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Innovative Ways to Address Mental Health Needs of African Americans: An Exploratory Study Examining the Importance of Understanding How African American Clergy Conceptualize and Attribute Causation of Mental Illness

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Innovative Ways to Address Mental Health Needs of African Americans: An Exploratory Study Examining the Importance of Understanding How African American Clergy Conceptualize and Attribute Causation of Mental Illness

by

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Dedication

To my mother, Inetha G. Farris, for her constant love, support, and prayers throughout my life.

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Innovative Ways to Address Mental Health Needs of African Americans: An Exploratory Study Examining the Importance of Understanding How African American Clergy Conceptualize and Attribute Causation of Mental Illness

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The purpose of this study is to examine how African American clergy conceptualize and attribute causation of mental illness and how these factors affect their ability to respond and provide services to individuals seeking help with mental illness. This study focuses on clergy's ability to recognize mental illness, the cause they attribute to the mental illness presented, and their perceived ability to provide assistance as well as their decision-making process used in the type of assistance they would provide to individuals in need of help. A convenience sample of African American clergy members and seminary students were given the Clergy's Perception of Mental Illness Survey (CPMI), which was developed with various instruments. The CPMI had three sections: (1) the demographic section, (2) presentation of vignettes and follow-up questions regarding causal attribution, decision-making, and beliefs about ability level, and (3)

additional questions. A total of 2,970 potential participants were contacted; however, only 125 complete and usable surveys were returned.

A hierarchical multiple regression analysis was used to examine the relationship between the variables conceptualization and causal attribution and the variables belief about ability level and decision making processes. Out of seven hypotheses explored, only one hypothesis was found to be statistically significant. Clergy who attributed cause to spiritual reasons or other life circumstances were more likely to have attempted to advise in a spiritual manner. Additionally, a direct relationship was found between the individual variable type of degree seeking and attempting to advise in a spiritual manner suggesting that participants seeking higher degrees were more likely to advise in a spiritual manner. A direct relationship was also found between attributing cause to spiritual or other life circumstances were more likely to advise in a spiritual manner.

Due to the exploratory nature of the study and the absence of an abundance of literature related to this area, a theoretical framework was provided to show the importance of continued research in this area. The exploratory nature of the study is noted as one of numerous limitations of this study. Implications of social work education, practice, research, and policy are discussed in detail.

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CHAPTER 1

INTRODUCTION

For years, researchers have examined where individuals in crisis tend to seek help. One of the initial explorations was the 1960 National Interview Survey, presented in the monograph, *Americans View Their Mental Health* (Gurin, Veroff & Feld, 1960). They found that 42% of survey participants reported seeking help from clergymen for mental health problems. Many of these earlier studies did not seek to determine if race influenced where individuals sought help. In recent years, researchers have also examined where African Americans tend to seek help due to the disparity in the use of specialty mental health services by this population.

When specifically focusing on African Americans, data from Waves II (1987-1988), III (1988-1989), and IV (1992) of the National Survey of Black Americans (NSBA) examined the frequency of formal resource usage in this population. Respondents to the survey were asked to indicate whether they had ever gone to a number of places or organizations for help including: hospital emergency room, medical clinic, social services or welfare agency, mental health center, private therapist, doctor's office, ministers or someone else in their place of worship. Findings were consistent across all three waves of data revealing the most frequently mentioned sources of assistance as the doctor's office (Wave II – 33.5%; Wave III – 25.4%; Wave IV – 33.3%) and the minister or someone else at a place of worship (Wave II – 32.2%; Wave III – 26.9%; Wave IV – 32.2%) (Taylor, Chatters, & Levin, 2004). These findings are consistent with the finding that African American clergy are often recognized as key

figures in the African American community as well as one of the first persons contacted by individuals in need of help (Neighbors, 2003).

STATEMENT OF THE PROBLEM

In times of crisis, many African Americans do not seek help from professional service providers; instead, they seek help first from African American clergy. Neighbors, Musick, & Williams (1998) note that data from the NSBA show that, when in distress, African Americans rely heavily on various alternative help resources, within social networks, to compensate for the perceived lack of access to specialty mental health resources and reluctance held by many to use the resources. Additionally, the NSBA (2003) conducted by Taylor and Chatters, which examined mental health and help-seeking among African Americans, found that when the need for treatment is defined by the presence of psychopathology, African Americans underutilize mental health services. Instead, African Americans tend to seek help through more informal social networks. For some, these social networks typically include individuals and settings considered as informal sources of support, specifically the church and church leaders, especially African American clergy. Therefore, African American clergy play a key role in meeting the needs of African American individuals, families, and communities, including caregivers and consumers.

Neighbors (2003) points out that African American clergy are positioned to play two critical roles in mental health care. He states, "…first, pastors are the first and possibly the only resource that an individual or family may contact for help. Second, pastors are in the position of being counselors or advisors with respect to mental and physical health needs" (Neighbors, 2003). Regardless of attempts to make mental health services more culturally relevant, Neighbors (2003) notes that most African Americans do not seek help through professional services. As highly respected community leaders,

he also notes that "…it makes sense that African American pastors are one of the first sources contacted by African Americans in psychological distress. Therefore, it is important to establish an accurate description of the role that African American pastors play in mental health" (Neighbors, 2003).

While the aforementioned literature points out that African American clergy are among those sought out first for help, acknowledging the importance of understanding the role that clergy play in mental health, it is also important to note that there is little known about the approach or content provided by clergy when approached for help. Are clergy providing services similar to mental health professionals? Do they place greater emphasis on spirituality and religious practices in suggestions for addressing mental health issues? Are there methods effective?

There has been little research regarding collaborative efforts between religious organizations, including the church and clergy, and formal mental health delivery systems, particularly the role of African American clergy as gatekeepers or sole service providers. The quality of mental health services provided by clergy, the use of clergy as referral sources to mental health delivery system and the efficacy of their referrals have been questioned (Neighbors, Musick, & Williams, 1998; Pickett-Schneck, 2002). Also, of great importance is developing an understanding of how African American clergy conceptualize mental illness and their beliefs regarding causation.

This study will examine how clergy conceptualize and attribute causation of mental illness and how these factors affect their ability to respond and provide services to individuals seeking help with mental illness. Examining the clergy's understanding of mental illness may provide insight into such decision-making processes including providing referrals to other sources, attempting to provide services, or providing other recommendations. Examining their beliefs about causation, such as biological or

environmental causes, demonic possession or supernatural causes, or other beliefs, may provide insight into attitudes held by clergy about mentally ill individuals and the effects on their decision-making.

PURPOSE OF THE STUDY

In this dissertation, the problem under study is to determine how African American clergy conceptualize and attribute causation of mental illness and how these factors affect the services provided to individuals that come for help with mental illness. Research questions that will be examined in this dissertation include the following:

(1) When presented with mental health/illness issues, are African American clergy able to recognize and attribute causation of the issue presented?

(2) What are African American clergy's beliefs regarding their ability to provide services for individuals in need of help?

(3) Are there certain demographic characteristics that influence outcomes of how clergy conceptualize and attribute causation of mental illness?

There is a paucity of literature examining how clergy conceptualize and attribute causation of mental illness. This area warrants further investigation especially in the African American community where it has been acknowledged that the Black church and African American clergy maintain a high degree of respect and trust and are among the first places and persons sought out for help. It is hoped that findings from this dissertation will not only contribute to the knowledge base but also increase discussion in an area often considered sensitive, especially for African Americans experiencing mental illness.

There have been many discussions in the literature of help-seeking, stigma, and service use by African Americans in the field of mental health. The literature presented will support the belief that clergy are among those being initially sought out for help in

dealing with mental illness issues. The findings within the literature will also support the importance of developing an understanding of how clergy's ability to recognize and attribute causation of mental illness affects their ability to respond and provide services to individuals seeking help for mental illness. Societal issues such as mental health and mental illness, the acceptance/non-acceptance of gays and lesbians, and the significant and continuous rise of HIV/AIDS are sensitive issues within the African American community as well as the Black church. Understanding culture may also affect the role of religious beliefs and perceptions of mental illness and the aforementioned societal issues (Morrison & Thornton, 1999).

Previous studies have examined how education and type of training affect mental health values, specifically open-mindedness versus closed-mindedness, of clergy (Gottlieb & Olfson, 1987; Mobley, Katz, & Elkins, 1985). While other studies have compared perceptions of clergy and their parishioners on the ability of the clergy to address mental health concerns (Kane, 2003; Kane & Willliams, 2000) as well as attitudes of Christians toward mental health interventions in the church (Kunst, 1993). Also, other studies have examined how clergy identify serious mental health problems and their willingness to refer (Taylor et al., 2000) and types of services that African American clergy provide, specifically focusing on type of training received, referral patterns, and the use/non-use of theological beliefs in the services they provide (Mollica et al., 1986). Only one study focused on conceptualizations of clergy; however, this study was specifically related to Korean-American clergy and their referral intent when approached for help (Kim-Goh, 1993). No literature was found specifically focusing on conceptualization and causal attributions of mental illness by African American clergy.

It is believed that this study will assist in providing a more in-depth understanding of the types of mental health issues that clergy recognize, their beliefs about causation,

and the types of services they offer. Specifically, it is hoped that a greater understanding will be developed regarding self-imposed limitations that may be held by clergy when approached for help. While it is believed that individuals are entitled to their own beliefs and core values, mental illness is a potentially life-altering condition with serious consequences to individuals dealing with mental illness as well as those in contact with the individuals. The quality of an individual's life seeking help from a member of the clergy could be affected in a positive or negative way, in turn leading to an outcome that shows an improvement, deterioration in that person's life, or possibly no change at all.

SIGNIFICANCE FOR SOCIAL WORK AND MENTAL HEALTH

Previous literature has suggested collaboration between social workers, social service agencies, churches and clergy members (Williams, 1994; Taylor et al., 2000) to assist African Americans in need of help; however, with the acknowledgment of lack of service use by African Americans and the disconnectedness between clergy and social service agencies, the social work profession may need to consider alternative approaches to address the mental health concerns of African Americans. It is hoped that examining this area will give social work an opportunity to learn more about what clergy are offering to individuals that come to them for help, a greater insight into their beliefs, and how what they are offering affects the individual's quality of life. With respect to understanding culture, the social work profession should consider "thinking outside of the box" in order to gain a more thorough understanding of culture. The role of culture may be more easily understood if thought of in terms the important roles of religion, religious participation, and spirituality play in the lives of African Americans.

Re-opening the dialogue on recognizing the importance of addressing spirituality and religiosity with African Americans and potential improvement of mental health outcomes is also thought to be a path to building upon the social work knowledge base

for education, practice, research and policy. This study attempts to offer social work an alternative view for seeking solutions.

As suggested by Edwards, Lim, McMinn, and Dominquez (1999) with regard to collaboration between psychologists and clergy, acknowledging common values and perspectives may encourage the possibility of shared dialogue. The authors note that both professions value self-evaluation and good interpersonal relationships, help people assign meaning to life circumstances, assist in the restorative process in others' lives, and empower individuals to function to their potential (Edwards et al., 1999). They recognize that as healthcare becomes increasingly multifaceted, multidisciplinary collaboration is regarded as a professional imperative (Edwards et al., 1999). As this study attempts to build on the knowledge base of the role of African American clergy addressing mental illness, it also has the potential for opening the door for discussion about understanding culture and diversity, as well as recognizing that true commitment to diversity in the field of mental health, effective practice and teaching strategies must consider the significance of identifying innovative solutions to helping those in need.

CHAPTER 2

LITERATURE REVIEW

This chapter examines previous research related to understanding the mental health needs of African Americans. A brief description of mental health statistics, along with prevalence studies discussing racial variations of mental illness and the receipt of treatment is presented. This is followed by a discussion of the significance of numerous issues that must be considered when examining why African Americans seek help from clergy and the importance of understanding how African American clergy conceptualize and attribute causation of mental illness. The conceptual framework guiding this study is discussed at the end of the chapter.

MENTAL HEALTH STATISTICS

In 2003, the National Survey on Drug Use and Health (NSDUH) reported that an estimated 19.6 million adults, ages 18 or older, had a serious mental illness representing 9.2 percent of all adults. This rate is higher than the rate of 8.3 percent in 2002. The NSDUH (2003) also reported that 8.4 percent of individuals with a serious mental illness were African American adults, ages 18 or older. In 2001, the Surgeon General's supplement report, *Culture, Race, and Ethnicity*, showed that approximately 12% (33.9 million individuals) of the United States population identified themselves as African American.

Previous studies examining the prevalence of serious mental illness in African Americans, including the National Comorbidity Study (NCS) and Epidemiologic Catchment Area (ECA) study showed that while there are existing variations for some disorders, the frequency of serious mental illness in African Americans was almost

comparable to that of Whites, with the exceptions of schizophrenia and phobias. For example, results of the ECA showed that 12-month occurrences of major depression were 2.2% for African Americans vs. 2.8% for Whites, and panic disorders were 1.0% for African Americans vs. 0.9% for Whites. Phobic disorders were higher among African Americans than Whites (16.2% vs. 9.1%, respectively). Results of the NCS showed that 12-month occurrences of major depression among African Americans were 8.2% vs. 9.9% for Whites, and panic disorders among African Americans were 1.1% vs. 2.4% for Whites. Phobic disorders were almost comparable (14.5% vs. 14.8%, respectively). Table 1-1 shows these results.

Table 1-1. Results of the ECA and NCS studies – 12 month occurrences

	ECA		NCS	
	African Americans	Whites	African Americans	Whites
12-month	%	%	%	%
Major Depression	2.2	2.8	8.2	9.9
Panic Disorders	1.0	0.9	1.1	2.4
Phobic Disorders	16.2	9.1	14.5	14.8

The findings of the NCS show that even without controlling for demographic and socioeconomic differences: African Americans had a lower lifetime prevalence of four specific types of mental illness than Whites (major depression – 11.6% of African Americans vs. 17.7% of Whites; dysthymia – 5.4% of African Americans vs. 6.7% of Whites; panic disorders – 1.4% of African Americans vs. 3.9% of Whites; phobic disorders – 19.2% of African Americans vs. 22.3% of Whites). Table 1-2 shows these results.

Table 1-2. Results of the NCS studies – Lifetime Prevalence

NCS		
	African Americans	Whites
Lifetime	%	%
Major Depression	11.6	17.7
Dysthmia	5.4	6.7
Panic Disorders	1.4	3.9
Phobic Disorders	19.2	22.3

However, this finding is subject to be challenged due to the overrepresentation of African Americans in high need populations, including psychiatric hospitals, prisons, the inner city, and poor rural areas that were not surveyed by researchers for accessibility reasons. The inclusion of the high need populations could increase the rates of mental illness among African Americans. The NCS also revealed that African Americans with serious mental illnesses are significantly less likely than Whites to seek treatment for mental health related problems (Neighbors, Musick, & Williams, 1998). This revelation leads to the question of whether African Americans in need of help recognize or know what the symptoms of mental illness are, how to evaluate their severity, or where to seek help.

The findings of the ECA study showed that African Americans suffer from higher rates of mental illness than Whites, with the differences being explained by the demographic composition of the groups. According to the ECA, African Americans had higher levels of any lifetime or current disorder than Whites. However, after accounting for differences in age, gender, marital status, and SES, the differences between African Americans and Whites were eliminated. The Surgeon General's report (2001) notes that results from these two epidemiological studies appear to agree that rates of mental illness

among African Americans are similar to those of Whites. The findings in those studies demonstrate the existence of disparities in terms of services for individuals of color, the limited knowledge about mental illness and culture, and the greater level of burden potentially faced by individuals of color due to unmet needs (Davis, 2001).

HELP-SEEKING BEHAVIORS AND AFRICAN AMERICANS

Historically, there has been an underutilization of mental health services by African Americans due in part to distrust of the mental health service system, lack of available community mental health resources, misdiagnosis of psychiatric symptoms, stigma, and low levels of knowledge in understanding the etiology of mental illness (Neighbors & Jackson, 1984; Pickett-Schneck, 2002). This may be related to the fact that cultural differences play a major role in use of mental health services (Biegel, Johnsen, & Shafran, 1997; Pickett-Schneck, 2002). Previous literature has focused on barriers to specific groups in regards to service delivery systems. Snowden, Collinge, & Runkle (1982) state

> "…the question of why potential clients do not become actual clients is considerably more complicated than is often recognized. Behind any potential episode of professional help is a background of perceptions, judgments, and actions, all moving the person toward or away from contact with services" (p.281).

Understanding reasons for underutilization of mental health services and help-seeking behaviors by African Americans is of great importance in relation to understanding the important role of African Americans clergy as providers of mental health services to their parishioners and others that come to them for help.

The theory of "help-seeking" has been examined in relation to how individuals choose to utilize services from health and mental health care, and other formal organizations (Snowden, Collinge, & Runkle, 1982). Gourash (1978) defines help-

seeking as "…any communication about a problem or troublesome event that is directed toward obtaining support, advice, or assistance in times of distress". Poole and Salgado de Snyder (2002), discuss help-seeking as a theory stating that "according to theory, people usually first try to remedy a symptom through *self-care*. They attribute the symptom to a physical or psychological problem, evaluate the severity of their pain and suffering, and apply their own knowledge of healing remedies" (p.51).

Veroff et al. (1981) modify how the term help-seeking is applied from the use or non-use of professional services to an individual's readiness for self-referral. They identify three decision points related to readiness for self-referral including: (a) defining the problem in mental health terms versus other terms; (b) seeking help versus not seeking help; and (c) choosing other alternative potential sources of help. Gourash (1978) also provides three major themes that occur in help-seeking including individuals who seek help, the role of social networks, and outcomes of help-seeking actions focusing on demographic characteristics. The author reports a difference by age and race of those that do not seek help, accepting that as people get older they seek help less, especially among African Americans. Another factor that influences help-seeking behaviors is the existence of social network relationships. It is presumed that many individuals undergoing stressful life events are inclined to seek help first from natural support systems, turning to formal organizations as the last option (Gourash, 1978).

The significance of social networks in some cases is also utilized when a "problem" is recognized as beyond the level of assistance that is available through the informal system and a decision with the assistance of family, friends, and lay people is made regarding seeking out interventions through formal services. Therefore, examining help seeking behavior has evolved from investigating the use of professional services as a

"discrete act" to a process that is seen as an ongoing process grounded in both personal attitudes and social experiences (Snowden et al, 1982).

Help seeking behaviors have also been examined under the auspices of the concept of help seeking "pathways". Rogler and Cortes (1993) define pathways as "the sequence of contacts with individuals and organizations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts" (p.555). Poole and Salgado de Snyder (2002) add to the definition stating "pathways are structured patterns of interaction with social networks, informal helping systems, and formal sources of care. Psychosocial and cultural factors shape the duration and direction of these pathways" (p.51). Within the help seeking pathways of individuals are social networks of individuals. As previously mentioned, social networks are defined by Rogler and Cortes (1993) as,

> "…a concept that has emerged in research on the utilization of professional mental health care, designates a specific set of linkages among a defined set of persons, with the additional property that the characteristics of the linkages as a whole may be used to interpret the social behavior of the persons involved. However, it is commonly recognized that social networks, as is evident in the family, are suffused with cultural beliefs and serve as vehicles for transmitting them" (p.557).

Rogler and Cortes (1993) quote Friedson (1960) in his theoretical formulation of the notion of social networks in help seeking stating the assumption that "…the whole process of seeking help involves a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant, and authoritative laymen, until the professional is reached" (p.377). Social networks usually consist of biological and extended family members, friends, and others that have an established relationship with the individual or family. When individuals are in need of help, the social network, in many cases, provide counsel, emotional support and financial

assistance, share personal experiences with comparable issues, and suggest ways to stabilize and improve their situation. In many cases, individuals are also connected to help outside of the network (Poole & Salgado de Snyder, 2002).

In understanding the role of social networks, it is also important to identify individuals and services that are included in the network and the importance of their role. For some, particularly African Americans, their social network typically includes individuals and settings that are considered as informal sources of support, specifically the church and informal helpers, which include church leaders, more specifically clergy. This relationship is of particular importance as it is related to the use and non-use of services offered through the mental health delivery system by African Americans.

SERVICE USE BY AFRICAN AMERICANS

The use of the mental health care system by African Americans has been examined by researchers attempting to gain an understanding of the reasons African Americans do not initially use the mental health care system. Snowden (1999) examined racial differences in use of mental health services, specifically specialty mental health and general medical sectors of care. Findings of the Snowden study supported previous research indicating an under-representation of mental health care services by African Americans, highlighting the necessity in accounting for clinical and sociodemographic differences, along with ensuring sampling difficult-to-reach populations. Before data adjustments, findings showed that African Americans were less likely than Whites to have sought help from private practice therapists, mental health centers, and physicians; there were no differences in race in using public sector therapists; and African Americans were more likely than Whites to use emergency room services. After data adjustments, accounting for race and social status, findings showed that African Americans were less likely than Whites to have sought help from any of the sources listed in the study.

Furthermore, the findings showed that inclusion of hard-to-reach populations did not show evidence of overrepresentation in treatment, instead indicating a lesser degree of underutilization. Explanation of these findings includes duplicate reporting due to recidivism and regional sampling bias. An excluded population of interest is the homeless, which also leads to an underestimation of service use. African Americans who have undergone mental health treatment are more likely than Whites to be confined to jails, prisons, and mental hospitals, and are more likely to be homeless (Snowden, 1999).

The Surgeon General's Report on Mental Health (2001) also discussed service use patterns. Findings showed that African Americans exhibited an underutilization of outpatient treatment services and an overrepresentation in inpatient treatment services. Also, African Americans were more likely to use emergency services, seek treatment from a primary care provider, rather than a mental health professional, or choose to use other sources of support, including family, friends, the church, and clergy. The National Mental Health Association (2000) attributed lower prevalence of seeking treatment to factors, which include a general mistrust of medical professionals, misdiagnosis and inadequate treatment, cultural barriers, co-occurring disorders, socioeconomic factors, and a primary reliance on family and the religious community in times of distress. Additionally, researchers have discussed the lack of community mental health resources, stigma, and low levels of knowledge in understanding the etiology of mental illness (Neighbors & Jackson, 1984; Pickett-Schneck, 2002).

When researchers have previously examined the underutilization of formal support group services by African Americans, similar answers surfaced as those found in the underutilization of other mental health services, including feelings of distrust, lack of available services within the community, and a lack of discussion that incorporates culturally relevant issues (Pickett-Schneck, 2002). In examining patterns of use of

informal and professional assistance, Neighbors and Jackson (1984) found that 43% of their respondents only utilized informal help, 44% of the respondents used a combination of informal and professional help, 4% used only professional support, and nearly 9% did not receive any outside assistance for their problems. The literature suggests that many African Americans use informal services, including an extended network of biological and non-biological kin as well as the church, rather than seeking help from outside organizations (Neighbors & Jackson, 1984; Finley, 1997; Pickett-Schneck, 2002).

As noted thus far, many African Americans use other networks including the church as a source of help for many reasons including mental health problems. Prior to discussing the role of the Black church in the lives of African Americans, an area that also warrants an acknowledgement as important is the role of religion and religious participation by African Americans. Of equal importance is the role of spirituality in the lives of African Americans and distinguishing the difference between religion and spirituality.

RELIGION, RELIGIOUS PARTICIPATION, AND MENTAL HEALTH

In this section of the literature review, religion will be defined and discussed followed by a definition and discussion of spirituality in the next section. As noted by Fallot (1998), definitions of religion and spirituality in clinical and research literature have frequently been ambiguous with ongoing attempts to refine the differences in the meanings for research purposes. Pargament (1997), as noted by Fallot (1998), defines religion as "the search for significance in ways related to the sacred" (p. 32). Fallot (1998) also notes that a general approach by many is to identify religion more or less closely with its institutional base.

Furthermore, Shafranske and Maloney (1990), as noted by Fallot (1998), stated that "religiousness, for instance, can refer to adherence to the beliefs and practices of an

organized church or religious institution" (p. 72). Fallot (1998) adopted a standard that accentuated experiential and institutional dimensions. In the experiential dimension, the meaning of religion becomes nearly synonymous with spirituality. However, Fallot (1998) notes that religion must be referred to in an institutional context and involves a defined set of beliefs, rituals, and practice, along with an identifiable community of believers.

In looking at the relationship between religion and African Americans, Taylor, Chatters, and Levin (2004) state "…religion and religious institutions of African Americans have had a profound impact on individuals and broader black communities. This influence is documented in the historical experiences of blacks within American society, as well as the role of religion and black churches in the development of independent black institutions and communities" (p.13). The authors also note that discussions regarding the form and purposes of religion and religious involvement among African Americans must be viewed through an understanding of historical origins of traditions as well as the social, cultural, economic, and political experiences that assisted in defining the individual and collective religious expression for this group (Taylor, Chatters, & Levin, 2004).

Previous literature has argued that theological orientations and religious practices of African Americans originated from the distinctive social, political, and historical circumstances characterizing their position within American society (Frazier, 1974; Lincoln & Mamiya, 1990; Taylor, Chatters, & Levin, 2004). However, because black religious expression also transpired within the context of an antagonistic larger society, the aims and purposes of religious belief and expression were distinctively adapted toward addressing life circumstances that were harmful to the well-being of African Americans (Taylor, Chatters, & Levin, 2004).

Also, as pointed out by Lincoln and Mamiya (1990), historically, religious traditions of African Americans have also reflected the significant issues of emancipation, individual and community enfranchisement, civil and human rights, and social and economic justice. In addition, both theological understandings and questions of fundamental concern were structured within the context of the unique conditions and life circumstances affecting African Americans (Taylor, Chatters, & Levin, 2004). The lasting emphasis on the development of the substantial life circumstances of African Americans implies that spiritual matters, as such, were but one of the intentions of black religious traditions (Taylor, Chatters, & Levin, 2004). Although there are varying degrees and different faith traditions, the surroundings of the immediate physical existence, along with the spiritual aspect of life, have put forth prominent and balancing influences on the nature and purposes of black religious expression (Taylor, Chatters, & Levin, 2004).

In examining the impact of religion on serious mental illness, Koenig, Larson, and Weaver (1998) mentioned the fact that for many years, the area of religion was considered by some mental health professionals and researchers to be a strong contributor to mental illness. Therefore, positive roles that religion may have played in the treatment of mental illness were overlooked. The authors also noted the belief of incompatibility between religion and science led most researchers to ignore the relationship between religion and mental illness (Koenig, Larson, & Weaver, 1998; Larson & Milano, 1997). Levin and Chatters (1998) noted that numerous epidemiologic and clinical studies have recognized the influence of religious affiliation and religious involvement on physical and mental health outcomes.

Although it has been an ambiguous area of research, various authors also noted that over 200 published studies investigated religious differences in numerous health

outcomes and examined the effects of dimensions of religiosity on health status indicators and measures of disease states (Levin & Chatters, 1998; Levin & Schiller, 1987). Health issues investigated include cardiovascular disease (Levin & Schiller, 1987), hypertension and stroke (Levin & Vanderpool, 1989), cancer, and overall and cause-specific mortality (Jarvis & Northcutt, 1987; Levin & Chatters, 1998). Though the influence of religious involvement on mental health outcomes has also been the focus of considerable research, these findings were not widely known or recognized within the fields of psychiatry or mental health research. Levin and Chatters (1998) noted that numerous reviews of the literature identified hundreds of published studies reporting relationships between religious variables and mental health outcomes (Bergin, 1983; Gartner, Larson, & Allen, 1991), commonly referring to a beneficial religious effect (Larson et al., 1992).

