# AFRICAN AMERICAN PASTORS' PERCEPTIONS OF THEIR CONGREGANTS' MENTAL HEALTH NEEDS

by

ELVERTA L. VASSOL

B.S., Kansas State University, 1994
M.S., Kansas State University, 1999

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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the

requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2005

# ABSTRACT

The purpose of this study was to examine the factors that influenced African American pastor's perceptions of mental health issues and to explore how those perceptions influenced the propensity of the pastor to counsel, consult, and or refer to mental health professionals. This study is divided into two parts. Part one examines the perceptions of the pastors and their beliefs about mental health. Part two concretized these perceptions by employing the Contextual Model of Family Stress as a guide for structuring the relationships between a pastor's perception and their attitudes toward mental health issues.

Data for this investigation were gathered from a sub-sample of African American pastors originally generated from a listing of churches throughout the country. Initially 300 locally based institutions were identified. A survey was mailed to the churches explaining the purpose and goals of the study. Nearly one-third of the pastors completed the sixty-one item questionnaire. Of those who returned the original questionnaires (102), nearly three-quarters were from African American pastors (73) all of whom were included in this study.

There were four hypotheses developed for this exploratory investigation: they examined the pastor's propensity to make mental health referrals; the tendency to spiritualize mental health issues; pastor's lack of support for congregants with mental health problems; and the influence of mental health training on the willingness to refer to mental health professionals. None of the hypotheses were directly supported.

The application and adaptation of the Contextual Model of Family Stress to how African American pastors perceived, utilized, and responded to mental health issues was

explored via path analysis. Overall, the final model explained 39% of the variance in why pastors chose to make referrals to mental health professionals.

The findings suggested that the African American pastors are concerned with the mental health of their congregants. Moreover, these pastors exhibited uncommon knowledge about mental health and displayed greater willingness to work with mental health professionals than originally believed. These findings reveal that African American pastors are in touch with their congregants on multiple plains—spiritual, soul, and body—three vital dimensions, according to church doctrines and beliefs.

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Approved by:

Major Professor
Farrell J. Webb, Ph.D.

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This is a process that I would not have ever in my life thought to accomplish. All of the glory I give to Jehovah and my Lord and Savior Jesus Christ, without His divine Will working through Dr. Webb, who is very detail-oriented, intelligent and diligent person, I would not have successfully completed my dissertation in a timely manner. Dr. Webb I am most grateful and I am indebted to you for your patience and time that you spent working me through this daunting process. I am grateful to Dr. Russell, Dr. Schumm, Dr. Stoney, and Dr. Warren for agreeing to be on my doctoral committee.

To my sample participants, the strong voices of African American pastors who were crucial to my completing this monumental task and to all of the pastors that returned the surveys… I am most thankful. Keep up the good work you are doing to help the people that you serve.

To my husband, Pastor Erick E. Vassol and our children (Erica, Tre'mon, Dan, Corey, Brandon, Nico and Precious) I am appreciative of the Lord Jesus for allowing each one of you to assist me in this undertaking at some level. Again, thank you and I love you all very much. I truly do have it all by having my husband, children, career, and ministry.

There is a cadre of people who were supportive of my endeavors including Bishop Clarence and Lady Wanda Williams, Pastor Angela P. Hollins, Prophetess Clara McAfee and Prophet Roland James, Sister Adeline Benson and the Living Word of Christ Fellowship Ministry-Kansas City, Missouri and many, many, others who cannot be named in this writing. These individuals are important African American people in my

Black church family that were always available to assist me with spiritual guidance and monetary support as needed.

I would also like to thank Mrs. Kathleen Greene, Director of Educational Supportive Services, Julie Peters Scott (my very helpful graduate assistant), ESS/McNair staff, and TRIO colleagues all over the country for their support and encouragement.

# PROLOGUE

Writing a prologue is generally not a part of the design for a doctoral dissertation document. Consequently, this prologue is provided at the recommendation of my doctoral committee to tell my story and help clarify the context, purpose, and reasons for pursuing this particular topic for my doctoral dissertation. I thought it necessary to put into words some of my life events with a few details to help readers understand my quest. I chose to conduct research for my dissertation on *African American Pastors' Perceptions of Their Congregant's Mental Health* because of the relevance to me and the connection I perceive is needed between the Black church community and the mental health field.

My parents and the Black church community were my first educators. As a child, I attended Sunday school and participated in church programs and activities with my father. I learned Bible basics, the importance of religion, and the traditions of the African American culture. Many Black leaders in the Black church have been and continue to be influential in my spiritual growth and leadership development. From this model I live my life and guide my seven children.

The pursuit of a college education was a goal I had wanted to achieve since I was a little girl. However, that desire had to be put on hold while my life took its course. As a teen-age parent, I completed my high school education within a traditional school system in a timely manner, in spite of the fact I was raising an infant son, with the help of an elderly aunt and uncle. Following high school, I got married and attended a local community college for one semester. After the birth of my second son, I took advantage of a free six-week training program to complete a certification as a Nurses' Assistant. Upon its successful completion, the hospital offered me employment as a Certified

Nursing Assistant. I was assigned to work where needed, but primarily on the psychiatric and geriatric units. I preferred the psychiatric unit, and my work experiences piqued my interest to pursue a career in the mental health field. My long-term career goal was to obtain a bachelor's degree as a registered nurse and work with patients admitted to inpatient mental health care facilities.

My family and I relocated to Manhattan, Kansas because of my Godparents offering us a better life with more opportunities in 1990. My desire to further my education was fulfilled by being admitted to Kansas State University and enrolling in the college of Arts and Sciences pre-nursing program. However, again life took its course, and I had to change my career focus to complete a Bachelor of Science degree in Psychology with the Psychological Technician option and a secondary major in Gerontology. After my undergraduate degree was completed, I immediately applied to the School of Family Studies and Human Services to pursue a master's degree in Life Span Human Development. Upon being accepted, and adding a graduate emphasis in Gerontology, I received a four-tenths time graduate research assistantship in the Center for Aging. My interest in leadership development led me to apply for a program called New Ventures in Leadership Partners for professionals of color developed by the American Society on Aging organization. I was chosen to receive a $6,000 scholarship sponsored by the Andrus Foundation to travel to select training sites around the country to develop my leadership and grant writing skills in the aging field.

Although graduating with my first master's was very gratifying, I still did not have the specific skills I thought necessary to do what my heart was calling me to do to work in the mental health profession. I then decided to continue my quest and applied to

the Marriage and Family Therapy Program (MFT) in the School of Family Studies and Human Services and was offered a slot in the program, which I accepted. The program was rigorous and it required me to study and practice in the field that I originally wanted to pursue. I completed the course work along with the 500 clinical hours needed to fulfill the program requirements, and graduated with my second master's degree with a specialization in Marriage and Family Therapy. The MFT program prepared me to provide appropriate counseling and collaboration with other social rehabilitative services and mental health professions.

Within nine years, I completed an undergraduate degree and two master's degrees. Pursuing a doctorate was not originally in my view. Applying to and being accepted in the Family Life Education and Consultation program was another welcome achievement for me. The ultimate achievement and final step in my journey is to complete this original work and implement the findings within the areas most needed.

Through out my academic career, I have been married twenty-one years, balanced the parental expectations of five sons and two daughters ranging in age from 12-26 years, worked full-time, assisted, and cared for newborns in my home, and coped with deaths of significant people in my life. In addition, I have weathered marriages and divorces of adult children, the arrival of six grandchildren, and taken on the responsibility of a full-time ministry and not to mention a myriad of other life altering events. Throughout all of this, my faith and the Black church have been there to push me through every finish line helping me to accomplish my goals and aspirations.

Considering the impact of the Black church on my life and in the African American community, I felt compelled to examine the influence of this institution on the

overall well-being of African Americans. Despite the Black church's strengths, I perceive a need for mental health expertise to be provided more effectively. It appears to me to be an area that is often overlooked, misunderstood, and not addressed in a manner that is relevant to the parishioner as an individual and the congregation as a whole.

The stage is set to apply my academic knowledge and personal experiences working with clients and parishioners to make mental health resources user-friendly in the Black church. My ultimate professional aspirations are to practice as a licensed marriage and family therapist working with adolescents and families, pursue a tenured-track professorship, and be available as a mental health consultant for faith-based organizations.

My dissertation is a direct result of my involvement in the Black church and the pastoral role my husband and I assume in a full-time, faith-based ministry in the Kansas City metropolitan area. Observations I have made regarding Black leadership's capacity to deal with mental health issues have led me to study the influence pastors have on mental health among Black parishioners in the church.

The uniqueness of the Black church is that it is a mass organization of a predominately homogenous group, based upon their racial and cultural predispositions. There is solidarity within this closely-knit group of resilient people. Based on my personal knowledge and experiences, mental illness is not a subject directly nor readily addressed in Black congregations despite increased attention given to the subject in the past few years. In fact, the attention to mental health is underexamined within the Black church. There is a need for valid and reliable research and evaluation about African

Americans for clergy and professionals to provide them with the tools necessary to assist Black churches.

In 2001, Dr. David Satcher, the United States Surgeon General at the time, provided a supplemental report on the mental health disparities between Whites and people of color. The report provided a clarion call for professionals to do a better job of providing services and discussed how mental health services are not being met in different segments and populations of society. Dr. Satcher suggested mental health providers work with clergy and other alternative groups to meet the needs of persons who are not receiving appropriate treatment due to a lack of understanding and not having insurance to cover mental health care.

My role as a pastor is a culmination of leadership experiences and the result of my husbands calling into pastoral leadership. Being a pastor is a calling and not an occupation, therefore the skills and tools needed to fulfill my calling are beyond theory and theology. Observations I have made regarding Black leadership's capacity to deal with mental health issues have led me to study the influence African American pastors have on mental health among African American parishioners in the Black church. I would like to implement protocols in local Black churches in an effort to assist other pastors and leaders to serve their congregants and provide a link between pastors and mental health providers.

My academic studies have enabled me to recognize the lack of knowledge by pastoral colleagues in the ministry, with regard to their mental health training and professional development on this topic. It is because of these professional and personal

reasons that I felt the call to explore a topic of great interests and need. I hope that this document can add to the continuing dialogue about improving the lives of people.

# CHAPTER I

## INTRODUCTION TO THE PROBLEM

The Surgeon General (United States Department of Health and Human Services [USDHHS], 2001) report on mental health states that very often, People of color are ignored or placed into elevated levels of psychiatric care when they do present with a problem or disorder. They typically seek care from their primary care physician to alleviate any mental health concerns they may be facing as do most people. The most often cited concerns for African Americans presenting with mental health issues are 1) mental health professionals relating to them and 2) having their needs met.

One institution that has been instrumental in aiding African American people is the "Black Church"[1] It is comprised of a variety of religious denominations that consists of Christian faith-based groups. Given the strong emphasis on religion as an all powerful institution it is not surprising then that African American pastors often seek religious solutions to mental health concerns as opposed to referral to psychiatric resources (Parham, 2002). Only recently has the mental health field recognized the common thread of religion and spirituality in the treatment process of African Americans (Boyd-Franklin, 2003). It is the relationship between the pastor, and his/her congregant and their mental health that has led me to this topic.

The Black Church serves as an enduring institution of strength, guidance and cohesiveness to the African American community (Baer & Singer, 2002; Billingsley, 1992; Boyd-Franklin, 2003; Chatters, 2000; Hill, 1999; Lincoln & Mamiya, 1990; Taylor, Chatters, Levin, 2004). It is thought of as a therapeutic resource for healing and

[1] The Black Church is defined as a predominately homogenous Christian faith based group that supports African American persons in a variety of ways not necessarily all religious.

restoration of broken people. The "Black Church" is an inclusive term that is indicative of the vast assistance it offers to all persons of African descent. Historically the church has openly engaged in services and support for African Americans who are members in the religious group officially or unofficially. A Black person does not have to be an official member of a Black controlled church organization to receive the benefits of the church. The ministry of the Black church has the capacity to develop leadership and follower-ship of all those who are connected to the church. The Black church is not a denomination, but a mass organization that is available to promote the betterment of African American persons (Lincoln, 1974; McRae, Carey, Scott-Anderson, 1998; Salvatore, 2005). Over time the Black church has evolved to meet sundry needs of its members and others who sought its rich resources and leadership. The Black church is seen as a safe haven for those in need of a support mechanism (Vassol, 1996). Both members and non-members are allowed to utilize the assistance of the church when there is an immediate and or long term needs for food, shelter, family problems and a myriad of other issues that may arise.

Historically, the African American family has endured tremendous hardship and pain due to the African Diaspora—often defined as the abrupt departure from their homeland to become slaves in an unknown land (Terborg-Penn, 1998; Sudarkasa, 1996). To help alleviate the burdens and barriers associated with social-economic constraints, African Americans have utilized the Black church as a resource to lessen the impact of the adversities they have experienced. Understanding the history of this group will help clarify the complexities of mental health and the connection to the Black church.

African Americans currently comprise 13% of the United States population, approximately 34 million people (McKinnon, 2002). There is a lack of accurate data that reflects the specific percentages of mental health access by the African American population (USDHHS, 2001). What is known is that African Americans are more likely to obtain emergency room services or seek help from their primary care physician along with seeking out alternative therapies for mental health issues. The Surgeon General reports (USDHHS, 2001) that African Americans are over-represented in inpatient treatment and under-represented in outpatient care. Albeit, they are less likely to seek out professional counseling or therapy due to the lack of trust of the psychological community (Boyd-Franklin, 2003; Parham, 2002; Parham, White, Ajamu, 1999). To help remove the stigma related to seeking or receiving mental health services, educators and the mental health community must provide the general public and other professionals (pastors, lawyers, et cetera) with the appropriate information to help persons who are in need of support.

Drawing from my personal experience in the Black church as a member, leader and a pastor, there is no apparent public or private dialogue between pastors and their congregants about mental health. What may be alluded to as meeting the mental health needs is often done through preaching or teaching about "the mind is a battle ground" and "renewing the mind." The pastor or religious leader is genuinely concerned about the congregant's mental health; however, it may be spiritualized or the perception is that the treatment for the dilemma is in the soul or there is a spiritual problem that prayer or scripture reading can be a catalyst for change. This is Biblical teaching; however, conveying to the congregants the application of the scriptural teaching is vague and at

times other-worldly thinking. Often times there is a lack of support for the use of prescribed medications for depression and anxiety or any other mental illness diagnosis among Black people (USDHHS, 2001). The traditional mindset of the Black church is if one is suffering from a mental disorder they must cope with it and "be strong." Neighbors, Musick & Williams (1998) reported that in the Black community a complaint of mental difficulties is viewed as a weakness. This misinformation is embedded in the psyche of many African Americans and can lead to the denial of need for mental health support or professional services (Schnittker, Freese, Powell, 2000).

When congregants experience mental illness, the pastor may tend to "spiritualize" the problem, that is to say, they may see it as a dilemma in the soul and/or a spiritual problem. For these pastors, prayer is the primary resolution for whatever is tormenting that person. Historically among many religious figures, psychological distress has been considered a form of spiritual possession (Walsh & Pryce, 2003); among some religions, formal spiritual ceremonies have been developed and practiced, for example, exorcism rituals. One of the assumptions pastors may have is that all the person needs is a stronger faith or more prayer. If the person increased their faith in the belief system then their problems would abate (Neighbors et al., 1998; Schnittker et al., 2000; Swanson, Crowther, Green, Armstrong, 2004).

The pastor's response to a congregant admitting to mental health problems may engender support or perpetuate ostracism throughout the congregation due to their inability to cope with their worry. The response from the pastor toward the member may be the deciding factor in the congregant's choice to seek help or to withdraw from any or all mental health or spiritual support. African American pastors are very influential in the

lives of their parishioners due to the congregant giving the authority to the pastor to give them advice and help make key decisions. The identified congregant may need clinical treatment and go without adequate medical management because of the pastor's guidance. Pastoral non-supportiveness may preclude members from seeking resources outside of the church for treatment or consultation (Chatters, 2000; Richardson, 1989).

## Purpose of the Study

The purpose of this dissertation is to examine perceptions African American pastors, in predominately historical Black churches have toward mental health issues among their congregations. First, the research will assess the pastor's views about mental health concerns among parishioners in the congregation. Second, the pastor's attitudes about mental health will be examined. The third component of this study will determine the willingness of the pastors to encourage referral to or discourage parishioners from receiving mental health counseling from outside professionals.

## Rationale

In my role as a pastor, I am often required to utilize my education and training as a marriage and family therapist. My mental health and counseling assessments are based upon the general systems framework and related theories and therapeutic models along with a Christian, faith-based scriptural lens. My assessments may not always follow the above order, but they are my foundational principles in assisting parishioners. One of the key assumptions of the systemic framework is the view that the whole is greater than the sum of its parts (Klein & White, 2002; McRae, Carey, Scott-Anderson, 1998). Hildreth, Boglin & Mask (2000) state that African Americans "have historically valued the whole

over the individual parts." From this paradigm I pursue my vocation with families, groups and individuals.

An ancillary goal of this investigation will be to address the stigma that can be associated with mental health issues faced by those with strong religious ties to a Christian faith-based system across several denominational sects and non-denominational organizations. This dissertation will address how African American pastors' perceptions can have an affect on the mental health concerns of the parishioners. To help clarify these positions and as an added refinement, I shall look at how the specifics of mental health issues are addressed within the Black church.

In many predominately African American congregations, the pastor's voice and leadership is highly respected by members and the community (Barna & Jackson, 2004). The parishioners characterize the pastor as a conduit through whom God speaks directly to the congregation (Barna & Jackson, 2004; Salvatore, 2005). Consequently, it is important to see what factors influence the pastor's attitudes, beliefs, behavior, and ideas about mental health and how that is translated to their congregations.

## Theoretical Framework

Reuben Hill originally formulated (Boss, 2002) the ABC-X model as a framework for understanding how families deal with stress (Boss, 2002). This model has relevance to the Black church because of the interactions within the congregation among the parishioners, and the pastor's relationship with the parishioners. The ABC-X model examines the role of the community and the individual as they influence a response to some impending crisis, in this case, mental health issues of a parishioner or person in need of help who is a member of the Black church. The role of the pastor as a strong

conduit to mental health services is an appropriate subject for the application of this theoretical construct. Some study variables of note are: the pastor's perceptions of mental health, the tendency to spiritualize the presenting mental health problem, and the willingness to refer congregants, consult and/or collaborate with mental health professionals.

The ABC–X model is defined as the following and illustrated in Figure 1.1:

- A is the stressor event.
- B is the family strengths at time of event.
- C is the meaning attached to the event.
- X is the crisis

Each variable can interact with each other. The following elements are examples of events that move from event "A" to event "B" and to event "C" and X is the outcome of those elements. For examples, element "A" is the death of a family member, element "B" is the circumstances of the death of the family member, element "C" is the meaning the surviving family members attach to the deceased; and "X" is the magnitude of the crisis that occurs if the death is sudden and traumatic or outcome.

