MENTAL HEALTH CRISIS IN THE BLACK CHURCH: EXPERIENCE OF THE

CLERGY

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by

Andrea T. J. Ross

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DEDICATION

To Nehemiah, Autumn, Adonai, Noah, Aubrey, and Najarad II: You are the inspiration for my commitment to a lifestyle of embracing growth and change. You make me want to be better, and you motivate me to do the work. Make sure you start where mommy stops. I love you!

To Ella Mae Jones Ross, thank you for teaching me strength. "We are not strong, we just do what we have to do". I will always carry you with me.

ABSTRACT

Ross, Andrea T. J., *Mental health crisis in the Black church: Experience of the clergy of the Black church.* Doctor of Philosophy, August, 2020, Sam Houston State University, Huntsville, Texas.

According to the Center for Disease Control and Prevention (CDC, 2020), suicide is the tenth leading cause of death in the United States. Researchers have demonstrated the impact of the Black Church on Blacks' health behavior (Lumpkins et al., 2013; Aten, Topping, Denney, & Bayne, 2010; Williams, Gorman, & Hankerson, 2014). I completed a transcendental phenomenological qualitative study (Moustakas, 1994) to describe the experiences of twelve (8 male and 4 female) clergy of the Black Church responding to mental health crises of their congregants. Each participant completed a demographic questionnaire and a semi-structured interview to describe their experience with crisis and suicide among members in their congregation. I analyzed the data using the Van Kaam method (Moustakas, 1994) through the lens of critical race theory (Delagado & Stefancic, 2013) and symbolic interactionism (Vejar, 2015). I identified six major themes with subthemes from the interviews: (a) a definition of crisis (b) cultural expectations around mental health, (b) causes of mental health crisis, (c) clergy response, (d) barriers to responding, and (e) identified needs. The common factor was community or the sense of connection with others through common attitudes, interests, and goals. Some of the implications for practice were (a) Black clergy, faith-based organizations, and counselors could partner and focus on crisis and suicide interventions through community-based education; (b) counselors could partner with clergy to offer services within their church to include counseling services and psychoeducational groups or trainings; and (c) counselor educators could provide increased opportunities for training focused on

spirituality in counseling and collaborative treatment with religious and spiritual leaders

in the Black community. As Blacks have been socialized not to seek counseling, an

increased presence of professional counselors in the Black community may increase help-

seeking behaviors through relationships and interactions which creates socialization

(Vejar, 2015).

KEY WORDS: African-American, Black, Black church, Clergy, Community, Counseling, Crisis, Isolation, Mental health, Peer-support, Suicide, Training

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CHAPTER I

Introduction

The Black Church has been a primary source of support and therapeutic

assistance since its creation during the Slavery era until the present day (Adksion-

Bradley et al., 2005). According to the Black Codes or Slave Codes of Southern

states, enslaved persons were not allowed to assemble in groups greater than five

and sometimes three persons without supervision from a White overseer. The law

barred enslaved persons and freed Blacks from meeting or gathering together

except with the approval of a master and then only for specific purposes, such as

attending church (Finkleman, 2009). These guidelines, established by many

plantation owners, inhibited enslaved people from developing a sense of

community and opportunities for socialization. Enslaved people began meeting

secretly and eventually more openly but could not escape the consequences of

oppression and racism even in worship services.

In 1807, Richard Allen established the first Black Church of the Methodist

denomination which is now rooted primarily in Baptist, Methodist, and Pentecostal

traditions (Avent & Cashwell, 2015; Plunkett, 2014). Enslaved people had a place to

assemble, be supported, and receive support that provided therapeutic relief from the

horrendous brutality of life on the plantation. In the Black Church, the members escaped

the identity of being a slave, thus transforming them into leaders, teachers, and people

with authority and power. The Black Church became a trusted source for meeting the

physical, educational, emotional, and psychological needs of enslaved people (Allen et

al., 2010; Plunkett, 2014). The Black Church became and remains a place of belonging and a resource as described by Dempsey, Butler, and Gaither (2016).

The role of the Black Church as a central institution for support and education continued through the Civil Rights Era as Black people sought freedom from the aggression and terrorism of Jim Crow South and segregation. The Black Church developed a self-help doctrine to cope with the unreliability of support from outside sources (Avent & Cashwell, 2015). This institution provided an outlet for organizing and educating. It has been a source for mobilization for economic and political change impacting Blacks spirituality, health, and social wellbeing (Collins, 2015; Plunkett, 2014). The Black Church also provided civil rights organizations such as the National Association for the Advancement of Colored People (NAACP) with emotional and financial support (Avent & Cashwell, 2015). Individuals within the Black community relied on their spiritual institutions for both spiritual and natural needs such as assistance when facing financial obligations, familial difficulties, and economic and social despair. The Black Church is a source of encouragement, empowerment, help, social support and coping strategies for the Black community (Hays, 2015).

The trusted institutional leader of the Black Church is the pastor. The pastor is valued as the minister, educator, mentor, advocate, and counselor for those in the Black community (Allenet al., 2010; Avent et al., 2015; Collins, 2015). Pastors were and are gatekeepers to their congregations, trusted to respond to the needs of the church membership (Allen et al., 2010; Plunkett, 2014). Many in the Black community seek the clergy first for support during crises (Allen et al., 2010). Clergy can use their influence as

leaders to impact help-seeking behaviors of those in the Black community (Breland-Noble et al., 2011; Lumpkins et al., 2011; Stanbury et al., 2012).

Although there has been growing research and increased efforts devoted to addressing the disparities in mental health treatment for Blacks, the deficiency of treatment persists (Austin & Harris, 2011; Dempsey et al., 2016). Existing barriers to accessing mental health treatment are mental health stigma, ineffective treatment, fear and shame, and mistrust of mental health providers (Samuel, 2015). Many Blacks may be distrustful of outside institutions including the counseling profession (Sue & Sue, 2012). However, the significance of the Black Church in supporting the holistic wellbeing of its congregants continues (Collins, 2015; Plunkett, 2014). Access to mental health services when experiencing crises may also affect help-seeking behaviors (Lumpkins et al., 2011). The negative perceptions associated with mental illness such as increased stress, discrimination, and a lack of faith are barriers that may be addressed through alternative forms of care provided by the Black Church (Breland-Noble et al., 2011). Clergy play a vital role in identifying and counseling those in mental health crises, working to implement coping strategies with the person suffering, and referring those experiencing mental health crises for psychological services. (Aten et al., 2011; Chatters et al., 2011).

Statement of the Problem

Researchers have demonstrated the impact of the Black Church on Blacks' health behavior (Lumpkins et al., 2013; Aten et al. 2010; Williams et al. 2014).

Within the context of Black churches, African American clergy have a significant role in the delivery of mental health care services for parishioners and their families. Working toward better linkages between faith-based communities and more formal

mental health care could help to provide more culturally sensitive and timely mental health care for African American families. (Allen et al., 2010 p. 117)

According to the Center for Disease Control and Prevention (CDC, 2019), in 2017, suicide was the third leading cause of death among Black youth ages 1-19, and the fourth leading cause of death for Black ages 20-44. Crenshaw (2015) postulated that research involving Black clergy and church members has dismissed the significance of suicide within the Black community. Although few studies have examined The Black Church and mental health issues, more research is needed to describe the role clergy play regarding mental health issues such as mental health crises (Hirsch et al., 2014; Wang et al., 2013). Avent, Cashwell, and Brown-Jeffy (2015), recommended that researchers investigate Black clergy's' "attitudes and experiences with suicide in their congregations (p. 45)."

Purpose of Study

In order to know what barriers exists between Black churches and mental health treatment, a study that is focused on the experiences of the leaders in Back churches was warranted. The purpose of this transcendental phenomenological study was to describe Black clergy's experiences with mental health crises among members of their congregations.

Significance of the Study

This study found its significance by giving voice to the experiences of Black clergy in predominately Black churches focused on how they coped with mental health crises in their congregations. Through this study, I shed light on the clergy's ideas of

perceived mental health needs within their congregations and the help-seeking behaviors of their congregants who experience mental health crises.

This study provided the clergy with the opportunity to express their concerns and desires in a manner that could hopefully bring about changes. The Black community receives its mental health support primarily from the Black Church (Dempsey et al., 2016) and thus this was the logical choice to gain insights into this important issue. Also, clergy were the gateway to entrance into many Black churches (Austin & Harris, 2011) and as a result often to access to mental health services. This study provided insight to understand possible barriers to seeking mental health treatment, as well as resources to mitigate those barriers.

Definition of Terms

Many terms are used in research to help readers gain insights into the thoughts of the researcher(s). The following terms are defined so that readers will be able to gain insights into the meanings derived from the outcomes of this study.

Black. For purposes of this study, Black is defined as people who identify themselves as Black, African American, or of African descent. Additionally, Black is identified as people with a predominant ancestry of Black African involuntary immigration to the United States for slavery. According to the United States Office of Management and Budget (OMB), *Black or African American* denotes someone with origins in any of the Black racial groups of Africa and includes Afro-Caribbean entries, such as Haitian and Jamaican. Black also includes more recent voluntary immigrants from African countries and the Caribbean (US Census, 2011).

The Black Church. A Christian organization/congregation whose clergy and parishioners largely identify themselves as African American or Black or of African descent (Avent & Caswell, 2015; Hays; 2014; Plunkett, 2014). For this study, all Black churches had more than 75% of their membership with Black identities and all of the clergy identified as Black.

Clergy. The body of all people ordained for religious duties, especially in the Christian Church (Lindberg, 2009).

Mental-health Crisis. Mental health crisis as a term takes on many different meanings depending on the location of the crisis event. For purposes of this study, a parishioner who experiences behavioral, emotional, or psychiatric conditions that would likely result in significantly decreased levels of functioning in daily living activities or the ability to function safely with others, and require crisis response services that may include but is not limited to placement in a more restrictive treatment setting will be identified as someone who has experienced a mental health crisis (NAMI, 2018).

Theoretical Framework

The theoretical frameworks used for this study were critical race theory (Delgado & Stefancic, 2013) and symbolic interactionism (Vejar, 2015). I used critical race theory for the primary framework because it was culturally sensitive and lended itself to the identification of racial issues in Black Churches. This was important considering the function of the Black Church in society as a cultural convention used to address the ails of racism and discrimination experienced by Blacks from the dominant cultural group.

"Critical race theory argues that white racism is a hegemonic, socially and historically constructed cultural force in American society (Simba, 2015, para. 2)."

Racism was expressed by believed myths, laws, and the established outlook of prestige and power through the notion of Whiteness (Simba, 2015). In critical race theory, members of a racialized non-dominant group (the Black community) are relegated to roles as subordinate members of the dominant group (Delgado, & Stefancic, 2013; Trahan & Lemberger, 2014). In critical race theory, the omnipresence of racism is integrated in all people's experiences (Trahan & Lemberger, 2014). Bell (2008) reflected "All coalesce into persuasive influences that render us all – racists and antiracists alike- subject to forces seemingly beyond our control and even our understanding (p. 631)." Flesh color adhesive bandages, nude-colored hose, or the reference of the first Black (ie., first Black President) are examples of the omnipresence of racism in American society. The three tenets of critical race theory are interest convergence, ordinariness of racism, and narrative storytelling. These tenets are useful in understanding and communicating the experiences of a non-dominant group.

Interest convergence is the belief that all forms of racism advance the interest of Whites, which results in a variation of defense and survival mechanisms within the Black community (Trahan & Lemberger, 2014). Kelly (2018) provided an example of interest convergence when she analyzed two bilingual education bills stating that the shift from supporting English learning to bilingualism was because of an economic and national security interest. The medical community's interest in addressing Black health disparities is argued through the lens of interest convergence theory, asserting the economic interest of hospitals may be motivating for hospitals to begin examining racial disparities in their service (Crossley, 2016). Ordinariness of racism is the idea that racism is ingrained in every aspect of social structures in America (Trahan & Lemberger, 2014). Narrative

storytelling is a recommended form of expression when describing experiences. Storytelling, counter-storytelling, and naming one's own reality are concepts of critical race theory beneficial for an honest exploration of another's experience (Delgado, & Stefancic, 2013). Critical race theory as a framework for describing the experiences of clergy in the Black Church who have experiences with parishioners who have experienced mental health crises can provide an appropriate framework to examine and interpret qualitative data.

Symbolic interactionism is a sociological framework that examines the phenomenon of the relationship between an individual's behavior and a social organization (Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2015). People seek to make meaning in their world. Handberg et al. (2015) pointed out that according to symbolic interactionism, people develop meaning through social interactions and assign meaning through their interpretation of those interactions. Studying the perceptions of Black clergy and their interactions with Black parishioners who have experienced mental health crises allowed me to assess the interaction between the church and the people.

Major components of symbolic interactionism include meaning, socialization, and cultural symbolism. Meaning is assigned through interpretations. Interpretations are developed through interaction that produces an emotion or feeling which then becomes associated with an object or construct (Vejar, 2015). An example is a warm, caring interaction with a mother. The person then incorporates meaning of mother as a caring supportive person. The processes of socialization are how people identify and shape their symbolic references. Through the act of establishing a complex sequence of relationships, people create symbolic determinations and build their behavior through these interactions

and relationships (Vejar, 2015). For example, a small child sneezes and several people respond with *Bless you*. This happens each time the child sneezes. After a series of these interactions or experiences, when the child hears someone sneeze, the child responds with *Bless you*. In cultural symbolism, behaviors are assumed through a subtle learning process intertwined with cultural implications (Vejar, 2015). For example, the amount of personal space deemed appropriate, is socially learned and formed based on the culture and may change from one culture to the next. According to Vejar, (2015), additional concepts to consider in symbolic interactionism are:

Definition of the Situation: Eliminating the predispositions that people possess which impair their ability to impart objectivity in a situation.

Looking-Glass Self: Internalizations that are initiated by the perceived appraisals of outside sources.

Resistance and Negotiation: A process that occurs when people refuse to fall prey to oppressive expectations.

Role Salience: The selection of roles and behaviors which match the identities that people create for themselves.

Self-Fulfilling Prophecy: A set of beliefs, which may be faulty, that are converted into reality.

Symbolic Violence: Subtle violent acts that are undetected based on their ambiguous or inconspicuous form and which encourage suppression and dominance by one group. (para 21)

The role of the Black Church in the lives of the members of the Black community was explored through the framework of symbolic interactionism. Understanding

symbolic interactionism including meaning and the influence of experiences on the making of meaning, is a useful heuristic tool to examine and interpret the qualitative data obtained in this study. Symbolic interactionism accounted for the socialization, meaning, and cultural symbolism found in the cultural norms of the Black community through their symbolic interactions in the Black Church.

Research Question

Utilizing a phenomenological approach (Creswell, 2013; Moustakas, 1994), the following research question was addressed:

What is the experience of Black clergy in the Black Church, with reference to congregants who experience mental health crises?

Limitations

I used clergy from a metropolitan area in the southwest region of the United States, thus the experiences of Black clergy in other regions of the United States may be different as well as the experiences of clergy in much smaller communities. The purpose of this study is to describe clergy of the Black Church experiences to add to literature that would possibly provide insight for that population. Also, I used transcendental phenomenological methodology to describe the experiences of Black clergy in their response to mental health crisis with congregants in their congregation and may not be reflective of all clergy. A final limitation was that the interviews were limited to self-report and the participants may have attempted to help the researcher by providing answers in a manner consistent with what they perceived was the goal of the study.

Delimitations

This study was delimited to participants that meet the criteria of being Black clergy in a predominately Black church in which more than 75% of the congregants identify as Black, African American, or of African descent. Data collected was from a small sample of Black clergy and therefore may not be reflective of the experiences of Black clergy because the data collected was limited to the clergy who participated. Additionally, while many predominately Black church congregations are led by Black clergy there are some that are led by non-Black clergy and those churches were not included in this study. Therefore, my participants do not represent the experiences of clergy of other ethnicities or congregations of other ethnicities.

Assumptions

For the purposes of this study, I relied upon three assumptions. First, I assumed participants responded honestly. Also, I assumed participants understood the purpose and language contained in the study. Finally, I assumed that the phenomenological methodology used is a reliable method of qualitative inquiry (Creswell, 2013; Moustakas, 1994).

