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Religious Coping and PTSD Symptom Management Among African Americans: A Clergy Perspective

Barbra Talley
Walden University

Walden University

College of Health Sciences

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Barbra D. Talley

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Dr. JaMuir Robinson, Committee Chairperson, Public Health Faculty
Dr. Jacqueline Fraser, Committee Member, Public Health Faculty
Dr. Ahmet Sapci, University Reviewer, Public Health Faculty

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Data indicated that although African Americans reported fewer occurrences of traumatic events than that of their racial/ethnic counterparts, however, the degree of traumatic events experienced by African Americans tends to be more serious and violent in nature. More so, lower recovery outcomes associated with PTSD among African Americans have been attributed to varying factors, such as financial restrictions, strained health care access, ineffective coping strategies as well as a mistrust of medical and clinical approaches, thus leading African Americans to seek faith-based approaches. This phenomenological study investigated clergy perspectives on religious coping constructs relative to the management of PTSD symptoms. The theory of religious coping was the theoretical framework: Based on Pargament's assertion that an individual's spirituality and religious disposition should be considered within the context of biopsychosocial analysis of mental health assessment in order to treat the whole person. Eight clergy members ordained within the African Methodist Episcopal Church denomination were interviewed in order to gain their perspectives relative to if and/or how religious coping constructs were exhibited during the management of PTSD symptoms. This investigation identified 10 themes associated with 4 constructs of religious coping: relevant training, establishment of a new normal, the relevancy of religion and the Black Church, purpose-centered trauma, divine personal encounters, active divine presence, divine reliance, the use of rituals, safe environment, and forgiveness of self, others and God. The results of this investigation reaffirmed that the inclusion of religious coping is a viable component of a holistic approach to addressing mental health adversities alongside medical and clinical approaches.

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Dedication

It’s said that a strong support system is a core component of an individual’s success. To that end, this body of work is being dedicated to all who have supported me throughout my entire academic journey. To those who continuous offered supportive words of encouragement that pushed me through class, after class, after class; to those who showed consideration when I just needed time and space; and to those who filled in the gaps when I couldn’t be in four places at one time. To my support system: my biological family, my church family, my friends, loved ones and even the occasional enemy, thank you for your prayers, patience, encouragement, and love.

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Chapter 1: Introduction to the Study

Introduction

Recent research indicated that, although African Americans, overall, report fewer occurrences of traumatic events than that of their racial/ethnic counterparts, the degree of traumatic events experienced by African Americans tends to be more serious and violent in nature (Pérez Benítez et al., 2014). More so, traumatic occurrences experienced by African Americans tend to result in higher rates of diagnoses of posttraumatic stress disorder (PTSD) than among other racial groups (Alegria et al., 2013; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). PTSD, a psychiatric disorder brought on by various forms of traumatic events and exhibited through symptoms of reexperiencing, avoidance, negative cognitions or mood, and hyperarousal (Norr, Albanese, Boffa, Short, & Schmidt, 2016). Pérez-Benítez et al. (2014) speculated that lower recovery rates from PTSD among African Americans were associated with a variety of contributing factors, including less access to financial resources for mental health care, greater levels of stress exposure among traumatized individuals, as well as ineffective coping strategies needed to address trauma-related occurrences. An abundance of research studies cited the impact of stress and the lack of financial resources on mental health care; however, coping strategies have been underexamined (Graves et al., 2011; Hankerson & Weissman, 2012; Leavey, Loewenthal & King, 2016; Pérez-Benítez et al., 2014; Williams, Gorman, & Hankerson, 2014).

Previous studies have indicated that African Americans are more likely to utilize faith-based resources in relation to mental health care than medical and clinical resources

(Hankerson & Weissman, 2012; Hays, 2015; Williams, Gorman, et al., 2014). What has not been sufficiently addressed in the current body of literature was research in which the variables of African Americans, PTSD, and religious coping are examined collectively. Given the increased use of faith-based resources among African Americans related to mental health care, the examination of these variables could further assist with the development of evidence-based, yet spiritually guided, PTSD-related services and resources.

The following discussion include a comprehensive overview of the origin, prevalence, and impact of PTSD in the United States and the clinical methods used to address it. The discussion will elaborate on PTSD prevalence in relation to gender, race, and ethnicity and then move to an in-depth discussion of the relationship of religion and mental health care in the African American community. The chapter includes a statement of the problem, the purpose of the study, the research questions, theoretical framework, research method, definition, assumptions, scope, and delimitations. The chapter concludes with the limitations and significance of the study.

Background

PTSD in the United States

PTSD was initially identified as shell shock or battle fatigue and associated with military and war trauma exposure (Barlow, Keane, Marx, Sloan, & DePrince, 2014; Williams, Gorman et al., 2014). However, over the past few decades, PTSD has been studied as a broader, more mainstream mental health condition associated with the long-term impact of trauma exposure. According to the National Comorbidity Survey

Replication, the lifetime prevalence of PTSD among individuals aged 15-54 years was estimated at 7.8% (Barlow et al., 2016). The lifetime prevalence rate of PTSD is higher among women (10.4%) than men (5.0%) although men tend to experience higher levels of trauma exposure than women (60.7% versus 51.2%, respectively; Barlow et al., 2014). Among men, the most commonly reported traumatic events are nonsexual assault, combat exposure, serious accidents, and the witnessing a death or injury; the greater triggers for women include rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse (Komarovskaya, Booker Loper, Warren, & Jackson, 2011; Zukerman, Fostick, & Korn, 2017).

From a quality of life perspective, Graves et al. (2011) indicated that 3.6 days of work impairment per month due to episodes of PTSD equates to an annual productivity loss of $3 billion in the United States Previous findings also identified PTSD as a contributing factor that was strongly associated with suicidal behavior, interpersonal conflict, parental conflict, and declines in household incomes (Sareen, 2014). While a majority of the population may experience some form of trauma during their lifetime, exposure to a traumatic event does not inevitably lead to the development of PTSD; however, as indicated by statistics, different exposures produce different effects in varying populations, potentially increasing the risk of PTSD development (Alegria et al., 2013; Asnaani & Hall-Clark, 2017; Greenwalt et al., 2011; Roberts et al., 2011; Weiss et al., 2017).

Development of PTSD

The onset of PTSD can occur as a result of the personal experience or witnessing of dangerous or violent incidents (e.g., combat exposure, childhood maltreatment, sexual and physical assault, and weapon threats) as well as life experience events, such as the unexpected or sudden death of a friend or loved one (Mayo Clinic, n.d.). The diagnostic process of PTSD is complex given the frequent co-occurrence of several other mental health disorders, such as major depression, anxiety disorder, and substance disorder (Graves et al., 2011). To establish a clinical diagnosis for PTSD, symptoms must meet the DSM-5 (American Psychiatric Association, *DSM-5*) criteria including the following: at least one reexperiencing symptom, one avoidance symptom, two arousal/reactivity symptoms, and two cognitive/mood symptoms; these must have been present for at least 1 month's time (National Institute of Mental Health [NIMH], n.d.). Reexperiencing symptoms, such as intrusive memories (e.g., flashbacks and dreams), cause the sufferer to continuously relive the event(s) as though it/they were occurring once again (Mayo Clinic, n.d.). Individuals may also avoid thinking or talking about the incident (i.e., avoidance) or begin to experience negative cognitive and affective alterations regarding themselves or the world around them (NIMH, n.d.). Emotional and physical distress is also symptomatic of PTSD, which can include irritability, sudden outbursts of anger, aggressive and self-destructive behavioral patterns, suicidal ideation, overwhelming guilt and shame, and an impairment of concentration and sleeping (NIMH, n.d.). Not everyone who experiences a traumatic event will develop PTSD. For those who do, several coping strategies can be used to manage the acute and chronic symptoms.

Impact of PTSD on Minority Groups

The lifetime prevalence of PTSD among American adults, in general, has been estimated at 6.8% (U.S. Department of Veterans Affairs, 2016), yet the lifetime prevalence of PTSD among African Americans has been measured at 8.7% versus 7.4%, 7.1%, and 4.0% among non-Hispanic European Americans, Hispanics, and Asians, respectively (Roberts et al., 2011). Roberts et al. (2011) indicated that the contributing factors to PTSD vary among racial populations. Among the African American population, exposure to child abuse and domestic violence are two of the primary triggers related to individuals diagnosed with PTSD (Roberts et al., 2011). African Americans experience lower rates of exposure yet have a higher risk of developing PTSD than European Americans and Asians (Roberts et al., 2011)

Racial disparities in the prevalence of PTSD are broad due to great apprehension among minority groups to use professional clinical services (Bryant-Davis et al., 2015; Williams, Malcoun, et al., 2014). In many minority communities, seeking clinical professional counseling for mental health issues is not the first course of action (American Psychological Association, 2013; Hankerson & Weissman, 2012). In fact, faith-based organizations, and religious coping mechanisms in general, are often the first course of action among community members who seek care and counseling related to mental health issues (American Psychological Association, 2013; Hankerson & Weissman, 2012).

Clinical Care of PTSD

Clinical treatments and therapies shown to be most effective at addressing the symptoms of PTSD are pharmacological and psychotherapies, administered individually

or in combination (NIMH, n.d.). Antidepressants, antianxiety, and sleeping aids are used to mitigate symptoms of sadness, worry, anger, and emotional numbness (Mayo Clinic, n.d.; NIMH, n.d.), while the psychotherapeutic approach utilizes cognitive therapy (i.e., one form of talk therapy) as a means of identifying negative thought processes and exploring cognitive restructuring (NIMH, n.d.). The objective of exposure therapy, another psychotherapeutic approach, is to create a safe environment that allows the individual to confront the fear produced by the traumatic incident in order to regain emotional control (NIMH, n.d.). Psychotherapeutic treatments also include stress management and eye movement desensitization reprocessing which pairs eye movements with cognitive processing of traumatic memories and is based on the premise that PTSD symptoms are the result of insufficient processing/integration of sensory, cognitive, and affective elements of the traumatic memory (Barlow et al., 2014). Yet, while the broad measure of clinical data generalizes the treatment and therapeutic approaches across various populations, races, and ethnicities, the research findings of Barlow and Comas-Diaz (2014) suggest that the efficacy of PTSD treatment plans may be improved by the use of culturally adapted interventions.

Religion, Mental Health Care, and the African American Community

Among the multitude of racial populations, African Americans, in general, are identified as being highly religious. African Americans have the highest rate of documented church attendance by race/ethnicity within the United States and 80% of African Americans reportedly pray on a daily basis (Adolfoli & Ullman, 2014; Williams, Gorman et al., 2014). Bryant-Davis, Ullman, Tsong, and Gobin (2011) indicated that

religion and spirituality are core fundamental coping tools within the African American culture (Davis, Ullman, Tsong, & Gobin, 2011). More so, religion and spiritually are two primary nonclinical approaches used to address mental health adversities among African Americans (Adofoli & Ullman, 2014). It must also be noted that, although African Americans experience lower incidence rates of mental health disorders in comparison to European Americans, African Americans experience greater disparities in diagnoses and treatment outcomes (Hays, 2015).

Mental health care is sought within faith-based environments among African Americans for several reasons, including the decreased willingness to pursue medical and clinical approaches; the presence of cultural sensitivity; easy accessibility to faith-based resources; and, greater trust in faith-based resources (Payne & Hays, 2016; Williams, Gorman et al., 2014). For decades, African Americans have found solace within faith-based environments, especially those that are considered “the Black church” (Plunkett, 2014). The Black church has consistently been a tremendous source of religious, spiritual, social, economic, and political influence for the African American community but more so, the Black church has also taken on the role of counselor to address various emotional, psychiatric, and psychological mental health crises (Plunkett, 2014).

Research has uncovered an association between religious involvement and the mental health help-seeking, decision-making process (Plunkett, 2014). The ideology of the pastor or spiritual leader and church doctrine have been identified as two of the greatest contributors to mental health help-seeking attitudes among African American congregants (Hays, 2015; Plunkett, 2014). The African American community seeks faith-

based counseling resources to address a myriad of issues related to marriage and family, stress and trauma, substance abuse, and even psychiatric disorders (Taylor, Woodward, Chatters, Mattis, & Jackson, 2011). Ironically, this degree of faith-based influence could be detrimental to the congregants, given that large portions of clergy members and faith institutions are not professionally trained to handle mental health crises (Asamoah, Osafo, & Agyapong, 2014; Hall & Gjesfjeld, 2013; Payne & Hays, 2016).

Problem Statement

Substantial research has established the efficacy of faith-based health promotion, especially within the African American community (Villatoro, Dixon & Mays, 2016). More so, research related to mental health interventions, specifically PTSD-related interventions, have been shown to reduce symptoms of PTSD and improve overall mental health status among military veterans (Church, 2014) and minority adolescents (Sinha & Rosenberg, 2013). Considering the association between African Americans and religious practices, further research was necessary to explore the efficacy of using religious coping to manage PTSD crises.

Koenig (2012) identified over a decade of research related to the efficacy of utilizing religious coping in association with biological, psychological, and social health crises ranging from diabetes and cancers to caregivers' burdens, bereavement, and end-of-life issues. Numerous studies have indicated that the use of religious coping is beneficial towards the management of these stresses and ailments (Assari, 2014; Bopp & Fallon, 2011; Koenig, 2012). However, the research related to religious coping and faith-based interventions relative to PTSD among African American adults was limited and

dated. Furthermore, the current body of literature was limited in data related specifically to clergy insights on assessing religious coping among parishioners managing symptoms of PTSD. By addressing this topic from the perspective of clergy members, I was able to further elaborate on the prevailing clergy attitudes, opinions, and beliefs that may hinder or promote the use of religious coping to address cases of PTSD among parishioners.

Purpose of the Study

The purpose of the study was to explore religious coping constructs among African Americans managing symptoms of PTSD. By exploring the presence or absence of religious coping constructs, further measures can be taken to develop suitable, spiritually guided, PTSD-related preventive and treatment services and resources. My intention in this study was to investigate the presence/absence of religious coping constructs by exploring clergy experiences in counseling African American adults in the management of symptoms of PTSD. According to the Pew Center (2009), 78% of African Americans in the United States who claim some form of religious affiliation are Protestant (i.e., Christian). With that in mind, the target population of my research was ordained clergy members from Protestant churches.

Research Questions

For the purpose of this study, the following research questions were explored:

RQ1: What are the experiences of Protestant clergy related to the presence/absence of religious coping constructs among African American parishioners managing symptoms of PTSD?

RQ2: How were religious coping constructs exhibited during the management of PTSD symptoms among African American parishioners?

Theoretical Framework

This research study was grounded by the theory of religious coping, which originated from the work of Pargament and colleagues who studied the relationship between religion and coping, especially associated with mental health and cognitive and emotional adjustment to life stressors (Pargament, Smith, Koenig, & Perez, 1998). The theory of religious coping is supported by the assumption that an individual's spirituality and religious disposition should be considered within the context of biopsychosocial analysis of mental health assessment in order to treat the whole person (Pargament et al., 1998). Pargament hypothesized that the use of positive religious coping methods could mitigate the negative effects of various traumatic, life-altering occurrences and crises that impact an individual's mental health status (Pargament et al., 1998). Weber and Pargament (2014) indicated that individuals with an active and positive religious belief system reported healthier mental health status and a better quality of life with less self-reported cases of depression, anxiety, and suicide ideation. Conversely, poorer mental health status was reported among individuals who reported negative religious coping methods (Pargament et al., 1998; Weber & Pargament, 2014).

The constructs of religious coping are meaning-making of a trauma experience; empowering and regaining control over the effects of the experience; finding comfort in closeness with God; and finding closeness with others (i.e., social support) (Pargament et al., 1998). The goal of this research was to explore the observations of Protestant clergy

members in relation to the identification of religious coping constructs in the management of PTSD symptoms among African American parishioners (Pargament et al., 2011). With this in mind, the constructs associated with the theory of religious coping were used to develop interview questions that explored clergy member experiences related to the observation of religious coping constructs in the management of PTSD symptoms among African American adults.

Nature of the Study

The research method used was a hermeneutic phenomenological approach. In general, phenomenological research is used to capture the essence of lived experiences of individuals as well as to gain knowledge of perceptions of the world in which they live (Kafle, 2013).The hermeneutic phenomenological approach empowers the researcher to capture the essence of the lived experience through a subjective lens: the lens of his or her own experience. By using a hermeneutic phenomenological approach, I was able to explore the lived experiences of Protestant clergy members who counseled African American adults who had been clinically diagnosed with PTSD. The focus of this study was to explore the experiences of clergy members in relation to the presence or absence of religious coping constructs and the ways in which they were exhibited in symptom management. My investigation was originally designed for a group of 12 clergy members with the assumption that more members would be added, as needed, in order to reach saturation, however due to the lack of full compliance to the prescribed participation criteria, a total of 8 clergy members participated. The use of clergy members was significant to this study given that most current research data related to religious coping

are self-reported from the survivors' perspective. The clergy members were not asked to divulge any personal or confidential information of parishioners; they were asked about their experiences and personal observations in relation to the presence or absence of religious coping constructs.

Definitions of Key Terms

Black church: A religious, Protestant (Christian) institution that serves a predominately African American congregation; an institution that is included among the seven predominate religious denominations associated with African American affiliation (Williams, Gorman, et al., 2014). The Black Church experience embodies worship styles, cultural traditions and religious practice indicative to African American community (Collins, 2015).

Clergy: Religious/spiritual leaders including pastors and ministers who tend to the spiritual, emotional, and social needs and development of a given community (Payne & Hays, 2016).

Negative religious coping: The interpretation of a negative life/traumatic event as punishment of a vengeful God, the avoidance of seeking help from a higher power (i.e., God) or in contrast, passively waiting for God to correct the stressor rather than take any self-imposed actions to correct the stressor (Xu, 2016). Negative religious coping is further identified by individuals' spiritual tensions and struggles with themselves, others, and their higher power Pargament et al., 2011).

Pastoral care/counseling: Clinical and non-clinical counseling practices that address the spiritual, emotional, and social well-being of a given religious community or group of people (Hall & Gjesfjeld, 2013; Kopacz, 2013).

