PREDICTORS OF RECEIPT OF COUNSELING SERVICES FROM RELIGIOUS LEADERS IN AFRICAN AMERICAN CHURCH POPULATIONS

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KELSEY N. CHRISTENSEN

M.A., Northwestern University, Evanston, IL
B.A., DePauw University, Greencastle, IN

Kansas City, Missouri

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Kelsey N. Christensen, Candidate for the Master of Arts Degree

University of Missouri-Kansas City, 2018

ABSTRACT

African Americans (AAs) are disproportionality affected by mental health issues. They are more likely to experience chronic depression, greater impairment from depression, and serious psychological distress than the general population. However, AAs are less likely to seek mental health services than Whites. The Black Church is a key institution of influence in the AA community. AAs have the highest rate of church attendance among all racial/ethnic groups in the United States and the Black Church has the potential to increase the reach of mental health services and address related concerns for parishioners and community members served through outreach ministries. Studies suggest that AA pastors/religious leaders have significant influence on church populations' health and that many may provide counseling services to their church and community members. Yet, few studies exist on who is using counseling services and why these services are being sought in faith-based settings. The present study examined predictors of receipt of counseling from a pastor/religious leader among AA church-affiliated populations. Using baseline data from a larger study, Project FIT (Faith Influencing Transformation), a cardiovascular disease/diabetes health promotion intervention piloted in 6 AA churches in the Kansas City metropolitan area. Participants were primarily female (69%), church members (90%), with an average age of 54 (*SD* = 13). Findings indicated that 50% of participants reported receipt of counseling.

Preliminary analyses indicated that education and several religious behaviors (e.g., frequency of thoughts of God, prayer, meditation, church attendance, reading scripture/holy writings, and direct experiences with God) were significantly related to receipt of counseling. Regression analyses indicated that only education was a marginally significant predictor in the model. Future studies should examine how education and religious behaviors may impact receipt of clergy counseling in AA churches. Implications for the design of mental health interventions for AA church populations are discussed. Future research should also examine frequency of help-seeking behaviors both in the AA church as well as outside the church.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the College of Arts and Sciences, have examined a thesis titled "Predictors of Receipt of Counseling Services from Religious Leaders in African American Church Populations," presented by Kelsey N. Christensen, candidate for the Master of Arts degree, and certify that in their opinion it is worthy of acceptance.

Supervisory Committee

Jannette Berkley-Patton, Ph.D., Committee Chair
School of Medicine, Department of Biomedical and Health Informatics

Joah Williams, Ph.D.
Department of Psychology

Kymberly Bennett, Ph.D.
Department of Psychology

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CHAPTER 1

INTRODUCTION

Recent initiatives by the World Health Organization (WHO) have sought to address the global burden of mental disorders, which result in high rates of disability, premature mortality, and income loss (WHO, 2013). The National Institute of Mental Health (NIMH) has also noted the growing mental health crisis in the U.S. (NIMH, 2015b). Major depressive disorder is the second leading cause of disability in the U.S., and 40,600 Americans die each year due to suicide (NIMH, 2015b; US Burden of Disease Collaborators, 2013). One of the key objectives of the WHO mental health-related initiatives is to implement comprehensive mental health care services in community-based settings, including faith-based organizations. They also advise particular attention to vulnerable populations, who are disproportionately affected, with poor access to mental health care (WHO, 2013). Likewise, the NIMH recommends implementing mental health interventions in community-based settings to reach underserved populations, especially ethnic minorities and low-income persons (NIMH, 2015b).

Depression is one of the most common mental illnesses and leading cause of disability worldwide; it affects over 300 million people (WHO, 2013). In the U.S., African Americans (AAs) make up 13% of the US population and national data estimate that the lifetime prevalence of major depression among AAs is between 10% to 12%, compared to 18% in Whites (Williams et al., 2007). However, lower depression prevalence estimates in AA populations may be due to underdetection. Studies have found that physicians are less likely to detect depression in AAs than Whites (Borowsky et al., 2000; Das, Olfson, McCurtis, & Weissman, 2006; DeJesus, Diaz, Gonsalves, & Carek, 2011). Additionally, mental health issues tend to be chronic and result in greater distress in AAs compared to Whites. A national survey (N = 6,082) found that major

depressive disorder was a chronic condition (e.g., lasting longer than one year) among 57% of AAs compared to 38% of Whites (Williams et al., 2007). Also, a national study (N = 14,710) found that AAs were 66% more likely to experience recurrent major depressive episodes compared to Whites (González, Tarraf, Whitfield, & Vega, 2010).

The symptomatic presentation of depression may vary based upon race/ethnicity. Studies have found that AAs with major depressive disorder were more likely to experience insomnia, early morning awakening, restlessness, and somatic complaints (e.g., headaches, pain, appetite change) than Whites (Hankerson et al., 2011; Myers et al., 2002; Snowden, 2001). Also, depressed AAs suffer from greater disability and impairment (e.g., disruptions in day-to-day living) due to depression compared to Whites (Bailey, Patel, Barker, Ali, & Jabeen, 2011; Gonzalez et al., 2010; Williams et al., 2007). For example, Williams et al. found that 75% of depressed AA patients viewed their impairments at home, at work, relationally, and socially to be severe or very severe compared to 67% of Whites. Compared to 34% of Whites, 55% of depressed AAs reported experiencing severe or very severe social impairment (e.g., how symptoms have disrupted leisure activities and social life) most frequently.

National data suggests that depression is more common among females. For example, among U.S. adults, 9% of females suffered from a major depressive episode in the past year, compared to 5% of males (NIMH, 2015a). Among AAs specifically, an estimated 13% of AA females met the criteria for depression at some point in their lifetime prior to assessment, compared to 7% of AA males (Williams et al., 2007). Suicide is also the third leading cause of death among AA females ages 15 through 19 and the fifth leading cause of death among AA females ages 20 through 24 (Center for Disease Control [CDC], 2014b). Recent studies indicate young AA men are experiencing increasing rates of suicide, which is the third leading cause of

death among AA males ages 15 through 24 (CDC, 2014c). Additionally, AAs tend to experience 10% more serious psychological distress in general (e.g., sadness, hopelessness, worthlessness) than Whites (Office of Minority Health [OMH], 2015).

Moreover, AAs are disproportionately affected by daily stressors, including socioeconomic stressors (e.g., poverty), perceived discrimination, and violence, which are linked to mental health issues (Jackson, Knight, & Rafferty, 2010; Lee, Ayers, & Kronenfeld, 2009). An estimated 24–26% of AAs live in poverty – the highest rate among all racial and ethnic groups (Proctor, Semega, & Kollar, 2016), and AAs make up 40% of the homeless population (Economic Policy Institute, 2011). Studies have well-established that life stressors increase the likelihood of the onset of mental health conditions such as depression, anxiety, and schizophrenia (Burns & Machin, 2013; Spinhoven et al., 2011; Walker, Mittal, & Tessner, 2008). AAs are also disproportionately affected by physical health stressors, such as diabetes, heart disease, and HIV/AIDS (CDC, 2015; CDC, 2014a; OMH, 2016a; OMH, 2016b). A national survey found that AAs with major depressive disorder were more likely to have a co-morbid medical disorder, including hypertension, obesity, or liver disease, compared to Whites (Hankerson et al., 2011). Chronic diseases and poor physical health may result in increased stress levels and exacerbate mental health issues among AAs.

Access to Mental Health Care

A number of studies have indicated that AAs are less likely than Whites to seek out mental health care (e.g., Alegría et al., 2008; Broman, 2012; Gonzalez et al., 2010; Lê Cook et al., 2014; Williams et al., 2007). Lê Cook et al. (2014) found that Whites were 1.5 to 1.7 times more likely to access and initiate mental health care than AAs. Other studies found that only 32% of AAs with a diagnosable mental illness sought out treatment (Neighbors et al., 2007).

Among AAs with major depression and severe or very severe symptoms, studies have found that only 40–50% sought treatment (Alegría et al., 2008; Williams et al., 2007). AAs with mild to moderate depression were more likely to receive services from non-traditional providers (e.g., clergy, chiropractors, self-help groups) than traditional healthcare providers (Williams et al., 2007). Notably, one study utilizing a church-based sample of AAs (N = 122; 87% AA) indicated higher levels of seeking mental health care than previous literature has indicated, with 64% of participants endorsing previously seeking help for mental health treatment—utilizing treatment nearly equitably from primary care physicians, mental health professionals, and clergy (Hankerson et al., 2015).