Organization of the Study

This dissertation is composed of five chapters. Chapter I is the introduction of this study which includes the statement of the problem, the purpose and significance of the study, definition of terms, and the theoretical framework, research question, limitations, delimitations and assumptions for this study Chapter II includes the literature review which is an in-depth and exhaustive review of published literature related to mental health crisis and the Black Church. The information acquired through a review of the

literature was used to construct the meaning and understanding of mental health crisis, clergy, and the Black Church and establishes the need and significance of this study. Chapter III includes the methodology. In Chapter III, I described the methodology used to select participants, collect data, and analyze the data needed to describe the essence Black clergy's experiences with mental health crisis among members of their congregations. Chapter IV comprises the results of the study. This chapter also contains an analysis of the data including demographic descriptive statistics, themes and a table. Finally, a discussion of the findings, implications for practice, and recommendations for further research comprise Chapter V.

CHAPTER II

Review of Literature

An in-depth search of scholarly journal articles, conference presentations, books, and dissertations was conducted to obtain manuscript data related to mental health crisis, suicide, and the Black Church. Most of these sources were located at university libraries or through database searches. Specifically, Academic Search Complete, Dissertation - Thesis via ProQuest, EBSCOHost, JSTOR, PsycINFO, and Wilson Education Full Text were the primary database resources used to obtain literature and information regarding clergy in the Black Church and their experiences with mental health crisis and suicide. Using the insight gained through the review of literature, a qualitative study of the experiences of clergy of the Black Church with mental health crisis and suicide is necessary. The following are the results of my literature search and review.

The Black Church

Blacks were generally considered on average highly religiously involved as a group (Holt et al., 2018). Members of the Black community were also viewed as more religious and spiritual than the nation when factors such as level of religious affiliation, attendance at religious services, frequency of prayer, and religion's importance in life are compared (Hays, 2015). The Pew Research Center (2018) reported that Blacks (83%) are more likely to report they believe in God with absolute certainty than Whites (61%) and Latinos (59%). Seventy-five percent of Blacks reported that religion was important to them and eight-in-ten Blacks self-identified as Christian (Pew Research Center, 2018).

The Black Church is possibly the most identifiable symbol of religion and spirituality, with a consistent and rich presence throughout its history, in the United

States (Avent & Cashwell, 2015; Gadzekpo, 1997; Lincoln & Mamiya, 1990; Plunkett,

2014). Many agree that the Black church is the "greatest institution developed by

Negroes on American soil (as cited in Lincoln & Mamiya, 1990 p. 92)."

The Black Church refers to those independent, historic, and totally African

American controlled denominations that constitute the core religious experience of the

majority of African American Christians (e.g., African Methodist Episcopal Church

[AME]; National Baptist Convention, USA, Inc., [NBC]; Church of God in Christ

[COGIC]). (Molock et al., 2008, pp.324-325)

Except for the Black family, the church is the prevalent institution of socialization

in the Black community (Hays, 2015; Moore-Thomas & Day-Vine, 2008).

Black churches have been and continue to be a central component of the Black

community, providing social, economic, and political opportunities for its members.

Plunkett (2014) noted that historically and traditionally the Black Church has operated as

the institution that provides the Black community with a place to meet their social,

religious, spiritual, and communal needs. The Black Church being central to the Black

individual and community life is evident in prominent levels of church attendance,

private devotional practices such as prayer, expression of religious sentiment and

identities, and reliance on church-based support networks (Chatters et al., 2011).

Black churches served a prevailing role as informal social services providers and

gatekeepers to formal services (Blank et al. 2002). Members of the Black community

utilize religious coping strategies, such as prayer, attending worship services, developing

a personal relationship with God, and private devotional practices (Chatters et al., 2008;

Mattis, 2002; Ward et al., 2013), more than other ethnic groups (Hays, 2015). According

to Hays and Lincoln (2017), in 2012, 815,000 Blacks were estimated to have had a serious mental illness, but only half received mental health treatment. However, researchers have also found that Blacks seek professional counseling services at a lower rate than other racial or ethnic groups (Avent & Cashwell, 2015; US Department of Health and Human Services, 2013). Barksdale and Molock (2009), asserted that Blacks were significantly less likely to seek mental health services from a mental health professional than Whites and preferred to seek help for mental health concerns from clergy and family instead.

Clergy were viewed as trusted members of the Black community and were often viewed as a support for those with mental health needs (Hays & Lincoln, 2017). The Black Church provided a range of prevention and treatment-oriented programs from substance abuse assistance to health screenings, education, and general support (Blank et al., 2002). Since the Black Church has substantial influence on the mental health seeking behaviors of Blacks (Hays, 2015), counselors must understand the history of the Black Church, its role in the Black community, and its influence on the help-seeking behaviors of church members when working with religious and/or spiritual Black community members (Avent & Cashwell, 2015).

The following review of the literature represents the literature relevant to understanding the Black Church, its clergy, and its influence on the help-seeking behavior of those in the Black community. Specifically, this review of the literature is organized into five sections: (a) the history of the Black Church, (b) the role of clergy in the Black Church, (c) mental health-seeking behaviors of the Black community, (d)

mental-health crisis and suicide in the Black community, and (e) clergy of the Black

Church with mental-health crisis and suicide.

History of the Black Church and Its Impact in the Black Community

The Black Church is the oldest consistent institution of support in the Black

community and has been central to the lives of Blacks since the time of slavery (Gaines,

2010; Hays, 2015; Stennis et al., 2015). Africans were enslaved and brought to the United

States through the "middle passage" which was a period between the mid-fifteenth and

early nineteenth centuries. During this period, over 10 million Africans were packed

"spoon-fashioned" in slave ships which were often called "floating coffins" and they

began the journey called "a voyage of death" because many African lives were lost to

disease, suicide and revolt due to lack of proper care on the long voyage (Frazier &

Lincoln, 1974; Mallipeddi, 2014). The Africans were packed in the ship without regards

to sex, age, clan or tribal differences, which made communication and social interaction

difficult if not impossible. Taken from their homes and families, isolated by language and

culture, there was no outlet for communal activities and sharing for the enslaved Africans

(Frazier & Lincoln, 1974). Frazier and Lincoln (1974) further explained the isolation of

those who were enslaved:

> The enslavement of the Negro not only destroyed the traditional African system
>
> of kinship and other forms of organized social life but it made insecure and

precarious the most elementary form of social life which tended to sprout anew, so to

speak, on American soil—the family. (p. 13)

Enslaved Africans were introduced to Christianity through efforts of Quakers,

Baptists, and Methodist missionaries (Frazier & Lincoln, 1974; Fountain, 2010). As

noted by Frazier and Lincoln (1974), religion provided the enslaved Africans an opportunity for connection with their fellow men and tended to "break down barriers that isolated them morally from their white masters (p. 16)." According to Fountain (2010), scholars postulated that components of West African religions (where a large portion of enslaved Africans originated) paralleled the evangelical Christianity of the Antebellum Southern United States. For example, both West African Traditional religion and evangelical Christianity "emphasize a single creator God, symbolic death and rebirth, water as a spiritual symbol, blood sacrifice, religious prayer and song, and belief in an afterlife (p.2)." The similarities may have helped them incorporate their familiar beliefs with the religion of their New World. Frazier and Lincoln (1974) described the origination of The Black Church as an "invisible institution" where enslaved persons would gather mostly in secret, to pray and sing together because in most states it was illegal for them to assemble in groups of five or more without the presence of an overseer or their master. The preacher was "called" to his office, chosen by God as the spiritual leader.

According to Frederick Douglass, the abolitionist orator who escaped from slavery

> ,… the preacher was one of the slave notabilities…The authority was given greater weight when the slave who had been called to preach was licensed by the Methodist or Baptist church…the Negro preacher was free to exercise his gifts and to direct his followers. (Douglass as cited in Frazier & Lincoln, 1976, pp. 24-25)

Since the Middle Passage, the Black Church has offered spiritual, emotional, and religious support along with safety (Stennis et al., 2015; Allen, Davey & Davey, 2010; Hirsch et al., 2014). The Black Church was one of the earliest organizations to serve as a shield for Blacks against the ramifications of racial discrimination and segregation. Black churches were often the only place available to the Black community to express feelings of fear, anger, and grief about living in a world that was cruel and hostile towards them (Hays, 2015).

Several states enacted laws "for the better government of Negros, Mulattoes, and Indians, bond or free" often referred to as "Slave Codes" which allowed "Negroes, Mulattos, and Indians" to legally suffer barbaric and savage punishments, such as dismemberment, cutting off of ears, severe whippings, castrating, branding on the cheek, and hamstringing for varied violations (Finkleman, 2006). For example, "the law also made it a crime, punishable by thirty lashes, for a free black to 'lift his or her hand, in opposition against any Christian, not being Negro, mulatto, or Indian' (Finkleman, 2006, para. 5). " Black churches have been vital in helping Blacks overcome slavery, segregation, discrimination, economic debauchery, educational inequalities, and other social injustices and have been experienced as places of reliability and strength in the Black community (Calhoun-Brown, 2000). In addition, the Black Church has had the duty of social service benefactor in the absence of sufficient government programs for the Black community (Barnes, 2004; Hays, 2015). Frazier and Lincoln (1974) pointed out that free Blacks in the North and the South developed an organized community life including mutual aid societies, economic welfare, and education which were incorporated

in the church which made the church the resource and wealth-rich component of their community.

The Free African Society (organized by Absalom Jones and Richard Allen, founders of the African Methodist Church) purposed to "support one another in sickness, and for the benefit of their widows and fatherless children (Frazier & Lincoln, 1974, p. 41)." For example, in 1787, a mass migration of Blacks to Philadelphia occurred, which made the need for support urgent. From that need, mutual aid societies grew out of the Black Church. According to Frazier and Lincoln (1974), the growth of beneficial societies connected with churches, such as nine beneficial societies in Atlanta immediately following the Civil War. Several societies throughout the United States continued growing after Emancipation and became instrumental in establishing businesses and enterprises, such as The True Reformers, which organized a: (a) weekly newspaper, (b) real estate firm, (c) bank, (d) hotel, (e) grocery store, and (f) building and loan association (Frazier & Lincoln, 1974). Barnes (2004) asserted over 90% of churches sponsor some type of social service program to include: (a) food and clothing distribution, (b) childcare, (c) family support, (d) youth programs, (e) hospice care, (f) employment counseling, and (g) senior citizens services.

The Development and Growth of the Black Church

Black churches faced difficulty in their beginning because they were not supported by the southern state and their slave owners. As time passed, the church began to grow, and its influence began to mount.

The Black Church during Slavery

Before the emergence of the Black Church, enslaved Africans faced loneliness and isolation, having been separated from their family and home by distance, language, and custom, with no opportunity for communal connection (Frazier & Lincoln, 1974). Enslaved Blacks began to gather in the night, often under trees away from the focus of the overseer as they listened to good news of liberation by faith, which was first heard from ministers from Quaker and Methodist and then Baptist traditions who shared the bible message from town to town. Frazier and Lincoln (1974) described this developing assembly of enslaved Blacks as the "invisible institution" which became known as the Negro Church. The Negro Church became the heart of the enslaved community, offering a place for education, socialization, communal spirituality, and fellowship that was unavailable anywhere else on the plantation (Avent & Cashwell, 2015; Plunkett, 2014).

Socialization opportunities, such as education, assembling, and even leaving the plantation without permission of the master were forbidden (Finkleman, 2006). The church provided the opportunity for enslaved Blacks to hold positions of authority allowing them the autonomy to be free of the title "slave." The church services provided therapeutic relief from the unbearable pressure faced in their daily lives on the plantation, and it was a source of empowerment and networking as it was the first and often only place enslaved Blacks could assemble and hold office. Enslaved Blacks could share beliefs, concerns and information as well as lead and make decisions in the church (Avent & Cashwell, 2015; Frazier & Lincoln, 1974; Plunkett, 2014). In 1777, the oldest Black church in the United States, The First African Baptist Church of Savannah, was established. The Free African Society in Philadelphia organized The African Church,

which was dedicated on July 17, 1794, and became a member in the Episcopal Diocese of Pennsylvania (African American Registry, 2013).

According to Frazier and Lincoln (1974), the population of free Blacks increased, and the increase came from five sources:

> (1) Children born of free colored persons; (2) mulatto children born of colored mothers; (3) mulatto children born of white servants or free women; (4) children of free Negro and Indian parentage; and (5) slaves who were set free. (p. 27)

The relationship between free Blacks and Whites in church was collaborative as the Quakers freed those they had enslaved and worked to remove legal restrictions opposing private affranchisement (freeing) of enslaved persons. The issue of Blacks and Whites in relationship related to religion became an issue on the question of status, such as the right to vote and position of leadership, when the Methodists and Baptists evangelized Blacks. In the South, the question of status was answered through segregated churches. In the North, Black preachers preached to predominantly white congregations. An example is Lemuel Haynes, "the illegitimate child of a Negro and a white woman who was born in Connecticut in 1753 (p. 32)," who was licensed to preach in the Congregational Church. Another example is Richard Allen who was born a slave in Philadelphia and purchased his freedom from his converted master. Allen became a preacher in 1780 and preached in the St. George Methodist Episcopal Church. Although Black ministers preached in White congregations in the North, the question of status remained. Frazier & Lincoln (1974) cited an account in 1786:

> When a number of Negroes attending St. George Methodist Episcopal Church increased, Negroes were removed from seats around the wall and ordered to sit in

the gallery. Mistaking the section of the gallery they were to occupy, Allen,

Absalom Jones, and another member were almost dragged from their knees as

they prayed. They left the church and together with other Black members founded

the Free African Society. (p.33)

The end of the Civil War and Emancipation marked the rise of the Negro Church

as an independent and separate institution (African American Registry, 2013). This

separation of Blacks from established dominant organizations was one of the first major

civil rights protests by this previously enslaved group, resulting in the formation of

predominantly Black congregations, which set the stage for the rise of the Black Church

in the era of the Civil Rights Movement (Avent & Cashwell, 2015).

The Black Church in the Civil Rights Era

The tumultuous decade of the Sixties marked a notable change from the

development of the Negro Church to the creation of the Black Church. The Black

consciousness movement, a revolution in consciousness or awareness of Blacks as a

distinct social group with the ability to organize for social change, encompassed Black

life which included the Black Church (Lincoln & Mamiya, 1990). The church focus on

salvation and liberation in this life and not just in the life to come marked an awakening

in the leaders of the church. According to C. Eric Lincoln, this era witnessed the death of

the Negro Church, and in its place, the birth of the still present conflict between

"conscienceless power" and "powerless conscience" in the Black Church (Frazier &

Lincoln, 1974).

The Black Church has consistently been essential in the fight of Black's struggle

against racial and social injustice (Smith, 2013). The ability of the Black Church to affect

change both socially and politically is evident throughout history (Gaines, 2010). The clergy of the Black Church taught social protest gospel providing a biblical justification to oppose oppression and protest injustice using social theology and liberation theology often called Black theology (Baumann, 2016; Calhoun-Brown, 2000; Fairclough, 1986). Black theology provided the community an interpretive way of understanding the meaning of activism including nonviolence, as a way of life (Calhoun-Brown, 2000). This theology which emphasized liberation and social gospel themes, provided resources and motivation for mobilization (Baumann, 2016).

The Civil Rights Era was a period when the power of the Black Church to mobilize for social and political change was apparent. As the dominant institution in the Black community, church culture is one of the most powerful systems of ritual and symbolic meaning in the Black community which allowed the leaders of the civil rights movement, who were often ministers, to mobilize people by providing a common message (Blank et al., 2002; Calhoun-Brown, 2000). As Black churches grew in size creating and growing relationships with each other through city-wide and state-wide ministerial alliances, a sense of solidarity through the Black consciousness movement birthed the civil rights movement led by Rev. Dr. Martin Luther King, Jr., a movement anchored by the Black Church (Lincoln & Mamiya, 1990).

Boycotts in both Tallahassee, Florida and Montgomery, Alabama were organized by ministerial groups. The boycott in Tallahassee was coordinated by the Inter-Civic Council (ICC) which had six ministers among its nine officers and in Montgomery, the Montgomery Improvement Association (MIA) was filled with ministers (Fairclough, 1986). During the Civil Rights Era, the Black Church birthed leaders, freedom fighters,

organizers, and organizations for change such as the Southern Christian Leadership

Conference and the Deacons for Defense and Justice providing meeting space and an

organizational base (African American Registry, 2013; Smith, 2013).

The movement to desegregate social and economic systems in the South was

often arguably attributed to Rev. Dr. Martin Luther King, Jr.; however, this movement for

civil rights was organized by many ministers with Dr. King, Jr. often serving the role of

spokesperson. The Southern Christian Leadership Conference (SCLC), was an example

of the organizing power of the leaders of the Black Church. The SCLC, the political arm

of the Black Church, was described as "a bunch of Baptist preachers" and as "a

movement, not an organization" was birthed out of the Montgomery Bus Boycott. The

SCLC included the ICC, MIA, and the Alabama Christian Movement for Human Rights

during a time when the National Association for the Advancement of Colored People

(NAACP) was under persecution by the state authorities strengthening local protest

organizations (Calhoun-Brown, 2000; Fairclough, 1986).