Positive religious coping: The interpretation on negative life events as salutary and God's will and; the recognition of a benevolent God's love and care amidst of trauma (Xu, 2016). Positive religious coping is perceived as a secure relationship with the higher power, a spiritual connectedness with others and a benevolent world view (Pargament et al., 2011).

Religion: "An organized system of beliefs, practices, and rituals designed to increase a sense of closeness to the sacred or transcendent…and to promote an understanding of one's relationship to and responsibility for others living in the community" (Streets, 2015, p. 475).

Religious coping: The use of religious cognitive and behavioral functions to process, address, and recover from stress and trauma-related events (Gerber et al., 2011).

Spirituality: An individual's experience and connectivity to a higher power (Streets, 2015).

Assumptions

Based upon the nature of the profession, a primary assumption made during this investigation was that clergy members have a significant degree of knowledge and experience identifying religious coping constructs and that the encounters between clergy members and parishioners were extensive enough to provide a substantive observation of the presence or absence of such constructs.

Scope and Delimitations

The scope of a study indicates the research variables or the specific problem under investigation (Simon & Goes, 2013). The focus of this research was clergy observations of the presence or absence of religious coping constructs in PTSD symptom management among African Americans, given the fact that African Americans experience greater conversion rates of trauma events to cases of PTSD than other races and ethnicities. This study was designed to focus on African Americans to the exclusion of other races and ethnicities.

Given that 78% of African Americans in the United States who claim some form of religious affiliation are Protestant (Pew Center, 2009), the scope of participation was limited to clergy members among Protestant congregations within the five boroughs of New York City as well as the counties of Westchester, Nassau, and Suffolk. Direct observation of clergy counseling was not conducted; the research was solely based on interviews that explored clergy's observations of behaviors and assessments related to religious coping constructs.

Limitations of the Study

A limitation within the investigation was the use of a sample size of 8 clergy members although it was originally prescribed that 12 participants would be suitable to reach saturation. In was found that only 8 clergy members fully met the originally prescribed participation criteria or were willing to participant in the study. Another limitation within this investigation was my personal experience as an ordained clergy member. This could have been viewed as researcher bias and considered an influence on

the investigation. To mitigate the effects of this potential bias, I, as the researcher, declared to the supervising committee members that I had no experience working with any parishioners diagnosed with PTSD and, while my experience as an ordained clergy member could offer analytical insights in relation to the observation of religious coping constructs, insights related to the association between religious coping constructs and PTSD management were solely based on data collected from the participants.

Significance of the Study

The research objective was to explore potential associations of religious coping constructs—such as meaning-making of a trauma experience; empowering and regaining control over the effects of the experience; finding comfort in closeness with God; and finding closeness with others (i.e., social support)—with the management of PTSD symptoms. It was advantageous to explore religious coping among individuals with PTSD as a means of developing suitable spiritually guided interventions to address PTSD symptom management among African American adults. The use of clergy members as the source of data was significant given the critical influence clergy members' etiological and theological ideologies have on the counseling dynamic between the helper and help-seeker, on mental health outcomes as well as on the determination of resources and services made available to parishioners (Collins, 2015; Hays, 2015; Payne & Hays, 2016). The results of this study further yielded information useful for improving mental health outcomes for African Americans given that African Americans are more likely to seek help within faith-based settings for mental health counseling (Hays, 2015).Appropriate interventions grounded by observed religious coping behaviors could

then be explored as a resiliency mechanism to reduce the risk of traumatic events developing into PTSD (Bryant-Davis & Wong, 2013; Xu, 2016). The significance of exploring religious coping was essential given the fact that the American Psychological Association ethically mandates psychologists to consider a client's religious and spiritual beliefs when contemplating a treatment plan (Bryant-Davis & Wong, 2013).

Summary

PTSD was once only identified with military and war trauma; however, over the past few decades, research on PTSD has been extended to civilian populations. As various mental health issues (i.e., suicide, depression) are further investigated as leading health indicators among Americans, PTSD is being studied as a broader, more mainstream, civilian mental health condition associated with the long-term impact of trauma exposure. The impact of PTSD on society is costly, resulting in a loss of job productivity, elevated educational failures, increase in teen pregnancy, marital complications, and increased unemployment rates (Graves et al., 2011). While the avoidance of any traumatic event over the course of a lifetime is inescapable, not all traumatic events ultimately develop into PTSD (Mayo Clinic, 2014). However, different exposures can result in different effects in varying populations and potentially increase the risk of PTSD development (Alegria et al., 2013; Asnaani & Hall-Clark, 2017; Greenwalt et al., 2011; Roberts et al., 2011; Weiss et al., 2017).

Despite the findings that indicate African American adults experience fewer occurrences of traumatic events, the actual rate of development of PTSD is disproportionately higher among African Americans, help-seeking and recovery are

disproportionately lower in comparison to other races and ethnicities (Pérez-Benítez et al., 2014; Robert et al., 2011). These disparities are compounded by a variety of socioeconomic factors, mistrust of medical and clinical treatment options, greater stress exposure, and ineffective coping strategies to address trauma-related events (Pérez-Benítez et al., 2014). Previous research has examined how stress, social determinants of health, and mistrust of medical and clinical practices have influenced mental health care among African Americans (Graves et al., 2011). Coping strategies, however, have been grossly underexamined.

For the African American population, religion, spirituality, and faith-based resources are the primary coping mechanisms used to address mental health adversities; they are used more than medical or clinical resources. Help-seeking among religious resources is further influenced by perceived cultural sensitivity, easy accessibility, and a greater degree of trust related to faith-based resources (Payne & Hays, 2016; Williams, Gorman et al., 2014). Additionally, clergy members have been an invaluable resource relative to the handling of mental health issues within faith-based environments, given the high level of trust and influence associated with the office as well as clergy members' position as the first point of contact for most parishioners (Williams, Gorman et al., 2014). This research study explored the management of PTSD symptoms among African American adults through the framework of religious coping based on clergy experience. The exploration of the presence or absence of religious coping produced results that could impact the development of suitable, spiritually guided, PTSD-related preventive services and resources.

Chapter 2 will include a comprehensive literature review based on three primary variables: PTSD, religious coping, and clergy experiences. The review will include information on PTSD as it relates to the development and risks based on race and ethnicity; the use of religious coping among African American adults; clergy etiological and theological position on religion and mental health; and mental health services, care, and coping methods within faith-based environments.

Chapter 3 includes an outline of the research method including the research design and rationale; the researcher's role and personal biases; the research methodology, as well as the method to address issues of trustworthiness and ethical procedures. Chapter 4 includes discussions on the interview process; the demographics of the participants; the data collection process; the data analysis process; evidence of trustworthiness; and the final research results. Chapter 5 concludes with a comparison/contrast reflection based on previous research as well as implications for social change and recommendations of future research areas.

Chapter 2: Literature Review

Introduction

The rate of treatment-seeking for PTSD across races and ethnicities is broad due to great apprehension among minority groups to utilize professional services (e.g., medical, clinical) (Roberts et al., 2011; Williams, Malcoun et al., 2014). In fact, faith-based settings and the etiological use of religious coping mechanisms in general, are often the first course of action among minority community members who seek care and counseling related to mental health issues (American Psychological Association, 2013; Hankerson & Weissman, 2012). Current research related to religious coping and faith-based initiatives addressing PTSD among African American adults was limited and dated. The current body of literature was also limited in data related to clergy experiences in caring for parishioners with PTSD as well as clergy insights on the presence or absence of religious coping constructs in the management of PTSD symptoms. Insight from the clergy population has significance given that clergy are often the first persons to encounter and counsel church members dealing with mental health issues (Williams, Gorman et al., 2014). Payne and Hays (2016) added that "the attitudes of the helper (i.e., clergy members) play[s] a critical role in the therapeutic relationship and mental health outcomes of the help-seeker" (p. 600). Addressing this topic from the perspective of clergy members assisted with further elaboration of the prevailing clergy attitudes, opinions, and beliefs that may hinder or promote the use of religious coping to manage symptoms of PTSD.

The purpose of this study was to explore clergy experiences in relation to the presence or absence of religious coping constructs among African American adults diagnosed with PTSD. My intention in this study was to explore this phenomenon by exploring clergy experiences with African American adults clinically diagnosed with PTSD. According to the Pew Center (2009), 78% of African Americans in the United States who claimed some form of religious affiliation are Protestant. With that in mind, the target population of my research was African American clergy members ordained in Protestant churches who pastored predominately African American congregations located within the five boroughs of New York City as well as the counties of Westchester, Nassau, and Suffolk.

In this chapter I discuss three primary variables: PTSD, religious coping theory, and clergy experiences with mental health counseling. First, I present a comprehensive overview of specific trauma triggers and psychosocial, conditional risk factors associated with PTSD most common among different races and ethnicities. Next, I discuss the theoretical framework of religious coping. Using the most current peer-reviewed articles available, I discuss the origin and primary constructs of religious coping. I conclude the chapter with a discussion of Protestant clergy etiological perspectives of mental health and mental illness including PTSD.

Literature Search Strategy

Literature retrieval was performed through a comprehensive search of Walden University Library databases (e.g., Thoreau, Google Scholar, Academic Search Complete, ProQuest Central, PyscINFO). The following keywords were used in a variety

of combinations (see Appendix A): *posttraumatic stress disorder, PTSD, African American, faith, faith-based institutions, FBI, faith-based organizations, FBO, church, interventions, religious coping, religious coping theory, mental health interventions.* Given the primary focus of the study is to examine clergy experiences in relation to PTSD and religious coping, the search process included the keyword terms *posttraumatic stress disorder/PTSD* AND *religious coping* AND *clergy*. This combination was selected as a means of retrieving literature that contained data on both PTSD and religious coping. The search was then narrowed to include *posttraumatic stress disorder*/*PTSD* AND *religious coping* AND *African Americans*. The initial search was first executed in the Thoreau and Academic Search Complete databases because of the feature to search multiple databases and multiple disciplines; following this, individual databases (i.e., PyscINFO) were searched in the event that relevant data within these databases were not linked to Thoreau and Academic Search Complete. Articles published between 2011 and 2018 are included in the review (see Appendix A).

Literature Review

PTSD-Related Trauma; Racial and Ethnic Comparisons

In studies in which trauma exposure was examined, Alegria et al. (2013), Asnaani and Hall-Clark (2017), Roberts et al. (2011), and Weiss et al. (2017) indicated that trauma associated with the development of PTSD varied across racial and ethnic boundaries. For example, the learning of a trauma experienced by a close family member or friend or the experience of an unexpected death was shown to have a greater impact on European Americans, whereas African Americans and Hispanics were impacted to a

greater degree by childhood maltreatment and the witnessing of acts of domestic violence (Roberts et al., 2011). Higher rates of war-related trauma were recognized in Asians, African American men, and Hispanic women than in European Americans (Roberts et al., 2011). In fact, according to Asnaani and Hall-Clark (2017), the primary source of trauma exposure in the Asian population stems from political violence and war-related events within their respective countries of origin. Asnaani and Hall-Clark (2017) also speculated that there was an association between this phenomenon and patterns of immigration to the United States due to the departure from various war zones. While risk and vulnerability to the effects of different trauma exposures has been shown to differ among various racial groups, Roberts et al. (2011) and Asnaani and Hall-Clark (2017) agreed that African Americans experienced the greatest degree of trauma brought on by violent acts while Asian research participants experienced the least amount of trauma resulting from violent acts when compared to their European American counterparts (Roberts et al., 2011). Conversely, when measured across the broad spectrum of all traumatic events, African Americans experienced lower rates of overall trauma exposure than European Americans. Despite this, African Americans were found to be at greater risk of developing PTSD once traumatic exposure occurred (Alegria et al., 2013; Robert et al., 2011).

The influence of psychosocial conditional risk factors such as acculturation, culture-based perceptions of domestic violence, education attainment, environmental risk exposure, discriminatory experiences, and racial stigmatization could increase the rate of developing PTSD once exposure to trauma has taken place (Alegria et al., 2013; Roberts

et al., 2011). Alegria et al. (2013) and Roberts et al. (2011) indicated that socio-economic factors such as higher educational attainment and higher incomes have the potential to reduce the risk of PTSD development due to speculation that higher socio-economic status is associated with lower exposure to PTSD-related traumas. This may further explain the disparity in the elevated rate of PTSD development when African Americans were compared to Asians given that Asians experienced lower rates of exposure to traumatic events except in the case of war-related occurrences (Roberts et al., 2011). Discriminatory experiences, racially motivated verbal assaults, and stigmatizations occurring in conjunction with trauma exposure could explain the higher rate of PTSD development among African Americans (Alegria et al., 2013; Roberts et al., 2011). Asnaani and Hall-Clark (2017) indicated a positive correlation between levels of perceived discriminatory acts, the rate of PTSD diagnoses, and the severity of PTSD. Among the various racial populations studied, Roberts et al. (2011) noted that the Asian participants (identified as non-Hispanic, native Hawaiian/pacific Islander/Asians) tended to have a higher resiliency and tolerance to trauma exposure. The Asian sample group in the study by Roberts et al. (2011) tended to experience a lower risk of exposure to traumatic events as well as a lower risk of developing PTSD once exposed to the trauma as compared to their European American counterparts (Roberts et al., 2011). Asnaani and Hall-Clark (2017) substantiated the findings of Roberts et al., indicating that lower rates of developing PTSD among Asian Americans was influenced by the population's philosophy of exercising self-control and the use of intellectualization over affective mechanisms to overcome negative mental afflictions. Variations in PTSD prevalence

based on race and ethnicity are also influenced by culturally diverse conditional risk factors such as stigma, acculturation, and ethnic identity, which affects the acknowledgement of PTSD symptoms, willingness to disclose trauma incidents, and treatment-seeking behaviors (Asnaani & Hall-Clark, 2017).

Racial Disparities in PTSD Diagnosis and Treatment

Spoont et al. (2015) claimed that symptoms of PTSD could possibly improve without the implementation of treatment; however, withholding treatment could increase the risk that symptoms progress to a more chronic stage. Despite the overall success of various treatment approaches, studies continue to indicate a gap in diagnosis and treatment among minorities, especially African Americans (Graves et al., 2011; Roberts et al., 2011). Spoont et al. (2015) indicated that Latinos and African Americans achieved lower rates of treatment retention in relation to pharmacotherapy and that African Americans experienced lower odds in continuing with and remaining in treatment programs. According to Williams, Malcoun, et al. (2014), African Americans are 1.5 times more likely to discontinue a prescribed treatment plan and 3 times more likely to not even initiate the process of treatment, despite being optimistic of treatment effectiveness and potential benefits.

Graves et al. (2011) examined the diagnosis and treatment process at the primary care level among a sample group (89 African Americans, 1 European American, and 1 Asian American) who exhibited symptoms of PTSD. They found that most of the sample population was either undiagnosed or undertreated as primary care patients. They further indicated that nearly half (49.7%) of the study participants never divulged the trauma

experience nor mental health symptoms to their primary care provider. Grave et al. (2011) concluded that, while 32% of the study participants were prescribed psychotropic medications, 68.1% did not receive sufficient pharmacological treatment and, while only 18.6% participated in some form of psychotherapy, 81.4% received inadequate psychotherapy. Graves et al. (2011) and Williams, Malcoun et al. (2014) argued that further deficiencies in the PTSD diagnostic and treatment process could further increase cases of functional impairment, probability of academic failure, teen pregnancy, marital instability, reduction in work productivity, morbidity, and mortality.

Cultural insensitivity is one of the primary causes why minorities, especially African Americans, are less likely to seek mental health treatment from conventional mainstream sources (Barlow & Comas-Díaz, 2014; Williams, Malcoun et al., 2014). One of the current opinions of mainstream psychotherapeutic practitioners is the argument that monoculture approaches are insensitive to cultural and spiritual experiences relevant to a multicultural population (Barlow & Comas-Díaz, 2014). Bryant-Davis and Wong (2013) further agreed that a culturally competent interpersonal trauma recovery process should be inclusive of spiritual and religious coping strategies as a means of creating a more holistic treatment plan. Regrettably, a vast percentage of mental health practitioners may not be sufficiently trained to address religious beliefs or spiritual needs (Bryant-Davis & Wong, 2013). Coupled with increased levels of underreporting of trauma events and experiences to primary care providers and the reduced likeliness of professional service use (Graves et al., 2011), the use of clergy and the faith environment was examined as a viable option to address religious and spiritual needs and to fill, or at least

bridge, this gap in service. In order to move forward in an examination of this assumption, a greater understanding was needed, in relation to the current attitudes and perceptions clergy members hold in relation to mental health and mental illness within the faith environment.

Clergy, Religious Coping, and PTSD Symptom Management

Current data related to religious coping and PTSD care are collected primarily within clinical, military, and secular settings as well as from the perspective of the help-seeker (Bonner et al., 2013; Bryant-Davis & Wong, 2013; Gerber, Boals, & Schuettler, 2011). However, treatment seeking among African American adults is less likely to occur in these settings (Graves et al., 2011; Hays, 2015; Taylor et al., 2011) and clinical professionals are less likely to be sufficiently equipped to address the cultural differences of help-seekers including their spiritual/religious beliefs and ideologies that influence mental health treatment approaches (Hays, 2015). The significance of utilizing clergy members as the sample population is justified with Xu's (2016) assertion that religious coping should be investigated beyond the internal lens (e.g., help-seeker) but with a usage of external lens (e.g., helper). Performing a qualitative investigation to explore the management of PTSD symptoms within the framework of religious coping and through the lens of the clergy experience utilized the presumed religious expertise of clergy members to offer a broader objective assessment of the degree and efficacy to which religious coping methods are used in symptom management.