When the focus is placed on African Americans, Taylor, Chatters, & Levin (2004) pointed out that similar to the increasing number of studies investigating a potential relationship between religion and physical health in African Americans, there has also been a growing empirical literature base examining the effects of religious factors on mental health indicators and psychological well-being as well. The authors also pointed out that previous studies have focused on the disease-preventative impact of religious participation on depression and other psychiatric outcomes, indicators of positive well-being, and other psychosocial constructs were completed by researchers including psychiatrists, geriatricians, medical sociologists, social psychologists, and epidemiologists (Taylor, Levin, & Chatters, 2004). Previous research has shown positive effects of religion on various mental health outcomes (Jang & Johnson, 2004, 2003; Johnson, Thompson, & Webb, 2002; Koenig, McCullough, & Larson, 2000; Levin, Markides, & Ray, 1996; Regnerus, 2003; Ross, 1990; Sherkat & Ellison, 1999; Williams et al., 1991). A great amount of the research ascribes the beneficial effects of religious

involvement to numerous factors that religion promotes, including social integration and support, psychological resources, coping behaviors and resources, and various positive emotions and healthy beliefs (Jang & Johnson, 2004).

Past research regarding mental health and religious effects has also shown that individuals who are actively involved in religion or are religiously committed are less distressed than those who are nominally religious or not religious at all (Jang & Johnson, 2004; Mirowsky & Ross, 1989; Sherkat & Ellison, 1999). Also, of great importance is the consistency of findings showing that religiosity is considered an important source of emotional and instrumental support, through an individual's relationship with co-religionists and God or a "divine order", with this especially being true for African Americans (Ellison, 1992; Jang & Johnson, 2004; Mattis & Jagers, 2001; Taylor, Chatters, & Jackson, 1997). Finally, mental health researchers have found that social patterns of distress offer evidence of the social origin of individuals' psychological well-being (Aneshensel, 1992; Jang & Johnson, 2004; Mirowsky & Ross, 1986, 1989; Pearlin, 1989). The social patterns show that individuals who live in disadvantaged positions in the social structure are more likely to face distressful situations than more advantaged individuals. With regards to African Americans, previous research on mental health show that many African Americans are more distressed than others due to more recurrent experiences of strain or stressors, including factors such as racism and economic disadvantage, due in large part to their disadvantaged social status including income, education, employment, and residential neighborhoods (Jang & Johnson, 2004; Mirowsky & Ross, 1989; Schulz et al., 2000)

Jang and Johnson (2004) examined the religious effects on the distress among African Americans. The authors suggested that special focus should be placed on religiosity for African Americans due to their moderately high levels of involvement in

religious institutions, specifically black churches, which continue to play vital roles in many African American communities. Historically, for African Americans, religious institutions, such as the black church have been a central agency of social organization. The authors specifically examined whether the variables sense of control and social support explain the effects of religiosity on psychological distress. The authors defined these variables in terms of a sociological theory proposed by Smith (2003). Sense of control was defined conceptually as the opposite end of helplessness on a continuum which was likely to reduce psychological distress. Social support was defined to include the probable as well as perceived and actual support that an individual may utilize in dealing with stressors or strain. Therefore, social support refers to the sense of not being cared for by others but also having intimate, personal relationships (Jang & Johnson, 2004).

Jang and Johnson (2004) found strong empirical evidence that religious effects on distress are partly explained by sense of control and social support. Religious African Americans tend to be less distressed because they have more sense of control and social support than their nonreligious or less religious counterparts. Additionally, though not their original focus, sense of control and social support were found to explain social patterns of distress involving an individual's socioeconomic status and children (Mirowsky & Ross, 1989). Family income was found to have negative effects on distress, while having children was positively related to distress. However, those findings were found to be non-significant once sense of control or social support is controlled for, indicating that individuals of low socioeconomic status and caregivers of children were likely to be distressed because they often lack sense of control and social support (Jang & Johnson, 2004).

Taylor, Chatters, and Levin (2004) note that religion reveals its' influence in two ways, which include: (1) a defense mechanism serving to protect against mental illness and psychological distress, and (2) a moderating factor serving to ease harmful impact of life stress and physical challenges on subsequent mental health and well-being. Furthermore, religion appears to exert disease prevention and health promotion influences for African Americans (Taylor, Chatters, & Levin, 2004). Fallot (1998) acknowledges the importance of the role of religion and spirituality in mental health, pointing out the following: both are essential to the self-understanding and recovery experiences of many individuals with mental illness; understanding the importance of religion with particular cultures is often important in offering culturally competent services; and research indicates that religion is many times related to more positive mental health outcomes. Fallot (1998) also notes that as all-inclusive, empowerment-focused, and culturally adjusted approaches to recovery and rehabilitation become more widely implemented, the integration of religion and spirituality will play a key role in the field of mental health.

Although there has been a vast amount of discussion and research on the positive outcomes on religion and mental health, there has also been an equal amount of discussion on concerns about religion in mental health services. Previous research has discussed religious coping and the helpful and harmful roles of religious coping as well as forms of religious coping with mixed implications and the relation to mental health. Pargament and Brant (1998) note that religious coping is multipurpose, multiform, and not uni-dimensional. It is viewed as multipurpose because it provides comfort, stimulates personal growth, enhances a sense of intimacy with God, facilitates closeness with others, or offers meaning and purpose in life (Pargament & Park, 1995). Religious coping is also viewed as multiform because it may be passive (waiting for God to resolve the crisis),

active (a force that motivates individuals to better the world), personal (seeking God's love and care), interpersonal (seeking support from clergy and congregation members), problem focused (aiding in problem solving), or emotion focused (looking to God for emotional reassurance) (Pargament & Brant, 1998).

Pargament and Brant (1998) identify three helpful forms of religious coping which include: (1) spiritual support and collaborative religious coping, (2) congregational support, and (3) benevolent religious reframing. Spiritual support and collaborative religious coping are noted by Pargament and Brant (1998) as beneficial in coping due to the perceptions of support, relationship with God, as well as guidance from God during stressful times. The authors highlight the notion of higher levels of spiritually-based coping are associated with higher levels of psychological adjustment to various stressors (Pargament & Brant, 1998).

Next, Pargament and Brant (1998) note that empirical studies have found that support received from the congregation and clergy during stressful times is also considered beneficial. In general, positive outcomes appear to be related to the support sought and received from the congregation, clergy, and God (Gibbs & Achterberg-Lawlis, 1978; Pargament & Brant, 1998). Finally, the authors discuss positive outcomes being related to benevolent religious reframing through attributions of negative events to God's will or to a loving God (Pargament & Brant, 1998). They discuss a study by Jenkins and Pargament (1988) that asked individuals with cancer how much they felt God was in control of their illness. Respondents who attributed more control over the illness to God described having feelings of higher self-esteem and better adjustment according to ratings provided by nurses (Jenkins & Pargament, 1998; Pargament & Brant, 1998).

Pargament and Brant (1998) also acknowledge that some religious coping methods are sometimes tied to poorer outcomes. Harmful forms of coping include: (1)

discontentment with congregation and God, and (2) negative religious reframing: God's punishment. Discontentment with congregation and God occurs when individuals speak in a negative manner of religion with their comments oftentimes targeting members of their congregation or clergy. Less frequently, individuals may also express negative feelings towards God (Pargament & Brant, 1998).

The individuals reporting dissatisfaction with the church, congregation, or God are more apt to experience poorer mental health status, more negative mood, and a poorer resolution to the negative life event (Pargament & Brant, 1998). The authors note that individuals feeling that God or their congregation has abandoned or let them down in time of need appears to be related with other negative feelings, including despair, hopelessness, and resentment. They also note that while these expressions are rare and in many cases limited, it is unknown if the effects of religious anger are long-lasting (Pargament & Brant, 1998).

Negative religious reframing is also viewed as rare when the reframing of the negative event is in terms of punishment from God. However, it is noted that the cost of this form of coping when perceived in terms of guilt and fear has further repercussions that may be too great (Pargament & Brant, 1998). Still, when this type of reframing occurs, poorer outcomes are the usual result. Previous studies have shown that individuals reporting more negative religious reframing also report higher levels of distress and negative mood (Grevengoed, 1985; Pargament et al., 1990).

Finally, forms of religious coping with mixed implications include: (1) religious rituals in response to crisis, and (2) self-directing, deferring, and pleading religious coping (Pargament & Brant, 1998). From a tally of 40 studies investigating religious coping and outcomes to negative life events, the authors found that religious rituals were associated with positive outcomes in 40% of statistical relationships and to poorer

outcomes in 23% of relationships. Explanations for the mixed results included the use of the cross-sectional design and measures of the study.

The authors note that using cross-sectional studies makes it difficult to distinguish whether rituals are the cause or the effect of poorer mental health outcomes. On the other hand, the authors also note that distress may mobilize the enactment of religious rituals. In addition, mixed results may also indicate the various types of rituals (ex. confession, mourning, and healing) assessed in the studies with some religious rituals being more helpful than others or some rituals being more helpful to certain groups than others (Pargament & Brant, 1998). In their discussion about the second form with mixed implications, self-directing, deferring, and pleading religious coping, they note that religion gives its supporters various ways to attain control in coping (Pargament & Brant, 1998).

In a study completed by Pargament et al. (1988), the authors tested three religious methods to gain control, which included: self-directing, deferring, and collaborative. The methods involved a different reported relationship between God and the individual. In the self-directing method, emphasis is placed on the individual's personal responsibility and active role in problem solving. God is believed to provide individuals the freedom and resources to direct their own lives. The deferring method places responsibility of problem solving on God; thus, rather than actively solving the problem themselves, the individuals wait for resolution to surface through the active efforts of God. Finally, the collaborative method reflects joint responsibility for problem solving by God and the individual with both participants seen as active partners (Pargament & Brant, 1998).

Each of the styles has different mental health implications (Pargament et al., 1988). The self-directing and collaborative approaches were associated with higher levels of psychological competence, while the deferring method was associated with

lower levels of competence. The self-directing approach has been linked with more negative than positive outcomes in some studies; whereas, the deferring method has been linked to positive rather than negative outcomes in some studies. The authors suggested that mixed findings were the result of differences in controllability of situations. In situations where individuals have little control, the more appropriate thing to do may be to defer to God; thus, the self-directing method may be of greater assistance in more controllable situations (Pargament & Brant, 1998).

While this approach is continuously examined by the mental health field, it has already been recognized and accepted by many African Americans as they have attempted to address various life issues including mental health. In a discussion by Koenig, Larson, & Weaver (1998) of religion in the treatment of patients with serious mental illness, the authors note that many individuals with serious mental illness receive treatment from the clergy. They discuss community surveys such as the National Institute of Mental Health Epidemiologic Catchment Area (ECA) study which examined types of disorders that persons with mental illness sought help from clergy. The findings of the study showed that both clergy and mental health professionals saw persons with the same severity of clinical diagnoses (Larson et al., 1988).

The researchers also found that African Americans with a mental illness, especially later in life, were much more likely to seek help for their problems through clergy than through mental health specialists (Husaini, Moore, & Cain, 1994). These findings support the belief that individuals with serious mental illness seek out clergy for help in dealing with mental health problems, and clergy are important sources of mental health support. As previously mentioned, clergy offer psychological support, assistance with daily living responsibilities, encouragement through prayer, and counseling guided by scripture and psychological principals. They add to social support through

involvement with individuals in religious congregational activities (Koenig, Larson, & Weaver, 1998; Larson et al., 1988; Weaver et al., 1997).

The effectiveness of the interventions provided by clergy is continuously in question. Koenig, Larson, and Weaver (1998) note that it is unlikely that the sole use of religious therapies is sufficient in managing individuals with serious mental illness; however, it is their belief that the religious therapies can be used to complement traditional therapies fairly well as shown through a study completed by Propst and others (1992). In their study on medical inpatients, the authors found that cognitive symptoms of depression, including hopelessness, depressed mood, etc., were less prevalent among individuals who maintained a heavy dependence on religious belief and activity in coping, while the more biological or somatic symptoms of depression, including weight loss, fatigue, insomnia, etc., were not associated with religious coping (Propst et al., 1992). As pointed out by Koenig, Larson, and Weaver (1998), these findings suggest that religious treatments are mostly beneficial for individuals with milder forms of depression with severe depression requiring more specialized psychiatric treatment and antidepressant drug therapy. They also note that combination treatment addressing psychological issues and conflicts (the mind), religious concerns (the spirit), and biological causes for mental illness (the body), may hold potential for the best results, although there has been little scientific research completed on such hypotheses.

Koenig, Larson, and Weaver (1998) acknowledge that religious commitment has often been an overlooked factor in mental health research. Therefore, they state that "it would be in mental health professionals'—and their patients'—best interest to begin to examine this overlooked factor in improving patient coping as well as treatment and care outcomes" (Koenig, Larson, & Weaver, 1998, p. 92). Just as the subject of religion and religious participation has raised concerns in the field of mental health, spirituality as

well as the ability to differentiate between religion and spirituality has done the same. However, as Fallot (1998) points out, there are compelling reasons for attention to be placed on addressing spiritual issues.

SPIRITUALITY AND MENTAL HEALTH

Pargament (1997a) defines spirituality as religion's most essential function, which is the "search for the sacred" (p. 39). Koenig (1994) asserts that spirituality may or may not include religion. In this view, spirituality has mainly personal and experiential connotations and may refer to a sophisticated search for both meaning and belonging in connection with core values (Sperry & Giblin, 1996) or to a relationship with an awe-inspiring realm or being (Fallot, 1998). Thus, spirituality may find expression in organized religious frameworks, or may remain outside these communities (Fallot, 1998).

Previous research has discussed the role of religion and spirituality in mental health services. Fallot (1998) provides reasons for including religion and spirituality in mental health services, including: (1) reflection of consumer self-understanding, (2) facilitation of recovery, (3) enhancement of cultural sensitivity in services, and (4) relates positively to psychosocial well-being. In reflecting on consumer self-understanding, religion and spirituality are fundamental to the self-understanding of many individuals with mental illness. Many individuals, including people with mental illness, may find profound sources of identity and meaning in religion and spirituality. Fallot (1998) notes that spirituality refers to who they are, what they do, and believe.

Recovery facilitation is another related reason for the inclusion of spirituality because not only does religious commitment assist in the clarification of an individual's identity, it may also serve as a resource of personal and social strength (Fallot, 1997). While the recovery model has become more fundamental in conceptualizing services for mentally ill individuals, emphasis has grown on enhanced self-esteem, greater

empowerment, and a clearer sense of purpose (Fallot, 1998). The necessity of examining a full range of resources for recovery has also grown at the same time with spirituality being prominent for many individuals. Fallot (1998) notes that spirituality has the potential to motivate, sustain, and consolidate the recovery process.

The third reason to include religion and spirituality in mental health services offered by Fallot (1998), enhancement of cultural sensitivity in services, is important because of the increasing recognition of the significance of culturally competent services. For many cultures and ethnic groups, religion and spirituality are essential sources of meaning and structure along with healing. The author also notes that mental health professionals are increasingly recognizing the awareness of strong religious beliefs and practices as not only a clinical advantage but also an ethical requirement. Also, there is increasing recognition among many accreditation organizations regarding spiritual needs as part of a comprehensive approach to service delivery (Fallot, 1998).

The final reason offered by Fallot (1998), relates positively to psychosocial well-being, is empirical because of the existence of a trend toward a small but positive association between most measures of religion and most measures of mental health. Fallot (1998) notes that all of the reasons mentioned are vital to the understanding of why expanding the role of religion and spirituality in mental health services is important. Research in this area calls for more attention placed on the potential role that religion and spirituality may play in positive psychosocial outcomes (Fallot, 1998).

The significance of spirituality in the lives of African Americans has also been discussed in the literature. The discussion of this significance has continued to build upon sources of support sought by African Americans and the historical implications of the role of spirituality in the lives of African Americans and social work. Martin and Martin (2002) explore how early Black caregivers and pioneering social workers used

spirituality in their work with Black people. The Black helping tradition was defined by Martin and Martin (2002) as "the largely independent struggle of Black people to collectively promote their survival and advancement from one generation to the next" (p. 11). Within the Black helping tradition, Martin and Martin (2002) define spirituality as "the sense of the sacred and divine" (p. 1). They also note that spirituality provided Black people with the strength to continue in the face of threats to their existence, self-worth, and dignity when "oppressive forces" were attempting to take away their humility, hope, even when there appeared to be none. Feelings of joy were also confronted by hardship, frustration, and pain (Martin & Martin, 2002).

When faced with demoralizing situations, it is noted that spirituality provided Black people with encouragement amid suffering and death because it gave them a will to live and determination to make their life worth living (Martin & Martin, 2002). Martin and Martin (2002) also discuss the historical expressions of Black spirituality which include: singing, dancing, moaning, mourning, affirming, worshipping, contemplating, reflecting, shouting, praying, preaching, and testifying. Of greater importance is the expression in the way that individuals lived their lives and the respect they held for life. The authors highlight the ways in which Black people historically spoke of spirituality including terms of: "…'lifting the spirit'; of finding that divine spark that would motivate them 'to keep on keeping on'; of being 'in the spirit'; of living their lives the way they believed God intended human beings to live; and of 'feeling the spirit' so deep in their souls…"(Martin & Martin, p. 2). However Black people decided to describe their sense of the sacred, spirituality was viewed as their encouragement to decency, respecting life, treating people appropriately, and carrying on their Black tradition of helping (Martin & Martin, 2002).

As noted by Martin and Martin (2002), it was apparent to early Black caregivers and pioneering Black social workers that Black people viewed themselves as a spiritual people who defined their reality and planned their lives accordingly in spiritual terms. They also noted that Black people did not make a clear distinction between religiosity and spirituality. Both of the concepts represented matters including: the sacred, eternal, and divine; dealt with justice and injustice issues, good and evil, suffering and redemption, death and eternal life, right and wrong human behavior; and involved a relationship between a vulnerable population and an unseen, omnipotent higher power. If any difference was made, religiosity was associated with a religious institution or denomination like the Black church, and spirituality was associated with an individual's personal and collective ties to an unseen supernatural realm regardless of an individual's affiliation to a religious institution or not (Martin & Martin, 2002).

Within the Black helping tradition, Martin and Martin (2002) acknowledge that spirituality tends to surpass religiosity where spirituality is considered in terms of a deep concern for and commitment to the collective well-being and religiosity is viewed as an expression of a spirituality based on human compassion and caring. They highlight that with the intimate connection to Black caregiving, within the Black helping tradition, spirituality offered the following:

- promoted a sense of community and social support
- enhanced communal and racial self-development
- established social myths to counter racial mythomania (lies or distortions)
- laid the foundation for creating a Black strengths perspective
- helped Black people to develop the ability to mourn
- served as a major source of inspiration and hope (Martin & Martin, 2002, p.5)

In particular, the role of spirituality in the Black helping tradition was focused on promoting community through Black communal solidarity and social support. Black spirituality sought to incorporate the isolated and disconnected strands of Black humanity with the group and was oriented toward balancing human relations, connecting Black people to social support networks, encouraging racial cooperation, and bringing individuals viewed as social deviants and outcasts back into the Black caring community (Martin & Martin, 2002).

To Black clergy, who were viewed as chief helping professionals in early African American history, inspiration was not only important, but it was considered the most important tool of their work. Early black social workers also viewed inspiration as crucial to evading the growth of alienation, defeatism, bitterness, and despair among Black people (Martin & Martin, 2002). Martin and Martin (2002) discuss the fact that even though spirituality in the past was considered to be the driving force behind Black caregiving, social work gradually became more of a fundamentally secularistic profession by focusing less on spiritual and religious roots and working from a naturalistic perspective.

The primary objectives of early Black male social workers included strengthening the social service and social change functions of the Black church, while attempting to meet other objectives by integrating spirituality and social work. Their spiritual objectives included:

- Carrying on the race work tradition of the historic Black church
- Advocating the race work idea of agency, destiny, and social debt
- Assessing the contradictions between White America's Christian beliefs and its cruel racist practices in order to gain social change, freedom, and first class citizenship

- Promotion of cultural diversity and interracial cooperation
- Helping Black people to develop an awareness of and realize their God-given talents and gifts (Martin & Martin, 2002).

It is interesting to note that four of the early black male social workers also studied to be ministers and with the exception of one, the others became ordained ministers in the African Methodist Episcopal Church. Martin and Martin (2002) note that during their studies the social workers began to feel as if the Black church was not living up to its Black uplift mission. They believed the Black church needed to place more emphasis on social service and "practical Christianity", which led them to the social work profession. The role of the Black church will be more thoroughly discussed in the next section of this literature review.

Within the Black helping tradition, spirituality signifies more than inspirational experiences of oneness with God, nature, or the universe and more than the existential probing of the meaning of life, death, good, and evil. In the Black experience, spirituality includes having a communally oriented, caregiving sense of destiny, purpose, and mission; maintaining an optimistic outlook on life even in the midst of oppression and despair; feeling a resounding sense of group belonging; experiencing an inner sense of responsibility for one's self and others; feeling a core sense of inner peace; and maintaining a feeling that families, elders, children, and parents are sacred, and that Black life in general is sacred (Martin & Martin, 2002). Finally, Martin and Martin (2002) note that early Black helping professionals spent a considerable amount of time attempting to live, feed, and feel the spirit along with being one with the spirit of their people. These professionals believed that to not have a spiritual self was to not have life itself (Martin & Martin, 2002).

Traditionally, many African American families have depended upon the Black church to provide both religious and spiritual guidance as well as emotional, financial, and social support as needed. Empirical findings suggest that religion has a special eminence in the lives of many African Americans, with the Black church assuming a particularly prominent role. Approximately 9 of 10 African Americans consider the church as fulfilling "multifaceted roles" in African American communities, and as having an encouraging influence on their lives (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Taylor, Thornton, & Chatters, 1987). Thus, it is important to discuss the role of religion and spirituality along with the significant role of the Black church in the lives of African American families and communities.

THE ROLE OF THE BLACK CHURCH

The role of the church in the lives of African American families, as an informal source of support, has been examined for many years. As noted by Taylor and Chatters (1988), historically, religion and the Black church maintained great importance in the lives of African Americans. This has been the case due to the high level of responsiveness of Black churches to the needs of the community, whereas access to formal social institutions has always been limited. Martin and Martin (2002) state that even when the Black church was under White control, the church primarily served as three things: (1) a social center, (2) a source of social therapy and social support, and (3) a form of social control.

The viability of the Black church as a support system is important to recognize with the existence of social problems faced by African Americans including mental illness (Caldwell et al., 1994).

The authors continue by pointing out:

> "the contemporary Black church is an extensive, strong, independent, economically viable, well-respected self-help institution in the African American community that spans a broad range of social classes and embraces a wide range of denominational affiliations. Most Black churches function as comprehensive and viable support systems for their members and the community at large" (p.153-154).

McRae, Carey, and Anderson-Scott (1998) maintain that the church operates as a social network where individuals are able to obtain assistance in handling the problems they face in day-to-day living, discover that they are not the only ones living their particular experiences, and are able to develop a feeling of acceptance within their social milieu. The positive experience gained from the church encourages hope and faith so that one can successfully resolve problems of daily living.

They also note that research on the religious experience of African Americans identifies the church as a supportive network that offers spiritual and personal assistance, guiding principles for moral behavior, and a sense of unity. Additionally, the NSBA (2003) found that 82% of study participants believed the church provided: spiritual assistance, personal support, guidelines for moral behavior, sustained and strengthened community and individuals, actively encouraged social progress, and served as a community gathering place (Taylor & Chatters, 2003). In contrast, approximately 5% reported a negative opinion of the church, while 12% reported that the church made no difference. Respondents reporting a negative opinion stated that churches and clergy were motivated by money, organized religion did not reflect a true sense of personal religiosity and spirituality, and Christianity, as a result of White culture, was intrinsically harmful to the condition of African Americans. However, the overall analysis revealed far-reaching support for the perception of the church as a having a beneficial impact on the lives of African Americans (Taylor, Chatters, & Levin, 2003).

Several studies have also discussed the extensive provision of support by African American churches to address the emotional and instrumental needs of the congregants as well as improve their well-being through a variety of services (Taylor & Chatters, 1988; Caldwell et al., 1994; McRae et al., 1998). Ellison (1994) notes that religious involvement may reduce psychological distress, increasing health in four ways, including: shaping behavioral patterns and lifestyles, generating social resources, enhancing psychological resources, including self-esteem and personal mastery, and providing specific coping resources.

Lincoln and Mamiya (1990) provide a conceptual framework for understanding features of Black churches and religious involvement, specifically, the pivotal role of the church in communities and the diverse functions and objectives it fulfills. The authors highlight particular characteristics of African American culture, within the larger American context, that have developed into a tradition in which religious and secular concerns are only partly differentiated (Lincoln & Mamiya, 1990). The mission within Black religious traditions has been historically defined as one of transforming the social and political conditions that influence the lives of African Americans as a whole, whether the involvement includes direct political action, civic projects, health ministries, or educational activities. The result is the inability to fully differentiate between religious pursuits from secular concerns (Taylor, Chatters, & Levin, 2003).

Evidence of this is seen through the Black church being viewed as instrumental in developing Black self-help traditions, such as mutual aid societies, and in the provision of institutional foundations for educational, civic, and commercial activities within the African American communities (Taylor, Chatters, & Levin, 2003). The historic and ethnographic research on the type of Black religious involvement validates its multidimensional quality (Cone, 1985). Therefore, Black churches are often noted for

their role in social welfare, political, and civic and community functions (Frazier, 1974; Taylor, Chatters, & Levin, 2003; Taylor, Thornton, & Chatters, 1987). Taylor, Chatters, and Levin (2003) note the evident diversity of roles within Black churches, and Black religious involvement by and large, suggesting numerous means by which spiritual, emotional, social, and political strivings of African Americans may be attained.

The significance of the diverse role within Black churches is also seen through a survey of African American congregations in the Northern United States (Billingsley, 1999; Caldwell, Chatters, Billingsley, & Taylor, 1995; Thomas, Quinn, Billingsley, & Caldwell, 1994) where findings showed more than 1,700 church-sponsored outreach programs. Approximately two-thirds of the churches within the sample sponsored at least one community outreach program with provision of various services, including assistance with basic needs such as food and clothing distribution, home care, income maintenance programs such as financial services and low-income housing, counseling and intervention for community members such as family counseling, parenting/sexuality seminars, and at-risk programs for youth, education and awareness programs such as child care, life skills, and academic tutoring, health-related activities such as HIV/AIDS care, substance abuse counseling, and recreational and fellowship activities for individuals and families (Taylor, Chatters, & Levin, 2003). Church-sponsored initiatives and outreach efforts draw on traditions of mutual assistance and self-sufficiency within the Black church to enhance the health and well-being of the congregation and community members.

Along with the initiatives and efforts, Black congregations make up an important social network for their Church members involving the exchange of various forms of social support. As pointed out by Taylor, Chatters, and Levin (2003), church-based support networks offer a distinctive opportunity to examine how social support functions

within a defined social group and to recognize what personal and social factors are related to receiving and providing assistance. However, the authors note that informal support from church members has received rather modest regular attention and scrutiny (Taylor, Chatters, & Levin, 2003).

Previous research completed by the authors among older (Taylor & Chatters, 1986a, 1986b) and adult Blacks (Taylor & Chatters, 1988) show that church members are considered a valuable source of informal assistance, with two-thirds of respondents reporting that church members offered some level of assistance to them. Individuals who were considered to be official church members, attending church on a more frequent basis reported religion as important and were more likely to receive support from other church members. The findings from these studies intimate that current assistance received from church members is dependent upon one's level of substantial investment in the life of the church and the previous participation record in church activities (Taylor & Chatters, 1988).

