Physicians of the Soul, Gatekeepers of the Mind: Perceptions, Willingness, and Preparedness Towards Mental Health Among African American Clergy

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Abstract

Congregants look to clergy for support beyond their spiritual needs when facing mental illnesses. Considered physicians of the soul and gatekeepers of the mind, clergy must act as a liaison for education, support, and referrals to professional services. This study surveyed 15 clergy from the A.M.E. Zion Church. Clergy were asked to explore their perceptions of mental health, willingness to collaborate with mental health professionals, and provide referrals to professional services. Findings showed that over fifty percent of clergy could recognize persons with a mental health disorder. Clergy showed a strongly belief that members feel more comfortable with pastoral counseling than seeking professional help because of stigmas attached to seeking therapy. Clergy also indicated high levels of willingness to refer members to counselors because of nervous breaks downs, domestic violence, sexual abuse, depression, alcohol/drug addiction, and anger. Clergy were comfortable with the idea of collaborating with mental health professionals and strongly believed their role would not be devalued by professionals' involvement. Most clergy were willing to make referrals beyond their expertise; however, preference was given to referrals to Christian professional counselors. These results indicate that clergy are providing education, support, and referrals to professional services for congregants with mental illnesses. Further examination of training, availability of resources, and stigmas associated with mental health are needed to strengthen the role of clergy.

INTRODUCTION

In the African American community, a central source of strength and support is closely related to family, community, and spiritual beliefs (Ward and Heidrich, 2009). Research by Colbert, Jefferson, Gallo, and Davis, (2009) supports that religious African Americans are less likely to seek formal mental health services outside the church. Globally, the church has become a hospital for the spiritually sick and mentally ill. Considered physicians of the soul and gatekeepers of the mind, clergy and church leaders are looked to as a source for spiritual care and mental support for the unmet needs of parishioners (Okunrounmu, Allen-Wilson, Davey, and Davey, 2016). For most congregants, clergy are considered a free, credible, less stigmatized, and comfortable resource for discussing mental issues (Bohnert et al., 2010). While clergy often seek training in theological studies, many lack the specialized knowledge required to provide adequate mental health support (Payne, 2009).

LITERATURE REVIEW

Knowledge of Mental Health &Perceptions Regarding Referrals

The definition and source for mental illnesses varies among race; moreover, religious affiliations. Clergy's readiness to consult, cooperate, and refer congregants to mental health professionals are closely examined within the literature. Stanford and Philpott found predominately Caucasian Baptist clergy perceptions of mental illness were based on biomedical knowledge but influenced by personal beliefs (2011). These findings correlate with suggestions that biological, influences for mental illness are greater than psychosocial or spiritual factors (Stanford and Philpott, 2011). Among Protestant clergy identified as Caucasian, views of depression were biological, whereas clergy who identified as African American reconciled depression with spiritual factors (Payne, 2009). Such results indicate that clergy often rely on

personal knowledge, race, and beliefs of illness when referring congregants to mental health professionals.

In term of principles and values, clergy are significantly more likely to refer congregants to professionals that reflect commonalities and their own religious beliefs (Stanford and Philpott, 2011). Most commonly, clergy are called upon for issues of bereavement, relationships, anxiety, depression, and crises of faith; additionally, clergy are less likely to be seen for suicide, self-harm, delusions, and substance issues (Wood, 2011). Findings by Wood (2011) advise that clergy show a greater willingness to provide parishioners with referrals for anxiety, depression, and suicidal thoughts more than faith, self-harm, and delusions. Approximately 86% of clergy believed they could identify a person with a mental health challenge and 89% of clergy are willing to make a referral if a congregant's issue expands beyond their scope and is more serious in nature (VanderWaal, Hernandez, and Sandman, 2012). Acknowledged mental illness dependent upon personal beliefs and use of fluctuating foundations can impede the effectiveness of clergy and influence the overall willingness of clergy to provide congregants with credible referrals.

Perceptions Regarding Referrals & Preparedness

Furthermore, minimal knowledge can influence one's perception and mislead their confidence to counsel others. For clergy, discrepancies exist in what type of training is needed before beginning to counsel parishioners. Approximately, 96% of pastors have a form of theological training (Payne, 2009). This included training for ordination, from specialized schools, or vocations related to ministry (Payne, 2009). Despite this, in only 25% of clergy reported having completed training in pastoral care or counseling (Payne, 2009). In contrast, Payne found that only in certain circumstances was education an influence to treating depression.

Clergy with limited education expressed confidence as the being the best source for treating depression, whereas clergy with training showed a greater confidence in referral to mental health professionals (2014). Thus, clergy who are not exposed to adequate training further disenfranchise congregates by not offering referrals due to increased confidence in their own experiences.

Knowledge of Mental Health & Preparedness

Subsequently, clergy tend to agree on understanding what mental health is but disagree about being prepared for pastoral counseling through ministry training (Wood, 2011). Nearly 50% of clergy have some instruction in counseling (Anthony, Johnson, and Schafer, 2015). Moreover, most clergy could identify signs of depression; however, 81% of clergy expressed the need for additional education (Anthony, Johnson, and Schafer, 2015). Farrel and Goebert (2008) found that 71% of clergy felt they were inadequately trained to recognize mental illness but expressed a strong willingness to counsel. Similar finding among Nigerian clergy showed that 69.2% of clergy received no mental health training; yet 59.8% were willing to provide mental health services (Igbinomwanhia, James, and Omoaregba, 2013). Willingness without proper training show a gap in perceived preparedness and actual readiness to assist with mental illness.