However, certain sociodemographic variables have been associated positively with seeking mental health care among AAs. Studies have found that younger age, higher education, being female, having health insurance, and having multiple medical conditions were associated with professional and informal mental health care help-seeking among AAs (Jang, Yoon, Chiriboga, Molinari, & Powers, 2015; Woodward, 2011; Neighbors et al., 2007). However, notably, another study found that among AA young adults, higher education was associated with less mental health service use (Broman, 2012).

Overall, AAs have been found to be less likely to seek outpatient treatment and more likely to receive mental health treatment in primary care settings and hospitals/emergency rooms than Whites (Bailey et al., 2011; Hankerson et al., 2011; Meyer & Takeuchi, 2014). Furthermore, if AAs do seek out mental health care, they are more likely to prematurely terminate treatment compared to Whites (Meyer & Takeuchi, 2014).

Barriers to Seeking Mental Health Care

Several barriers are associated with AAs' lower rates of seeking mental health treatment. At the *individual* level, limited financial resources, cost of care, and limited or no health insurance coverage have been found to impede mental health care seeking among AAs (Meyer and Takeuchi, 2014; O'Conner et al., 2010; Odeja & McGuire, 2006). An estimated 26% of AAs lack health insurance compared to 16% of Whites (CDC, 2013).

A pervasive *social* barrier to mental health care tends to be a general mistrust of medical providers (Anthony, Johnson, & Schafer, 2015; Awonson & Sandberg, 2011; Campbell & Long, 2014; O'Conner et al., 2010; Snowden et al., 2001; Whaley, 2001). Researchers have found that AAs viewed White physicians as less collaborative and participatory (e.g., not encouraging patient involvement) than physicians of the same race (Cooper-Patrick, 1999; Sewell, 2015). Studies have also demonstrated a relationship between AAs' negative personal experience(s) in therapy, often with a White provider, and subsequent mistrust in mental health professionals (O'Conner et al., 2010).

In fact, Townes, Chavez-Korell, and Cunningham (2009) found that approximately 31% of AA participants preferred to work with a Black therapist and that those with high levels of cultural mistrust, low assimilation attitudes, and high Afrocentric attitudes were related to preference for a Black therapist. Additionally, there is a notable shortage in the number of AA mental health providers (American Psychological Association, 2015), which is problematic given AAs' cultural mistrust and common preference for an AA therapist. Furthermore, therapeutic approaches (e.g., willingness to discuss racial/social issues, therapist reactions to issues of discrimination) used with minorities are sometimes viewed as culturally incongruent and

insensitive among AAs (Meyer & Takeuchi, 2014; Miller & Garran, 2007; Thompson, Bazile, & Akbar, 2004).

Stigma is another salient social barrier to seeking out mental health care among AAs. Studies have documented AAs' concerns regarding perceived stigma towards people living with a mental health condition as well as stigma associated with seeking out mental health care (e.g., fear of being judged, embarrassment, being perceived as dangerous) (O'Conner et al., 2010; Ojeda & McGuire, 2006; Ward, Wiltshire, Detry, & Brown, 2013). Studies suggest that many AAs view depression as a personal weakness and fear that seeking mental health treatment may result in rejection from family, friends, and the community at large (Anthony et al., 2015; Awonson & Sandberg, 2011; Bailey et al., 2011) and that AAs may prefer to cope using other means, such as religious coping (e.g., praying, talking with pastor) (Ward et al., 2013). A recent systematic review found that stigma was negatively associated with help-seeking behaviors and that stigma had a disproportionate effect on help-seeking behaviors, especially among AAs (Clement et al., 2015).

Regarding *environmental* barriers, geographical location may be an additional barrier to seeking mental health care. According to a recent census, 55% of AAs live in the southern U.S. region (United States Census Bureau, 2010), and this region is comprised of many rural communities that have few mental health services available (Hastings & Cohn, 2013; Housing Assistance Council, 2012; Murry, Heflinger, Suiter, & Brody, 2010). Studies have documented AAs' concerns regarding limited access to formal mental health treatment in rural settings, quality of care in rural settings, as well as transportation difficulties (Murry et al., 2010; O'Connor et al., 2010).

Religiosity and African Americans

Religiosity is a multifaceted construct that consists of behavioral, cognitive, spiritual, ritualistic, and social components as they relate to belief in a higher power (Connors, Tonigan, & Miller, 1996). Religiosity is customarily assessed by examining self-reported religious identification (e.g., religious, spiritual), subjective religiosity (e.g., intrinsic aspects of religious commitment), religious behaviors (e.g., church attendance, prayer, reading the Bible), and importance of religion in one's life (Chatters & McKeever-Billard et al., 2008; Connors et al., 1996; Koenig & Bussing, 2010).

National studies have found that AAs have the highest level of religiosity among all racial/ethnic groups (Chatters, Taylor, Bullard, & Jackson, 2009; Taylor, Chatters, & Jackson, 2007). In fact, an estimated 85% of AAs identify as Christian and 86% identify their religious faith as "very important" in their life (Barna Group, 2009; Lugo et al., 2008). National studies have found that AAs were more likely to attend church, attend Sunday school, pray, or read the Bible than any other ethnic group – an estimated 83% of AAs reported praying nearly every day and 51% of AAs reported reading at least once a week (Barna Group, 2009; Taylor, Chatters, Woodward & Brown, 2013). Regarding church attendance, national studies have found that 91% of AAs attend church as an adult, and between 33–47% of AAs attend church at least once per week (Lukachko, Myer, & Hankerson, 2015; Pew Research Center, 2014). Other studies have found even higher rates of church attendance among AAs. One recent study found that 79% of AAs reported attending church weekly (Berkley-Patton et al., 2016).

Religiosity has been shown to be a protective factor that fosters better mental health and well-being (Koenig, King, & Carson, 2012; Koenig, 2012). For example, church attendance and prayer have been found to be associated with better quality of life, psychological well-being, and

life satisfaction (Henderson et al., 2016; Jarvis, Kirmayer, Weinfeld, & Lasry, 2005). Also, studies have found that higher religious service attendance was related to a lower likelihood of being diagnosed with a lifetime mood disorder, and religious coping has been associated with fewer negative psychological outcomes, such as depression and anxiety (Ano & Vasconcelles, 2005; Chatters & McKeever-Billard et al., 2008; Taylor, Chatters, & Abelson, 2012). Reese, Thorpe, Bell, Bowie, and Laveist (2012) found that when religious service attendance was controlled for among a low-income, urban population, there was no longer a significant difference in depression diagnoses in AAs and Whites, suggesting that religious service attendance may serve as a protective factor.

Religiosity, especially church attendance, has also been associated with fewer substance use problems, particularly among AA adolescent and college students (Mailey, 2012; Menagi, Harrell, & June, 2008; Wills, Yaeger, & Sandy, 2003). Brechting and Giancola (2007) found that religiosity among adolescent boys predicted reduction in drug use years later. Ransome and Gilman (2016) found that religious involvement accounted for one-fifth lower odds of an alcohol use disorder (AUD) among AA men and nearly 50% lower odds of an AUD among AA women. The relationship between religiosity and better health may be a consequence of a living a healthier lifestyle (e.g., engaging in preventative health behaviors) (Park et al., 2016). The body as a temple of God is commonly cited as a scriptural basis for taking care of one's physical and mental health (e.g., refraining from smoking, eating well, taking efforts to lose weight; Bauer et al., 2017; Holt & McClure, 2006). Additionally, social support (e.g., assistance from one's informal support network [e.g., friends, family]) has been found to be a protective factor against many mental health issues, including depression, suicide, and anxiety among AAs (Compton, Thompson, & Kaslow, 2005; Levine, Taylor, Nguyen, Chatters, & Himle, 2015; Lincoln,

Chatters, & Taylor, 2005; Taylor, Chae, Lincoln, & Chatters, 2015; Taylor, Chatters, Woodward, & Brown, 2013).