The Montgomery Bus Boycott, December 5, 1955 to December 21, 1956 (381

days), a boycott to end segregation of the Montgomery bus system, was noted as the

beginning of the SCLC. The boycott was planned and executed by a newly organized

Montgomery Improvement Association (MIA), of which Martin Luther King, Jr. served

as President and Ralph David Abernathy served as Program Director, both ministers in

the Black Church (SCLC History, 2014).

It was one of history's most dramatic and massive nonviolent protests, stunning the

nation and the world… Despite a bombing of the home and church of Ralph David

Abernathy during the Atlanta meeting, 60 persons from 10 states assembled and

announced the founding of the Southern Leadership Conference on Transportation and Nonviolent Integration. The organization shortened its name to Southern Leadership Conference, established an Executive Board of Directors, and elected officers, including Dr. Martin Luther King, Jr. as President, Dr. Ralph David Abernathy as Financial Secretary-Treasurer, Rev. C. K. Steele of Tallahassee, Florida as Vice President, Rev. T. J. Jemison of Baton Rouge, Louisiana as Secretary, and Attorney I. M. Augustine of New Orleans, Louisiana as General Counsel. (SCLC History, 2014, para 1)

The Deacons for Defense (The Deacons) formed to defend the Black community from White terrorism, vigilante groups, and police violence (Hill, 2004; Strain, 1997). The first group was organized in March 1965 in Jonesboro, Louisiana by local Black men, all United States Army veterans, and devout Christians. They chose the name Deacons to reflect their religious background and their roles as servants of the community and "defenders of the faith (Strain, 1997, p. 44)." The Deacons were a group of barbers, mill hands, factory workers, and church deacons organized in twenty-one chapters with a national profile and had a stance of armed self-defense (Hill, 2004; Strain, 1997).

The Black Church provided support through spiritual upliftment and organized socio-political mobilization (Gaines, 2010). According to Smith (2013) and the African American Registry (2013), Black pastors and clergies led congregations in resistance through organized marches, protests, demonstrations, sit-ins, and rallies provoking retaliation from terrorist groups such as the Ku Klux Klan (KKK) who were implicated in church bombings. A noted example was the bombing of the Sixteenth Street Baptist

Church in Birmingham, Alabama, on September 15, 1963. During this attack of a Black church, four children were killed, and several members were injured. Because of this attack and the history of deadly aggression, members of the Black community lost their sense of security. In response, the Black Church continued to mobilize organizing increased resistance. Black clergy and their congregations were threatened, beaten, jailed, and murdered as they continued resisting the oppression and burden of racial and social injustice.

The Black Church Today

The Black Church remains the most resource-rich and centralized institutional sector in the Black community (Calhoun-Brown, 2000; Lincoln & Mamiya, 1990). According to The Gallup Poll, Blacks continue to attend church services with greater frequency than any other Americans and spiritual matters remain a primary focus for those in the Black community (Crabtree, 2002). The Gallup Poll also reported the Black Church is no longer highly politicized although 43% of the participating pastors report working for social justice in their congregations (Crabtree, 2002). The Black Church currently places emphasis on the preached word with a decline in its influence on voting and national political leadership (Molock et al., 2008).

The Black Church and Mental Health

There is a long history of the Black Church as central to and the primary source of support in the Black community (Frazier & Lincoln, 1974; Lincoln & Mamiya, 1990). Nearly nine out of 10 Blacks in America view the Black Church as having an intricate role in the Black community with a positive influence on their daily living (Taylor, Ellison, & Chatters, 2000). The Black Church served as a psychological support for the

Black community (Cullins, Solages, & McKnight, 2019; McRae, Thompson, & Cooper, 2011). Assari (2013) reported church-based social support mediated overall mental health among Blacks. The social support found in the Black Church was a factor that had beneficial health effects for Blacks in America (Assari, 2013; Holt et al., 2018). Kim (2017) identified congregational support as a mediating factor between racial micro aggressions and psychological well-being for Blacks. The Black Church has provided effective pathways for prevention, education and interventions for mental health other health behaviors such as cancer, HIV/AIDS, disaster relief, and depression (Aten et al., 2010; Cullins et al., 2019; Foster, Thomas, & Lewis, 2016; Molock et al., 2008).

The Role of Clergy in the Black Church

The Black Church has always operated as the prevailing institution in the Black community. The modern Black Church is arguably and distinctively positioned to have a greater influence on the Black community than any other institution (Collins, 2015; Gaines, 2010). The Black Church is a trusted institution in the Black community where its members seek advice and spiritual guidance for financial direction, educational pursuits, family issues and more (Collings, 2015). A pastor who is often a captivating leader, who motivates, guides, and meets the needs of the members and is empowered by God (Hays, 2015), characterizes the leadership of the Black Church. Clergy in the Black Church frequently serve as counselors (Allen et al., 2010; Hays, 2015; Stennis et al., 2015). In the Black Church, the clergy is a key figure who sets the direction for congregational life and is personally connected to parishioners (Hays, 2015). Clergy are an essential part of mental health care in the Black community. Clergy have aided individuals with addictions, socio-emotional problems, and serious mental disorders

(Aten et al., 2010; Stansbury et al., 2012). Many individuals have sought mental health help from clergy exclusively and did not pursue additional care from mental health professionals. While clergy tended to underestimate the gravity of psychotic symptomology and were less likely to recognize suicide lethality (Taylor et al., 2000); findings in research supported the idea that clergy were often as successful as mental health professionals in promoting positive change in mental health in those they served and may have helped to alleviate stigma, and influenced the willingness to initiate treatment (Blank et al., 2002). Clergy in the Black Church served as gatekeepers to the formal mental health system (Avent & Cashwell, 2015; Avent et al., 2015; Chatters et al., 2011; Crenshaw, 2015; Gaines, 2010; Hays, 2015; Stansbury et al., 2012). In their article on Black clergy's perceptions of pastoral care and pastoral counseling, Stansbury et al. (2012) discussed implications of collaboration for social work. They found that, "Collaboration between the two would allow both African American clergy and social workers to provide continuum of care to individuals contending with socio-emotional problems and serious mental illnesses (Stansbury et al., 2012, p. 967)."

Within the context of Black churches, Black clergy have a significant role in the delivery of mental health care services for parishioners and their families. In their study of mental health services in faith communities, Taylor et al. (2000) postulated that clergy's ability to identify serious mental health issues and their willingness to refer congregants to professional practitioners are determinants of the quality of the mental health services clergy provide. Working toward better linkages between faith-based communities and more formal mental health care could help to provide more culturally sensitive and timely mental health care for Black families (Allen et al., 2010). Only about

10 % of pastors refer their congregants to mental health professionals for specialized

services (Taylor et al., 2000). The stigma and the history of Blacks challenge clergy's

referral processes for mental health care, particularly secular, or outside of the church

(Avent et al., 2015). Avent et al. (2015) completed a study to investigate pastors within

the Black Church responses to members of their congregation who were experiencing

mental health issues. Black pastors valued spiritual and holistic coping strategies and

identified greater trust in Christian counselors when considering referral sources (Avent

et al., 2015).

Mental-health Help Seeking Behaviors of the Black Community

Black people have poorer mental-health results than Whites and are less likely to

seek professional help for mental-health concerns (Avent & Cashwell, 2015; Hays, 2015;

Marrast, Himmelstein, & Woodhandler, 2016). Access to professional mental health

services are lower for Blacks, and the available care is often of lesser quality (Chatters et

al., 2011). Although similar or lower prevalence rates of most mental disorders among

Blacks compared to other cultural groups were reported, racial disproportions in mental

health persist. Hays (2015) stated that Blacks have more severe, persistent, and disabling

depressive episodes compared to Whites. They are also reported by primary care facilities

with more depressive symptoms than any other cultural group (Hays, 2015).

There are several barriers to seeking help for mental-health issues among the

Black community including: (a) cultural mistrust, (b) denial of symptomology, (c)

ineffective treatment, (d) preference for a Black counselor, (e) mistrust of mental health

providers, (f) stigma regarding mental health problems, (g) fear, (h) shame, and (i)

alternative beliefs about the cause of mental-health issues (Avent, Cashwell, & Brown-

Jeffy, 2015; Buser, 2009; Hays, 2015; Samuel, 2015). Ford et al. (2013) conducted homogenous focus groups to seek solutions to increase participation in clinical health trials and concluded that; (a) diversifying research teams, (b) recognizing past research abuses, and (c) increasing community trust were specific solutions for engaging Blacks in research on health. Members of the Black community have a history of being negatively stereotyped by the social sciences. Consequently, interactions with the helping profession is often guarded (Stansbury, Harley, King, Nelson, & Speight, 2012).

Considering the history of treatment of Blacks by health professionals in America, Blacks' interaction with mental health professionals and institutions is guarded with suspicion and cultural mistrust (Chatters, Mattis, Woodward, Taylor, Neighbors, & Grayman, 2011; Stansbury et al., 2012). Scharff et al. (2010) studied barriers to research participation among Black adults and reported, "Mistrust of the health care system among African Americans in our sample is deeply ingrained and appears to cross socioeconomic lines (Scharff et al., 2010, p. 883)." Also, participants in this study indicated that their relationships with White America have historically been one-sided with no benefit to Blacks (p. 887). Scott, McCoy, Munson, Snowden, and McMillen (2011) reported issues of trust in the Black community are founded in historical and social context. They asserted mental health professionals must consider the social contextual experiences and the interactions and experiences of Black with the dominant culture to include public agencies and institutions (Fisher & Kalbaugh, 2011; Scott et al., 2011).

Researchers concluded that a lack of knowledge, unaffordability, mistrust, cultural insensitivity to the Black experience among mental-health service providers, as well as impersonal service were barriers to mental-health services further supporting the

disparity of mental-health treatment and help-seeking behaviors in the Black community

(Avent & Cashwell, 2015; Chatters et al., 2011; Hays, 2015; Stansbury et al., 2012).

Campbell and Long (2014), examined culturally shaped beliefs that may have impacted

help-seeking behaviors and service use for Blacks with depression. In their qualitative

study, the following themes emerged: (a) Black people don't get depressed, (b) I don't

trust the doctors and/or the treatment, and (c) you don't need a doctor- it'll go away or

just pray. Most participants also indicated that their culturally shaped beliefs kept Blacks

from seeking mental health services for depression.

For best practices in research and interventions, the researchers cautioned

practitioners to be aware that Blacks believe in using other forms of interventions such as

prayer and support from friends and family preferable to professional services. The

researchers also emphasized the notion that "mental health practitioners must understand

that Black Americans may distrust them and the services they offer because of injustices

suffered at the hands of the caring professions (p. 58)." Stigma, fears, and tolerance for

distress may increase reliance on the informal care networks available through the Black

Church (Blanks et al., 2002).

Members of the Black community often seek help for mental health needs in the

Black Church (Allen et al., 2010; Dempsey, Butler, & Gaither, 2016). Researchers'

findings indicated that the use of religious resources, strategies, and orientations for

dealing with challenging life events was highly evident within the U.S. population

(Chatters et al., 2008). In a study to assess if Black churches provided more social and

mental health services than White churches, Blank et al. (2002) found that Black

churches provided "many more supportive programs than White churches both in terms

of numbers and in terms of types of programs offered (p. 1671)." Clergy reported very little interaction with formal mental health services which resulted in diminished referrals for professional services (Blank et al., 2002).

Blacks frequently choose their spiritual leaders and their church as an avenue to meet their mental health needs instead of professional counselors (Avent & Cashwell, 2015). Cashwell and Watts (2010), stated that counselors must assess the influence of a client's spirituality and religion on his or her mental health and wellbeing. Arredondo et al. (1996) asserted that, "Culturally skilled counselors respect clients' religious and/ or spiritual beliefs and values … because they affect worldview, psychosocial functioning, and expressions of distress (p.2)." They also stated that culturally skilled counselors respected the practices of communities of color help-giving networks such as the help-giving function of the Black Church for the Black community. The culturally competent counselor understood that beliefs about spirituality and religion were central to the worldview of Blacks and could affect psychosocial operatives when working with members of the Black community (Cashwell & Watts, 2010).

Mental Health Crisis and Suicide in the Black Community

Across the United States, suicide rates rose from 1999 to 2016 (Stone et al., 2018). In 2017, the second highest rate of suicide occurred in adults 85 years of age or older. According to the Center for Disease Control and Prevention, suicide is the third leading cause of death among Black youth ages 1-19 (Heron, 2019). Also, the Centers for Disease Control and Prevention reported, nearly 89 people complete suicide daily in the United States (as cited in Borum, 2014). Between 1993 and 2012, suicide among Black children throughout the United States nearly doubled while in the same time period,

suicide declined for white children (Bridge et al., 2015). According to the CDC (2004), Blacks and Hispanic males exceeded White males in suicide attempts requiring medical attention for the first time (as cited in Molock et al., 2008). The increasing rate of suicide in the Black community calls for empirical studies to explore suicidal behaviors along with preventative and interventions for this population (Fitzpatrick, Piko, & Miller, 2008; Taylor et al., 2000; Wang et al., 2013).

There was a prevalent attitude in the Black community that suicide was not an issue for Blacks. The myth that suicide was a "White thing" therefore not a serious problem for Blacks, existed among members of the Black community (Wang et al., 2013). There was a belief in the Black community that was a stereotypical psychological strength which some individuals believe was evident by Blacks' ability to endure great suffering such as slavery, lynching, discrimination, and oppression. This stereotypical psychological strength was believed to be a protective factor from suicidality in the Black community (Day-Vines, 2007). Also, the inability to recognize suicidal symptomatology along with stigma and the belief Blacks are immune from suicide are prevailing beliefs in the Black community (Day-Vines, 2007; Taylor et al., 2000). In a study examining suicide and ethnic culture among Blacks, Borum (2014) asserted that integration and cultural assimilation were possible influences on suicidal behaviors in Black college students.

Contrary to prevailing beliefs, researchers conducted a longitudinal study of discrimination and risk for suicide and morbid ideation in Black youth and concluded that racial discrimination contributed to symptoms of depression and anxiety as well as subsequent suicide and morbid ideation (Walker et al., 2017). While studies designated

depressive symptomatology as the leading precipitant to suicide ideation, depression does not consistently predict suicide outcomes for Blacks. However, anxiety associated with hypervigilance and worry because of feelings of helplessness experienced by marginalized people may be a reliable precipitant (Walker et al., 2017). According to Walker et al. (2017), "more than 90% of Black preadolescents report having experienced racial discrimination (p. 89)."

According to Fitzpatrick et al. (2008) adolescents often view suicide as a way to cope with challenging life-circumstances so there is a need for culturally catered prevention and intervention strategies to be used with diverse populations. Protective factors for suicidality among Blacks included family support, religious coping, and sometimes negative attitudes toward suicide (Molock et al., 2008). Because Black families generally attended services, the Black Church may offer opportunity for family support with religious coping (Molock et al., 2008). The social support and religiosity found in relationship with the Black Church safeguarded the relationship between stress and suicidal behaviors among Blacks (Wang et al., 2013). For Blacks, religiosity mitigated thoughts of suicide in Blacks and should be considered in prevention and intervention strategies (Fitzpatrick et al., 2008; Walker et al., 2017).

Spirituality and religion were protective factors for mental health crisis and suicide; and were associated with lower rates of suicidality (Chatters et al., 2011; Day-Vines, 2007; Hays, 2015; Hirsch et al., 2014; Lincoln, Taylor, Chatters, & Joe, 2012; Wang et al., 2013). There was an increased risk of suicidal behavior for Blacks with no spiritual connection (Fitzpatrick et al., 2008; Wang et al., 2013). Chatters et al., (2011) found that people who have previously attempted suicide were more likely to engage

with church members as a general preventive strategy. Religion as a protective factor, when explained further as a perception of belonging to a spiritual community, was a significant factor in lowering odds of suicide ideation in Blacks (Fitzpatrick et al., 2008; Wang et al., 2013). Religion as a protective factor was described as having a relationship with God and religious practices such as attending worship services and prayer (Fitzpatrick et al., 2008; Wang eta l., 2013).