Denominational differences in church support show that Catholics were less likely to receive assistance from church members than Baptists (Taylor & Chatters, 1988). The authors attribute the findings of differences between groups with regard to the structure of the church, congregational climate, and the nature of worship services. This was particularly the case in the Catholic worship style and church structure being thought of as being more hierarchical and less communal, which in turn leads to impediment of informal assistance among church members. Lastly, the findings of the study showed that men and younger Black adults were more likely to receive assistance than women and older individuals, whereas divorced respondents were less likely to receive assistance from church members than were married people (Taylor & Chatters, 1988).

In the analyses focusing specifically on older adults, church attendance predicted how often Black elderly individuals received assistance as well as the amount of aid provided (Taylor & Chatters, 1986a). Additionally, dynamics of support from church members also depended on an individual's age. The elderly of very advanced years and those with adult children were more likely to receive assistance from church members than their childless counterparts. The authors report that this finding may suggest that adult children may perform, on behalf of elderly parents, to facilitate support interactions from church members (Taylor & Chatters, 1986a). Krause (2002a) found that older Blacks were considerably more likely than older Whites to describe the emotional and spiritual support received from their church members.

The literature discussing Black churches and extended families consistently highlights the church and the family as two of the most significant and established institutions within African American communities (Berry & Blassigame, 1982; Billingsley, 1992, 1999; Hill, 1999; Lincoln & Mamiya, 1990; McAdoo, 1981; Staples & Johnson, 1993, Taylor, Chatters, & Levin, 2003). Churches and families execute numerous important social support functions to address issues including chronic poverty (Stack, 1974), under- and unemployment (Taylor & Sellers, 1997), coping with loss of loved ones (Neighbors, Musick, & Williams, 1998), and provision of assistance to ill or disabled individuals (Dilworth-Anderson, Williams, & Cooper, 1999). Moreover, individuals and families frequently maintain lasting bonds with religious congregations that continue over numerous years or decades (Taylor & Chatters, 1988).

Lincoln and Mamiya (1990) concluded that Black churches are closely associated with Black family life; and, because of the church's teachings, belief systems, and rituals, these institutions sustain a shared relationship with each other. The authors note the significance of Black churches constituting a "quasi" family environment, such as the

church family, in which fellow congregants are thought of in terms of kinship and honorific titles are given to respected church elders. The concept of church family and kin symbolizes the special "family-like" quality of the relationships where rights and responsibilities of kinship are bestowed on fellow church members (Lincoln & Mamiya, 1990). This includes the development of lasting social and personal relationships and exchanges of informal social support (Chatters, Taylor, Lincoln, & Schroepfer, 2002).

Previous research findings show that social support contributes to better physical and mental health outcomes and psychological well-being (Lincoln, 2000). On the contrary, research findings also show that negative social interactions may lead to lower levels of happiness, life satisfaction, and other indicators of psychological well-being (Lincoln, 2000). It is not clear whether negative interaction involving family and friends counteract the positive effect of emotional support with research findings being equivocal. Some of the findings show stronger effects of negative interaction, while other research findings show that emotional support is more crucial for outcomes. Lastly, other research suggests that negative interaction and emotional support are roughly equal in their impact on outcomes (Lincoln, 2000).

Negative interactions, such as criticisms or unfavorable comments, are potentially damaging to psychological well-being for quite a few reasons. In many cases, family and friends represent an important reference group and as the people with whom common values and beliefs are shared and meaningful emotional and social attachments are maintained (Taylor, Chatters, & Levin, 2003). These relationships as well as the quality of social interactions within the reference groups are considered key in terms of how individuals view and define themselves. Thus, negative comments from these individuals regarding behaviors or attitudes have the capability of causing negative feelings such as embarrassment, sadness, or shame. These comments may also be especially disturbing

and significant because of the unexpectedness of customary social interactions (Taylor, Chatters, & Levin, 2003).

With regards to church members, it has been established that there is a close emotional bond and high degree of support and guidance that can occur within the church. In addition to the positive benefits of social relationships, church-based networks may also be a source of negative interaction (Taylor, Chatters, & Levin, 2003). Ellison (1994) notes that church congregations are considered to be of special importance and are powerful environments with regard to using negative social sanctions, such as criticism, for church member behavior that is considered inappropriate. Additionally, participation and membership within church-based networks may include problems connected to individual privacy and autonomy. Church members who move away from accepted behavioral standards in terms of lifestyle and moral conduct or who hold differing beliefs regarding church doctrine and practice may be subject to open criticism, gossip, and ostracism (Taylor, Chatters, & Levin, 2003). Finally, since involvement in church congregations may place heavy demands on time and financial resources for individual members, there may be disagreements between members about perceived differences in their contributions, along with the likely social benefits that stem from church involvement.

Because of the special circumstances of church networks, it is expected that negative interactions involving church members of the kind described would be an important issue in Black churches (Taylor, Chatters, & Levin, 2003). The concerns are viewed as particularly prominent for Black as opposed to White churches because of higher attendance levels at religious services and other church-based related activities. Thus, there appears to be more of an opportunity for positive emotional assistance and negative interaction (Taylor, Chatters, & Levin, 2003).

In their research on negative interactions among church members, Krause, Ellison, & Wuff (1998) found that negative interactions with church members has an adverse impact on psychological well-being. Three major areas of conflict among church members were identified: (1) conflict between church members, (2) conflict between church members and their clergy, and (3) conflict over church doctrine (Krause et al, 2000b). Negative interactions included gossip and formation of church cliques and conflict over doctrine centered on four issues, which included: abortion, religious teachings that involve the role of women in the family, alcohol use, and the acceptance of homosexuals attending the church. Krause and his colleagues provide insight into the nature and consequences of negative interaction within religious settings. It was important to discuss both the positive and negative interactions among individuals attending churches as it may add to the explanation of help-seeking behaviors of individuals with mental illness as well as how African American clergy recognize, attribute cause, and respond to a call for help.

AFRICAN AMERICAN CLERGY AS GATEKEEPERS

Within the Black church, African American clergy are acknowledged as pivotal figures whose guidance and direction are vital in order for parishioners to understand the types of programs organized in the church as well as the relationship of the church with the broader community. African American clergy assume various roles in relation to programs and interventions that are church-based, particularly as mediators of health-related behavioral and social changes. Programs and interventions offered include, but are not limited to health-care screenings, mentorship programs, programs for the disadvantaged including food pantries and temporary shelters, and community economic development programs. In relation to formal mental health services, clergy often serve as "gatekeepers" and referral sources.

The concept of a gatekeeper is defined by Poole and Salgado de Snyder (2002) as an individual who guides or connects people to promising sources of help. They identify gatekeepers as "family, friends, neighbors, ministers, priests, shopkeepers, beauticians, barbers, bartenders, and folk healers…" that serve as links to those in need of formal helping services in the community (p.52). Mental health researchers have often suggested that African American clergy be utilized as gatekeepers, collaborators, and referral sources to formal mental health services (Neighbors, 2003; Neighbors & Jackson, 1984; Neighbors, Musick, & Williams, 1998; Pickett-Schneck, 2002; Taylor et al., 2000).

However, as Neighbors (2003) points out, the idea of clergy only operating as gatekeepers or referral agents must be thought through more carefully. Viewing African American clergy only as gatekeepers or referral agents assumes that they are facing conditions they are not qualified to address (Neighbors, 2003). This view is not uniformly true; however, Neighbors (2003) acknowledges that it is not clear who is more qualified to treat issues faced by African Americans, clergy or formal mental health systems. Because individuals with a range of religious concerns as well as mental health problems seek help from clergy, religious leaders must be able to differentiate between problems they can solely respond to and those which warrant consultation from mental health professionals (Milstein, Midlarsky, Link, Rauc, & Bruce, 2000).

Taylor, Chatters, & Levin (2003) note that clergy counsel individuals on a wide variety of issues, including alcoholism and other forms of substance abuse, depression, marital and family conflict, teen pregnancy, unemployment, and legal problems. The authors state "…in fact, the type and severity of psychiatric problems that clergy encounter in counseling do not differ significantly from those seen by mental health practitioners. However, given the heterogeneity of this group, the counseling and referral practices of individual clergy diverge considerably…" (Taylor, Chatters, & Levin, 2003).

It is also noted that level of education of ministers is an important predictor of level of knowledge of mental health issues (Taylor, Chatters, & Levin, 2003). Previous literature has shown that clergy who have received post-graduate education receive minimal training in counseling individuals experiencing basic daily life problems (ex. marital and family conflict) and are completely unfamiliar with the area of psychopathology and symptoms of severe mental illness (Bentz, 1970; Gottlieb & Olfson, 1987; Virkler, 1979; Taylor, Chatters, & Levin, 2003).

Additionally, the literature has discussed the possibility of clergy underestimating the severity of psychotic symptoms, compared to other mental health practitioners, and may be least likely to recognize suicide lethality (Domino & Sevain, 1985-1986; Larson, 1968). The religious and ministerial training received by clergy may lead them to interpret mental or emotional problems in religious terms or interpret clinical symptoms, such as hallucinatory behaviors as evidence of religious conflict (Taylor, Chatters, & Levin, 2003). Regardless of these findings, Taylor, Chatters, & Levin (2003) also note that literature shows that clergy are very successful in responding to the general needs of their congregants, with a growing recognition among clergy of the importance of addressing the mental health needs of their congregants reflecting in the growth of the field of pastoral counseling and provision of graduate training in clinical counseling.

There has been minimal research regarding the collaboration between religious organizations such as the church and the mental health services delivery systems, which includes the roles of African American clergy as gatekeepers with regards to the formal mental health system (Williams, 1994; Taylor et al., 2000). Past research has questioned the quality of mental health services provided by clergy, use of clergy as referral sources, and the efficacy of those referrals in terms of helping the individuals and families in need (Neighbor, et al., 1998; Taylor et al., 2000). Taylor et al., (2000) notes “the quality of

mental health services provided by clergy is determined, in part, by their ability to identify serious mental health problems and their willingness to refer people to professional mental health practitioners" (p. 76). It is apparent that there will be a difference in the type of services that clergy are able to provide based upon the type and level of training that they have received. It is obvious that parallels exist in the support that individuals and families can receive from formal support groups as well as informal support systems such as the church. Examining the potential benefit of collaboration between these two systems has been a potentially overlooked solution in increasing the participation of African American individuals and families.

Previous literature has investigated the participation of the church and its members in other community programs including health initiatives (Perry, 1981; Haber, 1984; Levin, 1984, 1986; Williams & Williams, 1984; McAdoo & Crawford, 1990; Kumanyika & Charleston, 1992). These programs along with other variations of "community-based partnerships" acknowledge that the church occupies a high level of trust and respect within the African American community. The collaboration of these programs with the church has allowed efforts to show a greater level of effectiveness in tapping into longstanding traditions of communal assistance and self-sufficiency to improve the health of members of the participating communities (Taylor et al., 2000).

This same principle could be applied in connecting individuals and families from their informal support systems to formal support groups with the church as the link and clergy as the gatekeeper. Neighbors et al., (1998) recognize that "…more than any other influence on the help-seeking behaviors of African Americans, ministers hold the most potential for opening a wider pathway between the Black community and specialty mental health care" (p.774). Caldwell et al., (1994) states, "the greatest strengths of the

Black church as a family support system are its visibility and its stability in African American communities…" (p.157).

EXPANDING THE ROLE OF AFRICAN AMERICAN CLERGY

Regardless of attempts to make mental health services more culturally relevant, most African Americans do not seek help through professional services. There has been little research regarding collaborative efforts between religious organizations, including the church and clergy, and mental health service delivery systems, particularly the role of African American clergy as gatekeepers or sole service providers (Williams, 1994; Taylor et al., 2000). A modest amount of research has been conducted on the socially supportive role of the Black church, with an even smaller amount written about the role of African American clergy as counselors to African American individuals and families dealing with mental health issues.

As pointed out by Taylor, Chatters, and Levin (2003), when individuals are confronted by serious personal problems, they can choose from a variety of professional helpers, including psychiatrists, clinical psychologists, social workers, physicians, lawyers, marriage counselors, and vocational guidance counselors. However, previous research has shown that individuals choose clergy as their helper and they play a significant role in addressing a variety of personal problems and concerns (Taylor et al., 2000). In a study completed by Veroff and colleagues (1981), 39% of Americans with a serious personal problem sought help from clergy. Clergy were consulted more often than other categories of professional helpers (Veroff et al., 1981).

Clergy are consulted for life problems and concerns that are considered to be consistent with their traditional ministerial roles and training, including comforting the bereaved and advising individuals who are physically ill (Taylor, Chatters, & Levin, 2003). However, they also counsel individuals for concerns including marital and family

issues and serious mental health problems (Chalfant et al., 1990; Veroff et al., 1981). For African Americans, there is an indication of reliance on clergy for assistance with mental health issues (Neighbors, Musick, & Williams, 1998). As previously mentioned, African American clergy are very involved in assisting their congregation and ensuring their spiritual, emotional, and physical well-being (Taylor, Chatters, & Levin, 2003).

The existing inclination for seeking assistance from clergy may be related to several factors, including treatment expense, access, and experience with and knowledge of this type of help (Taylor, Chatters, & Levin, 2003). The authors also note that for disadvantaged individuals, clergy have a distinct advantage over other counselors as a chosen source of help because, unlike many other sources of help, they often do not charge for their services (Taylor, Chatters, & Levin, 2003). In Veroff et al.'s analysis (1981), they found that treatment expense was cited as a reason for not seeking help from a psychiatrist or psychologist. Even for individuals who are not disadvantaged, Taylor, Chatters, and Levin (2003) acknowledge that obstacles with access to professional assistance may also be an additional reason in choosing clergy over other sources of help.

The authors highlight the fact that insurance coverage, co-payments, or other bureaucratic actions for a consultation are not required by clergy. Contrary to psychiatrists, psychologists, marriage counselors, and other mental health specialists who are usually approached after a previous consultation with a referral source, the pathway to clergy is by and large direct and is infrequently mediated by either formal or informal referrals (Veroff et al., 1981). Additionally, individuals seeking help from clergy usually do so within the perspective of a meaningful personal relationship with their minister where trust has already been established. Lastly, individuals may be more apt to seek out clergy for help in dealing with personal issues because of the common philosophy shared with regard to helping others, shared worldviews about the sort of problems, and

traditional and accepted ways of coping with difficult experiences in life that are expressly religious (Taylor, Chatters, & Levin, 2003).

Within the existing literature, the quality of mental health services provided by clergy, the use of clergy as referral sources, and the efficacy of their referrals have been questioned. Also, of great importance is an understanding of how clergy conceptualize mental illness and their beliefs regarding causation. Studies show that there will be differences in the type of services that clergy are able to provide based upon the type and level of training that they have received. For example, in a study completed by Mollica, Streets, Boscarino, and Redlich (1986), the authors found that African American clergy place a higher level of importance on the use of theological beliefs in counseling. Additionally, African American clergy place greater importance on the therapeutic use of religious practices, including prayer, meditation, confession, faith healing, quoting scripture, and church attendance.

Mollica et al., (1986) also revealed that most referrals made by African American clergy were to other clergy who had specialized mental health training, and African American clergy indicated that they had never received referrals from mental health professionals. This study shows consistency in the view that there is limited contact between African American clergy and professional mental health services. Explanations for limited contact include: confusion of role-related tasks, lack of respect for clergy by mental health professionals, and philosophical conflicts between religious beliefs and psychological theories. In addition, pastors, in this study, indicated that they often sought out the distressed individuals and families rather than waiting for them to refer themselves for help.

It has been noted that clergy provide counsel on a variety of problems. Larson et al. (1988) note that the type and severity of psychiatric problems that clergy come upon

in counseling does not differ much from those seen by mental health practitioners. Yet, given the diversity of the group, the counseling and referral practices of individual clergy differ considerably (Gottlieb & Olfson, 1987). Several studies have discussed the minimal amount of training in counseling, even in post-graduate training, received by clergy in assisting individuals who are experiencing basic problems of daily life (ex. marital problems) and are completely unfamiliar with psychopathology and symptoms of severe mental illness (Bentz, 1970; Gottlieb & Olfson, 1987; Virkler, 1979).

Furthermore, previous research has shown that clergy are likely to misjudge the severity of psychotic symptoms (Larson, 1968) and, compared to other mental health practitioners, are least likely to recognize suicide ideations (Domino & Sevain, 1985, 1986). Religious and ministerial training may cause clergy to interpret mental or emotional problems in purely religious terms (Hong & Wiehe, 1974) or interpret clinical symptoms as an indication of religious conflict (Larson, 1968).

Taylor, Chatters, & Levin (2003) note that numerous studies imply that characteristics of clergy may have an impact on their counseling and referral activities with individual church members. An important predictor of their level of knowledge regarding mental health issues and services available from professionals and public agencies will be clergy members' level of education (Taylor, Chatters, & Levin, 2003). Gottlieb and Olfson (1987) believe that clergy with more education will be more confident in their understanding of mental health issues and interact more regularly with the mental health community than their less-educated peers.

Regardless of these factors, Taylor, Chatters, and Levin (2003) note that the literature also shows that clergy are very successful in taking action and responding to the general needs of their congregants and obtain appropriate services. It has also been noted that clergy provide an abundance of support to individuals in need, including basic living

needs. Furthermore, recognition among clergy is growing regarding the importance of addressing the mental health needs of congregants, as indicated through the growth of the field of pastoral counseling and the provision of graduate training in clinical counseling (Taylor, Chatters, & Levin, 2003).

Neighbors (2003) recognizes several significant points concerning the relationship between African American clergy and African American individuals and families. He states, "…first, the field of mental health and mental health professionals must understand that African American pastors are strongly rooted within African American communities in a way that mental health professionals will never be. Second, pastors are considered as accessible as other sources of informal support, including family and friends. Third, pastors maintain a level of respect and responsibility that places them in a special category within the lives of African Americans. Finally, pastors play a key role in meeting the needs of African American families, including caregivers and potential consumers".

THE IMPORTANCE OF UNDERSTANDING AFRICAN AMERICAN CLERGY'S CONCEPTUALIZATIONS

The literature presented supports the notion of clergy being initially sought out for help in dealing with issues surrounding mental health. These findings support the importance in developing an understanding of how pastors conceptualize and attribute causation regarding mental illness affects their ability to respond to individuals seeking help for issues surrounding mental illness. There has only been one study found related to pastors' conceptualizations of mental illness and referral intent which focused specifically on Korean Americans.

Kim-Goh (1993) examined the relationship between conceptualization of mental illness and referral intent of 50 Korean-American clergy. Participants were presented

with vignettes describing depression, psychotic symptoms with religious delusions, and psychotic symptoms with persecutory delusions, followed by questions evaluating problem conceptualization, causal attribution, and referral intent of mental health treatment. Findings showed that clergy with a psychological conceptualization were more willing to refer than those holding a religious conceptualization. Of the participating clergy, 56% stated they had made previous referrals. The clergy also noted that many help-seekers were resistant to following through with referrals, held skepticism toward the effectiveness of treatment, and found a lack of bilingual and bi-cultural mental health facilities.

The findings of this study may be attributed to the participant's vocation as clergy, and a high level of education and acculturation. Kim-Goh (1993) states "…whether the clergy's attitudes about mental disorder with religious symptoms is susceptible to change through mental health training is yet to be studied. However, acquisition of scientific knowledge on the possible etiologies of mental illness may enhance the pastors' sensitivity and empathy for the mentally ill and lessen the possibility of moralizing for 'lack of faith'…"(p. 409). Potential benefits of understanding conceptualizations of clergy include learning what clergy offer their parishioners, and clergy with mental health training may be able to assist in bridging the gap between the mental health system and non-referring clergymen/women "…without the risk of arousing a sense of inadequacy or failure among the clergymen" (Kim-Goh, 1993).

Within the literature, other variables for consideration include education and type of training received. Questions surround how education affects mental health values, such as open-mindedness versus closed-mindedness, of clergy along with their conceptualizations. Ruppert and Rogers (1985) found that experience in the field of

psychology and education of clergy was related to preference for particular mental health interventions in the church.

The authors also found that clergy with more experience with their own personal therapy were less likely to assign devotions, pray with individuals, confront individuals with sin, or advise them to participate in church activities (Ruppert & Rogers, 1985). Also, findings showed that an increase in the number of psychology and mental health courses was negatively correlated with assigning Bible or devotional readings as a part of the treatment plan. Clergy with higher education were less likely to assign prayer or devotions to individuals, but were more likely to use an "indirect approach" (Ruppert & Rogers, 1985).

In a more theoretical dialogue about mental health interventions in the church, Bufford and Buckler (1987) suggested a "mixture" strategy which would include church and traditional psychology techniques. The authors recommended techniques including mental health education, small support groups, therapy, discipleship, prayer, and social programs are all fitting approaches in order to promote mental health in the church (Bufford & Buckler, 1987). Gottlieb and Olfson (1987) acknowledge that as educational level of clergy increase, the likelihood that clergy will correctly recognize mental health issues and refer parishioners to mental health practitioners as necessary will also increase.

Kane and Williams (2000) discuss the educational requirements for Catholic seminary will include four years of graduate theological and pastoral education, and a pastoral internship prior to ordination, clinical pastoral counseling which incorporates mental health into seminary curriculum, and once ordained, clergy are encouraged to continue participation in pastoral education. Although this population maintains the educational background needed to identify mental health issues, the perceptions of the priest's abilities and competence held by their parishioners to address the issues are also

in question; thus, making the issue of how clergy conceptualize mental illness critical. An examination of other religious denominations is also necessary to note any similarities or differences.

Additionally, type of training received must be considered regarding the ability of pastors to assist individuals in need of help. Kane and Williams (2000) state that when clergy are approached by individuals in need of help, they must make an initial assessment of the type of "skilled help" that is most appropriate and decide if they maintain the skills and are capable of providing services or direct the individual to more appropriate sources. Other studies suggest that the type of training that many clergy receive is a result of denominational requirements of ministry (Mobley, Katz, & Elkins, 1985). The literature presented assists in underscoring the importance of this area being studied. The goal of this study is to gain an understanding of how pastors conceptualize and attribute causation of mental illness through the examination of their views as well as other demographic characteristics including education, type of training, and denominational background and how these factors affect how their approach to individuals seeking help.

CONCEPTUAL FRAMEWORK

The model chosen for this study, the bio-psycho-social-spiritual model is an extension of the traditional bio-psycho-social model, used specifically because of the addition of the spirituality concept. Before discussing the model, literature will be presented to provide a rationale for the use of this model. Schnittker, Freese, and Powell (2000) acknowledge that mental health professionals and the public embrace various conceptions about the causes of mental illness. Conceptions include biological causes, such as genetic inheritance or chemical imbalance or environmental factors, such as family background and social stressors. Still, others refuse to accept the "nature vs.

nurture" concept with the acceptance of both biological and environmental explanations concurrently or by thinking about mental illness in terms of individual responsibility or divine judgment (Schnittker, Freese, & Powell, 2000).

Previous literature has examined the lay beliefs about causes of mental illness (Brown, 1995; Furnham, 1988; Huber & Form, 1973; Hunt, 1996; Orbuch, 1997). There has been recognition by sociologists studying etiological beliefs of mental illness to examine various contributing explanations such as economic inequality, gender and race differences, education, homelessness, or environmental issues as they attempt to understand how individuals construct the beliefs about the world they live in, attitudes towards others, their definition and framing of social problems, endorsement of public policies, and their own behavior (Brown, 1992; Feagin, 1975; Furnham, 1988; Kluegal & Smith, 1986; Lee, Jones, & Lewis, 1990).

There has also been a fair amount of research conducted on the racial variation in etiological beliefs of mental illness. As noted by Schnittker, Freese, and Powell (2000), Hall and Tucker (1985) found that African Americans were more likely than Whites to hold various misconceptions about the nature and causes of mental illness, with many holding the belief that mental illness was a result of character flaws and that it could be overcome by an "avoidance of morbid thoughts". Milstein, Guarnaccia, and Midlarsky (1995) found that Whites' conceptions of mental illness were more likely to emulate the beliefs of mental health professionals than African Americans, suggesting that Whites endorsed a model of mental illness focusing on biological causes. However, much of the previous research had methodological shortcomings, failed to provide a consistent theoretical insight into reasons that may cause racial differences, and the focus of research being largely on racial differences in support of a constricted disease model of mental illness (Schnittker, Freese, and Powell, 2000).

The authors also discussed the lower use of mental health treatment services by African Americans (Schnittker, Freese, & Powell, 2000). Snowden and Cheung (1990) note that some research has focused on the greater cynicism held by African Americans toward the medical model of mental health treatment. Boyd-Franklin (1989) speculates that African Americans regard mental illness as having origins that can be resolved within the family, therefore, questioning the use of professional mental health systems. Schnitter, Freese, and Powell (2000) discuss three possible effects of racial differences on etiological beliefs: (1) apparent effects of race on beliefs about the etiology of mental illness may be merely artifacts of the relationship between race and socioeconomic status, (2) compared to Whites, African Americans may tend to reject biological explanations of mental illness and endorse environmental explanations, and (3) compared to Whites, African Americans may be more likely to endorse causes of mental illness that are neither biological nor environmental.

First, previous literature has discussed the racial differences in beliefs about causes of mental illness with findings suggesting that African Americans' differing beliefs may serve as a function of lower educational levels (Hall & Tucker 1985; Milstein, Guarnaccia, & Midlarsky, 1995). Neff and Husaini (1985) notes that background variables, such as income and education, influences "social knowledge", which in turn, structures etiological beliefs. Also, Ring and Schein (1970) believe that middle-class African Americans maintain beliefs about mental illness that are similar to Whites. However, Schnittker, Freese, and Powell (2000) argue that differences between African Americans and Whites would disappear when statistical controls of other sociodemographic characteristics are presented.

Additionally, research regarding distinctive experiences of African Americans and Whites as reasons for possible differences has also been discussed (Nickerson,

Helms, & Terrell, 1994). It has been suggested that variations in experiences often indicate differences in history, culture, and generalized experiences (Hunt, 1996) with the result being that African Americans tend to identify more with each other as a group than Whites or other disadvantaged groups (Gurin, Miller, & Gurin, 1980). The strong group identification has the potential to encourage African Americans to view social issues in terms of problems facing fellow African Americans even if they do not experience the problem themselves (Hunt, 1996). As a result, African Americans' beliefs about mental illness may be strongly influenced by circumstances faced as a group and by the inferences of various explanations of mental illness for public debates about race.

In the second explanation, the authors discuss that since Foucault (1965), researchers have maintained that changing the medical recasting of "madness" as "mental illness" is a historical development resulting as much from political and professional struggles as from scientific development (Brown, 1995; Mirowsky & Ross, 1989; Schnittker, Freese, & Powell, 2000). The emerging view of mental illness as a result of biological causes was more accepted by Whites than other minorities. Also, African Americans were disproportionately confronting environmental conditions that could potentially increase mental illness (Williams, Takeuchi, & Adair, 1992); as a result, the African American community may have a greater sensitivity than Whites to social origins of mental illness (Schnittker, Freese, & Powell, 2000).