Religious Coping and African Americans

Studies have shown that AAs tend to use their faith as means of coping with personal challenges and mental health issues (O'Connor et al., 2010; Ward et al., 2013). A national survey found that 90% of AAs reported prayer as an important source of coping when dealing with stress (Chatters, Taylor, & Jackson, 2008a). It is also well documented that AAs are more likely to rely on their family, church, and their community as means of coping with stress (Chatters et al., 2009; Krause, 2010; Lukachko et al., 2015; Rogers, 2007; Neighbors et al., 2007). For example, a study using a national sample found that 21% of AAs with a serious personal problem reported seeking counseling from a minister, the most common source of support compared to primary care physicians (16%), psychiatrists (9%), and mental health professionals (9%) (Chatters, Mattis, Woodward, Taylor, & Neighbors, 2011). Participants' reported benefits to seeking out counseling in faith-based settings included the trusted relationship between clergy and church members – and the counseling services tended to be free (Chatters et al., 2011; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

Among AA college students, one study found that AAs were more likely to rely on religious services (e.g., attending church) than professional mental health services in the past year compared to White counterparts (Ayalon and Young, 2005). However, notably, this study found low use of clergy counseling among AAs, and psychological distress did not predict religious service seeking or clergy counseling seeking. Additionally, Lukachko et al. (2015) found that high church attendance and increased beliefs on the importance of religion were associated with decreased utilization of professional mental health services among individuals

with and without a diagnosed mental illness. However, prayer was not associated with professional mental health service use. Contrary to the Lukachko et al. study, Hays and Lincoln (2017) found that among AAs with a diagnosed mental illness, high engagement in religious behaviors (e.g., prayer, reading scripture) was associated with higher use of informal (e.g., clergy, family) *and* formal (e.g., psychiatrist, mental health professional) sources of support. Additionally, they found that lower importance of religion in one's life was associated with use of informal support (e.g., clergy, family, and friends). Demographic variables (e.g., age, gender, education) were not associated with help-seeking behaviors in Hays and Lincoln's study.

Researchers have also studied how religious coping impacts mental health outcomes and help-seeking behaviors. The Religious Problem-Solving Scale (RPSS) examines problem-solving styles in the context of one's relationship with God (Pargament et al., 1988). In using the RPSS, a study by Andrews et al. (2011) conducted with predominantly AAs (70%) found that a self-directive religious problem-solving style, which is working independently from God, was a negative predictor of psychological help-seeking. However, those who had both self-directive and passive problem-solving styles had the least favorable attitudes towards seeking mental health care. The researchers attributed this interaction to conflicting attitudes towards the role God plays in their lives.

The Brief RCOPE was one of the first scales to assess types of religious problem-solving with a focus on beliefs about control as they relate to an individual's relationship with God (Pargament, 1988). Three types of religious coping are identified by this scale: collaborative religious coping (working with God), passive religious coping (deferring all control to God), and self-directive religious coping (working independently from God) (Pargament et al., 1988; Pargament, Feuille, & Burdzy, 2011). Studies have consistently found that a self-directive coping

styled was associated with negative mental health outcomes (e.g., stress, depression, lower well-being) (Brown, Carney, Parrish, & Klem, 2013; Corbett, 1999; Creedon, 2016) and have been found to be a negative predictor of seeking mental health care (Andrews, Stefurak, & Mehta, 2011). Conversely, collaborative religious coping has been found to be associated with positive well-being (Creedon, 2016; Grady, 2004).

Additionally, the RCOPE (Pargament, Koenig, & Perez, 2000; Pargament, 2011) has been used to assess positive and negative means of religious/spiritual coping. Positive religious coping depicts a confident and trusting relationship with God (Hebert, Zdaniuk, Schulz, & Scheier, 2009). Negative religious coping represents a fragile relationship with God (e.g., feeling abandoned/punished, doubting God's power) (Herbert et al., 2009). In using the RCOPE, Park, Holt, Le, Christie, and Williams (2017) found that baseline positive religious coping predicted fewer depressive symptoms, positive affect, and increases in self-esteem in AAs, and baseline negative religious coping predicted depressive symptoms, negative affect, and reductions in self-esteem two and a half years later. Taylor et al. (2012) also found that as positive religious coping increased, likelihood of a major depression diagnosis in the past year decreased among AAs. Overall, studies suggest that religious coping has varying effects on mental health, based upon the nature of one's relationship with God.

The Role of the Black Church in Addressing Mental Health

Black churches (e.g., churches that primarily serve AAs) are key influential institutions in the AA community and serve as a central source of support for many congregants (Hardy, 2012; Lincoln & Mamiya, 1990). Although mental health intervention studies in churches are limited, many researchers have suggested that the Black Church could play an important role in addressing mental health disparities among AAs (e.g., through forming partnerships between

churches and community agencies). (Allen, Davey, & Davey, 2010; Campbell et al., 2007; Dempsey, Butler, & Gaither, 2016; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Despite this potential, researchers have noted the hesitancy of many AA churches to collaborate with mental health agencies, due to historical factors (e.g., social injustices), experienced discrimination, and the lack of cultural sensitivity in the mental health field (Dempsey et al., 2016).

However, church members may be interested in churches addressing mental health. A focus group study with pastors, church members, and AA men with depression in a rural community found that participants commented on the need for the church to do more to emotionally support congregants dealing with depression (e.g., referrals, earlier detection of mental health issues). Participants also noted the importance of the role of the pastor in leading these mental health initiatives and preaching hope, as well as the role of church members in supporting their fellow congregants (Bryant, Haynes, Yeary, Greer-Williams, & Hartwig 2013). Another qualitative study examined pastors' perspectives on their counseling responsibilities and found that they were concerned about not having adequate training and felt overwhelmed by the concerns of their congregants (Kramer et al., 2007).

African American Faith-Based Mental Health Interventions

Although research has shown that AAs may seek out the support of religious leaders before seeking care from professional mental health providers (Neighbors, Musick, & Williams, 1998) and that religious leaders play a dual role in providing spiritual and emotional support (Allen et al., 2010; Kramer et al., 2007), only a few mental health interventions have been implemented in church-based settings. These interventions have primarily focused on mental health education and stigma. For example, using a non-experimental, one-arm design, nursing

students carried out a mental health education intervention (e.g., education on mental disorders, how to support those with mental disorders, interactive activities) with 38 AA churchgoers in the surrounding community and found an increase in mental health knowledge and a decrease in stigma (Winship, 2009). Another study conducted an eight-week, church-based support group including educational materials and speakers from mental health professionals with 23 AA family members of those with mental illness. They found that the intervention resulted in increased knowledge about mental illness and the mental health system, and increased morale (Pickett-Schenk, 2002). Suite, Rollin, Bowman, and La Bril (2007) conducted a three-hour, trauma training program (e.g., education on biopsychosocial components of trauma, connection of concepts to biblical characters' experiences), using a pretest posttest, one-arm design, with 426 church members (53% AA) to increase capacity of churches to assess and support congregants who experienced trauma. After the intervention, they found significant increases in trauma-based knowledge, and 91% of participants provided positive feedback about the training.

Additionally, a pilot study by Mynatt, Wicks, and Bolden (2008) used a pretest posttest, one-arm design to reduce depressive and anxiety symptoms in AA women. The 12-week group-based, cognitive-behavioral therapy intervention (e.g., stress management tools, assertiveness and communication strategies) with eight AA church members found improvements in depression. However, this study did not detect significant changes in anxiety, hopelessness, and loneliness scores. Only one church-based mental health screening intervention study has been conducted. Using a participatory research approach to engage church leadership, this study with 122 AA church members found that depression screening using the Patient Health Questionnaire in AA churches was feasible; 20% of participants screened positive for depression (Hankerson et al., 2015).

Some church-based interventions have focused on substance abuse. Using a non-experimental, one-arm design, a culturally-tailored, faith-based intervention (e.g., support groups, HIV risk reduction interventions, spiritual activities) designed to reduce HIV risk among cocaine and drug users conducted with 163 AAs found a decrease in substance use and HIV risk behaviors (MacMaster et al., 2007). Using a quasi-experimental, two-arm design, Stahler, Kirby, and Kerwin (2007) carried out a supplemental faith-based intervention (e.g., a mentor program, spiritual activities, and life skills workshops) designed to increase the effectiveness of a residential substance abuse treatment program among 18 cocaine-dependent AA women in residential treatment. They found that those in the intervention condition had significantly higher treatment retention rates than the residential treatment alone.