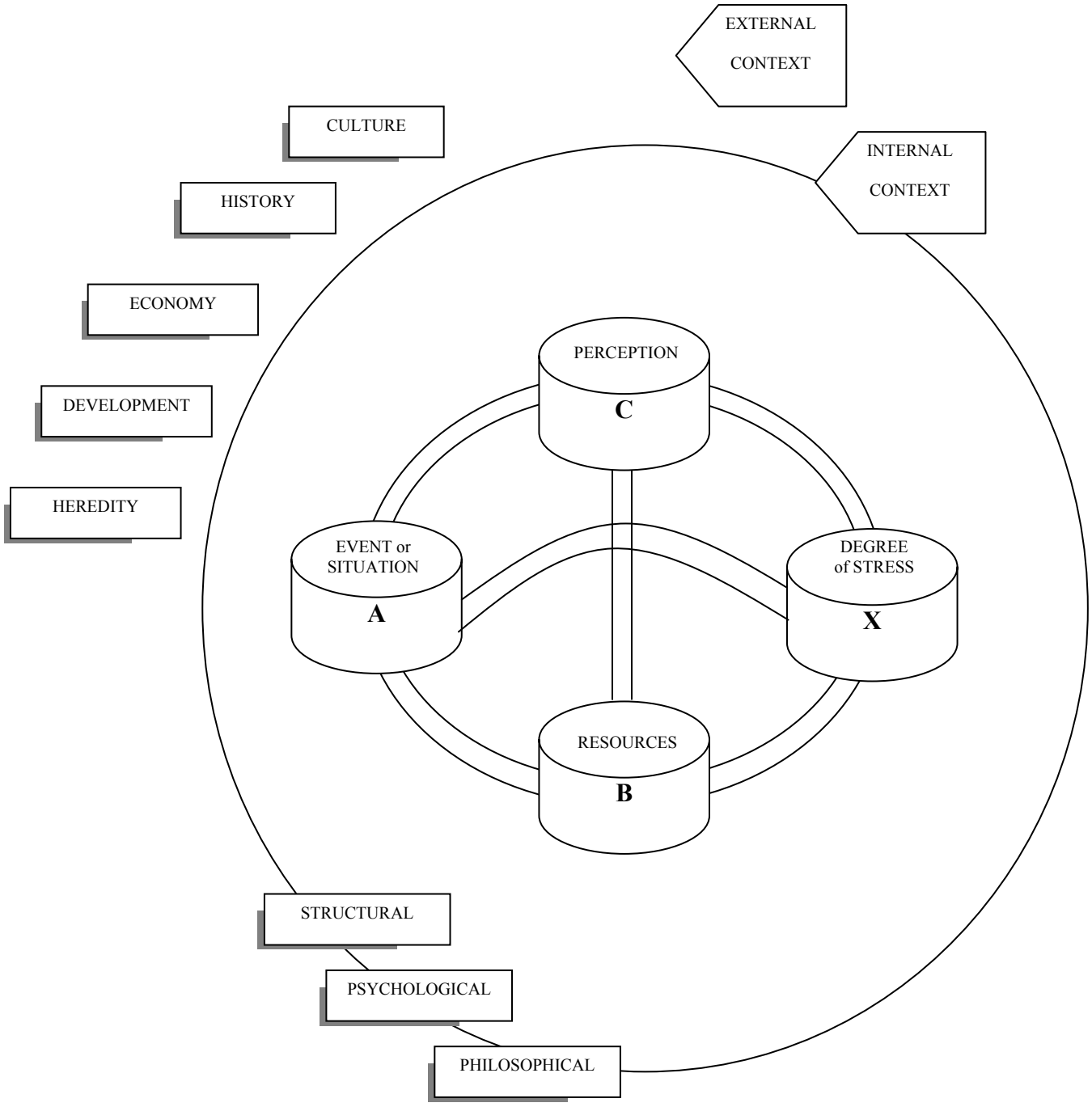


Figure 1.1 The Contextual Model of Family Stress (Boss, 2002)

The ABC-X model has taken on several different dimensions that are very useful in explaining how stress can affect families. Boss (2002) defines family stress as a change in the pressure in the family system. Accordingly, she suggests that stress is change, and similarly, change is stress.

Boss (2002) elaborates more on this model by adding the contextual model of family stress. Applying the way families handle stress takes into consideration the context of history, economics, development, heredity and culture to assist in the discussion of stress. All families are not the same and families may see stressor events in dissimilar ways. Eshleman (2003) concurs that the meaning or nature of the experience will determine how the family will go about handling the crisis.

One example might be that some Black families may define stress as the inability to cope with non-acceptance in the community; however, another family may see non-acceptance in the community as a way of life. Boss (2002) suggests that the perception of the event and the meaning to the individual is the determining factor that may or may not lead to a crisis.

The stressor event can provoke change in family balance (Boss, 2002) the stressor may not mean the same thing to an individual or family; however it can mean change. The stressor event can cause an individual to be stressed and then cause the family to be off balance. How a family or an individual perceives a stressor event can be measured by the external context or the timing and place where the stressor occurs in the family's life. Hence, how the family defines and perceives the event will determine if the event is a crisis, and the magnitude of the crisis.

The family's coping resources can include family resilience, extended family, finances, and religious values (Hildreth, Boglin & Mask, 2000; Walsh, 2003). According to Boss (2002), external contexts depicted in the model as rectangles, are events that one has no control over, including the environment, genetics, history or culture. When an individual is born into a family they have no control over what family that may be. For example, African Americans are identified most often by the pigmentation of their skin. For People of Color there is no escaping the color of one's skin, nor can one choose their racial and ethnic heritage.

Internal contexts, according to Boss (2002), are the events that a family can control and change. Boss (2002) provides three dimensions for internal context, which are depicted in the model in the rectangles: the structural context consists of boundaries the family has in place in terms of roles and rules, psychological context is the perception of the event and how the event affects the family, and/or individual, and the philosophical view for the family unit may be different from societal expectations.

In this study the "A" event is the mental health concern that causes the member to seek help from the pastor; the "B" event is the coping resources the pastor provides the member as well as the pastor's definition of mental illness; "C" is how the pastor identifies or interprets the cause of the mental health concern of the member, and "X" is the intervention for the crisis or the pastor's ability to provide counseling or make a referral. Such a direct connection between the concepts of the ABC-X model and the dynamics found in the Black church reinforces the variables related to the importance of mental health, social environment and cultural contexts to be measured in this study.

## Research Questions

My inquiry has led me to ask the following five questions to develop my hypotheses. Boss' (2002) contextual model of family stress will be the framework for establishing the premise for the research questions.

1. How do African American pastors define mental health?
2. How do African American pastors' perceptions influence propensity to refer church members to mental health professionals?
3. What are the factors that influence African American pastors to spiritualize the mental health condition of church members?
4. What are the factors that influence the mental health perceptions of African American pastors and may ultimately lead them to have negative responses toward church members who are experiencing mental health problems?
5. What are the factors that encourage pastors to collaborate, consult with, and make referrals to mental health professionals?

## Conceptual Definitions

In order to examine the proposed research questions, it is vital to clearly define the terms used in this investigation. This section is divided into two parts; part one provides general definitions and, part two examines the specific variables and their conceptual meanings.

- "Black Church" is used to designate a Black-controlled religious focused Christian organization with African Americans as the majority of the membership.

- "Pastor" is a religious leader of a group of people.
- "Member" is used interchangeably with parishioner and congregant and denotes the person is an official member of an organized Black-controlled church.

*Variables in the Study*

There are two types of measures: predictor variables and outcome variables, more commonly referred to as independent and dependent variables. The determination of the placement of variables into specific categories is based upon theory and the research of other investigators who have experience in studying the key concepts, as well as my own hypotheses, experience and observations regarding the role of pastors in facilitating mental health treatment. More details concerning the specific research design will be provided in Chapter Three of this document.

*Outcome Measures*

The outcome measure is the pastor's willingness to refer. This may vary among and between pastors. I would like to know exactly what motivates the pastor's perceptions. It may be their gender, race, education, religious affiliation or some of other factor. To that end, I have defined X as the willingness to consult, collaborate or refer.

*Predictor Measures*

The pastor's perception of mental health is one major predictor variable. It is composed of the following constructs:

(A) *Mental health stressor* – the respondent's ability to identify mental illness among the congregation.

(B) *Spiritualize* (diagnosis) – pastors perception that mental illness is based upon a lack of faith, demonic influence or imagining the problem.

(C) *Spiritualization* (treatment) – the pastor's perception that the presenting problem requires a spiritual cure, spiritual counseling, referral or collaboration with mental health professionals.

*Demographic Predictors*

Demographic variables are generally descriptive in nature, but are vital to the investigation described here. Those demographic fundamentals help provide a picture of the study in relationship to context and the outcome measures.

*Gender* – the biological sex of the respondent.

*Age* – the actual age of the respondent.

*Marital status* – married, divorced, separated, engaged, widowed or never married

*Denominational affiliation* – the identified sect or religious organization, the pastor and congregation are affiliated, for example, African Methodist Episcopal (AME), Baptist, Pentecostal, non-denominational or other.

*Zip Code* – the postal code where the respondent is located.

*Education* – Number of years of formal schooling reported by the respondent.

*Race* – the actual race/ethnic group of the respondent.

*Time in leadership* – number of years in pastoral ministry.

*Training in mental health* – indicator of mental health training received by the pastor at some point in their career and of their own volition.

## Relevance of Study

The significance of this study is derived from a theoretical examination of African American pastor's perception of mental health issues and how he/she influences their congregation to seek or eschew mental health care. There is a paucity of research on African American pastors and their direct influence on their congregation's mental health.

My experiences in the Black church as a layperson, pastor, and as an ordained elder bring these concerns to my attention on a regular basis. Too many members are facing mental health challenges without adequate or appropriate treatment. As a pastor, I would like to see more referral, consultation and collaboration by pastoral leaders with the mental health community along with providing members with adequate spiritual support.

The pastor's perception of mental health needs can be a factor in the bridge between mental health professionals and the faith-based communities. The Black church and its leadership can serve as a steward to provide a safe and qualified support mechanism for the members to receive assistance with mental health concerns and to refer to the appropriate professionals for further diagnosis and treatment (Cook, 1993; Neighbors et al., 1998).

## Organizational Overview

This dissertation is organized into five chapters. Chapter One, the introduction, explains the purpose, rationale and the theoretical context for the investigation into the African American pastor's perceptions of mental health in their congregation.

Chapter Two examines relevant literature that includes a review of the history of the Black Church; the influence the Black Church has upon African American families; mental health issues in the African American community; the role of the African American pastor; the connection between religion and spirituality; and a general overview of how these elements overlap.

Chapter Three will focus upon the methodology used to guide the research, research questions and hypotheses. This chapter will include a discussion of measures, instruments, and statistical methods used to summarize the data. Chapter Four and Five will discuss the results with specific attention on statistical analysis. The final section of the dissertation, chapter five will consist of discussion and conclusion of the study. Recommendations for future research as well as limitation and implications for the findings will be highlighted.

# CHAPTER II

# LITERATURE REVIEW

In this chapter, I will review the literature concerning the role the church represents in the African American community, the lack of participation in mental health services by African Americans, the pivotal role of the African American pastor's perceptions of mental health, and the influence of spirituality and religion upon the African American faith experience. Throughout this literature review, I shall use the terms Black and African American interchangeably as it is used in the literature.

## *The Black Church*

The Black church has served as a protective shield and ally for those who embrace it. The organization can be defined as a predominately Black congregation most often led by a male African American pastor and staff who most likely do not earn a salary (Brown, 2003).

The Black controlled church was borne in response to the racism and social restraints placed upon African slaves in America (Baer & Singer, 2002; Billingsley, 1992; Boyd-Franklin, 2003; Raboteau, 1995). Accordingly, the Black church served as a mechanism of racism by offering segregated worship services required by White slave holders. The intended role of religion as presented was to have the African slaves adapted and assimilated into the dominant White cultures belief system (Baer & Singer, 2002). Billingsley (1992) accurately phrased, "It is a mistake, then, to think of the black church in America as simply, or even primarily, religious institution in the same way the white church might be conceived" (p. 352).

The segregation of worship throughout the past 200 years in the United States has led African Americans to establish and maintain their own congregations. Dr. Martin Luther King Jr. is often quoted as saying that "the Sunday morning hour is the most segregated hour in America."(King, 1968) According to a recent survey, Sunday morning continues to be the most racially segregated in the local church (Barna, 2004). Approximately, eighty percent of the congregations in American are at least 90% racially homogeneous (Robinson, 2000). Thompson & McRae (2001); McRae, Carey, and Anderson-Scott (1998) found that membership or belonging to the Black church, is predominately defined by being Black and the historic need to belong with versus simply belonging to a group. Black persons are connected to the Black church because of the group cohesion primarily due to the collective oppression and cruelty placed upon their enslaved forefathers.

According to Scott & Black, (1998) the Black church can be seen as a keeper of the familial network and values that support the family. The way the church accomplishes this goal is by meeting the instrumental needs of the membership by providing social services (Boddie, 2004). Consequently, the expressive needs of the congregation are met by worship through singing, preaching, and teaching. As the Black church continues to provide support, it is a part of the kin network and can be a template for a "family" (Chatters et al. 2002; Boyd-Franklin, 2003; McRae et al., 1998). This family network can be seen in the terms most often used to refer to members of the Black church as "brother" or "sister" when addressing each other (Scott & Black, 1998).

Garland and Yanklee (as cited in Powell & Cassidy, 2000) define family in the religious context as:

> "those persons who commit themselves to God and then to one another to serve as family for one another for the rest of their lives. Family may include biologically and legally related relationships, such as parents and children, and spouses, but it is not necessarily limited to these culturally recognized relationships"(pp. 208).

Considering the scriptural framework for a familial definition there are terms used in the New Testament that depict believers as members of "the household of faith" and "the family of God." Many believers literally interpret this to mean they are connected to "this family" through Jesus Christ and the blood shed on Calvary. These relationships parallel the concept of family connected by church membership in this case, the local house of worship of one's choosing. Congregants will often refer to their place of worship as their "church home" (Boyd-Franklin, 2003).

Traditionally, there are several Black controlled mainstream denominations in the United States with a majority exclusive to Black membership. The eight major historically Black controlled organizations are the African Methodist Episcopal; African Methodist Episcopal Zion; Christian Methodist Episcopal; Church of God in Christ; National Baptist Convention of America; National Baptist Convention, USA; National Missionary Baptist Convention; and the Progressive National Baptist Convention. These organizations combined represent over 65,000 churches and more than 20 million members (DiIulio, 1999). According to data from the National Survey of Black Americans (NSBA), 68% of African-American adults are official members of a congregation and 92% of the congregants attend church (Neighbors et al., 1998). Recent data from Taylor, Chatters, Levin (2004) revealed that Blacks were more likely to be affiliated with Baptist, Methodist and Catholic churches, traditionally the top three

religious affiliations. Approximately 10% percent of Blacks attend church services in predominately White Catholic parishes and other mainstream White controlled protestant denominations (Baer & Singer, 2002).

Not only are Black churches affiliated with mainstream denominations and historically Black congregations, they are included in a phenomenon known as nondenominational congregations. The definition of nondenominational according to study conducted by Thumma (2001) was a Protestant Christian congregation that has independent of a major denominational body. Thumma (2001) surveyed 2,500 independent or nondenominational congregations and found there is an estimated 35,000 independent or nondenominational congregations in the United States with approximately 10,000,000 congregants. The racial disparity experienced in traditional congregation is not an issue within nondenominational fellowships. The race and ethnicity breakdown is of a more multiracial composition. Thumma (2001) reports those who regularly attend nondenominational churches are 68% White and 8% Black. The findings are not definitive about congregations who are exclusively African American.

Thumma (2001) suggested that the main model for nondenominational churches continue to practice their beliefs without making an allegiance to prescribed mainstream traditional denominational expectations and constraints. This has been a growing phenomenon over the past ten years. These congregations may be loosely associated with larger networks such as the Potters House Fellowship, Full Gospel Baptist Fellowship and others.

The Black church is viewed as another component of the extended family for individuals and families who are seeking mentoring, counseling, and a social outlet (Billingsley, 1992). African Americans traditionally do not seek outside sources for problems for personal or familial issues due to mistrust of outsiders (USDHHS, 2001). Therefore, it is common for African-American to seek support from the church when the internal family is unable to address issues.

The Black church is a foundational stone of many African-Americans in the United States and abroad. The Black church provides a place for social activity, mutual aid, a political platform, and respect for African-American's who would not otherwise receive these opportunities in the dominant culture (Ellison, 1997; Jang & Johnson, 2004; McRae et al., 1998). African Americans share a collective sense of community that includes four aspects: the church; the school; the business enterprise; and the voluntary association (Billingsley, 1992; Johnson & Staples, 2005). The interweaving of the four parts can help define African American strength and the ability to adapt to change**.**

Thompson and McRae (2001) examined the Black church tradition and the group process. They found that church participants felt an interpersonal connectedness with each other as members of their church group and that this connection gave them the means to function within the culture of the United States as individuals and as a group. In a related investigation, Taylor (2004) found that 82% of the respondents reported that the church was a key support mechanism in ameliorating problems Black American's face in the United States.

The Black church continues to be a thriving resource for individuals and families in the community who require spiritual guidance, academic support, drug and alcohol

rehabilitation, a political mechanism and a landmark for future generations (Johnson & Staples, 2005).

*The Black Church and the Black Family*

Understanding the complexities of Black families and how the Black church provides a foundation for its continued existence is the central theme of this section. Research on the Black is often conducted by authors who perceive the Black family as an enduring institution (Billingsley, 1992; Johnson & Staples, 2005; Lincoln & Mamyia, 1990).

Traditionally, the Black church carried a lot of the burdens for African slaves due to the involuntary transportation to America and continues to be a viable resource for Black families. The Black family is the predominate unit in the Black church and there are eight million Black families in the United States (Barna, 2004; Lincoln & Mamiya, 1999). There are approximately 70,000 Black churches and mosques in the United States according to (Franklin, 2003).

A definition provided by the U.S. Census Bureau (2004) of the family "is a group of two or more persons (one of whom is the householder) related by birth, marriage, or adoption and residing together"(p. 4). This definition is different from the religious context of defining family. The picture of the family can include blood relatives who are related biologically and the other picture can include fictive kin who can be chosen or elected to be a family member (Scott & Black, 1998).

The Black church in the African American community is considered an extended family (Johnson & Staples, 2005; Powell & Cassidy, 2000). One of the prevailing strengths of African-American families is the extended kin network (Billingsley, 1992).

These relationships can be a resource for the family, especially if a single parent is providing sole support to his/her children and requires assistance outside of the immediate family unit.

Johnson and Staples (2005) characterize the Black church as "the modern day tribe" primarily due to it being the foundation for strong families. This notion of strength and unity promotes a sense of community among and between church members. There may be a legacy of many generations holding membership to one church for many years. For example, two or three living generations may have traditionally attended that one church. There may have been past ancestors that also were life long members of that one church.

The Black church is a vehicle for families to develop children's understanding of the bible and providing them with leadership skills and public speaking by participating in plays and speeches. Moral codes are taught and the importance of valuing who you are continue to be important principles taught in the Black church (Billingsley, 1992; Johnson & Staples, 2005). Youth are considered the future of the Black church. Much emphasis is placed on preparing them for leadership in the organization and the communities where they will reside.

The Black family and the Black church cherish many values that are passed from one generation to the next. Respect and reverence are two of those important values to people of African descent. According to Sudarkasa, (1996) reverence is a concept that refers directly to the strength of religion in the community and is one of the seven values people of African descent held as a means to give credence to a higher power. Not only reverence, but respect for one's elders is a key value; therefore the Black family

maintains a strong heritage related to the past, present and future familial ties that have made them resilient.

