with depression and as African-American women living with depression while attending a Pentecostal church. These questions were posed in this manner because there was a recognition that participants might be identifying with two overlapping, yet distinct communities. Nine out of 14 research participants (Dinah, Esther, Jezebel, Lydia, Mary, Naomi, Rebekah, Ruth, and Vashti) felt that at some point they wore a mask or hid their depression and their reasons for doing so varied. Six did so for fear of criticism, judgement, or rejection, six wore masks to cope with discrimination, prejudice, racism, and stereotyping, four did so for fear of stigmatization, and four did so as a means of self-silencing, however this was often accompanied with feelings of anger.

Subtheme 1: Coping with 'isms' and stereotypes. Five of the nine research participants (Dinah, Eve, Lydia, Mary, and Naomi) all concealed their depression as a method of coping and self-protection.

Esther stated, "And for me, I just internalize it….Because anybody in the room at the table….Chinese and White.…they got angry, they're angry. If I get angry, I'm an angry Black woman, and so I'm troubled, okay?".

Mary concurred reporting, "…But you have to, you almost have to put on a certain face because if you don't put on that certain face, they have a worser [*sic*] impression of you…".

Subtheme 2: Fear of criticism, judgment, & rejection. Five of the nine participants (Dinah, Lydia, Mary, Naomi, and Vashti) indicated that they all wore their "masks" or hid their depression out of fear. They feared criticism, judgement, and rejection from their loved ones, peers, and church communities if their depression was discovered.

For example, Dinah explained, "I hid a lot of things I'm doing, I wouldn't share things with people because of, I just didn't want them to start asking a bunch of questions". Vashti went further stating,

> "My pastor…she worked in the mental health field, but I didn't like talking to her about my depression…and that's how she talked to me all the time, like I was a patient, and not like I was a human being".

Subtheme 3: Self-silencing. Five of the nine research participants (Esther, Mary, Naomi, Vashti, and Zipporah) engaged in self-silencing behaviors for fear of being labeled or misunderstood. However, this practice was often accompanied by feelings of anger.

Esther expressed the sentiments of her cohorts this way, "I think it's, if you don't watch out you could become angry and then blow up. You have to suppress it".

Naomi also shared stating, " It comes from constantly keeping quiet about things that you go through…".

Anger. Two of the five participants (Esther and Mary) felt anger over having to suppress their feelings and felt frustration over having to keep quiet. Esther shared,

> "I think it's, if you don't watch out you could become angry and then blow up. You have to suppress it….and that's why lately we've been having these stories or whatever things on the news where people are losing it....Some of them, yeah, have serious mental health issues, but I also think sometimes, it's just anger that has built up that you suppressed, and then it's like a.…pressure cooker, and when it blows up, boom....But, for me I've learned to suppress it".

Mary expressed sentiments like Esther. She said,

> "You're holding it in, and then you say, you know what the person doing [*sic*] and you're seeing what the person doing [*sic*] and you're like, okay that doesn't look too great and….It makes you angry. It makes you angry because, I mean....I would never do some of the things that I see people do to me".

Subtheme 4: Stigma. Four out of nine participants (Esther, Jezebel, Naomi, and Ruth) were concerned about the stigma associated with depression.

For instance, Jezebel stated, "As an African-American it's the stigma, like I am not allowed to have mental illness….it's just a stigma of not being able to break down like other women".

Ruth agreed, "But to me depression is like a stigma against African-American [*sic*]…so we tend to not get help or we're like in denial of that main depression because we don't want to be affiliated with it".

Theme 5: Use of Traditional Supports

Nine of the 14 participants (Dinah, Esther, Jezebel, Keturah, Lydia, Rebekah, Ruth, Vashti, and Zipporah) sought the help of their primary care physician, a therapist, a psychologist, or a psychiatrist to deal with their depression.

Subtheme 1: Therapy. All nine participants at some point worked with a therapist while dealing with depression. Seven participants' views about therapy were neutral or favorable while two participants' views were negative.

Favorable or neutral. Seven of the nine participants (Dinah, Keturah, Lydia, Rebekah, Ruth, Vashti, and Zipporah) had a neutral or favorable opinion about therapy.

For example, Rebekah stated, "So, I have a therapist, I already said that I have a therapist and a psychiatrist, so I guess that's help that I sought". While Vashti shared her positive experience,

> "Therapy is great. I, I love my therapist. She's very, very open, and, which is why I chose to go to therapy and not to my pastors, was because I wanted someone where I can sit down and have a conversation without feeling like I was being judged, so".

Negative. Two of the nine participants (Esther and Jezebel) had a negative view of therapy. Esther indicated, **"**And so I did go to therapy. It didn't last long because of the religion (laughs). Because when I went to therapy I looked at the therapist as….she was questioning my beliefs…". Esther went on to explain that her negative was deeper than that indicated above. "I looked at it as challenging, like she was evil. She would say to

me, Esther, what do you think of me?" Esther told me what she said to the therapist, laughing as she did, "So, and I would say to her, I think you're evil".

Jezebel's experience was negative for a different reason. She explained,

> "Because one time he said, I, I went in there and I said something, what happened, or something I was getting ready to say, and he said, I don't want to hear no bad news, with his hand up like that, so I'm thinking, I'm like, well who the hell am I supposed to tell my bad news to….after he said that I was kind of pissed…".

Faith-based therapy. Two of the nine participants (Dinah and Keturah) had therapists who were Pentecostal and practiced therapy from a Christian worldview. Dinah shared,

> "I didn't need a secular counselor, I didn't need really just a Christian counselor, I needed a Pentecostal one to help me separate things from what is normal and what is spiritual, and it was all jumbled in my head....and I found a counselor out on Long Island, New York....And she helped me quite a bit to separate, separate things".

Keturah found help in her church counseling center.

> "So, I said....I really need you to give me a top-notch spiritual warfare person....because I need a breakthrough....and so I met with her for about maybe, 3, 4 sessions and, and so we prayed, and, and we talked about it, and she gave me a little homework and things to do and stuff like that, so".

Subtheme 2: Medication. Four participants tried medication to help manage symptoms related to depression. Two participants were against taking medications altogether, albeit for different reasons.

Beneficial? Four of the participants (Lydia, Jezebel, Rebekah, and Vashti) had mixed reviews about their medication. For example, Jezebel stated,

> "I got off the drugs and the alcohol and got onto the psych meds….it was helping for me not to feel the pain of depression, of bad memories, PTSD….Now I don't, I, I really don't want to take the medication, but I'm afraid to get off the medication because I'm so afraid to go back to that dark place that I was before".

Rebekah had success with medication, but not without trial and error. She explained,

> "I was, the doctors hadn't given me the right meds....there was a certain medication….that made me restless, so I wouldn't take it, and then when I would go to class it was hard for me to sit in class and actually focus and concentrate....so I had to be hospitalized for two weeks during my semester, and luckily, they found a right medication that works well with me…".

No, meds, not ever. Two participants (Dinah and Jael) were against using medications, but their reasons for doing so differed significantly. Dinah stated, "But God had told me that He's going to get the glory out of this and if I take the medication, they'll say that the medication was delivering me, not God, so I didn't take it".