Researchers also reported church members were an avenue to obtain support resources (e.g. monetary aid, emotional support, and in-kind services) and continued support to cope with problematic circumstances (e.g. transportation to appointments, housing, and job referrals) (Chatters et al., 2011; Hirsch et al., 2014; Lincoln et al., 2012). Molock et al. (2008) explained:

> Suicide prevention programs for African American youth in African American churches may have broad appeal because: (1) the Black Church has a strong history of helping community members, regardless of church membership; (2) African Americans have the highest level of public and private religiousness; and (3) the church can help shape religious and cultural norms about mental health and help-seeking. (p. 323)

Understanding the influence of clergy and the rich-resources available in the Black Church, Blank et al. (2002) called for research to focus on barriers between providers of mental health services and faith communities. Understanding the experiences of the clergy may help with understanding possible barriers. Researchers suggested that further research on the nature of church-based support is needed to reveal the specific ways and methods of linking various aspects of church support and suicidality (Fitspartick et al.,

2008; Molock et al., 2008). Specifically, research investigating help-seeking from clergy on suicidal behaviors is needed (Chatters et al., 2011; Crenshaw. 2015).

Summary

Historically, the Black Church has been a safe place for Blacks to seek guidance and receive help (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013). As noted by Kalsibatseva and Leong (2014), "Recent meta-analyses and reviews have showed that culturally adapted mental health interventions are more effective for racial and ethnic minorities than traditional un-adapted psychotherapy (p. 433)." Although there have been research efforts devoted to addressing the disparities in mental health treatment for Blacks, the deficiency of treatment persists. Counselors must develop effective interventions for Blacks to address the disparities. Elements of effective multicultural competence includes the ability to develop appropriate interventions strategies and techniques (Wong, Maffini, & Shin, 2014). Counselors are challenged to gain insight and incorporate knowledge that includes the clients' faith backgrounds. Integrating spirituality in practice and collaboration with spiritual leaders may serve to help alleviate mental health care disparities in the Black community (Avent et al., 2015; Cashwell & Watts, 2010; Wong et al., 2014).

Mental health professionals have collaborated with the leaders of Black churches to provide successful treatment and care (Allen et al., 2010). Researchers have also demonstrated the impact of the Black Church on Blacks' health behavior (Aten et al., 2010; Lumpkins et al., 2013; McRae et al., 1999; Williams et al., 2014; Wong et al., 2014). The Black Church along with the family have been protective institutions that

have deterred Black people from lethal self-injurious behaviors and has been one of the strongest institutions for socialization in the Black community (Day-Vines, 2007).

Previous research involving Black clergy and church members has dismissed the significance of suicide to the Black community (Crenshaw, 2015). In their article on the role of church leaders and Black families seeking mental health care services, Avent et al., (2015), recommended that researchers investigate Black clergy "attitudes and experiences with suicide in their congregations (p. 45)." Considering the critical role of clergy as gatekeepers in the Black communities' help seeking behaviors, it is imperative to explore how clergy in the Black Church respond to specific types of problems (Chatters et al., 2011). Although few studies have examined The Black Church and mental health issues, more are needed to explore clergy in the Black Church perspectives in regard to mental health issues such as mental health crisis and suicide (Avent et al., 2015). The purpose of this phenomenological study is to describe clergies' experiences with mental health crisis and suicide in their congregations in Black churches in the United States.

In Chapter 3, I present the methodology that guided this study. Details as to the participants and all other methodology parameters are presented so that a complete understanding of the procedures to conduct this study can be understood with clarity and replicated.

CHAPTER III

Methodology

The purpose of this transcendental phenomenological study was to describe Black clergy's experiences with mental health crises among members of their congregations. This chapter includes the methodology employed to answer the following research question: What is the experience of clergy in the Black Church, in responding to mental health crises of their congregants? The chapter is organized into five sections: (a) research design (b) selection of participants, (c) instrumentation, (d) data collection, and (e) data analysis.

Research Design

In this study, I sought, using a transcendental phenomenological method (Moussakas, 1994), to gain insight into the perceptions of Black clergy regarding mental health crises in the Black Church. I chose this method because it was my desire to give a voice to a cultural group that is rarely given the opportunity to express their thoughts about mental health issues and it was more appropriate to do a qualitative study than to do a quantitative study.

Qualitative inquiry was chosen because I studied a cultural group, Black clergy, to gain a view of the clergy's perceptions of the role suicide and mental illness plays in the Black Church. The clergy's experiences could not be easily measured, so quantitative inquiry was not be the best method of research to understand and gain insight into the clergies' experiences. The best method for understanding the experiences of clergy in the Black church with mental health crisis and suicide was through qualitative inquiry because it allowed for their voices to be the basis of the results of the study.

According to Creswell (2013) there are several approaches to qualitative inquiry. Narrative research, a method for understanding the stories lived and told which is useful in understanding the identities of individuals and how they see themselves. Another approach to qualitative inquiry was grounded theory research which is used to develop a theory of behavioral processes. An ethnographic study may be used to a document the behaviors of a group or culture using data gathered from the researcher's observations and/or interactions with a cultural group. A case study is used to investigate an issue or problem by examining one or a few cases. The transcendental phenomenological design (Moustakas, 1994) was used in this study to describe clergy in the Black Church experiences with mental health crises among members of their congregation. The purpose of using a transcendental phenomenological research design was to condense the individual experiences with a phenomenon to a description of the universal essence (Creswell, 2013). A transcendental phenomenological approach uses a collection of data from participants who have experienced a phenomenon to develop a description of what and how they have experienced that phenomenon (Creswell, 2013: Moustakas, 1994). Transcendental phenomenology was the best approach for this study because it focused on understanding the lived experiences of the clergy and not the clergy as individuals. Also, it provided a deeper understanding of the experiences of clergy of the Black Church in responding to mental health crises of their congregants by talking directly with them and allowed them to tell their stories and describe their own experiences. (Creswell, 2013).

Selection of Participants

This study adhered to the guidelines of the American Counseling Association (ACA) code of Ethics (American Counseling Association, 2014) and was approved by an Institutional Review Board before data was collected. An application to the Institutional Review Board (IRB) at Sam Houston State University was made. After obtaining IRB approval, clergy of Black churches were recruited based on criterion sampling procedures. Onwuegbuzie and Collins (2007) noted that this sampling procedure referred to "Choosing settings, groups, and/or individuals because they represent one or more criteria (p. 286)" important to the collection of data for the research.

The clergy were identified by members of different congregations who could provide the contact information for the clergy so that effective recruiting could take place. I used purposeful sampling with criterion sampling which allowed me to choose the participants and the site (Creswell, 2013; Maxwell, 2013) based on predetermined demographic parameters. Purposive sampling, sometimes referred to as judgmental sampling (Johnson & Christensen, 2012) was utilized to identify participants who were not easily recognized (Creswell, 2013). Purposeful selection allowed the best data for my study by selecting participants who could provide a rich description of the phenomenon as it was experienced in conducting of their clerical duties (Maxwell, 2013). Purposeful sampling also allowed the opportunity to establish the most productive relationship with participants to be able to describe the experiences of clergy of the Black Church in responding to mental health crises (Maxwell, 2013) because it provided a level ground from which to begin the interview process. As noted by Maxwell (2013), purposive sampling was used so that participants were selected who adequately represented the

heterogeneity in the Black Church of being Black clergy who experienced mental health

crises in their congregations. As a Black woman who is a member of a Black church and

the daughter of a pastor in a Black church, my position may have enhanced trust and

made it easier to build rapport to facilitate greater sharing from the participants. In a later

section, I described how I bracketed my experiences so that they did not interfere with the

research study. Additionally, I recruited participants by using a recruitment flyer as well

as snowball sampling from other clergy in a metropolitan area in the southwest region of

the United States.

The eligibility criteria for participants was that they must be clergy (see definition

in Chapter 1) of a predominantly Black church who have experienced responding to the

mental health crises of their congregants. There were no age or gender limitations to

participation. I selected four women clergy and eight men clergy from various Christian

denominations. All participants self-identified as Black. I sought participants from

various age groups for diversity in their beliefs concerning mental health professionals

and the Black Church. I recruited 12 participants because data from 12 in-depth

interviews provided enough rich information to reach saturation; which is when no

additional information or data occurred and a pattern of findings was confirmed; and I

also had the data needed to describe and understand the universal essence of the clergy's

experiences of responding to the mental health crises of their congregants (Corbin &

Strauss, 2008; Creswell, 2013; Johnson & Christensen, 2012; Roy, 2012).

Instrumentation

After recruiting participants, each participant completed the informed consent

process. This process included a thorough discussion of the intent of the study, the

implications of their participation, measures to ensure confidentiality, the reassurance of the participants' anonymity, my contact information, and the contact information of the IRB representatives. I also reminded them that they could end their participation at any time without consequence. After obtaining written and verbal informed consent, I asked the participants to create pseudonyms to substitute for their actual names to protect their confidentiality. When the informed consent process was completed, the participants filled-out a demographic questionnaire. The demographic questionnaire was used to provide information about the characteristics of the participants. The characteristics of the participants found with the use of demographic questionnaires gave a reference for the major substantive questions that were subject to qualitative analysis as well as questions which were not the focus of the study but are a part of the study (Goldberg & Allen, 2015). The demographic questionnaire included the following questions:

(a) What is your gender?

(b) What is the denomination of your church?

(c) What is the total number of members you have in your congregation?

(d) What is your education level?

(e) Do you have specific training in the ministry and if so what type of training?

(f) Are you an ordained minister?

(g) How would you define mental health crisis? (Open ended question for data collection.)

Multiple in-depth interviews were my key instrument to collect data. Interviewing allowed the participant to provide a rich description of their experiences and included personal expressions and meanings in their cultural context and language. In-depth semi-

structured interviews allowed the participants freedom to express their experiences in their own terms, and provided reliable, comparable qualitative data (Cohen & Crabtree, 2006).

The data acquired through in-depth interviews was an appropriate form to answer the research question posed (Roulston, 2010): What is the experience of clergy in the Black Church, in responding to mental health crises of their congregants? In this qualitative study, both the researcher and the participants were aware that the discussion had the purpose to describe clergy's perception of the use of secular mental health services, their experiences with suicide among members of their congregations, and their perceived preparedness for handling crisis situations with parishioners. The participants provided meaning and explanation of concepts discussed in their description, and the questions were structured to provide a textural and structural description of the common experiences of the clergy (Creswell, 2013).

Each participant engaged in an audio-recorded 45 – 60 minute semi-structured, in-person interview in a confidential location, (e.g., the pastor's study). Generally, multiple broad questions allowed the participants to describe their experiences (Moustakas, 1994). In this study, I asked five open-ended grand tour questions to gather data to understand the experiences of the participants. The questions were based on recommendations for additional research found in the manuscripts reviewed for this study. Because the significance of this study was bound to the literature review, it was also important to maintain consistency in developing the interview questions with the literature. Each participant was asked to respond to the following questions:

(a) How have you experienced mental health crises in your congregation? (Avent,

Cashwell, & Brown-Jeffy, 2015; Crenshaw, 2015).

(b) How do you respond when a member of your congregation experiences a

mental health crisis? (Aten, Topping, Denney, & Bayne, 2010; Austin, &

Harris, 2011)

(c) What are the barriers you experience when responding to a mental health

crisis? (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy,

2005)

(d) How have you personally or within your family experienced suicide?

(Crenshaw, 2015)

(e) What supports are needed in crisis and suicide situations? (Adksion-Bradley,

Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Assari, 2013)

Credibility and Dependability

Possible internal threats to credibility in this study were descriptive validity,

structural corroboration, researcher biases, and reactivity (Maxwell, 2013). Descriptive

validity was addressed by validating the transcripts were accurately transcribed and using

member checks, or respondent validation. Structural corroboration was addressed through

triangulation. Researcher biases and reactivity was addressed through an initial interview

before the research to identify my beliefs and personal theories along with peer review or

debriefing.

There were several measures taken to ensure credibility and dependability of the

results of this study thus ensuring that trustworthiness was present. The use of multiple

methods to collect information and triangulation (multiple methods to check on one

another) was the first method used to validate this study (Creswell, 2013; Maxwell, 2013). Triangulation of data included collection a written response to an open-ended question, participation in a semi-structured interview, completion of a demographic questionnaire, and the collection of field notes from observations during the interviews. This process helped reduce the risk that the results reflected only the biases of the participants, which allowed greater rigor for understanding the participants' description of the phenomenon (Maxwell, 2013). The interviews were all audio-recorded, transcribed, and member-checked for accuracy. Each participant provided feedback about the conclusions from their interview as well as confirmation of meanings provided in their interview. Follow-up interviews were completed as needed. This process was called respondent validation or member checks (Maxwell, 2013) and provided consistent validation of the accuracy of the results.

In qualitative research, the researcher is the primary or foremost instrument in the data collection process (Lincoln & Guba, 1986). The experiences of the researcher are rich data that may impact the results of the study (Miles & Huberman, 1994) because the researcher could bring into the study her or his biases thus clouding the data collection process. The process of bracketing or epoche allowed me and my dissertation committee to become aware of our biases, as well as the opportunity to set aside those biases before interviewing the participants for the study (Moustakas, 1994). I participated in my own interview prior to collecting data which was conducted by my dissertation director. I examined what I knew and believed about mental health crises in the Black Church to diminish the effect of my beliefs on the participants and the data gathered from them. My

experiences were not ignored, but instead considered and accounted for through bracketing.

Being formally interviewed by my dissertation director helped me promote reflexivity by reflecting on my historical and socio-cultural experiences which described the biases I brought to the study along with my personal investment in the study (Onwuegbuzie & Leech, 2007). I also used debriefing the interpretive researcher as described by Hays and Singh (2012) and Onwuegbuzie, Leech, and Collins (2008). Debriefing is when another person, not involved or personally invested in the research, interviews the researcher during the data collection and analysis process. These data were used to help me reflect on how my biases could have potentially influenced different components of the study (Hays & Singh, 2012).

Debriefing interviews can also be useful in "helping the researcher leave and articulate an audit trail of both the participants' and researcher's growth" (Onwuebuzie, et al., 2008, p. 8). Through debriefing interviews, I was able to assess for (a) fairness-balance of all stakeholders of the study views to ensure balance in representing all participants; (b) ontological authenticity-assessing for increased level of awareness among the research participants; (c) educative authenticity-increased understanding of and appreciation for others outside the stakeholders; (d) catalytic authenticity-increased awareness and understanding as a result of participating in the study; and (e) tactical authenticity-the extent participants are empowered to act as a result of the study. The following are examples of insight gained through questioning used in my debriefing interviews (Onwuebuzie et al., 2008):

(a) I was able to interview representatives from various denominations of the Black Church as well as different positions that make up the clergy. In subsequent interviews, I targeted representation beyond senior pastors to include co-pastors, an elder, and an evangelist as well as female clergy.

(b) As a result of participating in this study, the participants seemed to increase their level of awareness of resources available especially during after interview debriefings as well as they were able to begin building resources of referring and linking members for services.

(c) My own empathy for and insights of the participants evolved during the process of interviewing the participants. I have an increased understanding of the plight and burden clergy experience as they serve their congregation. I have greater awareness of the need for emotional support for the clergy of the Black Church.

As a result of my debriefing interviews, I challenged myself to actively recruit participants that would allow greater balance and not simply depending on snowballing which was gearing the participants to be members of one denomination. I realized during the interviews I struggled with the clergy's perceived difficulty responding to mental health crisis. I wanted to rescue the participant which would have changed my focus from their experience to the participant. I initially desired to offer immediate assistance which would have impeded on the participant's storytelling. Instead, I learned to ask questions, then listen as the participant's story unfolded. I chose to use the insight gained from the authentic storytelling to guide follow-up questions and my questioning with later participants.

Positionality

      I am a Black, female who identifies as Christian. I grew up in the Black Church and my father is a pastor in the Black Church. I have been active with Black churches in both spiritual services and through providing mental health services. I currently serve as youth pastor in a predominantly Black church. Also, I work professionally as a member of a crisis intervention response team, a mobile crisis outreach team and a member of community crisis response team.

      Richard Henriksen Jr., Ph.D. is my dissertation director and he is a multiple heritage individual with roots in both Black and White ethnic identities. He is a Missouri Synod Lutheran and grew up in predominately Black congregations with White pastors. He has been active throughout his life with Black churches and has worked to increase the use of mental health services in the Black community. Dr. Henriksen has authored and co-authored several publications focused on the role of religion/spirituality in the lives of people and in counselor education.

      Rick Bruhn, Ed.D., LMFT-S, LPC-S is a former Professional Member of the Texas State Board of Examiners of Marriage and Family Therapists. He has been licensed as a LMFT since 1992 and has been a Clinical Member of AAMFT for over 30 years. He has made peer reviewed or invited presentations at AAMFT, AMFTRB (Association for Marriage and Family Therapy Regulatory Boards), TAMFT, ACA, TCA, and TACES. He is a full professor in the Department of Counselor Education at Sam Houston State University, where he teaches MFT classes, clinical hypnosis, practicum, and internships, at both the master's and doctoral levels. He has authored or co-authored a dozen articles or book chapters about MFT, play therapy, bi-lingual

education, and early music training. He has a small private practice in individual and couples' therapy and clinical hypnosis.