*Mental Health Services and the African American Community*

The Surgeon General (USDHHS, 2001) reports that the availability of mental health services for African Americans are generally through hospitals, community mental health centers and local health departments. Numbers of African American professionals providing mental health services are exceedingly low. Black mental health professionals comprise two percent of psychiatrists, and psychologists, and four percent of social workers, respectively.

People of color are less likely to seek formal mental health services for the following reasons, the cost of care, societal stigma, and a disjointed offering of available services and lack of trust (USDHHS, 2001; Parham, 2001). When they do seek care, they are not likely to find health care offered by professionals that look like them. Additionally, most White mental health professionals lack training and sensitivity to the issues faced by their clients. The African American community shares a great deal of mistrust of the mental health profession and that is based primarily on past misuse and abuse of People of Color in treatment and research endeavors (Neighbors et al., 1998; Turner, Wieling & Allen, 2004).

The definitions of mental health while precise and on their face generally do not stigmatize any individual based upon gender, race, ethnicity or creed, but who defines mental health can be and has been problematic for People of Color. The presenting mental health concern can range from circumstances related to poverty, illness and disease, homelessness, drug and alcohol addictions, and marital conflicts.

The definition of mental health, illness, and problems respectively, according to the Surgeon General supplement report (USDHHS, 2001) are:

> "The successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity." Mental illness is all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and /or impaired functioning. Mental problems are signs and symptoms of insufficient intensity or duration to meet the criteria for mental disorder" ( p.7).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition DSMIV (1994) a mental disorder is defined as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important area of functioning) or significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. XXI).

There tend to be higher diagnosed rates of mental illness in the African American community than in the White community (e.g. bi-polar) (USDHHS, 1999). Although African Americans are over represented in findings in comparison to their White counter parts the indications are that there may be greater percentages for some disorders than others compared to Whites. For example, African Americans were overdiagnosed with schizophrenia (Williams, 2005).

According to the Surgeon General's report 40% of those who have a mental health problem sought out clergy as a primary aid and resource (USDHHS, 1999). In the past the mental health field has been reticent to include religion and spirituality in the treatment process (Boyd-Franklin, 2003; Parham, 2002). The need for prevention, collaboration, and referral efforts between the church and the mental health field is

crucial to help persons with mental disorders and their families (Cook, 1993; Hildreth, Boglin, Mask, 2000; Milstein, 2003).

*The Role of the African American Pastor*

The subject of African American pastors perceptions of their members' mental health needs are nearly non-existent in the research literature. Research that is related to this topic is scarce and very limited (Neighbors et al., 1998; Taylor, Ellison, Chatters, Levin, Lincoln, 2000). Among the work that does exist, there is a strong consensus that the relationship between the church and the mental health services in the African American community is not a good one. In other words, misunderstandings on the part of both African American pastors and mental health providers about the possible religion or spirituality may exclude a valuable resource (Taylor et al, USDHHS, 2001).

Overall, there is paucity in the literature that speaks directly to the role of the pastor and the perceptions they may have toward parishioners who are facing mental health issues (Shabazz, 2002; Neighbors et al., 1998). The lack of relevant research from the pastor's view has led many to find other resources that may not be as beneficial for African Americans who need good mental health services.

The African American pastors are held in high esteem in traditional predominately Black congregations (Taylor et al, 2003; Walsh & Pryce, 2003). The African American pastor's credentials may include a calling exclusively from God and/or a ministerial license or ordination from an affiliated organization (Pipes, 1996). Billingsley (1992) reported data on ministers in the northeastern United States who received a college education also had Bible college training and more than one third received a master's or doctorate degree. Pastors are viewed by their followers as

possessing an aura of transcendence due to their calling from God (Johnson & Staples, 2005). Therefore, members perceive them to be of an all-knowing nature. For example, if a member is deluged with many financial woes, the pastor should in some way "know" their plight and do something about it. The doing something about it may include prayer or talking with the parishioner about the financial problem along with finding a reasonable solution to the presenting problem. Typically the pastor is able to help in these types of ordinary situations where resources are often available, thus furthering the notion that pastors are all-knowing.

To further understand the intricacies of the role and authority of African American pastors, one must understand the process. According to Barna & Jackson (2004) two thirds of all African American adults believed their pastor to provide a symbolic and active role in leadership in their congregation and the community. According to Bishop T.D. Jakes, "The Black community has never had a president, only a preacher. And Frederick Douglass to Martin Luther King to Jesse Jackson to Al Sharpton to T.D. Jakes, it doesn't matter who you want to name, they're always clergy…"(Edney, T. Retreived April 2, 2005).

The preferred response to pastoral leadership role is based upon a patriarchal hierarchy (Walsh & Pryce, 2003). The pastor must be multifaceted in his or her role as pastoral leader, administrator, and counselor. Members approach the leader with a myriad of complaints including physical, mental, and social evils (Boyd-Franklin, 2003; Taylor, Chatters, Levin, 2004).

Pastors have served as a surrogate and parental figure for Black congregants. The male pastor is viewed as the "father" or "elder" to the congregation (Johnson & Staples,

2005). If the pastor is married, his wife may take on the role of "mother of the church" within the congregation (Chatters, Taylor, Lincoln, Schroepfer, 2002). The metaphor of mother and father attached to the role of pastor is a consistent theme in the Black church that reinforces the sense of family (Boyd-Franklin, 2003; Chatters et al., 2002).

Black pastors are apt to influence church members' decisions about health, finances, and personal relationships (Boyd-Franklin, 2003; Taylor et al, 2004; Lincoln & Mamiya, 1990). One of the caveats of Black pastors providing counseling services to individuals and families is there is no hourly fee or charge for services (Taylor et al, 2004; Wright, Moreau & Haley, 1982;). For many African American families the Black church is an alternative system for mental health services. Their pastor can be a resource to provide consolation when depressed or needing financial support (USDHHS, 1999; Neighbors et al.1998).

Historically, pastors have been the gatekeepers to the Black community (Billingsley, 1992; Chatters, 2000; Richardson, 1989). The pastor can be a resource for referral to mental health professionals. How the pastor will deal with these mental health issues will be determined by his understanding and perception of the presenting problem. There may be some hesitation by African American pastors to refer parishioners to outside mental health service providers (Neighbors et al., 1998; Richardson, 1989). The hesitation to refer may be due to the stigma that can be placed upon persons needing mental health services especially for African Americans who have unmet insurance and income needs (Milstein, 2003). Pastors are involved with individuals, families and the community in a variety of roles. They provide counseling on a continuum of levels from individual counseling to group sessions (McRae, Carey, Anderson-Scott, 1998). Another

investigation found that 75% of the pastors they surveyed utilize scripture and prayer as the predominate method for counseling parishioners (Young, Griffith, & Williams 2003).

Amid the many expectations of Black pastors some of the primary duties are to be a change agent, team leader and provide spiritual guidance to the parishioners (Barna & Jackson, 2004). Parishioners expect the pastor to meet spiritual needs as wells as psychological, familial relations and other unmet needs. For the pastor to provide such a variety of services, he or she should have the appropriate spiritual and educational resources to assist parishioners, however, that is not always possible or true for a sizable proportion of African American pastors.

## Religion and Spirituality Influence on Mental Health

Western psychology and psychiatry traditionally has ignored the validity of religion and spirituality due, in part to, the views of the early researchers and clinicians of the field (Cross, 2001; Walsh & Pryce, 2003). Freud did not accept the reasonableness of religion as a way to cope with mental health issues, but on the contrary minimized religion as a crutch the weak person resorted to when they were feeling pressure (as cited in Lewis, 2001). The research community has avoided the use of religion due to the bias and misunderstanding of religion as a determinate of the outcome of their research (Chatters, 2000; Parham, 2002; Taylor et al., 2000). Chatters, (2000) suggested that researchers and clinicians may be less apt to be religious than the general public, therefore they were less likely to be sensitive to those who have a religious and spiritual focus.

The terms spirituality and religiosity are often used interchangeably (Taylor, 2004; Walsh & Pryce, 2003). However, there are distinct definitions for each word and

how they are defined may be based upon the understanding and belief of the group utilizing the terms. Commonly, religious participation can include denominational affiliation and church attendance. Spirituality is viewed as more personal, informal, and subjective to the individual's belief, attitudes, and experiences (Barna, 2004; Taylor, 2004; Chatters, 2000).

The word spirit was derived from the Latin word *spiritus* meaning breath of life (Walsh & Pryce, 2003). Accordingly, Hodges (2000) used the terms *pneuma* in Greek and *spirit* in Latin to sum up human spirituality. This definition was consistent with the Old Testament scriptures. Mattis (2000) suggests that this scripture makes the connection between God and man and their relationship to each other.

The Western paradigm of spirituality consists of tangible, rationally explained phenomena. Hodges (2000) provided similar definitions for spirituality as an intrinsic personal belief in and experience of a supreme being or an ultimate human condition, along with a set of values and active investment in those values, a sense of meaning, inner wholeness, a sense of connection, and an expansion of awareness. It can be said that as awareness expanded, so did a person's inner and outer responsibility to oneself and to others they encounter in daily life.

Cain, Markowski, & Cleghorn (1998) provided another definition for spirituality that included a multifaceted relationship or connection between humans and metaphysical systems. They defined faith, as cognition for which there is no material evidence; where direct proof was beyond intellect. The authors continued to define religion as an institutionalized spirituality with a codified belief system of doctrine or rituals.

Protestant, Catholic, and Muslims and hundreds more religions carry different interpretations and beliefs (Cain et al, 1998).

Religiosity and spirituality are dominant themes inherent in African American life. Religiosity can include formal church attendance, or informally practicing religiosity by personal prayer and bible reading. There is a strong adherence to spiritual connectedness intrinsic and extrinsic among Blacks as compared to Whites counterparts (Taylor et al. 2000). The African centered worldview of spirituality is comprised of the connection to being a spirit, with a direct influence of the unseen and the divine (Parham, 2002).

There is an old spiritual titled "*Give me that old time religion*" (Author unknown). This song sum up the desire to follow in the footsteps of their Black forefathers and mothers regarding their religion and spirituality. There is a distinct difference between spirituality and religion among African Americans. Practicing their beliefs may be formal by attending an organized worship service or informally with personal meditations and prayer time. The adherence to what their forefathers espoused are key to the current generations is needed to participate with others who are like them. African Americans' ancestry has its origin in Africa and the deep connection to spirituality is embedded into the psyche of African people and people of African descent—most notably Blacks (Boyd-Franklin, 2003; Parham, 2002).

Reports from the research suggested the impact of religious commitment was related to mental health predictors (Hodge, 2000; Larson, Larson, Koenig, 2000). The researchers found that drug abuse, alcohol abuse, and suicide prevention were less likely to occur when persons have strong or moderate religious or spiritual beliefs (Larson et al.

2000). People who were considered religious often experienced better health, less concerns with mental health problems and less drug and alcohol abuse (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Religion is a coping mechanism for many people experiencing challenges in their lives and it gives them a frame of reference to use as a tool to sort out how they will persevere (Walsh & Pryce, 2003). For many African Americans, religion has been the primary method of coping with stress.

## Summary

The Black church is an institution unique to all other social and groups or political entities in assisting and supporting African Americans in America. Individuals and families are under-girded by the strength and endurance of the Black church. Religion and spirituality are proponents that are foundational to the Black churches ability to provide resources that are indestructible. The Black church and the African American pastor provide a useful context for understanding the depth of commitment over the last two hundred years that African Americans have made to their church. Accordingly, the mental health community can utilize the Black church and the leaders of the Black church as partners in providing appropriate services to African American persons experiencing mental health issues.

My past and present experiences in the Black church, as a layperson and as a pastor allow me the opportunity to hear other pastors' concerns on a recurring basis about the needs of the parishioners being so great. Too many members are facing mental health challenges without the proper treatment. By measuring the pastors' perceptions of the congregations mental health needs, one can develop an understanding of capability and qualifications to assist congregants with their mental health issues. This knowledge will

in turn provide the mental health community with the information they need to collaborate with the pastors who are the first line of defense for their parishioners. The Black church and its leadership can serve as a steward to provide a safe and qualified support mechanism for the members to receive assistance with mental health concerns and to refer to the appropriate professionals for further diagnosis and treatment.

# CHAPTER III

# METHODOLOGY

The primary focus of this dissertation examines African American pastors' perceptions of mental health issues and how pastors influence and those parishioners who are experiencing mental illness. As discussed in Chapter Two, mental health literature and research has largely overlooked the role of African American pastors and their responses to mental health concerns. The data analysis and results revealed in this study will add to the scant body of research that is available on this subject. By examining the pastors of predominately African American congregants there will be data that can determine how they perceive mental illness and respond to it when there is a need. This study will give insight to pastors and mental health professionals along with relevant resources and recommendations to work together with the African American faith-based community.

## Research Questions

The literature review along with my current interests led me to develop five questions on the assumptions of how pastors perceive the mental health needs in their congregation. The five questions are designed to address African American pastors' assumptions and opinions concerning the mental health needs of those who attend their congregation in addition to their willingness to refer parishioners to professional counselors.

The questions are as follows:

1. How do African American pastors define mental illness?

2. How do African American pastor's perceptions influence their propensity to refer church members to mental health professionals?
3. What are the factors that influence African American pastors to spiritualize the mental health condition of congregants?
4. What are the factors that influence African American pastors to have negative responses toward congregants who are experiencing mental health problems?
5. What are the factors that will encourage pastors to refer, collaborate, and consult with mental health professionals?

## Research Hypotheses

Four hypotheses were developed in order to answer the research questions. Each hypothesis examines an important aspect of the current research questions and supported by the literature and stereotypes surrounding this subject. Each hypothesis is written with the belief that African American pastors are not a monolithic group with only one idea or one method of addressing issues. As such, it is important to examine the within group differences that influenced the outcomes. In other words, since the sample consists of African American pastors, the research questions refer to African American pastors and the hypotheses serve to address the questions, therefore it is inappropriate to construct between group hypothesis comparing African American pastors to non African American pastors. In this dissertation within group hypothesis are necessary for the structure of the current hypothesis. The hypotheses are essentially one-way, as such the comparisons are made but the opposite influence is implied. Stating the comparisons in the hypothesis would be awkward and unclear.

The hypotheses are as follows:

- *Hypothesis 1:* African American pastors' perceptions of their member's mental health concerns are *more likely* to be negative.
- *Hypothesis 2:* African American pastors are *less likely* to refer members to mental health professionals.
- *Hypothesis 3:* African American pastors are *more likely* to "spiritualize" the mental health condition as a lack of faith.
- *Hypothesis 4:* Pastors who have more specific training in mental health issues will be *more likely* to refer parishioners to mental health professionals regardless of the pastor's personal level of spirituality.

## Data Source

The current investigation comes from an original study based a questionnaire administered to approximately 300 randomly selected pastors. The survey instrument for this investigation used a similar design to a questionnaire developed by Shabazz (2002). The questionnaire was redeveloped and revised to reflect the questions and interests[2] related specifically for this research. Surveys were mailed to churches listed in the World Wide Web White Pages telephone directory retrieved from an Internet search engine within Kansas City White Pages and a list of African American pastor's from a listing of major cities where prominent African American churches are located. Each questionnaire included a cover letter stating the intent of the survey, the researcher's name and university and reason for the request, an informed consent form and a postage-

[2] The data collected also included responses from religious leaders, who although they were not in pastoral positions, they are leaders i.e., elders, ministers, evangelist within their congregations appointed by the pastors to minister to the spiritual needs of fellow parishioners including, but not limited to Bible study, prayer leaders and ministers of music. Thus, these religious leaders will heretofore be included in the analysis and referred to as church pastors.

paid, self-addressed envelope to return the completed survey and signed informed consent form. The pastors were informed that the information they provided would be kept confidential and would be used only for the purposes of data collection and analysis. The randomly selected pastors are in pastoral leadership in the inner city, rural towns, and suburban areas around the country. Their role as pastor gives them a variety of experiences working with parishioners and the community. The key question involved in the current investigation was to examine the perceived thinking of the pastor's ability to minister or counsel congregants who have mental illness. This data will support or dispute assumptions about pastor's ability to deal with mental health issues in the Black church.

## Operationalization of Research Variables

Examining and analyzing the data within these surveys requires that the variables used to conduct this investigation be operationally defined. Utilization of the theoretical model of family stress by Boss (2002) Figure 3.1 provides the representation and adaptation of the ABC-X model that pertains to this study's analytical scope.

### *Outcome Measures*

The respondent's perceptions concerning mental illness in their congregations were measured by asking a series of questions with Likert-scale items scored from (1) Not Likely At All to (5) Very Likely. The respondent's willingness to consult or collaborate with mental health professionals was a scaled variable scored in the same manner. The pastor's willingness to refer to a mental health professional was measured by a scaled variable that was designed to test the perception, and possible action of making a referral to a mental health professional.

*Predictor Measures*

The predictor measures used in this analysis include demographic variables, questions that focus on the pastor's perceptions of mental health within their congregation, and questions regarding the pastors' beliefs about how and why mental illness occurs among parishioners.

*Theoretical Model Measures:*

- *Spiritualization* (diagnosis*)*—The propensity of the pastor to perceive mental health stressors within a spiritual paradigm. The pastor's perception of the problem.
- *Spiritualize* (treatment)—Pastor's perceived conclusion of the member's conflict as it relates to their prescribed faith-based beliefs according to biblical text (scripture).

  (A) *Congregant's Stressor Event*—Pastor's awareness of a parishioners having had a mental health issue as evidenced by the pastor ever having offered counseling to a parishioner.

  (B) *Spiritualization* (*diagnosis*)—Pastor's perception of the congregant's need that the mental health issues are based upon lack of faith, demonic influence, or imagining of the problem.

  (C) *Spiritualize* (*treatment)*—Pastor's proposed solution to the presenting problem. It may be spiritual exercise, spiritual guidance, or referral or collaboration with mental health professionals. One approach to help with a parishioner's dilemma or spiritual problem is to suggest spiritual exercises such as prayer or scripture reading as resources for lessening of mental health stressors.

One of the assumptions pastors may have is that all the congregant needs to feel better or alleviate their symptoms is to have a deeper faith or more prayer. This will be measured by the responses to the question related to willingness to refer or likeliness to consult or collaborate with mental health specialists.

(X)- *Outcome—P*astor's willingness to refer, consult or collaborate.