Neighbors (1985) argues that African Americans are more dissatisfied with the professional mental health system than Whites because they believe that it does not emphasize social causes of psychiatric disorders. Sussman, Robins, and Earls (1987) build on that argument with the suggestion that African Americans may be so willing to accept and allude to potential social causes for personal problems that they think of the problems as a consequence of hard times and not an illness. The belief that mental illness

is mainly environmentally based may add to the explanation of why African Americans emphasize the role of family and community in solving personal problems more so than Whites (Schnittker, Freese, & Powell, 2000).

In the last effect presented by Schnittker, Freese, and Powell (2000), it is suggested that African Americans may be more likely than Whites to believe that mental illness is a result of God's will because of the reports of stronger religious beliefs, higher levels of religious participation (Taylor & Chatters, 1991; Taylor et al., 1996; Taylor, Levin, & Chatters, 2003), and the evidence showing that Blacks use prayer more or consult religious leaders for assistance with personal and psychological problems (Milstein, Guarnaccia, Midlarsky, 1995; Taylor & Chatters, 1991; Taylor, Chatters, & Levin, 2003). Previous literature has discussed the emphasis on the importance of prayer and willpower in overcoming psychiatric issues by some black religious leaders (Hall & Tucker, 1985; Taylor, Chatters, & Levin, 2003). Thus, African Americans may be more likely than Whites to attribute mental illness to bad character with some research showing that African Americans more commonly believe that disorders including schizophrenia and depression are due to lack of willpower (Hall & Tucker, 1985).

Schnittker, Freese, and Powell (2000) note that explanations such as God's will and bad character lie outside the nature-nurture continuum, attributing mental illness to either of those explanations does not prohibit an individual from also believing in causal influences of biological and/or environmental factors. Lastly, the authors also note that African Americans may be more skeptical than Whites to accept biological or environmental explanations may be attributed to the resemblance of arguments used to criticize African Americans as a group (Schnittker, Freese, & Powell, 2000). Initial studies of racial differences in physical and mental health, including cognitive ability,

moral behavior, and criminal tendency, oftentimes held an extremist stance promoting anti-black social policies (Gould, 1981; Krieger, 1987).

Findings of their study showed that compared to Whites, African Americans tended to reject genetic explanations of mental illness, but did not reject explanations of a chemical imbalance. At the same time, African Americans are more likely than Whites to reject the explanation of family upbringing, but not those explanations that blame life stress. They found that among study respondents without a college degree, African Americans were more likely than Whites to believe that a mental illness can be caused by an individual's bad character. They also found that African Americans may be slightly more likely than Whites to attribute mental illness to the will of God. This finding was thought to be consistent with the greater emphasis of religious leaders on both willpower and prayer. It is interesting to note that study respondents were more likely to support the biological factors or God's will as explanations for schizophrenia or depression rather than substance abuse. The reverse was true for the bad character explanation (Schnittker, Freese, & Powell). Dating back to publications such as *The Bell Curve* and "The Moynihan Report", the public has been provided with criticisms of African American families including provision of poor instruction to children, negligent supervision, and inappropriate models of conduct, with these problems, in turn, being used as explanations for the persistence of inequalities between African Americans and Whites (Schnittker, Freese, & Powell, 2000).

As pointed out by Schnittker, Freese, and Powell (2000), the unflattering depictions of African American families are still frequent in public discussions surrounding social issues such as welfare, aid to inner cities, education, and single-parent families. The explanations that focus on genetics and "problems" within the African American family still appear frequently in the public. Thus, African Americans are more

apt to react more negatively than Whites to the use of genetics or family upbringing as explanations for mental health issues, even when the explanations are not overtly directed against African Americans (Schnittker, Freese, & Powell, 2000).

Based on the findings and discussion of the study by Schnittker, Freese, and Powell (2000) and examination of beliefs about various etiologies of mental illness, the model chosen for this study is the bio-psycho-social-spiritual model, an extension of the bio-psycho-social model with the integration of spirituality. The bio-psycho-social model, proposed by George Engel in 1977 for the medical field is a way of looking at the mind and body of an individual as two important systems that are interconnected. This model considers the biological, psychological, and social issues as systems of the body. It makes a distinction between actual pathological processes that cause disease, and the individual's views of their health and effects on it, which is the illness (http://www.fact-index.com/b/bi/biopsychosocial_model.html).

Engel (1977) argues that illness and disease do not automatically run together. For example, an individual may be relatively well, meaning not sick, but if that individual feels unwell, it is considered an illness. In the same way, individuals with something physically wrong with them are diseased, though they may feel completely alright, they are not ill. The bio-psycho-social model assumes that it is important to handle the two together because they are both considered important. This model also gives great meaning to illness as well as the separate existence of disease and illness. The bio-psycho-social model states that workings of the mind can affect the body. This does not automatically mean that there is a direct effect between mind and body, but other intermediary aspects can form a bridge from thought to biological fact (Engel, 1977).

Within the field of social work, the goal of the psychosocial approach is to determine a psychosocial diagnosis of a client. Factors including history and

developmental processes are considered when making a diagnosis and employing the change efforts (Jordan & Franklin, 2003). Jordan and Franklin (2003) note the origination of person-in-environment with the thinking of this model. Figure 1.1 shows the bio-psycho-social framework for assessment.

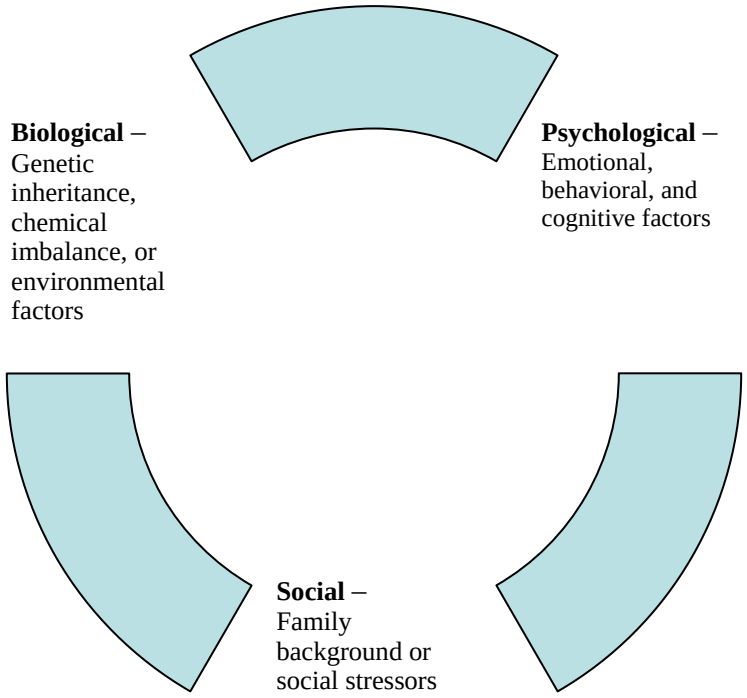

Figure 1.1: Bio-psycho-social framework for assessment

Cumella (2002) notes that Engel's model was adopted by health professions as the main model to use in order to conceptualize and treat physical and mental illness. The model acknowledges that mental illness occurs through an interactive process involving: (1) genetic and biomedical factors, (2) psychological, emotional, behavioral, and cognitive factors, and (3) social and family factors (Cumella, 2002). Cumella (2002) recognizes that each area may generate a susceptibility to, or protect against, the

development of specific mental illnesses. It is among the complex bio-psycho-social interactions that mental illness occurs, progresses, heals, or fails to develop at all (Cumella, 2002).

The recognition of the importance of spirituality in the lives of individuals has led to the addition of spirituality to the model to assist in understanding mental health and illness (Cumella, 2002). The author notes that because spiritual beliefs are assumed to influence thoughts and choices and are many times formed within a social context such as the family or church, conventional sources have begun to recognize spirituality as an important characteristic of individual psychology and social/family functioning. Thus, spirituality is viewed as a crucial part of the "psycho-social" part of the model (Cumella, 2002).

Cumella (2002) argues that Christians may accept a different view of the model. While they may agree with the role of spirituality in mental health and illness, they may disagree with reducing spirituality to simply psychological and social dimensions. Through Bible teachings, it is the belief of Christians that human beings possess a body, soul, and spirit. When connected to the model, Cumella (2002) notes that the body corresponds to the "bio" aspect, the soul, which translates from the New Testament word, psyche, corresponds to the "psycho" aspect, and Biblical concepts including family, congregation, the communal Body of Christ, and national identity convey dimensions corresponding to the "social" aspect of the model.

Many Christians also believe that humans maintain a spirit distinct from their soul, asserting the existence of an actual spiritual realm and believing that this spiritual reality interacts in a dynamic manner with the bio-psycho-social model. Therefore, Christians propose that spirituality cannot be simply reduced to psychological beliefs, emotional experiences, and church functions. To Christians, the existence of spirituality

is above and beyond these experiences and humans are considered bio-psycho-social-spiritual (Cumella, 2002). Cumella (2002) asserts that only a comprehensive model will completely address all dimensions of mental health and illness.

Sulmasy (2002) argues that according to this model, every individual has a spiritual history which unfolds for many in the context of an explicit religious tradition. Despite how it unfolds, the spiritual history helps shape individuals as whole people, and when life-threatening illnesses occur, it affects each individual in his or her totality (Ramsey, 1970). The totality includes biological, psychological, and social characteristics (Engel, 1992) of an individual and spiritual aspects of the whole person as well (King, 2000; McKee & Chappel, 1992).

Sulmasy (2002) emphasizes that the bio-psycho-social-spiritual model is not considered a "dualism" in which the "soul" accidentally occupies a body. In this model, each aspect, biological, psychological, social, and spiritual are considered as only diverse proportions of an individual, and no one aspect can be disaggregated from the whole. Each aspect can be affected differently depending upon an individual's history and illness, and each aspect can interact and affect other aspects of the individual (Sulmasy, 2002). As previously stated, this model is an extension of the bio-psycho-social model with the integration of spiritual. Since mental illness is thought to be an interactive process (Cumella, 2002), spirituality becomes an important and equivalent piece of the model. Figure 1.2 shows the addition of the spirituality component to the bio-psycho-social model.

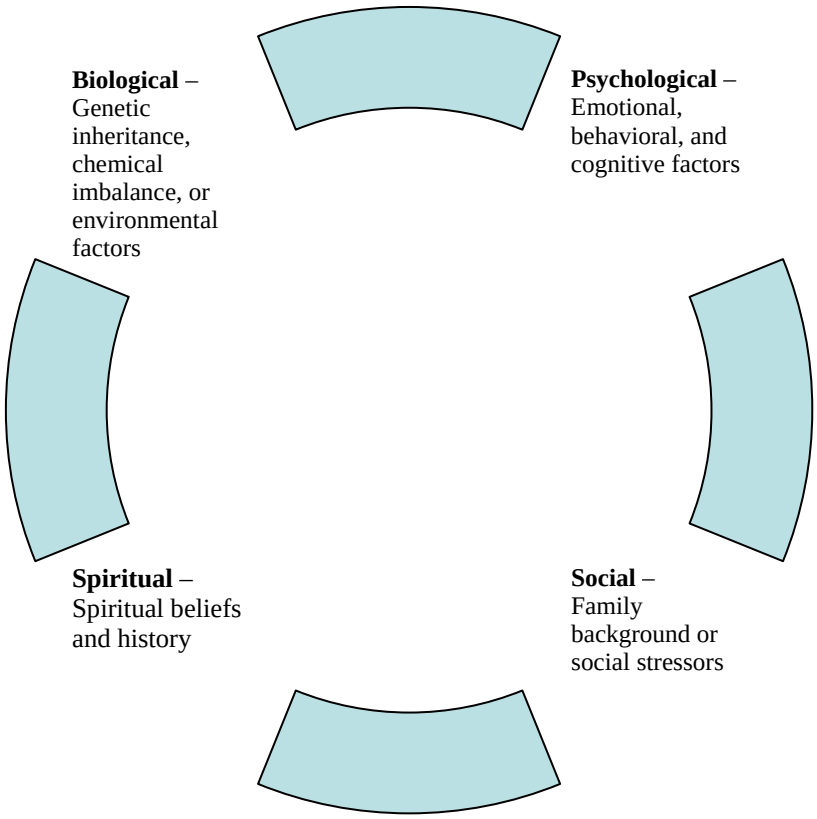

Figure 1.2: Bio-psycho-social-spiritual model

The bio-psycho-social-spiritual model was selected for this study because it is theorized that various demographic factors of African American ministers such as level of education, type of training, and denomination will contribute to which factor in the model the ministers will use in conceptualizing and attributing cause of mental illness. This model was integrated into the survey instrument through the use of the causal attributions selected to represent each area of the model. The causal attributions include the following: a chemical imbalance and genetic or inherited problem (biological factors), a nervous breakdown or a mental illness (psychological factors), own bad character, the way he/she was raised, or stressful circumstances (social factors), and God's will or a crisis in faith (spiritual factors).

CHAPTER 3

METHODOLOGY

The research design used for this study was a cross-sectional survey methodology which resulted in a single survey instrument derived from a number of previously developed instruments. The rationale for selecting this research design was to correlate responses from participants regarding: (1) their ability to provide services to individuals with mental illness and (2) the type of decision-making regarding how they would attempt to provide assistance to individuals with mental illness with various demographic variables, as well as participants' self-perceived ability to recognize and attribute causation of mental illness.

This chapter provides an overview of the research design utilized in this study. First, a description of participants, the recruitment process, and survey materials are discussed. Next, a detailed account of the development and design of the instrument, along with an explanation of the measurement of all variables used in the study are presented. Also, the procedures used, the rationale for the analysis, and the hypotheses that were explored are summarized.

PARTICIPANTS

Participants for this study included a convenience sample of African American clergy and seminary students. Seminary students recruited for this study were graduate level students seeking a Master's or Doctorate degree and currently enrolled in a seminary program, school of Theology, or school of Divinity. Clergy were recruited through mailing lists provided by the Baptist Convention of Virginia, the alumni mailing list from Virginia Union University, Samuel DeWitt Proctor School of Theology, and

church directories for states including California, Texas, Michigan, Illinois, Pennsylvania, Virginia, Washington, D.C., Maryland, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, and Tennessee. A total of 2,970 potential participants were contacted for this study. For clergy, a total of 1,200 survey packets were mailed and 70 surveys were distributed to clergy attending a Ministerial Alliance conference in Columbus, Georgia

A formal letter requesting permission to distribute surveys to seminary students was sent to Deans and Presidents of each institution. Letters granting permission were received from Howard University School of Divinity, located in Washington, D.C., Virginia Union University Samuel DeWitt Proctor School of Theology, located in Richmond, Virginia, and the Interdenominational Theological Center, located in Atlanta, Georgia with the appropriate contact person listed. A total of 425 survey packets were distributed to Virginia Union University students and in an attempt to increase the response rate, an additional 900 recruitment letters were distributed to the Virginia Union University alumni list with the regular alumni mailing from the School of Theology. Due to the large number of alumni and financial constraints, the researcher elected to mail only recruitment letters asking potential participants to complete the online version of the survey. A total of 75 survey packets were distributed to Interdenominational Theological Center students. A total of 300 seminary students attending Howard University were only given a copy of the cover letter with information about the study, including the web address, during a weekly Chapel session instead of the complete survey packet as requested by the Interim Dean of Academic Affairs.

A total of 130 surveys were returned; however, only 125 of those surveys were complete and usable, which represents a return rate of less than 5 percent. The response

rate is considered low and contributes to limitations of the study. The limitations will be discussed in detail in the next two chapters of this dissertation.

The initial group of potential participants (n = 1,770) were contacted through a single mailing of the survey packet. Survey packets included a cover letter, an endorsement letter from a local clergy member, the survey, and a labeled self-addressed return envelope with postage. The cover letter introduced the researcher, described the purpose of the study, potential benefits of participation and possible outcomes based upon findings as well as an explanation of risks or potential discomfort, the right to refuse participation or withdrawal without penalty, issues regarding confidentiality, and the opportunity to offer feedback. The cover letter also provided contact information of the Institutional Review Board (IRB) and the researcher in case of any questions or concerns. In essence, the cover letter served as the consent form (see Appendix A).

In order to assist in maintaining participants' confidentiality, the researcher requested and obtained a Waiver of Informed Consent from the IRB. This request was made because the inclusion of a consent form in the survey packets would have allowed the researcher to possibly identify study participants once the surveys and consent forms were mailed together back to the researcher. A letter of endorsement from a local clergy member was also included in the survey packets to assist in lending credibility to the study and the researcher as well as to encourage participation in the study (see Appendix B).

For seminary students, the content of the survey packets were the same as those mailed to clergy. However, the cover letters for seminary students also explained that their participation was strictly voluntary and not a class requirement (see Appendix C). Two weeks after the initial survey distribution, follow-up postcards were mailed to clergy to encourage participation. In addition, follow-up postcards were also mailed to contact

persons at the schools of Theology and Divinity for distribution to the students in order to encourage participation.

INSTRUMENTATION

The Clergy's Perception of Mental Illness (CPMI) Survey was the instrument developed for this study (see Appendix D). This instrument was designed to:

- measure the ability of clergy and seminary students to correctly recognize mental illness;
- examine how clergy and seminary students attribute cause of mental illness;
- examine perceived beliefs of clergy and seminary students regarding their ability to provide services; and,
- examine types of decision-making regarding how clergy and seminary students would attempt to provide services to individuals presenting mental illnesses.

This 45-item self-report instrument was a vignette design which included a combination of questions and vignettes about mental illness obtained from the 1996 General Social Survey (GSS). The instrument included specific questions regarding type, cause, and severity of the presented problem, a set of response categories from an article written by Larson (1969) regarding the degree to which participants would attempt to provide services, and questions developed by the researcher. A vignette design was used in this study due to the similarity of this type of design in earlier research which also examined individuals' perceptions of mental illness (Star, 1955; Schnittker, Freese, & Powell, 2000). The General Social Surveys were designed as part of a plan of social indicator research, duplicating questionnaire items and wording in order to assist time-

trend studies. The mental health module portion of the 1996 GSS survey was selected because of the mental health vignettes and follow-up questions.

The CPMI had three sections, which included: (1) the demographic section, (2) the presentation of vignettes and follow-up questions regarding causal attribution, types of decision-making, and beliefs about ability to provide services, and (3) additional questions. First, participants were instructed to complete the questionnaire by placing an X in the appropriate box or filling in the answer where instructed. It was noted that while some questions were specifically directed to clergy, others were specifically directed to seminary students with a category selection of Not Applicable (NA) if the question did not apply. For example,

Clergy were asked:

If you are clergy, did you attend seminary?

The response set for this question included a yes/no format:

- 1 = Yes
- 2 = No
- 3 = Not Applicable (NA)

Seminary students were asked:

If you are a student what type of degree are you seeking?

The response categories for this question included:

- 1 = Bachelors
- 2 = Masters
- 3 = Doctorate
- 4 = Not Applicable (NA)

Section 1: Demographics

The survey began with 13 demographic questions which included:

- age
- gender
- current status (clergy, seminary student, or both)
- highest level of education
- school currently attending (for seminary students)
- type of degree seeking
- type of training (seminary vs. non-seminary)
- state of residence
- denomination
- level of theological orientation
- number of years in the ministry
- number of members in the church congregation
- if specialized training in mental health was received.

Section 2: Vignettes and Follow-up Questions

Participants were given four vignettes describing an individual with variance in gender and race who exhibited symptoms consistent with one of four types of mental illness including schizophrenia, major depression, alcohol dependence, and a drug problem, as defined by the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association and one vignette describing an individual with no problem.

For example:

Situation 1:

John is a White man with a college education. During the last month, John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty, and he couldn't sleep, so he took another drink. His family has complained that he is often hung over, and has become unreliable – making plans one day, and canceling them the next.

In your opinion, what is John experiencing:

1. [ ] Alcohol dependence
2. [ ] A major depression
3. [ ] Schizophrenia
4. [ ] A drug problem
5. [ ] No problem

After each vignette was presented, participants were asked to identify the problem, a question regarding severity of the problem, a question regarding causal attribution with 10 probable causes in which participants were provided with a set of Likert scale responses for each cause, two questions regarding how they would attempt to handle the situation (in a clinical manner or in a spiritual manner), and a question regarding the amount of assistance needed to handle the situation presented.

An example of the question regarding severity of the problem is:

How serious would you consider John's problem to be?

- 1 = Very serious
- 2 = Somewhat serious
- 3 = Undecided

- 4 = Not very serious
- 5 = Not at all serious

An example of the causal attribution question is:

In your opinion, how likely is it that John's problem is caused by:

a. His own bad character
b. A chemical imbalance in the brain
c. The way he was raised
d. Stressful circumstances in his life
e. A genetic or inherited problem
f. God's will
g. A nervous breakdown
h. A mental illness
i. A physical illness
j. Crisis in faith

Likert scale responses that followed each potential cause included:

- 1 = Very likely
- 2 = Somewhat likely
- 3 = Undecided
- 4 = Not very likely
- 5 = Not at all likely

Examples of the questions regarding how participants would attempt to handle the situation include:

If John approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)?

Would you attempt to advise him in a spiritual manner (i.e. prayer or meditation)?

Likert type responses that followed each question included:

- 1 = Very likely
- 2 = Somewhat likely
- 3 = Undecided
- 4 = Not very likely
- 5 = Not at all likely

An example of the question regarding amount of assistance needed to provide assistance is:

If John approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

- 1 = I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).
- 2 = I could provide ***major assistance*** in conjunction with properly trained professional people.
- 3 = Undecided
- 4 = I could provide ***minor assistance*** in conjunction with properly trained professional people.
- 5 = I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

Section 3: Additional Questions

Additional questions were asked following the last vignette and follow-up questions regarding:

- type of ministries (outreach programs) provided by churches,
- interest in receiving specialized mental health training,

- knowledge of community mental health agencies that assist mentally ill individuals, and
- comfort level in referring individuals in need to community mental health agencies.

Examples of the questions include:

In your church, do you have a ministry (outreach program) devoted to assisting individuals with mental illness?

Response categories included:

- 1 = Yes
- 2 = No
- 3 = Not Applicable (NA)

If offered, would you attend training to work with individuals with mental illness:

Response categories included:

- 1 = Yes
- 2 = No

Are you aware of mental health resources that are available in your community:

Response categories included:

- 1 = Yes
- 2 = No

What is your level of comfort in referring individuals in need of help to social service agencies within your community:

Likert scale response categories included:

- 1 = Very comfortable
- 2 = Somewhat comfortable
- 3 = Undecided

- 4 = Not very comfortable
- 5 = Not at all comfortable

Participants were also given the opportunity to write any comments or recommendations they had regarding ways to address mental health needs of African Americans.

An example of the question is:

> Please write/type any comments or recommendations that you have regarding ways to address mental health needs of African Americans.

For seminary students, a question regarding their assessment of adequate preparation from school to assist individuals with mental illness was also included.

The question is:

> If you are still in school, do you feel that you are adequately prepared to assist individuals with mental illness?
>
> The Likert scale response that followed this question included:

- 1 = Strongly agree
- 2 = Agree
- 3 = Neutral
- 4 = Strongly disagree
- 5 = Disagree
- 6 = Not applicable (NA)

Due to the addition of response categories from the 1969 Larson article along with demographic and additional questions, the reliability and validity of the instrument was questioned. While the researcher was unable to locate a reliability coefficient for the General Social Survey (GSS), the National Opinion Research Center (NORC) noted in a description of the GSS that “the NORC also incorporates methodological experiments

into each year of the GSS data collection. These have involved question wording, context effects, use of different types of response scales, as well as random probes and other assessments of validity and reliability" (http://www.norc.uchicago.edu/projects/gensoc1.asp). The GSS is considered to be a standardized measure; however, the other measures used are not standardized. The measures that are not standardized contribute to the need to establish validity and reliability.

The preliminary instrument was pre-tested by five clergy members in order to ensure that all concepts were clear and understood as intended to assist in beginning the establishment of validity. Revisions to the instrument were based upon the feedback provided by individuals completing the preliminary instrument. Questions and response categories consistently identified as unclear were revised. Revisions to wording included:

- changing the use of the term minister or pastor to clergy;
- changing the term theology student to seminary student;
- the addition of the "other" category to the question regarding theological orientation; and,
- the addition of "crisis in faith" as an option of probable cause of mental illness.

The instrument was further tested for validity and reliability during data collection in order to determine if the instrument actually measured the concepts presented and answers were consistent as intended by the researcher. To assist in establishing validity and reliability, ten mental health professionals were contacted. They were asked to

review the instrument in order to ensure that all concepts were clear and understood as intended for validity. Revisions to wording included specifying examples for questions regarding types of decision-making to include:

- the addition of the words psychological or pastoral in parentheses to the clinical questions and,
- the addition of the words prayer or meditation in parentheses to the spiritual question

The ten mental health professionals were also asked to complete the portion of the survey specifically asking study participants to identify the mental illness presented after each vignette. A total of seven surveys were returned. Six of the 7 mental health professionals correctly identified each mental illness presented in the vignettes with the last professional incorrectly identifying the last mental illness in the vignette describing an individual with no problem.

Variables

There were two dependent variables which included: (1) belief about ability to provide services and (2) type of decision-making. The variable, belief about ability to provide services, was operationally defined in terms of the degree to which clergy would attempt to provide assistance:

- 1 = Able to handle the issue ***alone***
- 2 = Able to provide ***major assistance*** in combination with properly trained individuals
- 3 = Undecided
- 4 = Able to provide ***minor assistance*** in combination with properly trained individuals

- 5 = ***Not*** adequately trained to handle this issue other than refer to properly trained individuals

The variable, type of decision making, was operationally defined in terms of the degree to which the clergy would attempt to handle the situation in a clinical (psychological or pastoral type counseling) or spiritual manner (prayer or meditation):

- 1 = Very likely
- 2 = Somewhat likely
- 3 = Undecided
- 4 = Not very likely
- 5 = Not at all likely

There were two independent variables which included: (1) conceptualization of mental illness and (2) causal attribution of mental illness. Conceptualization was operationally defined as the number of mental illnesses that clergy and seminary students were able to correctly recognize. The range was from 0 – 5, representing the number of illnesses correctly recognized. Causal attribution was operationally defined as the number of factors that clergy and seminary students identified as contributing to the individual's problem presented in the vignette as a mental illness (a biological or psychological issue) or other life circumstances (a social or spiritual issue). The range was from 0 – 5, representing the number of factors identified by participants as being very or somewhat likely in contributing to the individual's presented problem.

Finally, the control variables included:

- gender
- highest level of education
- type of degree seeking
- type of training (seminary vs. non-seminary)

- denomination
- level of theological orientation
- number of years in the ministry
- number of members in the church congregation
- if specialized mental health training was received

The purpose for controlling for these variables was to examine if significant relationships identified between the independent and dependent variables were explained away by any of these variables.

Procedures

Surveys were distributed to participants through the mail and were also available for completion online. The online survey was placed on the Internet with the assistance of Systems Analyst, Robert Canon, Ph.D. of The University of Texas, School of Social Work. In addition, information on how to access the online version of the survey was included in the cover letter for individuals who preferred participating online. The web address for online access was: http://128.83.80.200/catmi/.

For the online version, an exact duplicate of the cover letter included in the survey packets was provided first for potential participants to read and either agree or disagree to continue participation in the study. If participants agreed, the site directed them to the survey. If participants disagreed, the site directed them to a page with a statement thanking them for consideration. Due to the large number of individuals being contacted for participation, survey distribution took two weeks to complete which began the first week of March 2005. Data was collected until May 16, 2005. As surveys were completed online, a date stamp was used to identify the time and dates that surveys were completed. For mailed surveys, dates were also recorded on return envelopes. The procedures for the mail survey have been previously discussed in the Participant section.