Clergy Etiological Position on Religion and Mental Health

Based on current research data, there is room for improvement in the approach to addressing mental health issues within faith-based environments, especially from the vantage point of clergy members. According to a 2014 survey of 1,000 Protestant pastors, more than half (66%) had seldom and 10% had never openly addressed the issue of mental health among their parishioners from the pulpit (Simietana, 2014). The research also revealed that 16% of the pastors addressed the subject of mental illness only once within a one-year span and 22% of the pastors were apprehensive about getting involved with cases of acute mental illness among congregants because it was a time-consuming process (Simietana, 2014). Conversely, another study which surveyed 99 Black clergy members, revealed that two out of five pastors experienced severely mentally ill persons among their congregants, two out of three counseled members with suicidal inclinations, and 10% of their counseling interventions were crisis related (Payne, 2014). Simietana (2014) identified some of the prevailing *'*key disconnects' that hindered faith-based mental health services from taking place including the lack of: a formal treatment/counseling plan of action; family-centered services, and resources; accessible skilled mental health counselors or trained leaders on staff; a dissemination plan of local mental health services and resources; and open discussion about mental health challenges.

Additional research examining clergy perceptions and attitudes towards treatment and healing of mental health issues revealed that clergy opinions of addressing mental health issues within faith-based environments varied across a broad spectrum of beliefs. Payne and Hays (2016) performed a qualitative, classic grounded theory analysis to

examine the social media dialogue of a global network of clergy members that addressed the question “If the church is where we are to come for healing, how do we handle people who are depressed, suicidal, suffering from PTSD or anxiety?” The analytical approach included the process of reflexivity that allowed the researchers to remain cognizant of their personal views and beliefs regarding the research subject. Data analysis also included substantive, open, and selective code processes as well as theoretical sampling. Through this analysis protocol, Payne and Hays (2016) identified a spectrum of clergy etiological views related to the cause mental illness. At the ‘spiritual’ end of the spectrum, clergy members indicated etiological agents of mental illness such as demonic possession, sin, ungodliness and the will of God and the sole approach to mental health treatment or healing was addressed by spiritual means such as the “casting out of demons”, fasting and prayer, and repentance (Payne & Hays, 2016). At the ‘medical’ end of the Payne/Hays spectrum, the contributing factors of adverse mental health were purely biological and physiological in origin; however, no surveyed clergy members accepted this hypothesis as the sole contributor to emotional problems, mental illness, depression or PTSD (Payne & Hays, 2016). According to Payne and Hays (2016), the perceptions and attitudes of a “fair amount” of clergy participants were positioned midpoint on the belief spectrum, arguing that demonic possession was not the source of PTSD. They surmised that the contributing factors of PTSD as well as depression were more likely various adversities, trauma experiences, and the unwillingness to address trauma issues. The results of the research by Payne and Hays (2016) and Smietana (2014) indicated that more than half of the pastors agreed, it is a clergy member’s and local

church's responsibility to address mental health issues among their parishioners whether by direct counseling interactions or to coordinate and collaborate with clinical practitioners as a part of the treatment process.

Services, Care, and Coping Methods in Faith Environments

While it has been well established that clergy and faith institutions are key components of the mental health outreach process, research has also indicated that the mental health services and care provided within faith environments are in need of further development (Singh, Shah, Gupta, Coverdale, & Harris, 2012). Because of the varying etiological and theological ideologies on the origin of mental illness, treatment, prevention, and coping strategies are inconsistent across a broad religious spectrum. Based on the current body of literature, four primary approaches seem to prevail in the attempt to address mental illness within faith environments including religious rituals, support services, clinical collaborations and referrals, and direct pastoral counseling (Asamoah, Osafo, & Agyapong, 2014; Hall & Gjesfjeld, 2013; Leavey, Loewenthal, & King, 2017; Payne, 2014; Payne & Hays, 2016; Pickard & Inoue, 2013; Singh et al., 2012; Streets, 2015; Taylor et al., 2011; Weber & Pargament, 2014; Wood, Watson, & Hayter, 2011).

Religious rituals. Among various faith-based environments, religious rituals are used as a component in mental-health care delivery (Asamoah et al., 2014). Van Uden and Zondag (2016) further argued that religious rituals add value to the therapeutic and recovery process of mental health treatments. Oftentimes members of the clergy self-report the ability to discern the source of a mental distress, whether physical,

psychological, or spiritual (Asamoah et al., 2014; DeHoff, 2015). In some instances, when mental distress has been identified as spiritual, many clergy members implement a religious treatment plan which includes, but is not limited to, the religious rituals of fasting, prayer, and even exorcism (Asamoah et al., 2014).

The ideology of mental illness being 'spiritual' in nature considers the origin of mental illness as spiritual inclusive of demon possession, the presence of unrepented sin, ungodliness, and the will of God and is addressed primarily through strict spiritual healing mechanisms (Payne & Hays, 2016). Religious entities that ascribe to the spiritual etiology attempt to 'heal' mental illness afflictions with various religious rituals such as exorcisms or the casting out of demons; prayer and fasting; and repentance (Payne & Hays, 2016). Since the modality of spiritual healing occurs autonomously within religious liberties and within the confines of religious institutions, it is often difficult to determine empirically the benefits or limitations of spiritual healing; further research is needed in order to substantiate the efficacy of this modality in relation to mental health outcomes. Leavey, Loewenthal, and King (2017) argue that the recognition of mental illness as spiritual in origin could hinder further help seeking from mental health professionals as well as complicate the patient/clinician relationship.

Support services. The 'Black' church has been a primary source of support services for the African American community for decades; even before formal governmental support services were ever established (Rowland & Isaac-Savage, 2014). Weber and Pargament (2014) emphasized the benefit of using support services to address mental health distress. Mental health programming within faith-based organizations often

incorporates various supportive services including support groups, workshops, and presentations on mental health and mental illness presented by those who have either worked with or personally experienced some form of mental health difficulty (Singh et al., 2012). The dissemination of educational literature on cause, prevention, and treatment of various mental health issues is also incorporated as a support service component of programming (Asamoah et al., 2014; Rowland & Isaac-Savage, 2014). While many faith institutions have indicated achieving successful outcomes through various mental health and wellness program implementation, Singh et al. (2012) indicated that the lack of formal assessment processes and the lack of use of validated outcome measures within faith-based mental health programming and services creates a challenge in determining generalizable program efficacy. To extend support services beyond those that are in direct relation to mental health outcomes, additional social service support mechanisms are put in place to help alleviate the pressure and stress caused by various social ills such as poverty, homelessness, and unemployment, which can substantially impact mental health (Asamoah et al., 2014).

Clinical collaboration and referral options. As previously indicated, a large number of clergy members admit their skill set and level of mental health education, training, and experience is insufficient to confidently address mental health concerns, yet research data further indicate that clinical/clergy collaborations and referrals to clinical professionals are not rapidly increasing (Hall & Gjesfjeld, 2013). Hall and Gjesfjeld (2013) indicated that increasing collaborative efforts between mental health professionals and clergy members could improve health care delivery systems, especially within rural

areas. Singh et al. (2012) further emphasized that clergy/clinician collaborative efforts could increase earlier identification of reduced mental health wellness and capacities as well as reduce the barriers associated with professional referrals. An effective clergy/clinician collaboration can potentially reduce clergy limitations when determining the most appropriate time for external referral and this collaborative effort could be advantageous for clinicians who seek greater recognition and understanding on the impact of spiritual and religious beliefs on mental health outcomes (Hall & Gjesfjeld, 2013).

Direct pastoral counseling services. Numerous research studies have been performed in relation to various mental health issues, traumas, and direct pastoral counseling/care services (Asamoah, Osafo & Agyapong, 2014; Kopacz, 2013; Leavey, Loewenthal, & King, 2017; Payne, 2014; Payne & Hays, 2016; Pickard & Inoue, 2013; Streets, 2015; Taylor et al., 2011; Wood, Watson, & Hayter, 2011). However, very few studies have been identified that examine the associations between PTSD and direct pastoral counseling services specifically. One specific qualitative study performed by Sigmund (2003) explored the integration of chaplain services within the Posttraumatic Stress Disorder Residential Rehabilitation Program (PRRP) located in the Dayton VA Medical Center. PRRP initially began solely as a Bible study group for the veterans; however, due to the need for substance abuse counseling among this population, Bible study services were eliminated, and a more clinical approach was adopted (Sigmund, 2003). Through the PRRP, chaplains assisted veterans to better understand and process anger associated with PTSD symptoms through either group counseling sessions or one-

on-one private consultations (Sigmund, 2003). As the program continued, additional therapeutic components were integrated to address destructive behaviors that disrupted the veterans' interpersonal relationships due to the isolation, shame, and social dysfunction found in PTSD patients (Sigmund, 2003). Ongoing development of the PRRP allowed the Daytona VA Medical Center to create a more holistic, clinical, and spiritual approach to addressing mental health issues among the veteran population (Sigmund, 2003). Through the PRRP, cross-training opportunities were developed; clinical team members were educated in areas of spirituality and clergy increased their clinical knowledge regarding treatment of mental disorders, including PTSD (Sigmund, 2003). Sigmund indicated that further research is needed in order to fully measure program outcomes.

Direct pastoral counseling tends to appear most often as spiritual/biblical and grief counseling. Depending on the skill set of the clergy member, the pastoral counseling process may consist of one-on-one, couples, or family interventions to address issues of intra or interpersonal conflicts, issues associated with depression, the occurrence of traumatic events, suicidal inclinations, grief, and substance and addiction issues (Hall & Gjesfjeld, 2013). Direct pastoral counseling methods have the advantage of incorporating religious faith into the therapeutic process; the congregant may experience less stigmatization by speaking with a clergy member rather than a mental health clinical professional, and in most cases, a built-in trust system is pre-established with clergy members (Hall & Gjesfjeld, 2013; Payne, 2014). Conversely, direct pastoral counseling approaches may be limited in terms of sufficient clinical counseling substance.

Many clergy members admit that their degree of mental health education and training is minimal or even inadequate (Asamoah, Osafo, & Agyapong, 2014; Hall & Gjesfjeld, 2013). They admit they lack the formal coursework instruction, training, and experience to sufficiently identify and address mental health issues (Payne, 2014). Payne examined the treatment practices for depression within the faith environment by surveying 204 Protestant pastors. Findings indicated that, while the pastors' secular educational experiences played an influential role in their confidence level to treat depression, theological educational experiences had no significant impact. Asamoah, Osafo, and Agyapong (2014) found that participants admitted that the overemphasis of theological education diminished a greater understanding of physiological (e.g., epileptic seizures) and psychological (e.g., schizophrenia, PTSD & depression) malfunctions associated with mental health. Based on current evidence, patterns indicate that the type and degree of educational training received can potentially influence a clergy member's willingness and ability to address mental health issues (Hall & Gjesfjeld, 2013; Payne, 2014). While non-formal skill sets contribute to unwillingness, some clergy members also admitted their unwillingness to address mental health issues among their congregants for fear of the 'healing' or recovery process being too time-consuming (Simietana, 2014).

Coping Strategies Related to Mental Health Crises

Trauma-related mental health crises are managed with various coping strategies. Iverson et al. (2013) examined PTSD coping strategies, specifically engagement coping (e.g., proactive strategies such as problem-solving, cognitive restructuring, emotional expression and eliciting social support) and disengagement coping (passive responses

such as problem avoidance, wishful thinking, self-criticism, and social withdrawal), within the realm of association between PTSD symptoms, dissociation, engagement and disengagement coping, and revictimization in intimate partner violence (IPV). Iverson et al. (2013) indicated that 37% of IPV survivors reported a reoccurrence of intimate partner abuse within one year from the initial report of abuse and 27-56% of IPV survivors will be involved in more than one abusive relationship over the course of their lifetime. Based on these statistics, Iverson et al. (2013) examined if PTSD symptoms, dissociation, and engagement and disengagement coping strategies were modifiable predictors associated with IPV reoccurrence. In this prospective study, IPV, PTSD symptoms, dissociative symptoms, and coping strategies were measured among 69 help-seeking women (66.7% African American, 30.4% European Americans, and 2.9% identified as 'other') who identified as survivors of IPV. The results indicated that all variables examined were contributing factors in revictimization; however, when the four variables, IPV, PTSD symptoms, dissociative symptoms, and coping strategies, were examined simultaneously, only the coping strategy components (engagement and disengagement) measured with significant association and had the most influence on revictimization. Iverson et al. (2013) determined that the use of disengagement as a coping strategy could increase women's vulnerability to additional IPV episodes while the use of engagement coping may influence a reduction in future occurrences.

In a study that examined the coping strategies of co-victims of homicide (i.e., surviving family members, loved ones and friends) and the relationship between case status (e.g., case investigation, case prosecution, case-closed), trauma symptoms, and life

satisfaction, Simmons, Duckworth and Tyler (2014) identified three categories of coping strategies: personal, interaction with others, and faith. Personal coping was identified by the personal actions or activities individuals may become involved with in order to mitigate or distract from the pain of loss. Positive personal coping strategies included activities such as exercise, reading, and keeping busy while negative coping manifested in the form of avoidance behaviors, overworking, or substance abuse. The second coping strategy related to persons who sought interaction with others; seeking social support and an opportunity to converse as a means of problem solving and making sense of the traumatic event. Of the 137 study participants (76.6% African American, 21.9% European American, 1.4% other), 55.5% received some form of external counseling through either a professional or spiritual agent, 89.8% of the participants endorsed the importance of talking with family members and friends. They further indicated that a substantial number of participants implemented aspects of religious coping including the use of prayer (94.60%), remaining active in church activities (70.10%), or practiced some form of meditation (54.76%).

In another study performed by Gerber et al. (2011), positive religious coping strategies were examined in association with PTSD and post-traumatic growth or the degree of personal growth and recovery achieved beyond the traumatic event. They indicated that greater levels of positive psychological outcomes such as acceptance, hope, life satisfaction, optimism, spiritual growth, and stress-related growth were associated with the presence of positive religious coping strategies. Gerber et al. (2011) also identified a positive association between negative religious coping and PTSD symptoms;

however, the authors concluded that current research findings on the impact of positive religious coping on PTSD symptoms have not been fully substantiated.

There are numerous coping strategies relative to the management of PTSD symptoms yet the measured results among the current research varies in statistical significance and can vary further when examined in conjunction with contributing variables (Gerber et al., 2011; Iverson et al., 2013; Johnson, Williams, & Pickard, 2016). Johnson et al. (2016) argued that religious activities such as prayer, Bible reading, and faith are frequently used coping strategies for African Americans and that these religious activities used in coping are further enhanced by the inclusion of social support historically found in faith-based environments. Iverson et al. (2013) found that the use of positive coping strategies such as engagement, social support, interaction with others, and faith were more effective at reducing the impact of trauma than negative coping options which included disengagement, avoidance, and substance use. They also indicated that religious coping was as influential on mental health improvement and impact reduction as various clinical and self-help methods of coping. With that in mind, further research on the association of religious coping methods in relation to PTSD exclusively is essential especially within the context of lived experiences of clergy members who assisted in the care of PTSD symptom management given clergy members' influence on the trajectory of early onset mental health issues.

Theoretical Framework

Theory and Constructs of Religious Coping

Pargament et al. (2011) identified religious coping as human "efforts to understand and deal with life stressors in ways related to the sacred" (p. 52). Pargament's assessment of religious coping is grounded by four constructs: 1) meaning-making of a trauma experience; 2) find comfort in closeness with God; 3); empowerment and regain control over the experience and; 4) find closeness with others (i.e., social support) (Hvidtjørn, Hjelmborg, Skytthe, Christensen, & Hvidt, 2014; Pargament et al., 1998; Pargament et al., 2011).

Meaning making, as it relates to religious coping, is the construct by which individuals attempt to find comfort or relief by attributing personal sufferings to a greater Godly purpose and attempt to comprehend events that seem incomprehensible to human logic (Van Uden & Zondag, 2016). According to Van Uden and Zondag (2016), individuals also embrace the construct of meaning-making in order to cognitively and emotionally reconcile the effects of a traumatic event when they contradict or conflict with the individual's convictions and worldview. Pargament et al. (2011) also identified the construct of *finding comfort in closeness with God* within the realm of religious coping. Pargament et al. (2011) argues that finding comfort in closeness with God begins by establishing an intimate, personal relationship with God. Through this personal relationship, individuals seek comfort and expect a personal degree of one-on-one support, love, care, intervention, and protection from God to address life-stressors (Pargament, Koenig, & Perez, 2000). The concept of establishing a personal relationship with God further undergirds the construct of *empowerment and regaining control* over the traumatic experience by creating a partnership with God in order to problem-solve

(Pargament et al., 2000). Empowerment and control are sought by the individual as they perceive God as an omnipotent and omniscient 'partner' who has control and influence over and above all human situations and circumstances. Furthermore, within the construct of *finding closeness with others*, the individual seeks comfort and support from other individuals who are spiritually or religiously like-minded (Pargament et al., 2000).

In this study, the constructs of religious coping (i.e., meaning-making, empowerment and regaining control, gain comfort in closeness to God, gain intimacy with others) were used to develop the interview questions that explored clergy experiences in the recognition of religious coping constructs during the management of PTSD symptoms among African American parishioners.

Application of Religious Coping

The theory of religious coping has been investigated by numerous researchers over the past few decades. Most recently, Lundmark (2016) performed a qualitative, longitudinal investigation of religious coping among practicing Christians living with cancer. Using a convenience sample of 20 participants, Lundmark (2016) investigated the religious coping construct of meaning-making or more specifically, suffering for others as religious meaning-making. During the religious coping process, individuals search for sacred significance in stressful times (Lundmark, 2016). With that in mind, Lundmark sought to investigate the concept of an individual's personal suffering being of benefit to someone else. Lundmark (2016) identified that, among this sample population, the sacred significance of personal suffering included: a) being a tool to share their faith in God; b) being prepared to share their experience with someone who would endure the same or

similar event and; c) having a new ‘assignment’ or purpose in life and giving them the opportunity to serve others in a new way.