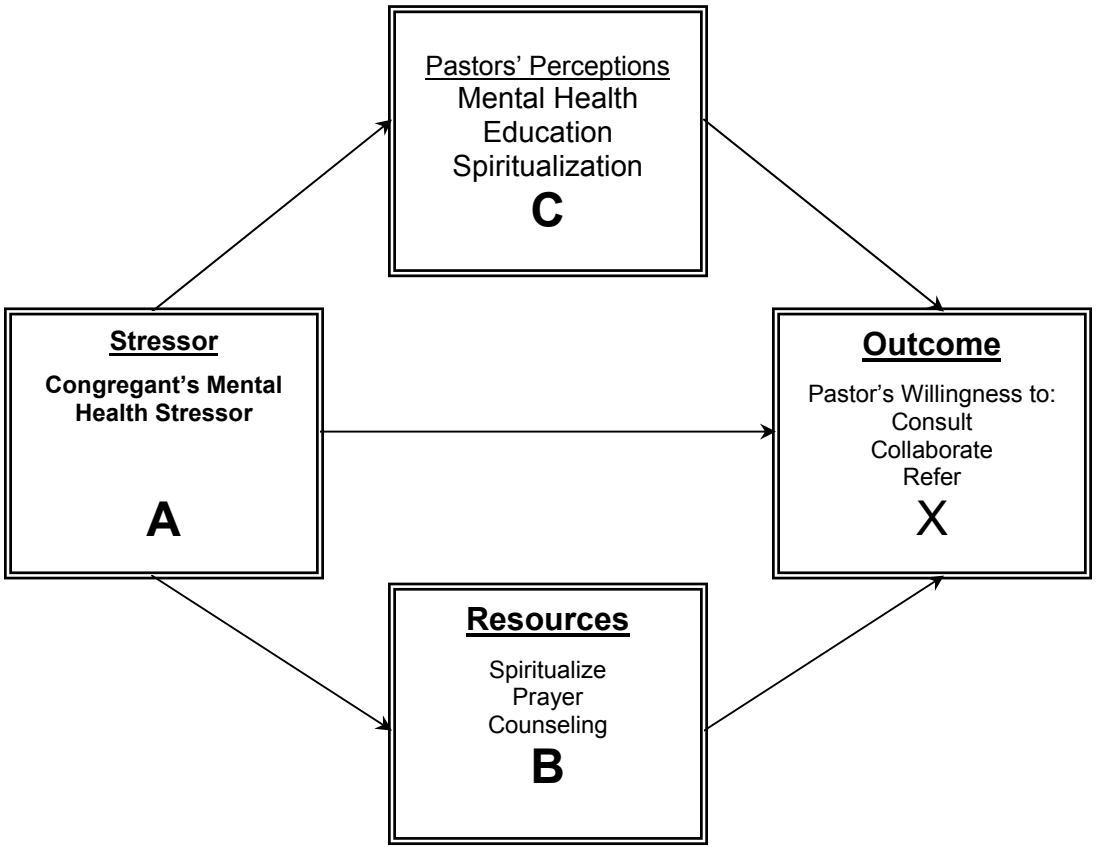


**Figure 3.1** Theoretical Model: ABC - X Stress Model defines the Characteristics of each Variable.

A – The Congregant's Mental Health Stressor (Presenting Problem)

B – Pastor's Resources Spiritualization (Diagnosis), Prayer, Spiritual Guidance

C – Pastor's Perceptions of Mental Health (Method of Treatment) spiritualize or refer and/or collaborate.

X – Pastor's Willingness to Consult, Collaborate, and/or Refer.

*Demographics*

Demographic questions such as age, gender, race, education, and religious affiliation are measured to assess their relationship to the pastor's perceptions of mental health concerns in the members of the congregation.

*Age* (AGE) – Actual age of the respondent as of their last birthday.

*Education* (EDUC) – Number of years of formal schooling completed by the Respondent.

*Gender* (SEX) – Biological sex of the respondent, (1) Male or (2) Female.

*Geographic location* – Area where the respondent lives, divided into the Following categories: (1) Suburban (2) Inner City, or (3) Rural.

*Marital status* (MSTAT) – Whether the respondent is: (1) Married, (2) Divorced, (3) Separated, (4) Engaged, (5) Widowed, or (6) Never Married.

*Multiple marriages* (MSTATUS1) – Number of times the respondent has been legally married.

*Race* (RACE) – Racial/ethnic group reported by the respondent including: (1) White, (2) African American, (3) Hispanic, (4) Asian American, (5) American Indian, or (6) Other

*Other variables included are*:

*Salary* (PAID) do they receive a salary as pastor of the congregation.

*Income* (MINCOME) – Based upon the annual income from ministry work in 2003.

*Years as pastor* (YEARS) – Number of years as pastor.

*Full-time pastor* (WORK) – "Full-time" ministry was defined as 32 hours or more Per week and "Part-time" ministry as 31 hours or less per week

*Religious denomination* (RELIG) – Actual denomination of their church as defined by the respondent including, denominational or non-denominational.

*Secular employment* (SECJOB) – Work outside of the church.

*Full-time secular employment* (SECSTAT) – 32 hours or more per week.

*Part time secular employment* (SECSTAT) – 31 hours or less per week.

*Annual household income* (FINCOME) – Income received from other sources, (i.e., Spouse, Pension, or Retirement).

*Education (*EDUC*)* –Years of formal education

*Degree* (DEGREE) diploma or degree Pastors have received

*Field* (FIELD*)* Specify the field the degree was earned

*Urban* (URBAN) The locale of the church urban, suburban, rural

*Edifice* (EDIFICE) Building structure where services are conducted

*Congregation* (CONG) Number of attendees on main worship day

*Class* (CLASS) Attended classes for academic credit for counseling, collaboration, consultation

*Seminar* (SEM) Attended seminars for counseling, collaboration or consultation

*Workshop* (WKSHP) Attended workshops for counseling, collaboration or consultation

*Mental Health* (MH1) Percentage of people the respondent thinks is mentally ill in America.

*Mental Health* (MH6) Have pastors ever provided counseling to members with mental illness?

*Plan of Analysis*

The data analysis approaches the research from general demographic questions to open-ended questions and questions with specific Likert-scale items. It is necessary to use measures that help explain the basic elements such as simple descriptive statistics. The researcher used means difference tests (T-test and ANOVA) when needed to address the four hypotheses used in this investigation. It was necessary to use multivariate analytical techniques to examine the theoretical construct of ABC-X model.

*Univariate Analysis*

Simple descriptive statistics of the sample are provided. Demographics were used to determine social and economic variations. Basic frequency distributions and concomitant measures of dispersion (means, medians, modes, standard deviations, and variances) were examined to explore any discrepancies in the data. Primary observations were made and examined in greater detail with more sophisticated techniques. These techniques were utilized at the bivariate and multivariate levels of analyses.

*Bivariate Analysis*

The nature of the current investigation requires that the mean differences between groups be examined. Multivariate exploratory analyses were done between gender and other dichotomous measures to see if there are differences associated with the outcome measure. In those cases concerning more than two groups, for example EDUCATION

and YEARS, Analysis of Variance (ANOVA) was used to fully explain the mean differences. The advantage of using an ANOVA was that it analyzed multiple means in which there were several predictor measures. Contingency table analysis is used to determine association among variables, while T-test measured mean differences between groups and between individuals.

*Multivariate Measures*

Answering each research question, hypothesis, and model testing requires utilizing techniques that are robust, clear, and practical in addition to providing an understandable methodology in social science research. The connection between measures were analyzed by correlation coefficients described in Pearson's r.

A simple analysis of variance (ANOVA) was used to see the difference between individuals and the difference between groups in the data. Multiple regression will be used to determine the mediating variables involved with independent and dependent variables.

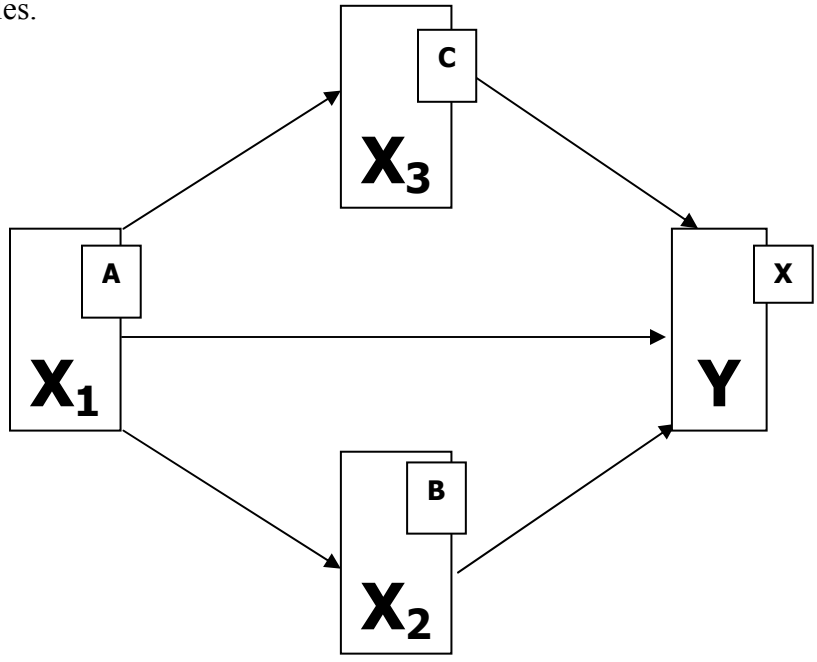


**Figure 3.2** Causal Model of African American Pastors.

**A** = $\mathbf{X}_1$ = Stressor event

**B** = $\mathbf{X}_2$ = Pastor as a Resource or Method of Treatment Regarding the Mental Issue

**C** = $\mathbf{X}_3$ = Pastor's Perceptions of the Event or Diagnosis

**Y** = Consultation, Collaboration, or Referral

$\mathbf{Y} = \mathbf{X}_1 + \mathbf{X}_2 + \mathbf{X}_3$

$\mathbf{X}_1$ = **Y** Congregant's Stressor Event is Referred by Pastor to a Mental Health Professional.

This causal model depicts the connection between the mental health stressor (causality) and the pastor's perceptions of the stressor event as it relates to the parishioners. The pastor's diagnosis/spiritualization of the parishioners mental health issue will influence how the pastor chose to treat or refer the parishioner. The stressor event may be of a degree that precludes the pastor's level of expertise or education. Therefore, if the pastor does not spiritualize the presenting problem by utilizing prayer and/or scripture the pastor will refer the parishioner to a mental health professional; albeit if the presenting problem is beyond their scope of practice. The arrow pointing to the X or outcome would by-pass the spiritualization of the mental health stressor by the pastor. Following this direction, the pastor will assess the congregant's mental health concern and will determine the appropriate resources for the congregant to receive assistance.

# CHAPTER IV

# RESULTS

This chapter is centered on explaining the current investigation's findings related to the outcome and predictor variables postulated to be related to an African American pastor's propensity to refer congregants to mental health professionals. The chapter is divided into three sections focused on the central theme of this dissertation that of African American pastors' perception of mental health and its relationship to the well-being of their congregants. The first section offers a detailed descriptive analysis of the sample population. Section two addresses the data using simple bivariate measures including results from t-tests, chi-squares, and correlations where appropriate. The final part is concerned with highlighting the relationships between outcome measures and predictor variables utilizing hypothesis-testing statistics.

## General Sample Characteristics

### Procedure

The procedure for conducting this study was partially derived from the Dillman (2000) Total Design Method (TDM). In this method, the original questionnaire was presented to a few African American pastors to determine if the questions were clear and easy to understand. The pastors offered comments and suggestions after completing the instrument. Utilizing their feedback, the instrument was expanded to ask more detailed questions related to mental illness and spiritual issues. In addition, it was determined that it would be necessary to send the survey with one-sided copying and more detailed instructions regarding the expectations for answering the questions.

Three hundred surveys were mailed to a sub-strata of random participants chosen from the World Wide Web White Pages telephone directory of churches combined with a list of African American pastors in the Kansas City metroplex.[3] Each questionnaire included a cover letter, an informed consent letter and a postage-paid self-addressed envelope. Of those 300 questionnaires, 102 questionnaires were completed and returned.[4] The response rate was over 30.0%. No incentives were provided to encourage responses and improve the return rate. After approximately two weeks, a follow-up post card was mailed reminding participants to return their questionnaires at their earliest convenience. Results from the follow-up post card technique were negligible; however, telephone follow-up helped to improve the overall response rate by approximately 10.0%.

*Instrument*

The instrument consisted of 61 questions including three open-ended questions assessing the pastor's perception toward mental health issues. Participants were assured of the confidentiality of their responses and were promised a written summary of the aggregated results at the end of the study.

Demographic measures examined in this study included age, race, gender, marital status, and formal level of education along with a host of other measures such as geographic location, type of church edifice and field of study in which the degree was earned. There were also questions that specifically addressed the pastor's ministry

[3] Zip Codes for the sample indicated that respondents from as far east as Washington, D.C. and as far west as California completed this survey. Questionnaires were returned from as far north as Wisconsin and some more remote locations in Colorado. In essence, the sample came from around the country with more input from the Kansas City metroplex.

[4] One participant e-mailed to ask for another questionnaire due to misplacing the previous one. Several participants called to say they would return the survey. In other instances, I received phone calls from participants stating they would not have time to complete the survey, but they wished me well with my endeavors. Three respondents sent brochures and business cards related to their faith.

including years as pastor, hours spent working for ministry, religious affiliation, number of ministers in the congregation, and annual income from the ministry. Other questions included full or part-time secular employment, annual secular income, and annual family income.

The twelve items related to collaboration, consultation and referral were selected for the Pastor's Issues in Family and Church Life measure were gathered from *the African American Clergy Consultation and Collaboration with Psychologists: A Questionnaire* developed by Shabazz (2002). Shabazz's questionnaire consisted of demographic inquiry and 12 items with a 5-point Likert scale that had responses ranging from Strongly disagree (SD) to Strongly agree (SA).[5] The items utilized in the current investigation were specific to the Shabazz (2002) categories of the instrument that assessed the pastor's collaboration, consultation and referral practices along with the relationship with mental health professionals. Additional materials for this dissertation were developed to assess the pastor's perceptions concerning spirituality within their congregation. There were three opened ended questions for written responses, and they were: 1) In your own words, define mental illness? 2) How would you perceive a member if they were diagnosed with mental illness? 3) What would you do if you knew a certain member was diagnosed with mental illness?

## Results

SPSS (Version 11.5) was used to analyze and describe the data. The predictor variables selected were pastor's perceptions about mental health, religious affiliation, educational attainment, years in the ministry, age of pastor, counseling related training

[5] The items in the Shabazz (2002) did not have numeric values assigned in the original instrument. Values were assigned for use in the current study.

and spiritualization of mental illness. The outcome measure selected was willingness to refer congregants to mental health professionals. Frequency distributions to report descriptive statistics, percentages, as well as correlation and ANOVA techniques were used to analysis and interpret the data. The overall return rate was 33.0% well within the acceptable ratings for mail-generated surveys. Of the 102 instruments that were returned 73 were from the focal group, African American pastors—the central groups of this study and the group for whom the subsequent analyses were done. Nine surveys were returned as undeliverable due to expired forwarding address or incorrect addresses. [6,7]

*Sample Demographics*

The gender composition of the sample was 63.0% male and 37.0% female. Not surprisingly, over three-fourths of the pastors were married (80.8%), with remaining groups divorced (9.6%), engaged (1.4%), widowed (4.1%) and never married (4.1%).

The age of respondents ranged from a minimum of 23 years to a maximum of 66 years. The mean age for pastors was 46.41 (sd = 8.17 years). The median age was slightly higher at 47.00 years. The pastors also exhibited higher levels of education than the general population. The mean numbers for formal education were 16.88 (sd = 3.15). At least 50.0% of all pastors in the sample had at least 17.00 years of formal education. Respondents had religious-related degrees in a number of fields (see Table 4.2).

Tenure as pastor was an important factor in this investigation. The average number of years the pastor served their congregations was approximately six years ( : = 5.86). Half of the pastors had been with their church for at least five years while the

[6] One pastor passed away in a plane crash before the survey submission deadline.
[7] One leader returned the survey, the letter, and the informed consent along with a note stating why he/she did not complete the survey due the fact that the questions. More specifically, he/she noted, "do not apply to this activity" "We do not have pastors such as are in individual churches."

other half for less. Despite the long tenure, ministerial salaries were somewhat below the national median of $54,000. The median African American pastor's salary reported was $37,322 with a standard deviation of $26,133.

Forty-eight percent (47.9%) of the respondents reported that they worked a full-time secular job and the other (8.2%) reported they worked in a part-time secular position. However, most pastors reported working an average of 33.62 hours per week on church business, which was the equivalent of another full-time job (see Table 4.2).

Geographic locality has often served as a marker for the Black Church. Most churches were urban (58.9%), with suburban (17.8%) and rural (23.3%) rounding out the final numbers. Another interesting yet unusual finding was where the church properties were located. Just under two-thirds (65.2 %) had an official church edifice while the remaining third (34.7%) was either rental property or without an identifiable building.

The respondents identified predominantly with mainstream Protestant sects that were part of historically-Black denominations[8]. Although there were a sizeable proportion of the churches that were considered non-denominational[9] (56.2%), this particular sect continues to thrive because of its ability to incorporate many of the teachings of the other Protestant sects without the formal structure of dogma found in highly organized denominations.

[8] Billingsley (1992) identifies that the top three historically Black denominations as Baptist, Methodist and Church of God in Christ (COGIC). Each of these sects is included in the current study.
[9] Nondenominational is defined as independent from the structure of a Protestant mainline organization.

Table 4.1
African American Pastoral Descriptive Data[a]

| Variable | Coding Scheme | n | *f* |
|---|---|---|---|
| Gender | Female | 27 | 37.0 |
| | Male | 46 | 63.0 |
| Marital Status | Married | 59 | 80.8 |
| | Divorced | 7 | 9.6 |
| | Engaged | 1 | 1.4 |
| | Widowed | 3 | 4.1 |
| | Never Married | 3 | 4.1 |
| Location | Urban | 43 | 58.9 |
| | Suburban | 13 | 17.8 |
| | Rural | 17 | 23.3 |
| Building Structure | Church Edifice | 45 | 65.2 |
| | Rental Property | 13 | 18.8 |
| | In the Process of Building | 3 | 4.3 |
| | Other | 8 | 11.6 |
| Religious Denomination | African Methodist Episcopal (AME) | 3 | 4.1 |
| | Baptist | 16 | 21.9 |
| | Christian | 1 | 1.4 |
| | Church of Christ | 1 | 1.4 |
| | Disciples of Christ | 1 | 1.4 |
| | Episcopal | 1 | 1.4 |
| | Methodist | 2 | 2.7 |
| | Pentecostal[b] | 7 | 9.6 |
| | Nondenominational | 41 | 56.2 |
| Secular Employment | No Employment | 32 | 43.8 |
| | Full-time | 35 | 47.9 |
| | Part-time | 6 | 8.2 |

Table 4.1 (continues)

Table 4.1 African American Pastoral Descriptive Data (Continued)

| Variable | Coding Scheme | n | *f* |
|---|---|---|---|
| Highest Education Completed | GED | 3 | 4.2 |
| | High School Diploma | 7 | 9.7 |
| | Associate's Degree | 8 | 11.1 |
| | BA, BS | 19 | 26.4 |
| | MA, MS, Med, Mdiv | 10 | 13.9 |
| | PhD, MD, JD | 4 | 5.6 |
| | Other | 21 | 29.2 |
| Ministry Salary | No | 38 | 52.1 |
| | Yes | 35 | 47.9 |
| Field Degree Earned[c] | Biblical Studies | 2 | 6.4 |
| | Christian Education | 2 | 6.4 |
| | Divinity | 3 | 9.8 |
| | Evangelism | 1 | 3.2 |
| | Ministry | 4 | 12.9 |
| | Pastoral Ministry | 6 | 19.3 |
| | Religion | 3 | 9.8 |
| | Theology | 10 | 32.3 |

[a] Not all the variables equal to total because of missing data; however, the percentages are adjusted to represent the non-missing data more accurately.
[b] Includes one Church of God in Christ (COGIC).
[c] N of cases does not equal to total since only those pastors with religious based degrees are listed.