Jael, on the other hand was concerned about its effects. She replied,

> "Well, take this pill. No, I will not! I've looked up everything. I look up things, I Google, I have every medical book I can get my hands on, and I will tell you, oh, the side effects of that, no, no, no, no, no, no, no, no, no, no!".

Theme 6: Strength Expectations

All research participants were asked questions related to the SBW identity, their possible personal identification with qualities they discussed, and how these two converged with their experiences with depression. Out of the 14 research participants, eight (Dinah, Esther, Jezebel, Lydia, Mary, Naomi, Ruth, and Vashti) agreed that African-American women are expected to be strong. Both Jezebel and Naomi relayed the sentiments of the group concisely.

Jezebel stated, "I'm supposed to be strong, I'm supposed to carry the world on my back, and it, it's just a stigma of not being able to break down like other women".

Naomi shared, "I think that….a lot of Black women have been stereotyped and pigeon-holed to, to the point where they got to be strong every day. They can never have a down day".

Theme 7: Blaming the Survivor

Seven of the 14 research participants (Esther, Jezebel, Lydia, Naomi, Rebekah, Vashti, and Zipporah) believed that the church blamed them for their experiences with depression. Six believed they were either topics of a sermon or given direct messages by church clergy or members, and it was suggested to four participants that they were dealing with demonic influences.

Subtheme 1: Church Messages. Six of the seven participants (Jezebel, Lydia, Naomi, Rebekah, Vashti, and Zipporah) were topics of the pastor's sermon or spoken to directly by clergy or a lay member.

Naomi, for example, was told, "So, then it's….you don't really want God. You don't really want to be delivered because you have, you, you're inconsistent".

Listening to a sermon Zipporah heard, "Ah! 'You need to pray'. 'You need to seek God's face'. 'Get in the word.…This book right here has all the answers you need for your whole life'….This is about Jesus'. 'This ain't about how you [*sic*] feeling".

Subtheme 2: Demons. Four the seven research participants (Jezebel, Lydia, Vashti, and Zipporah) were told directly or indirectly that they 'had a demon' or that demonic influences were at work in their life when they exhibited signs of or discussed their depression.

Jezebel, for instance, stated, "That the devil got you, sit still, the devil (laughs) got you bound…".

From the pulpit, Vashti heard, "…You have to come on up here for prayer….so we can get that demon out of you.".

Theme 8: Traumatic Experiences

Nine of the 14 participants (Dinah, Eve, Hagar, Jael, Keturah, Mary, Naomi, Rebekah, and Zipporah) attributed their experiences with depression to a traumatic event. Three were involved in instances of domestic violence, and three of the nine were victims of sexual trauma.

Subtheme 1: Domestic violence. Three of the nine participants (Dinah, Hagar, and Zipporah) recalled being victims of or witnessing domestic violence.

For example, Hagar shared what she saw. “My father had the gun, my mother started to walk down the road, and he pulled the trigger. The gun did not go off. Had it gone off he would have killed her”.

Whereas Zipporah’s experience was first hand. “My son's father treated me bad. He came to my mother's house….he hung me out the window by one arm, from the 2nd floor”.

Subtheme 2: Sexual trauma. Three of the nine research participants (Naomi, Rebekah, and Zipporah) were victims of sexual assault or molestation.

For example, Naomi relayed, “Well, I mean, personal, just for me personally, I have had to endure molestation and rape…” and Zipporah disclosed, “And he put his forearm across my neck, like right here, and he forced hisself [*sic*] on me”.

Subtheme 3:Grief and loss. Three of the nine participants (Eve, Jael, and Keturah) experienced grief and loss either through betrayal and heartbreak in an intimate partner relationship or with the death of a loved one.

Intimate relationship betrayal and heartbreak. Two of the three participants (Eve and Keturah) experienced betrayal and heartbreak with a spouse (Eve) and a fiancée (Keturah). Eve shared, “So he cheated on me the first year (laughs) that we got married, like the end of the first year”. After discussing this depression triggering event for a time, I asked how she felt. Eve replied,

“With him I was just, I went through different feelings, but I think overall, I was

> angry, I was real angry with him. Shame, anger….The shame….it was (pauses) that I wasn't as strong or that, that somehow that I had allowed this to happen to me".

Keturah's experience was different, but also painful.

> "But.…through the marriage counseling and the questions that they ask….based on the responses the facilitator turned to him and said, (pauses) do you really want to get married? And he was….(big sigh), like, no. I'm sitting there stunned….I mean you could see like a deep breath, like a sigh of relief….I didn't even know what to do….so, I pulled myself together and I was like, okay. And it took every strength in my body from literally. And now I can understand what rage is".

Death of a loved one. Two of the three participants (Eve and Jael) lost loved ones to death. Eve's maternal aunt, to whom she was extremely close and whom she considered to be a second mother, died of cancer. Eve took her death hard. She remembered,

> "She ended up getting cancer, and I saw her go through her experience, and I became very angry. Because it was Lord, she ended up passing and it's like, Lord, why? Why did this happen to her? Why did she lose this battle….I knew the power of God in terms of healing and that didn't happen for her. I was, I was angry with the situation".

Jael experienced the tragic loss of her daughter's boyfriend to gun violence and then subsequently lost her unborn son. She described what occurred.

> "I think I was depressed. I do. I….my daughter's boyfriend was shot in the head in January of 1992. I was due April 25….I went from the cold to the flu, influenza, to pneumonia, to complete respiratory distress, and ended up being in a coma for 5 months, and I lost my son. He was taken from me on January 30 and he lived an hour and a half and weighed 2 pounds, 9 ounces. I never saw him, never touched him, never nothing".

Theme 9: Psychological Harm Done

Two of the participants (Esther and Rebekah) believe they suffered psychologically because of participating in their Pentecostal churches. They both used the term "brainwashed" to describe their involvement in their congregations. In addition, each stated that they underwent significant changes in their appearance and demeanor because of their affiliation. Esther shared,

> "And before you know it, you're just like walking around and the person that you were before starts to change, but you don't realize it…. I felt that, to be honest, I felt that I went through withdrawal. It's almost like, for me I felt that I was in a cult".

Rebekah had a similar experience.

> "Another thing that made me feel uncomfortable or not uncomfortable but made me feel like they were making decisions for my life is, you couldn't wear jewelry, you couldn't wear makeup, you couldn't wear jeans if you were going to sing on the mic….I like having the freedom of choice to wear certain things, and you couldn't do that there".

When her mom visited the church with her, she became concerned. "…She felt like it was a cult".

Esther stated that it took her five years to get past the anger she felt towards the church. "Because I felt duped". She believed she had to be "deprogrammed" from what she learned. Esther indicated, "I still struggle…". Rebekah expressed the similar sentiments after being at her church six years. "So, I feel like I'm recovering from all those years that I was there". Esther attends church cautiously and irregularly. Rebekah no longer attends church.

Additional Findings

During the research study, information emerged during data collection and data analysis that seemed important to include although it did not fit into the general results. I do not refer to this information as discrepant data as this phrase carries a negative connotation. The data shared, albeit outside of consensus of the majority, was important enough to those few participants to relay. I honor their courage by including it here.