Mary Nichter, Ph.D. is a retired Professor of Counselor Education and Chair for the Department of Counselor Education at Sam Houston State University in Huntsville, TX. She is a Licensed Marriage and Family Therapist, Board approved Supervisor for Marriage and Family Therapist and Supervisor, License Professional Counselor Supervisor, and a Certified School Counselor. Dr. Nichter was a counselor educator for 20 years with teaching emphasis on marriage and family therapy courses, doctoral supervision courses, practicum, and field internship courses. Dr. Nichter has ten years of clinical practice working as a marriage and family therapist in private practice, hospitals, and at a Clinic for Pain Stress and Depression. She served as editor of an online counseling journal, Profession Issues in Counseling (PIIC) for nine years. Dr. Nichter's research interest includes strengths-based supervision and counseling, orientation of beginning marriage and family therapy students, identifying student impairment, and systemic influence and advocacy for school counselors.

Data Collection

With IRB approval, I recruited participants identified using purposeful criterion sampling as noted above. Although 15 individuals contacted me regarding their desire to participate in the study, three volunteers were not interviewed because data saturation was met with 12 participants. After recruiting participants, the participants completed the informed consent process. The participants were directed to choose pseudonyms to substitute for their actual names throughout the study; however, each participant declined choosing a pseudonym, so each participant was assigned a name. They then completed

and returned a demographic questionnaire. I then conducted face-to-face, semi-structured interviews with each participant which were audio recorded.

The interviews varied in length from 14:28 minutes to 52:02 minutes (M= 28:12). The recordings were kept locked on a password-protected computer program in a secure location, separate from identifying information. The recordings were transcribed, verified for accuracy and destroyed after the study was completed. The participants were given an opportunity to review and edit the information obtained from the interviews; however, none of my participants made any changes to the transcripts. All hard copies of consent forms, transcripts and demographic questionnaires were double locked in a cabinet in my office while not in use. All data collected and analyzed for this study was kept on a password-protected computer program and will be destroyed once the dissertation process is completed.

Data Analysis

I implemented Moustakas' (1994) modification of the Van Kaam method of analysis of phenomenological data to analyze the data collected in this study. Specifically, I applied the steps identified by Moustakas to my study. Moustakas (1994) outlined the following steps of the Van Kaam method, which are presented in sequence.

First, I recorded and then transcribed each participant interview using a secure, private and password-protected, internet-based transcription service. The transcribed interviews were maintained in a password-protected database created by the transcription service and accessed online. Each transcript was then analyzed by a coding team consisting of the researcher and two doctoral candidates. The researcher is a Black, female doctoral candidate. The coding team consisted of two Black, female doctoral

candidates. Both members of the coding team identified as members of the Black Church all of their lives and identifies with the Baptist denomination. They also reported having family members in the clergy but acknowledge they are not involved in the clergy.

The coding team met over several days and completed Moustakas' (1994) modified Van Kaam's (1959, 1966) method of data analysis for each participant's interview. We listed and created a preliminary grouping of participant responses that included every expression relevant to the experience. We created tables which included the relevant expressions and consisted of twelve groups. This table allowed us to outline reoccurring and prominent grouping across participants. Groups that did not contain a majority of participant responses were eliminated. For example, two participants mentioned sexual-identity concerns as a source of distress; however, the topic was not corroborated in data from any other interviews so that group was eliminated.

Next, we tested each expression for two requirements: (a) the expression contained a moment of the experience that was necessary and enough content for understanding the experience and (b) We were able to abstract and label the experience, the horizon of the experience. Expressions that did not meet the above requirements were eliminated. Also, overlapping, repetitive, and vague expressions were eliminated or presented in more exact descriptive terms. The expressions that remained were the invariant constituents.

The invariant constituents were clustered and thematized by placing the invariant constituents of the experience that were related into a thematic label such as the expressed need for peer-support and the expressed need for specialized training which were combined under the thematic label of the need for peer-supported crisis intervention

training. These labeled constituents were identified as the core themes of the experienced phenomenon. We finalized the identification of the invariant constituents and themes by checking the invariant constituents and their accompanying theme against the complete record of each participant. We questioned if the themes were expressed explicitly in the complete transcription and if they were compatible if not explicitly expressed. If the themes were not explicit or compatible, they were not relevant to the participants experience and were deleted.

I constructed an individual textural description of the experience using the relevant, validated invariant constituents and themes. I included verbatim quotes from the transcribed interview as examples. Also, I constructed an individual structural description of the experience based on the individual textural description and imaginative variation. To accomplish this, I examined the emotional, social, and cultural connections between what participants said and created a description. Finally, I constructed for each participant, a textural-structural description of the meanings and essences of the experience, incorporating the invariant constituents and themes. Considering the participants emotional, social, and cultural conceptualization of the participants' experience, I used the individual textural-structural descriptions to develop a composite description of the meanings and essences of the experience that represented the group as a whole which is discussed in Chapter IV (Moustakas, 1994, pp. 120-121). The results of the data analysis provided the naming and detailing of six major themes found in the interviews which allowed the identification of the final result which was the essence of the study.

Summary

I completed a transcendental phenomenological qualitative study (Moustakas, 1994) to describe the experiences of clergy of the Black Church responding to mental health crises of their congregants. This chapter included the methodology that was used to answer the following research question: What is the experience of clergy in the Black Church, in responding to mental health crises of their congregants? A transcendental phenomenological research design was used to describe the lived experiences of the participants.

Participants were selected using purposeful sampling and criterion sampling. A developed set of questions were used to guide the interview process. Multiple in-depth in-person, semi-structured interviews that focused on a bracketed topic and question were conducted. Follow-up interviews were completed when needed. Using a coding team, I organized and analyzed the data collected to develop individual textural and structural descriptions, a composite textural description, a composite structural description, and a synthesis of textural and structural meanings and essences (Moustakas, 1994)**.** The results of the analysis are presented in the following chapter.

CHAPTER V

Results

The purpose of this transcendental phenomenological study was to describe Black clergy's experiences with mental health crises among members in their congregations. Through an in-depth examination of the experiences of the study participants, insight was gained on clergy's perceptions of their ability to respond to mental health crises in their congregations. Further, an increased understanding of the clergy's ideas regarding the perceived help needed and the help-seeking behaviors of congregants who experienced mental health crises was obtained. In this chapter, the results of twelve interviews are presented in order to answer the research question, What is the experience of Black clergy in the Black Church, with reference to congregants who experience mental health crises?

Demographic Information

Before beginning the semi-structured interview, each participant completed a demographic questionnaire that included six items: (a) age; (b) gender; (c) total numbers in congregation; (d) education level; (e) specific training in ministry; and (f) if ordained minister. The participants were also asked to write their definition of a mental health crisis. Participants' ages ranged from 44 to 65 years old with a mean age of 55 years old. Four different Christian denominations were represented among the participants: Baptist, Church of God in Christ (COGIC), Non-denomination, and Pentecostal. The participants' identified their education levels as high school graduates (2), some college/trade school (5), bachelor's degree (3), and some post-graduate training (2). Excluding one

participant, every participant was bi-vocational; however, the participant who was not employed outside the church setting was at the time retired.

The participants were from Baptist (1), Church of God in Christ (1), Non-denominational (8), and Pentecostal (2) denominations. There were clergy who self-identified as bishop (1), pastor (7), co-pastor (2), elder (1), and evangelist (1). The participants self-identified as male (8) or female (4) gender.

Participants

With the focus of this study having been to share the collective experiences of the participants, in the following paragraphs I introduce the 12 individuals who were interviewed. Each participant was assigned a pseudonym.

Josiah was a 65-year-old Black male, who served his congregation as an ordained-minister and received specific training in ministry through a seminary college. He was the pastor of a congregation that consisted of 101-200 members in the Church of God in Christ (COGIC) denomination.

Matthew was a 65-year-old male, who served his congregation as an ordained-minister and received specific training in ministry through seminary. He was the co-pastor of a congregation that consisted of 1-100 members and identified the church he pastors as Non-denominational.

Richard was a 63-year-old male, who served his congregation as an ordained-minister and received specific training in ministry through biblical studies at a bible college. He was the pastor of a congregation that consisted of 1-100 members in the Baptist denomination.

Grace was a 44-year-old female, who served her congregation as an ordained-minister and received no specific training in ministry. Identifying as Non-denominational, she pastored a congregation that consisted of 1-100 members.

Mark was a 56-year-old male, who served his church as an ordained-minister and received specific training in ministry through a seminary. He was the bishop of a congregation that consisted of 1-100 members and identified the church he pastored as Non-denominational.

Faith was a 54-year-old female, who served her church as an ordained-minister and received specific training in ministry through a seminary. She was an evangelist in a congregation that consisted of 401-1,000 members and identified the church in which she ministered as Non-denominational.

Steve was a 60-year-old male, who served his church as an ordained-minister and received specific training in ministry through a seminary. He was the pastor of a congregation that consisted of 1-100 members and identified the church he pastored as Non-denominational.

John was a 56-year-old male, who served his church ordained-minister and received specific training in ministry through a seminary. He was an elder in a congregation that consisted of 401-1,000 members and identified the church in which he served as Non-denominational.

Stephanie was a 51-year-old female, who served her church ordained-minister and received specific training in ministry through biblical studies. She was the pastor of a congregation that consisted of 1-100 members and identified the church she pastored as Pentecostal.

Nathan was a 52-year-old male, who served his church ordained-minister and received specific training in ministry through biblical studies. He was the co-pastor of a congregation consisted of 1-100 members and identified the church he pastored as Pentecostal.

Kristi was a 46-year-old female, who served her church ordained-minister and received no specific training in ministry. She was the pastor in a church with a congregation that consisted of 1-100 members and identified the church she pastored as Non-denominational.

Allan was a 47-year-old male, who served his church ordained-minister and received no specific training in ministry. He was the pastor in a church with a congregation that consisted of 1-100 members and identified the church he pastored as Non-denominational.

Results of written demographic question

There were eleven written responses to the question, how would you define mental health crisis? One participant did not respond. Six participants described mental health crisis as the inability to cope with life issues. They described these issues as problems in marriage, family, and work. For example, Mark described "someone who's in need of help dealing with everyday life issues, marriage, family, co-workers." Four of the participants used the word "problems" and two used "normal" when they described life issues. Nathan defined mental health crisis as "anyone having problems coping with life or any disorder that stops someone from functioning in a healthy way." Faith reported mental health crisis is when "someone [is] talking about killing themselves or others." They may be "thinking about doing things to (society)." John reported crisis as when "a

person can't take care of themselves because of mental issues." Two of the participants

described mental health crisis as the need for stabilization services with one of those

participants describing the crisis as a lack of resources for mental health needs. For

example, Stephanie wrote about a "situation where a person is dealing with the effects of

mental illness and is in need of help or support in order to stabilize their mental health

situation." Finally, based on the answers provided, there was no consistent definition of a

mental health crisis.

Phenomenological Themes

Significant themes emerged through the analysis process. Six major themes with

subthemes were identified from the interviews and noted in Figure 1. The themes

included: (a) a definition of crisis (b) cultural expectations around mental health, (b)

causes of mental health crisis, (c) clergy response, (d) barriers to responding, and (e)

identified needs.

Figure 1.

Mental health crisis and the Black Church phenomenological themes and subthemes.

Crisis defined	Self-harm and/or harm to others Psychosis
Cultural expectation	Self-reliance Suppression
Causes	Shame Social isolation Substance use
Clergy response	Spiritual intervention Counseling intervention Referral
Barriers	Lack of family support Person experiencing crisis
Needs	Resources Crisis training Collaborative partnering with mental health professionals

A Definition of Crisis

The participants provided a definition of mental health crisis as they described their experience with mental health crisis in their congregations. From the interviews of seven participants, self-harm (suicidal ideations or suicidal behaviors) or harm to others emerged, as their definition of mental health crisis. Faith reported that someone came to her and talked "about [how] they wanted to kill themselves…they no longer wanted to live." Richard stated, "They take their life to relieve the pressure" as he described suicidal ideation as he experienced crisis in his congregation. Matthew also defined mental health crisis in terms of suicidal ideation, "He'll call me sometime and say you know, pray for me 'cause I'm thinking about taking my life." Grace provided a detailed description of harm to others as a crisis as she described the threat to the lives of children in the car, "…the husband has a drug problem. And he will be high and pick his kids up from school

and drive around the city, falling asleep behind the wheel…your children could be in

danger."

Mental health crisis was defined in terms of psychosis (when thought and

emotions are so impaired that connection with external reality is severed) by five

participants. Steve reported:

I've experienced certain cries, certain outcomes, certain basically just an

outburst… they're crying or they're just upset and doing some derogatory things

that you wouldn't normally do… and then sometimes the feeling give a false sense

of reality, a false sense of even trained thought."

John stated, "I feel like when certain people don't have certain mental states, they, either

refuse to take the medication or they, they're refusing, stop and do something and then

they out-bursting." Matthew defined mental health crisis as someone experiencing

psychosis with auditory and visual hallucinations when he reported that "he sees it

different than he sees as he has not delusion, but times where he hear things and spirits."

Josiah's definition of mental health crisis (psychosis) is described when he reported, "she

see things, and she may jump up and start screaming and hollering, 'they trying to kill

me, they trying to kill me'."

Cultural Expectation around Mental Health

The theme of cultural expectation around mental health was an overall theme

(endorsed by nine of the 12 participants). As the cultural expectations around mental

health were analyzed, two subthemes emerged from the interviews. The participants

described that cultural expectations around mental health are embedded in the cultural

norms of the Black community. They described the cultural expectation of self-reliance

and suppression/avoidance. The participants reported that both subthemes influenced help-seeking behaviors. The participants indicated awareness that in the Black community, the expectation is that mental health issues are not dealt with or acknowledged within the family and help seeking from the medical community is not encouraged.

Self-reliance

The theme of self-reliance as a cultural expectation emerged in the analysis of six participant interviews. Steve described self-reliance when he reported that, "Pride, kind of bring[s] in inner confidence. … Pride feel[s] like I can do it, I don't want nobody else to do it, because you … [were] taught to just like this mentality…" He further explains, "Our community from my observation … would rather have a hero syndrome and do it ourselves." Matthew expresses self-reliance as a cultural expectation in the following statement:

> You know, so it contributed to it and our race as Black people period. We have put a lot of pressure on our own race because, like you say with suicide, that was not important to us. We were taught no matter what was going on, you take it; you deal with it; you don't talk about it. You … [were] taught not even to tell Jesus about it.

Mark stated, "You know, I find a lot of times that people that are going through issues like that, the first thing they say is, 'I really didn't want to bother you with this because you have enough on your plate.'" Kristi described self-reliance in terms of personal strength, "I think we're very strong, but sometimes we don't allow ourselves to be weak and we let it grow."

Suppression

Five of the participants indicated suppression or avoidance as a cultural expectation around mental health in the Black community. Matthew stated:

We as Black people have, especially boys I think, were always taught to not talk your business out…That's another thing we were taught in our race not to even talk about...We were taught no matter what was going on, you take it, you deal with it, you don't talk about it…but we were taught not to deal with issues and to confess that we're healed or delivered from something. When in actuality, we weren't, but we were taught to just put that on the back and that leads to other problems. One thing in the church, the Black Church, that's why I think not other White people, I'll put it in perspective. They have been taught to deal with more of their issues and in touch with their feelings, where we wasn't.

Matthew further expressed, "You can't bundle all that up inside of you and expect to be walking around here as a whole person." The description of boiling over as a result of suppression was indicated when John stated, "And he's stressed out to a point where he's gotten to a point where he's mentally just his body is releasing everything." He continued stating that one should "Be able to talk and process your own thoughts and get those things broken down because we hold so much. We let stuff build up and we go on."

Stephanie stated, "I think that some of it, [is] just people not knowing how to cope with the pain, family secrets, you know, people that just don't, they call themselves hiding things that eventually it's coming out." Then Kristi described this cultural expectation with consequence when she communicated, "It's cultural…what's done in my house or say it stays in my house. We don't talk about not feeling well because we haven't

had the opportunity to do that." She further explains, "When we let things go and we don't acknowledge them and then it just, we push it back, we push it back and then it comes up…something makes it all come up that it's too overwhelming to deal with." Stephanie reported "People just didn't even talk about stuff. They don't, you just deal with it and you just move on." as a response to stress and distressing emotions.