Previous investigations grounded by the theory of religious coping also focused on trauma treatment, management, and recovery. Bryant-Davis and Wong (2013) investigated the impact of utilizing religious coping within the context of trauma recovery. More specifically, Bryant-Davis and Wong’s (2013) broadened academic knowledge in relation to the importance of mental health professionals utilizing religion and spirituality in the trauma recovery process especially among traumatic experiences such as child abuse, sexual violence, and war. In one such research case, Gall, Basque, Damasceno-Scott, and Vardy (2007) investigated the current adjustment of adult survivors of childhood sexual abuse (CSA) relative to the religious coping construct of ‘finding comfort in closeness to God’. In a study of 101 male and female adult survivors of CSA, Gall et al. (2007) hypothesized that:

> (1) relationship with a benevolent God or higher power will be related to a greater sense of current adjustment for CSA survivors in general; (2) relationship with a benevolent God or higher power will be related to lesser self- and God blame, greater hope, and greater self-acceptance; and (3) relationship with a benevolent God or higher power will significantly predict current adjustment beyond the contribution of demographics, abuse characteristics, and other person factors (e.g., hope) (p. 104).

A study on the relevancy of a ‘relationship with a benevolent God’ is significant given Pargament’s (1990) argument that this religious coping construct is associated with

positive health outcomes. The researchers concluded that, among both male and female participants, those experiencing a relationship with a benevolent God exhibited greater levels of emotional reconciliation towards the abuse incidents, and greater personal growth and self-acceptance (Gall et al., 2007).

Religious coping was further investigated in relation to PTSD, posttraumatic growth (PTG), and gender based on Gerber, Boals, and Schuettler's (2011) argument that religious coping was essential to the overall study of the coping process. Gerber et al. (2011) investigated religious coping and the association with PTSD and PTG among males and females. Furthermore, Gerber et al. (2011) sought to analyze the role of religious coping in association with trauma outcomes in relation to gender and PTG. Unlike the negative mental health outcomes associated with PTSD, PTG hinges on the construct of empowerment, recovery, and the resiliency of individuals to regain control and adapt to negative experiences as well as gain the ability to achieve growth in the development of self, interpersonal relationships, philosophies of life, and spiritually (Gerber et al., 2011). Using a quantitative research approach, Gerber et al. (2011) utilized four measures (Brief COPE, Brief religious COPE, Traumatic events questionnaire, and PTSD Checklist) to measure various coping strategies, levels of trauma exposure, and PTSD symptoms among a study sample of 1,016 participants (67% female and 33% male). From the perspective of gender, although women experience higher levels of symptoms associated with PTSD, Gerber et al. (2011) indicated that the use of religious coping methods and higher levels of PTG were greater among females. The overall

research objectives of Gerber et al. (2011) were to further understand the role of religious coping as a mediator among gender and PTG.

Research indicates that religious coping along with social support systems, formal and informal, have been effective at mitigating the effects of trauma experiences, especially sexual assaults (Bryant-Davis et al., 2015). In the second wave of a dual-wave study performed in the Chicago area among sexual assault survivors, male and female, Bryant et al. (2015) examined the potential reduction of PTSD symptoms through the usage of religious coping strategies as well as social support. Among the 413 participants from the first-wave, 252 females participated in a 1-year follow-up study in order for the researchers to examine further impact of religious coping and social support on PTSD symptoms 1 year later. Researchers concluded that populations who have an increased vulnerability to sexual assaults (e.g., African American women) are more likely to utilize greater religious coping methods to manage symptoms due to the assault. Bryant-Davis et al. (2015) further speculated that sexual survivors with greater social support systems were less likely to endorse symptoms related to depression and PTSD.

Summary

Current literature has well established that minorities are more likely to seek help for mental health issues from a faith-based organization rather than from a clinical or medical professional (Hankerson & Weissman, 2012; Hays, 2015; Williams, Gorman, et al., 2014). Current literature has also indicated that clergy members play a significant role in the care and counseling process of various mental health issues (Asamoah, Osafo & Agyapong, 2014; Kopacz, 2013; Leavey, Loewenthal, & King, 2017; Payne, 2014; Payne

& Hays, 2016; Pickard & Inoue, 2013; Streets, 2015; Taylor et al., 2011; Wood, Watson, & Hayter, 2011). An examination of the current body of data indicated that different categories of trauma affect various races differently. European Americans experience greater levels of trauma caused by sudden or expected deaths whereas African Americans and Hispanics experience greater vulnerabilities to trauma associated with victimization including child maltreatment and domestic violence; Asians are more susceptible to trauma due to political violence (Asnaani & Hall-Clark, 2017; Roberts et al. 2011). Previous researchers argued that African Americans overall experience lower rates of trauma than other ethnicities; however, they experience greater levels of PTSD development which may be associated with a decreased rate of treatment seeking from clinical and medical professionals (Asnaani & Hall-Clark, 2017; Pérez Benítez et al., 2014; Roberts et al., 2011; Williams, Malcoun et al., 2014). In fact, it is more likely that a member of the African American community would seek care for a trauma-related mental health issue within a faith-based environment or from a clergy member than from clinical professionals (Hankerson & Weissman, 2012; Hays, 2015; Williams, Gorman, et al., 2014).

Although faith-based environments and clergy members are a primary source of care for various mental health issues, the care options are not without variation given the varying etiological positions of clergy members towards the origin of mental illness. The attitudes and approaches to care are broad in terms of the spectrum of beliefs. Etiological beliefs among clergy members range from ‘demonic possession’ to purely biological/physiological although a fair amount of clergy members were positioned mid-

point of the spectrum and argued that demonic possession was not the source of PTSD (Payne & Hays, 2016). Given the varying etiological positions, it stands to reason that the approaches to care used by a broad body of clergy members will vary as well. Within faith-based environments, mental health issues are addressed by numerous approaches; the four primary approaches are: religious rituals, support services, clinical collaborations and referrals, and direct pastoral counseling; the latter is one of the primary variables of this investigation.

Given the population under investigation were African American adults who sought care for PTSD within faith-based organizations, it stands to reason that an investigation grounded by the theory of religious coping was appropriate. Current literature did not thoroughly address the presence/absence of religious coping constructs in the symptom management of PTSD among civilian populations; for the population most investigated in relation to PTSD and religious coping strategies were military veterans. As the issue of PTSD is becoming more mainstream, it is necessary to examine this phenomenon among civilian populations and more specifically among African Americans since they experience a greater likelihood that traumatic incidences can potentially develop into full cases of PTSD. The investigation explored the presence or absence of religious coping constructs from the clergy members' perspective to further understand how PTSD symptoms are managed among African American adults within faith-based environments. The data gleaned from this investigation has the potential to be used to create new and further improve the development of mental health programming.

Chapter 3: Research Method

Introduction

In this study, I examined the presence or absence of religious coping constructs from the clergy perspective in an effort to further understand how PTSD symptoms are managed among African American adults within faith-based environments. The data gleaned from this investigation could influence and improve further development of mental wellness programming in Protestant churches. In this chapter, first, I discussed the overall phenomenological research design and my rationale as to why this approach was most appropriate and I discussed the data analysis plan implemented in this investigation. I then explained my role as the researcher and highlighted potential biases, including being an ordained clergy member. Further, I discussed participation criteria, the recruitment process, and the ethical procedures employed within the investigation. Finally, the steps to increase overall trustworthiness of the process were discussed in detail.

Research Design and Rationale

In this study, I employed a hermeneutic phenomenological research approach to explore the two research questions:

RQ1: What are the experiences of Protestant clergy related to the presence/absence of religious coping constructs among African American parishioners managing symptoms of PTSD?

RQ2: How were religious coping constructs exhibited during the management of PTSD symptoms among African American parishioners?

More specifically, I explored the lived experiences of Protestant clergy members as a means of identifying if or what religious coping constructs were identified in the management of PTSD symptoms among African American adults who exhibited symptoms of PTSD and sought care from clergy.

The hermeneutic phenomenological approach was found to be the most suitable among the varying phenomenological approaches (i.e., transcendental, existential) based on Heidegger's assumption that the lived experience of human beings is subjective and therefore must be interpreted as such (Kafle, 2013). Furthermore, the hermeneutic phenomenological approach was most suitable based upon the selected population (i.e., clergy) and Heidegger's phenomenological concept of being a part of the lived experience and not solely to provide a description of the experience (Reiners, 2012). Given that I am a member of the targeted population (i.e., ordained clergy member) and entered into this investigation with prior experience related to the constructs of religious coping, I bracketed my personal knowledge and experiences related to religious coping constructs to analyze and interpret data from the most objective position possible.

The phenomenological research approach was selected as most suitable to examine the lived experiences of a group of individuals to determine if commonalities or differences related to a given phenomenon exist (Creswell, 2013). A phenomenological approach was used to explore the lived experiences of clergy members regarding associations between religious coping constructs and PTSD symptom management. Clergy members are often the first point of contact for African Americans dealing with mental health issues, especially within faith settings and clergy members are uniquely

positioned to influence the trajectory of early onset mental health issues (Collins, 2015; Hays, 2015). Examining the experiences of this group efforted the opportunity to gather insights from another perspective not sufficiently explored. Current data related to religious coping and PTSD is grounded by the self-reported data of the clients; however, using a phenomenological approach created an opportunity to explore PTSD within the framework of religious coping from the lens of clergy members.

The actual writing process undertaken in the hermeneutic phenomenological methodological approach is just as significant to the research process as is the collection of data; writing is a component of the total research process (Henriksson, 2009). According to Goble and Yin (2014), our world experiences have significant meaning and the function of the phenomenological research method is to describe phenomena as they occur in everyday life activities. However, Henriksson (2009) broadens that thought process by emphasizing that the phenomenological process should include writing a narrative that intimately shares the experiences of the participants rather than just writing *'about'* the lived experiences. The phenomenological reflective writing process describes a human experience in such a way that it transforms raw research data of the lived experiences into a descriptive anecdotal narrative (Henriksson, 2009). In the hermeneutic phenomenological writing process, Henriksson (2009) emphasizes the significance of using language that truly captures the essence of the lived experiences; language that evokes a feeling and brings greater understanding or awareness to the reader as a result of experiencing the experience.

Researcher's Role and Personal Biases

First, it is important to disclose that I have been an ordained clergy member for more than 12 years; however, to date, I have had no experience with working with any persons diagnosed with PTSD. While my experience and expertise as an ordained clergy member can offer analytical insights in relation to the identification of religious coping constructs, insights related to the association between religious coping and PTSD management were solely based on data collected from the research participants. In summary, as an ordained clergy member, I do not solely believe that mental health crises can or should be addressed only through spiritual means; however, neither do I hold the position that the care of mental health and mental illness should only be approached from a medical perspective. As a great body of research has already indicated, it behooves mental health professionals to incorporate an individual's faith and belief system into the assessment process and treatment plan. Taking this into consideration, my primary role as the researcher was to administer a phenomenological approach to interview clergy in relation to their ministry and counseling background, experiences with congregants who have indicated personal experiences with PTSD, and knowledge and experience in the recognition of religious coping strategies.

Methodology

Participant Recruitment

The involvement of clergy members is significant to this study given that most of the current research data related to religious coping are self-reported from the survivors' perspective. Based upon the nature of their profession, it was assumed that clergy members had a degree of knowledge and experience in the identification of religious

coping constructs. The snowball sampling strategy was utilized to recruit participants. Inclusion criteria for the sample included: ordained, Protestant clergy member (no ethnic or denomination exclusion), pastored predominantly African American adults, had previous experience working with a minimum of one parishioner who exhibited symptoms of PTSD and was under the participants' spiritual care, and reside within the five boroughs of New York City or in the counties of Westchester, Nassau, or Suffolk.

The initial research population (i.e., ordained pastors and ministers) are governed by a group of presiding elders within the African Methodist Episcopal denomination. It is important to note that affiliation with the African Methodist Episcopal denomination is not a mandatory requirement for participation. Under the approval of the presiding elders, various church-related information and notifications are distributed among the clergy membership throughout the districts. To utilize this database of clergy members, a formal recruitment request was submitted to the governing presiding elders (see Appendix B). Once IRB approval was obtained from Walden University, the recruitment process began by requesting that the 'invitation of participation' be sent to the database of pastors and ministers on my behalf (see Appendix C). To increase the potential for further recruitment, a statement was incorporated within the initial invitation requesting that initial recruits extend the research invitation to additional ordained clergy of Protestant faith. As I received participation requests from eligible respondents who fit the inclusion criteria, I began to schedule interview appointments at the respondent's earliest convenience. To ensure that confidentiality is maintained, approved study participants

were assigned a participation code (i.e., Participant A; Participant B; etc.) and all research data was stored in the security of a private home office.

A sample size of one in qualitative research can produce a significant amount of insight on a particular research topic (Boddy, 2016). However, Boddy further argued that the selection of a sample size should also be predicated on factors such as research context, scientific paradigm, and the need to achieve saturation. Previous research findings suggest that a sample size of 12 is generally when saturation is reached among a relatively homogenous population (Boddy, 2016). In previous qualitative research in which clergy members were the research population with research topics related to religious coping, trauma, mental health/illness, or PTSD (Abraham, 2014; Asamoah et al., 2014; Kopacz, 2013; Leavey, Loewenthal, & King, 2016, 2017; Payne & Hays, 2016; Pickard & Inoue, 2013; Sigmund, 2003; Wood, Watson, & Hayter, 2011), the sample sizes ranged from one participant to upwards of 1,000 participants. Given Boddy's findings, as well as the limitation of research time and cost constraints, I originally proposed a sample size of 12 clergy members with more participants to be added as needed in order to reach saturation, however, due to the lack of participants that fully met research criteria the sample size was reduced to 8 clergy members; this change is discussed in detail in Chapter 4.

Instrumentation

The data collection instrument was a researcher-developed interview guide based on the constructs of religious coping. As previously indicated, the constructs of religious coping are based on the discovery of meaning and significance of a trauma experience;

on empowerment and regaining control over the effects of the traumatic experience; on finding comfort in closeness with God; and finding closeness with others (Hvidtjørn et al., 2014; Pargament, Smith et al., 1998; Pargament et al., 2011). With that in mind, these constructs were used to develop the interview questions used to gain greater insight on the use of religious coping to management the symptoms of PTSD (see Appendix E).

The interview questions were reviewed and confirmed by an expert in the field. This was a clergy member who had knowledge of religious coping constructs and also had counseling experience with persons who exhibited symptoms of PTSD. I began the search for the field expert through an inquiry among my clergy peers. Based on established criteria (i.e., ordained minister, experience with cases of PTSD among parishioners, understanding of religious coping, Masters, or doctoral-level course work experience), I made an appeal among my peers for someone meeting the criteria who could offer their assistance and expertise to this research project.

The efficacy of the data collection instrument was tested with a pilot study consisting of the first two research participants recruited. The pilot study was used to ensure all questions were clear and addressed the phenomena appropriately. It was proposed that, if the results of the pilot study confirm that the collection instrument is sufficient, I would move on to the full study; if not, the necessary changes would be made to adjust the data collection instrument accordingly.

Data Collection Process

As the researcher, I was the primary instrument of data collection and interpretation. Data collection was performed using a phenomenological interview

approach (PIA). The PIA is an informal yet interactive one-on-one interview process, which allowed me to capture direct descriptions and explore lived-through moments and personal experiences with the phenomenon under examination (Patton, 2015). The use of PIA allowed me to establish first-hand accounts of clergy members' experiences with the use of religious coping constructs among parishioners diagnosed with PTSD who sought their care. I utilized face-to-face interviews to maximize the opportunity to capture a more organic flow of data and interviews via e-mail were avoided due to the concern that this interview option would interrupt the natural flow of data.

As stated, data was collected from a sample of 8 ordained protestant clergy members. The interviews were held at a suitable, confidential location most convenient for the participant; a private office located at the participant's house of worship. The selection of the location was established based will the participant's preference and flexibility. To accommodate for possible time constraints, I allocated one hour for each interview; however, additional time was given as needed. With approval from the study participants, interview data was collected through electronic recording devices to ensure all pertinent data are secured.

After each interview session, each participant was asked to supply any additional information they deemed pertinent yet was not addressed within the primary interview protocol. Participants were advised that a copy of the interview transcript would be forwarded to them via e-mail for their review and approval with the opportunity to make necessary corrections or clarifications. In order to improve the validity of the findings, I

requested permission from each interviewee to follow-up with a phone call, if necessary, after the initial interview in case any interview responses needed further clarification.

Data Analysis Plan

From a philosophical perspective, a sound phenomenological analytical research plan is one that is designed to refrain from making judgments and presuppositions (Patton, 2015). During the data analysis process, the phenomenologist should remain consciously aware of any personal biases and opinions towards the subject matter and eliminate personal involvement with the subject matter during the process (Patton, 2015). This approach assists the researcher during the process of bracketing and phenomenological reduction as well as further reinforces research rigor (Patton, 2015). The phenomenological approach to analyzing interview data will be carried out based on a suggested format of Hycner (1985). According to Hycner (1985), the following are the components of analysis: transcription, bracketing and reduction, identifying units of general meaning, identifying units of relevant meaning relative to the research question, eliminating redundancies, clustering relevant meanings, identifying themes, and summarizing interviews independently and collectively. These actions are not meant solely as a means of creating a step-by-step method of analysis which could restrict the interpretation of the findings, they can also heighten the researcher's sensitivity to the actual phenomenon taking place.

Data analysis continued with multiple reviews of the audio and written transcription to further expand the initial codes into more specific codes. Following Hycner's (1985) suggestion, the data analysis process included an examination of each

word, phrase, sentence, paragraph and significant nonverbal communication in order to elicit the participant's meaning. These components were considered the units of general meaning and were used to create a clear understanding of the participants' responses but were not yet related to the research question (Hycner, 1985). Once the units of general meaning were made clear, units of relevant meaning were established by examining the units of general meaning in relation to the research questions. Each unit of general meaning was classified as either relevant or irrelevant to the phenomenon and research question. However, Hycner (1985) indicated that if the relevancy of a unit of general meaning is ambiguous or uncertain, it is best to include it as a unit of relevant meaning. The list of relevant meanings will be included in the findings as a means of relevancy verification.

Data analysis continued through the process of clustering. The clustering process allowed me to examine the units of relevant meaning to see if common themes existed among them. As a validity check, Hycner (1985) suggested performing a second interview with the participants to review the interview summary, the established themes and to confirm if the true essence of the first interview was captured. This is known as member checking. Following Hycner's recommendation, this "second interview" occurred in the form of follow-up e-mail to the participants to review the interview summary and confirm data accuracy. Once the follow-up e-mail was completed, the codes reviewed in order to investigate the common themes among all the interviews, collectively or uniqueness among the interviews, individually. Based upon the results of all interviews performed, a composite summary was written to capture the substance of

the phenomenon under investigation in totality. The research results were also represented in a table. The table provided a concise explanation of how the identified themes are linked to the codes.