Of the pastors who had a degree related to their profession, almost one-third (32.3%) held degrees in Theology. Degrees in Pastoral Ministry (19.3%) and Ministry (12.9%) rounded out the top three-degree areas for ministers in this study. Few held degrees in more traditional areas such as Evangelism (3.2%), Biblical studies (6.4%), and Christian Education (6.4%). Ironically, both Religion (9.8%) and Divinity (9.8%) studies had equal representation among this subpopulation of African American ministers.

Table 4.2
African American Pastor's Selected Demographic Mean and Median Scores

| Variable | Mean | Std Dev | Median | n |
|---|---|---|---|---|
| Age (23-66) | 46.41 | 8.17 | 47.00 | 71 |
| Education (9-25) | 16.88 | 3.15 | 17.00 | 67 |
| Years as pastor (0-32) | 5.86 | 5.40 | 5.00 | 73 |
| Ministry Income ($100-$115K) | $37,322 | $26,133 | $33,300 | 36 |
| Family Income (Under $1K to $175K) | $67,533 | $35,489 | $60,000 | 54 |
| Secular Income ($5K to $91K) | $40,266 | $19,276 | $35,000 | 29 |
| Congregation Size (15-2100) | 325 | 475 | 100 | 69 |
| Ministers in Congregation (1-200) | 10.71 | 24.28 | 6.00 | 73 |
| Hours Worked Per Week (0-90 hrs) | 33.62 | 23.42 | 35.00 | 73 |

The average congregation size was 325 (sd = 475) and a range up to 2,100 persons on a regular worship day. To service a multiplicity of congregants, some churches had many ministers ($\mu$ = 10.82, sd = 24.43) providing assistance with their religious duties.

*Knowledge of Mental Illness*

Respondents were asked to estimate what percentage of persons in the United States is mentally ill. Some of the pastors correctly reported the 22.0% figure (41.8%) that matches the National Institute of Mental Health (2005) recent estimates as highlighted in italics in Table 4.3. However, the majority (58.2%) answered incorrectly.

Table 4.3
African American Pastor's Estimates of
Percent Mentally Ill Persons in the United States

| Variable | Coding Scheme | *f* | % |
|---|---|---|---|
| Estimate of Number of Mentally Ill | 3% | 1 | 1.5 |
| | 5% | 9 | 13.4 |
| | 8% | 10 | 14.9 |
| | 10% | 17 | 25.4 |
| | *22%* | *28* | *41.8* |
| | Other | 2 | 3.0 |
| Total | | 73 | 100.0 |

Notably, the inability of African American pastors to correctly identify the proportional estimates of mentally ill people was inconsistent with their sense of knowledge about being able to recognize a mental illness. This was contrary to their responses related to their ability to recognize a severe mental illness where they report they were unlikely to in 15.1% of cases and 84.9% were likely. On the one hand, 24.7% said that they would be able to diagnose and treat a mental illness (see Table 4.4). While on the other hand, 75.3% reported they would not know how to diagnose and treat a mental illness.

Table 4.4
African American Pastor's Assessment of Their Knowledge of Mental Illness

| Variable | n | *f* |
|---|---|---|
| Able to Recognize | | |
| Unlikely | 11 | 15.1 |
| Likely | 62 | 84.9 |
| Can Diagnose and Treat | | |
| Unlikely | 55 | 75.3 |
| Likely | 18 | 24.7 |

*Referral and Collaboration Issues*

As mentioned above nearly one-quarter of the African American pastors admitted they could diagnose and treat mental illness. The factors that enable these pastors to develop such beliefs are explored in the contingency tables that follow. The central question of this investigation was whether or not African American pastors were willing to refer congregants to mental health professionals. The data in this section focused on developing rudimentary answers to this complex, yet very simple question.

*Mastery of Mental Health Related Issues*

What are the factors that influence African American pastors to refer congregants to mental health professionals? One factor that plays an important role in whether or not African American pastors ultimately refer and collaborate with mental health professionals was their sense of mastery concerning the issue of mental health. In other words, did pastors think they were as capable of addressing mental health issues among congregants, as were other professionals? As seen, there was an inconsistency between actual knowledge and practice among some African American pastors. To address this

issue contingency table analysis was used to help sort out the associations between ideas and practice more fully.

The likelihood of being able to diagnose and treat mental illness was examined in relationship to other factors related to the African American pastor's response to mental health issues. These variables ranged from simply providing counseling to factors involving the use of medication. The aim here was to see if in fact there was an association between these variables. The chi-square measure of association was used in these analyses.

In terms of those who perceived that they could diagnose and treat a mental illness, there were some interesting findings. When asked if they provided counseling, most indicated that they would be able to offer counseling but not be able to diagnose and treat mental illness (58.2%), while almost all of those who believed they could diagnose and treat mental illness (94.4%) also offered counseling ($\chi^2 = 8.08$, df = 1, $p < .01$). When the same measure was examined with the ability to recognize a mental illness ($\chi^2 = 4.23$, df = 1, $p < .05$), or think mental illness is demonic ($\chi^2 = 3.59$, df = 1, $p < .01$), whether or not the pastor thought congregants would imagine mental health problems ($\chi^2 = 19.97$, df = 1, $p < .01$), and would encourage discontinuation of medication ($\chi^2 = 4.00$, df = 1, $p < .05$) all yielded significant results (see Table 4.5). In other words, the likelihood to address issues of mental illness was associated with a pastor's perception of mental health.

The ability to diagnose and treat a mental illness was also examined using some of the interval level variables. Table 4.6 contains the findings from differences of means test (Student t-test). In general, there were no significant differences for age, length as

pastors, hours worked per week, or family income in terms of likelihood to diagnose and treat a mental illness. The only real differences came in terms of formal education ($t = -2.06$, $p < .05$) where those who were more likely to think that they could diagnose and treat mental illness had more education ($\mu = 18.53$, $sd = 2.93$) than those who did not ($\mu = 16.32$, $sd = 3.05$).

*Willingness to Consult with Mental Health Professionals*

This variable will be examined in relationship with other key variables to see what factors influence pastors to consult with mental health professionals. In Table 4.7 we again use a contingency table to look at the possibility of pastors consulting with mental health professionals in relationship to other variables. These variables ranged from recognizing mental illness to how pastors felt about the use of psychotropic medication. The goal was to examine if there was an association between these variables. The chi-square measure of association was used in these analyses.

Among those willing to consult with mental health professionals the findings were less dramatic. Pastors who indicated that they would recognize mental illness were more likely to consult with mental health professionals ($\chi^2 = 11.53$, $df = 1$, $p < .05$). Pastors who supported a medication regimen in general ($\chi^2 = 7.65$, $df = 1$, $p < .05$) as well as support for parishioners taking medication ($\chi^2 = 9.83$, $df = 1$, $p < .05$) and encouragement to congregants to discontinue use of medications in lieu of spiritual healing ($\chi^2 = 8.52$, $df = 1$ $p < .05$) produced significant results on the chi-square tests regarding the pastor's perception of mental health.

Table 4.5

Likelihood to Address Issues of Mental Illness as Reported by African American Pastors

| Selected Variables | Unlikely | | Likely | |
|---|---|---|---|---|
| | *n* | *f* | *n* | *f* |
| Provided Counseling | | | | |
| No | 23 | 41.8 | 1 | 5.6 |
| Yes | 32 | 58.2 | 17 | 94.4 |
| | $\chi^2 = 8.08$**, df = 1 | | | |
| Recognize Mental Illness | | | | |
| No | 11 | 20.0 | 0 | 0.0 |
| Yes | 44 | 80.0 | 18 | 100.0 |
| | $\chi^2 = 4.23$*, df = 1 | | | |
| Think mental illness is Demonic | | | | |
| No | 40 | 74.1 | 9 | 50.0 |
| Yes | 14 | 25.9 | 9 | 50.0 |
| | $\chi^2 = 3.59$**, df = 1 | | | |
| Think congregants are imagining problems | | | | |
| No | 55 | 100.0 | 12 | 66.7 |
| Yes | 0 | 0.0 | 6 | 33.3 |
| | $\chi^2 = 19.97$**, df = 1 | | | |
| Think problem is biological or physiological | | | | |
| No | 17 | 31.5 | 6 | 33.3 |
| Yes | 37 | 68.5 | 12 | 66.7 |
| | $\chi^2 = 0.21$, df = 1 | | | |
| Think they should support medication regimen | | | | |
| No | 25 | 45.5 | 6 | 33.3 |
| Yes | 30 | 54.5 | 12 | 66.7 |
| | $\chi^2 = 0.81$, df = 1 | | | |
| Will support taking medication | | | | |
| No | 6 | 10.9 | 1 | 5.6 |
| Yes | 49 | 89.1 | 17 | 94.4 |
| | $\chi^2 = 0.44$, df = 1 | | | |
| Will encourage discontinuation of medication | | | | |
| No | 50 | 90.9 | 13 | 72.2 |
| Yes | 5 | 9.1 | 5 | 27.8 |
| | $\chi^2 = 4.00$*, df = 1 | | | |

* $p < .05$. ** $p < .01$.

Table 4.6
Mean Scores for African American Pastors Likelihood to Diagnose
And Treat Mental Illness with Selected Demographic Measures

| Variable | Unlikely Mean (sd) | Likely Mean (sd) | t-score |
|---|---|---|---|
| Age | 46.53 (8.00) | 46.00 (8.97) | 0.22 |
| Years as Pastor | 5.71 (5.19) | 6.33 (6.12) | -0.42 |
| Hours Worked Per Week | 32.11 (21.81) | 38.22 (27.96) | -0.96 |
| Family Income | $66,575 ($31,354) | $70,886 ($48,872) | -0.36 |
| Formal Education | 16.32 (3.05) | 18.53 (2.93) | -2.60* |

* $p <. 05$.

Difference of means tests were conducted to see if some of the interval level measures had an influence on the likelihood of pastors to consult with mental health professionals (see Table 4.8). The only factor that seemed to make a difference was age ($t = -1.92$, $p < .05$), where those who were younger ($\mu = 43.18$, sd 10.35) were less likely to consult than older pastors ($\mu = 47.51$, sd = 7.21).

Table 4.7
Likelihood to Consult With Mental Health Professionals as Reported by African American Pastors

| Selected Variables | Unlikely | | Likely | |
|---|---|---|---|---|
| | *n* | *f* | *n* | *f* |
| Provide Counseling | | | | |
| No | 4 | 23.5 | 19 | 34.5 |
| Yes | 13 | 76.5 | 36 | 65.5 |
| | $\chi^2 = 0.72$, df = 1 | | | |
| Recognize Mental Illness | | | | |
| No | 7 | 41.2 | 4 | 7.3 |
| Yes | 10 | 58.8 | 51 | 92.7 |
| | $\chi^2 = 11.53$*, df = 1 | | | |
| Think Mental Illness is Demonic | | | | |
| No | 11 | 68.8 | 37 | 67.3 |
| Yes | 5 | 31.3 | 18 | 32.7 |
| | $\chi^2 = 0.01$, df = 1 | | | |
| Think Congregants are Imagining Problems | | | | |
| No | 15 | 88.2 | 51 | 92.7 |
| Yes | 2 | 11.8 | 4 | 7.3 |
| | $\chi^2 = 0.34$, df = 1 | | | |
| Think Problem is Biological or Physiological | | | | |
| No | 8 | 50.0 | 15 | 27.3 |
| Yes | 8 | 50.0 | 40 | 72.7 |
| | $\chi^2 = 2.92$, df = 1 | | | |
| Think They Should Support Medication Regimen | | | | |
| No | 12 | 70.6 | 18 | 32.7 |
| Yes | 5 | 29.4 | 37 | 67.3 |
| | $\chi^2 = 7.65$*, df = 1 | | | |
| Will Support Taking Medication | | | | |
| No | 5 | 29.4 | 2 | 3.6 |
| Yes | 12 | 70.6 | 53 | 96.4 |
| | $\chi^2 = 9.83$*, df= 1 | | | |
| Will Encourage Discontinuation of Medication | | | | |
| No | 11 | 64.7 | 51 | 92.7 |
| Yes | 6 | 35.3 | 4 | 7.3 |
| | $\chi^2 = 8.52$*, df = 1 | | | |

* $p < .05$.

Table 4.8
African American Pastors Compared Means Likelihood to Consult With Other Mental Health Professionals Variables

| Variable | Unlikely Mean (sd) | Likely Mean (sd) | t-score |
|---|---|---|---|
| Age | 43.18 (10.35) | 47.51 (7.21) | -1.92* |
| Years as Pastor | 6.12 (4.58) | 5.89 (5.65) | 0.15 |
| Hours Worked Per Week | 40.53 (19.13) | 32.09 (24.17) | 1.31 |
| Family Income ($40,078) | $80,555 | $62,795 ($33,489) | 1.61 |
| Formal Education | 16.20 (2.88) | 17.16 (3.20) | -1.03 |

* p <. 05.

Testing Theoretical Assumptions and Hypotheses

In this section, the basic theoretical assumption was framed by the adaptation of Reuben Hills ABC-X and *Boss's ABC X Stress Model* (2002*),* which were are examined by a series of hypotheses. I tailored the ABC-X model to use as the theoretical construct as it related to African American pastors and their congregations.

Four hypotheses were developed in order to answer the research questions. Each hypothesis examined an important aspect of the current research questions. The discussion reviews each one of the hypotheses.

Hypotheses one, two and three called for simple means difference testing, and hypothesis four required use of ANOVA analyses. The most efficient method of explaining each of the hypotheses was to revisit each one and then examine how the

analyses either supported or negated each hypothesis. The results of these findings are in Tables 4.9 and 4.10.

- *Hypothesis 1:* African American pastors' perceptions of their member's mental health concerns are *more likely* to be negative toward congregants.

The first hypothesis predicted that African American pastors perceptions were not very supportive toward their parishioners mental health concerns and their ability to accept or not accept mental illness. African American pastors were more likely to support their parishioner rather than not support them ($t = -1.55$, $df = 68$, $p < .001$) in their mental health concerns. In essence, African American pastors are supportive of those in their congregation who are experiencing difficulties just like any other member of the church. Given this information, hypothesis one was not supported.

The second hypothesis suggests that pastors were again unlikely to support members in their seeking out mental health resources by not referring them to mental health professionals because of the stigma attached to those who seek out counseling from professionals.

- *Hypothesis 2*: African American pastors *less likely* to refer members to mental health professionals.

This hypothesis was examined by looking at respondents who indicated they would allow mental health professionals to provide services to their church members. Pastors reported they were willing to allow a mental health professional entrée to their congregation. ($t = -3.75$, $df = 64$, $p < .001$). This hypothesis was again not supported by the analysis. It is apparent that pastors are willing to refer congregants to mental health providers.

- *Hypothesis 3:* African American pastors are *more likely* to "spiritualize" the mental health condition as a lack of faith.

The third hypothesis was based upon the pastor's propensity to spiritualize mental health problems based on the lack of faith among congregants.

The results of the hypothesis test ($t = -3.63$, $df = 69$, $p < .001$) reveals pastors are unlikely to relate their congregants' mental health issues to demonic influence and did not perceive their parishioners mental illness as a lack of faith. From the results it appears that pastors do not hold their congregant's spiritual well-being responsible for their mental health issues. This hypothesis was not supported.

Table 4.9
Mean Scores by Hypotheses and Selected Outcome Measures

| Hypotheses | Unlikely Mean (sd) | Likely Mean (sd) | t-score |
|---|---|---|---|
| $H_1$ Support Mental Health | 2.57 (0.51) | 2.83 (0.42) | -1.55 |
| $H_2$ Consult in Church | 3.50 (0.52) | 4.12 (0.54) | -3.37*** |
| $H_3$ Lack of Faith | 1.63 (0.78) | 2.59 (1.43) | -3.63*** |

*** $p < .001$.

Hypothesis four called for an ANOVA test to determine the results of the variables (see Table 4.10).

- *Hypothesis 4:* Pastors who have more specific training in mental health issues will be *more likely* to refer parishioners to mental health professionals regardless of the pastor's personal level of spirituality.

Again this assumption was negated because the pastors who had more training that incorporated both spiritual and secular ideas were less likely to refer parishioners to

mental health professionals ($F_{2, 69} = 0.689$, $p <$ ns). This finding is not significant at any level (see Table 4.10).

Subsequently, data analysis revealed that pastors who were more educated were more likely to counsel their congregant and not refer to outside mental health professionals. This relates to earlier findings that pastors who are educated are more likely to diagnose and treat parishioners; however, they are unable to recognize mental illness. These are contradictory findings. Nevertheless, the pastors must believe they are qualified at some degree to feel confident enough to provide treatment to members who are willing to report they are experiencing symptoms of mental health concerns.

*Table 4.10*
Reported One-Way ANOVA Results for the Influence of Training on Propensity to Refer

| Propensity to Refer Parishioners | Sum of Squares | Mean Square | df | F |
|---|---|---|---|---|
| Between | 14.008 | 7.004 | 2 | 0.689 |
| Within | 711.828 | 10.169 | 70 | |
| Total | 725.836 | | 72 | |

Although none of the original hypotheses received support, there are interesting and meaningful results that can and do come from such findings. One idea is that there is now a clear direction to follow brought on by the wrong direction as originally hypothesized. The importance of the new direction is largely what the theoretical construct proposed for use in this study will explore.

The next step was to apply the constructs in a structural causal model that focused on the interrelationships between and among the components of the modified ABC-X

used in this investigation. As with any theory building it was important to examine the simple relationships first. This was done via the use of correlation analysis where specific elements related to the ABC components were being examined for their relationship with the X element—propensity to refer.

## ABC-X Construct and African American Pastors

### *Correlations Analysis*

The variables used in this analysis were shown to have some theoretical relationship to the ABC-X model and were elements that would add to the understanding of the ABC-X construct as applied to African American pastors and their willingness to refer congregants to mental health professionals. Initially the variables selected were those believed to have a strong connection to the elements of the ABC-X model developed for use in this study. For example, the pastor's perception of mental illness, the awareness of mental health issues, and whether or not there was a spiritual element in the willingness to refer.

As can be seen in Table 4.11 there were significant relationships found. The correlations used a one-tailed significance because there was already an implicit sense of directionality due largely to the research questions, hypotheses and the general construct of the ABC-X model.

### *The ABC Construct*

"A" The Stressor. The first construct of the ABC-X model is the "A" component. This component is labeled as the stressor event or the thing that represents what is commonly called a presenting issue or problem. Whether or not a congregant has presented him or herself to a pastor for counseling is the initial event. The data show that

there is a significant relationship with pastors having provided counseling and the pastor's ability to recognize mental illness ($r = .210$, $p < .05$). On one hand, pastor's mental health awareness or knowledge of the current estimate of mentally ill people in the United States ($r = .224$, $p < .05$) was significant. One the other hand, the pastor's propensity to diagnose and treat congregants was not ($r = .078$, $p <$ ns). This finding was not surprising since pastors were unlikely to diagnose and treat mental illness as reported in earlier results.

"B" The Resources. The demographic measures had some strong connections to the outcome measures and corresponded to the "B" resources aspect of the ABC-X model. Age ($r = - .305$, $p < .01$), number of ministers in the congregation ($r = -.361$, $p < .01$) all revealed important relationships with the outcome measure of willingness to refer. On the contrary, neither the number of hours worked per week ($r = -.161$, $p <$ ns) nor the number of years of education ($r = - .141$, $p <$ ns) or training ($r = .133$, $p <$ ns) had significant relationships.