Using a quasi-experimental, two-arm design, Marcus et al. (2004) conducted a faith-based, substance abuse prevention program (e.g., life skills training, scripture-based lessons regarding curriculum, education about HIV/STDs) designed to reduce substance abuse and HIV risk among 61 AA adolescents. They found that participants in the intervention reported significantly less marijuana/drug use, more fear of AIDs, and endorsed fewer stigmatized attitudes towards HIV (e.g., agreeing that people with AIDS needs to be treated with compassion) than those in the comparison group. Additionally, Brown et al. (2006) carried out a university-based program that sought to educate AA faith-based organizations (N = 23) on how to implement youth substance abuse prevention programs (e.g., program planning, substance use resources, group facilitation strategies). Over a three-year period, the findings indicated that one-third of participants successfully implemented a substance use prevention program and that one-third were in process of developing a program.

A few church-based interventions have focused on smoking cessation. Voorhees et al. (1996) conducted a randomized control trial with a two-arm design, implementing a church-based smoking cessation intervention (e.g., sermons on smoking, spiritually-based smoking cessation guides, access to support groups) among 292 AAs designed to foster smoking cessation. They found that those in the intervention were more likely to make positive progress in stage of change compared to the control group. Using a quasi-experimental, two-arm design, Schorling et al. (1997) also conducted a church-based smoking cessation intervention (e.g., one-on-one counseling from trained AA church member, self-help materials, smoking cessation devotionals) among 452 AA smokers. At follow-up, those in the intervention condition (10%) had higher smoking cessation rates than the control condition (5%), however, the differences were not statistically significant. They found that those in the intervention condition were more likely to progress in stage of change than those in the control condition.

Based upon the studies reviewed, few mental health interventions have been carried out in AA churches. Of the mental health focused interventions conducted, many have been education-based, targeting increased knowledge and decreased stigma (Pickett-Schenk, 2002; Suite et al., 2007; Winship, 2009). Several interventions have targeted reducing substance use and smoking cessation (McMaster et al., 2007; Marcus et al., 2004; Schorling et al., 1997; Stahler et al., 2007; Voorhees et al., 1996). To our knowledge, only one study has directly targeted depressive symptoms (Mynatt et al., 2008). Hankerson et al. (2015) examined the feasibility of using a validated depression screening tool in AA churches among 122 church members (N = 122; 87% AA). Findings indicated that 20% of participants screened positive for depression (e.g., PHQ-9 = 10 or higher, range 0-27) (Hankerson et al., 2015). Given that few studies have examined depression screening feasibility in AA churches, researchers should

further examine this and the capacity of the church to provide referrals, if needed. Given that effective church-based substance use interventions have used religiously-tailored tools (e.g., sermons, spiritually-based lessons) (MacMaster et al., 2007; Marcus et al., 2004; Schorling et al., 1997; Stahler et al., 2007; Voorhees et al., 1996) in their intervention design, researchers should consider utilizing religiously-tailored messages and tools in future mental health interventions.

Predictors of Seeking Counseling from Clergy

Even fewer studies exist that have examined predictors of receipt of counseling in faith-based settings. Only two studies to date have examined predictors of receipt of counseling from clergy using national survey data. A study conducted by Neighbors et al. (1998) with a non-church population of 2,107 AAs with serious emotional problems examined psychosocial factors related to clergy help-seeking and found that females and those with death/bereavement problems were more likely to seek help from clergy, whereas those with economic problems were less likely to seek help. Additionally, they found that AAs who first used clergy as a means of support were less likely to go to another source of support afterwards. A study by Chatters et al. (2011) with a non-church population of 2,103 AAs experiencing significant personal distress found that those with higher levels of education, income, and church attendance were more likely to seek pastoral support. Consistent with Neighbors et al. (1998), Chatters et al. found that those who experienced death of a loved one were most likely to seek help (28%) and those with economic problems were least likely to seek pastoral support (12%) (Chatters et al., 2011).

Yet, there is still much to learn about *who* is seeking counseling support in church settings, particularly for the development of church-based mental health interventions that may be able to reach underserved AAs. To our knowledge, no studies have examined predictors of receipt of counseling among AA church members in faith-based settings. Previous studies have

only examined receipt of counseling in churches using national survey data (Chatters et al., 2011; Neighbors et al., 1998). The present study seeks to examine traditional and nontraditional (e.g., body in relation to God beliefs, substance use) factors that may predict clergy counseling seeking behaviors among AA church members and community members served through church outreach ministries. Based on past studies, it was hypothesized that: (1) higher levels of education/income would be positively related to receipt of clergy counseling, as would (2) health insurance coverage, (3) gender, (4) age, (5) past mental health diagnosis and screening, (6) a history of personal/familial exposure to violence, (7) higher perceived stress, (8) religious behaviors would be positively related to receipt of clergy counseling, as would (9) church membership, and (10) higher collaborative religious coping (working with God). Additionally, it was hypothesized that (11) higher self-directive coping (working independently from God) and (12) higher passive religious coping (putting everything in hands of God) would be negatively related to seeking clergy counseling. The study will also explore nontraditional potential predictors that have received little attention in the literature (the body in relationship to God beliefs [e.g., my body is a temple of God], substance use [alcohol and cigarette use], self-reported overall health) regarding use of clergy counseling. Findings from this study could assist in developing mental health interventions tailored for implementation in AA churches.

CHAPTER 2

METHODOLOGY

Participants and Procedures

This study will use baseline survey data collected from Project FIT (Faith Influencing Transformation), a clustered, randomized faith-based pilot study that tested a diabetes and heart disease/stroke prevention, screening, and linkage to care intervention against a health education arm in AA churches over eight months. Participants ($N = 352$) from six AA churches in the Kansas City metropolitan area were recruited and randomized to the diabetes and heart disease/stroke prevention intervention or the health education arm.

Participants were recruited during church services and community outreach events. Pastors and AA members of the research team made church announcements about the study during church services and at outreach events. Individuals who expressed interest in Project FIT received further information about the study, were screened for eligibility, and completed the informed consent process in church settings. Eligibility criteria for Project FIT participants included: (a) self-identifying as AA, (b) being between the ages of 18 and 80 years, (c) having willingness to participate in two surveys and health screenings held at their church, (d) having the ability to complete the survey without assistance and with fluency in English, (e) having willingness to provide contact information, (f) not currently being pregnant (or planning to become pregnant over the next year), and (g) not having sickle cell anemia.

Participants were church members ($n = 311$) who attended church services at least once per month and community members ($n = 34$) who used church outreach services (e.g., food pantry programs, daycare services) a minimum of four times per year. Participants volunteered to complete a survey on health beliefs and behaviors, including demographics, dietary intake

behavioral and psychosocial measures, health screenings, and religiosity (e.g., religious identification, body in relationship to God, religious behaviors). For the purposes of the current study, only the survey procedures and measures central to the current study will be described. Baseline survey events were held on-site at participating churches with opportunities for participants to complete the survey before, during, or after Sunday church services. Survey completion took approximately 30-45 minutes, and all participants were compensated $20 for their time. Study procedures were approved by the University of Missouri-Kansas City Institutional Review Board.

Survey Measures

Demographics. Demographic items included age, gender at birth, marital status, and type of affiliation with the church (e.g., church or community member). Other items asked about education level, health insurance coverage, and average monthly income.

Perceived overall health. One question assessed perceived overall health (1 = *poor* to 5 = *excellent).*

Depression. Regarding mental health, participants were asked if they had: a) a depression or other mental health screening in the past 12 months (0 = *no screening* to 1 = *screening*) and b) a depression or other mental health diagnosis ever in their lifetime (0 = *no past diagnosis* to 1 = *past diagnosis*).

Stress. Stress was assessed using the Perceived Stress Scale, which is widely used to measure the degree to which situations in one's life are appraised as stressful and assess the degree to which individuals find their lives unpredictable and overloaded (Cohen, Kamarck, & Mermelstein, 1983). The measure consisted of 14 items (e.g., feeling unable to control things,

felt nervous or stressed; Cronbach's α = .77). Response categories ranged from 0 = *never* to 4 = *very often*. Summed scores ranged from 0 to 56, with higher scores indicating increased stress.

Violence exposure. One question assessed violence exposure in asking if they (or someone in their family) has been a victim of a violent act (e.g., gunshot, assault; 0 = *no* to 1 = *yes*).

Substance use. Substance use was assessed with two questions. Tobacco use was assessed inquiring if they currently smoke cigarettes (1 = *not at all* to 3 = *everyday*). Alcohol consumption was assessed regarding how often one drinks alcoholic beverages (0 = *never* to 7 = *daily*).