Issues of Trustworthiness

The primary focus of this research study was to gain further insight from the clergy perspective, as to whether religious coping constructs were present in the management of symptoms related to PTSD among African Americans. To increase trustworthiness and secure a rich and robust data set, the following strategies were implemented.

Credibility

Credibility, also known as internal validity, is used as a research criteria to establish that the proposed research methods will measure and test the actual phenomena under investigation (Shenton, 2004). Anney (2014) further indicated that the implementation of credibility strategies can assist to ensure that the interpretation of data is an accurate representation of the participants' original and authentic views. To enhance the credibility of the research findings, sufficient participant contact, and ample, yet a respectful period of time was committed to the interview process; this assisted with building a sufficient rapport with each research participant (Anney, 2014). During the interview process, statements of clarification were presented as needed to ensure I had a clear and concise understanding of data being collected. Credibility of the research findings were also enhanced through member checking. Anney (2014) indicated that the process of member checking is the heart of credibility and as previously indicated, the

member check process involved a follow-up phone e-mail to each participant to review the interview summary and established themes. Results were presented back to the participants to ensure that the interpretation and analysis of data is an accurate representation of the participants' input (Anney, 2014).

Transferability

The construct of transferability refers to the degree to which the results of a given investigation can be transferred into other settings and among other populations (Anney, 2014; Cope, 2014; Shenton, 2004). In an effort to decrease the difficulty of data comparison in future investigations, a structured interview guide was used to ensure that the same line of inquiry was pursued with each research participant (Patton, 2015). Furthermore, solid qualitative research is grounded by rich, thick contextual descriptions of qualitative data (Anney, 2014). The transferability of final research outcomes was increased through the process of creating thick, substantive descriptions of clergy experiences included in the current research results.

Dependability

The process of establishing dependability is to ensure that consistent results will be obtained if the investigation was replicated within the same context, with the same methods, and among the same study population (Anney, 2014; Cope, 2014; Shenton, 2004). To strengthen the dependability of my research results, the interview questions were reviewed and confirmed by an expert in the field. The expert reviewed the interview questions to ensure that the were clear, concise, and were in alignment with the research

objects. Finally, member checking was further implemented as a means of enhancing dependability.

Confirmability

Confirmability is the criterion by which the researcher establishes that data and the interpretation of data is solely derived from the study participants and has not been tainted by any researcher biases or influences (Anney, 2014). However, according to Patton (2015), given the naturalistic, experiential nature of qualitative research, absolute objectivity is impossible to achieve in practice. To increase the potential of retaining objectivity throughout the research process, as the researcher, I maintained a clear and conscious awareness of my personal biases and viewpoint related to religion and mental health that were previously divulged. The thick descriptions and a concise audit trail were also used to provide sound-proof of result origins.

Ethical Procedures

No aspect of the research process could begin until the established research design received full approval from the Walden University Institutional Review Board (IRB: Approval No, 08-16-18-0423986). Once the IRB was satisfied that all research activities met the necessary criteria to protect the rights of human participants, I then began the recruitment process. A request was submitted to the presiding elders of the target districts of New York City as well as Westchester, Nassau, Suffolk Counties (Appendix B) for permission to solicit research participants from the ordained clergy within their respective districts. Upon receiving approval to recruit and upon the approval of the Walden

University IRB, I moved forward by requesting the presiding elders submit the invitation to participate to the clergy members within their districts.

The recruitment process continued through the submission of the Letter of Invitation (Appendix C) to the clergy members of the African Methodist Episcopal Church in New York City ministerial database; an e-mail database which consisted of ordained clergy members as well as evangelists and ministerial licentiates. Eligible members who were interested in participating could contact me to schedule interview appointments. On the day of the interview, eligibility was be re-confirmed and the informed consent form (Appendix D) will be executed. Prior to the interview, interview and research procedures were verbally reiterated including the purpose of the research, processes and rights to maintain confidentiality, right to terminate the research process at any time, methods of data collection and storage, and dissemination process.

Summary

In this chapter, I discussed the qualitative phenomenological research approach used to examine the use of religious coping constructs from the clergy perspective to further understand how PTSD symptoms are managed among African American adults within faith-based environments. I also justified why a phenomenological approach was most appropriate to examine the lived experiences of clergy relative to the research topic. I further exposed my background as an ordained clergy member and my personal etiological perspective in relation to the source of mental health crises.

To increase the likelihood that rich and robust data was be secured, sufficient participant contact time was provided. In addition, ample time was committed to the

interview process (credibility). A structured interview guide was used to ensure the same basic lines of inquiry were pursued with each research participant (transferability) and an expert in the field of religious coping and mental health and wellness approved the interview protocol (dependability).

In Chapter 4, I present the final research findings. Chapter 4 includes discussions relative to the specific settings in which the interviews occurred, the demographics of the participants, the data collection process, the data analysis process, evidence of trustworthiness, and the final research results.

Chapter 4: Results

Introduction

The goal of this study was to explore the presence or absence of four religious coping constructs (i.e., meaning-making; finding comfort and closeness with God; gaining empowerment and regaining control and; finding comfort and closeness with others) relative to the management of PTSD symptoms among African American parishioners of the African Methodist Episcopal denomination in New York City. The study was constructed using a hermeneutic phenomenological design in order to obtain first-hand clergy member experiences related to the presence/absence of religious coping constructs among parishioners counseled in relation to PTSD (Kafle, 2013; Reiners, 2012). In the following chapter, I reveal data to answer following research questions:

RQ1: What are the experiences of Protestant clergy related to the presence/absence of religious coping constructs among African American parishioners managing symptoms of PTSD?

RQ2: How were religious coping constructs exhibited during the management of PTSD symptoms among African American parishioners?

Pilot Study

The interviews of Participant 1 and Participant 2 were used to perform the pilot study. The pilot study allowed me to determine if the initial interview questions were sufficiently and succinctly presented. Based on the results of the first two interviews, minor revisions were necessary. In the original version of interview questions, the participants were asked to describe their specific “counseling training”; however, it was

determined that additional specificity was necessary. Interview Question 3 was originally "What counseling training was included in your religious training?"; however, it was modified to reflect an inquiry of specific counseling training sources such as *religious/seminary, secular,* and *denominational.*

IQ3a: What counseling training was included in your religious/seminary training?

IQ3b: What counseling training was included in your secular training?

IQ3c: What counseling training was included in your denominational training?

It should also be noted that data of Participant 1 and Participant 2 were included in the main study as well.

Study Setting

Using the PIA, all interviews were performed one-on-one, face-to-face at locations most convenient for each participant. Each interview was performed in a private office which preserved the element of confidentiality. The interview appointment times were established based on the flexibility of each participant's schedule. The geographical locations of the interviews included the counties of Queens (n = 4), Brooklyn (n = 1), Westchester (n = 1) and Nassau (n = 2).

Data Collection

The data collection process began by sending the initial Letter of Invitation to Participate in Research (Appendix C) to the database of A.M.E. clergy members. Of approximately 125 potential candidates who received the e-mail, a total of 8 clergy members fully complied with the prescribed criteria and were willing to participate in the research. Additional clergy members replied to the e-mail request with a willingness to

participate yet indicated that their lack of participation was due to their inability to substantiate a clinical diagnosis of PTSD. It was originally proposed that a sample size of 12 participants would suffice in this research exploration; however, since a total of 12 participants could not be secured within the originally prescribed research parameters, it was necessary to initiate a Request for Change in Procedure from the Walden University IRB to expand the research territory from the five boroughs of New York City and the counties of Nassau, Suffolk, and Westchester to all areas within the states of New York, New Jersey, and Connecticut. Unfortunately, the change in procedure did not produce any additional participants, however, it was advised that a sufficient amount of diligence was performed during the recruitment process and approval was obtained to move forward with the collected data.

Interview appointments were scheduled for each of the eight participants. At each interview, two recording instruments were used to perform the interviews: a JWD digital voice recorder as well as the recording feature on an iPhone 6 as a back-up. Upon completion of each interview, a digital version of the interview was uploaded to the computer. To ensure that each participant had a clear understanding of the research topic and objectives, each interview began with the reading of a summation of the purpose and goal of the research project. Once each participant verified their clarity and understanding of the topic and objectives, the interview questions were then administered. Member checking was performed through the process of submitting the initial transcript to the participant for review and to confirm accuracy.

Participant Demographics

All research participants were clergy members ordained within the African Methodist Episcopal Church. English was the primary language of all clergy members so there were no barriers in communication related to language. All participants were African American and diverse regarding gender, clerical position such as senior pastor, associate minister; and clerical employment type such as the role of clergy being their primary source of employment at the time of the interview (see Table 1). The years of ordination ranged from 6 to 29 years and the degrees and sources of counseling training varied as well (see Table 2). The sources of counseling training related to mental health but more specifically, PTSD, received by the participants was distinguished by training received within their seminary education, their denominational education, as well as counseling training received through secular means which included employment, military, personal development training. Research inquiry further identified each clergy member's case history experience relative to PTSD-related counseling (see Table 2).

Table 1

Clergy Demographics

	Gender	# of years ordained	Current clergy position	Clergy employment type
1	M	8	Senior pastor	Full-time
2	F	13	Senior pastor	Part-time
3	F	8	Senior pastor	Full-time
4	F	13	Senior pastor	Full-time
5	F	15	Associate minister	Full-time
6	F	23	Senior pastor	Full-time
7	F	29	Associate minister	Part-time
8	M	6	Senior pastor	Part-time

Table 2

Clergy Counseling Training and Case History Profiles

	Counseling training received during seminary education	Counseling training received during denominational education	Counseling training received in secular training	Overall # of PTSD-related cases handled	# of diagnosed parishioners currently under spiritual care
1	None	None	Certification ACPE (Chaplin)	4	Unknown
2	Didn't recall	Pastoral care and counseling	Social worker Chaplin	4	Unknown
3	Pastoral care and counseling (Narcissism, PTSD, Mood imbalances)	Pastoral care and counseling related to Urban Ministry	BA/Psychology MD	4	3
4	None	None	MSED in Counseling	10-15	1
5	Pastoral care and counseling	None indicated	Gestalt Therapy Neuro Lingusitic Programming	15-20	"Handful"
6	Pastoral care and counseling	None	MS Psychology Ph.D. Marriage/Family Counseling	5	5
7	Didn't recall	Biblically-based instruction	Principal of a mental health facility for children	50	3
8	One course	None	Extensive training through the U.S. Navy Chaplaincy Program	40-50	2

Data Analysis

Based on Hycner's (1985) suggested approach to phenomenological analysis, my data analysis process consisted of transcription, the identification of general meanings, the identification of relevant meanings, and clustering. The analysis process included an inductive reasoning approach as well as deductive reasoning. Inductive reasoning analysis was used in order to identify the units of general meaning (i.e., codes). The inductive analysis process also allowed me to investigate the overall experiences and observations of the clergy members and allow codes to organically emerge (Miles, Huberman, & Saldana, 2014). Further, a deductive reasoning analysis was used as a means to directly target data related to the specific religious coping constructs under investigation (Miles et al., 2014). During the analysis process, relevant data were investigated in direct relation to the established research questions.

Step 1. Transcription

The first step in the analysis process began by submitting an electronic file of each recorded interview to Rev.com for transcription. Digital recordings were submitted to and transcribed by REV.COM, a fee-based online transcription company. Before contracting with REV.COM, a Confidentiality Agreement (Appendix G) was signed by the account manager of REV.COM to ensure that data they had access to would be kept strictly confidential. Upon receiving the written transcriptions, I reviewed and compared them to the audio version of the interview for accuracy; minimal corrections/revisions were necessary. All interviews were submitted within 6 hours from the conclusion of each interview session. Within 4-8 hours from submission, a transcribed copy of each

interview was returned to me at which time I compared the written transcription to the recorded file copy to ensure accuracy. Once my review was complete and my revisions were made, I submitted the written and recorded version of the interview to each participant for their review and approval.

Step 2. Initial Reading of all Interviews Data

The data collection process extended over a 4-month period. Given the extended period of time, the next step in the analysis process was performed by re-reading each interview as a refresher and to re-acquaint myself with data as a collective whole. During this first collective reading, my primary focus was to re-familiarize myself with data.

Step 3. Identification of General Codes

A second reading was then performed. During the second reading of the transcripts, an inductive analysis using a Microsoft Excel spreadsheet was performed to begin the process of clearly identifying general codes relative to the participants' responses to the overall research topic. The intention of this step was not yet to focus on the specific research questions but to identify general, broad codes.

Step 4. Identification of Relevant Statements

A third reading was then performed. During the third reading of the transcripts, a deductive analysis was performed to flesh out significant statements relative to the specific religious coping constructs. A Microsoft Excel spreadsheet was created and used to isolate and organize relevant phrases and sentences in preparation for code identification. As each participant's statements were reviewed, words, phrases, and sentences related to religious coping constructs were identified and isolated. The use of

the Microsoft Excel spreadsheet also assisted in the process of organizing and preparing data for presentation. To organize and arrange data in a more succinct manner, I continued to use the Microsoft Excel spreadsheet throughout this phase.

Step 5. Identification of Relevant Meanings (Codes and Themes)

A fourth reading was then performed. During the fourth reading, a further deductive analysis of the isolated relative statements was performed in order to identify potential themes based on the established codes. Utilizing the codes drawn from the relevant statements established in Step 4, relative themes began to emerge (Table 3). The codes were established as a result of a minimum of 3 participants sharing the same sentiment or response to a given subject inquiry.

Table 3

Themes and Codes

Codes	Theme
Training received through chaplaincy training	Relevant training
No religious training in mental health	
Clergy have not been sufficiently prepared to provide support	
Training received by secular means	
Training received through secular academic means	
Minimal/no training received at the denominational level relative to mental health	
Pastoral care and counseling received at the denominational level	
Never get past the event	Establishing a new normal
PTSD is not going away…It will forever affect their life	
Create for them a new normal	
Not overcome…but they learn how to deal with it	
Still gets triggers	
The Black church has always been the way they could go	Relevancy of religion and the Black church
Church is needed, God is needed	
Black folks aren't going to counseling	
Church has become all of that	
Church has always been the place…	
Faith will forever be a permanent part of the process	
Started coaching others	Purpose-centered trauma
Called to work with other trauma victims	
I'm a better person; Helping other veterans	
Empowered to help other women in the same situation	
Reach his Marines…going through the same shame	
Coming back to hear God; the God they met	Divine personal encounter
Prayer deterred him	
Developing a personal relationship with God	
Communing with God	
Symptoms push him to God	
Allow God or religiosity to guide them	Active divine presence
God in the midst; God has worked and still working	
Acknowledging God in the midst of it	
A part of her that blames God	
God saved her life	

(table continues)

Codes	Theme
Let God handle it	Divine reliance
As she continued to pray, he put down the gun. Through prayer, God protected her	
Call upon God	
She goes to God; She goes to God more frequently	
"If it had not been for the Lord on my side…"	
It's God that's keeping him	
Prayer, Meditation, Spiritual Reflection	Use of rituals
Church Attendance	
Focused Bible Readings	
Personalized activities	
Prayer	
Prayer, Focused Bible Readings, Bible-based Group Support	
Spiritual Practices	
Face their reality; Non-judgmental presence; Preserve their dignity	Safe environment
Able to verbalize that she was struggling	
Ability to address conflicting issues related to faith without judgement	
Prevent isolation; Express love; Develop closer relationship with God and other women; Environment to talk about PTSD experiences	
Place of acceptance; Ability to let your guard down and be vulnerable	
Doesn't need to have his guard up	
Lift his hands; Cry, Scream, Jump	
non-judgmental place; Free expression	
Free expression of trauma is unacceptable on the battlefield	
Cannot have free expression of trauma with fellow Marines	
The community becomes the eyes, ears, and sometimes the voice of God	
Environment of Believers	
Blame Themselves	Forgiveness of self, others, and God
Inability to Forgive	
Forgive the Offender	
Blames God	
Forgiveness of God	

Results

The following results emerged from an investigation of two research questions:

1. What are the experiences of Protestant clergy related to the presence/absence of religious coping constructs among African American parishioners managing symptoms of PTSD.

2. How were religious coping constructs exhibited during the management of PTSD symptoms among African American parishioners?

It is important to note that the emerging themes were not all associated with every religious coping construct and only two themes, rituals and forgiveness, were found to be associated with all four religious coping constructs.

Theme 1: Relevant Training

Data from this investigation revealed that sufficient or appropriate mental health counseling training was obtained more frequently through external means rather than denominational means. Participant 1 [of the pilot study] stated:

> Specifically, to counseling, I don't have formal training in counseling. I do, however, have pastoral training as a chaplain certified by the ACPE [Association of Clinical Pastoral Education] and I have four units of CPE. So, it's pastoral education but it's not formal, counseling training.

When asked “what counseling was included in religious training”, Participant 1 replied: “None. As I've acknowledged, that we have not necessarily, in the clergy, have been trained to provide the support they need. Thankfully I have pastoral education training that allows me to form a bridge.”

Relative to this theme, Participant 2 indicated:

> My background and my training related to counseling is that I am a social worker and I've also taken a certificate program. . . a year certificate program in pastoral care and counseling. I currently. . . I have four units of CPE, which is counseling. . . it's a thin line between chaplain. . . being a chaplain and being a counselor.

When asked about possible counseling training in seminary, Participant 2 further elaborated: “I don't recall. It's been so long but I don't recall doing any counseling training when I did seminary” and when asked “Did you do any other religious training besides seminary?” Participant 2 replied: “Pastoral care and counseling.”