"C" The Perceptions. The next construct examined was the "C" element or the perceptions that influenced propensity to refer. The measure that focused on how a pastor incorporates mental health issues into their ministry is included in this section. Specific measures of a pastor's attitude and behaviors toward mental health revealed significant relationships between allowing mental health consultation in the church ($r = .241$, $p < .05$), allowing mental health professionals to lead seminars ($r = .203$, $p < .05$) directly consulting mental health specialists about a church member ($r = .339$, $p < .01$) and actually allowing the mental health specialist to lead a support group in the church ($r = .398$, $p < .01$). Ironically, both the overall measure of pastor's perceptions ($r = .119$, p

< ns) and spiritualization (r = -.057, p < ns) revealed no important connection to the outcome measure. In truth, this is not surprising since these elements also failed to garner any significance with the earlier hypotheses.

Table 4.11
Pearson Correlations for Selected Predictor Variables from ABC-X Paradigm with the Outcome Variable Propensity to Refer[a]

| Variable | Correlation Coefficient |
|---|---|
| **"A" Components** | |
| Mental Awareness | .224* |
| Providing Counseling | .287** |
| Recognize Mental Illness | .210* |
| Can Diagnose and Treat | .078 |
| Years | -.305** |
| Training | .133 |
| **"B" Components** | |
| Age | .282* |
| Number of Years Educated | -.141 |
| Number of Hours Worked | -.161 |
| Number of Ministers | -.361** |
| **"C" Components** | |
| Would Work with Mental Health Professional | -.133 |
| Spiritual | -.057 |
| Would Let MH Professional Lead Support Group | .338** |
| Allow MH Professional to Lead Seminar | .203* |

* p < .05. ** p < .01.
[a]Using one-tailed test. N of cases varied between 68 and 66 due to the use of listwise procedures for correlations.

## Modeling the ABC-X Construct to African American Pastors

One contribution of this dissertation is to utilize the ABC-X construct to examine responses among African American pastors that influenced their attitude toward mental illness. The current study is focused on exploring and identifying the factors that contributed to African American pastor's propensity to refer congregants to mental health

specialists. To that end, those elements which revealed salience in the simple zero-order correlation tests were matched to the research paradigm used in this study.

The variables selected for the causal analysis match the theoretical assumptions for inclusion in the ABC-X model used in this study. Variables selected were based on three things: 1) theoretical import—how important the variable was to the concept being measured; 2) variable strength—whether the variable exhibited a moderate to strong relationship with the outcome measure; and 3) the general logic necessary for theory building and connection of ideas—something essential in an applied investigation such as this one.

The method used for examining the theoretical construct of the ABC-X paradigm was causal modeling or path analysis. Use of path analysis in model and theory building was well supported in the literature (Blalock, 1960, 1961, 1978, Tacq 1997). Path modeling derived its ability to use a robust statistical technique in a more adaptive manner than one would traditionally use regression analyses. The ABC-X model can be tested using the following causal or path equations based on ordinary least squares (OLS) multiple regression analysis:

[Eq. 4.1] $Y = X_1 \$_1 + X_2 \$_2 + X_3 \$_3 + X_4 \$_4 + X_5 \$_5 + ,$

or in the language of the ABC-X model.

[Eq 4.2] $X = A_1 \$_1 + B_2 \$_2 + B_3 \$_3 + B_4 \$_4 + C_1 \$_1 + ,$

Where $X_1 = A_1$
$X_2 = B_1$
$X_3 = B_2$
$X_4 = B_3$
$X_5 = C_4$
and Y = X = Referral
, = Error term

The results of the equation can be seen in the theoretical model listed in Figure 4.1. Each of the elements corresponded to a particular aspect of the ABC-X paradigm. There was also a specific variable assigned to each of the components. The equations above and the figure below provided a "best guess" estimate of how the ABC-X model can be used in determining African American pastor's attitudes toward mental health professionals.

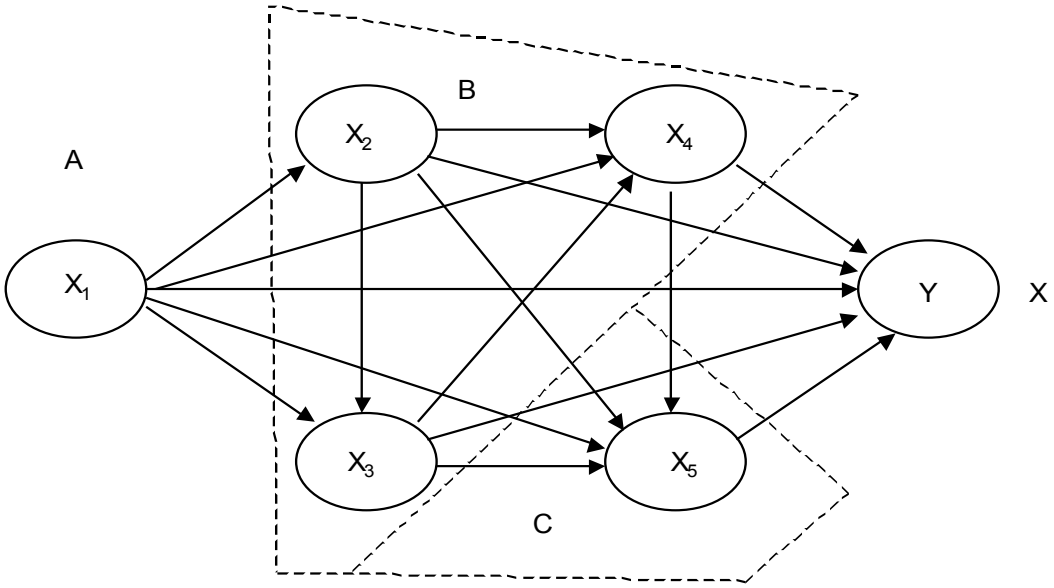


**Figure 4.1.** Theoretical Path Model Measuring the Influence of the ABC-X Elements on the Propensity of African American Pastors to Refer Congregants to Mental Health Professionals.

The outcome of the path analysis is found in Table 4.12. As can be seen all the variables selected produced significant findings. In other words, knowledge of whether a minister had ever provided counseling ($\beta = .336$, $p < .001$), the pastor's age was ($\beta = -.272$, $p < .001$), and the number of years one has been a pastor ($\beta = .274$, $p < .001$) were all strong indicators of whether or not an African American pastor would refer congregants to a mental health professional. Additional elements derived from the general ABC-X paradigm also pointed toward the salience of the data with the current design. It would appear that the number of ministers in a church ($\beta = .234$, $p < .001$) and whether or not a pastor would have a mental health support group in his/her church ($\beta = -.296$, $p < .001$) all were factors in the pastor's willingness to refer congregants to a mental health professional.

Table 4.12
Final Path Model Coefficients for testing ABC-X Paradigm and its Influence on African American Pastor's Propensity to Refer Congregants to Mental Health Professionals

| Variables | Path Coefficient |
|---|---|
| Pastor Provides Counseling | .336*** |
| Age of Pastor | -.272*** |
| Years as Pastor | .274*** |
| Number of Ministers in Church | .234*** |
| Would Allow MH Professional to Lead Support Group | -.296*** |
| Constant | 2.571*** |
| $R^2$ | 0.435 |
| $R^2_{adj}$ | 0.388 |

** $p < .01$. *** $p < 001$.

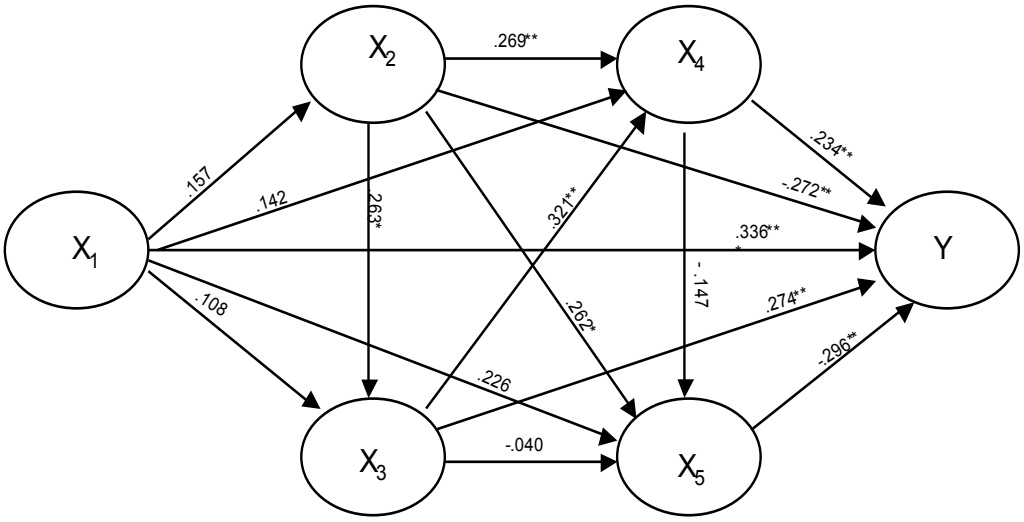


**Figure 4.2**. Final Path Model testing ABC-X Paradigm for Factors Influencing African American Pastors Willingness to Referral Congregants to Mental Health Specialists.

The significant path coefficients and the strong direct relationships also posit the idea that the ABC-X model application as used here is appropriate, just as originally believed. Overall the general model accounted for approximately 39% of the variance explained ($R^2 = .435$, $R^2_{adj} = .388$, $F_{5,60} = 9.230$, $p < .001$). Such a large amount of variance explained points towards the importance of the theoretical construct conceived in this dissertation (see Figure 4.2).

The overall aim was to see if the ABC-X paradigm could be applied to a non-crisis factor. The results suggested that it was not only possible, but that the ABC-X paradigm

was perhaps more robust. The meanings and implications of these findings are discussed in greater detail in Chapter Five.

# CHAPTER V

# DISCUSSION AND CONCLUSION

## Overview

This chapter summarizes the purpose of the study, methodology, discussion of research findings, and conclusion with the limitations of the study and recommendations for future research. The study's focus was African American pastor's responses to issues of mental health and its relationship to spirituality. Both the objective responses of the pastors as well as their voices will be interspersed throughout the chapter to bring a personal affect to the analysis.

## Purpose

The purpose of this study was to examine the perceptions of African American pastors on mental health issues in their congregations. The exploratory nature of this investigation allowed for both theoretical and applied perspectives to be used. On the theoretical side, four hypotheses related to current views of African American pastors were examined. On the applied side, the elements from the ABC-X model were tested vis-à-vis the actual perceptions and behaviors of African American pastors. An important outcome of this investigation was how an understanding of African American pastors approached the subject of mental illness with their congregants.

The topic of African American pastors and mental health issues is not well documented in the research literature. One study conducted by Shabazz (2002) examined African American pastors' consultation, collaboration, and referral propensity as it relates to Christian psychologists. The findings were based on a random sample of 77 African American clergy. Shabazz (2002) concluded that as a group, clergy were apt to consult,

collaborate, and refer to Christian psychologists but it was unclear if they would refer to other non-Christian mental health specialist. There continues to be paucity in the research literature concerning African American pastors and their perceptions about mental health among their individual congregants and their congregations as a whole. The primary objective of this exploratory investigation was to provide baseline data about African American pastors' perceptions about mental health specifically, the focus was on their willingness to refer congregants to mental health professionals.

## Methodology

The sample for this study consisted of 102 pastors selected from the World Wide Web White Pages telephone directory of churches combined with a list of African American pastors in the Kansas City metroplex. Of those 300 questionnaires ultimately, 73 African American pastors were found among the sample.

Receiving a significant return from African American pastors is impressive considering that the literature suggested that African American men (a substantial number of African American pastors are male) were less likely to participate in surveys and other methods related to collecting research data (Williams, 2005). In this investigation, questionnaires were returned equally from both male and female pastoral leaders. However, the majority of the questionnaires received were from male pastors[10]. It would appear that African American pastors no matter what sex group were interested in the topic and believe issues of mental health were important and should be addressed.

[10] It is important to note that this may be a result of the sender inequity that is often found within the ministry.

## Research Findings

*Gender and Marital Status within the Black church*

Historically, men have out-numbered women in pastoral positions in the Black church. The results of this study revealed no difference. More than over three-fourths of the pastors were married at the time the survey was completed. Having a spouse has traditionally been viewed as important in the Black church because it suggests stability, commitment and piety, and is symbolic of Christ's love for the church.

It was important for my husband to have me actively involved in pastoral duties and responsibilities. When he has other responsibilities, he looks to me to step in my role as co-pastor to provide direction to the congregation.

*Places of Worship*

Pastors who have their own church building represent an implied stability and commitment to their congregants. The need to have a significant amount of funds generated to provide upkeep of the church is secondary to the symbolic meaning of *having* a church. In historically Black churches, the building symbolizes a landmark in the community. The financial stability of a church to own their own property and building is very important to historical Black congregations. However, some pastors are renting space for the regular worship gatherings. In the current exploratory investigation, a sizeable majority of the pastors maintained their church buildings.

*Denominational Affiliations*

Several religious denominations were reported in the data. Most reflect traditional Black congregational memberships, and the others denoted membership to mainline Protestant congregations, including Episcopal, Baptist, Christian, Church of

Christ, and Methodist. One participant reported that that their denomination officials and the church board did not permit pastors to complete research surveys. In fact, several surveys mailed to this historically Black denomination were not returned.

A recent trend among religious circles is the ongoing growth of nondenominational churches. Over 56% of the pastors in this study reported their religious affiliation as nondenominational reflecting the current trend. It can be assumed that most of the data analysis was influenced by this unique and powerful group of pastors. The study of nondenominational groups a relatively new domain that should be explored in future studies. According to Thumma, (2001) this is not a recent phenomenon. However, there has been a significant increase in the numbers of nondenominational churches in the past ten years. Although the majority of the adherents were White (68%), the survey reported that 53% of nondenominational churches were racially diverse and 24% had multiracial congregations where no one racial group had prevalence.

From my experiences with African American nondenominational congregations, the leadership is often younger, some-what better educated, and frequently independent of traditional mainline denominations. This entrepreneurial operation allows leadership to be autonomous without the stringent structural expectations of traditional hierarchical religious denominations. This may be interpreted as openness to ideas and concepts that in the past twenty years were not accepted in the Black church. Independence allows pastors to establish their own internal structures for leadership and worship. Concomitantly, with this independence is the tendency to see the minister as being all-

powerful and all-knowing. As a result, congregants turn to pastors—even in areas where the pastors may have little to no experience, such as mental health.

These pastors can include women in leadership where men have previously had exclusive ownership of these roles. For example, African American pastors who have been in sole leadership are appointing their wives to co-pastoral roles. Not only are women in co-pastoral positions, they are also in church administrative positions as elders, deaconess, and bishops. Another unique feature of nondenominational churches is the mindset that people who attend the churches are not traditional parishioners of the past. Today's members are in need of a variety of services such as drug and alcohol rehabilitation, financial advisement, and family counseling.

*Secular Employment and Ministerial Income*

Almost half of the sample had employment in full-time secular positions, about a third was not employed in a secular job, and a smaller percentage of the pastors have part-time secular jobs. The average ministerial income was $37,000 per year. It should be noted that this is about $20,000 under the national average for secular yearly income, so it is easy to see why many pastors feel they need to have a full-time secular job. Pastors who work in the secular arena and maintain a full-time pastorate are expected to fulfill family obligations and pastoral duties at the same time.

African American pastors receiving a yearly salary may be the exception and not the rule for many full-time pastors. Often times the alternative to a full-time salary will be a stipend for gas and food and a honorarium for preaching or teaching for the regular worship day. This point is prevalent in many congregations due to the moderate monies available to support the ministry. Another point is that pastors who have to work full-

time at a secular job are less likely to have time to spend quality-counseling time with their congregants. Factors such as these place emphasis upon the importance of pastors being skilled to meet the mental health needs of their congregation.

*Educational Achievement*

Educational attainment was noteworthy because many pastors had received at least a four-year college degree or seminary. Over 50% of the sample earned degrees in religion or religious affiliated fields. However, none of the African American pastors in this sample has behavioral science degrees in social work, psychology, marriage, and family therapy or medical degrees in Psychiatry. The pastors surveyed are qualified to lead their congregations based on their level of education and field of study. In the past African American pastors did not have the opportunity to attend secular or theological seminaries because of institutional racism, the laws of the land, and blatant discrimination against Black men and women in general.

Historically, African American pastors may have been the most educated person in the congregation, and his or her ability to read or interpret the Bible was an important quality (Raboteau, 1995). Congregants continue to expect the pastor to be a readily available source of knowledge, guidance, and information on a variety of subjects, including areas where they have no real training such as mental health. In my experience as a congregant, I expected the pastor to answer spiritual and Biblical questions and to provide direction for personal problems.

*Knowledge of Mental Illness*

Nearly 60% of the pastors in this study incorrectly estimated the percentage of mentally ill people in the United States. Lack of current facts about the increasing rate of

mental illness among African Americans in the United States suggests that pastors are not informed with the facts nor are they aware of when their congregants may exhibit mental illness symptoms. Another possible explanation for pastors not answering this question correctly may be that pastors define mental illness differently than mental health professionals. Pastors may notice symptoms of mental illness, but perceive them as a spiritual problem as postulated in this study. Therefore, they are unlikely to recognize the specific criteria for mental health concerns particularly as described in the (DSMIV, 1994).

Yet, pastors overwhelmingly reported that they could recognize mental illness. More surprisingly, however, a small percentage believed they could diagnose and treat mental illness, too. This seems hard to believe, considering they do not know the correct proportional estimates of the mentally ill in the United States, nor do the results suggest they have specialized training in the mental health field.

Overall, the pastoral responses indicate they cannot competently diagnose and treat mental illness as necessary. The level of mental health training received by African American pastors is another area of concern. None of the pastors indicated they had degrees specific in psychology or counseling; however some did report they received some type of training related to collaboration, consultation, and referral in regards to mental health. The fact that pastors are furthering their professional development by attending seminars and workshop again lends itself to a more educated pool of African American pastors. Pastors are open to attending denominational conferences and other types of gatherings that offer a variety of workshops and seminars related to the family and pastoral counseling. African American pastors who are located in rural areas are less

likely to travel long distances to attend the larger seminaries for degrees. Local colleges and universities provide on campus classes and Internet courses related the to counseling and social work domain.

As found in this exploratory study African American pastors are in full-time ministry and if necessary secular jobs. It is amazing that they can fit in their schedule attending a conference, taking course work on top of the demands of their congregation and secular employment. My personal goal to complete a doctoral degree in family studies is directly related to having the academic background along with the spiritual and theological framework to better assist our congregation. The mental health needs of our congregants are important to us and our level of skill and expertise must be current and valid to meet the needs of our congregation.

*Referral and Collaboration Issues*

According to the data analysis, pastors indicate they refer and collaborate with mental health professionals based upon their mastery of knowledge about mental health issues. Significantly, the predictor variables used to gauge their propensity to refer and collaborate with mental health professionals was correlated with their admission that they counsel congregants, their ability to recognize a mental illness, lack of perception of mental illness as a result of demonic influence, and their belief that the parishioner was imagining their mental illness. These findings may be a result of the pastor's long-term experiences in working with congregants as well as additional training. Nonetheless, these factors were all relevant to the pastors' likelihood to address mental illness in their congregations. Importantly, Shabazz (2002) found in her sample of African American clergy that pastors have positive perceptions about their ability to recognize and refer

parishioners to Christian psychologists. The current investigation, while using some of the constructs and notions from Shabazz (2002), enhances the literature by combining ideas from the family stress theory arena with the protocol approach used by African American ministers addressing issues of mental health. Preliminary results revealed that the applicability of the Contextual Model of Family Stress has some import for understanding how African American pastors reach decisions about mental health issues, something that has not been done in the previous investigations.