Emoting Through Anger and Sex

Anger and aggression. During her interview, Vashti was the only participant who noted that anger and aggressive behavior were directly associated with her depression. The emotions came quickly and unexpectedly. She explained,

> "Anger issues, the lack of self, the lack of self-control. I'm not like a typically a [*sic*] angry person, but I can be pushy, and I can be very aggressive. And there was this one particular time where I started a new job, we're 3 weeks in, it's training still, and they put up the dates for on-the-floor training. And, I'm, I'm a

> student, I can't do these dates. And I'm sitting there and I'm stressing out, and….I raised my hand and I asked the woman a series of 5 or 6 questions and never gave her a chance to answer, completely overwhelmed her….I had went [*sic*] up, and I didn't even realize that I had gone that far....Completely freaked her out".

Sex. Naomi indicated that sex was a way of coping with her depressive symptoms. No other participant indicated this in her interview. She bravely disclosed,

> "I mean, a lot of times you then become promiscuous…. you get molested, and then that person no longer is interested….that's your first form of rejection….And you, when you, you feel the shame of it, yes, you know that it's wrong, it's still rejection. Yeah. So, then you start to want attention, and from, from anyone, especially from men".

Is Depression Just a Word?

Eve was the only participant that would only categorize herself as someone who had been at a *low point*. She was careful not to categorize herself as depressed but acknowledged that she had shared symptoms like those associated with depression throughout her interview. For example,

> "Not necessarily being able to get up and go to work. Kind of not being present, you're going through the motions. Well, I'll have to say I've gone through the motions, with my low point, so that would fit me right there".

She did not provide an explanation as to why this distinction in terminology was important to her.

Sexism in the Church

In Keturah's data analysis, the theme of sexism in the church emerged as a potential cause of depression among Pentecostal women. Keturah indicated that the Pentecostal denomination perpetuated a "double standard" for women in terms of dress attire, positions of authority in the church despite spiritual gifts, and systematic suppression of women voices outside of acceptable maternal roles (e.g., Sunday school teacher).

> "Okay, well, first of all, let's just talk about Pentecostal religion, the ideologies that go with that and the double standards, alright? Women don't belong on the pulpit. We have to be always covered with the hat, and, and you can't have your ears pierced….the dresses must be down to the ankles 'cause you can't show flesh, all this crap".

Keturah recalled this from her youth and other experiences in her life in Pentecostal churches. She stated that she did not believe that "loving God was supposed to be so costly".

Hagar also expressed some of similar views during her interview, although they did not come up as main themes in data analysis. With a sigh she stated,

> "The thing that the church could do for women like this, is stop telling women to be submissive. Stop telling them that. Women have a right to stand up against wrongdoing. What they need to do is teach the males to stop trying to rule over women, because that is messing up the children".

Non-significant Data

Finally, information related to education and income was collected from each research participant at the time of her face-to-face interview. This demographic data presented a clearer social portrait of the participants. However, not one participant mentioned educational levels or socioeconomic status as being a contributing factor towards depression.

Summary

In answering the research question, what are the lived experiences of African-American women with self-reported depression who attend Pentecostal churches living in the Northeast, United States, the findings would be as follows: (a) the Pentecostal church is currently ineffective in its ability to provide support for individuals with depression, (b) the research participants derived great comfort from their personal faith and relationship with Jesus Christ, (c) participants often emoted through maladaptive behaviors like overeating and drug use, (d) the research participants wore "masks" or concealed the fact that they had depression as a coping mechanism for "isms" and stereotypes, for fear of criticism, judgement, and rejection, as a tool of self-silencing, which for some resulted in suppressed anger, and because of stigmatization, (e) the research participants at some point used traditional supports like therapy to cope with depression and some used medication, (f) African-American women are expected to be strong cross-culturally, (g) survivors are often blamed for having depression via direct or indirect messages from clergy or members, (h) depression for these women was associated with some type of trauma, and (i) several participants felt that the Pentecostal church they attended did them

psychological harm. The three additional findings included that depression was sometimes displayed negatively through aggression, anger, or sexual encounter, there was a reluctance to use the word depression to describe the lived experience, and that sexist practices in the church are in some way related to depression in African-American women.

In chapter 5 the purpose, nature, and rationale for the study are explained, the key findings of the study are summarized, findings are discussed in relation to how they add to the current body of literature as well as what has been confirmed or disconfirmed in the literature. The findings will be analyzed and interpreted in the context of both the theoretical foundation and the conceptual framework. The limitations of the study will be discussed and recommendations for future research will be explored. The chapter will also include a discussion on the potential positive social change implications this study will have and any methodical, theoretical, or empirical implications, if any, will be shared. Finally, practice recommendations will be made along with a final message about the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, phenomenological research study was to explore the lived experiences of African-American women who had self-reported depression or depressive symptoms while attending Pentecostal churches in the Northeast United States. Fourteen face-to-face, semistructured interviews using open-ended questions were conducted with African-American women between 20 to 76 years of age. All the research participants lived or worked in the Commonwealth of Massachusetts or the State of Connecticut.

This study was conducted to explore the experiences of self-reported depression as it related to the research participants personal assumptions, beliefs, and perceptions, biopsychosocial factors, ethnic and religious cultural experiences, and gendered role expectations. The key findings of the study, discussed in more detail later in this chapter, were that the church is ineffective in dealing with depression and blamed the survivors, participants drew comfort from their personal faith in God, participants used various coping mechanisms (i.e., emoting, traditional supports) to deal with their depression or depressive symptoms, biopsychosocial factors affected depression and coping (i.e., strength expectations, traumatic experiences, wearing a mask), and participants felt psychological harm was done to them as a result of membership in a Pentecostal church.

This chapter includes an interpretation of the study findings, discussing what was learned and how it relates to, contradicts, or extends the literature. The findings will be discussed relationally to both the conceptual and theoretical framework as well as the

limitations to the study. Recommendations for future research are discussed as well as this study's implications as it relates to positive social change, specifically targeting practical applications. The chapter will conclude with thoughtful impressions capturing the essence of the study.

Interpretation of the Findings

The overwhelming view of the research participants was that the church has been ineffective in dealing with depression. The literature supported this finding on two levels. The first is that pastors recognized their churches' deficiencies in handling members with depression (Graham, 2013; Payne, 2014). Others (Asamoah et al., 2014) acknowledged that the pastors had no mental health training whatsoever. The second, yet more subtle, is that African-American women still seek out clergy to assist them with serious issues. This was demonstrated by Chatters et al. (2011) and later by Hardy (2014). Women desire support from the church; the one place that has provided them solace (Townsend-Gilkes, 2001).

Theme 1: Church Ineffectiveness with Depression

Subtheme 1: Simplistic solutions. The research participants also felt that when help was offered, it was simplistic in nature. They were either directed to God for help, encouraged to pray, or told to have a grateful or joyful attitude. This finding corroborated the views of Pentecostal students in Trice and Bjorck's (2006) study. The students believed that faith-based treatments (e.g., spiritual practices like church attendance, prayer, and reading the Bible) were the most effective in dealing with depression. Pentecostal clergy in Hardwick's (2013) study also believed these practices were

important but acknowledged that members might benefit from referrals to a Christian mental health counselor. The primary concern of those clergy was that God not be left out of the healing process (Hardwick, 2013).