Religiosity. Religiosity was assessed using a widely used scale on religious background and behavior (Connors et al., 1996). Religious identification was assessed with one item, which asked participants to describe their level of religiosity, with response options ranging from 1 = *atheist* to 5 = *religious*. Religious behaviors were assessed using the six-item scale. Participants were asked how often they thought of God, prayed, meditated, attended church services, read scriptures/holy writings, or had direct experiences with God) (Cronbach's α = .76). Response options ranged from 1 = *never* to 8 = *more than once a day*. The six items assessing frequency of religious behaviors were examined individually.

Body in relationship to God beliefs. Participants' perceptions of their body in relationship to God were assessed using a five-item scale (Cronbach's α = .97). Responses ranged from 1 = *strongly disagree* to 7 = *strongly agree*. Sample items included "*My body is a temple of God*" and "*The power of God moves through my body*." Items were summed to create a measure of religiosity in relation to one's body, with total scores ranging from 5 to 35, with higher scores indicating stronger perceptions of connectedness between their body and God.

Religious coping. Religious coping was assessed using the Brief RCOPE (Pargament et al., 1988; Pargament et al., 2000; Pargament et al., 2011). The Brief RCOPE is a comprehensive measure that assesses both positive and negative coping. The present study examined the religious and spiritual methods of coping as means of gaining control using the three Brief RCOPE subscales: collaborative religious coping, self-directive religious coping, and passive religious coping styles. Collaborative religious coping indicates working in conjunction with God (e.g., "*I work together with God as partners*"). Self-directive religious coping is working independently from God (e.g., "*I try to make sense of the situation without relying on God*"). Passive religious coping is deferring everything to God (e.g., "*I don't do much; just expect God to solve my problems for me*"). The Brief RCOPE consists of three items for each coping style, and responses ranged from 0 = *not at all* to 3 = *a great deal*. Internal consistency for each scale is as follows: collaborative religious coping (Cronbach's $\alpha = .84$), self-directive religious coping (Cronbach's $\alpha = .74$), and passive religious coping (Cronbach's $\alpha = .79$). Subscale items were summed to create three measures for each of the coping styles and scores ranged from 0 to 9, with higher scores indicating more religious coping.

Receipt of counseling from a pastor/religious leader. The primary outcome variable was receipt of counseling from a pastor or religious leader. Participants were asked if they had ever received counseling from their pastor or religious leader regarding nine issues (e.g., romantic relationship issues, family issues, mental health issues, spiritual healing, some other issue). For the purposes of the present study, no receipt of counseling was coded as (0) and receipt of counseling for one or more issues was coded as (1).

Data Analysis

Descriptive statistics were used to examine participant characteristics, religiosity items, and receipt of counseling services from pastors/religious leaders. Frequencies and proportions were examined for categorical variables (e.g., gender, education) and means and standard deviations were examined for continuous variables (e.g., religious engagement, age). Chi-square analyses were conducted to determine group differences for categorical variables (e.g., gender, education, health insurance, past mental health diagnosis) in those who reported receipt of counseling and those who did not. *T*-tests were used to determine significant mean differences in continuous variables (e.g., perceived stress, church attendance, prayer frequency, alcohol consumption, collaborative religious coping) in those who received counseling and those who did not receive counseling. Given the exploratory nature of much of the present study, a *p*-value of < 0.1 was used to identify variables from the *t*-test and chi-square analyses to include in the logistic regression analysis to determine predictors of seeking clergy counseling. The model's overall fit was assessed using Nagelkerke R Square.

CHAPTER 3

RESULTS

Participants were primarily female (69%, $n = 240$), as illustrated in Table 1, and had a mean age of 54 ($SD = 13$; range 18 to 80). Participants' responses indicated high levels of religious identification, with 99% ($n = 337$) of participants identifying themselves as religious or spiritual. Results also indicated that 97% ($n = 338$) of participants reported thinking of God almost daily or more, and 91% ($n = 310$) reported attending church once a week or more. Furthermore, 94% ($n = 326$) of participants reported praying daily or more, 68% ($n = 227$) of participants reported meditating almost daily or more, and 67% ($n = 132$) of participants reported reading scriptures/writings almost daily or more. Additionally, to examine church-specific effects (e.g., between the six different churches in our sample), bivariate analyses were conducted between church affiliation and receipt of counseling. Analyses indicated there were no church-specific effects related to receipt of counseling ($r = .003$, $p = .95$).

Additionally, 50% ($n = 175$) of participants reported receipt of counseling from their pastor or religious leader. The most commonly cited reasons for receipt of counseling were spiritual growth (25%), family issues (24%), and romantic relationship issues (22%). Findings also indicated that 8% of participants sought counseling for mental health issues and 3% sought counseling for substance abuse issues. On average, participants endorsed seeking counseling for one to two reasons ($M = 1.24$, $SD = 1.80$).

Preliminary Analyses

Preliminary analyses (utilizing a p–value of $< .1$) were first conducted to determine which variables to include in the logistic regression. Chi-square analyses were conducted among categorical variables, as shown in Table 1. As illustrated in Table 1, there was a significant

relationship between education and seeking counseling, with higher levels of education being related to receipt of counseling ($\chi 2$ (1) = 3.75, p = .05). There were no significant relationships observed between seeking counseling and gender, income, church membership, health insurance, depression screening/diagnosis, or violence exposure.

Independent *t*-tests were conducted with continuous variables to assess which variables to include in the logistic regression, as shown in Table 2. Findings indicated significant differences in several of the religiosity variables among those who reported receipt of counseling and those who did not report receipt of counseling. For example, participants who reported receipt of counseling reported more frequent thoughts of God (t (277.89) = -2.3, p = .02), prayer (t (307.37) = -1.90, p = .06), and meditation (t (324.59) = -1.90, p = .06) than those who did not report receipt of counseling. Additionally, those who endorsed receipt of counseling reported more frequent church attendance (t (338) = -2.29, p = .02), reading scriptures/writings (t (326.73) = -2.44, p = .02), and direct experiences with God (t (330.29) = -2.43, p = .02) than those who did not report receipt of counseling.

There were no significant mean differences observed for age, overall health, perceived stress, body in relationship to God beliefs, religious identification, alcohol use, and tobacco use among those who endorsed receipt of counseling and those who did not. Additionally, no significant mean differences were observed for collaborative religious coping, self-directive religious coping, and passive religious coping in those who reported receipt of counseling and those who did not report receipt of counseling.

Table 1. *Participant characteristics, sociodemographic variables related to receipt of counseling (Frequencies, chi-square analyses)*

			No Counseling		Sought Counseling		Test statistic	*P*-value
	N	%	*n*	%	*n*	%	$\chi 2$	*p*
Sought Counseling								
Yes	175	49.7						
No	177	50.3						
Gender								
Male	106	30.6	49	28.7	57	32.6	.62	.43
Female	240	69.4	122	71.3	118	64.4		
Affiliation to church								
Church member	311	90.1	152	88.9	159	91.4	.60	.44
Community member	34	9.9	19	11.1	15	8.6		
Education								
Low (11^{th} Grade – some college)	174	50.3	95	55.6	79	45.1	3.75	.05*
High (Associates degree – grad school)	172	48.7	76	44.4	96	54.9		
Income								
Low ($0-$3,000/month)	169	59.7	84	60.4	85	59.0	.06	.81
High ($3,000/month)	114	40.3	55	39.6	59	41.0		
Health Insurance								
Yes	295	16.2	148	83.4	147	16.0	.01	.92
No	57	83.8	29	16.4	28	84.0		
Depression/mental health diagnosis								
Yes	30	8.5	164	7.3	13	9.7	.63	.43
No	322	91.5	158	92.7	17	90.3		
Depression/mental health screening								
Yes	24	6.8	10	5.6	14	8.0	.77	.38
No	328	93.2	167	94.4	161	92.0		
Violence exposure								
Yes	104	29.5	51	29.1	53	31.8	.27	.60
No	238	67.6	124	70.9	114	68.3		

*$p < .1$ ** $p < .05$ *** $p < .001$

Table 2. *Sociodemographic and religiosity variables related to receipt of counseling (Means, t-test analyses).*