Kitchener and Jorm (2002) found a greater confidence among those who participated in Mental Health First Aid Training in assisting individuals with mental illness. Knowledge of mental health, perceptions regarding referrals, as well as lack of preparedness serve as challenges for clergy in providing support to parishioners. If, to remain a place of solace for the infirmed, churches must explore proactive trainings that will improve clergy facilitation of mental health. Therefore, the purpose of this study will examine knowledge of mental illness, perceptions regarding referrals, and mental health preparedness among African American clergy.

METHODOLOGY

Population

The target population of interest for this survey includes clergy (pastors and ministers) in the African Methodist Episcopal Zion Church (A.M.E. Zion Church). “Pastors” are being defined as the head of a house of worship. “Ministers” are defined as licensed (local preachers) and/or ordained (Deacon, Elder, or Bishop) by the A.M.E. Zion Church.

Inclusion/ Exclusion Criteria

Specific inclusion criteria are: 1) Church leaders who have been identified clergy (pastors, ministers, local preachers, elders, or deacons) in the A.M.E. Zion Church; 2) at least 18 years of age; 3) Understanding English; and 4) currently have an accessible e-mail address. Exclusion criteria were leaders who were not identified clergy in the A.M.E. Zion Church, individuals under the age of 18, inability to answer survey questions in English, or did not have an accessible e-mail address. A.M.E. Zion pastors were chosen for this study, allowing for a limited sample of pastors of a specific denomination. Clergy from other religious denominations were not included due to a constraint on the sample size of 15 participants for this study.

Recruitment

The African Methodist Episcopal Zion Church uses an episcopal system of governance, in which there are 12 episcopal districts or geographical areas. Each episcopal district is comprised of one or more annual conferences. Each annual conference has one or more presiding elder districts that a define local churches by area. For this study the Piedmont Episcopal District, Western North Carolina Conference, Lincolnton District was the focus population. Clergy in the district were contacted through email addresses provided by the District Directory of Churches. Clergy received an email (Appendix A), digital copy of consent form (Appendix

B), and a hyperlink to an anonymous survey (Appendix C). Follow up emails were sent one week after the initial contact. After no responses, the survey was then extended to additional episcopal areas via email and a closed Facebook group.

Instrument

The online survey was adapted from The Grand Rapids Congregational Mental Health and Substance Abuse Survey developed by Curtis VanderWaal, Ph.D. Written consent was sent and approved by Dr. VanderWaal for the survey to be used for the purposes of the study during the 2016-2017 academic semester. Survey was adapted to include questions regarding clergy preparedness for mental health.

Measurements

The online survey was designed to collect quantitative and qualitative responses from participants. The survey is a 57 questionnaire (including demographic questions, questions regarding clergy perceptions of mental health and substance abuse within their church, willingness to refer congregants, or work with mental health professionals, and preparedness for mental health) (Appendix C). The survey responses were scored on Likert scales.

Procedure

Upon Livingstone College IRB approval on November 26, 2016, targeted clergy were sent an email discussing the study and provided with a link to the anonymous online survey. Upon agreement and informed consent, participants completed the 57 questionnaire online. Digital results were downloaded from the server to a password protected computer on a secure network. Data was analyzed for trends and descriptive analysis. After completion of research, data was stored on a secure flash drive and locked in the researcher advisor’s office for one year.

Theoretical Framework

This study is based upon the Socioecological Framework (SEF) provided by McLeroy, Steckler, and Bibeau. The SEF implies that levels of influences act as a system that determine the whole. SEF consists of five levels that influence health: intrapersonal, interpersonal, community, institution, and policy (McLeroy, Bibeau, Steckler & Glanz, 1988, p. 355). Within this study Intrapersonal refers to individual clergy beliefs, whereas Interpersonal level consists of relationships between clergy and congregants. In addition, the Community level refers to mental health resources. On the Institutional level, there are rules, regulations, policies, and limits that impact the role of clergy in mental health. Finally, Policy refers to procedures, environments, and structures that impact mental health. Thus, this theory was chosen because of its adaptability to context and the experience of individuals.

Data Collection

The first email request to complete the survey was sent on November 29, 2016, to approximately 41 clergy and church email addresses. Two follow-up reminders were sent on December 2, 2016, and December 6, 2016. The initial response of clergy prompted the survey to be extended until December 10, 2016, and an additional 60 invitations to be sent to clergy in other Episcopal areas. By the end of data collection on December 10, 2016, 19 clergy completed the survey, representing a final response rate of 18.8%. After final data review, four surveys were removed due to either being incomplete or duplicated entries by a clergy. Thus, 15 survey responses remained for analysis (Appendix D).