It is also important to acknowledge that the solutions offered, although simplistic, are deemed culturally acceptable for most African-American women. As previously stated in Chapter 1, Bible reading, church attendance, and prayer are all activities engaged in regularly (Pew Research Center, 2009). Using these practices does not diminish the socially constructed SBW ideal. Dinah said, "We go to God, you know we don't go to psychologists....God can handle it." Yet, the research participants found these solutions lacking.

Subtheme 2: Depression is not accepted or taken seriously. Five participants believed their condition was minimized and not considered a legitimate health condition. This makes sense given that African-American pastors are more likely to consider depression to be the result of spiritual or moral issues (Payne, 2009) with Pentecostal clergy attributing mental illness to demonic activity or sin (Leavey, 2010). Ministerial staff in Hardwick's (2013) study believed that depression could have a biological etiology along with being associated with life circumstances. However, the staff acknowledged that the disease was demonized in the past (Hardwick, 2013). These attitudes have negatively contributed to the dialogue about depression and reinforce my research participants' beliefs that their experiences are not valid.

Subtheme 3: No resources available. Three participants stated that Pentecostal churches did not have any resources available to deal with depression. This discovery is

in alignment with the literature as pastors were not ignorant to these concerns. Clergy recognized they bear some responsibility to their members to provide resources or support (e.g., referrals for services) as it relates to dealing with depression (Asamoah et al., 2014; Montesano et al., 2011; Wood et al., 2010). Clergy know they lacked the money, personnel, and training to provide mental health support for their congregants (Asamoah et al. 2014; Montesano et al., 2011).

Subtheme 4: Silence on the topic. Two participants noted that the church is completely silent on the topic of depression. However, I found no literature to support this assertion. Clergy have thoughts about depression as it relates to causality and treatment (see Bryant et al., 2014; Harley, 2006; Payne, 2009; Payne, 2013). They believe they have a role in the care of their parishioners with depression (see Hankerson et al., 2013). Some even go as far as to allow screening for depression at their churches (Hankerson et al., 2015). It is plausible however that the silence described is related to the concern pastors have about doing harm to members. In both Bryant's (2014) and Hankerson's et al. (2013) studies, clergy recognized the weight their words carried from the pulpit. Perhaps the silence observed was to avoid maleficence.

Subthemes 5: Church cannot deal with depression. Two participants stated that church leadership is not equipped to deal with this mental health issue. This assertion is amply supported by the literature and acknowledged by pastors themselves. Pastors recognized their limitations in terms of training and resources (see Subtheme 3; Hardwick, 2013 Montesano et al., 2011). Moreover, their negative attributions about the etiology of depression (see Subtheme 2) inhibit their ability to deal with the disorder

(Leavey, Loewenthal, & King, 2016; Payne, 2009). Perhaps clergy expressions of inadequacy on the subject of depression coupled with negative views of the disorder have been unconsciously communicated to parishioners. Thus, leading to the ideas of research participants in this study.

Theme 2: Comfort from Personal Faith

Ten participants reported receiving a great deal of comfort from their personal faith in God. This is not surprising given religion is important to 80% of African-American women (Pew Research Center, 2009). Eight of those 10 used spiritual practices like prayer and scripture reading to console and encourage themselves. These practices were observed by the Pew Research Center (2009) to be consistent with activities African-American women participated in to relieve stress. Sixty percent of African-American women also attended church regularly. Two participants found comfort by joining in ecstatic expression (e.g., hand-clapping, dancing in the spirit) during church worship services. For Pentecostals, this type of engagement is common (Sanders, 1996).

However, Mouzon (2017) was not able to positively affirm that any of these practices in and of themselves contributed to the lower depression rates of African-Americans in contrast to their Caucasian counterparts. Symptomology for African-Americans was 29% lower than that of Whites and this was after controlling for activity, attendance, and membership (Mouzon, 2017). This number remained the same when examining spiritual practices like prayer and Bible reading, perhaps suggesting that other factors like community and identity influenced these outcomes (Mouzon, 2017). Alternatively, Anderson and Nunnelley (2016) reviewed 21 studies to ascertain the

relationship that private prayer had with several mental health conditions. In nine of the 11 studies that looked at depression, symptoms diminished as a result of the constant spiritual practice bolstering the findings of this study as prayer is seen as an extension of the God relationship for these research participants (Anderson & Nunnelley, 2016). These outcomes (Anderson & Nunnelley, 2016; Pew Research Center, 2009) lend credibility to my study findings recognizing the strength of personal faith. Although, Mouzon (2017) could not specifically credit spiritual practices with the reduction of depression symptomology, Mouzon did not discount the possible influence either, suggesting that a confluence of factors, including personal faith are beneficial as research participants in my study reported.

Theme 3: Emoting Through Behavior

Ten participants acknowledged that they were communicating their emotions through specific behaviors like overeating, not eating, or using drugs. This finding confirmed what has been repeatedly suggested in the literature: the SBW construct negatively affected the physical and psychological health of African-American women (Black & Peacock, 2011; Holden et al., 2015). As culturally and psychically acceptable coping strategies are often limited for African-American women, research participants in my study turned to harmful practices.

Subtheme 1: Overeating. Six participants coped with their depression by overeating. This finding is in line with the literature which suggested that African-American women used their bodies as a mouth piece protesting against the unrealistic expectations of the SBW (Beauboeuf-Lafontant, 2003; 2005). The socially-constructed

image pressures African-American women to hide and stow away their emotions and needs, while repeatedly deferring to others (Beauboeuf-Lafontant, 2005a; 2005b; 2007). This self-denial resulted in maladaptive coping, where stowing away food exemplified the stuffing of emotions (Beauboeuf-Lafontant, 2003; 2005). Harrington et al. (2010) furthered this concept, indicating that internalized cultural scripts limited African-American women's coping responses. Therefore, stuffing food seems to have become synonymous with stuffing emotions, a practice acknowledged. by the six research participants.

Subtheme 2: Loss of appetite. Two of the participants did not overeat, but instead experienced a loss of appetite because of depression. This is one of the most common and oft cited indicators of someone having depression (WHO, 2012).

Subtheme 3: Drug use. Two participants reported that they engaged in drug use to cope with their depression. Although drug use is not addressed in the literature review, life stressors are. The biopsychosocial model explores the biological, psychological, and social factors that contribute to illness (Engel, 1977/1992). Each woman who indicated she used drugs was dealing with significant life stressors (e.g., trauma) which contributed to her depression. Life stressors and more importantly the internalized assessment and meaning making of them, have an impact on our physical and psychological health (Porter & Pacquiao, 2011). Biopsychosocial events, particularly those that are negative, can have devastating effects on individuals inclined towards maladaptive coping as discovered with research participants in the current study.