Demographic factor	Overall mean	No counseling	Sought counseling	Test statistic	*P*-value
	M (SD)	*M (SD)*	*M (SD)*	*t*	*p*
Age	53.66 (13.10)	54.27 (13.88)	53.15 (12.32)	.72	.47
Overall health	3.08 (.79)	3.12 (.75)	3.04 (.84)	.86	.39
Perceived stress	22.54 (6.99)	22.07 (7.47)	23.01 (6.47)	-1.25	.21
Religious identifier	4.85 (.39)	4.85 (.36)	4.85 (.42)	-.12	.91
Thought of God	7.77 (.54)	7.61 (.66)	7.84 (.39)	-2.3	.02**
Prayer	7.53 (.96)	7.43 (1.12)	7.62 (.77)	-1.90	.06*
Meditation	6.33 (2.22)	6.10 (2.35)	6.56 (2.06)	-1.90	.06*
Church attendance	5.87 (1.44)	5.69 (1.49)	6.05 (1.37)	-2.29	.02**
Reading scriptures/writings	6.55 (1.65)	6.34 (1.82)	6.76 (1.44)	-2.44	.02**
Direct experience with God	6.53 (2.04)	6.27 (2.21)	6.8 (1.81)	-2.42	.02**
Body in relationship to God beliefs	32.44 (6.49)	32.07 (7.18)	32.81 (5.71)	-1.06	.29
Collaborative religious coping	9.99 (2.30)	9.81 (2.48)	10.16 (2.11)	-1.40	.16
Self-directive religious coping	5.22 (2.48)	5.34 (2.51)	5.10 (2.46)	.88	.38
Passive religious coping	5.39 (2.64)	5.36 (2.72)	5.41 (2.57)	-.20	.84
Alcohol use	1.93 (1.20)	1.96 (1.22)	1.91 (1.17)	.41	.68
Tobacco use	1.21 (.54)	1.24 (.57)	1.17 (.51)	1.08	.28

*$p < .1$ ** p <.05 *** $p < .001$

Logistic Regression

A direct binary logistic regression analysis was conducted to predict receipt of counseling using education, thoughts of God, prayer, meditation, church attendance, reading of scriptures/writings, and direct experiences with God, as indicated by preliminary analyses. Data screening indicated no issues with multi-collinearity. The constant only model was first examined, but was not significant (X^2 (1) = .08, p = .50). This model classified all cases as seeking counseling, which correctly classified 52% of the cases at chance. The full model included the variables listed above and was significant (X^2 (7) = 14.24, p = .047, Nagelkerke R^2 = .06. The Hosmer-Lemeshow test indicated that the model had good fit with a non-significant chi-square (X^2 (8) = 14.10, p = .08). Overall, 59% of the participants were correctly classified, with better classification for the receipt of counseling group (71%) than those who did not report receipt of counseling (45%).

Table 3. *Sociodemographic and religiosity predictors of receipt of counseling (Exponent B, significance values)*

	B	*S.E.*	*Wald*	*p*	Exp (B)
Education	.39	.23	2.79	.095	1.47
Thought of God	.12	.29	.15	.70	1.12
Prayer	-.09	.17	.28	.60	.92
Meditation	.04	.07	.36	.55	1.04
Church attendance	.05	.10	.24	.63	1.05
Read scripture/holy writings	.10	.09	1.15	.28	1.1
Direct experience with God	.10	.07	2.06	.15	1.11

*p < .05 ** p < .01 *** p < .001
Note. df=1.

As shown in Table 3, education was a marginally significant predictor of receipt of counseling; those with higher levels of education were 1.5 times more likely to report receipt of counseling compared to individuals with lower levels of education. Thoughts of God, prayer,

meditation, church attendance, reading of scriptures/writings, and direct experiences with God were non-significant predictors of receipt of counseling in the logistic regression model.

CHAPTER 4

DISCUSSION

To our knowledge, this is the first study to examine factors related to receipt of clergy counseling in an AA faith-based population, unlike previous studies that reported on national AA samples (Chatters et al., 2011; Neighbors et al., 1998). Given that AAs have the highest levels of church attendance among all racial/ethnic groups, better understanding factors related to receipt of clergy counseling in church-based samples can assist in informing faith-based intervention efforts. Results indicate that 50% of participants reported receipt of counseling from a pastor and/or religious leader, consistent with previous studies indicating high use of clergy counseling (53%) among church-affiliated AAs (Hankerson et al., 2015). This finding suggests that a large number of church and community members value the guidance and support provided by religious leaders (Kramer et al., 2007). Church-affiliated populations may also view clergy counseling as more accessible and less stigmatizing than professional mental health counseling.

Nearly 50% of the reasons for seeking counseling were due to relationship issues (e.g., family, romantic) followed by spiritual, mental health, and substance abuse issues. Only 9% of participants indicated a history of a mental health diagnosis, which was unrelated to receipt of counseling in our study. Mental health diagnosis may be under-represented among our AA church-affiliated populations, especially since studies indicate AAs tend not to receive mental health screenings and are often under-diagnosed (Bailey et al., 2011; DeJesus et al., 2011). A newly released CDC report found that an undiagnosed mental health condition (CDC, 2018) was a key characteristic among the majority of persons who committed suicide between 2009 and 2016, and called for community sectors to assist in providing referrals to mental health services. Considering other key suicide risk factors in the CDC study included relationship, substance use,

and life stressor issues (e.g., low income, housing) – issues for which participants primarily sought religious leader counseling. Clergy and other religious leaders could play an important role as first responders for church and community members in crisis. With training, they could be well-positioned to assist in addressing CDC's recommended risk reduction activities for community sector. Suggested activities that align with the faith sector include organizing activities that reduce isolation and socially connect their members, enhance problem solving and coping skills, and provide assistance to address the basic needs of their members, particularly through their inreach and outreach ministries (e.g., utility assistance, social services, food programs).

Future research should examine pastors' perceived and actual competency in effectively assisting parishioners with presenting concerns and providing referrals (when needed), given that previous studies have noted pastors' concerns regarding their limited training to effectively address concerns of parishioners (Kramer et al., 2007). Moreover, given the prevalence of relationship concerns as reason for reporting receipt of counseling in our study, religious leaders may benefit from training in family systems, learning how provide referrals mental health services, and developing/expanding their community outreach ministries to help members stay connected and to subsist.

Sociodemographic Variables

Findings indicated that there were no significant differences across gender, age range, insurance coverage, and church affiliation in their association with receipt of counseling from a pastor/religious leader. These findings were inconsistent with previous literature, which demonstrated females and younger individuals were more likely to seek clergy and professional counseling services (Chatters et al., 2011; Neighbors et al., 1998; Neighbors et al., 2007;

Woodward et al., 2011). Insignificant findings for these sociodemographic variables (e.g., gender, church affiliation, income) may be due to our sample being predominantly female, older, and church members with access to health insurance.

Consistent with our hypotheses and previous literature (e.g., Chatters et al., 2011; Neighbors et al., 2007; & Woodward et al., 2011), findings indicated higher education was related to receipt of counseling, however, education was only marginally significant in the regression (e.g., $p < .1$) and should be interpreted with caution. Education may indicate knowledge of mental health issues, access to information regarding services available, and/or attitudes towards help-seeking (Neighbors et al., 2007; Woodward et al., 2011). Furthermore, knowledge and information regarding mental health (e.g., prevalence) may combat stigma regarding experiencing mental health issues and seeking help. Future research examining receipt of counseling should examine specific mechanisms (e.g., knowledge, attitudes, awareness of community-based services) through which education may impact help-seeking behaviors. Further understanding mechanisms can assist in tailoring faith-based mental health intervention efforts.

Income was not related to receipt of counseling in our study, contrary to a study by Chatters et al. (2011), suggesting that there was a balanced representation of high and low income participants utilizing clergy counseling. However, given that individuals of low socioeconomic status (e.g., community members served through outreach ministries such as pantries) may experience greater financial and social barriers to seeking mental health care, the Black Church may be in a unique position to provide mental health services to individuals of low socioeconomic status.

Health and Mental Health Variables

Contrary to our hypotheses, preliminary analyses indicated that both a history of a depression/mental health diagnosis, a depression/mental health screening, and violence exposure were not related to receipt of counseling. This may be due to low endorsement of these items (e.g., 7% reported receipt of mental health screening, 9% reported receipt of a mental health diagnosis), which is consistent with previous research indicating low levels of help-seeking among AAs (Alegría et al., 2008; Neighbors et al., 2007; Williams et al., 2007) and low rates of detection of mental health conditions in healthcare settings among AAs (Borowsky et al., 2000; Das et al., 2006; DeJesus et al., 2011). Low rates of professional help-seeking (e.g., receiving a screening and/or diagnosis) among AAs may be due to socio-ecological barriers such as stigma, mistrust in providers, and geographical barriers (Clement et al., 2015; Murry et al., 2010; O'Connor et al., 2010; Ward et al., 2013), and seeking support from a pastor/religious leader within a trusted institution may be more normative in AA culture.