Participant 3 indicated that her:

> Background in counseling training [is a] bachelor's degree in psychology with a concentration in child psych and then, through seminary, I took about 15 credit hours under pastoral care and counseling, narcissism, PTSD and mood imbalances. Denominational training in the [African Methodist Episcopal Church Ministerial] Institute they also did pastoral care and counseling, but they related it to urban ministry. . . I feel PTSD is something that needs more professional, outside of what I as a pastor, minister can give. But I think at least knowing it's there, it allows people to take that first step. [My] medical training was a key factor in the counseling process. I always jokingly say I try not to diagnose my congregation (laughs) because sometimes I can see the struggle. I can—I can see when- when someone comes in heavy burdened…My [medical] training allows

> me to probably be a little bit more sensitive… helps me be a little bit more discerning and in tune to when individuals are dealing with things.

In regard to relevant training, Participant 4 added that she holds an MSED in counseling from a secular academic institution, however, she did not recall any counseling training within her seminary training nor her denominational training.

The training experienced by Participant 5 included:

> Pastoral counseling classes [in seminary]. I also took a year of Gestalt therapy as a practitioner. And also, neuro linguistic programming, which is also another type of framework for counseling and working with people. So, I both have practitioner certifications in those [areas]. Participant 5 further included, at the denominational level of training, "there was one time we had a mental health professional come to our church, but it wasn't part of the denomination. It was something we did on our own. Participant 5 expressed the sentiment that:
>
> the denominations and the seminary do not equip ministers to do this…We're not equipped. We're not equipped. Because we're dealing with our own trauma. And you got traumatized people trying to heal traumatized people**,** and so we don't realize it that those constructs have to, not only be lifted up, with support of information so we can deal with this. So yeah really lack this stability to deal with this.

Participant 6 stated that her training started with her academic schooling.

> So, the first official training program was school [with a Masters' Degree in] Psychology [then] continuing education courses and a PhD in marriage and

> family counseling. Seminary training, that was a while ago. Pastoral care was a year; a year's course. And I think that was it, in terms of counseling.
>
> Denominational training at the Ministerial Institute, there was one course, um, not specifically in counseling, more in personality and self-assessment, and awareness of the self and the development of the self. So, I would say at least a year's course.

Also addressing the issue of mental health training, Participant 7 stated:

> My background really comes a lot with my secular job as a, um, principal working in a mental health facility. I work with, um, children who have actually experienced PTSD. A lot of post-traumatic stress, kids with bipolar disorders, students with suicide and depression ideation. Um, so a lot of my counseling background comes from that as well as being a minister for many years, um, through the A.M.E Church. Um, I believe I had a foundation in some counseling there, as well. I don't recall any specific counseling in my seminary training. [In] denominational training I know that from 1990 to about 1995 we had to sit through a training to become an A.M.E minister. Some of the classes that were taken during that time, they were some counseling, um, related classes, but a lot of it had to do also with a lot of biblical studies.

Participant 8 elaborated that his counselor's training experience included:

> one semester in counseling in seminary training and then, as a [United States Navy] chaplain I attend several training courses that gave me some expertise analysis on different issues, including PTSD, and then finally a one-year residency in clinical pastoral education. [From the] chaplain perspective, I've had

> more extensive training, workshops, and like yearly training on the issue, and from time to time, maybe hour and a half, two hour half. . . 2 hour long training over a period of 10 years, so roughly give or take about 2 hours yearly. Denominational training, None.

Theme 2: Establishing A New Normal

The second theme derived from data relative to the first research question was clergy sentiment and opinion that the symptoms of PTSD are never really *"healed",* nor will the individual revert back to the affective and cognitive state of mind they possessed prior to the event. Participant 1 expressed the sentiment that:

> "they'll never get past the event [i.e., traumatic experience]. The best thing we (i.e., clergy) do for people exhibiting PTSD symptoms is to sort of create for them a new normal, a new acceptance of their new reality. The fact is you can't go back, right? But you can be a part with us in fellowship and community; create what's a new normal."

In regard to proceeding through the recovery process, Participant 2 went on to say:

> "Although they experienced that trauma, that they can look back over their life now and see that it worked out for their good. That God was at work in the midst of it. And, how they've overcome it. . . not overcome it but they learn how to deal with it because the more we talk, you can still sense and feel as if they're back in that situation."

Participant 4 indicated that her congregant “still gets triggered, you know, once a year, but it started off as, you know, that date [of the incident], she'd start crying 2 or 3 weeks before that.” Participant 4 elaborated:

> She's still, still a mess over it. But at least now she's talking through it and she knows that she can't stalk him on Facebook to see if he's finally in jail because he'll probably never go to jail. I think she's growing, and some things have fallen back, but not to the level of when, when she first came here. I think she could be doing better if she was [still] here, or anywhere. She's not in church right now.

Participant 4 concluded that:

> PTSD is not going away...it will forever affect their life, how they transfer that to others, how they, um, how they impart that when they see certain things, or when the trauma is being relived in other people's experience... is something that they will have to live with forever; however, again, I think the norm, or if there is any norm in their life besides family, is Church...Because it's a place where they...they receive strength, it's a place where they can be in touch with God ... and just lay it all down if you will.

Theme 3: Relevancy of Religion and the Black Church

The third theme derived from the data relative to the second research question was the relevancy of religion and the Black Church to the PTSD symptom management process. Participant 1 expressed the opinion:

> that there is uh, something to consider, an undercurrent that all African Americans suffer from PTSD as it relates to our slavery. I don't think that we

> should ever not recognize the full impact that that has had on our community generationally. So, I do get the focus of the study in the context of um, violence, um, sudden deaths, etc., etc., etc., and I think while that compartmentalizes, I do think that there is something to be said about the um, the generational effects of that trauma. . . But I'm saying there is still cause and effect, because most people probably even right now, particularly in the African American community, have learned how to live with it. And, uh, that leans, I think, towards why. . . and the church. The black church has always been the way they could go, where they could go in the absence of everything else.

Expressing the feeling on the relevancy of religion and the Black Church, Participant 4 indicated that:

> Church is needed, God is needed, everything that we do on a Sunday morning, if they don't show back up until Sunday morning, it's desperately needed. Because black folk aren't going to counseling, all for the reasons you said. I don't wanna pay that co-pay every week, or worse yet they don't have insurance at all, um they don't want people in their business, um you know, they don't wanna feel like they have a mental illness. Um and so church has become all of that, even if they're not um saying anything. it's funny because with all the stuff with the, you know, the failing churches and um pastors doing stuff they're not supposed to be doing and all of that, um you know, people are asking the question, should the church still exist? I'm like, it has to. Without the church, and seriously, where would black folks be. Even if I can't, assist them in their, in that work, church is it. We would

> be really messed up. If we didn't have Jesus as a savior, someone who we could look up to, out to, whatever, inside, um to, I don't know where we would be.

Participant 5 further elaborated on the relevancy of religion and the Black church by stating:

> And so, the reality is, is that the church has always been the place that we have come to pray it out, shout it out, wail it out, what have you, but not recognizing that we now are in trauma. That this is what this is.

Participant 8 shared his experience related to the relevancy of religion indicating:

> One of things we do when we are deployed with marines or sailors, uh, is to have. . . a quick five-minute word, and those are the kind of people that were like, "Hey chaps, you know, I'm going on the, you know, I'm, uh, I'm, uh, going on a patrol, I need a prayer before I go, um, because they. . . while they trust their [military] training, they know they need God's protection to help them go [through] stuff like that. So, definitely, uh, faith will forever be a permanent part of, um, their process, um, because it is a process as well, and um, and I think that, you know, there are other people that own pieces of it, the, you know, the psychiatrists, and the counselors, um, but they have made their stake, and their claim on God. No one asked them to do that. Uh, they chose to do that, and they choose to do that because they know how important faith and God help them, and it's more than just an emotional exercise. . . something in, um, spiritually is going on inside, that is. . . that he- [God] that helps heal the physical, emotional, and psychological pain and that, um, doctors and stuff can't do.

Theme 4: Purpose-Centered Trauma

Purpose-centered trauma, defined within the parameters of this research inquiry, is a traumatic event by which the victim perceives that the experience will serve a greater benefit. In this investigation, purpose-centered trauma was associated only with the construct of meaning-making. The theme of purpose-centered trauma was identified through statements made by four out of the eight participants.

Participant 4 stated that her parishioner:

> definitely found a bigger, a purpose out of it, and even wrote a book about it. Um and so she feels that she is now called to work with women who have been through PTSD, or at least shared her experiences with that...she's also started coaching women who have been through some type of traumatic experience. So she's also thought about doing chaplaincy work in the hospitals as well, which to me is like [a] big deal but just the thought that she's thinking about it and is gonna put herself into those types of situations where she's gonna have to think about things of her past.

Relative to purpose-centered trauma, Participant 6 indicated that:

> the outcome, in terms of finding meaning, has been "I'm a better person. I grew closer to God." Without attributing the incident to divine providence, it's almost as if God is with me in every circumstance, without saying God prescribed this for me. And this is someone who is still battling the symptoms, yet in the midst of it, helping other veterans. Creating avenues for them, um, and that's how he copes.

Participant 7 further indicated that the parishioner found a need to "help other women who may find themselves in the same situation". Participant 8 conferred that "he (the parishioner) can now reach his Marines who are young or who are going through the same shame…"

Theme 5: Divine Personal Encounter

The theme of divine personal encounter emerged only within the construct of closeness with God and among the data collected, three participants indicated that divine personal encounters with God were associated with an individual's ability to manage symptoms of PTSD.

Participant 1 observed the congregant's attempt to get closer to God through the action of

> Coming back to hear God; [the God] that they were introduced to; [the God] that they met. There is something that compels them to keep coming, because the help that they need, and the closeness that they feel with God is something that is working for their good.

Participant 5 further reflected on a congregant's divine encounter

> Thinking of a situation with one of our members who was in a physically abusive, domestic violence situation with her spouse and how she woke up one morning and her husband had a gun to her head and was threatening to kill her. Um, and, and the part in which she started praying…and he kept telling her to stop praying and then as she continued to pray, he put down the gun. Um, and she was able to get away from him. So, she looks at that as…Her epiphany was, that through her prayer, that God was there and protected her. That she would believe that if she

had not been praying, um, that he would've pulled the gun; the act of prayer [to God] deterred him (*the assailant*) [from further assault]".

Relative to this theme**,** Participant 6 further indicated that the parishioner utilized the common activity of fishing to manage PTSD symptoms, indicating that it was a means of communing with God. "Gets up early in the morning. Takes walks and is finding peace, in his spiritual practices, which he really had put aside until he really could not manage the [PTSD] symptoms". Participant 6 also indicated that "[PTSD] symptoms sort of, kind of did push him to seek God more personally."

Theme 6: Active Divine Presence

Data drawn from the research participants revealed some level of active divine presence in various areas of daily life as well as personal growth and development. The theme of active divine presence emerged within the religious construct of closeness with God as well as the construct of empowerment and regaining control. Participant 2 stated that one parishioner is "still learning how to allow God or religiosity to guide them along [through the process of healing]" yet they "see and can acknowledge God in the midst and how God has worked and [is] still working that situation out for them." Participant 5 indicated that the parishioner believed "God saved her life when she was willing to die." While these statements inferred a degree of positivity in relation to God's active involvement, Participant 3 noted that a parishioner indicated a negative encounter stating that "there's a part of her that she thinks blames God" for her suffering [trauma].

Theme 7: Divine Reliance

According to data, the theme of divine reliance emerged within the management of PTSD symptoms and was most closely associated with the religious constructs of closeness with God and empowerment and regaining control. Divine reliance was present in statements such as:

> so, in terms of the anxiety, in terms of the worry, in terms of recalling the situation, prayer and the comradery is what helps her, so she goes to God and because of it; she goes to God more [frequently]. (Participant 5).

Relative to divine reliance, Participant 8 also suggested that it:

> would be foolish to say that medication doesn't play a part, but for a person like him [the parishioner], because there are days when I have to ask him "Hey dude, did you take your medication?" but he'll go back to the old spiritual [perspective]. . ."if it had not been for the Lord on my side" or "we have come this far by faith..." Yes, the doctors play a role, but it's God that's keeping him.

Participant 8 also concluded that:

> faith plays a very important part in his (the parishioner's) life and because faith is the center of his life, God is the source. God is the person that ties everything together; the progress [in] his ability to deal with PTSD or cope with PTSD is God because again, he has his good days and his bad days, and I've seen both of those days.

An opposing perspective of struggle with divine reliance emerged in Participant 3's statement that a congregant struggled in her faith and blamed God for some of the negative events that occurred.

Theme 8: Use of Rituals

As previously indicated, the use of rituals was one of only two emerging themes associated with all four religious coping constructs. The use of rituals theme was also identified in most of the participants' responses (6 out of 8 participants). Participant 8 expressed the sentiment that "ritual is the Black Church experience". While Participant 1 indicated that the attendance of "worship services" and "religious practices (i.e., prayer and reflection)" helped and were relevant to symptom management, Participants 1, 2, and 7 all indicated that the reading/studying of focused biblical scriptures relative to a specific struggle (i.e., trust, forgiveness, imprisonment) were important components of the process of management. Participants 1 and 5 were of the belief that being active in 'community' further assisted the management of PTSD symptoms.

Participant 1 expressed the sentiment that:

> They all come and they're part of a social network. There is involvement in the ministries. Find your place, the things you're good at. You are involved in the life of a community and you can see what benefit you are bringing. The best thing we do for people exhibiting PTSD symptoms is to sort of create for them a new normal, a new acceptance of their new reality. The fact is you can't go back, right? But you can be a part with us in fellowship and community create what's a new normal.

Relative to the need to use rituals in symptom management, Participant 5 observed that:

> They cannot get past their PTSD. They can't get past the loss of that grandfather, passed the loss of that divorce. . .there [are] folks that come into the church that

> are just here because they've always been here, and they may know how to serve. They don't know the relationship part. And the thing about Post Traumatic Stress Disorder is, you gotta do this in community. It’s gotta be, you know, with a deeper relationship with God, but our relationship with God, even though to some extent it's individual, but in many extents it's not. Because God didn't create us to be, you know, just individual, but he created us to be a community. Because it's the people that recognize your calling, it's the people that affirm us and so, for those that utilize those constructs and I think those are excellent, but those who utilize constructs, they're able to get through those valley moments experiences. It's what helps them manage. For those who don't, they stay stuck. And sometimes just regress. And they can't get through it. . .

Beyond the conventional components of religious rituals (church attendance, prayer, scripture reading, etc.), Participant 4 indicated that rituals could also be personalized to the individual:

> So, her ritual was, she actually took pictures, I thought it was brilliant. Took pictures from different parts of her life when she was younger and a teenager, when she started having all these issues with her parents, and her issues with the church, and then [the] time she became anorexic… So [for] these very big monumental times, she had a picture. And I don't really remember exactly what we did, but I know we took all of her pictures, went to the altar, she laid them out, she also had some [items] like her bible that she had as a child, her bible now, bookmarks that special people had given her. Actually, that was the other part of

> it, people who had helped her and who had given her like items to help her through, they were all laid out and her favorite scriptures. We actually read scriptures; it was, it was strange, but it was almost like a deliverance service, but very, like um, non-emotional if you want to put it that way. She, we burned candle, a candle, lit a candle for her life, her new life, so forth and so on and that she was able to actually let go of some stuff. . ..

Theme 9: Safe Environment

A safe environment emerged as a common theme in association with the management of PTSD symptoms and was associated with the religious coping constructs of closeness with God and closeness with others among the participants' responses. In the context of this research, a safe environment allows a person to be open and transparent to reveal and express struggles, fears, and emotions without the fear of criticism, ridicule, and judgement.

Participant 1 expressed that:

> In terms of religious coping here in the church, our prayer time is really specific to allowing people to kind of face that reality, but in a safe environment. Where they're not judged. And we try to create a non-judgmental presence while at the same time trying to help preserve their dignity, because as you know, most of the time I think people who suffer from PTSD, they have a hard time [and] they're triggers that cause them to revert, if you will to, to a reality that's not really theirs in the moment. And so, keeping them in the present while helping them see that there is more to them, and preserving your dignity is where my experience is in

> the religious environment. They are most happy in, in the community of where they're worshiping and serving and being vulnerable and feeling the freedom to cry when they want to cryand to scream or, and, not be judged by it.

Participant 3 stated:

> we actually have a support group that really grows out of some of, the parishioners trying to deal with, um, childhood traumas, um, marital discord, grief, um, over a loved one. So, it was really identified as a need in the congregation, so the support group was developed.

Participant 8 suggested that "Church is one of the only place[s] where he (the parishioner) feel[s] that he doesn't need to have his guard up". Participant 8 further indicated that remaining in "the environment of the [Christian] believers. . . that's still helping him (the parishioner) to continue to process what he's going through." Furthermore, Participant 3 felt it necessary to create a safe space, even for the parishioner who finds herself "wrestling with her faith in God"; wrestling with her feelings of blaming God for 'allowing' the traumatic experiences to occur.

Theme 10: Forgiveness of Self, Others, and God

The theme of forgiveness was yet another significant theme found in relation to the management of PTSD symptoms. The theme of forgiveness was the second of only two themes associated with all four religious coping constructs. Participant 1 indicated that several parishioners "blamed themselves" and struggled with "their inability to forgive themselves for what has happened to them", while the parishioner of Participant 3

struggled with the process of blaming God for the trauma that occurred and admitted that she's wrestling with her faith in God. Participant 7 described an incident of a woman:

> who grew up in her home, continually raped by her father. It was coming out to church on a regular basis that, one day she, she finally, um, learned how to forgive him, and that was her release; that's what gave her freedom. She works very closely with me now in women's ministry, but, um, the religious coping piece definitely came out of, um, finally being able to, um, release what happened by forgiving him and she learned that through church [experience] and one-to-one.

Participant 7 further indicated that the parishioner obtained spiritual freedom when she "learned how to forgive him [her assailant]" and suggested the "forgiveness was a real piece in her being able to move forward [from the traumatic experience]."

Research Question 1

Ten primary themes emerged within this investigation. Relative to the first research question which focused on clergy experiences, the three themes derived from the data included (a) relevant training, (b) establishing a new normal and (c) the relevancy of religion and the Black Church. While each of the 8 participants made reference to the degree of relevant mental health training available at the denominational (church) level, four of the eight participants made mention that religious constructs help to establish a "new norm" of coping. Four out of 8 participants made reference of the relevancy of religion and the Black Church to the management of symptoms caused by PTSD and mental health, in general.