Analysis

A hierarchical multiple regression was the statistical test used for this study in order to examine the relationship between the independent and dependent variables after controlling for the effects of other independent variables on the dependent variable. As previously stated, the independent variables were conceptualization and causal attribution, the dependent variables were beliefs about the ability to provide services and types of decision-making, and the control variables for this study were gender, level of education, type of training (seminary vs. non-seminary), type of degree seeking, level of theological orientation, denomination, number of years in the ministry, number of members in the church congregation, and if specialized mental health training was received.

The goal of this analysis was to determine the existence of an overall relationship between the independent and dependent variables, the existence of a relationship between each added control variable and the dependent variables, and if the addition of the control variables reduced the error in predicting the dependent variables and changed the percent of variance in the dependent variables explained by the independent variables. Frequencies and descriptives were also run on the data and will be discussed in the next chapter.

In order to attempt to determine which control variables should be included in the model for analysis, a factor analysis was performed as a method of reducing the number of variables that should be statistically included in the hierarchical regression model. While the factor analysis showed significant relationships through the loadings of certain variables on various components, the relationships could not be logically explained. Thus, control variables included in the analyses were based upon the logic of the researcher. Before beginning the analysis, non-metric variables were dummy-coded in

order to meet the requirements of the type of variables that should be included in this type of analysis (see Appendix E). Also, Likert scale responses with the following categories were recoded:

- 1 = Very likely
- 2 = Somewhat likely
- 3 = Undecided
- 4 = Not very likely
- 5 = Not at all likely

The undecided category was placed into the middle of the continuum; thus, the new categories included the following:

- 1 = Very likely
- 2 = Somewhat likely
- 3 = Undecided
- 4 = Not very likely
- 5 = Not at all likely

The purpose of recoding this category was to present a better representation of the continuum, where 1 represents more of the attribute and 5 represents less of the attribute. Other variables that were recoded included: type of degree seeking, denomination, and level of theological orientation. An explanation of all recoded variables can be found in Appendix F. Due to the low sample size, the researcher was not able test the hypotheses; instead, the hypotheses were explored for identification of potential relationships that can be further tested in future research. This limitation will be elaborated on further in the next chapter.

The hypotheses that were explored included:

$H_{1:}$ After controlling for demographic variables, clergy who correctly recognize a higher number of mental illnesses will be more likely to attempt to advise or counsel in a clinical manner.

$H_{2:}$ After controlling for demographic variables, clergy who correctly recognize a lower number of mental illnesses will be more likely to attempt to advise in a spiritual manner.

$H_{3:}$ After controlling for demographic variables, clergy who correctly recognize a higher number of mental illness will report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals.

$H_{4:}$ After controlling for demographic variables, clergy who attribute cause to biological or psychological reasons will be more likely to attempt to advise or counsel in a clinical manner.

$H_{5:}$ After controlling for demographic variables, clergy who attribute cause to spiritual reasons or other life circumstances will be more likely to attempt to advise in a spiritual manner.

$H_{6:}$ After controlling for demographic variables, clergy who attribute cause to biological or psychological reasons will report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals.

$H_{7:}$ After controlling for demographic variables, clergy who attribute cause to spiritual reasons or other life circumstances will be more likely to report their ability to handle the situation alone.

The hypotheses were developed by building on previous literature. Neighbors (2003) discussed the importance of understanding the role that clergy play in mental health. Also, Kim-Goh (1993) previously examined the conceptualizations and referral intent of Korean American clergy. Their findings of the differences in referral intent based upon psychological conceptualizations versus religious conceptualizations along with the questions raised by Neighbors assisted in the development of the hypotheses.

CHAPTER 4

RESULTS

In this chapter, the results of all analyses will be presented. First, descriptive statistics of demographic variables included in the analyses are summarized. Next, results from the hierarchical multiple regression models are discussed. Also, a brief description of the validation analysis used for the models are presented.

Descriptive Statistics of Demographic Variables

Demographic variables entered into the analysis included: gender, level of education, type of degree seeking (by students), seminary attendance, level of theological orientation, denomination, receipt of specialized training, number of years in the ministry, and number of congregation members. These variables were used as control variables and entered into the analysis accordingly. As shown in Table 4-1, 70.4% of participants were male, while 29.6% were female. In terms of level of education, the majority of participants (54.4%) reported having a Masters degree, 28.0% reported having a Bachelor's degree, 11.2% reported having a Doctoral degree, 5.6% reported having some college or no degree, and 0.8% did not answer the question and were coded and entered as missing. Individuals currently attending seminary, 32.8% reported seeking a Master's degree, 3.2% reported seeking a Doctorate degree, and 64.0% answered the question as Not Applicable. Finally, individuals identifying themselves as clergy members were asked about seminary attendance. Approximately 44.8% reported attending seminary, 19.2% reported not attending, 30.4% answered the question as Not Applicable, and 5.6% did not answer the question and were coded and entered as missing.

With regard to denomination, 37.6% of participants reported their denomination as Baptist, 36% of participants as an Other denomination, 25.6% of participants as African Methodist Episcopal (AME), and 0.8% of participants did not report a denomination and were coded and entered as missing. Along with denomination, participants were also asked to report their theological orientation as fundamentalist, moderate, or liberal. The majority of participants (43.6%) identified their theological orientation as moderate, 33.6% as liberal, and 14.4% as fundamentalist with the mean value of 2.21 showing that most participants categorized themselves as having a moderate theological orientation. Participants were also asked if they had ever received specialized training in the area of mental health. The majority of participants (51.2%) reported having received training, 44.0% reported not having received training, and 4.8% did not answer the question and were coded and entered as missing.

Table 4-1. Characteristics of Study Participants

Category	N	%
Gender		
Male	37	70.4
Female	88	29.6
Level of Education		
Some college/no degree	7	5.6
College graduate	35	28.0
Master's degree	68	54.4
Doctorate degree	14	11.2
Missing	1	0.8
Type of Degree Seeking		
Master's degree	41	32.8
Doctorate degree	4	3.2
Not applicable	80	64.0
Seminary Attendance		
Yes	56	44.8
No	24	19.2
Not applicable	38	30.4
Missing	7	5.6
Denomination		
Baptist	47	37.6
African Methodist Episcopal	32	25.6
Other	45	36.0
Missing	1	0.8
Level of Theological Orientation		
Fundamentalist	18	14.4
Moderate	54	43.2
Liberal	42	33.6
Missing	11	8.8
Received Specialized Training		
Yes	64	51.2
No	55	44.0
Missing	9	4.8

As shown in table 4.2, participants reported a minimum of 1 year to a maximum of 51 years in the ministry. The mean number of years in the ministry was 19.38 years. Regarding number of members in the congregation, participants reported a minimum of 2 members to a maximum of 10,000 members. The mean number of members in the congregation was 621.49 members. Finally, the mean value of theological orientation was 2.21 showing that most participants categorized themselves as having a moderate theological orientation. The variable level of theological orientation was coded as: 1 = Fundamentalist, 2 = Moderate, and 3 = Liberal.

Table 4-2. Mean Values of Study Participants' Characteristics

Category	Minimum	Maximum	Mean
Number of years in the ministry	1	51	19.38
Number of members in congregation	2	10,000	621.49
Level of theological orientation	1	3	2.21

Evaluation of Missing Data, Outliers, and Assumptions

Prior to beginning the analyses, the data set was examined for missing data, outliers, and assumptions of normality, linearity, and homogeneity. There were no problems found with missing data. With regards to outliers, the dependent variable decision making in a clinical manner was identified as an outlier. However, the case was left in the data set because of the characteristics of the participant.

In terms of testing assumptions for normality, linearity, and homogeneity, a number of the variables did not meet the requirements of any of the assumptions. Since transformations of variables did not succeed, limitations of interpreting any significant relationships found are acknowledged and will be discussed in the next chapter.

The independent variables explored included:

Conceptualization:

(1) number of mental illness correctly recognized,

Causal Attributions:

(1) average number of causes attributed to mental factors,

(2) average number of causes attributed to social/spiritual factors.

The dependent variables explored included:

Decision making:

(1) attempt to counsel in a clinical manner,

(2) attempt to advise in a spiritual manner, and

Perceived ability level to provide help:

(1) total help level score of perceived ability to provide services.

Multivariate Analyses of Independent and Dependent Variables

There were seven hypotheses explored in this study using a hierarchical multiple regression analysis. The significance level of .05 was used to evaluate the overall regression and the individual relationships between independent and dependent variables.

Hypothesis 1:

$H_{1:}$ After controlling for demographic variables, clergy who correctly recognize a higher number of mental illnesses will be more likely to attempt to advise or counsel in a clinical manner.

For hypothesis 1, results showed that the overall regression relationship for all independent variables was not statistically significant ($F (10, 48) = 1.283$, $p = 0.267$). Once the predictor variable, number of mental illnesses correctly recognized, was added to the model, it was also found not to be statistically significant and did not contribute to the overall relationship with the dependent variable ($F (1, 48) = .453$, $p = 0.504$). Thus, hypothesis 1 was not supported.

In terms of examining relationships between individual independent variables to dependent variables, the individual variables that were significant and those close to significance were interpreted. Due to the limitation of the small sample size, the reported variables that were close to significance should be examined more carefully in future research with a larger sample size to determine if the relationships between variables are found to be statistically significance. For hypothesis 1, there was one variable that was statistically significant (level of education) and one variable that was close to significance (type of degree seeking). The significance level for the independent variable level of

education was less than 0.05 (t = -2.152, p = 0.036) showing a statistically significant relationship between level of education and attempting to advise or counsel in a clinical manner. The b coefficient associated with the variable level of education (-0.304) was found to have an inverse relationship which suggested that participants with higher levels of education were less likely to attempt to advise or counsel in a clinical manner.

For the independent variable type of degree seeking, the significance level found was slightly greater than the level of significance of 0.05 (t = 1.959, p = 0.056). Therefore, there was not a statistically significant relationship found between type of degree seeking and attempting to advise or counsel in a clinical manner. Since the relationship was close to being significant, it was interpreted as a possible direct relationship (b = 0.739) which suggested that participants seeking a higher type of degree (doctoral degree) were more likely to attempt to advise or counsel in a clinical manner. Table 4-3 shows the results of the analysis of Hypothesis 1.

Table 4-3. Hypothesis 1: Analysis of Conceptualization of Mental Illness, Decision Making in a Clinical Manner, and Significant Control Variables

Independent Variables	B	Beta	t	p
Gender - male	-5.331	-.016	-.109	.914
Level of education	-.304	-.324	-2.152	.036**
Type of degree seeking	.739	.308	1.959	.056
Denomination - Baptist	-.506	-.204	-1.207	.234
Level of theological orientation	-.185	-.108	-.797	.429
Number of years in ministry	-1.329	-.128	-.881	.382
Number of members in congregation	3.220	.125	.882	.382
Seminary attendance	-.203	-.073	-.488	.628
Number of mental illnesses correctly recognized	-.110	-.091	-.673	.504

Note. R^2 = .211, F (10, 48) = 1.283, p = 0.267; Adjusted R^2 = .046; R^2 Change = .007; F (1, 48) = .453, p = 0.504; **p<.05

Hypothesis 2:

$H_{2:}$ After controlling for demographic variables, clergy who correctly recognize a lower number of mental illnesses will be more likely to attempt to advise in a spiritual manner.

For hypothesis 2, results showed that the overall regression relationship for all independent variables was statistically significance (F (10, 48) = 2.378, p = 0.022). However, once the predictor variable, number of mental illnesses correctly recognized, was added to the model, it was not statistically significant and the addition of the predictor variable did not contribute to the overall relationship with the dependent variable (F (1, 48) = .398, p = 0.531). Thus, hypothesis 2 was not supported.

In terms of examining relationships between individual independent variables to dependent variables, two variables, type of degree and Baptist denomination were significant, and one variable, level of theological orientation, was close to significance. The independent variable type of degree was less than the level of significance of 0.05 ($t = 2.157$, $p = 0.013$). There was a statistically significant relationship found between type of degree and attempting to advise in a spiritual manner. The b coefficient associated with type of degree (0.867) was positive, indicating a direct relationship which suggested that participants seeking a higher degree (doctorate) would be more likely to attempt to advise in a spiritual manner.

The independent variable Baptist denomination was also statistically significant ($t = -2.085$, $p = 0.042$). There was a statistically significant relationship found between Baptist denomination and attempting to advise in a spiritual manner. The b coefficient (-0.781) associated with Baptist denomination indicated an inverse relationship which suggested that participants identifying their denomination as Baptist were less likely than other denominations to attempt to advise in a spiritual manner.

Finally, the significance level found for the independent variable level of theological orientation was slightly greater than the level of significance of 0.05 ($t = -.1928$, $p = 0.060$). Since the b coefficient (-0.399) was close to being significant, it was interpreted as a possible inverse relationship which suggested that participants who identified their theological orientation as more liberal were less likely to attempt to advise in a spiritual manner. Table 4-4 shows the results of the analysis of Hypothesis 2.

Table 4-4. Hypothesis 2: Analysis of Conceptualization of Mental Illness, Decision Making in a Spiritual Manner, and Control Variables

Independent Variables	B	Beta	t	p
Gender – male	-.212	-.066	-.484	.631
Level of education	-.174	-.192	-1.383	.173
Seminary attendance	-.238	-.088	-.641	.524
Type of degree seeking	.867	.372	2.571	.013**
Denomination - Baptist	-.781	-.325	-2.085	.042**
Denomination - AME	-7.229	-.003	-.019	.985
Level of theological orientation	-.399	-.240	-1.928	.060
Number of years in ministry	-.004	-.044	-.0329	.743
Number of members in congregation	2.450	.098	.751	.456
Number of mental illnesses correctly recognized	9.228	.146	.631	.531

Note. R^2 = .331, F (10, 48) = 2.378, p = 0.022; Adjusted R^2 = .192; R^2 Change = .006, F (1, 48) = .398, p = 0.531; **p<.05

Hypothesis 3:

$H_{3:}$ After controlling for demographic variables, clergy who correctly recognize mental illness will report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals.

Results of hypothesis 3 for the overall regression relationship for all independent variables was not statistically significant (F (10, 46) = 1.624, p = 0.130). Once the predictor variable, number of mental illnesses correctly recognized, was added to the model, it also was not statistically significant and did not contribute to the overall regression relationship (F (1, 46) = 1.029, p = 0.316). Hypothesis 3 was not supported.

For hypothesis 3, there was one individual independent variable that was close to significance (type of degree seeking). The significance level for the independent variable type of degree seeking was slightly greater than .05 ($t = 1.882$, $p = 0.066$) showing that there was not a statistically significant relationship found between type of degree seeking and belief about ability level to provide services. Since the b coefficient was close to being significant, it was interpreted as a possible direct relationship ($b = 0.875$) which suggested that participants seeking a higher type of degree (doctoral degree) were more likely to report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals. Table 4-5 shows the results of the analysis of Hypothesis 3.

Table 4-5. Hypothesis 3: Analysis of Conceptualization of Mental Illness, Belief About Ability Level, and Control Variables

Independent Variables	B	Beta	t	p
Gender - male	.494	.122	.824	.414
Level of education	.135	.117	.778	.440
Seminary attendance	-.532	-.155	-1.054	.297
Level of theological orientation	-.337	-.158	-1.180	.244
Number of years in ministry	.013	.099	.697	.489
Number of members in congregation	-.001	-.197	-1.415	.164
Type of degree seeking	.875	.292	1.882	.066
Denomination – Baptist	-.340	-.111	-.661	.512
Denomination – AME	-.528	-.168	-1.010	.318
Number of mental illnesses correctly recognized	.222	.134	1.014	.316

Note. R^2 = .261, F (10, 46) = 1.624, p = 0.130; Adjusted R^2 = .100; R^2 Change = .017, F (1, 46) = 1.029, p = 0.316; **p<.05

Hypothesis 4:

$H_{4:}$ After controlling for demographic variables, clergy who attribute cause to biological or psychological reasons will be more likely to attempt to advise or counsel in a clinical manner.

Results of hypothesis 4 showed the overall regression relationship for all independent variables was not statistically significant (F (10, 48) = 1.352, p = 0.231). After the predictor variable, attributing cause of mental illness to biological or psychological reasons, was added to the model, it was also found not to be statistically

significant and did not contribute to the overall relationship with the dependent variable ($F(1, 48) = 1.006$, $p = 0.321$). Hypothesis 4 was not supported.

For hypothesis 4, one individual independent variable was significant (level of education) and one variable was close to significance (type of degree seeking). For the independent variable level of education, there was a statistically significant relationship found between level of education and attempting to advise or counsel in a clinical manner ($t = -2.202$, $p = 0.033$). There was an inverse relationship found ($b = -0.309$) which suggested that participants with higher levels of education were less likely to attempt to advise or counsel in a clinical manner.

The significance level for variable type of degree seeking was slightly greater than 0.05 ($t = 1.733$, $p = 0.090$). There was not a statistically significant relationship found between type of degree seeking and attempting to advise or counsel in a clinical manner. Since the b coefficient was close to being significant, it was interpreted as a possible direct relationship ($b = 0.657$) which suggested that participants seeking a higher type of degree (doctoral degree) were more likely to attempt to advise or counsel in a clinical manner. Table 4-6 shows the results of the analysis of Hypothesis 4.

Table 4-6. Hypothesis 4: Analysis of Causes Attributed to Mental Health Reasons, Decision Making in a Clinical Manner, and Control Variables

Independent Variables	B	Beta	t	p
Gender - male	-7.444	-.023	-.153	.879
Level of education	-.309	-.330	-2.202	.033**
Seminary attendance	-8.686	-.031	-.211	.834
Level of theological orientation	-.205	-.119	-.885	.380
Number of years in ministry	-.008	-.081	-.551	.584
Number of members in congregation	2.584	.100	.700	.487
Type of degree seeking	.657	.274	1.733	.090
Denomination – Baptist	-.540	-.218	-1.317	.194
Denomination – AME	-.457	-.182	-1.057	.296
Causal attributions – Mental	.180	.140	1.003	.321

Note. R^2 = .220, F (10, 48) = 1.352, p = 0.231; Adjusted R^2 = .057; R^2 Change = .016, F (1, 48) = 1.006, p = 0.321; **p<.05

Hypothesis 5:

$H_{5:}$ After controlling for demographic variables, clergy who attribute cause to spiritual reasons or other life circumstances will be more likely to attempt to advise in a spiritual manner.

For hypothesis 5, results showed that the overall regression relationship for all independent variables was statistically significant (F (10, 48) = 2.928, p = 0.006). Once the predictor variable, attributing cause to spiritual reasons or other life circumstances, was added to the model, it was also found to be statistically significant and contributed to the overall relationship with the dependent variable (F (1, 48) = 4.106, p = 0.048). The addition of the predictor variable, attributing cause to spiritual reasons or other life

circumstances, reduced the independent influence of decision making in a spiritual manner by 5.3%. Although the reduction was relatively small, hypothesis 5 was supported.

Two individual independent variables were significant (type of degree seeking and attributing cause to spiritual reasons or other life circumstances) and one variable was close to significance (level of education). For the independent variable type of degree, there was a statistically significant relationship found between type of degree seeking and attempting to advise in a spiritual manner ($t = 2.130$, $p = 0.038$). The direct relationship ($b = 0.713$) suggested that participants seeking a higher type of degree were more likely to attempt to advise in a spiritual manner.

The variable attributing cause to spiritual reasons or other life circumstances was also statistically significant ($t = 2.026$, $p = 0.048$). Therefore, a statistically significant relationship was found between attributing cause to spiritual reasons or other life circumstances and attempting to advise in a spiritual manner. The b coefficient ($b = 0.411$) was interpreted as a direct relationship which suggested that participants attributing cause to spiritual reasons or other life circumstances were more likely to attempt to advise in a spiritual manner. Table 4-7 shows the results of the analysis of Hypothesis 5.

Table 4-7. Hypothesis 5: Analysis of Causes Attributed to Spiritual Reasons, Decision Making in a Spiritual Manner, and Control Variables

Independent Variables	B	Beta	t	p
Gender – male	-.331	-.103	-.773	.443
Level of education	-.206	-.226	-1.679	.100
Type of degree seeking	.713	.306	2.130	.038**
Seminary attendance	-.051	-.019	-.138	.891
Level of theological orientation	-.330	-.198	-1.633	.109
Number of years in ministry	.000	-.004	-.029	.977
Number of members in congregation	.000	-.005	-.036	.972
Denomination – Baptist	-.582	-.242	-1.602	.116
Denomination - AME	7.698	.032	.210	.835
Causal attributions – Spiritual	.411	.277	2.026	.048**

Note. R^2 = .379, F (10, 48) = 2.928, p = 0.006; Adjusted R^2 = .249; R^2 Change = .053, F (1, 48) = 4.106, p = 0.048; **p<.05

Hypothesis 6:

$H_{6:}$ After controlling for demographic variables, clergy who attribute cause to biological or psychological reasons will report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals.

Results of hypothesis 6 for the overall regression relationship for all independent variables was not statistically significant (F (10, 46) = 1.494, p = 0.172). Once the predictor variable, attributing cause of mental illness to biological or psychological reasons, was added to the model, it was also found not to be statistically significant and did not contribute to the overall relationship with the dependent variable (F (1, 46) = 0.049, p = 0.826). Thus, hypothesis 6 was not supported.

For hypothesis 6, one individual independent variable was close to significance (type of degree seeking). The significance level for the independent variable type of degree seeking was slightly greater than 0.05 ($t = 1.779$, $p = 0.082$) and there was not a statistically significant relationship found between type of degree seeking and belief about ability level to provide services. Since the variable was close to significance, it was interpreted as a possible, positive relationship ($b = 0.853$) which suggested that participants seeking a higher type of degree were more likely to report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals. Table 4-8 shows the results of the analysis of Hypothesis 6.

Table 4-8. Hypothesis 6: Analysis of Causes Attributed to Mental Health Reasons, Belief About Ability Level, and Control Variables

Independent Variables	B	Beta	t	p
Gender - male	.543	.134	.901	.372
Level of education	.150	.130	.856	.397
Seminary attendance	-.589	-.171	-1.149	.256
Level of theological orientation	-.355	-.166	-1.223	.228
Number of years in ministry	1.150	.088	.605	.548
Number of members in congregation	-.001	-.211	-1.470	.148
Type of degree seeking	.853	.285	1.779	.082
Denomination – Baptist	-.253	-.082	-.492	.625
Denomination – AME	-.490	-.156	-.894	.376
Causal Attributions – Mental	5.011	.032	.221	.826

Note. R^2 = .245, F (10, 46) = 1.494, p = 0.172; Adjusted R^2 = .081; R^2 Change = .001, F (1, 46) = 0.049, p = 0.826; **p<.05

Hypothesis 7:

$H_{7:}$ After controlling for demographic variables, clergy who attribute cause to spiritual reasons or other life circumstances will be more likely to report their ability to handle the situation alone.

Results of hypothesis 7 showed that the overall regression relationship for all independent variables was not statistically significant (F (10, 46) = 1.494, p = 0.172). The addition of the predictor variable, attributing cause of mental illness to spiritual reasons or other life circumstances, was not statistically significant and did not contribute

to the overall relationship with the dependent variable ($F(1, 46) = 0.052$, $p = 0.820$). Therefore, hypothesis 7 was not supported.

One individual independent variable, type of degree seeking, was close to significance ($t = 1.741$, $p = 0.088$) and there was not a statistically significant relationship found between type of degree seeking and belief about ability level to provide services. Since the variable was close to significance, it was interpreted as a possible, positive relationship ($b = 0.846$) which suggested that participants seeking a higher type of degree (doctoral degree) were more likely to report their ability to handle the situation alone or provide major assistance in combination with properly trained individuals. Table 4-9 shows the results of the analysis of Hypothesis 7.

Table 4-9. Hypothesis 7: Analysis of Causes Attributed to Spiritual Reasons, Belief About Ability Level, and Significant Control Variables

Independent Variables	B	Beta	t	p
Gender – male	.524	.129	.860	.394
Level of education	.144	.125	.818	.418
Seminary attendance	-.570	-.166	-1.069	.291
Level of theological orientation	-.334	-.156	-1.133	.263
Number of years in ministry	1.149	.088	.606	.547
Number of members in congregation	-.001	-.217	-1.440	.157
Type of degree seeking	.846	.282	1.741	.088
Denomination – Baptist	-.236	-.077	-.452	.654
Denomination – AME	-.509	-.162	-.957	.343
Causal attributions – Spiritual	6.738	.295	.228	.820

Note. R^2 = .245, (F (10, 46) = 1.494, p = 0.172 ; Adjusted R^2 = .081; R^2 Change = .001, F (1, 46) = 0.052, p = 0.820; **p<.05

Validation Analysis

To validate the results of the hierarchical multiple regression analysis, a 75/25 percent cross-validation was used in order to attempt to duplicate the pattern of statistical significance or lack of statistical significance found in the full data set for the 75 percent training sample. The validation analysis confirmed the significant and close to significant relationships found in each hypothesis. However, it is noted that because of the small sample size, the findings must be accepted with caution and cannot be generalized beyond the study's conditions.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore how African American clergy members conceptualize and attribute causation of mental illness after accounting for demographic differences. Due to the exploratory nature of the study and the absence of an abundance of literature related to this area, it was important to provide a theoretical framework and attempt to show the importance of continued research in this area. The study became more exploratory in nature because of the low response rate and small sample size which made it difficult to test hypotheses and detect any significant differences as well as the inability to generalize any significant findings to a wider population. The exploratory nature is noted as a limitation of the study because as noted by Rubin and Babbie (2001), one of the shortcomings of exploratory research is the inability to offer answers that are considered satisfactory to answering the research questions. Other limitations identified will also be discussed in more detail.

There were seven hypotheses explored in this study. Out of the seven hypotheses, only one was found to be statistically significant for the overall regression relationship as well as once the predictor variable was added to the model. Hypothesis 5 stated:

> After controlling for demographic variables, clergy who attribute cause to spiritual reasons or other life circumstances will be more likely to attempt to advise in a spiritual manner.

Although the independent influence of the addition of the predictor variable was small (5.3%), the hypothesis was still supported. The significant finding of the individual variable attributing cause to spiritual reasons or other life circumstances partially

substantiated the researcher's assumption that clergy would view spiritual assistance as the acceptable intervention if they interpreted the problem as having a spiritual base. Thus, advising individuals to pray or meditate over these types of problems is considered as a reasonable solution to the individual in need of help.

The individual independent variable type of degree seeking was also found to be significant and the direction of the relationship found was surprising. There was a positive, direct relationship found between type of degree seeking and attempting to advise in a spiritual manner in which individuals seeking a higher degree (doctoral degree) were more likely to advise in a spiritual manner. During the conceptualization of this hypothesis, the researcher thought that based on the problem or issue presented to the clergy member that individuals seeking a higher degree would be able to recognize and differentiate between problems of a spiritual nature and other problems of a more clinical nature. It was believed that individuals currently seeking a higher degree may have more opportunity for the most recent training that may be (depending on the type of training) more clinical in nature which in turn would provide them with tools to discern whether they should advise or counsel in a clinical or spiritual manner based upon the issue presented. This would allow them to approach their decision making process from a proactive standpoint and decide how they would be of greatest assistance to the person in need of help.