RESULTS

Clergy were asked to provide demographic information related to sex, race, age, education, current clergy role, years in ministry, church location, and if they had completed any advance training in mental health. Their responses are recorded in the Appendix D: Table 1. Demographics show that 8 of 15 participants were female, whereas 7 of 15 participants were male. All clergy were African American/ Black. Of those surveyed, the majority were between the ages of 50-64 (46.7%). Clergy was also represented in age the age ranges of 18-29, 30-49, and 65+ with the percent of respondents being 13.3%, 33.3%, and 6.7%, respectively. Overall, 14 of 15 (93%) clergy had some form of higher education beyond a GED or High School Diploma. Two fifths (6; 40%) of those surveyed possessed either a Master's degree, Master of Divinity or a doctoral degree (PhD, DMin, MD, JD). One third (5; 33.3%) of clergy had either an Associate's degree or Bachelor's degree. One fifth (3, 20%) of clergy report having some college. Clergy were also asked to identify their current role in their local church. The majority of clergy identified as pastors (9, 60%) followed by local preachers (5, 33.3%) and an ordained deacon (1, 6.7%). When asked to discuss their years in ministry, one third (5, 33.3%) of clergy had served between 11 -20 years. Other clergy had served for either less than 5 years (5, 20%), 5-10 years (5, 20%), 21-30 years (1, 6.7%), or over 31 years (5, 20%).

Knowledge and Beliefs About Mental Health

Clergy were presented with statements about their knowledge and beliefs about mental health issues (Appendix D: Table 2) and asked to select their agreeability (Strongly Disagree, Disagree, Not Sure, Agree, Strongly Agree). The majority of clergy agreed or strongly agreed that they could recognize a person with a serious mental health disorder. When asked if they believed a person with a serious mental health challenged could be possessed by a demon, 40

percent agreed to the statement and 6.7 percent of clergy strongly agreed with the statement. Clergy mostly (53.3%) disagreed with beliefs that persons with mental health challenges were imagining their problems.

Overall, clergy favored a medical perspective to mental health. Over half of the clergy believe there is a biological or physical basis for mental health challenges and strongly disagreed with encouraging members to stop taking medication for a mental health challenge over seeking spiritual healing. Likewise, over 50 percent of clergy disagreed with that statement, "I believe that a church member often lacks faith when they are going through a mental health challenge." When asked about not referring members to mental health service because of fear of confidentiality being broken, the majority of clergy disagreed (46.7%) or strongly disagreed (33.3%) with this statement. Two thirds of clergy agreed that church members could not afford mental health services; however, three were unsure and three strongly disagreed with this statement. Furthermore, over 50 percent of clergy believed church members felt more comfortable with pastoral care and believed members chose not to seek care because of the stigma attached to therapy.

Frequency of Problems Experienced by Church Members

To understand issues faced by congregants, clergy were asked about the frequency of encounters to various mental health and substance abuse issues in their role (Appendix D: Table 3). Problems included: 1) mental health challenges, 2) substance abuse challenges, 3) violence (family and community), 4) sexual abuse, and 5) marriage and family problems. Data showed the most encountered problem for clergy a few times a year was sexual abuse (53.3%). Mental health challenges and violence were closely encountered few times a year by 46.7 percent of clergy. Both substance abuse and marriage/family problems were encountered weekly by 33.3%

of clergy. These results indicate that substance abuse and marriage/family are encountered more often by clergy, while mental health challenges, violence, and sexual abuse are encountered less frequently.

Willingness to Make Referrals

Clergy were asked to indicate their level of willingness to refer a member to a counselor for 13 areas (Appendix D: Table 4). The question stated, "In my role as clergy, I would be likely willing to refer church members to a mental health professional (counselor) if they have problems with..." Clergy showed a high willingness to refer members who faced problems of nervous breakdown (53.3%), domestic violence (86.7%), sexual abuse (93.3%), depression (80%), and alcohol/drug addiction (73.3%). Clergy showed an equal level of high and moderate willingness for referrals for members with an anger problem (46.6%). Clergy indicated moderate willingness for referrals related to anxiety (66.7%), marital relationships (66.7%), and finances (40%). Clergy shared a moderate to low level of referral willingness for parenting (40%) and life problems (40%). Clergy were least likely willing to refer members facing problems of racism/discrimination (46.7%) and work (40%).

Preferences for Consulting, Collaborating, and Referral Relationships

Clergy were next asked a series of statements to determine their relationship preference for consulting, collaborating, and referrals (Appendix D: Table 5). All clergy expressed they were either likely (40%) or very likely (60%) to allow a mental health professional to present a seminar in their church and allow that professional to lead a support group in the church. When asked if they would allow a mental health professional to have an office in their church, two clergy indicated that it would not be likely, while four clergy were unsure. Three clergy indicated that they would be likely and six indicated they would be very likely to provide office space.

Most clergy (66.7%) agreed that they did not feel their role would be compromised or devalued by the involvement of a mental health professional within their congregation. In fact, 73.3 percent of clergy were likely to very likely to consult with a mental health professional about a member's mental health issue. Similarly, when asked if they "would consider making a referral to a mental health professional when the circumstances are beyond the scope of my knowledge and/or expertise" clergy were either likely (13.3%/) or very likely (86.7%) to make a referral. Clergy showed no preference for mental health professional of the same race or ethnicity.