Substance Use

Findings indicated that neither alcohol use nor tobacco use were significantly related to receipt of counseling in faith-based populations. This may be due to floor effects of low substance use within the sample (e.g., 78% reported never/almost never consuming alcohol, 86% reported no tobacco use), which is consistent with previous studies that indicated that higher levels of religiosity was associated with less alcohol consumption (Mailey, 2012; Menagi et al., 2008).

Religiosity

Consistent with previous literature, findings indicated that religious behaviors (e.g., frequency of thoughts of God, prayer, meditation, church attendance, reading scriptures/writings,

and direct experiences with God) were higher in those who reported receipt of counseling compared to those who did not report receipt of counseling. Contrary to our hypotheses, religious behaviors (e.g., frequency of prayer, church attendance) did not remain significant in the logistic regression analysis. Further research is needed to better understand how religious behaviors may impact the likelihood of seeking faith-based counseling and if a wide breadth of religious practices and experiences may be uniquely related to receipt of clergy counseling. Consideration should be given to how tailoring promotion of religious leader counseling and mental health protective behaviors could be feasible/acceptable with church-affiliated populations.

Contrary to previous literature (e.g., Andrews et al., 2011) and our hypotheses, self-directive religious coping, passive religious coping, and collaborative religious coping were not associated with receipt of counseling. This may be due to our sample consisting of highly religious AAs and participants being less likely to rely on independent coping methods (e.g., self-directive religious coping). Body in relationship to God beliefs, a commonly cited scriptural basis for taking care of one's body and health (Bauer et al., 2017; Holt & McClure, 2006), was also not significantly related to receipt of counseling. This may be a consequence of a restricted range of responses, due to participants endorsing high body in relationship to God beliefs

Limitations

The present study has several limitations. Our study was conducted among highly religious AA church members in the Midwest, an area that some would consider to be in the "Bible Belt" (Tweedie, 1978). Thus, generalizability may be limited to AA faith-based populations within this region. With regards to our mental health screening variable, it may have lacked clarity regarding what a screening entails (e.g., seeking a professional, online questionnaire, brief primary care screening). Additionally, the receipt of counseling variable was

self-reported and may be subject to response biases (e.g., social desirability). Furthermore, it encompassed seeking counseling for a wide range of issues (e.g., spiritual growth, spiritual healing, mental health issues, and substance use issues). Therefore, there may be high variability in the reasons and experiences motivating participants to seek counseling (e.g., spiritual growth versus imminent mental health issues). In addition, we did not access frequency of receipt of counseling and were unable to access the degree to which participants utilized clergy counseling (e.g., once versus regularly). We also did not examine receipt of mental health services outside of the AA church. Future research should examine frequency of receipt of counseling among AAs to further understand the degree of service utilization inside and outside church settings.

Implications

National initiatives have identified the need for mental health services in community-based settings, such as faith-based organizations, in order to target mental health Disparities (NIMH, 2015b; WHO, 2013). AAs are more likely to experience chronic depression and greater impairment from depression (Bailey et al., 2011; Williams et al., 2007). Additionally, studies have documented underdetection of mental health issues among AAs in healthcare settings (Borowsky et al., 2000; Das et al., 2006; DeJesus et al., 2011), and AAs are less likely to initiate professional mental health care (Alegría et al., 2008; Neighbors et al., 2007; Williams et al., 2007).

Given the historical trust of AA churches (Chatters et al., 2011; Taylor et al., 2000), the Black Church has the potential to implement faith-based mental health interventions. Church-based interventions may educate members on mental health issues (e.g., symptoms, commonplace nature, treatments available) as well as normalize seeking out mental health services. Churches could also play an important role in reducing stigma related to use of mental

health services in AA communities (O'Conner et al., 2010; Ojeda & McGuire, 2006; Ward et al., 2013) and promote use of these services along with promoting healthy behaviors that can be protective against mental illness.

Additionally, AA churches should consider forming community-based partnerships with mental health agencies. Future interventions should may provide education about the varying presentations of depression, particularly given that AAs often experience different manifestations of depressive symptoms (e.g., headaches, pain, sleep difficulty), personal testimonials of mental health issues and healing, as well as seminars. The Black Church has the potential to serve as a bridge between spiritual/church support and professional mental health care among AAs. Studies indicate that utilizing brief screening tools in faith-based settings may be feasible (Hankerson et al., 2015) and engaging church leadership (e.g., clergy, deacons) has been indicated to be important in developing successful partnerships between AA churches and mental health agencies (Allen et al., 2010). Church-based mental health screening in conjunction with mental health agency partnerships may be an effective way to connect AAs to mental health care – given that it occurs within the trusted institution of the church.

Overall, national studies indicate that AAs experience more chronic depression, greater impairment due to depression, and are less likely to seek professional mental health care than Whites. Our study indicates high use of clergy counseling (50%), with many participants seeking counseling for relationship issues. Given the pivotal influence of the Black Church, faith-based interventions may provide an opportunity to provide mental health education, reduce stigma, and normalize seeking mental health care among AAs. Clergy and religious leaders may also play a pivotal role in responding to AAs in crisis, and forming partnerships between AA churches and community agencies may serve as a bridge between church support and professional mental

health care. Although our findings suggest a trend that some psychosocial factors (e.g., education, religious behaviors) may differ among AAs who seek clergy counseling and those who do not, more research is needed to better understand this relationship and to tailor faith-based intervention efforts that target mental health disparities.

APPENDIX

This section includes items used to measure demographic variables.

Demographics (BL)

1. How old are you?
   Enter age _____

2. What was your gender at birth?
   ☐ Male
   ☐ Female

3. Do you identify your ethnicity as being of Hispanic or Latino origin?
   ☐ No, not of Hispanic or Latino origin
   ☐ Yes, Mexican, Puerto Rican, Cuban, or another Hispanic, Latino, or Spanish origin
   (For example, Argentinian, Columbian, Dominican, Puerto Rican, Nicaraguan, Salvadorian, Spaniard, and so on.)
   ☐ Unknown
   ☐ Refuse to answer

4. Do you identify your race as: *(Check One)*
   ☐ Black or African American
   ☐ White or Caucasian
   ☐ American Indian or Alaska Native
   ☐ Asian
   ☐ Native Hawaiian or other Pacific Islander
   ☐ More than one race
   ☐ Other race
   ☐ Unknown
   ☐ Refuse to answer

5. What is your highest level of education completed?
   ☐ 11th grade or less
   ☐ High school graduate or GED
   ☐ Post high school technical training
   ☐ Some college (but no degree)
   ☐ Associate's degree (AA) or technical school certificate
   ☐ Bachelor's degree (BA, BS)
   ☐ Some graduate school or graduate degree

6. What is your current marital status?
   ☐ Single, never married
   ☐ Living with partner, but not married
   ☐ Married
   ☐ Separated
   ☐ Divorced
   ☐ Widowed

7. a. Do you have any children?
   ☐ Yes
   ☐ No

   b. If yes, how many of your children are currently living in your household?
   _____

8. What is the denomination of your church? *(Check One)*
   ☐ Baptist
   ☐ Church of God in Christ
   ☐ Methodist
   ☐ Lutheran
   ☐ Pentecostal
   ☐ Catholic
   ☐ African Methodist Episcopal
   ☐ Jehovah's Witness
   ☐ Muslim
   ☐ Seventh Day Adventist
   ☐ Non-Denominational
   ☐ Other (please list):
   _____

9. a. Are you a member of this church?
   ☐ Yes
   ☐ No

b. If yes, how long have you been a member or attended services at this church?
   # of Years _____ and/or # of Months_____

10. If you are not a member, how are you connected to this church? *(Check all that apply)*
   ☐ Guest
   ☐ Person who received health screening or participated in a health fair
   ☐ Person who received food, clothing, or utility assistance (like for electric or gas bill) services
   ☐ Person who received support services (like a support group, recovery program)
   ☐ Parent of a child in church daycare, summer school, or after-school program
   ☐ Other (please list):
   _____