Upon further investigation of the independent variable type of degree seeking, the researcher looked for differences between the decision making process of clergy. The findings of cross-tabulations showed clergy did not appear to differentiate between attempting to advise or counsel in a clinical manner and those attempting to advise in a spiritual manner (see Appendix G). It was surmised from the findings that clergy participating in this study may not have viewed issues presented to them separately in

terms of a mental health issue or a spiritual issue. Thus, clergy advised individuals approaching them for help from a combination of both clinical and spiritual counseling.

The significant finding of the overall hypothesis is consistent with literature presented earlier in the study. Sussman, Robins, and Earls (1987) suggested that African Americans may be more willing to accept potential social causation for personal problems often thought of as the consequence of hard times and not an illness. Schnittker, Freese, and Powell (2000) noted that the belief that mental illness is primarily environmentally-based adds to the explanation of why African Americans emphasize the role of family and community in solving personal issues more so than Whites. The authors also suggested that African Americans may be more likely than Whites to think of mental illness as a result of God's will because of the reports of stronger religious beliefs, and higher levels of religious participation (Taylor & Chatters, 1991; Taylor et al., 1996, Taylor, Levin, & Chatters, 2003); and, the evidence shows that Blacks use prayer or consult religious leaders more often than Whites with religious leaders for assistance with personal and psychological problems (Milstein, Guarnaccia, & Midlarsky, 1995; Taylor & Chatters, 1991; Taylor, Chatters, & Levin, 2003). Previous literature has highlighted the emphasis by some African American religious leaders placed on the importance of prayer and willpower in overcoming psychiatric problems (Hall & Tucker, 1985; Taylor, Chatters, & Levin, 2003).

Even though only one hypothesis was supported, the researcher explored significant individual independent variables for the other six hypotheses. While it is unconventional to examine individual independent variables once it has been determined that the overall regression relationship is not statistically significant, the researcher reported the individual relationships to highlight variables that should be considered for exploration in future studies. For example, hypothesis 1 focused on the ability of clergy

members to correctly recognize mental illnesses and attempting to advise or counsel in a clinical manner. The variable level of education was significant with an inverse relationship while the variable type of degree seeking was close to significant with a positive relationship.

The inverse relationship of the variable level of education was interpreted as suggesting that participants with higher levels of education were less likely to advise in a clinical manner. The positive relationship of the variable type of degree seeking was interpreted as participants seeking higher types of degrees were less likely to advise in a clinical manner. These findings were surprising to the researcher in that it was assumed that the relationships would be reversed. Upon further inspection of the differences in participants' level of education and their decision to advise or counsel in a clinical or spiritual manner, there was a small difference between individuals with a master's degree and their decision to advise or counsel in a clinical or spiritual manner and individuals reporting other levels of education and their decision to advise or counsel in a clinical manner or spiritual manner (see Appendix G). This finding again suggests that there was not a major difference in how clergy decided to advise. Instead, it appears that clergy used a combination of clinical and spiritual methods.

Hypothesis 2 focused on the ability of clergy to correctly recognize mental illnesses and attempting to advise in a spiritual manner and was not statistically significant. The variables type of degree seeking and Baptist denomination were significant while level of theological orientation was close to significance. In similar fashion to hypothesis 1, the direction of relationships found was surprising. For the variable type of degree seeking, the findings showed that individuals seeking a higher type of degree were more likely to advise in a spiritual manner. Individuals who identified themselves as Baptist were less likely to advise in a spiritual manner. While

the result of the Baptist denomination was especially surprising, there was no clear cut reason to explain the finding. For level of theological orientation, individuals who reported a more moderate viewpoint were less likely to advise in a spiritual manner. Since the variable level of theological orientation was close to significance, it warrants further exploration in a larger sample. This variable is of particular importance to the researcher because it is believed that the type of orientation held by the clergy member is often passed onto members of their congregations through sermons and possibly when they are approached in one-on-one type situations presenting distressful situations.

Hypothesis 3 focused on the number of illnesses correctly recognized by clergy members and belief about ability level. The variable type of degree seeking was close to significance and was interpreted as individuals seeking a higher type of degree were more likely to report their ability to handle the situation alone or provide major assistance in conjunction with mental health professionals. This finding was not surprising for two reasons. First, it was originally conceptualized that as education of participants increase so would the comfort level of individuals in providing services. Second, if there is acceptance of the earlier notion that participants in this study did not differentiate between mental or spiritual issues, thus providing a combination of clinical and spiritual assistance, then this potential finding follows suit with how clergy members believe they are able to provide assistance to individuals in need of help.

When investigating the findings of hypothesis 2 and 3, it is important to refer back to the bio-psycho-social-spiritual framework. As presented in the discussion of the conceptual framework, Cumella (2002) notes that the bio-psycho-social model presented by Engel was originally adopted by health professions as the main model to use in order to conceptualize and treat physical and mental illness. There are three areas acknowledged as occurring through an interactive process when examining mental

illness: (1) genetic and biomedical factors, (2) psychological, emotional, behavioral, and cognitive factors, and (3) social and family factors (Cumella, 2002). Along with those three areas, the author recognized the importance of spirituality in the lives of individuals, therefore leading to the addition of spirituality to the bio-psycho-social model to assist in understanding mental health and illness (Cumella, 2002). Spiritual beliefs are assumed to influence thoughts and choices and are many times formed within a social context including the family or church. Conventional sources have begun to recognize spirituality as an important characteristic of individual psychology and social/family functioning. As a result, spirituality is viewed as a crucial part of the "psycho-social" part of the model (Cumella, 2002).

Cumella (2002) argues that Christians may acknowledge a different view of the model. While they may agree with the role of spirituality in mental health and illness, they may disagree with reducing spirituality to simply psychological and social dimensions. Through Bible teachings, it is the belief of Christians that human beings possess a body, soul, and spirit as well as the belief that humans maintain a spirit distinct from their soul, asserting the existence of an actual spiritual realm and believing that this spiritual reality interacts in a dynamic manner with the bio-psycho-social model. Therefore, Christians propose that spirituality cannot be simply reduced to psychological beliefs, emotional experiences, and church functions. Cumella (2002) asserts that only a comprehensive model will completely address all dimensions of mental health and illness. If the belief that a comprehensive, integrative model includes spirituality is accepted by clergy members as well as the acceptance of their combined role of clergy and mental health professionals, then the findings of hypothesis 2 and 3 among this sample are acceptable.

Hypothesis 4 focused on causes attributed to mental factors and the decision of clergy to advise or counsel in a clinical manner. The individual variable level of education was significant and the inverse relationship found suggested that clergy with higher levels of education were less likely to advise or counsel in a clinical manner. The individual variable type of degree seeking was close to significant and the possible, inverse relationship found suggested that clergy seeking a higher type of degree were less likely to attempt to advise or counsel in a clinical manner. Hypothesis 6 focused on causes attributed to mental factors and the perceived ability level of clergy to provide assistance, while hypothesis 7 focused on causes attributed to spiritual factors and the ability level of clergy to provide assistance. In both hypotheses, the individual variable type of degree seeking was close to significant with a possible, positive relationship which suggested that higher type of degree seeking by clergy were more likely to report ability to handle the situation presented alone or provide major assistance in conjunction with mental health professionals.

In an attempt to gain a better understanding of the direction of the relationships found, the researcher also used cross-tabulations of causes attributed to mental or spiritual factors and belief about ability level to provide assistance. The findings showed a small difference in the number of causes attributed to mental and spiritual factors (see Appendix H). Thus, it appears that participants did not differentiate between causal attributions and regardless of the type or cause of mental illness, participants reported being able to handle the situation presented alone or provide major assistance in conjunction with mental health professionals.

In the development of the conceptual framework, it was theorized that various demographic factors would contribute to which factor in the model clergy would use in their conceptualization and causal attribution of mental illness. One of the demographic

factors included a question which asked participants if they ever received specialized mental health training. While approximately 51% reported that they received specialized treatment, there was only a 13% difference among study participants receipt of specialized training and causes attributed to mental and spiritual factors. Furthermore, there was a small difference between participants that reported attempting to advise in a clinical or spiritual manner and those that did not receive specialized training and those who reported advising in a clinical or spiritual manner and those that did or did not receive specialized training (see Appendix I). These findings did not support the explanation of the how the bio-psycho-social-spiritual framework would be used by clergy in their conceptualization and causal attribution of mental illness.

However, it did add to the notion that clergy did not attribute causes to specific areas of the model. It is possible that clergy in this study view themselves as more than just a clergy member, but also a mental health professional, and they did not differentiate between the type of counseling or advice that they provided if they were approached for help. Previous literature supports this notion through the implication that characteristics of clergy having a potential impact on their counseling and referral activities with individual church members (Taylor, Chatters, & Levin, 2003). The author acknowledges that an important predictor of their level of knowledge regarding mental health issues and services available from professionals and public agencies will be clergy members' level of education (Taylor, Chatters, & Levin, 2003). Furthermore, Gottlieb and Olfson (1987) believe that clergy with more education will be more confident in their understanding of mental health issues and interact more regularly with the mental health community than their less-educated peers.

Regardless of these factors, Taylor, Chatters, and Levin (2003) note that the literature also shows that clergy are very successful in taking action and responding to the

general needs of their congregants and obtain appropriate services. It has also been noted that clergy provide an abundance of support to individuals in need, including basic living needs. Additionally, recognition among clergy is growing regarding the importance of addressing the mental health needs of congregants, as indicated through the growth of the field of pastoral counseling and the provision of graduate training in clinical counseling (Taylor, Chatters, & Levin, 2003). The findings along with the support of background literature are important and should be examined further, along with an attempt in understanding a theoretical framework that clergy members may use or attempt to identify with in assisting individuals in need of help.

The findings of the three research questions posed earlier also contributed to the notion that this area of research should be examined further. For question 1, when presented with mental health/illness issues, are African American clergy able to recognize and attribute causation of the issue presented, the majority of participants correctly recognized a higher number of mental illnesses presented in the vignettes. Overall, they tended to attribute cause to a combination of clinical and spiritual issues. For question 2, what are the beliefs of African American clergy regarding their ability to provide services or individuals in need of help, the majority of participants believed they were able to handle the situation presented alone or provide major assistance in combination with another professional. For question 3, are there certain demographics that have an affect on outcomes of conceptualizations and causal attributions, it appears that demographic variables such as level of education, type of degree seeking, denomination, and level of theological orientation had some affect on perceived belief about ability level to provide services rather than on conceptualization and causal attributions. Since only one previous study has examined clergy members' conceptualization and their referral intent which focused specifically on Korean

Americans, it is believed that more exploration is needed among African Americans even with the numerous limitations of this study.

Limitations of the Study

One of the major limitations identified in this study is the low response rate and small sample size. The researcher attempted to increase the response rate in several ways, which included extending the sampling area, including a cover letter as well as a letter of support from a local clergy member in the survey packet, providing the survey online, and sending follow-up postcards. The initial mailings were sent to clergy in states which included: Texas, Georgia, Washington, D.C., and Virginia. In order to reach more clergy, the mailings were sent to states including: California, Michigan, Illinois, Pennsylvania, Maryland, Louisiana, Mississippi, Alabama, Florida, South Carolina, North Carolina, and Tennessee.

With the low response rate, the researcher was only able to explore potential differences and was not able to test the hypotheses. The inability to test the hypotheses lowered the internal and external validity of the study and did not allow for the researcher to make any inferences found due to the inability to detect any significant differences. The small sample size also contributed to the testing assumptions for normality, linearity, and homogeneity. Since a number of the variables did not meet the requirements of any of the assumptions and transformations of variables did not succeed, there were increased limitations in interpreting the significant relationship found.

Another limitation was the sampling method used in the study. The original sampling method used was a convenience sampling method which did not allow for a representative sample of clergy members. While seminary students were also recruited for participation, not all students were contacted in the same method which lowered the overall response rate from students. As requested by one of the schools, the Interim Dean

requested that only cover letters be distributed to students. It is possible, although not definite, that distributing survey packets to those students may have increased the response rate. In spite of the fact that findings were not statistically significant, if more of the hypotheses were found significant, the low sample size also would have contributed to the inability to generalize to a wider population.

A possible solution to increase the sample size as well as a more comprehensive sampling method would be through the use of a multistage cluster sampling with stratification method. The researcher would start the process by listing by region as defined by the Census Bureau and stratifying and sampling by denomination in order to get a more representative sample. Another possible solution would be to attempt to contact and gain buy-in from top leaders such as Bishops in various denominations identified through various associations of denominational districts or jurisdictional headquarters. Finally, identifying various conferences that are held and attended by large numbers of clergy may also assist in increasing the response rate because the researcher would be present and it would hopefully increase the trust level of the clergy member in responding to the survey.

Since many of the clergy were not familiar with the researcher and mental illness is a sensitive topic to many, it is not surprising that many did not return the survey. However, this is a continued area of interest and the researcher has decided to rethink the methodology used for future research. Beginning with the survey, a combination of previous surveys were used to measure the variables of interest; however, it was acknowledged by the researcher as well as the group of clergy members consulted about the content that the survey was very long and could be viewed as tedious. Also, the vignettes presented in the surveys may have been leading. This may have allowed clergy to respond in a socially desirable manner. In future research, it would be important to

take more time with the measure incorporating the feedback of clergy, seminary students, and mental health professionals during the development stages of the survey. A series of focus groups may assist in developing a survey that is more appealing to potential participants.

This may also be an opportunity for the use of Concept Mapping in order to assess methods that clergy use when assisting individuals presenting a mental illness. Since the findings of this study alluded to clergy members possibly using a combination of clinical and spiritual methods and thinking of themselves as both clergy and mental health professionals, it would also be interesting to examine the similarities and differences in the type of methods that are used by mental health professionals. The use of the Concept Mapping method may also assist in explaining why clergy decide to use a particular type of method. Lastly, the use of this method would be a means of bringing together clergy, seminary students, and mental health professionals and open a new and collaborative dialogue.

It is important to discuss whether the lack of statistical significance found for the majority of the hypotheses were due to the small sample size or whether the hypotheses should be revised. The problem may not be the ability for clergy to identify a mental illness or in the conceptualization. Although it must be stated that the vignettes given did not present mental illnesses such as bipolar disorder, schizoaffective disorder, or attachment disorders which may have been much harder for clergy to identify unless they had a mental health background. The problem may be how once clergy are approached by individuals in need of help they choose to deal with the issue and what type of message is being given and received. One of the main variables focused on whether they would attempt to advise or counsel in a clinical or spiritual manner. It did not probe deeper to find out more about what the advice entails. To probe more into this area, a

more qualitative method may be needed. Regardless of the number of limitations and the inability to thoroughly examine the research questions, the researcher still views this topic as an area of importance. The significant outcomes and lack of outcomes of the study have been a little discouraging; yet, the researcher remains committed to pursuing this area of research in the future.

What is the Role of Social Work?

The issues presented including understanding how African American clergy conceptualize and attribute causation of mental illness in order to effectively meet the needs of mental health in the African American community. One of the purposes of the study was to contribute to the mental health knowledge base. As far as the role of social work is concerned, it was hoped that this would also open a dialogue of recognizing the importance of addressing spirituality and religiosity with African Americans and potential improvement of mental health outcomes. Also, it was hoped that this study would also begin a discussion regarding the adequate preparation of social work students to collaborate with mutually helping social networks and the inclusion of spirituality in the social work curriculum. The overarching theme is the importance of understanding culture and social workers maintaining the ability to provide services that are culturally relevant to their population through identifying innovative ways to reach the community. In order to effectively meet clients' needs, culture must be acknowledged as an important variable; thus, the discussion of evaluating the preparation of social work students in working with mutually helping social networks and incorporating spirituality into the curriculum are important. It is necessary for social work students to have exposure to these topics as they prepare to enter the profession in order to have a better grasp of the individuals, families, and communities that they will have contact with and provide assistance.

Along with literature regarding help-seeking behaviors and service use by African Americans, there has also been a wealth of research on the underutilization of formal support groups by African Americans (Cook, Heller, & Schneck, 1999; Heller, Roccoforte, & Cook, 1997). Formal groups, such as the National Alliance for the Mentally Ill (NAMI) have attempted to diversify their membership; however, barriers remain in the participation of families of color, in particular African Americans. Few studies have attempted to address the issues of comfort level and the impact of culture on participation by African Americans. Studies show there is a difference in the type of services that pastors provide based upon the type and level of training they have received (Mollica et al., 1986; Neighbors, 2003; Taylor et al., 2000).

Previous studies have also discussed the obvious parallels that exist in the support that individuals and families can receive from formal support groups as well as informal support networks such as the church and the pastor (Neighbors, Musick, & Williams, 1998; Pickett-Schneck, 2002). These studies suggest that collaboration between informal and formal support groups could lead to solutions, in turn increasing the participation by African Americans. The term ***collaboration*** is defined as a planned strategy, in which two or more systems form a cooperative relationship around one or more functions, designed to improve the achievement of mutual goals and improvement in the quality of life of the severely mentally disabled (Davis, 2003).

As previously mentioned, many African American clergy participate with their congregations in other formal community programs. These programs, along with other variations of community-based partnerships, spearheaded by pastors, acknowledge that the church and pastors occupy a high level of trust and respect within the African American community. The collaboration of these programs with the church has allowed efforts to show a greater level of effectiveness in tapping into longstanding traditions of

communal assistance and self-sufficiency to improve the health of members of the participating communities (Taylor et al., 2000). It has been suggested that the same recognition should be given in mental health by connecting individuals and families from their informal support systems to formal support groups with the pastor as the gatekeeper. More than any other influence on help-seeking behaviors of African Americans, clergy hold the most potential for opening a wider pathway between the African American community and specialty mental health care (Neighbors, Musick, & Williams, 1998).

There have been suggestions made for modes of implementation of collaboration from social work literature. Chalfant et al. (1990) suggest that attempts be made to work out a bi-directional referral system between mental health professionals and clergy. In order to make this system beneficial, the authors recommend an intensive community mental health care orientation for clergy, practitioners of family medicine, psychiatrists/psychologists, and psychiatric social workers. By creating this type of system, the referral process between clergy and mental health professionals becomes a two way street. This, in turn would allow individuals in need to continue doing what they already do. They can go to different sources depending on their perception of need in order to obtain guidance from the sources most suited to their particular needs by way of a referral system between pastors and mental health professionals.

In addition, Taylor, Ellison, et al., (2000) proposed that use of a liaison between service agencies and clergy would open a line of communication between formal and informal systems, providing a pathway of access to individuals and families, and present legitimacy of the relationship between the two groups. The authors suggest that service providers and formal support groups should provide in-service training programs for clergy and other church leaders, providing pastors with the ability to address referral issues. In turn, clergy could train service providers and formal support group leaders on

religious beliefs and practices that may influence experiences of personal and family problems. Collaborative efforts between the groups would be useful in addressing issues of individuals and families, including serious and persistent issues of concern, such as caregiving, that call into question an individual's basic conviction about life and the meaning of their role in their family member's life (Taylor, Ellison, et al., 2000).

It is noted that collaboration requires commitment and a cooperative effort on the part of service delivery systems, policy makers, and pastors in order to make a difference. In order for the collaboration to reach its potential, the church with the pastor being recognized as the key individual must put aside possible feelings of disinclination to form a partnership. This is due, in part, to the longstanding history of mistrust of the formal institutions based on previous patterns of both discrimination and prejudice by helping professionals in their dealings with African American communities (Neighbors, 2003). Furthermore, individuals in the helping profession must reflect upon their own personal views and biases regarding religion and religious institutions, and their willingness to work in a collaborative effort with the Black church and the pastor (Taylor, Ellison, et al., 2000).

The field of psychology has also examined collaboration between psychologists and clergy providing professionals with suggestions. Plante (1999) notes the American Psychological Association and other professional organizations have highlighted issues of ethnic, cultural, and racial diversity in graduate and postgraduate curriculum, books, articles, policy statements and guidelines, but issues related to religious and spiritual diversity and sensitivity have been ignored. Many of these suggestions mirror those provided in the social work literature. However, the research provided in the psychology literature supports the notion that many clients would like their therapists to address

religious issues in psychotherapy and often prefer services from those sharing religious traditions and beliefs (Privette, Quackenbos, & Bundrick, 1994).

Furthermore, professional psychological services have been used to evaluate and screen potential clergy and help religious communities deal with various mental health issues. Professional journals have also begun integrating religion and psychology, including *Mental Health, Religion, and Culture*. Finally, training for clergy now frequently involves education in psychology and psychological counseling. Edwards, Lim, McMinn, & Dominquez (1999) suggest bidirectional collaboration between psychologists and clergy highlights common values and perspectives creating the possibility of shared dialogue. The authors note that both professions value self-evaluation and good interpersonal relationships, help people assign meaning to life circumstances, assist in the restorative process in others' lives, and empower individuals to function to their potential. They also note growing evidence that certain faith practices enhance mental health suggesting that collaboration may help improve mental health services and as health care has become increasingly multifaceted, multidisciplinary collaboration has been regarded as a professional imperative (Edwards et al., 1999).

Finally, in developing relationships between clergy and psychologists, Plante (1999) suggests applying the following principles:

- Understanding the client's religious system
- Knowing the language
- Networking
- Expanding the view of what can be done to help
- Providing the highest standards of professional and ethical service

The literature presented discussed how those already in the field can establish collaborative relationships with clergy. The questions that remain are: Are social work

students taught to collaborate with mutually helping social networks, specifically the social worker/client relationship and the social worker/community relationship? Should the principles presented in the literature be applied to social work education?

Inclusion of Spirituality in the Social Work Curriculum

Previous literature has focused on the role of the church in meeting needs of African Americans not successfully met by other service institutions, patterns of religious involvement, mediating effects of religion on psychological and physical health, and integrating spirituality in therapy when counseling African Americans (Billingsley & Caldwell, 1991; Chatters, Levin, & Taylor, 1992; Chatters & Taylor, 1989; Levin, Taylor, & Chatters, 1995; McAdoo, 995; Wallace & Williams, 1997; Williams, Larson, Buckler, Heckmann, & Pyle, 1991). In thinking about integrating spirituality into therapy and the significant role of spirituality in the lives of many African Americans, the questions that loom are:

- Should the social work curriculum incorporate content on spirituality?
- Should the course(s) be required or offered as an elective?
- Can social workers provide training to willing clergy if spirituality has not been adequately addressed in the curriculum?

Previous studies have examined the views and experiences of social work students, faculty, and practitioners. While the findings from the studies have varied, all groups held positive views about inclusion of spirituality in the curriculum but differences held in regards to the how it should be included in the content (required vs. elective) as well as its place in practice (Sheridan & Bullis, 1992; Sheridan & Hemert, 1999; Sheridan & Wilmer, 1994). Also, of great importance are the implications the authors noted.

In the 1999 study by Sheridan and Hemert comparing students' views to practitioners and educators, the authors note that inclusion of religion and spirituality would be consistent with the 1992 Curriculum Policy Statement from the Council on Social Work Education which reintroduced references to both religion and spiritual diversity in the sections including diversity, populations-at-risk, and social work practice. The authors suggest future research on exploring views and experiences of different groups of social workers in various locations. Sheridan and Wilmer (1994) examined the views of inclusion of spirituality held by social work educators. They noted a shift in the earlier forms of social work influenced by religious teaching to a secular orientation as a result of the conflicts between social work goals and values and religious teachers. They suggested that inattention to those issues turns out practitioners who are not equipped to deal with clients and their communities. In the implications, the authors stated the design and delivery of the content are critical to its effectiveness in social work education and the findings of studies could be useful in determining the appropriate criteria for inclusion in the curriculum (Sheridan & Wilmer, 1994).

Sheridan and Bullis (1992) compared attitudes of practitioners including clinical social workers, psychologists, and professional counselors toward religion and spirituality. The authors state "…by recognizing and affirming clients' social, ethnic, and cultural diversity, the social worker puts into practice the two hallmark values of the profession: (1) the clients' right to dignity and self-worth, and (2) the clients' right to self-determination" (p. 190). They also note the growing recognition of the important role of religion and spirituality by social workers is consistent with the current voice of the American public. If religious and spiritual beliefs are an important part of a client's life as a source of meaning and resources, it is important to know how practitioners handle this area with their clients.

In their implications for practice, Sheridan and Bullis (1992) note a need for recognition of religious and spiritual issues in effective service delivery. They also highlight that along with the importance of examining one's views on diversity of culture, socioeconomic factors, race, ethnicity, gender, and sexual orientation, it is also important to have awareness about personal beliefs, biases, or prejudices concerning religiosity and spirituality. Practitioners without self-knowledge of religious and spiritual issues run the risk of being ineffective with, or may even be harmful to his or her clients. Religious and spiritual histories of clients must be taken as important as the psychosocial or social histories in assessing their current status and previous life experiences (Sheridan & Bullis, 1992).

For practice, innovative solutions can still develop bidirectional collaboration as previously suggested in past studies, including the development of mental health training programs for clergy through collaboration with divinity programs. Social workers or social service agencies involved in the development of mental health programs, if wanted by the church and clergy, must still acknowledge the clergy as the "focal point" since they are viewed with respect and are rooted within the community. Encouraging development of mental health programs would follow in the same steps of other programs that many churches often have in place such as programs for the disadvantaged, health care screenings, and other outreach programs.

For education, the authors note the implications for inclusion in the curriculum stemmed from study participants' stated need for more training in religious and spiritual issues and views that training would be desirable for all practitioners. They believe professional education should include: content on religious/spiritual dimension on human behavior, religious and spiritual diversity, practice applications, and the role of religious and spiritual groups in developing policy and providing services. The curriculum should

include content on the role that religious and spiritual organizations played in the development of social policy and the provision of social services and their current role (Sheridan & Bullis, 1992). True commitment to diversity involves developing effective practice and teaching strategies that recognize the significance of religion and spirituality in people's lives and society.

With the needs of many African American caregivers and consumers remaining unmet, acknowledging the significance and the role of the pastor is congruent with literature presented and recommendations from the President's New Freedom Commission on Mental Health (2003). Social work practitioners are in the best position to collaborate with mutually helping social networks, such as the Black church, increasing comfort and providing support to pastors, families, and consumers, and guiding to formal mental health services as needed. Inclusion of pastors in bidirectional collaborations and training for social work students would assist practitioners in teaching consumers and families ways to navigate the system, address cultural issues; therefore improving quality of care with culturally relevant services in order to reach those not readily served. For educators, this is an opportunity to discuss the relevancy of incorporating mandatory spirituality courses into the curriculum as well as courses that address adequate preparation for social work students to work with mutually helping social networks, such as churches and clergy members. It is also an opportunity to develop continuing education training opportunities for professionals already in the field.

It is important for policymakers to follow suggestions offered by the Surgeon General's Report on Mental Health (2001) and the President's New Freedom Commission on Mental Health Report (2003). First, it is imperative that policymakers continuously assist in the development of comprehensive federal and state plans along with creating early screening programs. It is also important for policymakers to

recognize the need for comprehensive plans in order to provide effective services that are easily navigated and utilize flexible funding streams in order to loosen restrictions on how and for whom funds are used. Development of early screening programs lead to promotion of assessments and referrals as common practice rather than as the last resort. Provision of federal funding should be used to address important issues of accessibility and accountability, remove policy barriers, to encourage choice and self-determination of consumers and families along with involving them in planning, evaluating treatment processes, and support services.

In terms of research, this study may provide social work with the opportunity to expand the area of research to include examining pastoral counseling and education, dual degree programs between schools of social work and schools of theology, and differences of types and level of education on the ability to recognize and attribute causation of mental illness by clergy. Also, researchers would have an opportunity to learn more about the services that are provided by clergy and compare and contrast their services with social work. Through collaboration with members of the clergy, researchers may have the opportunity to evaluate the outcomes of individuals they have helped in order to determine the efficacy of the services they provide. Research is especially important in the development and advancement of the knowledge base of understudied areas, populations, effective treatments, and service delivery strategies. Also, evidence-based practice reflects the range of effective treatments and services.