## Hypotheses

The hypothesis development was based upon the many years I have spent in the Black church and my own personal experiences in the Black church as it relates to spiritual, social, emotional and physical domains. According to personal experiences, there are no apparent safe-guards in place for people who are in need of counseling specific to mental health concerns. Although, the pastors are available to the congregants, it is not clear to what level they can be of psychological assistance to their parishioners.

The four hypotheses in this study were developed from the five research questions to determine the pastor's attitudes toward mental illness and their responses to mental health issues in their congregations. Each hypothesis took a specific direction of more or less likely to measure the differences within the sample of African American pastors who were more likely to refer to a mental health professional and those who were not likely to refer to a mental health professional. In effect, the hypotheses are statements that addressed the specific issues raised in the research questions. It is possible to derive the

research questions from the hypotheses, just as it is possible to state the research questions as hypotheses.

The first hypothesis surmised that African American pastors perceptions of their member's mental health concerns are more likely to be negative. The second hypothesis queried how likely pastors were to refer congregants to mental health professionals. The third hypothesis suggested that the pastors were more likely to spiritualize or diagnosis the member's mental illness as a lack of faith. Finally, hypothesis four assumed pastors would be more amenable to referring to mental health professionals if trained to identify mental health issues.

- *Hypothesis 1:* African American pastors' perceptions of their members' mental health concerns are *more likely* to be negative toward congregants.

Hypothesis one is based on an assumption that when a congregant goes to the pastor with specific mental health issues the pastor would respond to the congregant with a dismissive attitude. The findings in this investigation found quite the contrary. Pastors reported that they will support a congregant if they admitted they were experiencing mental health problems.

Unlike the pastors in this sample, in the past, African American pastor's negative reactions may have been based on African American pastors deeming a congregant as demonically possessed or being out of the will of God. One of the pastor's comments match with the basic assumptions behind the first hypothesis:

> "I think the church has resisted mental health ministry for too long. It is encouraging to think that the church can truly benefit from it. It's time to seek God in this area."

Another pastor wrote:

> "My perception would be to help them. Pastors recognize the spiritual and physical elements of mental illness and do not perceive members negatively."

The above responses are an illustration of African American pastors supporting their parishioners when they are experiencing some type of mental health concern. Overall, most pastor's responses were positive toward mental health concerns and how they would perceive their parishioners. It would appear that pastors are not perpetuating a negative opinion of mental health issues in the Black church.

- Hypothesis 2*:* African American pastors are *less likely* to refer members to *mental health professionals*.

This hypothesis is predicated upon the idea that African American pastors and parishioners are skeptical of outside help and do not trust mental health providers to be sensitive to their mental health concerns. Another important point is that pastors know that some of their parishioners are under-insured, and/or do not have insurance and lack the finances for the necessary medical attention. Sometimes a co-payment is too much for a congregant to give toward mental health services. However, the pastors reported a willingness to consult with mental health professionals and refer their parishioners to mental health professionals. Thus, the second hypothesis did not have substantial support. One explanation for this is that twenty-first century African American pastors are more educated, have more connections to the community, and have access to resources for their parishioners. Most mental health professionals and community centers advertise and have a referral mechanism in place that pastors can access if needed. In some cases, there are sliding scales and free services. All of these things can and do play a part in some perceptions held by African American pastors.

When asked the open-ended question, "What would you do if you were certain a member has a diagnosed mental illness?" Pastors responded in the following manner:

> "Refer them to professional help."
>
> "Advise them to seek professional help."
>
> "The same way I would any other problem—with love, compassion and a desire to see them helped. Just as there are sicknesses of the body, there are sicknesses of the mind. Each needs to be treated with professional in that field are (sic) prayer has been offered along with ongoing support."
>
> "I have some and they are treated no differently than the non-mental ill. I don't feel that this is a disease, but rather a result from something that happen (sic) to the individual that was not dealt with properly or an accident that occurred."

- *Hypothesis 3:* African American pastors are *more likely* to "spiritualize" the mental health condition as a lack of faith.

The third hypothesis was based upon the perception that pastors are most likely to misinterpret mental health problems as a moral defect or spiritual flaw (Taylor et al, 2000). In other words, African American pastors would utilize a spiritual paradigm to explain the origins of mental illness. Historically, African American pastors have not been receptive to secular theories regarding mental health issues likewise; the professional mental health community has been reluctant to accept religion or spirituality as a valid response to mental health concerns. Previously, pastors perceived congregants who were experiencing mental illness as possessed or not strong enough in their faith. On the contrary, pastors did not report that parishioner's mental illness or concerns were based upon a lack of faith.

> "I would use all of the venues available to assist them, be it prayer and the Word of God, medication, counseling, hospitalization, etc."

"Give them much support through the Word of God and keep positive words flowing in their life."

"Suggest counseling."

Pastors are more willing to move beyond the boundaries of spiritual answers to biological and physiological explanations for congregants' mental illness. For some pastors, admitting there may be some other source for mental illness would not be a viable option. Personally, I believe the method used to survey the pastors allowed them the freedom to be candid with their responses. Using a face-to-face interview approach may have biased the pastor's responses.

- *Hypothesis 4:* Pastors who have more training in mental health issues will be *more likely* to refer parishioners to mental health professionals regardless of the pastor's personal level of spirituality.

According to Taylor et al (2000, 2004) pastors with advanced training and less conservative theologies are more likely to make referrals to mental health professionals than pastors who do not have advanced training or open-minded theologies. The presumption was that if African American pastors who have advanced education and/or training, might be more proficient in identifying mental health warning signs and would refer or consult with mental health providers rather than counsel the parishioner independently.

The results, however, did not support this hypothesis. Conversely, the pastors who had advanced training were *less likely* to refer congregants to mental health professionals than those with less advanced education or training. In reality, the African American

pastors in this study who were the least likely to refer were those with little to no training and those with advanced training on mental health issues.

The first and third hypotheses were not substantiated by the appropriate selected statistical measures. The likelihood of the second and fourth hypotheses being unsubstantiated was a surprise considering that the literature supported the bias pastors have concerning working with mental health professionals. Neighbors, et al (1998) suggested that pastors may hesitate to refer parishioners to mental health specialists due to the possible shame and mistrust that the congregant may face when visiting with mental health professionals. An additional factor may be the pastor's own competence and ability to cope with or address spiritual issues, if the congregant is questioned about the pastor's counseling expertise. Another point is that African Americans prefer alternative treatment modalities rather than traditional social expectations concerning mental health concerns. They do not feel comfortable or understood visiting traditional mental health professionals (USDHHS, 2001). One of the alternative treatment modalities is the Black church are dependent upon the pastor to provide support and guidance. Pastors' responses illustrate how they are providing support to parishioners. The question posed to the pastors "What would you do if you were certain a member has a diagnosed mental illness." Resulted in some of the following responses:

> "We have someone in our congregation who is paranoid schizophrenic. She is loved and cared for and nurtured through the word of God, and prayer. She is given ministry tasks and is very reliable."

Another pastor also said:

"Varies with circumstances. In some instances, no change is necessary. In other instances, I work with the counselor and provide a support person(s) in the church."

Pastor's willingness to provide resources are apparent. For example, one pastor noted that he/she should:

"Find resources to help that person and the family."

"My first instinct would help them (the severity of their problem) and then secure the proper assistance to help them."

"Refer to professional or social worker who has training and expertise."

Overall, the findings are revealing, but a rational explanation is available. Two of the hypotheses accordingly hypothesis two and hypothesis three hypothesis are based upon collegial experiences with other African American pastors. These experiences may be the exception instead of the rule. Discussions among fellow pastors have concurred with my hypotheses and related questions. However, the results of this investigation suggest something completely different. One plausible explanation may be that African American pastors are providing a holistic ministerial approach for their congregations. For example, some pastors described that they would:

"Use my skills in counseling to assess and make a professional recommendation."

"I would extend the same pastoral services that I would any member with the exception the member would allow pastor-member/physician communication as needed."

"With continuous prayer for that member, prepare myself in training, to use a "wholistic" (sic) approach to treatment in counseling."

"I would call them in and recommend immediate consultation (sic) (in order to verify that they were doing all to treat the mental illness)."

Experiences are unique to each congregation. One glaring example that troubled one Black church community over a year ago is the homicide and suicide of a couple who were married for many years and who attended church faithfully. The husband was an alcoholic and was abusive throughout their thirty plus years of marriage. One evening following a Wednesday night Bible study the couple got into an altercation at their home and he shot his wife in the head and then turned the gun on himself. Many in the congregation were directly effected by this tragic event and many thought that the needs of the couple were not being met appropriately in their place of worship.

One reason for this study was to probe the sentiments of pastors to understand how and why they think about mental illness in the way that they do and to define areas that can be enhanced by theory and application to help them to be more competent pastors.

An alternative rationale may be based upon stereotypes placed upon traditional African American pastors as hard-nosed-task-masters who are allowed to control the congregation to the where the congregations becomes dysfunctional. Another way of looking at these findings may be to think of the current pool of African American pastors as more progressive in their thinking, better educated, and more aware of society and the real world in which they live just as Taylor et al (2004) suggested.

Although there is disparity in the research outcomes based on the hypotheses, there is now a bit more information available to the academic community to better grasp

the needs of the pastors and parishioners attending the Black church based upon this investigation.

*ABC-X Contextual Model and African American Pastors*

One of the caveats of the ABC-X model is its versatility. The three constructs allow for variables that are fluid and fixed to be placed in the appropriate domain and tested to provide results for the outcome variable. A causal model developed for this investigation was based on the theoretical ideas and assumptions about African American pastors' propensity to refer to mental health professionals. The ability to adapt the ABC-X model to this issue is an example of its versatility.

African American pastors' likelihood to consult with mental health professionals were validated by the age of the pastor, how long the pastor has been in leadership, the amount of hours he or she works in the ministry per week, the family income, and the amount of formal education the pastor has obtained. Each one of the predictors was significant to the pastors' likelihood to consult with mental health professionals. The results suggested that pastors who were most likely to consult are in their late forties. Time and experience may have taught the pastors where their strengths and challenges lie within working with people who are experiencing mental health issues.

*Modeling the ABC-X Construct to African American Pastors*

The purpose of applying the ABC-X model to selected variables, was to measure the pastors' likelihood to refer congregants to mental health professionals. This method provided a theoretical model by which significant predictors related to referring parishioners could be applied. The results demonstrated a useful way to determine the validity of the assumptions and hypotheses. Singular elements were more important than

scaled variables. Theory building requires a willingness to adjust one's thinking about the area of study.

## Path Analysis

The utility of path analysis allows one to look at the moderating and mediating factors that influence an outcome. It was important to see the results of how other variables, along with the outcome variable, yielded significant findings. The ABC-X model gave the selected variables context for understanding how they affect one another. The "A" element is the presenting mental health stressor or the reason the parishioner goes to the pastor for counseling, "B" is the coping resource available to the congregant to help them address the issues. "C" is the pastor's perception of the presenting problem and "X" is the outcome, the pastor's—willingness to refer.

Five variables were selected that are related to a pastor's willingness to refer mental health professionals. Each of these factors is related to a specific component of the ABC-X model as used in this study (See Figure 3.1 on page 44).

These factors combined were then structured into a path model designed to explain why pastors might refer congregants to mental health specialists. The elements were tested independently and then grouped together in the final model. The findings were significant. In short, the application of the ABC-X model allowed for 39% of variance in the pastor's decision to refer to be explained.

It is clear that the ABC-X model, as used here, provides an excellent context for understanding the relationship between pastors and their willingness to refer parishioners to mental health specialists. Theoretical constructs are important to theory building and having a theory to assist pastors with their congregants' mental health needs will also

assure that pastors are better trained to meet the mental health needs of their congregants, instead of an "all or nothing" paradigm as is used now.

Although the ABC-X model has been used to explicate stress and levels of stress, its flexibility was demonstrated for this investigation. The ability to apply a non-stressor outcome to the model suggests that the model is very flexible and can be user friendly in a number of issues where human behavior is involved.

*African American Pastors' Perceptions of Mental Health*

In this section, there will be discussion about the results; specific quotes from the pastors, and the implications of this purposive study. The cultural context for this model is predicated upon the premise that when African Americans have mental health issues, they perceive a need to visit with their pastor rather than a mental health specialist. African American pastors report that they do not have a problem working with mental health providers in their community. Consequently, there is a need for the pastoral leadership to be made better qualified to provide counseling, collaboration, and referral. Pastors can influence members with mental health issues to seek out professional mental health services. Pastoral leadership is responsible for guiding parishioners that are underserved by the mental health community.

According to the pastors' responses, they tend to provide counseling for a myriad of presenting issues that the congregants bring to them. Pastors defined mental illness and reported it as a disease that they were willing to work with.

Some of the African American pastors' responses defining mental illness can be summed up as: that mental illness is defined by a person experiencing irrational thinking, varying degrees of irresponsibility and behavioral issues. Other African American

pastors perceived mental illness as a form of demonic possession. The following quotes illustrate this point:

> "A mind thing."
>
> "A chemical imbalance in the brain area. Demonic forces might influence some cases. Pray for discernment of what is happening."

Another respondent characterized people with mental illness as:

> "[P]eople who are mentally unstable."
>
> "[A] person that could become overwhelm with grief, stress and depression, possessed or health related."

A few of the African American pastors commented that there is a problem with the parishioners' spirituality when they are mentally ill. The written responses collectively shared the view that there must be a balance between the spirit, soul, and body. One could safely infer that African American pastors prefer a holistic approach to mental health concerns.

> "My perception would be to help them. Pastors recognized the spiritual and physical elements of mental illness and do not perceive members negatively."

The data analysis did not yield significant results concerning African American pastors' preference for Christian counselors, however, some pastors responded that they would prefer to work with Christian mental health professionals.

Some pastors stated their preferences:

> "If mental health personnel/counselors are Christians to include bible believing individuals I would work closely with that person."

> "Any mental health professional who would attend our church for counseling, I would prefer one who is a spirit-filled believer."

The pastors preferred to be the facilitator of mental health treatment, and they did not mind collaborating with mental health professionals. Pastors supported counseling parishioners, collaborating and referring them to appropriate professionals. Pastors responded in the following manner:

> "Counsel, question, and if necessary refer to Christian counselor."
>
> "Talk to professional and ask for advice."
>
> "I would call them in and recommend immediate consultation in order to verify that they were doing all to treat the mental illness."
>
> "I believe that it is healthy to bring cooperative and collaborative synthesis of mental health practitioners and those of pastoral care."

The second research question asked what factors influenced perceptions of African American pastors to have a negative response toward church members who are experiencing mental health problems. It would appear that there was no one set of responses inferred the answers varied:

> "My perception would be to help them. Pastors recognize the spiritual and physical elements of mental illness and do not perceive members negatively."
>
> "Frequently what is diagnosed as mental illness for African Americans is really a "normal" response to the stress of being Black in American---particularly among males."
>
> "They will be perceived as individuals that need recovery beginning with diagnosis and eventually moving into successful management. This also included educating these

> people about their illness and the treatment available which the Word of God can offer. Empowering these people through the support of peers and family members and how they can be of help to others after recovery."

Overall, pastors did not have a negative view of parishioners who were experiencing mental health concerns. They did not have a problem providing support as they would any other member of the congregation. The likelihood that pastors are willing to allow a mental health professional to lead a support group within their church was another important finding. Pastors indicated that having a mental health professional come into their church most helpful compared to just consulting with a mental health professional.

## Implications

The research findings from this investigation have two major of implications for African American pastors, clergy working with persons of color, and the mental health services delivery community. First, there is an evident need for research and information dissemination to pastors about recognizing mental illness and referring congregants to mental health professionals. Second, there are stereotypes and attitudes in some Black churches among the congregants about the pastor's position on mental health and his or her willingness to collaborate, refer or consult with outside entities in the mental health field.

### *Research and Information Implications*

Some of the key findings are fascinating. African American pastors evidently are using multiple methods of ministering. Obviously, there are pastors that still believe that any mental illness is a result of some type of spiritual malady. For those African

American pastors who have negative perceptions of mental illness, the findings of this dissertation are essential for them to know.

African American pastors should possess a balanced ministry approach considering, their congregants are human beings that have a spirit, soul, and body.

One pastor illustrates this point very clearly:

> "…This is an area that churches must take a good and long look at. Mental illness is point for study. The physical, mental, and spiritual are related!"

*Stereotypes and Attitudes about Mental Health*

Pastors are expected to provide spiritual guidance to parishioners. Two of the methods most commonly associated with Christian faith-based beliefs include prayer and scripture reading. These options are still vital resources to assist parishioners who are experiencing mood disorders and other mental health concerns. The caveat of pastoral counseling is that congregants can expect prayer and scripture reading to take place, unlike with secular mental health providers. Pastors and congregants share a common paradigm regarding their perceptions of spirituality and religion (Taylor et al 2004). This unique cultural and spiritual context within the Black church is paramount for parishioners who need mental health services.

According to African American pastors responses, they echo a holistic approach to pastoral ministry. Pastors may realize that the congregants require assessment of the whole person and not just meeting their congregant's spiritual needs. Pastor's responses revealed a willingness to work with secular mental health professionals. The only hesitation for some of the pastors, according to their written comments, is that they

preferred to refer congregants to a Christian counselor if available. The following quotes by African American pastors illustrate this point.

> Some pastors described:
>
> "Counsel, question, and if necessary refer to Christian professional counselor."
>
> "…I would prefer one who is a spirit-filled believer. This would help educate me professionally as well as spiritually."
>
> "The level of involvement with this congregation would depend heavily on the person/counselor's skills & sensitivity to the transforming power of God and the unique African American social, economic, ethnic, racial & religious historical experiences."
>
> "If mental health personnel/counselors are Christians to include Bible believing individuals I would work closely with that person."

African American pastors counsel members regularly for a variety of reasons from marital problems to spiritual challenges that they are facing. Although pastors know they are expected to be prepared to counsel, they also must spend time preparing sermons, over looking the business portions of the ministry and many other expectations. Sometimes, pastors have other ministers on staff assign them to assist with counseling members and other ministerial duties. One of the participants informed me that the pastor does not do any counseling due to his schedule; however, he refers all of his counseling requests to another minister on staff.

In my role as a pastor, I would like to see more facilitation by pastoral leaders to provide counseling in partnership with mental health professional. Utilizing this information is imperative because of the state and federal fiscal policies regarding the care of the mentally ill. Resources are limited around the country and the church will

need to step up in its ability to provide the mental health assistance for parishioner and non-members alike. The fundamental guiding principle of the Bible is love and not just for one group, but for all people.

Throughout this investigation, beginning at the literature review, preparing the methodology and now to the actual data analyses, African American pastors are distinguished as strong leaders with powerful voices in the Black church and their communities. The strong voice of the African American pastor will continue to resonate around the world because of the numbers of people who follow those voices.

This dissertation will add to the knowledge skills and abilities of the Black church community and the mental health community by adding to the literature and providing the pastoral leadership and the mental health community with pertinent data results and recommendations for future reference. Research findings from this study supported some assumptions and dispelled other conjecture and stereotypes that are associated with the Black church and the leadership of this unique institution.