Preferences Regarding Religious & Ethnic/Racial Characteristics of Referral Professionals

Clergy's willingness to refer congregants were examined in relationship to religious and ethnic/racial characteristics (Appendix D: Table 6). Clergy were asked how important it was to refer members to a counselor that is 1) Christian, 2) the same denomination, 3) same ethnic or racial background as them. It was important to clergy for the professional to be Christian. Over 46 percent indicated that it was important for the professional counselor to be Christian; 33.3 percent said it was very important. Almost all the clergy indicated that the denomination of and ethnicity of the profession was not important to them.

Clergy Response to Person with a Serious Mental Health Challenge

Clergy were asked to examine their responses if one of their church members or persons they know were experiencing a serious mental health challenge (Appendix D: Table 7). Over 50 percent of clergy responded by stating they were unlikely to solely give prayer and spiritual counseling if a member was experiencing a serious mental challenge. Approximately 47 percent of clergy were willing very likely to refer members to a hospital or likely to a medical doctor. Clergy were very likely (73.3%) or likely (26.7%) to make referrals to a mental health

counselors. Only six clergy were likely and four very likely willing to refer a member to another pastor who has more training or experience.

Frequency of Referrals to Mental Health Counselor or Counseling Center

Clergy were asked to identify the number of referrals to a local mental health counselor or counseling center they had done in the last six months (Appendix D: Table 8). Although almost half of the clergy did not make any referrals, over 40 percent did refer one to five persons to counseling services. Two clergy (13.3%) indicated that they refer over 20 persons in the last six months for services.

Frequency of Referrals to Substance Abuse Counselor or Alcohol Treatment Center

Clergy were also asked to report approximately how many people have they referred to a substance abuse counselor or alcohol treatment center in the past six months (Appendix D: Table 9). The majority of clergy (60%) indicated that had not made any referrals for substance abuse in the past 6 months. Four clergy (26.7%) indicated that they had referred one to five persons for substance abuse in the last six months. Two clergy (13.3%) indicated that they referred over 20 persons in the last six months for services.

DISCUSSION

As clergy continue to be one the first sources for mental support for congregants, it is significant that the results from VanderWaal, Hernandez, and Sandman (2012) and this the study indicate most clergy can recognize serious mental health issues. Bohnert et al., in 2010, argued that clergy are considered a free, credible, less stigmatized, and comfortable resources for discussing mental issues. This study showed similar findings expressed by clergy as they believed members could not afford mental health services and were more comfortable with clergy due to the stigma attached to seeking therapy. Despite this there is concern as many clergy

still express beliefs that persons with a serious mental health challenge could be possessed by demons; yet, clergy readily deny that individuals are imagining mental health problems. While clergy do seek training in theological studies, results still show that many lack the advanced or specialized training as discussed by Payne (2009). While perceived differently by clergy, further clarification is needed regarding being mentally possessed. It may be beneficial for clergy to have a clear understanding of the complexity of symptoms and triggers of mental illness.

Survey findings correlate with the 2011 suggestions by Stanford and Philpott, which express biological influences for mental illness are greater than psychosocial or spiritual factors. Clergy expressed similar strong beliefs that there is a biological or physical basis for mental health challenges and would not encourage a church member to stop taking medication for a mental health challenge in favor of seeking spiritual healing. Also, it is important to note that clergy responded with beliefs that a church member does not often lack faith when they are going through a mental health challenge. This understanding of mental illness may be beneficial for clergy as they continue to provide support for congregants in reducing stigma associated with mental health. The recognition of a biological or physical basis for mental health resulted in clergy having a high willingness to refer to a physician or hospital.

Findings by Wood (2011) advised that clergy showed a greater willingness to provide parishioners with referrals for anxiety, depression, and suicidal thoughts more than faith, self-harm, and delusions. Results from the study indicate that clergy are more apt to provide referrals for depression, and anxiety; moreover, for nervous breakdowns, domestic violence, sexual abuse, and addiction. Clergy's low willingness to provide referrals for parenting, life, racism/discrimination, and work are slightly concerning as these can lead to further mental issues and can impede the overall effectiveness of support.

The discrepancy in training among clergy still exist – pastoral care is not a substitute for mental health. Clergy believe church members usually feel more comfortable receiving pastoral counseling than going to a mental health professional. Within the study, only 40 percent had theological or pastoral counseling training. This is an increase from Payne's 2009 study that showed only 25 percent of clergy having additional training. Clergy have both more training and can readily identify when to refer a member. Despite this, clergy have little to no referrals within the last six months. As previously stated, clergy who are not exposed to adequate training further disenfranchise congregants by not offering referrals due to increased confidence in their own experiences.

Though willing, clergy show a gap in perceived preparedness and actual referrals to assist with mental illness. Clergy frequently experience substance abuse and marriage/family problems but are only likely to refer for substance abuse. This imbalance in willingness should be examined further. Clergy seem to be comfortable with consulting and collaborations and a preference for a Christian counselor. Thus, clergy are willing to make referrals within their specific beliefs over their race or denomination. Preferences for clergy referral reflect clergy comfortably handle many problems without outside counsel. Clergy should be provided with information on mental health, offering training, and a network of services provided by Christian professionals. Clergy must continue to increase understanding, support, and referrals for congregants with mental health.