Theme 4: Wearing a Mask

Nine of the participants felt they had to wear a mask while operating in their two distinct, sometimes overlapping, communities (i.e., African-American and Pentecostal church communities). The literature abundantly supports the idea of African-American women having to maintain a façade (Abrams et al., 2014; Beauboeuf-Lafontant, 2005) or switch (Jones & Shorter-Gooden, 2003) to engage in their everyday lives. Their reasons for doing so are further explained.

Subtheme 1: Coping with 'isms' and stereotypes. Five participants reported wearing a mask as a means of coping and for self-protection against discrimination, gendered racism, and prejudice. Historically, African-American women were forced into positions of familial leadership due to slavery, yet castigated for doing so (Abrams et al., 2014; Robinson, 1983). Such behavior continues today as these women try to make their way in the world despite the prison system confining Black men (Collins, 2000; Hill, 2009). Other participants discussed being labeled as the angry Black woman, a eurocentric social construct mentioned and previously conceived to degrade Black women (Harris-Perry, 2011; West, 2008). These psychosocial factors contribute to emotional distress which is often somatized (Porter & Pacquiao, 2011).

Subtheme 3: Self-silencing. Five participants engaged in self-silencing behaviors out of fear. For two of those participants, they felt anger as a result. These findings confirm and perhaps extend what is in the literature. The SBW construct promotes prescriptive strength (Beauboeuf-Lafontant, 2007); a form of strength somewhat toxic to the preservation of self for African-American women. The practice of self-silencing is

also perpetuated by fear of being categorized into negative stereotypes like the Sapphire image (Harris-Perry, 2011). Abrams, Hill, and Maxwell (2018) found women who believed or endorsed the characteristics of the SBW schema were more likely to engage in self-silencing behavior which led to depression. These women were also more likely to adhere to "externalized self-perceptions" (Abrams et al., 2018, p. 2) where their sense of self was culturally constructed via the SBW narrative. In all cases, women endorsing or holding these beliefs were more likely to exhibit depressive symptoms. Simply put, participants would have increased displays of depressive symptoms the more they felt they had to be strong. These constructs trap African-American women in a perpetual cycle of reticence for fear of losing credibility in-group and hurting the race collectively (Abrams et al., 2018; Holden et al., 2015). However, doing so engenders anger which again is often internalized and somatized.

Subthemes 2 & 4: Fear of criticism, judgement, and rejection and stigma. Five participants stated they hid their depression out of fear of criticism, judgement, and rejection, while four participants were concerned about the stigma associated with having depression. These concerns are in line with the literature as Sirey et al. (2014) and Ward et al. (2013) reported that both African-American men and women were highly concerned about ostracism and rejection by their peers if mental health conditions were known. These concerns were also prevalent in relationship to their church communities as mental illness was viewed as a moral or spiritual failing or caused by demonic forces (Leavey, 2010; Payne, 2009; Trice & Bjorck, 2006).

There is a great deal of stigma associated with mental illness in the African-American community (Okeke, 2013). Exhibiting any type of mental illness is viewed as a personal weakness and considered an affront to ancestors who lived through significant violence associated with slavery (Okeke, 2013). Participants in Campbell and Mowbray's (2016) study had similar views about depression. In their semistructured interviews, 17 African-American men (*n*=4) and women (*n*=13) agreed that acknowledging a depression diagnosis was potentially detrimental to self in terms of how one was perceived by other members of the Black community (Campbell & Mowbray, 2016). Derogatory labels were regularly associated with depression and an individual's "racial status" was even called into question (Campbell & Mowbray, 2016, p. 260). As Esther, a participant in my study, said, "We all have our, I think that we all try to make people think we're doing great (laughing) because I think that it's a sign of weakness." Her statement captures what many African-American women believe. Any demonstration of weakness, especially as it relates to mental health, is viewed with disdain and may result in rejection.

According to Oakley et al. (2011), African-American women were likely to self-stigmatize resembling women in other ethnic groups. Mengesha (2013) found that Black Christian women with depression felt conflicted about identifying themselves as a Christian and an SBW. However, it was unclear from where the conflict arose and how depression mitigated the two. What is clear however is that the multilayers of sociocultural attribution as it relates to depression create a quagmire for African-American women with depression who attend Pentecostal churches.

Theme 5: Use of Traditional Supports

Subtheme 1 & 2: Therapy and medication. All nine participants at some point went to therapy. Seven had a favorable or neutral opinion about therapy and two of those received counseling from Pentecostal Christian therapists. Two participants had negative views about therapy. Four participants tried medication to treat their depression and two participants were against taking medication.

These findings extend the literature in that most of the research participants tried to access therapy at some point. This is unusual because the literature reported that African-American women were twice as likely to turn to pastoral counseling (Chatters et al., 2011). This was specifically true for Pentecostals. Hardy (2014) found similar results stating that pastoral counseling was preferred before secular forms of counseling. Seventy-two percent of the research study participants were female (Hardy, 2014). It is important to note here that in Hardy's study, when it came to seeking help for depression, African -American Christians stated they would choose a psychologist or psychiatrist first. Those who received help from Pentecostal clinicians were in line with pastoral referral preferences (Hardy, 2014).

Chatters et al.'s (2017) findings seem to support those in this study. African-Americans were less likely than their non-Hispanic White counterparts to seek help from clergy for serious life concerns or issues (Chatters et al., 2017). This outcome remained constant even when controlling for education, income, marital status, and problem type (Chatters et al., 2017). The study sample was predominately female and predominately African-American (Chatters et al., 2017). There was a significant denominational

difference with Pentecostals being more likely to seek help from clergy as with earlier research (Chatters et al., 2011); however, this turn towards mainstream care should not be ignored. Mental health practitioners and health care professionals need to be prepared to provide culturally-sensitive support. African-American women seem to be grappling between two sets of cultural expectations. Yet despite these struggles but are assigning their mental health needs as the priority.

In terms of medication use, again these findings extend the literature. Use of medication is generally viewed negatively (Payne, 2008) and faith-based supports the preferred method of treatment (Hardwick, 2013; Trice & Bjorck, 2006). At the same time, there is recognition by some clergy (Hardwick, 2013; Kramer et al., 2007; Leavey, 2010) that there may be biological and environmental causes for mental health conditions. This awareness may lend itself to openness about medication as a form of treatment.

Theme 6: Strength Expectations

Eight of the research participants agreed that African-American women are expected to be strong. These participants also agreed that these expectations are not just from the African-American community, but from society at large, confirming what has been asserted in the literature. Researchers (Abrams et al., 2014; Beauboeuf-Lafontant, 2003, 2005, 2007, 2008; Romero, 2000; Shambley-Ebron & Boyle, 2006; Woods-Giscombe, 2010) agreed strength is the core characteristic of the SBW script. African-American women are groomed from childhood to develop these traits. Campbell (2017) affirmed this, discovering that her 17 research participants had begun to normalize their

depressed feelings, accepting them as part of the Black experience. Both men and women adhered to the strength narrative in that study, although the aforementioned literature (see Abrams et al., 2014; Woods-Giscombe, 2010) has established that African-American women bear the brunt of the image expectations. Eventually participants assessed the emotional, physical, and psychological costs of doing so were too high (Campbell, 2017). They acknowledged that the social constructs of strength, depression, and the character of African-Americans as a collective people influenced their behavior; primarily the rejection of help. Research participants in the current study mirrored similar experiences (Campbell, 2017).