Cause of Mental Health Crisis

The participants described their experience responding to mental health crisis among members of their congregation and, ten identified causes of mental health crisis. Although participants discussed multiple causes of mental health crisis as Nathan noted:

It's not just one thing. Okay. It's not just drugs, it's not just alcohol. It's not just

mental illness is not just poor familial relationships that breed into it. It's a

combination of some of those four or five things.

Three subthemes of causes of mental health crisis emerged from the interviews of the participants. Shame, social isolation, and substance use were identified as causes of mental health crisis in the experiences of the participants.

Shame

Six participants described shame as a cause of mental health crisis. The participants expressed they experienced the presentation of shame as silence. Participants suggested that the consequence of the silence is a mental health crisis. Josiah reported, "The majority, I think, [face a mental health crisis] because of not facing what is going on and not being allowed to talk about what your experience was." Matthew explained that experiencing mental health issues may cause someone to appear to lack faith:

In our faith. I'll put it this way, because if you don't it's a reflection on the minister that saying well, you're healed. You've been taught to lie. What it does, it teaches you to lie. You want to show everybody else that you're saved and it's the whole misinterpretation… You lie and say that I'm delivered or God has done this, when in reality you haven't even dealt with the issues that's causing it.

Richard reported, "You don't [want] to be embarrassed. You don't want anybody to know that you've got some major issues." Steve provided his experience as he identified shame using the work pride as a reason Black men in particular stay in silence when he stated, "Pride, feel like I can do it, I don't want nobody else to do it, because you was taught to just like this mentality of man talk, if a man cried then he's less than a man and that's not so." John also identified shame in the form of pride in response to mental health issues,

The first thing I realized is that they begin to think that if they would do something like seek counsel, they'd be crazy. You know what I'm saying? I don't want to seem crazy. People are more prideful in and they don't want no one to know. They struggle with certain things and people in this world, it matters how it looks…Everybody struggles with something and you know, and that's the understanding that at that time they are shame.

Stephanie stated, "…people having shame over their mental state" as a cause of people getting to a place of crisis. Finally, Matthew described, "no matter how uncomfortable it may be or how embarrassing it may be, so God had to take me through all of what I went through and I had to deal with the guilt and the shame."

Social Isolation

Participants reported isolation as one cause of mental health crisis. Social isolation including the lost sense of community was a subtheme which emerged through the analysis process. Seven of 12 participants described social isolation with the change from being a cohesive community as the cause of increased in mental health crisis for the members of the Black community. They identified how social isolation impacts the wellbeing of the elderly and children. Richard reported:

Loneliness of companionship, of someone you have been with such a long time, feel like your world now is to an end, because people forget you. Because they feel like they not loved, they feel like that, they raised their kids, raised the grandchildren, and now they're off having their own life, and now who's there for them.

Faith described the social isolation experienced stating, "They feel like they're useless or they feel like they don't belong." Matthew revealed the isolation he personally experienced "I had nobody I could go to. You can't go to at least at that age you're thinking how can I go and tell the church that one of their ministers is doing this." Steve reported, "When she's isolated and incubated is when she have the most problem and then sometimes if she's around you, you can be around people, but you're still not engaged with people, so therefore you're still isolated." Nathan described the isolation of a person in crisis when he stated, "So you all have your family connections that the normal person would have are in somewhat unavailable, alienated in some shape, form or fashion or just not there." He continued to explain, "So you are alone and you going to people that you just met or people that you really don't not connect it to get help." Richard stated, "The Black family have always been a cohesive bond, but this generation has changed."

Nathan acknowledged, "Isolation from their family because of the decisions that they make" as a cause of crisis. John provided a detailed description of the isolation through the loss of community when he stated:

> What was different in the Black community? Now we used to know each other's neighbor. We used to be able to talk about it all the time. Well, my neighbor could tell my mother and my mother would (get us too), I had to watch myself in my own neighborhood because everybody knew each other, and neighbors were accountable for one another. And that that had made you very scared to do something in your own neighborhood. So, it gave you a sense of pride and responsibility to give, made you govern yourself… We don't have a village to raise a kid anymore because no one trusts anyone.

Steve described the isolation through the lost sense of community, "We just know of each other, but we don't really know each other, because we won't express ourselves to each other." Steve also stated, "I think we're the generation that was able to invest more into us, now it's about me my four and no more, my two and that will do." Mark described the influence of community and connection when he responded, "Some of the stuff she's dealing with me as an adult, I couldn't deal with. But, I'm there for her, to make sure that she don't have to feel like you have nobody to talk to or you have nowhere to turn."

Substance use

Substance use was also described by eight of the participants as a cause of mental health crisis by the participants. Grace reported, "…the husband has a drug problem" as she described the effects of a husband's substance use the cause of immediate danger or crisis for the family. Steve stated, "…then you have the other parent that is either off on

drugs" as he described the cause of mental health crisis in the Black Church. Mark

reported substance use as a contributor to the distress that causes mental health crisis

when he stated "You've got dad, who is strung out on heroin." Richard described how

substance use provides cause and opportunity for suicide,

> We have a high use of medication there. Medication addiction. Especially for
>
> senior citizens is high. When it comes to prescribed drugs. And because we have
>
> power of life and death in our hand and our medicine cabinets. It's easy to commit
>
> suicide…

Matthew described how shame/silence leads to substance use which causes mental health

crisis:

> The majority I think, because of not facing what is going on and not being
>
> allowed to talk about what your experience was, it leads you to do other things.
>
> Which normally leaves open the gateway to drugs. Then from there, you get even
>
> a greater chemical imbalance 'cause not you're dependence is on this.

Josiah reported simply, "drugs" causes mental health crisis. He goes on to describe over

use of medication, alcohol abuse, and other drug use as causes of mental health crises.

Josiah stated, "They were drugging... Baby come out a alcoholic. Some come out and that

messes up they brain. They messing up they brain." Stephanie stated, "Many of them

already. Brain is fried." Nathan reported a combination of influences that included

substance use and isolation when he stated:

> I've seen a heightened level of crisis and usually it's a multifaceted crisis. It's not
>
> just one thing. Okay. It's not just drugs, it's not just alcohol. It's not just mental
>
> illness is not just poor familial relationships that breed into it… isolation from

their family because of, um, the decisions that they make, whether they've stolen

from them, whether they use drugs and the family is just tired of dealing with

them or don't allow them to come to their home.

Clergy Response

The participants described responding to mental health crises in several ways and

some participants reported responding in more than one way. Six participants reported

responding using spiritual interventions. Eight participants described counseling

interventions as they described how they responded to crises among their congregants.

The final response noted by six participants was to refer the individual or family

experiencing mental health crisis.

Spiritual Intervention

Prayer was reported by participants as their response to mental health crises and is

used to intervene in the crisis situation. Steve reported, "And you start to pray." Matthew

described using spirituality and faith when intervening in crisis:

> What the Holy Spirit revealed to me is that you have to really take the time no
>
> matter how many times they slip or fall, you gotta take that time to be there for
>
> them. That awakened me to the mental crisis and what leads to what, especially in
>
> our faith.

Mark described using prayer and faith to guide him for spiritual intervention when he

reported, "I have a different level of faith because I have the faith to believe that God can

do anything…whenever the Holy Spirit give me something to tell you, I am going to tell

you that." Josiah reported "I let the God handle it. I start calling on the name of Jesus,

and I'll lay hand on her and not long after that, she's calm." Faith reported using faith in

God and scriptures to intervene in during a crisis, "And I began to tell them how God brought me out…I refer back to the Bible." Kristi reported using spiritual interventions, "I will teach them the Gospel, I will pray for them. I will intercede cause that's my job."

Counseling Intervention

Steve used a solution-focused and client-centered approach as he described his response to a crisis when he stated, "After we do that, then we try to find a medium that they can understand to try to if it's encouragement, enlightenment we just find a middle medium that we can get them out of that train of thinking, that thought pattern." Steve reported that he uses encouragement to divert their attention from how they are or the state that they're currently in, to bring them to a calmer, rational state. He also described using a client-centered approach when he stated "…you don't' have to play hero and give all the answers. You can just be an understanding leaning post and say, 'Okay, I understand that'." Grace reported using counseling interventions. She stated:

> So for us, we've had several counseling sessions, we've tried to have like an offbeat intervention where we're like look, 'This is what's going on.' We've even pulled him to the side at funerals and made him look at bodies and be like, 'This could be you. This could be your kids. What are you going to do if this happens?'

Matthew described using a client-centered approach, "You have to listen. I mean, if they don't have the skills to communicate it, give them that time to express it and if it come out in anger or if it come out with them breaking down and crying, listen." Faith reported using individual counseling sessions to intervene in a crisis, "I would ask them, 'Well what's going on? Could you sit and tell me what's going on?' And I would hear what they have to say." Also, Faith described using solution-focused and motivational

interviewing approaches. For example she asked, "But did you think about the kids, how they're going to be uprooted and not, you know, they're going to be all over the place? 'Well no, I ain't think about that.'." Mark used a solution-focused approach, "And you just kind of tap into that. What I've known to be the most effective is when you see something that don't look right, you address it then." He also demonstrated using a solution-focused approach when he reported, "Listen, let's set you some short term and long term goals" as he reported working with the person to stay future focused and helping her to work through the crisis by getting her mind off of her present situation. Nathan described his counseling intervention:

> Well, you, you do a whole lot of listening because you need to hear where that person is, what's affecting them and hear from them… And once you listen, then though the experiences in use of skills that you have helps steer you in the direction that you feel that it's best and most appropriate for that particular person or family.

Kristi reported using counseling intervention to help her parishioners, "Counseling sessions and I get a chance to ask questions and kind of dive deeper on how they move through life and where they are." She continued and explained:

> I think when someone is saying they're trying to harm themselves, the most important thing is to make sure that they get in a space where they're safe because they might not have the mental capacity to get their mind around healing, so to speak. So safety is first.

Allan reported using scriptures to affirm the person in crisis which appeared to be both a spiritual and counseling intervention:

The first thing that I do is I would affirm them. I would speak the word over them because a lot of times people in that, in that situation, on that state of mind has not had anyone speak anything positive over them probably in so long.

Referral

John reported that,

most of the time you have to just give them that time and space and, and let them get to that point, … but then try to get them help once it's possible… Try to get them the therapy, the medicine they need.

Faith stated, "And I share with them how to go about seeking help. Whether it's going to the doctor for physical health or going to the doctor for mental health." Mark described referring to counseling when working with someone he thought he was not helping effectively, "You should go and find a counselor." Stephanie reported using both spiritual intervention and referral, "You gotta be okay with that knowing that, well, that's why hospitals are there because sure you pray, but go and let the doctor deal with that…I'm going to pray and I'm going to say, here's a phone number." Kristi reported, "If they are expressing concerns about harming themselves and wanting to commit suicide or something like that, I am going to report in handover…that they need as far as the licensed professional counselor or psychiatrist or psychologist." Allan reported referral as a response to dealing with crisis among members of his congregation when he said, "that's when we would call them professionals and we'll refer them to a professional."

Barriers to Responding

All twelve of the clergy of the Black Church who participated in this study acknowledged barriers they faced when responding to members who experience crisis.

The barriers described by the participants were relational issues the person in crisis experienced; how they relate with their family and how they related while in crisis. Nine participants recognized a lack of family support and seven participants identified the person experiencing the crisis as barriers they experienced.

Lack of Family Support

Josiah stated, "If parents will stop trying to be their children friend and be their parent, I think children will grow up better." Stephanie reported:

> She seemed more amicable towards her church than she was her family...so the church is a surrogate family. We said it takes a village and it's just the truth, especially when it comes to the issues we're talking about now with mental illness and all that.

Steve described, "Because there's such a detached in the homes, you don't have both parents to keep you structured and to give you an example of balance in our community is lacking." He also stated,

> Mothers, either single parent home or that parent has to work in order to provide …or they might be dealing with the same thing and they never got help so they couldn't help their loved ones or their kids or their relatives.

Richard described the lack of family support and its impact on the individual,

> Family forget you, you know? You marry into a family, but the family you marry into... The son dies. The family you marry into forget about …They gone. And the family you thought you might have had or people in place that you thought was going to help you… You feel abandoned.

Matthew recounted an experience, "…this young lady said she was ready to take her life at 3:00 whenever time we left here, because her parents rejected her because of their faith." Grace described, "If they don't have a strong foundation at home, where somebody is telling them I love you, you have a purpose" as she identified a lack of family support as a cause of mental health crisis. Mark reported:

> You've got dad, who is strung out on heroin. You've got mom who's working and trying to keep the family together. She's in school, trying to keep her grades up. She's got two younger siblings that she's responsible for and she said, 'It's too much, that I just don't like living like this.'

John simply stated, "Family has been torn down." Richard described a lack of family support, "The black family have always been a cohesive bond, but this generation has changed."

The Person Experiencing Crisis

Seven of 12 participants described the person in crisis as their barrier to responding to crisis. They described how the person in crisis' erratic behaviors and their unwillingness to seek help was an obstacle the clergy faced when they attempted to help someone in crisis. Josiah described how the person and those around them, "They wouldn't let you do what you had to do." Matthew stated, "Some of them have been so hurt that they have this wall up to where they're not gonna' receive what you say anyway." Grace reported, "Sometimes they don't want to hear anything." Nathan stated, "They don't take their medication." Kristi described, "Sometimes they're the barrier...it's very difficult sometimes to get a person to participate in their healing. You can't just come and get prayer and be okay, God is able, but you have to have some actions around

those things." Allan reported, "The biggest barrier is it feels like some people like their hurt. Some people like the attention they get from being a victim."

Identified Needs

The participants in the study identified needs as they experienced responding to mental health crisis with members in their congregations. They identified three major needs. The need for created resources and linkage to available resources, crisis training for members of the church to effectively respond to crisis, and partnering relationships with mental health professionals were all identified needs by the participants.

Resources

The identified need for resources emerged from the interviews of seven participants. John identified connection to resources as a need and stated "a lot of times people suffer because they don't know that they can be helped. There's resources." Stephanie reported, "The resources are available but the lack of knowledge that they are there…Just not knowing where to go. I mean it's a big city. It's very resourceful city. But where do I start?" Stephanie explained the need for resources, "So sometimes that there's just a barrier, as far as having the right resource to be able to send people to, that's beyond what the church can offer" as she described:

> So, and then in a lot of our churches too, you have in inner cities, um, a lot of
> people who are the ones who've been here for a while, they're going to be on fixed
> income. And then you have a pool of people who are your working class, then
> you have children and then you have people who don't work at all or they're on
> some kind of subsidize. You see what I'm saying? So just having the kinds of, um,

it takes lots of, the more challenging the situation, the greater the resources that

are needed.

Nathan reported the need for resources "if you don't have the services in house, you have

to know where the service is all available in the community so that you can steer

members and the community back to those agencies that are providing those services."

He further explained, "Some type of financial benevolent fund. Because money is always

going to be an issue for a lot of people." Kristi also identified a need and benefit of

resources, "Now, not as many resources. People didn't then, not as many resources.

People didn't talk about it very much. It was a hush hush thing. But if you, if you're

seeking at least now you can, you can get some help." Allan stated, "I think a big part of

it is to give them resources because if you could really alleviate some of the normal, then

they can start fighting in the spirit."

Crisis training

The need for specialized crisis intervention training to teach both clergy and lay

parishioners in the church how to intervene and respond during a crisis emerged. The

participants reported a desire to receive training by mental health professionals on crisis

intervention. They also expressed they would like congregants within their ministry who

have been personally impacted by mental health issues or who have experienced mental

health crisis to receive training that would educate the congregant on how to support

someone experiencing a mental health crisis. Nine of 12 participants expressed the value

of personal experience paired with specialized training as needed in the Black Church.

Matthew stated:

They'll come at you. You can tell me about Paul and Silas, but what has God done

for you. I believe in God. You know this. I'm spiritual, but I do know the natural

side, we need help...Without the training and to know the signals and to know the

key, you're really not helping them.

Richard stated, "Yeah, but they don't know. They're limited. They know military, they

don't know ministry" as he reported his desire for trained people who understand the

spiritual aspect as well as the practical aspect of crisis intervention. Grace reported, "I try

to be transparent with a lot of stuff that I've been through to let them know, you can get

through this. I've been through this" while describing the value of personal experience

when responding to crisis. Mark pointed out, "You know, you guys go to school for this,

so they tell you all what to do. With us we got to you know, kind of shoot from the hip"

as he described the need for crisis intervention training. Steve stated:

Certain trainings that key individuals we have to be able to deal with crisis. We're

more comfortable with talking with another guy that can identify with whatever it

is that we're encountering. Have someone else too that you know have

experienced something of that magnitude, and you can always bring them in too

to witness or attest to what's going on.