Limitations

There are several limitations to this study. First, the sample size was relatively small in comparison to the large target population. Survey participants represent approximately 15 percent of the target population. Second, the survey was only provided to those in the A.M.E. Zion Church. By expanding to various denominations, reported views, perceptions, and referrals could have been dissimilar. Thirdly, terminology in the survey should have been further explained for a broader interpretation by participants. Terms such as mental health, mental health professional, substance abuse professional, counselor, and demon were left to interpretation of clergy. Furthermore, this language limits clergy from making referrals to other professionals that may assist with mental health. Fourth, since clergy were not asked their congregation size or the number of congregants seen with mental illness, it is difficult to understand the scale of referrals. Lastly, clergy responses were limited due to questions being closed answered only. Further conversation with clergy and discussion regarding mental health can assist in understanding their perspectives on mental health.

Conclusion

Serving as spiritual support, clergy have a unique opportunity to influence how their members perceive and handle mental health. Therefore, clergy must be willing to: 1) seek out adequate mental health training that addresses the biological and physical symptoms of mental health, 2) develop a network of trusted support professionals who they identify with, and 3) increase willingness to make referrals to mental health professionals when necessary. Further research is needed to address specific mental illnesses and training needs. By improving in these three areas, clergy ensure the mental wellness of congregants while remaining physicians of the soul and gatekeepers of the mind.

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APPENDIX A: Email Recruitment Prompt

[Date]

Dear Clergy,

Recent research has shown that your role continues to expand as congregants need evolve. Clergy and church leaders are looked to as a source for spiritual care and mental support for the unmet needs of parishioners. Traditionally, the church has served as hospital for the spiritually sick; however, in more recent years it has become a solace for the mentally ill. You are considered physicians of the soul and gatekeepers of the mind. Currently, I am an undergraduate student majoring in Psychology at Livingstone College. For my senior thesis, I will be conducting a survey on Physicians of the Soul, Gatekeepers of the Mind: Perceptions, Willingness, and Preparedness Towards Mental Health Among African American Clergy.

The purpose of this online survey is to examine clergy perceptions regarding mental health, their willingness to refer congregants to mental health professionals, and preparedness in serving congregants with mental illnesses. As both a Christian Educator and Christian worker, I intend for the research to inform both clergy and professionals as to how they can improve awareness and collaboration in mental health.

To participate, you will complete the 57-item survey and a brief demographic questionnaire. The survey will measure your attitude regarding mental illness based upon a series of statements. Completing the survey may take up to 30 minutes. The study was approved by Livingstone College Institution Review Board on November 26, 2016. This email invitation is being sent to you because you have been identified by the Lincolnton District of the Western North Carolina Conference – A. M.E. Zion Church as a clergy. To participate, you must meet the following requirements:

- Be an identified clergy (pastors, ministers, local preachers, elders, or deacons) in the A.M.E. Zion Church
- At least 18 years of age
- Understanding English
- currently have an accessible e-mail address.

Your participation is completely voluntary and anonymous. You may withdraw from the study at any given time. No significant risk to your safety or wellness have been identified. As a benefit of your participation, the results of this study will provide date for improving the relationship between clergy, congregants, and mental health professionals. Approximately 15 clergy will be participating in this study. All identifying personal information from the directory list will remain separate from the collected data. All collected data will be collected anonymously via online service. Only researchers and authorized accountability representatives from Livingston College may review the data. I hope the result will help you begin the conversation regarding mental health training in your local church. To complete the survey, please go to the following research survey link, which will lead you fist to the informed consent document.

Thank you for your contribution and consideration,
Angellica S. Sweat

APPENDIX B: Informed Consent Form

The purpose of this 57- item online survey is to examine clergy perceptions regarding mental health, their willingness to refer congregants to mental health professionals, and preparedness in serving congregants with mental illnesses. want to know how you feel about mental health services.

Investigator(s)
Angellica Sweat, Livingstone College

Eligibility Criteria: You are eligible if you are clergy within the A.M.E. Zion Church, are over the age of 18, ability to answer survey questions in English, or have an accessible e-mail address.

Exclusion Criteria: You are ineligible if you are not clergy within the A.M.E. Zion Church, are under the age of 18, inability to answer survey questions in English, or did not have an accessible e-mail address.

If you agree to be in this study, you will clink the link button at the end of the study which shows your willingness to participate in the study. You will then be directed to complete a demographic questionnaire and a 57-item survey online. The survey will examine your attitude regarding mental health based on your agreements with the statements. The survey should take about 30 minutes. This study has been approved by Livingstone College Institutional Review Board on … and will expire on….

Risks and Benefits of Participation
Only minimal risk is associated with this research; participants will discuss their experiences and perceptions about mental health. There is no other anticipated risk beyond the risk one could incur when reviewing personal experiences. All opinions are valid and welcome

- As a benefit of your participation, the results of this study will provide date for improving the relationship between clergy, congregants, and mental health professionals.

Volunteer Statement
You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may stop at any time. You will not be treated any differently if you decide not to participate in the study or if you stop once you have started.

Confidentiality Statement

The following steps will be taken to keep all confidential information as secure as possible:

- Digitally records are anonymous and will be coded so that no personally identifying information is available; they will be kept in a secure place (a locked file cabinet in the investigator's office); and they will be viewed only for research purposes by Angellica Sweat. Data may be retained for possible future analysis. When analysis is complete, the responses will be erased or destroyed.