The issues of collaboration of social workers with mutually helping social networks and inclusion of spirituality in the social work curriculum are important. In order for these issues to be placed on the table for serious consideration, there must be a buy-in from all groups including pastors, social work students, practitioners, educators, and the community. The Black church has long been a source of support for African

American families and communities faced with day-to-day struggles, with the pastor being one of the most influential and easily recognized leaders and support systems.

Also, the literature presented has shown the Black church, specifically the African American pastor as holding the most potential for opening a pathway between the African American community and mental health. As noted by Neighbors et al., (1998) state "it is time we mount more aggressive mental health education efforts designed to bring the Black clergy and the mental health professional closer together. Once this is accomplished, we stand a much better chance of increasing access for African Americans in need of professional care" (p. 774).

As more research continues to surface showing the benefits of collaboration between pastors and mental health professionals, it is hoped that these groups will be able to come together and educate one another about the needs of a population that has typically been faced with difficulties and challenges. Working together for the greater good will begin to make positive steps and progress through practice, policy, and research in ensuring that African American families receive the quality care and support that they need and deserve. Culture and providing culturally relevant services is the key to creating innovative ways to reach minority communities.

Appendix A. Cover Letter for Clergy

Dear Potential Study Participant:

My name is Kimberly Farris and I am a doctoral student at The University of Texas at Austin, School of Social Work, located in Austin, Texas. I am currently conducting a study for my dissertation about views and attitudes of African American clergy and seminary students regarding mental illness. The goal of my study is to identify innovative ways to address the mental health needs of African Americans with mental health issues.

A great amount of literature discusses the important role of clergy as one of the first sources that African Americans approach for help, including mental health issues. With this being the case and as an African American, I believe it is important to learn more about the perceptions of clergy and seminary students. I am writing to ask your participation in my study. Your response is very important because it will increase the value of my study. If you are a seminary student, your participation is strictly voluntary and is not a class requirement. Also, your decision to participate will in no way influence your grade or status in your program.

At this time there are no harmful effects anticipated from participation and potential benefits may occur on an individual basis. Participants may indirectly benefit from having the opportunity to discuss views, attitudes, and experiences with providing assistance for individuals with mental illness. However, if at any time you feel any discomfort or decide that you do not wish to continue participation, you have the right to refuse participation and withdraw from the study without penalty or loss of benefits to which you are otherwise entitled. Your refusal will not influence current or future relationships with The University of Texas at Austin.

This survey packet includes the survey, a self-addressed return envelope, and also a web address in case you prefer to complete the survey online. Before entering the survey website, you will be asked to give your consent to participate in the study. **The web address for access to the online version of the survey is:** http://128.83.80.200/catmi/**.** The survey will take approximately 45 minutes to complete. One of the purposes of this study is to open a dialogue in the area of mental health and mental illness and contribute to the knowledge base for an area that is often considered sensitive, especially for African Americans experiencing mental illness.

If you have any questions or concerns about the study, please do not hesitate to contact me, Kimberly Farris, at 512-835-9422 or kfarris@mail.utexas.edu. If you have any questions about your rights as a research participant, please contact Clarke A. Burnham, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the

Protection of Human Subjects, 512-232-4383. If the results are published or presented at scientific meetings, your identity will not be disclosed. Beyond publishing or presenting the results from the study, the investigator will not benefit in any other way from your participation in this study. Thank you for your consideration, attention, and time.

Respectfully,

Kimberly D. Farris, MSW

Appendix B. Letter of Support from Local Clergy Member

Agape Baptist Church

Austin Agape Ministries, Inc.

7801 North Lamar Blvd.
Bldg. F-15
Austin, Texas 78752
512/ 454-1547
H. Ed Calahan, Pastor

February 9, 2005

Letter of Endorsement and Support

Dear Brother and Sisters in Christ:

My name is H. Ed Calahan, pastor of Agape Baptist Church in Austin, Texas. I am recently retired from the Texas Department of Mental Health and Mental Retardation after 30 years of service and support to programs that provided treatment to persons with severe and persistent mental illness, developmental disabilities and substance abuse. I was contacted by Ms. Kimberly Farris, an African American Doctoral student at the University of Texas, concerning her dissertation on the views and attitudes of African American clergy and seminary students regarding mental illness. The study will focus on "Innovative Ways to Address Mental Health Needs of African Americans." It will be an exploratory study examining the importance of understanding how African American Ministers conceptualize and attribute causation of mental illness.

I have been informed by Ms. Farris that the results of her study may also assist in the development of training programs for clergy in the area of improvement of pastoral skills in relation to mental health issues, the development of training programs for clergy in church-related family life ministries/programs, and increase the ability of clergy to provide more assistance to individuals experiencing mental health issues.

I have reviewed the instrument and am supportive of its content. As a pastor and member of the clergy, I readily see the need for such a study and do plan to respond and I am requesting that you do the same when contacted by Ms. Farris. Please know that your participation is voluntary and anonymous. Please free to contact me if there is a need. Thank you for supporting this young lady.

Sincerely in Christ,

H. Ed Calahan, Pastor

Appendix C. Cover Letter for Seminary Students

Dear Seminary Student:

My name is Kimberly Farris and I am a doctoral student at The University of Texas at Austin, School of Social Work, located in Austin, Texas. I am currently conducting a study for my dissertation about views and attitudes of African American clergy and seminary students regarding mental illness. The goal of my study is to identify innovative ways to address the mental health needs of African Americans with mental health issues.

A great amount of literature discusses the important role of ministers as one of the first sources that African Americans approach for help, including mental health issues. With this being the case and as an African American, I believe it is important to learn more about the perceptions of clergy and seminary students. I am writing to ask your participation in my study. Your response is very important because it will increase the value of my study.

The results of this study may also assist in the development of training programs for clergy in the area of improvement of pastoral skills in relation to mental health issues, the development of training programs for clergy in church-related family life ministries/programs, and increase the ability of clergy to provide more assistance to individuals experiencing mental health issues. Your participation is strictly voluntary and is not a class requirement. Also, your decision to participate will in no way influence your grade or status in your program.

The survey packet that you receive will include the survey and a self-addressed return envelope. The survey can also be completed online. **The web address for access to the online version of the survey is:** http://128.83.80.200/catmi/**.** At this time there are no harmful effects anticipated from participation and potential benefits may occur on an individual basis. Participants may indirectly benefit from having the opportunity to discuss views, attitudes, and experiences with providing assistance for individuals with mental illness. However, if at any time you feel any discomfort or decide that you do not wish to continue participation, you have the right to refuse participation and withdraw from the study without penalty or loss of benefits to which you are otherwise entitled. Your refusal will not influence current or future relationships with The University of Texas at Austin.

If you choose to return the mail survey, the returned survey will also serve as your consent to participation in the study in order to help to maintain your anonymity. If you choose to complete the online version, you will be asked to give your consent to participate in the study before entering the website. The survey will take approximately 45 minutes to complete. One of the purposes of this study is to open a dialogue in the area of mental health and mental illness and contribute to the knowledge base for an area

that is often considered sensitive, especially for African Americans experiencing mental illness.

If you have any questions or concerns about the study, please do not hesitate to contact me, Kimberly Farris, at 512-835-9422 or kfarris@mail.utexas.edu. If you have any questions about your rights as a research participant, please contact Clarke A. Burnham, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, 512-232-4383. If the results are published or presented at scientific meetings, your identity will not be disclosed. Beyond publishing or presenting the results from the study, the investigators will not benefit in any other way from your participation in this study. Thank you for your consideration, attention, and time.

Respectfully,

Kimberly D. Farris, MSW

Appendix D. Clergy's Perception of Mental Illness Survey

General Instructions: Please complete this questionnaire by placing an X in the appropriate box or filling in the answer where instructed. This questionnaire is being completed by clergy and seminary students. Some questions may be directed to specifically clergy or seminary students. Please place an X in the box marked Not applicable (NA), if the question does not apply to you.

1. Age: ____ years of age (**please fill in your age**)

2. Gender: 1. [ ] female 2. [ ] male

3. Current Status: 1. [ ] clergy 2. [ ] seminary student 3. [ ] both

4. Highest level of education completed: 1. [ ] 8th grade or less 2. [ ] High school grad/GED 3. [ ] College graduate 7. [ ] Doctoral degree
4. [ ] 9th-12th grade 5. [ ] Some college/No degree 6. [ ] Master's degree

5. If you are a seminary, student what school do you currently attend: 1. [ ] Howard University 2. [ ] Virginia Union University 3. [ ] Interdenominational Theological Center
4. [ ] Virginia University (Lynchburg) 5. [ ] Other: (**please specify**)_____

6. If you are a student, what type of degree are you seeking: 1. [ ] Bachelors 2. [ ] Master's 3. [ ] Doctorate 4. [ ] NA

7. If you are clergy, did you attend seminary: 1. [ ] Yes 2. [ ] No 3. [ ] NA

8. State of residence: 1. [ ] Georgia 2. [ ] Washington, DC 3. [ ] Virginia 4. [ ] Texas
5. [ ] Other: (**please specify**) _____

9. Denomination: 1. [ ] Baptist 2. [ ] United Methodist 3. [ ] AME 4. [ ] Church of God in Christ
5. [ ] Presbyterian 6. [ ] Episcopalian 7. [ ] Other: (**please specify**) _____

10. How would you rate your theological orientation: 1. [ ] Fundamentalist 2. [ ] Moderate 3. [ ] Liberal 4. [ ] Other: _____ (**please specify)**

11. Number of years in the ministry, (if applicable): _____ (**please fill in a number**)

12. Number of members in your congregation (if applicable): _____ (**please fill in a number**)

13. Have you ever received any specialized training in the area of mental health through a degree program, continuing education classes, workshops, or seminars: 1. [ ] Yes 2. [ ] No

Next, you will be provided with five descriptions of different people in various situations. After you read the description, there will be a set of questions about how you think and feel about him/her, and your opinion about your ability to help him/her. There are no right or wrong answers.

Situation 1:
John is a White man with a college education. During the last month, John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty, and he couldn't sleep, so he took another drink. His family has complained that he is often hung over, and has become unreliable – making plans one day, and canceling them the next.

14. In your opinion, what is John experiencing:

1. [ ] Alcohol dependence

2. [ ] A major depression

3. [ ] Schizophrenia

4. [ ] A drug problem

5. [ ] No problem

	Very serious	**Somewhat serious**	**Not very serious**	**Not at all serious**	**Undecided**
15. How serious would you consider John's problem to be?	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

16. In your opinion, how likely is it that John's situation might be caused by:	**Very likely**	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Undecided**
a. His own bad character	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
b. A chemical imbalance in the brain	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
c. The way he was raised	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
d. Stressful circumstances in his life	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
e. A genetic or inherited problem	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
f. God's will	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
g. A nervous breakdown	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
h. A mental illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
i. A physical illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
j. Crisis in faith	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

17a. If John approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
17b. Would you attempt to advise him in a spiritual manner (i.e. prayer or meditation):	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

18. If John approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

1. [ ] I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).

2. [ ] I could provide ***major assistance*** in conjunction with properly trained professional people.

3. [ ] I could provide ***minor assistance*** in conjunction with properly trained professional people.

4. [ ] I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

5. [ ] Undecided

Situation 2:
Mary is a Hispanic woman with a high school education. For the past two weeks, Mary has been feeling really down. She wakes up in the morning with a flat heavy feeling that sticks with her all day long. She isn't enjoying things the way she normally would. In fact, nothing gives her pleasure. Even when good things happen, they don't seem to make Mary happy. She pushes on through her days, but it is really hard. The smallest tasks are difficult to accomplish. She finds it hard to concentrate on anything. She feels out of energy and out of steam. And even though Mary feels tired, when night comes she can't go to sleep. Mary feels pretty worthless, and very discouraged. Mary's family has noticed that she hasn't been herself for about the last month and that she has pulled away from them. Mary just doesn't feel like talking.

19. In your opinion, what is Mary experiencing:

1. [ ] Alcohol dependence

2. [ ] A major depression

3. [ ] Schizophrenia

4. [ ] A drug problem

5. [ ] No problem

	Very serious	**Somewhat serious**	**Not very serious**	**Not at all serious**	**Undecided**
20. How serious would you consider Mary's problem to be?	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

21. In your opinion, how likely is it that Mary's situation might be caused by:	**Very likely**	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Undecided**
a. Her own bad character	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
b. A chemical imbalance in the brain	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
c. The way she was raised	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
d. Stressful circumstances in her life	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
e. A genetic or inherited problem	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
f. God's will	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
g. A nervous breakdown	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
h. A mental illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
i. A physical illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
j. Crisis in faith	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

22a. If Mary approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
22b. Would you attempt to advise her in a spiritual manner (i.e. prayer or meditation):	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

23. If Mary approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

1. [ ] I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).

2. [ ] I could provide ***major assistance*** in conjunction with properly trained professional people.

3. [ ] I could provide ***minor assistance*** in conjunction with properly trained professional people.

4. [ ] I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

5. [ ] Undecided

Situation 3:
Maria is an African American woman with a college education. Up until a year ago, life was pretty okay for Maria. But then, things started to change. She thought that people around her were making disapproving comments, and talking behind her back. Maria was convinced that people were spying on her and that they could hear what she was thinking. Maria lost her drive to participate in her usual work and family activities and retreated to her home, eventually spending most of her day in her room. Maria was hearing voices even though no one else was around. These voices told her what to do and what to think. She has been living this way for six months.

24. In your opinion, what is Maria experiencing:

1. [ ] Alcohol dependence

2. [ ] A major depression

3. [ ] Schizophrenia

4. [ ] A drug problem

5. [ ] No problem

	Very serious	**Somewhat serious**	**Not very serious**	**Not at all serious**	**Undecided**
25. How serious would you consider Maria's problem to be?	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

26. In your opinion, how likely is it that Maria's situation might be caused by:	**Very likely**	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Undecided**
a. Her own bad character	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
b. A chemical imbalance in the brain	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
c. The way she was raised	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
d. Stressful circumstances in her life	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
e. A genetic or inherited problem	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
f. God's will	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
g. A nervous breakdown	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
h. A mental illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
i. A physical illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
j. Crisis in faith	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

27a. If Maria approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
27b. Would you attempt to advise her in a spiritual manner (i.e. prayer or meditation):	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

28. If Maria approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

1. [ ] I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).

2. [ ] I could provide ***major assistance*** in conjunction with properly trained professional people.

3. [ ] I could provide ***minor assistance*** in conjunction with properly trained professional people.

4. [ ] I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

5. [ ] Undecided

Situation 4:
Juan is a Hispanic man with an eighth grade education. A year ago, Juan sniffed cocaine for the first time with friends at a party. During the last few months, he has been snorting it in binges that last several days at a time. He has lost weight and often experiences chills when binging. Juan has spent his savings to buy cocaine. When Juan's friends try to talk about the changes they see, he becomes angry and storms out. Friends and family have also noticed missing possessions and suspect Juan has stolen them. He has tried to stop snorting cocaine, but can't. Each time he tries to stop he feels very tired, depressed, and unable to sleep. He lost his job a month ago, after not showing up for work.

29. In your opinion, what is Juan experiencing:

1. [ ] Alcohol dependence

2. [ ] A major depression

3. [ ] Schizophrenia

4. [ ] A drug problem

5. [ ] No problem

	Very serious	**Somewhat serious**	**Not very serious**	**Not at all serious**	**Undecided**
30. How serious would you consider Juan's problem to be?	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

31. In your opinion, how likely is it that Juan's situation might be caused by:	**Very likely**	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Undecided**
a. His own bad character	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
b. A chemical imbalance in the brain	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
c. The way he was raised	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
d. Stressful circumstances in his life	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
e. A genetic or inherited problem	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
f. God's will	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
g. A nervous breakdown	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
h. A mental illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
i. A physical illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
j. Crisis in faith	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

32a. If Juan approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
32b. Would you attempt to advise him in a spiritual manner (i.e. prayer or meditation):	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

33. If Juan approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

1. [ ] I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).

2. [ ] I could provide ***major assistance*** in conjunction with properly trained professional people.

3. [ ] I could provide ***minor assistance*** in conjunction with properly trained professional people.

4. [ ] I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

5. [ ] Undecided

Situation 5:
John is an African American man with a high school education. Up until a year ago, life was pretty okay for John. While nothing much was going wrong in John's life he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and that when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people and although John sometimes argues with his family, John has been getting along pretty well with his family.

34. In your opinion, what is John experiencing:

1. [ ] Alcohol dependence

2. [ ] A major depression

3. [ ] Schizophrenia

4. [ ] A drug problem

5. [ ] No problem

	Very serious	**Somewhat serious**	**Not very serious**	**Not at all serious**	**Undecided**
35. How serious would you consider John's problem to be?	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

36. In your opinion, how likely is it that John's situation might be caused by:	**Very likely**	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Undecided**
a. His own bad character	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
b. A chemical imbalance in the brain	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
c. The way he was raised	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
d. Stressful circumstances in his life	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
e. A genetic or inherited problem	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
f. God's will	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
g. A nervous breakdown	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
h. A mental illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
i. A physical illness	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
j. Crisis in faith	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

37a. If John approached you for help with this situation, would you attempt to advise or counsel (i.e. psychological or pastoral)	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]
37b. Would you attempt to advise him in a spiritual manner (i.e. prayer or meditation):	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

38. If John approached you for help with this situation, at what level do you feel that you would be able to provide assistance:

    1. [ ] I can handle this situation ***alone*** (i.e. I have adequate training to handle situations of this sort).

    2. [ ] I could provide ***major assistance*** in conjunction with properly trained professional people.

    3. [ ] I could provide ***minor assistance*** in conjunction with properly trained professional people.

    4. [ ] I am ***not*** adequately trained to handle situations of this sort other than to refer to professional people.

    5. [ ] Undecided

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**NA**
39. If you are still in school, do you feel that you are adequately prepared to assist individuals with mental illness:	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]	6. [ ]

	Yes	**No**	**NA**
40. In your church, do you have a ministry (outreach program) devoted to assisting individuals with mental health issues:	1. [ ]	2. [ ]	3. [ ]

41. Please list the ministries (outreach programs) offered by your church:

    1. _____ 5. _____

    2. _____ 6. _____

    3. _____ 7. _____

    4. _____ 8. _____

	Yes	No
42. Are you aware of mental health resources that are available in your community:	1. [ ]	2. [ ]

	Very comfortable	Somewhat comfortable	Not very comfortable	Not at all comfortable	Undecided
43. What is your level of comfort in referring individuals in need of help to social service agencies within your community:	1. [ ]	2. [ ]	3. [ ]	4. [ ]	5. [ ]

	Yes	No
44. If offered, would you attend training to work with individuals with mental illness:	1. [ ]	2. [ ]

45. Please write/type any comments or recommendations that you have regarding addressing mental health needs of African Americans:

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your participation!!!

Appendix E. Table of Non-Metric Dummy Coded Variables

Variable	Definition
Gender	
Male	Male = 1, Otherwise = 0
Female (reference category)	
Seminary Attendance	
Yes	Attended seminary = 1, Otherwise = 0
No (reference category)	
Denomination	
Baptist	Baptist = 1, Otherwise = 0
AME	AME = 1, Otherwise = 0
Other (reference category)	
Current Status	
Clergy	Clergy member = 1, Otherwise = 0
Student	Student = 1, Otherwise = 0
Both Clergy and Student (reference category)	
Type of Degree Seeking	
Master's	Master's degree = 1, Otherwise = 0
Doctorate	Doctorate degree = 1, Otherwise = 0
Specialized Training Received	
Yes	Received specialized training = 1, Otherwise = 0
No	Did not receive specialize training = 1, Otherwise = 0

Appendix F. Table of Recoded Variables

Variable	Definition
Denomination	Reduced the number of categories from 16 to 3 which include: (1) Baptist, (2) African Methodist Episcopal, and (3) Other.
Level of Theological Orientation	Reduced the number of categories from 12 to 3 consolidating categories based on the researcher's logic. The ordinal level variables included: (1) Fundamentalist, (2) Moderate, and (3) Liberal.
Type of Degree Seeking	Reduced the number of categories to represent graduate level education being sought by participants. The variables were: (1) Master's degree and (2) Doctorate degree.

Appendix G. Table of Cross-tabulations for H_1 & H_2 – Causal Attribution, Decision-Making by Type of Degree Seeking

	Master's degree	Doctorate Degree	Total
Clinical attribution	49	9	58
Spiritual attribution	51	10	61

Appendix H. Table of Cross-tabulations for H_6 & H_7 – Causal Attribution, Belief about Ability Level by Type of Degree Seeking

	Master's degree	Doctorate degree	Total
Clinical Attribution	26	3	29
Spiritual Attribution	23	4	27

Appendix I. Table of Cross-tabulations for Demographic Variable – Receipt of Specialized Mental Health Training and Causal Attribution

	Received Training	Did not receive training	Total
Clinical Attribution	49	35	84
Spiritual Attribution	50	35	85

References

Adlerfer, C. (1982). Problems of changing white males' behavior and beliefs concerning race relations. *Change in Organizations*. San Francisco, CA: Jossey-Bass.

Amir, Y. (1969). Contact hypothesis in ethnic relations. *Psychological Bulletin*, 71, 319-342.

Aneshensel, C. (1992). Social distress: Theory and research. *Annual Review of Sociology*, 18, 15-38.

Angermeyer, M., & Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science and Medicine*, 43, 1721-1728.

Bagley, C., & Carroll, J. (1998). Healing forces in African American families. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. A. Futrell (Eds.), *Resiliency in African American families* (pp. 117-142). Thousand Oaks, CA: Sage.

Battaglino, L. (1987). Family empowerment through self-help groups. In A. B. Hatfield (Ed.). *Families of the mentally ill: Meeting the challenges* (pp. 43-52). San Francisco: Josey-Bass.

Bentz, W. (1970). The clergyman's role in community mental health. *Journal of Religion and Health*, 9, 7-15.

Bergin, A. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. *Professional Psychology: Research and Practice*, 14, 170-184l.

Berry, M, & Blassigame, J. (1982). *Long memory: The black experience in America*. New York: Oxford University Press.

Bhugra, D. (1989). Attitudes toward mental illness: A review of the literature. *Acta Psychiatrica Scandinavica,* 80, 1-12.

Biegel, D., Johnsen, J., & Shafran, R. (1997). Overcoming barriers faced by African American families with a family member with mental illness. *Family Relations,* 46, 163-178.

Billingsley, A. (1992). *Climbing Jacob's ladder.* New York: Simon & Schuster.

Billingsley, A. (1999). *Mighty like a river: The Black Church and social reform*. New York: Oxford University Press.

Bordieri, J., & Dremer, D. (1986). Hiring decisions for disabled workers: Looking at the cause. *Journal of Applied Social Psychology*, 16, 197-208.

Boyd-Franklin, N. (1989). *Black Families in Therapy: A Multisystems Approach*. Guilford.

Brockington, I., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry*, 162, 93-99.

Brodie, M., Kjellson, N., Hoff, T., & Parker, M. (1999). Perceptions of Latinos, African Americans, and Whites on media as a health information source. *The Howard Journal of Communications*, 10, 147-167.

Brown, P. (1992). Popular epidemiology and toxic waste contamination: Lay and professional ways of knowing. *Journal of Health and Social Behavior*, 33, 267-281.

Brown, P. (1995). Naming and Framing: The social construction of diagnosis and illness. *Journal of Health and Social Behavior*, 36, 34-52.

Brown, R., & Turner, J. (1981). Interpersonal and intergroup behavior. In *Intergroup Behavior*. Edited by J. Turner, & H. Giles. Chicago: University of Chicago Press.

Bufford, R., & Buckler, R. (1987). Counseling and the church: A proposed strategy for ministering to mental health needs in the church. *Journal of Psychology and Christianity*, 6, 21-29.

Caldwell, C., Chatters, L., Billingsley, A., & Taylor, R. (1995). Church-based support programs for elderly black adults: Congregational and clergy characteristics. In M. Kimble, S. McFadden, J. Ellor, & J. Seeber (Eds.), *Aging, spirituality, and religion: A handbook* (pp. 306-324). Minneapolis, MN: Fortress Press.

Caldwell, C., Greene, A., & Billingsley, A. (1992). The black church as a family support system: Instrumental and expressive functions. *National Journal of Sociology*, 6, 21-40.

Caldwell, C., Greene, A., & Billingsley, A. (1994). Family support programs in black churches: A new look at old functions. In S. L. Kagan, & B. Weissbourd (Eds.). *Putting Families First: America's Support Movement and the Challenge of Change*. (pp.137-160). San Francisco: Jossey-Bass.

Carll, E. (2003). Psychology, news media, and public policy: Promoting social change. *American Behavioral Scientist*, 46, 1591-1593.

Center for Mental Health Services. *Mental Health, United States, 2000.* R. Manderschied, and M. Henderson (Eds). DHHS Pub No. (SMA) 01-3537. Washington, DC: Supt. of Docs., U. S. Govt. Print. Off., 2001.

Chalfant, H., Heller, P., Roberts, A., Briones, D., Aguirre-Hochbaum, S., Farr, W. (1990). The clergy as a resource for those encountering psychological distress. *Review of Religious Research,* 31, 305-313.

Cone, J. (1985). Black theology in American religion. *Journal of the American Academy of Religion*, 53, 755-771.

Cook, J., Heller, T., & Pickett-Schneck, S. (1999). The effect of support group participation on caregiver burden among parents of adult offspring with severe mental illness. *Family Relations*, 48, 405-410.

Corrigan, P., Backs, A., Green, A., Diwan, S., & Penn, D. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, 27, 219-225.

Corrigan, P., Green, A., Lundin, R., Kubiak, M., & Penn, D. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services*, 52, 953-958.

Corrigan, P., & Penn, D. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54, 765-776.

Corrigan, P., River, L., Lundin, R., Uphoff Washowski, K., Campion, J., Mathisen, J., Goldstein, H., Bergman, M., Gagnon, C., & Kubiak, M. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology*, 28, 91-102.

Cumella, E. (2002). Bio-psycho-social –spiritual: Completing the model. *The Remuda Review: The Christian Journal of Eating Disorders*, 1, 1-5.

Davis, K. (2001). The Intersection of Fee for Service, Managed Health Care, and Cultural Competence. In N. Veeder and W. Peebles-Wilkins (Eds). *Managed Care Services: Policies, Programs, and Research*. (pp. 50-73). New York: Oxford University Press.

Dilworth-Anderson, P., Williams, S., & Cooper, T. (1999). The contexts of experiencing emotional distress among family caregivers to elderly African Americans. In Interventions for family caregivers [Special issue]. *Family Relations: Interdisciplinary Journal of Applied Family Studies*, 48, 391-396.

Domino, G. (1983). Impact of the film, "One Flew Over the Cuckoo's Nest," on attitudes toward mental illness. *Psychological Reports*, 53, 179-182.

Domino, G., & Servain, B. (1985-1986). Recognition of suicide lethality and attitudes toward suicide in mental health professionals. *Omega: Journal of Death and Dying*, 16, 3010-3018.

Edwards, L., Lim, B., McMinn, M., & Dominguez, A. (1999). Examples of collaboration between psychologists and clergy. *Professional Psychology: Research and Practice*, 30, 547-551.