John reported his feelings this way, "I think the church needs ministers that qualify to be

able to spend time with people and talk things through." Stephanie described this in the

following words:

The truth is they [clergy] would be more helpful to some of the people coming in

if they knew, wow, so you mean you dealt with… And some of us as

practitioners and as ministers, we have, you know, some counseling in our

background somewhere you've taken a little course or whatever. But I see a

situation that honestly, I don't feel equipped to deal with…

Kristi pointed out, "I think as pastors, because we believe so deeply and we've seen so

much that God has done that sometimes we forget our limits" as she described the need

for specialized crisis intervention training.

Collaborative Partnering with Mental Health Professionals

Eight participants expressed a need for collaborative partnering between clergy,

the church, and mental health professionals. Matthew stated it this way:

I'm spiritual, but I do know the natural side, you need help. We've been taught as

black people not to seek help from psychologists. I had to sit down and talk to a

therapist about what happened to me. It helped me tremendously. We can't

blame the church for saying they're not doing it, because they're not trained in

that area to do it.

Mark provided his opinion:

I think if we had had more people like yourself in ministries that we could say

like, I will give you an example, Lakewood has their own team and if you have an

issue we direct you right to this team who has the ability to deal with whatever

crisis you dealing with. Because a lot of stuff we haven't dealt with, as pastors we

haven't. I feel like if we had more Christian counselors, Yeah I feel like if the

church had a way to send people.

Stephanie expressed her experience in the form of a request:

I almost wish we could get a psychologist a Christian. Now I would want it to be

a bible believing counselor, but somebody on retainer that you could just send

some of these people to, you know, and where you even can start an educational

process helping people to understand.

Also, Kristi reported:

I think volunteering, the volunteering of time and having those resources or even

having someone on call that can just show up or make an appointment to be a

sounding board or come meet with the pastor and the person and be a liaison

between the two to say this is my recommendation.

Essence of the experience

The overall essence as described by the clergy of the Black Church is a call or

need for community. Clergy in the Black church recognized they are unable to

successfully work as individuals but depend on the collective group or community to

meet the needs of the individuals who have experienced mental health crisis within their

congregation. The clergy acknowledged the role of isolation and silence in mental health

crisis as they called for togetherness. As Steve conveyed, "Together we are overcome,

that's why we have to open our mouth and let somebody know our experience." Clergy in

the Black Church expressed an essence of not being heard or separate from the mental

health component of mental health crisis. They explained feeling inadequate or ill

prepared and called for collaboration with mental health professionals.

The clergy's call for community included a call to redefine the stakeholders of the

Black community. Stephanie identified, "We said it takes a village and it's just the truth,

especially when it comes to the issues we're talking about now with mental illness and all

that." The clergy expressed ideal stakeholders are the clergy, families, lay members, and

mental health professionals. They recognized the Black Church as central to what is

needed in the Black community. Nathan pronounced the call for the church to provide community:

> Reaching out to youth in the community where the children can come in and have a place that they can be safe. Okay. Where they can feel love and support. The safe place so that we can show children that who aren't getting love at home, who aren't getting treated the way that they should at home. They could see it modeled in a different way here at church.

Stephanie noted the call of the Black Church, "so the church is a surrogate family" to build community and connection. Faith defined the call for community and connection:

> Just letting them know that you there for them at any time. Loving on them, even taking initiative to go by and see them… We are needed all over, whether you at the door keeper or sweeping or whatever, at the pastor's aid. We are all needed. We are all needed.

Steve summarized his interview, "We're going to be helpers one to another. So have to be, don't be so caught up in ourselves and our own individual group settings and family that we can't see and hear from anybody else." The overall essence of clergy in the Black Church experience with mental health crisis among members of their congregation is that they are working on the *battlefield* alone and they desire to be *armed* with a community that understands, is trained, and equipped to respond to the needs of the congregants.

Summary

Interviews of clergy in the Black Church were conducted utilizing a semi-structured interview protocol. This allowed me to obtain the data necessary for exploring the participants' experiences which led to an in-depth exploration of the phenomenon. I

used Moustakas's (1994) adaptation of Van Kaam's method for analyzing qualitative interview data. Through this data analysis process, six major themes with subthemes emerged. I included participants' words in relationship to the themes that emerged after analyzing the data obtained during the interviews. The themes of my research helped to capture the true essence of the phenomenon, the experiences of Black clergy responding to mental health crisis of their congregants.

Chapter V provides answers to the research question and a discussion of the findings. Also, implications for counselors, counselor educators, and community agencies are provided. Finally, recommendations for future research is provided in Chapter V.

CHAPTER V

Discussion

Introduction

In previous chapters, this transcendental phenomenological study and the analysis

of the data collected were reported. In Chapter V, I present a summary of the purpose,

discussion of the findings, implications for practice, and recommendations for further

research. The findings of this study have been explained through the lens of the

theoretical framework utilized during this research, to provide additional insight for

counselors, counselor educators, and community agencies.

Summary of the Study

The purpose of this transcendental phenomenological study was to describe Black

clergy's experiences with mental health crises among members of their congregations.

The perceptions and experiences of Black clergy as they responded to mental health crisis

and issues of suicide with their parishioners were gathered through one-on-one, face-to-

face interviews.

Twelve clergy in the Black Church who had experienced mental health crises with

members in their congregation were interviewed using open ended questions that focused

on the following research question: What is the experience of Black clergy in the Black

Church, with reference to congregants who experience mental health crises? Follow up

questions were asked for clarity and to develop a rich description.

Discussion of the Findings

Before the interview, participants were requested to define mental health crisis on

the demographic questionnaire. Some participants described mental health crisis as an

experience that is a result of the stress of life. Other participants reported on the inability to cope with stress as mental health crisis. Hooper et al., (2017) described that environmental stress increased feelings of hopelessness and that the stress in everyday lives of the participants in their study increased the likelihood of suicide attempts. This research was consistent with the description of a mental health crisis as the inability to cope with life issues provided by six of the participants in their written definition of a mental health crisis. The participants in this study also reported stress as a factor for suicidality which is consistent with Hooper et al., (2017). For example, Faith described a parishioner reported suicidal thoughts because of life issues in her marriage, "Well, they came to me and they was talking about they wanted to kill themselves. They was going through some marriage crisis, and they no longer wanted to live". There was no consistent definition of mental health crisis provided by the participants on their written questionnaire.

Six major themes with subthemes were identified from the interviews. The themes included: (a) a definition of crisis (b) cultural expectations around mental health, (b) causes of mental health crisis, (c) clergy response, (d) barriers to responding, and (e) identified needs. Each theme was processed through the lens of critical race theory (Delagado & Stefancic, 2013) and symbolic interactionism (Vejar, 2015) and the common factor identified was community or the sense of connection with others through common attitudes, interests, and goals. Cultural expectations formed in community, isolation from community, the congregant's response as a barrier to community, and peer-crisis intervention as a benefit of community. "Connection to community and a

sense of belonging have been recognized as critical components of mental health

recovery (Bromage et al., 2017, p. 218)."

A Definition of Crisis

Although the participants did not provide a concise definition of mental health

crisis in writing on the demographic questionnaire, a clearer definition emerged from the

interviews with the participants. The definition of mental health crisis was defined

through the description of the clergy experiences. The participants defined mental health

crisis as behaviors that express possible to harm self or others and psychosis. The

participants' expressed definition was consistent with the definition of mental health

crisis used for the purpose of this study as defined by NAMI (2018).

The definition of mental health crisis provided for the purpose of this study was a

parishioner who experiences behavioral, emotional, or psychiatric conditions that would

likely result in significantly decreased levels of functioning in daily living activities or

the ability to function safely with others, and requires crisis response services that may

include but is not limited to placement in a more restrictive treatment setting (NAMI,

2018). Also, the word *normal* was mentioned both in the writings and the interviews of

the participants as they defined mental health crisis. Clinicians, researchers, and those

working with and within the Black community should get a clear understanding of what

is *normal* to better understand *abnormal* or crisis behaviors. Both clergy in the Black

Church, members of their congregation, and mental health professionals may benefit

from a continued discussion to increase understanding of mental health crisis and how

mental health crisis may present in members of the Black community to create a

consistent definition of mental health crisis.

Cultural Expectations around Mental Health

The participants described experiencing the cultural expectation around mental health of self-reliance and suppression/avoidance. They described the expectation of suppression as to avoid the acknowledgement of mental health illness and difficulties with emotional distress or to keep emotional distress and mental health illness a secret. As noted by Matthew:

> We as Black people have, especially boys I think, were always taught to not talk your business out…That's another thing we were taught in our race not to even talk about...We were taught no matter what was going on, you take it, you deal with it, you don't talk about it.

The cultural expectations of self-reliance and suppression, and maintaining mental health issues as a secret, continuing as if there was no emotional distress was illustrated by the participants in the results.

Displaying symptoms of mental illness and experienced emotional distress was described as weakness. Kristi noted this as she expressed the cultural expectation of self-reliance, "I think we're very strong, but sometimes we don't allow ourselves to be weak and we let it grow", using *strong* to denote the ability for take care of self while noting *weak* as acknowledging emotional distress and seeking help. Alang (2016) reported mental illness, specifically depression, was seen as a sign of weakness and expressing distress was frowned upon by participants in her study of how some Black populations perceive depression. Participants described seeking help or fully experiencing negative emotion as perceived weakness in contradiction to Black people as perceived strong. Samuel (2015) reported that often Black people hold a cultural belief that Black people

are resilient because of the hardships and environmental stressors Blacks have overcome so, there is a "toughen inner strength" that enables them to handle mental health problems on their own (p. 37). Matthew described this cultural belief when he stated "We were never supposed to be crazy. We don't have [mental health issues] White people get that, not us." He also described, "no matter what was going on, you take it, you deal with it, you don't talk about it." The cultural trope of self-reliance along with the cultural expectation to suffer in silence or push through, deters the person suffering from seeking help.

Within Black culture, to seek help for mental illness allows the person to be perceived as weak; provides opportunity to be labeled (e.g. crazy); and the stigma related to use of psychotropic medication influences of how Black people respond to mental health distress (Planey, Smith, et al., 2019). According to the participant's experience, the response is often suppression or avoidance which often leads to the person experiencing mental health crisis.

Causes of Mental Health Crisis

The participants identified shame, social isolation, and substance use as causes of mental health crisis. The participants identified shame as a barrier that hinders help-seeking behaviors of their congregation. They highlighted the role of social isolation leading to mental health crisis. Also, the clergy of this study identified substance use as an influencer in crisis behaviors as well as a barrier in the congregant to obtaining help needed.

Shame

Shame is a powerful influencer on help-seeking behaviors. The participants identified shame's involvement in mental health crisis experienced by their congregants. Crowder & Kemmelmeier (2018) utilized a meta-analysis of two studies with 1,147 Americans and identified that all participants were more likely to link the experience of shame to suicidality. Shame can be an exceedingly compelling emotion. Researchers demonstrated "the influence of shame on perceptions of suicide occurred for everyone, regardless of cultural background (Crowder & Kemmelmeir, 2018, p. 417)." The participants reported the shamed experience often keeps individuals from seeking help and then their emotions become too overwhelming.

Social isolation

Isolation is a key antecedent of mental health crisis experienced by the congregants the clergy worked with. Isolation was created in various forms such as isolation from family, church, and community connection.

Integration has been attributed to the loss of the traditional Black community. Integration has been credited with raiding the Black community of the resources and interdependence that once bounded the community (Fairclough, 2004). The new opportunity to patronize white-owned business, attend schools with more resources, and seek the American dream through integration lured many in the Black community to gather their resources and skills, shedding the bond of the Black community for the hope of acceptance in the dominant culture through assimilation. The shift left Blacks who left to integrate with a sense of loss of connection to the Black community (Olgetree, 2004). Assimilation and acculturative stress was attributed to the increase in suicide among Black youth because the once protective factors found in the institution of the Black

family and the Black Church lost influence as Blacks integrated (Walker, 2007; Walker et al., 2017).

The Black community has experienced a gradual shift from a collectivist culture towards an individualist culture in America which has impacted the cohesion once found in the Black community (Olgetree, 2004). Participants described the change in the Black community that resulted in isolation and a loss of connection. Richard described the change in these words, "The Black family have always been a cohesive bond, but this generation has changed". This change is also noted in how John described the Black community before, "What was different in the Black community? Now we used to know each other's neighbor" while Steve described the Black community now, "We just know of each other, but we don't really know each other, because we won't express ourselves to each other."

The isolation was also created in the absence of connection between family members. Steve noted the disconnection in families, "Because there's such a detached in the homes, you don't have both parents to keep you structured and to give you an example of balance in our community is lacking." Consistent with the results of this study, Lincoln et. al, (2011) asserted the importance of social relationships as protective factors for suicide, suicidal ideation, and suicide attempts among Blacks. The influential social relationships noted were religious based social supports and support from family members. A lack of social connectedness has been linked to suicidal thoughts and behaviors (Cole-Lewis et al., 2016).

In the Black community, "the concept of family extends beyond biological familial bonds and is rooted in traditions that survived slavery" (Walker, 2018, p.3).

Stephanie described this phenomena, "She seemed more amicable towards her church than she was her family...so the church is a surrogate family." Participants described the lack of family support or family connection as a source of isolation and a barrier to receiving help. Matthew discussed a parishioner who reported suicidal intent because of her disconnection from her family, "…this young lady said she was ready to take her life at 3:00 whenever time we left here, because her parents rejected her because of their faith." Grace also noted the influence of family support on suicidal behaviors, "if they don't have a strong foundation at home, where somebody is telling them I love you, you have a purpose" as she identified lack of family involvement as a cause of mental health crisis. Clergy identified the cause of the broken bond of family connection as parent's preoccupation with untreated mental-health issues; single-parent households, and the absence of extended family and fictitious kin. Hollingsworth et al. (2016), reported feelings of social disconnection and the "feeling that one does not belong to a group of people" as a risk factor for suicide among Blacks (pg. 176) which was consistent with the experiences of the participants in this study.

Substance use

According to the National Institute on Drug Abuse (2020), alcohol and other drug use is a health-related behavior that contributes to the leading cause of death and disability among youth and adults. The National Institute of Drug Abuse (2018) reported every year, illicit drugs, prescription drugs, and alcohol (*drugs*) contribute to the death of more than 90,000 Americans. The participants described the effects of substance use, specifically drugs and alcohol, and its role in causing mental health crisis in their experiences. They expressed their experience with members of their congregation

substance use causing them to be in circumstances that trigger mental health crisis.

Nathan described drug use causes isolation from support because of the choices the

person makes while using drugs:

> Isolation from their family because of the decisions that they make, whether
>
> they've stolen from them, whether they use drugs and the family is just tired of
>
> dealing with them or don't allow them to come to their home. They can't have that
>
> safe place to go when they're in crisis. So they, they're on their own.

They also described mental health crisis in terms of psychosis as a direct result of

substance use. For example, Grace discussed a father's mental state and behaviors after

recent drug use caused his children to be at imminent risk of harm. John expressed how

the addiction to drugs take over people's lives and they become hopeless then suicidal,

"…they see no way out …And you find it a lot that people would just, that do drugs, you

know… because they get the, what do they think his life is in the drug." Drug use by

caregivers may cause chaos, stress-filled homes, abuse and neglect for the children

(NIDA, 2018), which may influence family support and social isolation.

Clergy response

From the participants' description of how they responded to mental health crisis,

three themes emerged. Those themes were the use of spiritual interventions, counseling

interventions, and referral to respond to mental health crisis. The participants described

using spiritual interventions such as prayer, faith in God, and the scriptures. Hodge et al.,

(2019) postulates the positive influence of spirituality on the behaviors of Blacks. Prayer,

worship, and church services attendance are protective factors in the Black community.

The participants described the use of counseling interventions such as listening, the use of

positive regard, what seemed like motivational interviewing, and safety planning when responding to mental health crisis. Matthew demonstrated his skills when intervening in a crisis situation:

> I learn to listen first. Not so quick to answer them or say no, you need to do this. This is what we do when people want to get to know Christ. No, you can't wear this. You can't do this. Listen to what their experiences are. Then the Holy Spirit reveals to you whether at that moment to show them compassion, to show them love and how to respond to them.