- Authorized persons from Livingstone College, members of the Institutional Review Board, and study sponsors have the legal right to review your research records and will protect the confidentiality of those records to the extent permitted by law. The final report and all ensuing publications will exclude any information that will make it possible to identify you as a subject.

Information or quotes that are recorded will be presented in a manner so that they will not be attributed to a specific individual. Pseudonyms will be used and specific details that might be revealing will be disguised.

If you have any questions about the actual project or study, please contact Angellica Sweat.

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am 18 years of age and agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the principal investigator of this research study.

_____

Participant Digital Signature (Last Name Date (00/00/00)

_____ _____

Investigator Signature **DATE**

APPENDIX C:
Physicians of the Soul, Gatekeepers of the Mind: Perceptions, Willingness, and Preparedness Towards Mental Health Among African-American Clergy Survey
Available on November 26, 2016, via https://goo.gl/forms/vpKSLdM8MjwOn70n1

Demographics

Sex
Male
Female
Prefer not to say

Race/Ethnicity
Black/African American
White/Caucasian
Hispanic/Latino
Other...

Age
18-29
30-49
50-64
65+

Education
GED/ HS Diploma
Some college
Associates
Bachelors
Masters / MDiv
PhD, DMin, MD, JD
Other _____

Years in Ministry
Less than 5 years
5-10 years
11-20 years
21-30 years
31+ years

Clergy Role
Bishop
Pastor
Ordained Elder
Ordained Deacon
Local Preacher
Other: _____

Church Location
Short answer _____

Have you completed any advance training for mental health? If so, please list your credentials.
I.e., Certification, Licensure, or any formal training. If not applicable, please enter N/A
Short answer _____

APPENDIX C:
Knowledge and Beliefs about Mental Health

Options for Answer: Strongly Disagree, Disagree, Not Sure, Agree, Strongly Agree

Question 1.
I can recognize a person with a serious mental health challenge.

Question 2.
I believe that persons with a serious mental health challenge could be possessed by demons.

Question 3.
I believe that persons with mental health challenges are often imagining their problems.

Question 4.
I believe there is a biological or physical basis for mental health challenges.

Question 5.
I would encourage a church member to stop taking medication for a mental health challenge in favor of seeking spiritual healing.

Question 6.
I believe that a church member often lacks faith when they are going through a mental health challenge.

Question 7.
I have not referred church members to mental health services because of fears that confidentiality may be broken.

Question 8.
I believe that church members often cannot afford mental health services.

Question 9.
I believe church members usually feel more comfortable receiving pastoral counseling than going to a mental health professional.

Question 10.
I believe that church members may choose not to seek mental health services because of the stigma attached to seeking therapy.

APPENDIX C:
Problem Areas

In my role as clergy, I encounter the following problems with church members or people in the community:

Options for Answer: Almost Never, A few times a year, Monthly, Weekly, Almost Daily

Area 1.
Mental Health Challenges

Area 2.
Substance Abuse Problems

Area 3.
Violence (Family or Community)

Area 4.
Sexual Abuse

Area 5.
Marriage and Family Problems

Willingness to Refer Church Members to Counselor

In my role as clergy, I would be likely willing to refer church members to a mental health professional (counselor) if they have problems with...

Options for Answer: Low, Moderate or High Level of Willingness

Problem 1.
Nervous Breakdown

Problem 2.
Domestic Violence

Problem 3.
Sexual Abuse

Problem 4.
Depression

Problem 5.
Alcohol/Drug Addiction

Problem 6.
Anger

Problem 7.
Anxiety

Problem 8.
Marital Relationships

Problem 9.
Parenting

Problem 10.
Adjusting to Life

Problem 11.
Racism/Discrimination

Problem 12.
Finances

Problem 13.
Work

Preferences for Consulting, Collaboration, and Referral Relationships

In my role as clergy, I encounter the following problems with church members or people in the community:

Options for Answer: Not likely at all, Unlikely, Not sure, Likely, Very likely

Statement 1.
I would allow a mental health professional to present a seminar in my church.

Statement 2.
I would allow a mental health professional to lead a support group in my church.

Statement 3.
I would allow a mental health professional to have an office in my church.

Statement 4.
I would welcome the invitation to work together on a community service outreach project with a mental health professional.

Statement 5.
I feel my role as a pastor or leader would be compromised or devalued by the involvement of a mental health professional within the congregation.

Statement 6.
As a pastor, I would consult with a mental health professional about a church member's mental health issue.

Statement 7.
I would consider making a referral to a mental health professional when the circumstances are beyond the scope of my knowledge and/or expertise.

Statement 8.
I would prefer consulting with a mental health professional who is the same ethnicity as me.

Preferences Regarding Religious and Ethnic/Racial Characteristics of Referral Professionals

If you were to refer someone to a professional counselor for substance abuse or mental health challenges, how important is it that the counselor is...

Options for Answer: Not important at all, Somewhat important, Not sure, Important, Very important

Preference 1.
... is Christian?

Preference 2.
... is the same denomination as you?

Preference 3.
... has the same ethnic or racial background as your church member?

Clergy Response to Persons with a Serious Mental Health Challenge

If one of your church members or persons you know was experiencing a serious mental health challenge, how likely would you be to do the following:

Options for Answer: Not likely at all, Unlikely, Not sure, Likely, Very likely

Option 1.
Give them prayer and spiritual counseling only.