It was interesting to note that not all the participants in my study believed they had a right to classify themselves as an SBW. Dinah most notably stated that she did not believe she had a right to consider herself an SBW because of her inconsistency, despite it being pointed out that her behavior was related to depression. Research participants in my study seemed to intuitively recognize the limitations the SBW construct placed on their lives. Naomi stated that she could "never have a down day". Black and Peacock (2011) reported that women understood the burden placed on them and tried to figure out how to get from under its weight. Perhaps, the disassociation from the SBW identity for some participants in my study was due to feelings of shame for not being able to live up to those expectations (e.g.. Dinah). While others (e.g., Jezebel and Naomi) determined that disassociation was a means of survival and that they would do so despite the cost.

Theme 7: Blaming the Survivor

Subtheme 1: Church messages. Six participants believed they were the subject of their pastor's sermon in a negative way. Payne (2008) found that in their sermons, African-American preachers referred to depression as a weakness or a problem. Depression was also characterized as having an attitude or being crazy (Payne, 2008). In their messages, preachers suggested that individuals dealing with depression were not relying on God and that Jesus should be their source of comfort and the use of medication or the accessing of mental health services was discussed negatively (Payne, 2008). These types of comments used by clergy may perpetuate the stigma associated with depression and mental illness perhaps causing parishioners, like the six research participants to feel singled out.

Subtheme 2: Demons. Four research participants were told directly or indirectly that, because they dealt with depression or depressive symptoms, they had a demon or that demonic influences were operating in their life. Unfortunately, the literature substantiates these experiences as Pentecostal clergy have historically believed mental illness is associated with demonic activity and believe it is a tool of Satan (Hardwick, 2013; Leavey, 2010). Trice and Bjorck (2006) found that Pentecostal students believed depression is caused by faith-based problems one of which was demonic possession or oppression. Clergy in Asamoah et al. (2014) had similar views attributing depression to demonic or supernatural causes. In a more recent study conducted by Leavey et al. (2016), Pentecostal pastors interviewed were still more likely to attribute mental illness to malevolent spiritual forces. Acknowledgement of any biological etiology had more to do

with generational afflictions stemming from spiritual sources rather than medical ones (Leavy et al., 2016). Although the generalizability of Leavey et al.'s findings are limited given that (a) the number of Pentecostal clergies interviewed within the modest qualitative sample (i.e., *n*=32) is unknown, and (b) the study was conducted in the United Kingdom, the social constructs that frame some of Pentecostalism's causality for mental illness etiology seem transcontinental. Thus, leaving church members, like the four research participants aforementioned, to be subjected to accusations of the allowance of demonic activity in their lives.

Theme 8: Traumatic Experiences

Subthemes 1, 2, & 3: Domestic violence, sexual trauma, grief, and loss. Nine participants experienced some type of traumatic event which contributed to or caused their depression. Three participants were either victims or witnesses of domestic violence. Three were victims of sexual assault and molestation and three experienced grief and loss through intimate partner betrayal and heartbreak in addition to death of a loved one. The literature strongly associated biopsychosocial factors with depression although the literature review of this study has limited address of traumatic events. Doornbos et al. (2012) reported that issues which fracture the family and create life stressors contribute to depression. Moreover, the implications of these issues are that chronic stressors not only exacerbate depression but consequently create conditions for other medical concerns to arise (Holden et al, 2012; 2013).

Theme 9: Psychological Harm Done

Two participants believed that they suffered psychological harm as a result of membership in their specific Pentecostal churches. These experiences were what Sorenson (2013) feared might occur given that the prevailing view of Christendom is that depression is related to a spiritual failing. He expressed concern that pastors might exacerbate the cognitive dissonance parishioners might experience because their lived reality (i.e., depressed mood) does not line up with church teachings (i.e., Christians should be joyful). Mercer (2013) has some similar sentiments, albeit stated more forcefully. She asserted that if Pentecostal pastors view issues like depression from purely a spiritual perspective, harm could be done to individuals if treatments used are solely spiritual in nature (e.g., deliverance sessions through casting out demonic spirits).

Additional Findings

Emoting through anger and sex. One participant disclosed that feelings of anger and aggression were associated with her depression. This finding is atypical as anger and aggression was not identified in the literature review as being related to depression. However, anecdotal evidence suggests that for some individuals, irritability is associated with depression. Another participant reported that sex was a coping mechanism she used to deal with depression. The one reference to sex in the literature was in relation to the Jezebel stereotype (Collins, 2000; Harris-Perry, 2011). However, this reference does not confirm this result given that this socially constructed image is not at all endorsed by African-Americans. On the other hand, maladaptive coping caused by trauma, like sexual promiscuity, can be confirmed through the literature (Harrington et al., 2010).

Is depression just a word? One participant was reluctant to use the word depression in any form and would only characterize her experience as a low point. This outcome was confirmed in the literature as clergy in Hankerson's et al. (2013) study were resistant to utilizing the word depression and suggested a name change to avoid any stigmatization of the program they were considering. Payne (2008) found similar results when analyzing sermons of African-American preachers. In that study the word depression was only used three times within 10 90-minute sermons. It is possible that this reluctance is unconsciously related to the stigma associated with depression in both the African-American and Pentecostal communities. Changing the terminology to describe depression adapts to the cultural expectations (i.e., strength and spiritual victory) of both communities.

Sexism in the church. One participant suggested that depression might be the result of sexist practices in the church which perpetuate double standards that adversely affect female congregants. There is acknowledgement in the literature that the Pentecostal denomination is "counterculture" in nature (Trice & Bjorck, 2006, p. 284) This practice applies to its adherence and belief in traditional gender roles, suggesting limitations in how women would operate within the church culture. Such limitations could engender self-silencing behavior and cause internalized anger.

Limitations of the Study

The primary limitation of this study is the sample size of 14 participants. Although it is not unusual for sample sizes to be small when conducting qualitative, phenomenological research (Robinson, 2014), this does cause limitations to the

generalizability of the findings. With that said, the findings have merit for generalizability when samples have parallel demographics (Leung, 2015). Moreover, the provision of "thick description" of the data collection and analysis process enhance the likelihood of follow-up studies (Anney, 2014, p. 278).

An additional limitation of the study is that participants' experiences of depression were obtained through self-report. Although it is possible some research participants have been formally diagnosed by a mental health professional or clinician (even likely given that several women identified engagement in professional mental health services), doing so was not a requirement of participation in this study. Similar to Campbell (2017) this study relied of self-reports of depression. Albeit not a formal diagnostic tool, the recruitment flyer for the study did ask questions related about experiences of sadness for long periods of time and about difficulty engaging in leisure, social, or work activities. Those who believed they had these experiences and met the other criteria for the study were those who called and inquired about participation.

Another potential limitation of the study had to do with the information shared by research participants. As discussed in chapter 2, there was some concern that participants may be concerned about expressing negative views about their clergy or their church for fear of reprisal. Any self-censorship or omissions could compromise the integrity of the research findings. To reduce the likely of this occurrence, pseudonyms were used to protect the identities of research participants. In addition, any information that could potentially expose them was omitted for their protection. These actions fostered a sense of trust, emotional safety, and enhanced rapport (Anney, 2014).