After providing spiritual interventions, counseling interventions, or sometimes both interventions, the participants used referrals to respond to mental health crisis. Participants reported referring members of their congregation experiencing crisis when they felt it was beyond their scope of experience or ability. The participants in this study reported feeling inadequate, although they demonstrate counseling skills in how they respond, because they had no or little professional training. Mark pointed out, "You know, you guys go to school for this, so they tell you all what to do. With us we got to you know, kind of shoot from the hip." Kristi expressed this sentiment:

> I'm very clear when I do any type of, counseling with anyone because I'm not a licensed counselor of what it is that we're doing and how far I can go and if any, if they are expressing concerns about harming themselves and wanting to commit suicide or something like that, I am going to report in handover. Hand over [to] someone else because that's beyond my area of expertise and what I can do as far as them getting the legal help and legal counsel that they need as far as the

licensed professional counselor or psychiatrist or psychologist. So I'll refer them

away if it's something that's severe.

Barriers to Responding

The clergy interviewed in this study described barriers they faced as they

responded to individuals in their congregation experiencing mental health crisis. They

identified a lack of family support and the individual in crisis as their barriers to

responding. The clergy reported being present and willing to respond, however, as they

intervened, they reported these barriers impeded their ability to assist. These barriers

must be adequately understood and addressed to increase the clergy's perceived

effectiveness.

Lack of family support

The participants described the lack of family support as a barrier when they are

responding to a mental health crisis. The participants expressed feeling overwhelmed

with the burden of crisis in the times there was little family participation or support. The

clergy who participated in this study reiterated the need for social connection and support

from family. The clergy's responses ignited questions. How can mental health

professionals engage families for involvement during a crisis situation? How can

clinicians work with clients with establishing fictitious kin or *cultural family* historically

found in the Black Church? Mental health professionals must seek awareness and the

skills to help clients define cultural family (includes friends, pets, church members,

neighbors) versus traditional family (biological and legal family).

The person in crisis is the barrier

People who have experienced mental health crisis have described feeling out of control; emotional darkness; and loneliness. Many have described the mental health crisis experienced as chaotic, feeling loss of control, loss of energy, and feelings of hopelessness (Gullslett et al., 2016). Jane, a participant in a study to describe the experience of mental health crisis, reported "It's chaos! It's hell! Everything's turned upside down. Not only yourself, but those around you too, friends, family… (Gullslett et al., 2016, p. 165)." This is often how clergy experienced mental health crisis with the person they were trying to help. Josiah described a parishioner experiencing mental health crisis, "She see things, and she may jump up and start screaming and hollering, 'they trying to kill me, they trying to kill me'." The chaos and loss of control experienced by their parishioner, became the barrier the clergy experienced.

There was no previous literature that addressed the clergy in the Black Church feelings when responding to mental health crisis. This study offered insight on the experiences of the clergy as they responded to parishioners experiencing mental health crises. They described having difficulty responding to their parishioner in a state of hopelessness who was resistant to help or unable to receive help in the form they offered. Josiah noted while trying to respond to someone in crisis, "They wouldn't let you do what you had to do." Some clergy described believing the person did not want help. Grace described this belief when she stated, "Sometimes they don't want to hear anything." The clergy described this experience as a boundary or wall they believed kept the parishioner from getting help as reported by Matthew when he stated, "Some of them have been so hurt that they have this wall up to where they're not gonna' receive what you say anyway." As a result, the clergy described feeling helpless and ineffective. Matthew

expressed, "I'm spiritual, but I do know the natural side, we need help...Without the training and to know the signals and to know the key, you're really not helping them." Also, Stephanie described feeling unequipped, "And some of us as practitioners and as ministers, we have, you know, some counseling in our background somewhere you've taken a little course or whatever. But I see a situation that honestly, I don't feel equipped to deal with…"

Identified Needs

Resources, crisis training, and collaborative partnering with mental health professionals were the needs identified by the clergy in this study. Identifying and connecting with resources as well as receiving specialized intervention training are needed components of a collaborative partnering relationship between clergy, the Black Church, and mental health professionals. Rickard and Inoue (2013) recommended a "public-private partnership" to help clergy recognize when to refer and to help improve relationships between clergy and mental health professionals (p. 633). The needs identified by the participants in this study may be addressed through a created community whose members would be those in the Black community, the clergy, and mental health professionals.

Interventions provided through the Black Church are beneficial to the mental health of Blacks by employing their natural supports and social networks (Holt et al., 2018). Specialized crisis training was identified as a need. Clergy have a significant role in suicide prevention but report being insufficiently trained (Mason et al., 2019). The need for both clergy and people who have experienced crisis to be trained to respond to mental health crisis was identified by several participants. Mark reported "we got to you

know, kind of shoot from the hip" as he described the impact of having no training to respond to crises. Matthew expressed without training the person in crisis is not being helped. Boukouvalas et al., (2018) asserts training in Mental Health First Aid, with enough practice, prepares individuals appropriately to respond to a mental health crisis. Mason et al., (2019) identified the need for clergy to receive suicide prevention training. Collaborative partnering with mental health professionals is beneficial for training and connection to resources. Mental health professionals can use the rubric developed by Mason et al., (2019) to identify the stage of development and guide the clergy on how to improve their suicide prevention skills (p. 357).

The clergy reported that people who have experienced mental health crisis are then able to offer connection, empathy, and reassurance to others experiencing mental health crisis. Several participants reported using their personal experience with mental health issues to connect with the parishioner and validate their experience. Also, participants reported using people within the congregation, if available, to attempt to create the empathic atmosphere to build rapport and trust with the parishioner experiencing mental health crisis. People with lived experience act as good role models, increasing hope and motivation for those with severe mental illness (Slayer et al., 2009).

As previously discussed, the participants in this study described social isolation as a possible barrier to responding to those experiencing mental health crisis. Trained peers within the Black Church may help alleviate the social isolation some congregants experience and may provide greater support to the congregants from other members within their church. Peer-support provides an avenue for helping a Black person experiencing mental health crisis with increased hope which may safeguard against the

negative effects of loneliness and isolation as well as prevent or reduce suicidal desire (Hollingsworth et al., 2016). Peer-support during crisis and crisis intervention training is also effective for reducing stigma and social isolation (Holley, et al., 2015; Thornicroft et al., 2016).

Implication for Practice

Religion and spirituality are an integral component of the Black Community, important to the lives of its members (Chatters et al., 2008; Chatters et al., 2011; Cole-Lewis, 2016; Plunkett, 2014). The results of this study add to our understanding of mental health crisis as experienced by clergy in the Black Church, help-seeking behaviors, the role of lived experience in responding to crisis, and the important role clergy and the Black community play in supporting and responding to black church members experiencing mental health crisis.

The Black Church has been successful in stimulating positive health behaviors with a history of being used as a partner with public health organizations and medical agencies for community health interventions (Brewer & Williams, 2019, p. 385). Black clergy, faith-based organizations, and counselors could partner and focus on crisis and suicide interventions through community-based education. For example, churches and counselors could partner with revivals that consist of mental-health related workshops or psychoeducational groups in the day then spiritual services at night. The counselors would lead the day service and the minsters would lead the evening service. Counselors could also partner with clergy to offer services within their church through counseling services and psychoeducational groups or trainings such as utilizing office space within churches or partnering for a direct referral system in which clergy could refer

congregants to a list of counselors with relationships in their community. In the instance of small churches with limited resources, several churches could pool their resources to staff counselors who would provide services.

As Blacks have been socialized to not seek counseling, an increase presence of professional counselors in the Black community may increase help-seeking behaviors through relationships and interactions which creates socialization (Vejar, 2015). Also, counselors should use interventions that increase hope and connection such as hope-based psychotherapies. Counselors could work with clergy to develop crisis prevention training curriculum for clergy and laymen in the Black Church.

Counselor educators could provide increased opportunities for training focused on spirituality in counseling and collaborative treatment with religious and spiritual leaders in the Black community. Counselor educators could provide these opportunities through relationships with churches as sites for internships, project-based learning opportunities incorporated in curriculum to encourage exploration of spirituality in counseling and multi-cultural competency, and counselor educators could invite clergy and counselors with experience in counseling in the Black Church or with the Black community to guest lecture.

Recommendations for Further Study

Findings from this study described the experiences of Black clergy with mental health crisis; however, these findings are limited to the participants in one city in the Southwest region of the United States. Further study should be conducted with Black clergy of the Black Church across the United States to further illuminate help-seeking behaviors. Such a study should provide a more comprehensive perspective of Black

clergy's experience with mental health crisis in the Black Church. Studies to explore the experiences of clergy with mental health crisis among members of their congregation in suburban and rural areas are needed. Additionally, a developmental model of Black clergy with engagement with suicidal parishioners should be studied. The participants reported feeling overwhelmed and incompetent when the person they are helping is the barrier. A study to explore competency in crisis intervention skills with the ability to navigate the barriers of the lack of family support and the person in crisis' behaviors is needed. The subjective experience of mental health crisis from the Black person's perspective as a phenomenon should also be studied. We should study the impact of integration on the psychological wellbeing of Blacks. Finally, a study to explore the benefits of participation in a religious or spiritual community as it relates to positive mental health impact and retaining support, may be beneficial.

Conclusion

When someone experiences mental health crisis, where can they go? Often for members of the Black Church, they turn to the clergy. The clergy in this study detailed their experiences when a member of their congregation is in mental health crisis. The participants of this study defined mental health crisis, described the causes, their response, barriers they face, and what they thought was needed when addressing mental health crisis in the Black Church. The clergy described the role of community. They described the importance of social connectedness as they detailed the danger of isolation for the members and in how they respond.

The findings of this study affirmed the adage from the Nigerian proverb, *it takes a village to raise a child*, highlighting the importance of community. Mental health crisis in the

Black Church, experienced through the lens of Black clergy, illuminated community and connectedness as important for prevention and effective response to mental health crisis. A closer look is needed to examine of what stakeholders are needed for the village or Black community. Possible stakeholders are Black families, clergy, and mental health professionals. Families, clergy, and mental health professionals could benefit from a mutual collaborative relationship which would allow them to work in concert to improve community and mental health. A study is needed to explore if a community comprised of Black families, clergy, and mental health professionals and its impact on the wellbeing of those community members.

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APPENDIX A

Sam Houston State University

Consent for Participation in Research

Mental Health Crisis in the Black Church: Experience of the Clergy of the Black Church

Why am I being asked?

You are being asked to be a participant in a research study to describe clergy in the Black Church, experiences with mental health crisis in their congregations. The study will be conducted by Andrea T.J. Ross, a doctoral student in the Department of Counselor Education at Sam Houston State University. I am conducting this research under the direction of Dr. Richard C. Henriksen, Jr. You have been asked to participate in the research because you are clergy in a church whose members are predominantly Black, and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Sam Houston State University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

Why is this research being done?

This research is being conducted because the Black church is instrumental in supporting the Black community. There is not enough research about the experiences of clergy who are the leaders of the Black Church. This study may help add to the information available and possibly give greater insight on the clergy and the Black Church.

What is the purpose of this research?

The purpose of this study will be to describe Black clergy's experiences with mental health crises in their congregations.

What procedures are involved?

If you agree to be in this research, we would ask you to do the following things:

Read and agree to the terms of the study by signing the consent form.

Participate in a face-to-face interview with Andrea T.J. Ross at an agreed time and location where she will ask you a series of questions and audiotape your responses.

When the results of the research are published, or discussed in conferences, no information will be included that would reveal your identity. Audiotaped recordings of you will be transcribed, checked for accuracy, then destroyed; your identity will be protected or disguised. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

You have the right to review/edit your audiotaped responses prior to the finalization of the study. Only Andrea T.J. Ross will have access to the audiotape as it will be used for the purpose of completing the research.

Your personal information, such as your name and church will not be disclosed in the study. Your responses and information will be coded by an alias. When not in use, audiotapes will be stored in a locked location to prevent access by unauthorized personnel.

Upon completion of the study and analyses of data, all audio recordings will be permanently erased after data has been transcribed and verified.

What are the costs for participating in this research?

There are no additional research costs associated with this research.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

As a volunteer participant, you will be responsible for any travel fees, parking, and any related fees in meeting with the researcher for the interview. There will be no reimbursements for your participation.

Can I withdraw or be removed from the study?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

Who should I contact if I have questions?

The researcher conducting this study is Andrea T.J. Ross. You may ask any questions you have now. If you have questions later, you may contact the researcher at:

atr017@shsu.edu or her advisor, Dr. Richard Henriksen, Jr. at rch008@shsu.edu or (936)

294 – 1209.

What are my rights as a research subject?

If you believe that you have not been treated according to the descriptions in this

form, or you have any questions about your rights as a research participant, you may call

the Office of Research and Sponsored Programs – Sharla Miles at (936) 294 – 4875 or e-

mail ORSP at sharla_miles@shsu.edu.

You may choose not to participate or to stop your participation in this research at

any time. Your decision whether or not to participate will not affect your current or

future relations with the University.

You will not be offered or receive any special consideration if you participate in

this research.

Agreement to Participate

I have read the above information. I have been given an opportunity to ask

questions and my questions have been answered to my satisfaction. I agree to participate

in this research.

Consent: I have read and understand the above information, and I willingly consent to participate in this study. I understand that if I should have any questions about my rights as a research subject, I can contact Andrea T.J. Ross by email at atr017@shsu.edu or Dr. Richard Henriksen, Jr. at rch008@shsu.edu or (936) 294 – 1209. I have received a copy of this consent form.

Your name (printed): _____No Name Required_____

Signature: _____No Signature Required_____ Date: _____

APPENDIX B

Demographic Questions:

Name (alias) _____

Age _____

What is your gender?

Female

Male

Denomination of your church _____

What is the total number of members you have in your congregation?

1-100

101-200

201-400

401-1,000

1,001-1,999

2,000 or more

What is your education level?

Completed some high school

High school graduate

Completed some college

Associate degree

Bachelor's degree

Completed some postgraduate

Master's degree

Ph.D., law or medical degree

Other advanced degree beyond a Master's degree

Do you have specific training in the ministry and if so what type of training?

Yes or No

If yes, what type of training _____

_____

_____

Are you an ordained minister?   Yes   or   No

How would you define mental health crisis?

_____

_____

_____

_____

_____

_____

_____

VITA

Andrea T.J. Ross

EDUCATION

Sam Houston State University ● 2020

- PhD in Counselor Education

Prairie View A & M University

- MA
- Counseling

Western Carolina University

- BS
- Sociology with emphasis in Social Work

PROFESSIONAL EXPERIENCE

Teaching

Department of Counselor Education ● Adjunct Faculty (on-line/Blackboard)
> Sam Houston State University, Huntsville, Texas
- COUN 4379 Wellness Counseling

Department of Counselor Education ● Co-Teacher
> Sam Houston State University, Huntsville, Texas
- COUN 5364 Theories of Counseling

Department of Counselor Education ● Guest Lecturer
> Sam Houston State University, Huntsville, Texas
- COUN 3321 Introduction to the Helping Relationship

Department of Counselor Education● Guest Lecturer
> Sam Houston State University, Huntsville, Texas
- COUN 5394 Crisis and Trauma Counseling

Department of Counselor Education
> Sam Houston State University, Huntsville, Texas
- COUN 5394 Crisis and Trauma Counseling, Mini-Internship (Teacher Assistant)

Clinical/Counseling Experience

- The Harris Center for Mental Health & IDD ● Houston, TX.
  - Mobile Crisis Outreach Team (LPHA, MCOT Clinician II)
  - Respond to community members in crisis via the crisis hotline, need of mental health services as well as other Inter and Inter agency staff, both inpatient and outpatient.
  - Crisis Intervention Response Team (LPHA, CIRT Clinician)
- Westpark Springs Hospital ● Richmond, TX.
  - Mobile Assessor

- Another Way Therapeutic Center, PLLC ● Houston, TX.
  - Clinical Director
- ReMIND Depression and Bipolar Support ● Houston, TX.
  - facilitator
- Power Source Christian Center, Inc. ● Houston, TX.
  - Youth Pastor/ Biblical Applications Instructor
- SHSU – Center for Research and Clinical Training in Trauma ● Houston, TX.
  - Research Assistant
- IntraCare Behavioral Health ● Houston, TX.
  - Therapist (PRN)

SCHOLARLSHIP AND RESEARCH

Publications

- Refereed Articles
  - **2018**

Henriksen, R.C., Jr., & **Ross, A.T.J.** (2018) Black clergy and mental health. *Journal of Applied Christian Counseling. 4(1). p. 6-12*

  - **2016**

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Credentials

- Texas Educators Certificate (Generalist EC-6 & Special Education K-12)

State Board for Educator Certification

- Licensed Professional Counselor

  Texas State Board of Examiners of Professional Counselors