11. How do you support yourself?
   ☐ Working part-time
   ☐ Working full-time
   ☐ Self-employed in your own business
   ☐ Social Security/Private disability insurance
   ☐ Unemployment compensation
   ☐ No income
   ☐ Other

12. Do you have health insurance or coverage that helps pay for part of your medical bills?
   ☐ Yes, Medicare
   ☐ Yes, Medicaid
   ☐ Yes, Private insurance (e.g., Blue Cross/Blue Shield, Kaiser, United Healthcare)
   ☐ Yes, Some other insurance
   ☐ No, I do not have health insurance

13. What is your current housing status?
   ☐ Own a home
   ☐ Renting
   ☐ Staying with family or friends
   ☐ Living in temporary/emergency housing
   ☐ Homeless
   ☐ Other

14. For the past 12 months, please estimate the average monthly income of your household:
   ☐ $0 - $1,000
   ☐ $1,001 - $2,000
   ☐ $2,001 - $3,000
   ☐ More than $3,000
   ☐ Don't know
   ☐ Refuse to answer

Health Behaviors and Screenings

7. a. Do you currently smoke cigarettes? *(Check One)* **If "not at all," skip to question #9**

☐ Not at all
☐ Some days
☐ Everyday
☐ Don't know
☐ Refuse to answer

b. If you currently smoke cigarettes, on the days that you smoke, how many cigarettes do you smoke?
_____(Write in the number of cigarettes)

9. How often do you drink alcoholic beverages?

☐ Never
☐ Very seldom/almost never
☐ 1-3 times a month
☐ 3-2 times a week
☐ Once a week
☐ 6-4 times a week
☐ Daily
☐ Don't know
☐ Refuse to answer

10. During the past 30 days, on the days when you drank, about how many drinks did you drink on average?

One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.

NOTE: A 40 ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

____ Number of drinks

☐ Don't know
☐ Refuse to answer

13. Have you had any of the following health screenings in the past 12 months? *(Check all that apply)*

☐ Blood pressure
☐ Cholesterol
☐ Blood glucose ("Sugar")
☐ Sexually transmitted infections (gonorrhea, chlamydia, syphilis, HIV, trichomoniasis)
☐ Asthma
☐ Heart disease
☐ Stroke
☐ Thyroid condition
☐ Colon cancer
☐ Prostate cancer
☐ Breast cancer (Mammography)
☐ Cervical cancer (Pap test)
☐ Polycystic ovary syndrome
☐ Gestational diabetes
☐ Depression or other mental health condition
☐ Don't know
☐ Refuse to answer

14. Have you ever been diagnosed with any of the following health conditions? *(Check all that apply)*

☐ High blood pressure
☐ High cholesterol
☐ Diabetes
☐ Sexually transmitted infections (gonorrhea, chlamydia, syphilis, HIV, trichomoniasis)
☐ Asthma
☐ Heart disease
☐ Stroke
☐ Thyroid condition
☐ Colon cancer
☐ Prostate cancer
☐ Breast cancer

Self-reported Health

1. In general, how would you describe your overall health?

   ☐ Poor
   ☐ Fair
   ☐ Good
   ☐ Very good
   ☐ Excellent
   ☐ Don't know
   ☐ Refuse to answer

Perceived Stress

The following questions will ask you about your <u>feelings and thoughts over the last 7 days</u>. In each case, you will be asked to indicate how often you felt a certain way. Some of these questions may sound similar, but please treat each question separately. Try to answer each question fairly quickly -- do not try to count up the number of times you felt a particular way, but rather provide your best guess.

In the last week how often have you…	Never	Almost never	Some times	Fairly often	Very often
1. Been upset because of something that happened unexpectedly?	O	O	O	O	O
2. Felt that you were unable to control the important things in your life?	O	O	O	O	O
3. Felt nervous and "stressed"?	O	O	O	O	O
4. Dealt successfully with irritating life hassles?	O	O	O	O	O
5. Felt that you were effectively coping with important changes that were occurring in your life?	O	O	O	O	O
6. Felt confident about your ability to handle your personal problems?	O	O	O	O	O
7. Felt that things were going your way?	O	O	O	O	O
8. Found that you could not cope with all the things that you had to do?	O	O	O	O	O
9. Been able to control irritations in your life?	O	O	O	O	O
10. Felt that you were on top of things?	O	O	O	O	O
11. Been angered because of things that happened that were outside of your control?	O	O	O	O	O
12. Found yourself thinking about things that you have to accomplish?	O	O	O	O	O
13. Been able to control the way you spend your time?	O	O	O	O	O
14. Felt difficulties were piling up so high that you could not overcome them?	O	O	O	O	O

Religiosity

1. Which of the following best describes you at this time? *(Check One)*

☐ Atheist: I do not believe in God.
☐ Agnostic: I believe we can't really know about God.
☐ Unsure: I don't know what to believe about God.
☐ Spiritual: I believe in God, but I'm not religious.
☐ Religious: I believe in God and practice religion

For the <u>past 8 months</u>, how often have you done each of the following? *(Check a response to each statement.)*

	Never	Rarely	Once a month	Twice a month	Once a week	Twice a week	Almost daily	More than once a day
2. Thought of God	O	O	O	O	O	O	O	O
3. Prayed	O	O	O	O	O	O	O	O
4. Meditated	O	O	O	O	O	O	O	O
5. Attended a worship service	O	O	O	O	O	O	O	O
6. Read scriptures or holy	O	O	O	O	O	O	O	O
7. Had direct experiences with God	O	O	O	O	O	O	O	O

The following questions ask about how you think about your body in relationship to God. Respond to each item on a scale of 1 – 7, with 1 = Strongly disagree" to 4 = "Somewhat disagree/agree" to 7 = "Strongly agree".

	1	2	3	4	5	6	7
10. My body is a temple of God	O	O	O	O	O	O	O
11. My body is created in God's image	O	O	O	O	O	O	O
12. My body is a gift from God	O	O	O	O	O	O	O
13. God uses my body to do God's will	O	O	O	O	O	O	O
14. The power of God moves through my body	O	O	O	O	O	O	O

Receipt of Counseling

15. Have you ever received counseling services from your pastor or other religious leader? If so, please check all of the issues you discussed with your pastor or other religious leader. *(Check all that apply)*

☐ No, I have never received counseling service from my pastor or some other religious leader
☐ Romantic relationship issues regarding your husband, wife, boyfriend, or girlfriend
☐ Family issues regarding your children, parents, sister, brother, and/or family members
☐ Mental health issues (stress, feeling overwhelmed, depression, anxiety)
☐ Substance abuse issues (cigarette smoking, drug use, alcohol use)
☐ Personal physical health issues (dealing with test results, fear of illness, managing a disease)
☐ Spiritual healing (forgiveness, anger, grief)
☐ Financial and/or employment issues
☐ Spiritual growth (regarding your faith, your relationship with God, understanding the bible)
☐ Some other issue; write in the issue you discussed with pastor/other religious leader:

_____

☐ Don't know
☐ Refuse to answer

Religious Coping

The following questions are specifically about religious or spiritual ways you might cope with eating healthy and getting enough exercise. Indicate how much you use each of the following methods to cope with eating healthy and getting enough exercise. When the items refer to God, please think of this as referring to your Higher Power.

	Not at all	A little	A medium amount	A great deal
16. I don't do much; just expect God to solve my problems for me.	O	O	O	O
17. I work together with God as partners.	O	O	O	O
18. I try to put my plans into action together with God.	O	O	O	O
19. I try to make sense of the situation with God.	O	O	O	O
20. I try to deal with my feelings without God's help.	O	O	O	O
21. I don't try much of anything; simply expect God to take control.	O	O	O	O
22. I make decisions about what to do without God's help.	O	O	O	O
23. I don't try to cope; only expect God to take my worries away.	O	O	O	O
24. I try to make sense of the situation without relying on God.	O	O	O	O

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VITA

Kelsey Christensen was born February 3, 1992, in Barrington, Illinois. She holds her Bachelor of Arts in Psychology and Communication from DePauw University in Greencastle, Indiana, where she graduated cum laude in 2014. Kelsey holds her Master of Arts in Counseling Psychology from Northwestern University in Evanston, IL, where she graduated in 2016. In August 2016, Kelsey began pursuing her PhD in Clinical-Health Psychology at the University of Missouri – Kansas City.