Research Question 2

Of the 10 emerging themes, seven themes were associated with the second research question which focused on the ways in which the religious coping constructs were exhibited. While no one emerging theme was associated with all 8 participants, 5 themes (i.e., divine personal encounters with God; active divine presence, divine reliance; safe environment; and forgiveness of self, others, and God) were each associated to the responses of 3 participants, The theme of purpose-centered trauma was identified through statements made by 4 out of the 8 participants; and the use of rituals was associated with 6 out of 8 participants.

Discrepant Data

Discrepant data drawn within the context of this research were identified as significant statements or sentiments relative to religious coping constructs or data which could not be further translated into a theme due to the lack of connectivity with other research participants' statements and sentiments. According to Plunkett (2014), the "Black Church" has historical significance as a primary source of help and support in relation to addressing mental health issues; however, only Participant 1 mentioned that "the black church has always been the way they could go, where they could go in the absence of everything else [other mental health resources]. . ." In another significant yet uncorroborated statement, Participant 3 was the only participant to identify a congregant that "struggled in [her] faith" about seeking secular (i.e., medical, clinical) mental health assistance. Furthermore, relative to the construct of closeness with God, this same

congregant was also the only example of a congregant who blamed God for the trauma they experienced. Through the process of healing, Participant 3 indicated that:

> the interesting thing she said is, she needed to understand her place, um, with God as a result of the things that happened to her. She, um, she said there's a part of her that she thinks blames God. But then, um, there's another part of her that really. . . she's wrestling with her faith in God. . ..

Evidence of Trustworthiness

The degree of trustworthiness established in a research study can ultimately affect the degree of validity and rigor of research data. The degree of trustworthiness of qualitative data is guided by creditability, transferability, dependability, objectivity, and confirmability. To increase the trustworthiness of research data collected, the following steps were taken.

Credibility

To sustain the credibility (internal validity) of collected data, several strategies were implemented. First, a clergy member with enough expertise and experience in secular and religious mental health counseling and in the management of PTSD-related symptoms reviewed the interview guide to ensure that each interview question was clearly associated with the overall research objectives. Second, before each interview, a clear and concise summary of the research topic was read to all participants to ensure they had a clear understanding of the research topic and objectives. Thirdly, on average each interview lasted approximately 35 minutes in length; however as designed, 1 hour was allocated for each interview to ensure that sufficient time was given to each

participant to manage any unforeseen occurrences or address any unforeseen questions that arose. One hour was also sufficient in order to remain respectful of the participant's schedule and reduce frustration of a lengthy interview process.

Transferability

To decrease potential difficulty of transferability or data comparison among future and diverse populations, a structured interview guide was utilized to ensure that the same baseline of inquiry was pursued with each research participant (Patton, 2015). The use of a structured guide would allow for future research possibilities of varying populations yet be guided by the same interview parameters.

Dependability

The dependability of data was addressed through the process of member checking. Within 72 hours of the conclusion of each interview, a typed and recorded version of the interview was reviewed by me as well as the participants to confirm for accuracy and corrections. A response was received from each participant and corrections, if any, were advised and made accordingly.

Objectivity

As previously disclosed, as an ordained minister, I have acquired a certain degree of knowledge and experience in relation to the presence/absence of religious coping constructs in various areas. However, to preserve the trustworthiness of collected data, during the interview process, I refrained from expressing any professional and personal theological responses, reflections or insights as discussed by Patton (2015). Strongly

maintaining the position of researcher, data analysis was performed strictly within the context of interview responses only.

Summary

The focus of this phenomenological investigation was to explore the absence or presence of religious coping constructs within the management of symptoms related to PTSD among African American Christians through the lens of ordained clergy members. A total of 8 clergy members, male (n = 2) and female (n = 6), with varying degrees of denominational, secular, and seminary counseling training participated in this research by answering a series of open-ended questions related to their counseling training background, experience related to counseling parishioners diagnosed with PTSD, and their personal observations on the presence or absence of religious coping constructs within the management of symptoms. Within this investigation 10 themes emerged and were identified in this chapter.

In Chapter 5, I present the findings within in the context of religious coping theory, a comparison/contrast reflection based on previous research as well as implications for social change and recommendations of future research areas.

Chapter 5: Discussion Recommendations, and Conclusion

Introduction

The purpose of this phenomenological study was to explore the presence or absence of religious coping constructs in relation to the management of PTSD symptoms among African Americans within faith-based environments. Among varying ethnic groups, it has been documented that African Americans experience higher rates of PTSD diagnoses related to traumatic experiences (Alegria et al., 2013; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011) as well as lower rates of recovery from PTSD than among their ethnic counterparts (Pérez-Benítez et al., 2014). Furthermore, previous research indicated that African Americans were more likely to utilize faith-based approaches to address mental health issues rather than medical or clinical approaches due to a mistrust of medical and clinical institutions, cultural insensitivity of conventional mainstream resources, and various financial limitations (Barlow & Comas-Díaz, 2014; Hankerson & Weissman, 2012; Hays, 2015; Williams, Gorman, et al., 2014; Williams, Malcoun et al., 2014).

Given the percentage of African Americans who proclaim some form of religious affiliation (78%; Pew Center, 2009) and the strong gravitation towards faith-based approaches, I recognized the need to explore this issue through the lens of ordained clergy members who had previous experience counseling congregants in managing PTSD symptoms given that clergy members are often the first point of contact when addressing mental health issues among African Americans (Williams, Gorman et al., 2014). The research decision to utilize clergy members allowed me to draw data from faith-based

counseling professionals in the same manner as medical and clinical data are drawn from medical and clinical professionals.

Ten relevant themes materialized from this investigation. As speculated, several of the findings coincided with previous research findings as well as produced new insights relative to religious coping and the management of PTSD symptoms within faith-based environments. The implications of these findings have the potential to influence: (a) the manner in which mental health issues are addressed in faith-based environments as well as (b) the manner in which faith-based institutions are considered as viable resource options in the management of PTSD symptoms.

Relative to the first research question which focused on clergy experiences, this investigation identified clergy members' experiences relative to obtaining relevant training, the establishment of a new normal, and the relevancy of religion and the Black Church in PTSD symptom management. Relative to the second research question which investigated if and/or how religious coping constructs were exhibited during symptom management, seven themes emerged including: purpose-centered trauma, divine personal encounter, active divine presence, divine reliance, the use of rituals, forgiveness, and safe environment. In this chapter—based on data collected from a purposeful sample of 8 ordained clergy members within the African Methodist Episcopal denomination—I present my interpretation of the findings, the limitations of the study, recommendations for future research, and implications for positive social change.

Interpretation of Findings

From a religious coping perspective, the results of this investigation uncovered several indirect and direct themes associated with religious coping relative to the management of PTSD symptoms. The sufficiency of counselor's training, counselor's ideology of treatment outcomes, as well as a community sensitive to cultural ideologies can have an influential impact on the process of symptom management. More so, personal interactions with a higher power, having an influential support system and environment, and a willful resolve to address internal conflicts were found to be present and influential characteristics of symptom management from a religious coping perspective. The interpretation of these findings is discussed further as identified by specific theme.

Theme 1: Relevant Training

In the counseling process of symptom management, the skill-set of the counselor occupies a significant role. Given that clergy members are often a first point of contact to address mental health issues in faith environments, the concept of relevant training in relation to mental health assessment and counseling manifested as a critical need to the counseling process. Previous research conducted by Hall and Gjesfjeld (2013) highlighted clergy members' apprehensions towards addressing mental health issues due to a lack of confidence in their own education, training, and experience skill set relative to addressing mental health adversities. Concurrent with Hall and Gjesfjeld's findings, the findings of this study reconfirmed through clergy members' admission, that they had not obtained a sufficient degree of relevant training, at the denomination or church level,

necessary to thoroughly assess or actively address adverse mental health issues. The need for properly trained clergy members is imperative given that 2 out of 5 pastors experience severely mentally ill persons among their congregants, 2 out of 3 clergy members counsel congregants with suicidal inclinations, and 10% of religious/spiritual counseling interventions are crisis related (Payne, 2014). In contrast, Payne (2014) investigated the impact of secular educational experiences vs theological educational experiences of 204 Protestant pastors and found that while secular experiences had an impact on depression treatment outcomes, theological experiences had no significant impact. Further research is needed to examine this finding in the context of PTSD.

Theme 2: Establishing A New Normal

The counselor's ideology of treatment outcomes was grounded by clergy's opinion that the symptoms of PTSD would not be fully healed yet religious coping constructs were significantly present in the development of a new normal of symptom management. While prior research included the etiological and theological ideologies of clergy members, the present study further conveyed the personal opinion of clergy members that the symptoms of PTSD do not fully "heal"; that the cognitive function of individuals is not fully restored to the same state of mind prior to the traumatic experience. Contrary to clergy opinion on treatment outcomes, Spoont et al. (2015) argued that the symptoms of PTSD could very well improve even in the absence of treatment or progress to a chronic state if treatment was withheld.

Clergy members felt that, although the symptoms of PTSD do not completely cease from existing, the symptoms can be managed with some degree of success utilizing

religious activities essential to the management of PTSD symptoms. This is a significant finding given that help-seeking, decision-making attitudes as well as the services and resources provided within a faith-based environment are highly influenced by the ideology of clergy members, spiritual leaders, and church doctrine (Plunkett, 2014).The counselors' ideology of treatment outcomes ultimately have the potential to impact and effect the type or degree of support that will be extended to congregants seeking assistance with symptom management.

Theme 3: Relevancy of Religion and the Black Church

Cultural insensitivity has been found to be a primary cause for refusal of conventional treatments among African Americans (Barlow & Comas-Díaz, 2014; Williams, Malcoun et al., 2014). Supporting this finding, clergy members' views on the relevancy of religion and the Black Church were positively affirmed in the sense that they admitted to and agreed with the effectiveness of medical and clinical interventions for symptom management; however, 'God' would be the ultimate healer of their trauma or affliction. Current clergy members' opinions validated previous research findings that suggested religion/spirituality and religious institutions, specifically the Black Church, are viable components of a holistic approach to symptom management (Bryant-Davis & Wong, 2013). Although the results of this study did not conclude that participating clergy members felt it was their responsibility or obligation to address mental health issues, they did feel the need to be prepared in the likelihood a mental health case or crisis presented itself. The relevancy and significance of religion and the Black Church was further affirmed as necessary given that a vast percentage of secular mental health practitioners

may not be sufficiently trained to address religious beliefs or spiritual needs (Bryant-Davis & Wong, 2013). Conversely, further research is necessary to investigate potential religious efficacy bias that may occur due to clergy members' strong religious convictions.

Based on the findings, I concluded that the use of both secular and religious/spiritual mental health interventions are a beneficial approach to address mental health issues among individuals who were actively practicing their religion. Payne and Hays (2016) and Smietana (2014) argue that clergy members and local churches have a responsibility to address mental health issues among their parishioners whether by direct counseling interactions or by coordinating and collaborating with clinical practitioners as a part of the treatment process. Although previous research indicated the growth of religious/clinical collaboration was not rapidly increasing (Hall & Gjesfjeld, 2013), the participants in this investigation were open to the possibility of collaborative efforts with clinicians.

Theme 4: Purpose-Centered Trauma

Purpose-centered trauma was identified as a traumatic experience by which the victim perceived said experience as having purposeful benefit that extended beyond negative traumatic impact (Lundmark, 2016). During the religious coping process, an individual will try to formulate a meaning, make sense of, or attribute the traumatic occurrence to a greater Godly purpose (Van Uden and Zondag, 2016). Within this study clergy reported that Godly purpose manifested in the form of the congregants' increased desire to assist others to overcome the same or similar trauma; by authorship (i.e., wrote a

book); personal coaching; and spiritual growth and personal improvement. Study findings indicate that, by reframing the traumatic experience within the context of having a greater Godly purpose, it could mitigate internal turmoil and reduce the feeling of senseless suffering. During this investigation, purpose-centered trauma was found to be associated with the religious coping construct of meaning-making. This association further validates the assertion by Van Uden and Zondag (2016) that meaning making is embraced during the process of cognitive and emotional reconciliation of traumatic occurrences. More so, the cognitive reframing process that occurred during the reconciliation process associated with purpose-centered trauma was also in alignment with the view by Brelsford et al. (2015) of emotion-focused coping which assists the survivor with coming to terms with the trauma and reframing the adverse thoughts of trauma in a more positive way.

Theme 5: Divine Personal Encounter

Previous research discussed divine interactions between the trauma survivor and a higher power within the realm of religious coping (Lundmark, 2016). The results of this investigation further defined these relational interactions in more specific terms such as divine personal encounters, the existence of a divine presence, and the benefit and protection of divine reliance. Clergy members indicated that their congregants' divine personal encounters with God manifested in such acts as "meeting", "being introduced" or "hearing" from God; experiencing divine intervention from a harmful and dangerous situation, and; communion with God within everyday activities. Experiencing divine personal encounters, specifically during the process of symptom management, offered a degree of comfort and relief to the congregant, fortifying their belief that a benevolent

God personally intervened and offered protection from a dangerous situation; that God personally took the time to care for them and offered comfort during painful situations. This finding suggests that the idea of experiencing a divine personal encounter could mitigate some of the harmful effects and damage associated with trauma experiences. This is consistent with the argument made by Pargament (1990) that this degree of personal relationship with a benevolent God was associated with positive health outcomes and achieved greater degrees of success in the reconciliation of abusive incidents.

Theme 6: Active Divine Presence

Further elaborating on the concept of divine interactions during the process of symptom management, clergy members perceived that, while active divine presence was displayed in congregants' acknowledgement that God is a guiding force that is present during the process of healing and that God is the performer of life-saving actions. Conversely, clergy members also recognized that an active divine presence was also associated with blaming God for the lack of prevention or protection from trauma suffering. While the application of religious coping has proven to have positive health associations, negative associations are also feasible including poorer mental health status (Brelsford et al., 2015). From a negative coping perspective, blaming God for the lack of prevention or protection is in direct conflict with the construct of empowerment and regaining control given that under the perception of this concept an individual has the expectation that God has control and influence over and above all human situations and circumstances (Pargament, 2000).

Theme 7: Divine Reliance

The third finding relative to divine interactions was the concept of divine reliance. The management of PTSD symptoms such as anxiety and recall were associated with divine reliance and the confidence that God can be sought after for comfort when symptoms were present. Divine reliance was also manifested in the clergy's admission that, in some cases, pharmacological treatments were necessary for symptom management, however, clergy believed faith in God was the primary source of coping and management. The results of this study placed the participating clergy members collectively midpoint on the Payne and Hays (2016) belief spectrum indicating that the etiological source of mental health adversity is neither fully spiritual nor fully medical/biological; however, study results also indicated that, although a clinical/spiritual intervention is favorable and would be embraced, the religious/spiritual intervention is utilized most regularly within faith-based environments.

Theme 8: Use of Rituals

Within faith-based environments, Asamoah et al., (2014) identified the use of rituals in the delivery of mental health care services and Van Uden and Zondag (2016) further argued that religious rituals add value to the therapeutic and recovery process of mental health treatments. In this study, the use of rituals manifested in practices such as prayer, meditation, spiritual reflection, church attendance, focused bible readings, personalized activities, biblically based group support and varied in use among the identified congregants. Confirmed by previous findings, religious rituals are a primary component of mental health care within faith environments adding value to the

therapeutic and recovery process (Asamoah et al., 2014). Within the context of rituals, the implementation of religious activities allowed the congregant to connect and create a bond and closeness with God as well as with a group of individuals who were like-minded in religious /spiritual beliefs and who may have struggled with similar challenges and traumas. In previous studies, Johnson et al. (2016) and Iverson et al. (2013) agreed that the use of various religious activities such as prayer, focused Bible readings, faith, rituals, and social support were frequently used in the coping process; however, previous research did not indicate whether or not symptoms of PTSD could be fully overcome with the use of these activities.

Theme 9: Safe Environment

The concept of a safe environment was identified as an essential factor in the management process of PTSD symptoms. An analysis of the study data showed that a safe environment was closely associated with the concept of social support identified in previous research. However, through the personal insights specifically shared by clergy members, the findings further indicated that a safe environment was an environment in which an individual can be open and transparent to reveal and express struggles, fears, and emotions without the fear of criticism, ridicule, and judgement. This finding is grounded by the research of Hall and Gjesfjeld (2013) and Payne (2014) which found reduced degrees of stigmatization and a built-in trust system prevalent in clergy members/congregant relationships. Moreover, a safe environment was identified as one aspect of divine or human retribution from negative thoughts and feelings especially related to a sentiment that God was somehow responsible or did not prevent the trauma

from occurring. Relative to symptom management, a safe environment has the potential to enhance the psychotherapeutic approach of cognitive therapy, which helps to identify negative thought processes and explores cognitive restructuring and reframing (NIMH, n.d.).

Theme 10: Forgiveness of Self, Others, and God

Another conceptualization further identified within this study was the virtue of forgiveness relative to PTSD symptom management. Forgiveness was recognized in congregants' sentiments that expressed blame of self, the inability to forgive, the need to forgive the offender, the blaming of God, as well as receiving forgiveness from God. The reconciliation of blame is essential to the adjustment process (Gall et al., 2007) and should be reinforced in the symptom management process. Findings suggest an association between the individual's willingness to forgive or receive forgiveness and the ability to achieve positive symptom management outcomes. In cases where the congregant struggled with the act of unforgiveness, whether towards the assailant or towards God, the congregant also identified prolonged symptoms associated with PTSD including difficulty sleeping and re-experiencing the traumatic event. In a previous study which examined program recovery outcomes among veterans with PTSD relative to their degree of spirituality, an association was made between a veteran's capacity to forgive and recovery program success; however, additional indicators played a role in this association including the veteran's daily spiritual experiences, spiritual practices, positive religious coping, and organizational religiousness (Currier, Holland, and Drescher, 2015). In previous research, Reinert, Campbell, Bandeen-Roche, Lee, and Szanton (2016) found

that the positive virtues of forgiveness and gratitude mitigated the negative impact of adverse childhood experiences of adult survivors. Based on the present findings and previous research, I concluded that the exercise of forgiveness would further enhance the cognitive, behavioral, and affective treatment process of symptom management.