Option 2.
Refer them to a hospital emergency room.

Option 3.
Refer them to a medical doctor.

Option 4.
Refer them to a mental health counselor.

Option 5.
Refer them to another pastor who has more training or experience

Frequency of Referrals to Mental Health Counselor or Counseling Services

In the past 6 months, approximately how many people have you referred to a local mental health counselor or counseling center?

0 persons
1-5 persons
6-10 persons
11-15 persons
16-20 persons
More than 20 persons

Frequency of Referrals to Substance Abuse Counselor or Drug or Alcohol Treatment Center

In the past 6 months, approximately how many people have you referred to a local substance abuse counselor or drug or alcohol treatment center?

0 persons
1-5 persons
6-10 persons
11-15 persons
16-20 persons
More than 20 persons

APPENDIX D:

Table 1: Demographics

Characteristic	N (%)
Sex	
Male	7 (46.7)
Female	8 (53.3)
Race	
Black/African American	15 (100)
Age	
18-29	2 (13.3)
30-49	5 (33.3)
50-64	7 (46.7)
65+	1 (6.7)
Education	
GED/ HS Diploma	1 (6.7)
Some College	3 (20)
Associate	2 (13.3)
Bachelor	3 (20)
Master / MDiv	4 (26.7)
PhD, DMin, MD, JD	2 (13.3)
Clergy Role	
Pastor	9 (60)
Ordained Deacon	1 (6.7)
Local Preacher	5 (33.3)
Years in Ministry	
Less than 5 years	3 (20)
5-10 years	3 (20)
11-20 years	5 (33.3)
21-30 years	3 (20)
31+ years	1 (6.7)
Church Location	
Illinois (*Chicago*)	1 (6.7)
Missouri (*St. Louis*)	1 (6.7)
North Carolina (*Belmont, Bessemer City, Cherryville, Gastonia, Kings Mountain, Lincolnton*)	12 (80)
Texas (*Houston*)	1 (6.7)
Advanced Training	
Yes (*Associate Professional, MA in Counseling, EdS in Mental Health Counseling, NCI and BBP training*)	6 (40)
N/A or No	9 (60)

APPENDIX D:

Table 2: Knowledge and Beliefs*

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I can recognize a person with a serious mental health challenge.	0 (0%)	1 (6.7%)	2 (13.3%)	8 (53.3%)	4 (26.7%)
2. I believe that persons with a serious mental health challenge could be possessed by demons.	1 (6.7%)	4 (26.7%)	3 (20%)	6 (40%)	1 (6.7%)
3. I believe that persons with mental health challenges are often imagining their problems.	3 (20%)	8 (53.3%)	2 (13.3%)	2 (13.3%)	0 (0%)
4. I believe there is a biological or physical basis for mental health challenges.	0 (0%)	1 (6.7%)	1 (6.7%)	8 (53.3%)	5 (33.3%)
5. I would encourage a church member to stop taking medication for a mental health challenge in favor of seeking spiritual healing.	8 (53.3%)	6 (40%)	0 (0%)	0 (0%)	1 (6.7%)
6. I believe that a church member often lacks faith when they are going through a mental health challenge.	5 (33.3%)	8 (53.3%)	1 (6.7%)	1 (6.7%)	0 (0%)
7. I have not referred church members to mental health services because of fears that confidentiality may be broken.	7 (46.7%)	5 (33.3%)	1 (6.7%)	2 (13.3%)	0 (0%)
8. I believe that church members often cannot afford mental health services.	3 (20%)	1 (6.7%)	3 (20%)	6 (40%)	2 (13.3%)
9. I believe church members usually feel more comfortable receiving pastoral counseling than going to a mental health professional.	1 (6.7%)	0 (0%)	2 (13.3%)	9 (60%)	3 (20%)
10. I believe that church members may choose not to seek mental health services because of the stigma attached to seeking therapy.	0 (0%)	2 (13.3%)	0 (0%)	3 (20%)	10 (66.7%)

* Shaded areas indicate highest percentage per statement

APPENDIX D:

Table 3: Problem Areas Identified by Clergy *

In my role as a pastor, I encounter the following problems with church members of people in the community:	**Almost Never**	**A Few Times A Year**	**Monthly**	**Weekly**	**Almost Every Day**
1. Mental Health Challenges	4 (26.7%)	7 (46.7%)	2 (13.3%)	2 (13.3%)	0 (0%)
2. Substance Abuse Problems	2 (13.3%)	3 (20%)	3 (20%)	5 (33.3%)	2 (13.3%)
3. Violence (family or community)	5 (33.3%)	7 (46.7%)	1 (6.7%)	1 (6.7%)	1 (6.7%)
4. Sexual Abuse	6 (40%)	8 (53.3%)	0 (0%)	0 (0%)	1 (6.7%)
5. Marriage and Family problems	3 (20%)	3 (20%)	2 (13.3%)	5 (33.3%)	2 (13.3%)