The age differences between participants may also be a potential limitation to the study. All but two of the 14 research participants were over the age of 40. Literature (Baldwin-Clark, Vakalahi, & Anderson, 2016; Longmire-Avital & Robinson, 2018) suggests that there are differences in assumptions, beliefs, and perceptions about depression as it relates to age. It is unclear if additional findings would be presented had this sample included more individuals under the age of 40.

Recommendations

It may be prudent to revisit this study demographic to see if there are differences between the lived experiences of individuals who are actively attending Pentecostal churches and those individuals who are former members or no longer attending. In the current study, Rebekah and Esther believed that psychological harm was done to them as a result of attending specific Pentecostal churches. Rebekah reported that she no longer attended church and Esther stated that she occasionally attended services, but not at any church espousing Pentecostal doctrine. It is unclear if this belief stems from disassociation from the Pentecostal church and if church attendance or membership is a mediating factor regarding such beliefs.

Depression, sexism, and gender roles would be a potential area for future research. Given that 75% to 80% of the membership in Pentecostal church is female, women play an integral role in raising finances and service provision, but still experience depression during their membership, it seems appropriate to explore the dynamics associated with clergy views on gender roles, women in leadership positions, and the effects of sexism on organizational structure.

Another potential area for study is related to the risky behaviors (e.g., sex) as a maladaptive coping strategy. For that participant, sexual promiscuity was a result of sexual trauma. It may be important to determine what other types of high-risk behaviors individuals with depression engage in. Research could center focus on if these behaviors occur in isolation, solely related to depression or in relation to trauma or other events.

Finally, the current study might benefit from replication, this time utilizing a mixed methods research design. Now that information about this population has been gathered qualitatively, incorporating measurement tools, specifically those dealing with depression, coupled with interviews or focus groups might provide a broader perspective on the topic as it relates to differences between the population who self-report and those who are clinically diagnosed with the disorder.

Implications

This research study has the potential impact for positive social change on the individual, family, societal, and organizational levels. On the individual level, each woman that came forth to share her experience has given voice to her personal struggles and her triumphs. Each woman hopefully found some liberation in articulating her story and reflecting on it. On the familial level, this research study provided insight to those family members who may have had limited understanding of what was occurring for their loved ones. Study of the phenomenon provided families with valuable information as to how they may best support their loved ones dealing with depression.

On the organization level, churches and clergy now have some knowledge as to where they have fallen short, need to improve, or are succeeding in their support of

congregants with depression or depressive symptoms. Clergy learned what practices they may currently be engaging in that are harmful to their members and what African-American women would view as helpful in terms of supports. Moreover, clergy have gained insight regarding the potential needs of their congregants. It is hoped that this knowledge will engender action towards gathering information faith-based and secular resources and treatment options available in their communities.

On a societal level, mental health practitioners gained knowledge about the experiences of participants in one of the more conservative religious groups. Hopefully, this information will better inform their practice and provide a platform from which to discuss issues that may be relevant to their clients. Dixon and Arthur (2015) emphasized the need for cultural competence on the part of the clinician who seeks to engage in an effect therapeutic relationship with Black Pentecostals. Understanding faith practices specific to the denomination will aid in developing a therapeutic alliance and lessen the likelihood of pathologizing what are considered to be normal religious practices.

Also, general practitioners may find this information helpful as many African-American women initially seek help for treating depression from them. In a study about primary care practice and depression, Keller et al. (2016) found that both African-American and White women had difficulty recognizing depression in themselves. It is possible that similar to participants in Campbell's (2017) study, African-American women accept certain states as normal making it difficult to identify depression accurately when it is present. Additionally, atypical presentations or somatization of symptoms may cause misidentification of the disorder and ineffective treatment

recommendations. Demonstrating empathy and understanding about the multiple cultural layers African-American Pentecostal women with depression face will better inform their approaches to service delivery and treatment.

Conclusion

This research study seems to suggest that despite the favorability of having personal faith or deriving comfort from personal relationships with God, African-American women operating in Pentecostal church systems that fail to recognize their issues and needs will have limited reprieve from depressive symptoms. However, if the condition is properly acknowledged and strategies are effectively implemented, Pentecostal churches can develop supports for congregants that reflect their religious values and engender confidence in genuine commitment of clergy to their wellbeing.

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Appendix A: Interview Protocol

Thank you for agreeing to meet with me today. Your participation will help us better understand the experiences of African-American women who attend Pentecostal churches and experience depression or suffer from depressive symptoms.

REVIEW INFORMED CONSENT, CONFIDENTIALITY, RISKS & BENEFITS, AND VOLUNTARY NATURE OF THE STUDY. PROVIDE LIST OF LOCAL MENTAL HEALTH RESOURCES

Do you have any further questions about the research?

1. To get started, can you describe in as much detail as possible, what are your experiences as an African-American woman with depression or depressive symptoms?
2. What are some of the health problems (if any) you have experienced because of depression or depressive symptoms?
3. How does your depression or depressive symptoms affect your day-to-day activities?
4. What are ways to you cope with depression or depressive symptoms?
5. What types of help have you sought to deal with depression?

There has been a lot of research that talks about how the role of Black women today has been shaped by historical forces that demand more from Black women than from other women.

6. Thinking in terms of an ideal image, can you describe the expectations your community or society has for an African-American woman?
7. In what ways do you personally identify with this image?

8. How does depression or depressive symptoms impact this identity?

Now I would like to ask you a few questions about being a member of a Pentecostal Church.

9. What is it like to be an African-American woman with depression or depressive symptoms in a Pentecostal church?
10. What messages do you receive from the church community about depression or depressive symptoms?
11. How does that make you feel as a person who has experienced depression or depressive symptoms?
12. What do you think the church could do to help women like yourself who experience depression or depressive symptoms?

We have covered a lot of material in the last hour or so. Is there anything else you think would be important for me to know in order to understand your experience with depression or depressive symptoms? I want to thank you again for taking the time to speak with me today. Your participation in this research study will help give insight into this very important topic.

REMIND RESEARCH STUDY PARTICIPANT ABOUT LOCAL RESOURCES AND FOLLOW-UP CONTACT FOR TRANSCRIPTION REVIEW.