Themes in Association to Theory Constructs

Grounded by the theoretical framework underpinning this investigation, this study revealed insights and associations relative to the Pargament et al. (1998) theory of religious coping which hypothesized that an individual's spirituality and religious disposition should be considered within the context of the biopsychosocial analysis of mental health assessment in order to treat the whole person. Through this investigation I was able to identify and associate specific themes relative to the religious constructs of meaning-making of a trauma experience over the effects of the experience, finding comfort in closeness with God, finding comfort in closeness with others, and empowerment and regaining control, in varying degrees.

In general, these themes represented the channel through which the religious coping constructs were exhibited. For instance, while the construct of meaning-making was associated solely with purpose-centered trauma, and closeness with God associated only with divine personal encounter, two themes, active divine presence and divine reliance, were dually associated with the constructs of closeness with God and empowerment and regaining control. Moreover, the two themes identified as use of rituals and forgiveness of self, others, and God were found to be associated with all four religious coping constructs and the theme of safe environment was simultaneously

associated to closeness with God and closeness with others. Moreover, two themes, the use of rituals and forgiveness of self, others, and God, were found to be associated with all four religious coping constructs and present in the management of PTSD symptoms.

In summary, the presence of religious coping constructs in the symptom management process demonstrated how survivors of trauma attempted to mitigate the negative effects associated with traumatic experiences. The results of this investigation suggested that, during the symptom management process, survivors attempted to find significance or a greater purpose for their affliction; they found support, comfort, and internal strength in the establishment of a relationship with a higher power and attempted to find comfort in the reconciliation of intra- and interpersonal conflicts. Based on the research findings, the two most prevalent or utilized components of symptom management, within this context, was the incorporation of various religious rituals and the process of reconciliation through forgiveness.

Limitations of the Study

In this study, I explored clergy members' lived experiences related to the presence or absence of religious coping constructs in relation to the management of PTSD symptoms. Due to the passion and conviction clergy members have towards the perceived power and effectiveness of religious and spiritual treatment methods, I surmise that this study possessed a certain degree of religion/spirituality efficacy bias. This type of bias relates to a degree of perceived certainty that practices of a religious/spiritual nature would be innately effective in symptom management. Within the current research method, clergy members had the opportunity to discuss only one case. Barring time

limitations, if clergy members had the opportunity to discuss multiple cases, inquiries could have been made about different outcomes in order to explore if efficacy bias was present.

Another limitation of this study was the exclusive use of only ordained clergy members. Within the African Methodist Episcopal Church, there are additional ministerial personnel who hold non-ordained ministerial positions and may encounter and interact with congregants who are managing symptoms of PTSD. This group of non-ordained personnel are not under the obligation or requirement to attend seminary or follow the track towards ordination; however, in many cases they interact with congregants to the same or similar degree as ordained clergy members and have the potential to offer additional insights related to this issue. Because of the extensive access and interaction many of these ministry workers have with congregational members, the exclusion of their input lessens the opportunity to secure pertinent data relative to the presence or absence of religious coping constructs. Moreover, the influential yet perceived power and esteem attributed to the position of ordained clergy can oftentimes be intimidating to a congregant; hence, it is possible congregants may be more open and forthcoming with non-ordained ministry workers than with ordained clergy members and feel less intimidated to share their personal experiences related to managing PTSD symptoms.

Recommendations for Future Research

This study provided pertinent insights from the clergy perspective related to the presence or absence of religious coping constructs in the management of PTSD

symptoms. In this study, I found that the religious coping constructs of meaning-making of a trauma experience over the effects of the experience, finding comfort in closeness with God, finding comfort in closeness with others, and empowerment and regaining control were present in symptom management among religion-practicing African Americans but in varying degrees. Based on the specific results of this study, future research should include an investigation of potential religion efficacy bias through the exploration of multiple cases among each research participant. By examining multiple cases, researchers can investigate if clergy members' perceptions of religious efficacy are consistent among each case as well as explore cases in which clergy felt religious coping was not present or did not produce positive outcomes. Next, future research investigations should include an examination of religious coping constructs among other denominations to determine whether or not the research results are an isolated phenomenon within the A.M.E denomination. Additionally, future research should include an exploration of religious coping constructs and themes in relation to other mental health adversities including depression, anxiety, and substance abuse.

Implications for Positive Social Change

From a clinical perspective, African Americans are 1.5 times more likely to discontinue a prescribed treatment plan and 3 times more likely to not even initiate the process of treatment, despite being optimistic of treatment effectiveness and potential benefits (Williams, Malcoun et al., 2014). Furthermore, while African Americans consider clinical and medical interventions as less viable options due to varying financial constraints and a general apprehension to utilize these services, the use of interventions

grounded by faith, religion, and spirituality are more likely to be utilized. More so, an individual's faith and religious ideology has been identified as an influential and contributing factor in the decision-making process related to health. Over the past few years, the use of religious coping has become such a viable component in the treatment process that the American Psychological Association ethically mandates researchers, clinicians, and advocates to take into account a client's religious and spiritual beliefs when contemplating a treatment plan (Bryant-Davis & Wong, 2013).

Given that cultural insensitivity is one of the primary causes why minorities, especially African Americans, are less likely to seek mental health treatment from conventional mainstream sources (Barlow & Comas-Díaz, 2014; Williams, Malcoun et al., 2014), positive social change would include the improvement, reinforcement, and implementation of evidence-based counseling programming grounded by religious coping constructs within faith-based environments as well as in clinical settings. Whether as an independent effort or in collaboration with clinical specialists, there is a greater need for faith-based organizations to improve service-delivery to address the mental health adversities prevalent among its congregants. Moreover, given that clergy members are oftentimes the first point of contact for African Americans seeking assistance with mental health issues, it behooves faith organizations to implement mental health assessment training, especially at the denomination or church level, as a means of conducting more thorough assessments of the potential issues present before them. During the assessment process it can then be determined if the organization has the capacity or skill set to address the issue or is a clinical referral necessary. As a means of

initiating this social change, a report summarizing the findings and conclusions of this study will be submitted to the governing body of the African Methodist Episcopal Church for their review and consideration. It is the hope that the submission of this study will create an opportunity for me to present the findings to a broader group of A.M.E clergy and ministerial personnel not only in the New York City but in the tri-state area of New York, New Jersey, and Connecticut. Ultimately, the dissemination of these findings across multiple states could further expediate the process of broadening the faith community's awareness of it's potential to influence change in mental health outcomes.

Conclusion

The premise of this study was grounded by the fact that, although African Americans overall suffer less trauma experiences than their racial and ethnic counterparts, the trauma experienced by this population is more likely to convert into cases of PTSD. Given that African Americans are less likely to seek clinical and medical treatment for mental health adversities and more likely to seek faith-based alternatives (Hankerson & Weissman, 2012; Hays, 2015; Williams, Gorman, et al., 2014), it was necessary to explore the potentiality of utilizing faith-based organizations to address mental health issues in a greater capacity. Exploring the presence or absence of religious coping constructs allowed me to investigate whether efforts to address mental health concerns, specifically PTSD, in faith environments were religious-based or simply a secular means housed within faith institutions. This study revealed that religious concepts were pervasively utilized as a means of making sense of traumatic experiences; finding comfort and relief from pain, anger, worry, and unforgiveness due to trauma; reconciling

conflicting emotions and; regaining a degree of emotional and cognitive control. Given the prevalence of PTSD among African Americans and the desired mode of treatment, this study confirmed that religion and the Black Church continue to remain a viable and necessary part of a holistic approach to addressing mental health adversities and with necessary improvements, faith-based organizations can become primary partners alongside medical and clinical communities.

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Appendix A: Literature Search Terms

Post-traumatic stress disorder, African American
Post-traumatic stress disorder, African American, Faith-Based Institutions
Post-traumatic stress disorder, African American, Faith-Based Organizations
Post-traumatic stress disorder, African American, Faith
Post-traumatic stress disorder, African American
Post-traumatic stress disorder, African American, Church
Post-traumatic stress disorder, Interventions, Faith-Based Organizations
Post-traumatic stress disorder, Interventions
Post-traumatic stress disorder, Interventions, African American
Post-traumatic stress disorder, Interventions, Faith-Based
Religious coping
Religious coping, African American
Religious coping, African American, Interventions
Religious coping, African American, Interventions, Post traumatic stress disorder
mental health interventions faith-based
African Americans mental health PTSD interventions faith-based
African American, PTSD, interventions, faith-based
Post-traumatic stress disorder, interventions, faith-based organizations, African Americans
Post-traumatic stress disorder, interventions, African Americans
Post-traumatic stress disorder, interventions, faith-based organizations
Post-traumatic stress disorder, interventions, faith-based institutions
Post-traumatic stress disorder, interventions, churches
Post-traumatic stress disorder, interventions, churches, African Americans
Post-traumatic stress disorder, religious coping, African Americans, faith based institutions
Post-traumatic stress disorder, religious coping, African Americans
Religious coping theory, mental health, African Americans
Religious coping theory, mental health
Religious coping theory, post-traumatic stress disorder
Religious coping theory, post-traumatic stress disorder
Post-traumatic stress disorder, AA, religious coping

Race, ethnicity, trauma exposure
Race, ethnicity, trauma exposure, Post traumatic stress disorder
Post-traumatic stress disorder, clergy, coping
Post-traumatic stress disorder, African Americans, clergy
Post-traumatic stress disorder, clergy
Clergy, mental health treatment
Clergy, post-traumatic stress disorder treatment
Pastoral counseling, post-traumatic stress disorder
Clergy counseling, post-traumatic stress disorder
Pastoral counseling, post-traumatic stress disorder
Clergy counseling, post-traumatic stress disorder
Clergy counseling, post-traumatic stress disorder
Pastoral counseling, post-traumatic stress disorder
Clergy, counseling, post-traumatic stress disorder
Pastoral, counseling, post-traumatic stress disorder
Pastoral, counseling, post-traumatic stress disorder
Pastoral counseling, religious coping, post-traumatic stress disorder
Pastoral counseling, religious coping, post-traumatic stress disorder
Pastoral care, post-traumatic stress disorder
Clergy, pastoral care, post-traumatic stress disorder
Religious coping, post-traumatic stress disorder (not) veterans
Coping strategies, post-traumatic stress disorder (not) veterans
Religious coping, post-traumatic stress disorder, race, (not) military

Appendix B: Recruitment Approval

Re: Fw: Permission to recruit for dissertation participants
Barbra Talley

Reply all |
Tue 8/29, 3:10 PM
Lauren Wilson <pewilson.assistant@gmail.com>;
Hi Lauren. This is excellent news and thank you so much for the quick response. There are a few additional steps within the dissertation process that I must complete before the letter is submitted to the ministers so with that in mind, I will reach out to you and Elder Wilson when I receive final approval from the school's IRB. Please extend my thanks and appreciation to Elder Wilson!

Sincerely,
Rev. Barbra Talley

From: Lauren Wilson <pewilson.assistant@gmail.com>
Sent: Tuesday, August 29, 2017 3:02 PM
To: Barbra Talley
Subject: Re: Fw: Permission to recruit for dissertation participants

Rev. Talley,

Elder Wilson is not by a computer right now, but he has given me permission to accept it on his behalf. I will give him the letter to give to his pastors.

Yes, I give Rev. Barbra Talley permission to invite the ordained clergy members of my district to participate in her dissertation research study.

On Tue, Aug 29, 2017 at 2:29 PM, Barbra Talley <barbra.talley@waldenu.edu> wrote:
Good afternoon.

My primary target audience would be ordained clergy members that fit the research criteria would be considered as well.

Thank you

From: Lauren Wilson <pewilson.assistant@gmail.com>
Sent: Tuesday, August 29, 2017 12:19 PM
To: Barbra Talley
Subject: Re: Fw: Permission to recruit for dissertation participants

Good Afternoon Rev. Talley,

Would you like all pastors or all ordained clergy that includes pastors?

-Lauren Wilson

On Tue, Aug 29, 2017 at 11:33 AM, Barbra Talley <barbra.talley@waldenu.edu> wrote:

From: Barbra Talley
Sent: Tuesday, August 29, 2017 11:31 AM
To: pemewilson@gmail.com
Cc: ewol3@aol.com; btalley@moriahcity.org
Subject: Permission to recruit for dissertation participants

To: Rev. Melvin Wilson

Presiding Elder of the Brooklyn/Westchester District of the New York Annual Conference

From: Rev. Barbra Talley
Mt. Moriah AME Church; Ph.D. candidate, Walden University

Cc: Rev. Robert Lowe

Senior Pastor, Mt. Moriah AME Church

Re: Request for research authorization

Dear Presiding Elder Wilson;

Over the past three years, I've had the privilege of working towards obtaining my doctorate in public health with a concentration in community health. I am happy to report that I have completed all of the necessary course work and I am now in the process of working on my dissertation. The primary focus of my research is to obtain further insight on clergy experiences related to the use of religious coping in the management symptoms associated with post-traumatic stress disorder (PTSD) among church congregants. It is my hope and intention to increase the current pool of empirical-based data related to this topic in order to further support the development of sound empirical based initiatives and

more holistic approaches to the care of mental health crises within the faith-based community.

To move forward in the research process, I am seeking to invite the ordained clergy members of the New York Annual Conference to participate in the research study (See attached Letter of Invitation). In order to the begin the recruitment process, I must receive formal authorization from the governing authorities in order to solicit participation. With that in mind, I formally request your permission to invite the ordained clergy members of the New York Annual Conference to participate in this research study. I am confident that the results of my research will further benefit the faith community as well as the scientific community. As a formal acknowledgement to this request, please reply back to this e-mail request as either:

a. **Yes**, I give Rev. Barbra Talley permission to invite the ordained clergy members of my district to participate in her dissertation research study

OR

b. **No**, I ***DO NOT*** give Rev. Barbra Talley permission to invite the ordained clergy members of my district to participate in her dissertation research study

Elder Wilson, with all sincerity, thank you in advance for your assistance in this process. Beyond the purpose of dissertation, the results of this study have the potential to produce valuable information necessary to create sound and more holistic approaches to address mental health crises with the faith community. I look forward to your expedient response.

Sincerely,
Rev. Barbra Talley

Lauren Wilson, P.E. Melvin Wilson's Assistant
Phone: 914.363.0142
E-mail: PEWilson.Assistant@gmail.com
FB: www.Facebook.com/BWDNYC/

Appendix C: Letter of Invitation to Participate in Research

Date: _____

To: Ordained Colleagues of the New York Annual Conference

From: Rev. Barbra Talley, Mt. Moriah AME Church

Dear colleagues:

Over the past three years, I've had the privilege of working towards obtaining my doctorate in public health (concentration in community health). I am happy to report that I have completed all of the necessary course work and I am now in the process of working on my dissertation. The primary focus of my research is to obtain further insight on clergy experiences related to the use of religious coping in the management of symptoms associated with post-traumatic stress disorder (PTSD). ***At no time will you be asked to divulge any personal information pertaining to a congregant.*** It is my hope and intention to increase the current pool of empirical-based data related to this topic in order to further support the development of sound empirical based initiatives and more holistic approaches to the care of mental health crises within the faith-based community.

To move forward in the research process, I am soliciting your assistance by inviting the ordained clergy pastors and ministers of the New York Annual Conference to participate in this strictly voluntary research study. Eligible participants must: a) be an ordained clergy member; b) must be a protestant clergy member (no ethnic exclusion) who has pastored or ministered to predominantly African American adults and c) must have experience working with individuals who indicated a history of PTSD and was under your ministerial care. Please note that this invitation can be extended *(forwarded)* to clergy members beyond the New York Annual Conference and the African Methodist Episcopal Church (A.M.E.) who meet the outlined research criteria.

Please also note that I am working within a narrow time frame so an expedient response to this request is greatly appreciated. For those who meet the criteria and are interested in participating, please contact me at either barbra.talley@waldenu.edu or 347-885-4546 for more details outlined in the formal Letter of Intent.

In all sincerity, thank you in advance for your consideration and future participation in this research study. Beyond the purpose of dissertation, the results of this study have the potential to produce valuable information necessary to create sound and holistic approaches to addresses mental health crises with the faith community.

With sincerest thanks,

Rev. Barbra Talley

Appendix D: Interview Guide

Note: the following criteria have previously been established: all participants are ordained clergy within the protestant denomination; pastored/ministered to predominately African American congregations; reported having experience with extending ministerial care to persons diagnosed with PTSD.

IQ1: Describe your experience as it relates to the presence/absence of religious coping in the management of PTSD symptoms among parishioners under your ministerial care.

IQ2: How many parishioners with PTSD-related symptoms have been under your ministerial care?

IQ3: How many parishioners with PTSD-related symptoms are presently under your ministerial care?

Identify one case and:

IQ4: Describe if/how you believe a parishioner found meaning and significance in their traumatic experience. Based on your observation, how did the identified meaning and significance relate to religious coping?

IQ5: Describe if/how you believe the parishioner achieved empowerment and regained control over the experience. Based on your observation, were there any underlying religious means used to achieve empowerment and regain control over the experience (i.e., biblical scriptures, prayer, etc.)?

IQ6: Describe if/how you believe the parishioner exhibited finding comfort in closeness with God. Based on your observation, how did you observe this relationship in relation to the management of PTSD symptoms?

IQ7: Describe if/how you believe the parishioner exhibited finding closeness with others (social support). Based on your observation, describe the social support system(s) most commonly used and how did you observe them in relation to the management of PTSD symptoms?

Appendix E: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer: Cheryl Brown - Account Manager

During the course of my activity in collecting data for this research: *"Religious Coping and PTSD Among African Americans: Clergy Perspective"*, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. The researcher has the duty to report any criminal activity or issues of child/elder abuse to legal authorities.
3. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
4. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
5. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
6. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
7. I understand that violation of this agreement will have legal implications.
8. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: Cheryl Brown **Date:** 09/10/2018