## Suggestions for Further Research

There are many issues that have been raised in this exploratory study. Some of the issues provided answers and others lead to more questions. The suggestions for research are based upon the relevant issues that must be addressed in future investigations. They are discussed below:

- The next investigation should increase sample size. The current sample size closely replicates Shabazz's (2002) study with 77 in her sample and 73 in the current investigation. A sample size of at least 300 African American pastors

would give more power to the results and allow for some inferential statements to be made.

- A comparative study should be done. Comparison of findings between African American and White pastors would reveal if race was as an important factor as believed. It should be noted that twenty-nine White pastors returned questionnaires. Some respondents informed us that they did not have Black parishioners in the congregations, but they would complete and return the survey nevertheless, the ideas expressed about mental health by these respondents still are vital to understanding pastor's perceptions about mental health and illness, with an overlay of race. In the future, this will be another opportunity to compare the findings from those pastors.
- Controlling for socioeconomic status of congregants. Parishioner's economic level may influence what kinds of mental health problems and the method used by pastors to counsel pastors.
- Provide case scenarios. Case scenarios may help pastors with the theory and application of their responses to problems among their congregants, and in some cases, provide direction about what to do when they observe similar problems with congregants.
- Offer incentives to increase response rate. Incentives can encourage participants to return the survey in the allotted time. There should be some reward for responding to the questionnaire.

- Plan to survey the congregation. Congregational responses to questions related to mental illness and how the pastor responds as perceived by the congregants is important.
- Contrast with Catholic Priests. Contrasting results with this unique group of clergy would result in findings will be of interest to the religious community in total.
- Pastor's theology or spiritual worldview should be more closely examined, this will be interesting to know the theology and ideology of pastors and how those ideologies effect their perceptions of mental health and mental illness issues.
- Do a comparative study of mental health professional's and pastor's perceptions about mental health in the Black Church. So far, the studies have all been in one direction with the pastors as the central focus. What would the results look like if both groups were examined? It is an interesting area for future studies.
- Expand the measurement instrument to include more questions and eliminate others that did not directly relate to the predictor variable used in this data analysis.
- Using a face-to-face interview approach may provide more revealing and detailed responses.

## Limitations of the Study

With any investigation, there is a need to address the limitations of the research. There are common limitations and there are limitation directly related to this exploratory that have been observed and will be noted in this section. The limitations are as follows:

- Cost limitations. The expense of mailing out the surveys and the return postage for the envelopes for the pastors was very exorbitant. A recommendation to alleviate costs is to submit a grant or request departmental funding that will offset the costs attached to return postage and follow-up post cards and any extra surveys that will be sent to participants that lost or misplaced their questionnaire.
- Some of the questions were ambiguous for the pastors. Pastors needed more clarification of terms and meanings related to the questions in the survey.
- Pastors needed more time to return the questionnaire. Time constraints placed upon the researcher limited the multilevel approach. This was a key concern administering a field study in this way. Following the instructions suggested by Dillman's Tailored Design Method—the original return date for the questionnaire was approximately fourteen days. Many pastors did not return the questionnaire in a timely manner. This delayed the completion of the statistical analysis.
- Another limitation was the inability to build in a great deal of randomness in the sample. The participants were randomly selected from the White pages via the World Wide Web. Initially a mid-western metropolitan area was selected with several Black churches in the community. However, this too is limiting in terms of sample.
- Limited literature available specific to African American pastors perceptions and spiritual beliefs made it difficult to fully compare and understand the findings of this investigation.
- I did not conduct face-to-face interviews. By conducting face-to-face interviews, the researcher can expound and explain questions. A pencil and paper instrument

versus personal interviews did not allow the respondent the opportunity to talk in their responses to the questions in more detail and or ask questions that would allow them to better understand the questions they may not have understood.

## Conclusion

The findings in this study were surprising; nevertheless, they are very informative to researchers, leaders of Black churches and community and government officials. Considering the impact African American pastors have upon their congregation and the community, the findings are refreshing because it means that pastors can influence others in a positive direction regarding mental health concerns. It is also apparent that pastors have a great deal of autonomy as leaders of Black congregations. This autonomy is a positive for congregants who face non-traditional problems that in the past they may have felt they could not discuss with their spiritual leader or a mental health professional for fear of social stigmas.

The results of this investigation suggest that African American pastors are open and willing to work with their congregations. This willingness to refer their congregants is opening a gate that may have been closed in the past, allowing for mental health specialists to work with clients that are members of the Black church. Pastors are not only willing to work with members, but they are willing to collaborate and refer to mental health specialists.

According to President Bush's New Freedom Commission on Mental health the purpose is to "improve America's mental health service delivery service for individuals with serious mental illness and children with serious emotional disturbances." A policy options paper submitted to the President by the cultural competence subcommittee

discussing the review of the level of care and support for ethnic and racial populations in the United States indicates a level of concern for mental health issues among People of Color in this country.

Mental health related research is in the forefront of the news. Researchers are publishing studies with results that continue to show the disparity and barriers affecting the general population and the lack of delivery of services to people of color. The Black church is a stakeholder in this national move to change behavioral health services for African Americans.

Mental health education and research must facilitate the removal of barriers constructed by society and the mental health profession. In an effort to assist persons who are plagued with mental health concerns, the Black church and the leaders of the Black church can be proponents for disseminating a proactive health message to their congregants who need and/or know those who require mental health services. Removing the stigma of mental illness as it relates to being an African American should be an immediate priority in both the Black church and the community-at-large. The findings from this exploratory study of African American pastors can be useful in the Black church and the mental health professional community. Obviously, the results of this analysis is adding an original body of work to the research on mental health and supplementing the research that is all ready available on this topic. There are two points that are made with the outcomes of this study. One is the fact that African American pastors' voices not only have volume but they have context and content as it related to mental health issues. Point number two is the applicability of the significant findings about the likelihood of pastor's propensity to refer to mental health specialist. All though

the pastors did not retreat from referring congregants, they were also amenable to allowing a mental health professional in their church to provide counseling. The findings of this study will be useful to the mental health professionals seeking opportunities to disseminate information about mental illness.

Personally, I would like to work with mental health professional to develop a faith-based program specifically tailored to meet the needs of African American groups, families, and individuals. This program would provide a climate that is amenable to removing the stigma and barriers that are closely associated with African Americans mental, emotional, and physical concerns. Addressing the needs and requests of chronically mentally ill persons in the church will have a focal point in the near future considering the cuts that are being made at the federal and state level.

The Black church has historically been the buffer for the congregant to have their needs met. African American pastors must be prepared to meet the challenges that face their congregants and the community. From the evidence of the results of this investigation, African American pastors have the potential and the capacity to provide a full range of mental health services to their congregation and the community.

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Appendix A
Pastor's Letter

March 31, 2005

Dear Pastor:

My name is Elverta L. Vassol; I am an African American doctoral candidate at Kansas State University in the School of Family Studies and Human Services completing my doctoral dissertation requirement. This would assist me with my research on the role pastors have in counseling their congregants with mental health issues. My interest in this topic is directly related to my co-pastoral position in a predominately African American congregation and my academic and clinical work in the marriage and family therapy field. I value and respect the role of the church in the lives of African American people. My desire is to help provide resources specifically for pastors to guide their congregants to spiritual, mental and social maturity. According to Proverbs 4:7 "Wisdom is the principal thing; therefore get wisdom. And in all your getting, get understanding".

To that end, I am seeking to find out as much as I can about how pastors influence the lives of their congregants. Please remember your participation is strictly voluntary as well as confidential. The enclosed informed consent form is required for me to complete my research. Your consent form will be held separately from the questionnaire. Please sign the consent form, complete the questionnaire, and return both in the self- addressed envelope provided for your convenience. Please return as soon as possible. My goal is to collect all data as soon as possible. If you have any questions about completing this questionnaire please feel free to contact me at (785) 532-5642. Dr. Farrell J. Webb is my major professor and you may also contact him with questions or concerns related to this research project at (785) 532-5510.

Once again I would like to assure you that your responses are confidential. The protocols for data security and protection of human subjects ensure that no individual responses will be shared and that only aggregate responses will be reported.

Thank you so much for your cooperation and attention in this matter. Your help is truly appreciated.

Sincerely,

Elverta L. Vassol, M.S.

Appendix B
IRB Consent Form

KANSAS STATE UNIVERSITY
INFORMED CONSENT TEMPLATE

PROJECT TITLE: African American Pastor Perceptions of Their Congregant's Mental Health Needs

APPROVAL DATE OF PROJECT: 12/7/04 EXPIRATION DATE OF PROJECT: 12/7/07

PRINCIPAL INVESTIGATOR: CO-INVESTIGATOR(S): Dr. Farrell J. Webb and Elverta L. Vassol

CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS: Dr. Farrell J. Webb, 785-532-1478

IRB CHAIR CONTACT/PHONE INFORMATION: Rick Scheidt, 785-532-3224

SPONSOR OF PROJECT: None

PURPOSE OF THE RESEARCH: Research project to fulfill my doctoral requirements.

PROCEDURES OR METHODS TO BE USED: Questionnaire

ALTERNATIVE PROCEDURES OR TREATMENTS, IF ANY, THAT MIGHT BE ADVANTAGEOUS TO SUBJECT:

None

LENGTH OF STUDY: One time completion of pastor's questionnaire

RISKS ANTICIPATED: none

BENEFITS ANTICIPATED: Completion of the questionnaire will add to African American research.

EXTENT OF CONFIDENTIALITY: Questionnaires and signed consent forms will be kept in a locked file for three years and after three years will be shredded.

IS COMPENSATION OR MEDICAL TREATMENT AVAILABLE IF INJURY OCCURS: None

PARENTAL APPROVAL FOR MINORS: None

TERMS OF PARTICIPATION: I understand this project is research, and that my participation is completely voluntary. I also understand that if I decide to participate in this study, I may withdraw my consent at any time, and stop participating at any time without explanation, penalty, or loss of benefits, or academic standing to which I may otherwise be entitled.

I verify that my signature below indicates that I have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that my signature acknowledges that I have received a signed and dated copy of this consent form.

(Remember that it is a requirement for the P.I. to maintain a signed and dated copy of the same consent form signed and kept by the participant

Participant Name _____ Date _____

Participant Signature _____ Date _____

Witness to Signature (project Staff) _____ Date _____

Appendix C
Pastor's Questionnaire

# Pastor's Questionnaire
# Issues in Family and Church Life Study

I would like to thank you for agreeing to participate in this study. Your opinions are very important to me and I shall keep your answers in utmost confidence. This questionnaire is divided into several parts. Each time you see a box, such as this one, that is your clue that I am going to change subjects. Please answer the questions to the best of your ability. Remember, no one knows who you are and your answers cannot be linked back to you in any way. Let us begin with some basic demographic questions.

1. What is your biological sex (gender)?

☐ Male ☐ Female

2. How old were you at your last birthday? ___ ___ (e.g. 4 2)

3. What is your marital status?

☐ Married ☐ Divorced ☐ Separated
☐ Engaged ☐ Widowed ☐ Never married

3A. If married, specify which marriage is it for you, is it your first, second, third or more marriage?

☐ 1st ☐ 2nd ☐ 3rd ☐ other ☐ not married

4. To what racial/ethnic group would you say you are member?

☐ White ☐ African Am ☐ Hispanic—GO TO 4A
☐ Asian Am ☐ Am Indian ☐ Other—GO TO 4B

4A. If you are Hispanic, to what group do you consider yourself a member?

_____ (e.g., Puerto Rican)

4B. To what other racial/ethnic group do you consider yourself to be a member?

_____ (please specify the group)

Thank you for your cooperation thus far. Now, I would like to ask you about your work as a pastor of this church. These questions will help me to get a better picture of how you do your work in this church.

5. How many years have you been the pastor of this congregation? ___ ___

6. On average, how many hours do you work on behalf of your congregation per week?

   ___ ___ (e.g., 3 2)

7. What is your current religious denomination? (Please write the specific one)

   _____

8. How many ministers are in your congregation? ___ ___

9. Do you receive a salary as minister of this congregation? ☐ Yes ☐ No

10. What is your annual income from ministry work for 2003?

    $___ ___ ___, ___ ___ ___ . 00 (e.g., $1 4, 6 1 2 .00)

11. What benefits do you receive from this congregation? Please include all that are appropriate (check as many that apply to you)

    ☐ housing allowance ☐ car benefit ☐ insurance
    ☐ pension plan ☐ other (please specify)_____

At this point, I would like you to think a little about your personal life. These questions are important because I am interested in the costs and benefits associated with pastoral life.

12. Do you have a secular job (one outside of the church)?
    ☐ Yes ☐ No

13. Do you currently work full time (32 hours or more per week) or part-time (31 or less hours per week)?
    ☐ Full-time ☐ Part-time

14. What would you say was your annual income from your secular job in 2004?

    $___ ___ ___, ___ ___ ___.00

15. What was your annual family income for 2004?

$___ ___ ___, ___ ___ ___.00

16. How many years of formal education have you received? (e.g., if you have an associates degree you would say 14 years)

___ ___ Years of Formal Education

17. What type of diploma or degree do you currently possess?

❑ GED ❑ High School diploma ❑ Associate's degree
❑ BA, BS ❑ MA,MS ❑ PhD, MD, JD ❑ Other_____

17A. Please specify the field in which this degree was earned?

_____

18. Would you say that your church is located in an urban (100,000 or more people), suburban (99,999-40,000 people) or rural (39,999 or less people) setting?

❑ Urban ❑ Suburban ❑ Rural

19. What kind of building structure represents the type in which you conduct services?

❑ Church edifice ❑ Rental property Other _____

❑ In the process building a place of worship

20. What is the zip code where it is located? ___ ___ ___ ___ ___

21. How large is the congregation in attendance on your main worship day? ___ ___ ___ ___

Next, I would like to ask you some questions about training activities you have completed or attended dealing with counseling/collaboration/consultation with and for mental health professionals.

22. Please indicate in the grid below how many classes, seminars, or workshops you have attended involving issues of counseling, collaboration (*how to work with mental health professionals*), and consultation (*how to use mental health professionals for assistance with a congregant*). Provide your best guess or estimate.

| | Counseling | Collaboration | Consultation | Other |
|---|---|---|---|---|
| Academic Class | | | | |
| Seminar | | | | |
| Workshop | | | | |

23. Please indicate in how many of the following areas you have offered counseling services. (Please check as many that apply to you)

- ☐ Bereavement
- ☐ Premarital
- ☐ Marital
- ☐ Divorce
- ☐ Child behavioral problems
- ☐ Adolescent behavioral problems
- ☐ Depression
- ☐ Unemployment
- ☐ Grief
- ☐ Discrimination
- ☐ Family violence
- ☐ Hospital visitation
- ☐ Other _____
- ☐ Financial
- ☐ HIV/AIDS
- ☐ Prison ministry
- ☐ Substance abuse
- ☐ Intimate partner violence
- ☐ Legal problems
- ☐ Gang activity
- ☐ Gay and lesbian
- ☐ Addiction
- ☐ Individual
- ☐ Group Counseling
- ☐ Housing
- ☐ Food assistance

---

24. Do you have a separate room for privately counseling?

☐ Yes ☐ No

If no, where do you conduct sessions? _____

25. Do you have a mental health center where you may refer an individual?

☐ Yes ☐ No

26. Do you currently have a grant for providing program services? (e.g. breast cancer awareness, after school program)

☐ Yes ☐ No

27. Do you have other program services?

☐ Yes ☐ No

28. Do you have a housing program for the homeless or people in transition?

☐ Yes ☐ No

29. Estimate how many people you think are mentally ill in America? (Give a percentage)

❑ 3% ❑ 5% ❑ 8% ❑ 10% ❑ 22%

30. In your own words, how would you define mental illness?

31. What would you say should be the treatment modality for their mental illness? (Please mark all those that apply)

❑ medication ❑ counseling ❑ prayer ❑ hospitalization

❑ social support ❑ education for family ❑ treatment for couples or family

32. How would you perceive a member if they revealed they have a diagnosed mental illness?

33. What would you do if you were certain a member has a diagnosed mental illness?

34. Have you provided counseling to members who have experienced mental illness?

❑ Yes ❑ No

Directions: Please circle the choice for each question that best describes your feelings or perception:

Not Likely at all ***1*** Unlikely ***2*** Not Sure ***3*** Likely ***4*** Very Likely ***5***

35. How likely are you to recognize severe mental illness? ***1 2 3 4 5***

36. How likely are you to be able to diagnose and treat mental illness? ***1 2 3 4 5***

37. How likely are you to think the mentally ill have encountered a demon? ***1 2 3 4 5***

38. How likely are you to think the mentally ill are imagining these problems? ***1 2 3 4 5***

39. How likely are you to think there is a biological or physiological basis for their mental illness? ***1 2 3 4 5***

40. How likely are you to think the mentally ill should take medication for the mental health problem? ***1 2 3 4 5***

41. How likely are you to support a member taking medication for mental health problems? ***1 2 3 4 5***

42. How likely are you to encourage a member to stop taking medication for mental illness in favor of and seek spiritual healing? ***1 2 3 4 5***

43. How likely are you to perceive a member to lack faith when they are experiencing mental health problems? ***1 2 3 4 5***

**Directions: Please consider your interests consultation and collaboration with mental health professionals. Circle the choice for each question that best describes your feelings or perception of mental health:**

Not Likely at all ***1*** Unlikely ***2*** Not Sure ***3*** Likely ***4*** Very Likely ***5***

| | | | | | | |
|---|---|---|---|---|---|---|
| 44. | I would welcome the invitation to work together on a community service outreach with a mental health professional. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 45. | I would allow a mental health professional (e.g., counselor) to have an office in my church. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 46. | I feel my role as a pastor or leader would be compromised or devalued by the involvement of a mental health professional within the congregation. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 47. | I would consider a mental health professional providing consultation in my church. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 48. | I would prefer consulting with an African American mental health professional. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 49. | I would consult with a mental health professional as a pastor about a church member issue. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 50. | I would allow a mental health professional to present a seminar in my church. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 51. | I would allow a mental health professional to lead a support group in my church. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 52. | The race of the mental health professional would matter. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 53. | I would consider referring to a mental health professional. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 54. | I would consider making a referral to a mental health professional when the circumstances are beyond the scope of my knowledge and or expertise. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |

**Directions: Circle the choice for each question that best describes your feelings or perception of mental health:**

***I am not in favor of referring to a mental health professional because:***

Not Likely at all ***1*** Unlikely ***2*** Not Sure ***3*** Likely ***4*** Very Likely ***5***

| | | | | | |
|---|---|---|---|---|---|
| 55. They do not understand spiritual issues as well as a member of the clergy. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 56. Confidentiality of the church member may be breeched in the process of referral. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 57. Members may not be able to afford services. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 58. Members feel more comfortable receiving pastoral counseling. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 59. There is a stigma attached with seeking therapy. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |
| 60. I have not had the opportunity to meet any. | ***1*** | ***2*** | ***3*** | ***4*** | ***5*** |

61. Please write any additional comments and ideas:

_____
_____
_____
_____
_____

Thank you.

Thank you for your assistance in completing this survey. Any information that you provide will be kept strictly confidential. All data will be analyzed and reported as group data. You will be sent a summary when the study is complete. Please return this survey in the stamped self addressed envelope provided. Please return by February 25, 2005. Thank you again.

Questions concerning this project should be directed to Dr. Farrell Webb, 302 Justin Hall, Kansas State University, Manhattan KS. 785-532-5510.