Appendix B: Demographic Questionnaire

1. Age
   - □ 20 to 30
   - □ 31 to 40
   - □ 41 to 50
   - □ 51 to 60
   - □ 61 and up

2. Race (check all that apply)
   - □ Black/African
   - □ Black/African-American
   - □ Black/Afro-Caribbean
   - □ Black/ Biracial
   - □ Black/Multiracial

3. Ethnicity
   - □ Hispanic
   - □ Non-Hispanic

4. Marital Status
   - □ Single
   - □ Married
   - □ Separated
   - □ Divorced
   - □ Widowed

5. Highest Level of Education
   - □ High school diploma or less
   - □ Vocational or technical degree
   - □ Some college, no degree
   - □ Associate's degree
   - □ Bachelor's degree
   - □ Graduate degree

6. Working Status
   - Homemaker
   - Full-time
   - Part-time
   - Self-Employed
   - Retired
   - Student
   - Unemployed
   - Unable to work

7. Household income
   - Less than $30,000
   - $30,000 to $49,999
   - $50,000 to $69,999
   - $70,000 to $99,999
   - $100,000 and up

8. Number of children
   - 0
   - 1 to 2
   - 3 to 4
   - 5 and up

9. Place of Work/Residence
   - Connecticut
   - Massachusetts

10. Denomination
    - Pentecostal
    - Pentecostal-Holiness
    - Pentecostal-Apostolic
    - Apostolic-Oneness

11. Church Affiliation
    - □ Name (please specify)_____
        - □ ***YES***, This church ***IS*** part of an organization (If yes, please see question 11)
        - □ ***NO***, This church ***IS NOT*** part of an organization

12. Church Organization
    - □ Assemblies of God (A of G)
    - □ Bible Way Church of Our Lord Jesus Christ, World-Wide, Inc.
    - □ Church Of God In Christ (COGIC)
    - □ Church Of Our Lord Jesus Christ of the Apostolic Faith, Inc. (COOLJC)
    - □ Pentecostal Assemblies of the World, Inc. (PAW)
    - □ The Way of the Cross Church of Christ, Intl.
    - □ United Pentecostal Church International, Inc. (UPIC)
    - □ Other (please specify)_____

Appendix C: Introduction of the Study Letter

Pastor Applewood
Any Church
000 Any Street
Any City, Any State 00000-0000

Dear Pastor Applewood:

Praise the Lord! My name is Dawn Davis and I am a doctoral student in the Health Psychology PhD program at Walden University. I am in the dissertation phase of my program and I am conducting a study exploring the lived experiences of African-American women with (or had) depression or depressive symptoms who attend Pentecostal churches. I need your help.

For many of us in the Pentecostal community, depression seems like a foreign concept. At the same time, we recognize that many people who come through our doors are dealing with a myriad of conditions, issues, and problems that require a response that meets both spiritual and natural needs. Through my study, I hope to help us better understand some of these needs. I would like your support in this endeavor.

I have enclosed a flyer about my study which includes the participation requirements of the study along with my contact information. I am requesting that this flyer be posted on your church bulletin board for the next two months. I would also ask that information about the study be included in your weekly announcements for the same duration. When my study is complete, I would be happy to provide you with a summary of my research findings if you return the bottom part of this letter to me.

If you have any questions about my study, please feel free to contact me at. Thank you in advance for your support in my dissertation study. Be blessed.

Sincerely,

Dawn E. Davis, M.Ed., CRC
Doctoral Student

Please check the appropriate boxes, detach, and mail in the envelope provided

---

☐ **Yes, I would like a summary of your dissertation research findings.**

- ☐ **I prefer an electronic version. Email the information to:**
  _____@_____
- ☐ **I prefer a print version. Please mail the information to:**
  _____
  _____

Appendix D: Recruitment Flyer

Have you ever felt sad for long periods of time?

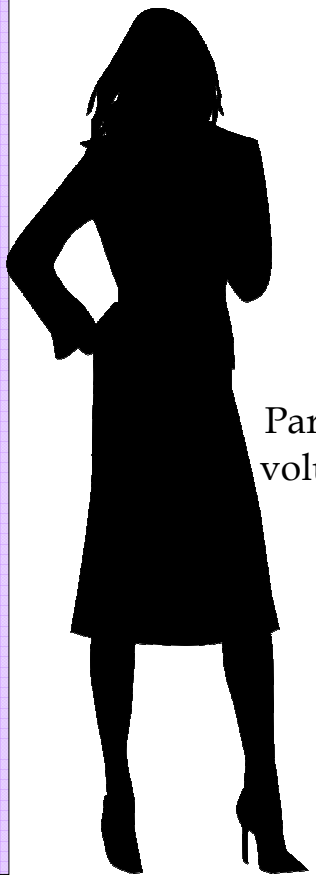
Have these feelings of sadness made it difficult to go to work, go out with friends, or even make you want to stay home from church?

Did you ever feel like no one in church understood?

African-American Women Needed

to participate in a study exploring depression and involvement in the Pentecostal Church.

Looking for African-American women between the age of 20 and older who:



- Regularly attend or have attended a Pentecostal church
- Live or work in Massachusetts or Connecticut

Participation is completely voluntary and confidential.

If you are interested in learning more about this study, please contact: Dawn Davis

Email:

Appendix E: Advertisement for Community Newspapers

African-American women between the ages of 20 and older needed to participate in a dissertation study exploring the lived experiences of women with (or had) depression or depressive symptoms who are (or have) been involved with the Pentecostal church. Participation is voluntary and confidential. Interested individuals please contact Dawn Davis at or.

Appendix F: Study Eligibility Screening Tool

The following questions will be asked of each potential study participant when contacted to determine eligibility to participate in the research study. Each participant must meet all of the criteria to participate in the study.

1. Are you between the ages of 20 and older?
2. Do you live or work in the State of Connecticut or the Commonwealth of Massachusetts?
3. Do you identify yourself as Black or African-American?
4. Do you regularly attend a Pentecostal church or consider yourself a member of a Pentecostal church?

   OR

   Have you ever attended a Pentecostal church or considered yourself a member of a Pentecostal church?
5. Have you ever suffered from depression or experienced depressive symptoms while you were attending a Pentecostal church or a member of a Pentecostal church?
6. Did you give birth recently?
7. *(Ask if Question 6 is answered yes)* Do you believe any of the symptoms you are experiencing could be related to recent childbirth?

Appendix G: Use of Building Consent Form

LETTER OF AUTHORIZATION BY OWNER TO USE PROPERTY

I, _____ authorize **Dawn E. Davis**
(Name of authorized individual) (Name of Researcher)

a doctoral student at Walden University to use the property located at _____

_____
(Building/House Number and Address Name)

in _____ from _____
(City, State, Zip Code) (Date(s))

for the purposes of _____related to her dissertation research. (Activity/Reason)

By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Authorizer _____

Signature of Authorizer _____

Date of Consent _____

Appendix H: Transcriptionist Confidentiality Agreement

I, _____ have been contracted to transcribe the audio digital
(Name of Transcriber)
recordings of research study participant interviews. I understand that the information contained in these interviews is confidential and as such, I agree that I will maintain the strictest confidentiality in the handling of the information associated with these interviews.

Therefore, I agree to:

1. Keep all of the research information (i.e., audio digital recordings, printed transcripts and any other related materials) confidential: I will not discuss or share any of the research information, in any format, with anyone other than Dawn Davis, hereafter referred to as the researcher.
2. Keep all of the research information, in any format, in a secure location while it is in my possession.
3. To not make copies of the research information, in any format, unless specifically requested by the researcher.
4. Return all of the research information, in any format, to the researcher upon request and in a timely manner.
5. At the request of the researcher or upon the completion of my contract, I agree to erase or destroy all research information, in any format (e.g., files on computer hard-drive, mobile devices, online backup files, etc.)

Printed Name of the Transcriber _____

Signature of the Transcriber _____

Date of Consent _____