* Shaded areas indicate highest percentage per statement

Table 4: Willingness to Refer Church Member to Counselor *

	High Willingness	**Moderate Willingness**	**Low Willingness**
1. Nervous Breakdown	8 (53.3%)	6 (40%)	1 (6.7%)
2. Domestic Violence	13 (86.7%)	2 (13.3%)	0 (0%)
3. Sexual Abuse	14 (93.3%)	1 (6.7%)	0 (0%)
4. Depression	12 (80%)	3 (20%)	0 (0%)
5. Alcohol / Drug Addiction	11 (73.3%)	4 (26.7%)	0 (0%)
6. Anger	7 (46.7%)	7 (46.7%)	1 (6.7%)
7. Anxiety	4 (26.7%)	10 (66.7%)	1 (6.75%)
8. Marital Relationship	3 (20%)	10 (66.7%)	2 (13.3%)
9. Parenting	3 (20%)	6 (40%)	6 (40%)
10. Adjusting to Life	3 (20%)	6 (40%)	6 (40%)
11. Racism / Discrimination	3 (20%)	5 (33.3%)	7 (46.7%)
12. Finances	5 (33.3%)	6 (40%)	4 (26.7%)
13. Work	4 (26.7%)	5 (33.3%)	6 (40%)

* Shaded areas indicate highest percentage per statement

APPENDIX D:

Table 5: Preferences for Consulting, Collaboration, and Referral Relationship *

	Not likely at all	Unlikely	Not sure	Likely	Very likely
1. I would allow a mental health professional to present a seminar in my church.	0 (0%)	0 (0%)	0 (0%)	6 (40%)	9 (60%)
2. I would allow a mental health professional to lead a support group in my church.	0 (0%)	0 (0%)	0 (0%)	6 (40%)	9 (60%)
3. I would allow a mental health professional to have an office in my church.	1 (6.7%)	1 (6.7%)	4 (26.7%)	3 (20%)	6 (40%)
4. I would welcome the invitation to work together on a community service outreach project with a mental health professional.	0 (0%)	0 (0%)	0 (0%)	5 (33.3%)	10 (66.7%)
5. I feel my role as a pastor or leader would be compromised or devalued by the involvement of a mental health professional within the congregation.	10 (66.7%)	1 (6.7%)	4 (26.7%)	0 (0%)	0 (0%)
6. As a pastor, I would consult with a mental health professional about a church member's mental health issue.	1 (6.7%)	0 (0%)	3 (20%)	6 (40%)	5 (33.3%)
7. I would consider making a referral to a mental health professional when the circumstances are beyond the scope of my knowledge and/or expertise.	0 (0%)	0 (0%)	0 (0%)	2 (13.3%)	13 (86.7%)
8. I would prefer consulting with a mental health professional who is the same ethnicity as me.	6 (40%)	5 (33.3%)	1 (6.7%)	2 (13.3%)	1 (6.7%)

* Shaded areas indicate highest percentage per statement

APPENDIX D:

Table 6: Clergy Preferences Regarding Religious and Ethnic/Racial Characteristics of Referral Professionals *

If you were to refer someone to a professional counselor for substance abuse or mental health challenges, how important is it that the counselor is…	**Not important at all**	**Somewhat important**	**Not sure**	**Important**	**Very important**
1. …is a Christian?	0 (0%)	2 (13.3%)	1 (6.7%)	7 (46.7%)	5 (33.3%)
2. … is the same denomination as your church?	14 (93.3%)	1 (6.7%)	0 (0%)	0 (0%)	0 (0%)
3. … has the same ethnic or racial background as you?	10 (66.7%)	2 (13.3%)	0 (0%)	3 (20%)	0 (0%)

* Shaded areas indicate highest percentage per statement

Table 7: Clergy Response to Person with a Serious Mental Health Challenge *

If one of your church members or persons you know was experiencing a serious mental health challenge, how likely would you be to do the following:	**Not likely at all**	**Unlikely**	**Not sure**	**Likely**	**Very likely**
1. Give them prayer and spiritual counseling only.	2 (13.3%)	8 (53.3%)	1 (6.7%)	1 (6.7%)	3 (20%)
2. Refer them to a hospital emergency room.	0 (0%)	0 (0%)	5 (33.3%)	3 (20%)	7 (46.7%)
3. Refer them to a medical doctor.	0 (0%)	1 (6.7%)	4 (26.7%)	7 (46.7%)	3 (20%)
4. Refer them to a mental health counselor.	0 (0%)	0 (0%)	0 (0%)	4 (26.7%)	11 (73.3%)
5. Refer them to another pastor who has more training or experience.	1 (6.7%)	2 (13.3%)	2 (13.3%)	6 (40%)	4 (26.7%)

* Shaded areas indicate highest percentage per statement

APPENDIX D:

Table 8: Frequency of Referrals to Mental Health Counselor or Counseling Center

In the past 6 months, approximately how many people have you referred to a local mental health counselor or counseling center?	**N (%)**
0 persons	7 (46.7%)
1-5 persons	6 (40%)
6-10 persons	0 (0%)
11-15 persons	0 (0%)
16-20 persons	0 (0%)
More than 20 persons	2 (13.3%)

Table 9: Frequency of Referrals to Substance Abuse Counselor or Alcohol Treatment Center

In the past 6 months, approximately how many people have you referred to a substance abuse counselor or alcohol treatment center?	**N (%)**
0 persons	9 (60%)
1-5 persons	4 (26.7%)
6-10 persons	0 (0%)
11-15 persons	0 (0%)
16-20 persons	0 (0%)
More than 20 persons	2 (13.3%)