Ellison, C. (1992). Are religious people nice people? Evidence from the national survey of black Americans. *Social Forces*, 71, 411-430.

Ellison, C. (1994). Religion, the life-stress paradigm, and the study of depression. In J. Levin (Ed.), *Religion in aging and health: Theoretical foundations and methodological frontiers* (pp. 78-121). Thousand Oaks, CA: Sage.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129-136.

Faiver, C., O'Brien, E., & McNally, C. (1998). 'The friendly clergy': Characteristics and referral. *Counseling & Values*, 42, 217-222.

Fallot, R. (1998). The place for spirituality and religion in mental health. In R. Fallot (ed). *Spirituality and Religion in Recovery from Mental Illness, New Directions for Mental Health Services, no. 80*, (pp. 3-12). San Francisco: Josey-Bass.

Fallot, R. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry*, 13, 110-116.

Farina, A., & Felner, R. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology*, 82, 268-272.

Farina, A., Felner, R., & Boudreau, L. (1973). Reactions of workers to male and female mental patient job applicants. *Journal of Consulting and Clinical Psychology*, 41, 363-372.

Feagin, J. (1975). *Subordinating the Poor: Welfare and American Beliefs.* New Jersey: Prentice-Hall.

Fink, P., & Tasman, A. (Eds). (1992). *Stigma and mental illness*. Washington, DC: American Psychiatric Press.

Finley, L. (1998). The cultural context: Families coping with severe mental illness. *Psychiatric Rehabilitation Journal*, 21, 230-241.

Fiske, S. (1998). Stereotyping, prejudice, and discrimination. In D. Gilbert, S. Fiske, & L. Gardner (Eds.), *The handbook of social psychology, Vol 2*., (4th edition, pp. 357-411). Boston: McGraw-Hill.

Frazier, E. (1974). *The Negro church in America*. New York: Schocken.

Friedson, E. (1960). Client control and medical practice. *American Journal of Sociology*, 65, 374-382.

Furnham, A. (1988). *Lay Theories: Everyday Understanding of Problems in the Social Sciences*. Pergamon.

Gartner, J., Larson, D., & Allen, G. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology*, 19, 6-25.

Gerbner, G. (1980). Dreams that hurt: Mental illness in the mass media. In R. Baron Rutman, & B. Klaczynska. (Eds). *The community imperative* (pp. 19-23). Philadelphia: Horizon House Institute.

Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1980). The "mainstreaming" of America: Violence profile no. 11. *Journal of Communication*, 30, 10-29.

Gibbs, H., & Achterberg-Lawlis, J. (1978). Spiritual values and death anxiety: Implications for counseling with terminal cancer patients. *Journal of Counseling Psychology*, 25, 563-569.

Gottlieb, J., & Olfson, M. (1987). Current referral practices of mental health care providers. *Hospital and Community Psychiatry*, 38, 1171-1181.

Gould, S. (1981). *The Mismeasure of Man*. Norton.

Gourash, N. (1978). Help seeking: A review of the literature. *American Journal of Community Psychology*, 6, 413-424.

Granello, D., Pauley, P., & Carmichael, A. (1999). Relationship of the media to attitudes toward people with mental illness. *Journal of Humanistic Counseling, Education and Development*, 38, 98-111.

Greenley, J. (1984). Social factors, mental illness, and psychiatric care: Recent advances from a sociological perspective. *Hospital and Community Psychiatry*, 35, 813-820.

Grella, C., & Grusky, O. (1989). Families of the severely mentally ill and their satisfaction with services. *Hospital and Community Psychiatry*, 40, 831-835.

Grevengoed, N. (1985). *Attributions for death: An examination of the role of religion and the relationship between attributions and mental health.* Unpublished master's thesis, Bowling Green State University, Bowling Green, OH.

Gurin, G., Miller, A., Gurin, G. (1980). Stratum identification and consciousness. *Social Psychology Quarterly*, 43, 30-47.

Gurin, G., Veroff, J., & Feld, S. (1960). *Americans View Their Mental Health: A Nationwide Interview Survey*. New York: Basic Books, Inc.

Haber, D. (1984). Church-based programs for black caregivers of non-institutionalized elders. *Journal of Gerontological Social Work,* 7, 43-56.

Hair, Jr., J., Anderson, R., Tatham, R., & Black, W. (1998). *Multivariate Data Analysis*. (5th ed.). New Jersey: Prentice Hall.

Hall, L., & Tucker, C. (1985). Relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help. *Psychological Reports*, 57, 907-916.

Hamre, P., Dahl, A., & Malt, U. (1994). Public attitudes to the quality of psychiatric treatment, psychiatric patients, and prevalence of mental disorders. *Norwegian Journal of Psychiatry*, 4, 275-281.

Heller, T., Roccoforte, J., & Cook, J. (1997). Predictors of support group participation among families of persons with mental illness. *Family Relations*, 47, 437-442.

Hill, R. (1999). *The strengths of African American families: Twenty-five years later* (2nd ed.). Thousand Oaks, CA: Sage.

Hines-Martin, V. (1998). Environmental context of caregiving for severely mentally ill adults: An African American experience. *Issues in Mental Health Nursing*, 19, 433-451.

Holmes, E., Corrigan, P., Williams, P., et al. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin*, 25, 447-456.

Holmes, E., River,L. (1998). Individual strategies for coping with the stigma of severe mental illness. *Cognitive and Behavioral Practice*, 5, 231-239.

Hong, B., & Wiehe, V. (1974). Referral patterns of the clergy. *Journal of Psychology & Theology*, 2, 291-297.

Hornik, R. (1988). *Development communication. Information, agriculture and nutrition in the Third World.* New York: Longman.

Huber, J., & Form, W. (1973). *Income and Ideology*. Free Press.

Hunt, M. (1996). The individual, society, or both? A comparison of Black, Latino, and White beliefs about the causes of poverty. *Social Forces,* 75, 293-322.

Husiani, B., Moore, S., & Cain, V. (1994). Psychiatric symptoms and help-seeking behavior among the elderly: An analysis of racial and gender differences. *Journal of Gerontological Social Work,* 21, 177-195.

Jang, S., & Johnson, B. (2003). Strain, negative emotions, and deviant coping among African Americans: A test of general strain theory. *Journal of Quantitative Criminology,* 19, 79-105.

Jang, S., & Johnson, B. (2004). Explaining religious effects on distress among African Americans. *Journal of the Scientific Study of Religion*, 43, 239-260.

Jansson, B. (1997). *The reluctant welfare state*. (3rd ed.). Pacific Grove, CA: Brooks/ Cole.

Jarvis, G., & Northcutt, H. (1987). Religion and differences in morbidity and mortality. *Social Science and Medicine,* 25, 813-824.

Jenkins, R., & Pargament, K. (1988). Cognitive appraisals in cancer patients. *Social Science & Medicine*, 26, 625-633.

Johnson, B., Thompson, R., & Webb, D. (2002). *Objective hope—Assessing the effectiveness of faith-based organizations: A review of the literature*. CRRUCS report. Philadelphia: University of Pennsylvania.

Johnston, L., Hewstone, M. (1992). Cognitive models of stereotype change: 3. subtyping and the perceived typicality of disconfirming group members. *Journal of Experimental Social Psychology*, 28, 360-386.

Jordan, C., & Franklin, C. (2003). *Clinical Assessment for Social Workers: Quantitative and Qualitative Methods*. (2nd ed.). Chicago: Lyceum Books, Inc.

Kane, M. (2003). Skilled help for mental health concerns: Comparing the perceptions of Catholic priests and Catholic parishioners. *Mental Health, Religion, & Culture*, 6, 261-275.

Kane, M., & Williams, M. (2000). Perceptions of south Florida Hispanic and Anglo Catholics: From whom would they seek help? *Journal of Religion and Health*, 39, 107-121.

Keane, M. (1990). Contemporary beliefs about mental illness among medical students: Implications for education and practice. *Academic Psychiatry*, 14, 172-177.

Keane, M. (1991). Acceptance vs. rejection: Nursing students' attitudes about mental illness. *Perspectives in Psychiatric Care*, 27, 13-18.

Kim-Goh, M. (1993). Conceptualization of mental illness among Korean-American clergymen and implications for mental health service delivery. *Community Mental Health Journal*, 29, 405-411.

King, D. (2000). *Faith, spirituality, and medicine: Toward the making of a healing practitioner.* Binghamton, NY: Haworth Pastoral Press.

Kluegal, J., & Smith, E. (1986). *Beliefs about Inequality*. Aldine de Gruyter.

Koenig, H., Larson, D., & Weaver, A. (1998). Research on religion and serious mental illness. In R. Fallot (Ed). *Spirituality and Religion in Recovery from Mental Illness: New Directions for Mental Health Services*. (pp. 81-95). San Francisco: Jossey-Bass.

Koenig, H., McCullough, M., & Larson, D. (2000). *Handbook of religion and health*. New York: Oxford University Press.

Kolodziej, M., & Johnson B. (1996). Interpersonal contact and acceptance of persons with psychiatric disorders: A research synthesis. *Journal of Consulting and Clinical Psychology*, 64, 1387-1396.

Krause, N. (2002a). Church-based social support and health in old age: Variations by race. *Journal of Gerontologist: Social Sciences*, 57B, S332-S347.

Krause, N., Chatters, L., Meltzer, T., & Morgan, D. (2000b). Using focus groups to explore the nature of prayer in late life. *Journal of Aging* Studies, 14, 191-212.

Krause, N., Ellison, C., & Wulff, K. (1998). Emotional support, negative interaction, and psychological well-being in the church. *Journal for the Scientific Study of Religion*, 37, 726-742.

Krieger, N. (1987). Shades of difference: Theoretical underpinnings of the medical controversy on Black/White differences in the United States, 1830-1870. *International Journal of Health Services*, 17, 259-278.

Kumanyika, S., & Charleston, J. (1992). Lose weight and win: A church-based weight loss program for blood pressure control among black women. *Patient Education and Counseling*, 19, 19-32.

Larson, R. (1968). The clergyman's role in the therapeutic process: Disagreement between clergymen and psychiatrists. *Psychiatry*, 31, 250-260.

Larson, R. (1969). Clergymen's subjective feelings of competence when dealing with emotionally disturbed people. *Review of Religious Research*, 10, 140-150.

Larson, D., Hohmann, A., Kessler, L., Meador, K., Boyd, J., & McSherry, E. (1988). The couch and the cloth: The need for linkage. *Hospital and Community Psychiatry*, 39, 1064-1069.

Larson D., & Milano, M. (1997). Making the case for spiritual interventions in clinical practice. *Mind/Body Medicine*, 2, 20-30.

Larson, D., Sherrill, K., Lyons, J., Craigie, F., Jr., Thielman, S., Greenwold, M., & Larson, S. (1992). Associations between dimensions of religious commitment and mental health reported in the *American Journal of Psychiatry* and *Archives of General Psychiatry*: 1978-1989. *American Journal of Psychiatry*, 149, 557-559.

Lee, B., Jones, S., & Lewis, D. (1990). Public beliefs about the causes of homelessness. *Social Forces*, 69, 253-265.

Lefley. H. (1998). Families coping with mental illness: The cultural context. *New Directions for Mental Health Services*, 77.

Levey, S., & Howells, K. (1995). Dangerousness, unpredictability, and the fear of people with schizophrenia. *Journal of Forensic Psychiatry*, 6, 19-39.

Levin, J. (1984). The role of the black church in community medicine. *Journal of the National Medical Association*, 76, 477-483.

Levin, J. (1986). Roles for the black pastor in preventive medicine. *Pastoral Psychology*, 35, 94-103.

Levin, J., & Chatters, L. (1998b). Research on religion and mental health: An overview of empirical findings and theoretical issues. In H. Koenig (Ed.), *Handbook on religion and mental health* (pp. 33-50). San Diego: Academic Press.

Levin, J., Markides, K., & Ray, L. (1996). Religious attendance and psychological well-being in Mexican Americans: A panel analysis of three-generations data. *Gerontologist*, 36, 454-463.

Levin, J., & Schiller, P. (1987). Is there a religious factor in health? *Journal of Religion and Health*, 26, 9-36.

Levin, J., & Vanderpool, H. (1989). Is religion therapeutically significant for hypertension? *Social Science and Medicine*, 29, 69-78.

Lincoln, K. (2000). Social support, negative social interactions, and psychological well-being. *Social Science Review*, 74, 231-252.

Lincoln, C., & Mayima, L. (1990). *The Black church in the African American experience.* Durham, NC: Duke University Press.

Link, B. (1982). Mental patient status, work and income: An examination of the effects of a psychiatric label. *American Sociological Review*, 47, 202-215.

Link, B. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52, 96-112.

Link, B., & Cullen, F. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior*, 27, 289-302.

Link, B., Phelan, J., Bresnahan, M., Stueve, A., Pescosolido, B. (1999). Public conceptions of mental illness: Labels, causes, dangerousness, and social distance. *American Journal of Public Health*, 89, 1328-1333.

McAdoo, H. (1981). *Black families*. Beverly Hill, CA: Sage.

McAdoo, H., & Crawford, V. (1990). The black church and family support programs. *Prevention and Human Services*, 9, 193-203.

McRae, M., Carey, P., Anderson-Scott, R. (1998). Black churches as therapeutic systems: A group process perspective. *Health Education & Behavior*, 25, 778-789.

McKee, D., & Chappel, J. (1992). Spirituality and medical practice. *Journal of Family Practice*, 35, 201, 205-208.

Macrae, C., Bodenhausen, G., Milne, A., & Jetten, J. (1994). Out of mind but back in sight: Stereotypes on the rebound. *Journal of Personality and Social Psychology*, 67, 808-817.

Mandianos, M., Madianou, D., Vlachonikolis, J., & Stefanis, C. (1987). Attitudes toward mental illness in the Athens area: Implications for community mental health intervention. *Acta Psychiatrica Scandinavia*, 75, 158-165.

March, P. (1999). Ethical responses to media depictions of mental illness: An advocacy approach. *Journal of Humanistic Counseling, Education & Development*, 38, 70-80.

Marcos, L. (1989). Media power and public mental health policy. *American Journal of Psychiatry*, 146, 1185-1189.

Martin, E., & Martin, J. (2002). *Spirituality and the Black helping tradition in social work.* Washington, DC: NASW Press.

Matas, M., el-Guebaly, N., Peterkin, A., Green, M., & Harper, D. (1985). Mental illness and the media: An assessment of attitudes and communication. *Canadian Journal of Psychiatry*, 30, 12-17.

Mattis, J., & Jagers, R. (2001). A relational framework for the study of religiosity and spirituality in the lives of African Americans. *Journal of Community Psychology*, 29, 519-539.

Milstein, G., Guarnaccia, P., & Midlarsky, E. (1995). Ethnic differences in the interpretation of mental illness: Perspectives of caregivers. *Research in Community and Mental Health*, 8, 155-178.

Mirowsky, J., & Ross, C. (1986). Social patterns of distress. *Annual Review of Sociology*, 12, 23-45.

Mirowsky, J., & Ross, C. (1989). *Social causes of psychological distress*. New York: Aldine de Gruyter.

Mobley, M., Katz, E., & Elkins, R. (1985). Academic psychiatry and the clergy: An analysis of ministerial referrals. *Hospital and Community Psychiatry*, 14, 323-328.

Mollica, R., Streets, F., Boscarino, J., & Redlich, F. (1986). A community study for Formal pastoral counseling activities of the clergy. *American Journal of Psychiatry*,14, 323-328.

Morrison, E., & Thornton, K. (1999). Influence of southern spiritual beliefs on perceptions of mental illness. *Issues in Mental Health Nursing*, 20, 443-458.

Neff, J., & Husaini, B. (1985). Lay images of mental illness: Social knowledge and tolerance of the mentally ill. *Journal of Community Psychology*, 13, 3-12.

Neighbors, H. (1985). Seeking professional health for personal problems: Black Americans use of health and mental health services. *Community Mental Health Journal*, 21, 156-166.

Neighbors, H. (2003, November). The African American minister as a source of help for serious personal problems: Bridge or barrier to mental health care? Paper presented at the meeting of the Central Texas African American Families Support Conference, Austin, TX.

Neighbors, H., & Jackson, J. (1984). The use of formal and informal help: Four patterns of illness behavior in the black community. *American Journal of Community Psychology*, 12, 629-644.

Neighbors, H., & Jackson, J. (1996). *Mental health in black America.* Thousand Oaks, CA: Sage.

Neighbors, H., Musick, M., Williams, D. (1998). The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education & Behavior*, 25, 759-777.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Nickerson, K., Helms, J., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counselors. *Journal of Counseling Psychology*, 41, 378-385.

Orbuch, T. (1997). People's accounts count: The sociology of accounts. *Annual Review of Sociology*, 23, 455-478.

Page, S. (1983). Psychiatric stigma. Two studies of behavior when the chips are down. *Canadian Journal of Community Mental Health*, 2, 13-19.

Pargament, K. (1997). *The Psychology of Religion and Coping: Theory, Research, and Practice*. New York: Guilford Press.

Pargament, K. (1997a). The psychology of religion and spirituality? Yes and no. In M. Krejci (ed), *Psychology of Religion Newsletter*, 22, 1-9.

Pargament, K., & Brant, C. (1998). Religion and coping. In H. Koenig (Ed.), *Handbook of religion and mental health* (pp. 111-128). San Diego: Academic Press.

Pargament, K., Ensing, D., Falgout, K., Olsen H., Reilly, B., Van Haitsma, K., & Warren, R. (1990). God help me: (I) Religious coping efforts as predictors of the outcomes to significant negative life events. *American Journal of Community Psychology*, 18, 793-823.

Pargament, K., & Park, C. (1995). Merely a defense? The variety of religious means and ends. *Journal of Social Issues*, 51, 13-32.

Penn, D., Guynan, K., Daily, T., Spaulding, W., Garbin, C., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, 25, 437-446.

Penn, D., & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly*, 69, 235-247.

Pearlin, L. (1989). The sociological study of stress. *Journal of Health and Social Behavior*, 30, 241-256.

Perry, E. (1981).The Memphis church-based high blood pressure program. *Urban Health*, pp. 69-70.

Pescosolido, B., Monahan, J., Link, B., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, 89, 1339-1345.

Philo, G., Secker, J., Platt, S., Henderson, L., McLaughlin, G., & Burnside, J. (1994). The impact of the mass media on public images of mental illness: Media content and audience belief. *Health Education Journal*, 53, 271-281.

Pickett-Schneck, S. (2002). Church-based support groups for African American families coping with mental illness: Outreach and outcomes. *Psychiatric Rehabilitation Journal*, 26, 173-180.

Poole, D., & Salgado de Snyder, V. (2002). Pathways to health and mental health care: Guidelines for culturally competent practice. In A. Roberts, & G. Gilbert (Eds.) *Social Workers' Desk Reference* (pp. 51-56.). New York: Oxford.

Propst, L., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavior therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology*, 60, 94-103.

Rabkin, J. (1974). Public attitudes toward mental illness: A review of the literature. *Psychological Bulletin*, 10, 9-33.

Regnerus, M. (2003). Religion and positive adolescent outcomes: A review of research and theory. *Review of Religious Research*, 44, 394-413.

Ring, S., & Schien, L. (1970). Attitudes toward mental illness and the use of caretakers in a Black community. *American Journal of Orthopsychiatry*, 40, 710-716.

Rogler, L., & Cortes, D. (1993). Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry*, 150, 554-561.

Roman, P., & Floyd, H. (1981). Social acceptance of psychiatric illness and psychiatric treatment. *Social Psychiatry*, 16, 16-21.

Ross, C. (1990). Religion and psychological distress. *Journal of the Scientific Study of Religion*, 29, 236-245.

Ruppert, P., & Rogers, M. (1985). Needs assessment in the development of a clergy consultation service: A key informant approach. *Journal of Psychology and Theology*, 13, 50-60.

Schnittker, J., Freese, J., & Powell, B. (2000). Nature, nurture, neither, nor: Black-White differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces*, 78, 1101-1130.

Schulz, A., Williams, D., Israel, B., Becker, A., Parker, C., James, S., & Jackson, J. (2000). Unfair treatment, neighborhood effects, and mental health in the Detroit metropolitan area. *Journal of Health and Social Behavior*, 41, 314-332.

Schumacher, M., Corrigan, P., & DeJong, T. (2003). Examining cues that signal mental illness stigma. *Journal of Social and Clinical Psychology*, 22, 467-476.

Shafranske, E., & Malony, H. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.

Shankar, R. (1994). Interventions with families of people with schizophrenia in India. In A. B. Hatfied (Ed.). *New Directions in Mental Health* (no. 62). San Francisco, CA: Josey-Bass.

Sherkat, D., & Ellison, C. (1999). Recent developments and current controversies in the sociology of religion. *Annual Review of Sociology*, 25, 363-394.

Siegelman, L., & Welch, S. (1993). The contact hypothesis revisited: Black-white interaction and positive racial attitudes. *Social Forces*, 71, 781-795.

Smith, C. (2003a). Theorizing religious effects among American adolescents. *Journal for the Scientific Study of Religion*, 42, 17-30.

Snowden, L. (1999). African American service use for mental health problems. *Journal of Community Psychology*, 27, 303-313.

Snowden, L., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45, 347-355.

Snowden, L., Collinge, W., & Runkle, M. (1982). Help seeking and underservice. In L. R. Snowden (Ed.). *Reaching the Underserved: Mental Health Needs of Neglected Populations* (pp. 281-298). Beverly Hills: Sage.

Solomon, P. (1998). The cultural context of interventions for family members with a seriously mentally ill relative. In H. P. Lefley (Eds.) *New Directions for Mental Health Services* (no.77). San Francisco, CA: Josey-Bass.

Spainol, L., Jung, H., Zipple, A., & Fitzgerald, S. (1987). Families as a resource in the rehabilitation of the severely psychiatrically disabled. In A. B. Hatfield & H. P. Lefley (Eds.). *Families of the mentally ill: Coping and adaptation* (pp. 167-190). New York: Guilford.

Sperry, L., & Giblin, P. (1996). Marital and family therapy with religious persons. In E. Shafranske (Ed.), *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Stack, C. (1974). *All our kin*. New York: Harper & Row.

Staples, R., & Johnson, L. (1993). *Black families at the crossroads: Challenges and prospects.* San Francisco: Jossey-Bass.

Stedman, D. (1977). Politics, Political Structures, and Advocacy Activities. In J. Paul, D. Stedman, & G. Neufield (Eds.). *Deinstitutionalization* (pp. 57). Syracuse, NY: Syracuse University Press.

Substance Abuse and Mental Health Services Administration. (2003). *Overview of Findings from the 2002 National Survey on Drug Use and Health* (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD.

Sulmasy, D. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, 42, 24-33.

Sussman, L., Robins, L., & Earls, F. (1987). Treatment-seeking for depression by Black and White Americans. *Social Science and Medicine*, 24, 187-196.

Taylor, R., & Chatters, L. (1986a). Church-based informal support among elderly blacks. *The Gerontologist*, 26, 637-642.

Taylor, R., & Chatters, L. (1986b). Patterns of informal support to elderly black adults: Family, friends, and church members. *Social Work*, 31, 432-438.

Taylor, R., & Chatters, L. (1988). Church members as a source of informal social support. *Review of Religious Research*, 30, 193-203.

Taylor, R., & Chatters, L. (1991). Religious life. In J. Jackson (Ed.), *Life in Black America.* (pp. 105-123). Thousand Oaks, CA: Sage.

Taylor, R., & Chatters, L. (2003). National survey of black Americans. In R. Taylor, & Chatters, L. (Eds.). *Religion in the lives of African Americans.* Thousand Oaks, CA: Sage.

Taylor, R., Chatters, L., & Jackson, J. (1997). Changes over time in support network Involvement among black Americans. In R. Taylor, J. Jackson, & L. Chatters (Eds.), *Family life in black America* (pp. 295-318). Thousand Oaks, CA: Sage.

Taylor, R., Chatters, L., Jayakody, R., & Levin, J. (1996). Black and White differences in religious participation: A multisample comparison. *Journal for the Scientific Study of Religion*, 35, 403-410.

Taylor, R., Chatters, L., & Levin, J. (2004). Religion in the lives of African Americans: Social, Psychological, and Health Perspectives. Thousand Oaks, CA: Sage.

Taylor, R., Ellison, C., Chatters, L., Levin, J., & Lincoln, K. (2000). Mental health services in faith communities: The role of clergy in black churches. *Social Work*, 45, 73-87.

Taylor, R., & Sellers, S. (1997). Informal ties and employment among black Americans. In R. Taylor, J. Jackson, & L. Chatters (Eds.), *Family life in black America* (pp. 146-156). Thousand Oaks, CA: Sage.

Thomas, S., Quinn, S., Billingsley, A., & Caldwell, C. (1994). The characteristics of northern black churches with community health outreach programs. *American Journal of Public Health*, 84, 575-579.

Thornton, J., & Wahl, O. (1996). Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology*, 24, 17-25.

U. S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

Vargas, L., & dePyssler, B. (1999). U. S. Latino newspapers as health communication resources: A content analysis. *The Howard Journal of Communications*, 10, 189-205.

Veroff, J., Douvan, E., & Kulka, R. (1981). *The inner American: A self portrait from 1957 to 1976*. New York: Basic Books.

Virkler, H. (1979). Counseling demands, procedures, and preparation of parish ministers: A descriptive study. *Journal of Psychology & Theology*, 7, 271-280.

Wahl, O. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology*, 20, 343-352.

Wahl, O. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25, 467-478.

Wahl, O. (2003). News media portrayal of mental illness: Implications for public policy. *American Behavioral Scientist*, 46, 1594-1600.

Wahl, O., & Lefkowits, J. (1989). Impact of a television film on attitudes toward mental illness. *American Journal of Community Psychology*, 17, 521-528.

Weaver, A., Koenig, H., & Larson D. (1997). Marital and family therapists and the clergy: A need for collaboration, training, and research. *Journal of Marital and Family Therapy*, 23, 13-25.

Weber, R., & Crocker, J. (1983). Cognitive processes in the revision of stereotypic beliefs. *Journal of Personality and Social Psychology*, 28, 360-386.

Whitehorn, K. (1990). The use of the media in the promotion of mental health. *International Journal of Mental Health*, 18, 40-46.

Williams, D. (1994). The measurement of religion in epidemiological studies: Problems and prospects. In J. S. Levin (Ed.), *Religion in aging and health: Theoretical foundations and methodological frontiers* (pp. 125-148). Thousand Oaks, CA: Sage.

Williams, R. (1977). *Mutual accommodation: Ethnic conflict and cooperation*. Minneapolis: University of Minnesota Press.

Williams, D., Larson, D., Buckler, R., Heckmann, R., & Pyle, C. (1991). Religion and psychological distress in a community sample. *Social Science and Medicine*, 11, 1257-1262.

Williams, D., Takeuchi, D., & Adair, R. (1992). Marital status and psychiatric disorders among Blacks and Whites. *Journal of Health and Social Behavior*, 33, 140-157.

Williams, C., & Williams, H. (1984). Contemporary voluntary associations in the urban black church: The development and growth of mutual aid societes. *Journal of Voluntary Action Research*, 13, 19-30.

Wolff, G., Pathare, S., Craig, T., et al. (1996). Community knowledge of mental illness and reaction to mentally ill people. *British Journal of Psychiatry*, 168, 191-198.

Worsley, A. (1989). Perceived reliability of sources of health information. *Health Education Research*, 4, 367-376.

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