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From the Pastor's Desk: A Quantitative Analysis of African American Pastors' leading with Congregants Experiencing Mental Health Issues

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Several studies indicate there may be a significant increase in African Americans being diagnosed and suffering with severe mental illnesses (Avent, Cashwell, & Brown-Jeffy, 2015; Williams & Cabrera-Nguyen, 2016). Many African Americans, however, are shown to seek psychological support from their pastors rather than seek formal mental health services (Avent et al., 2015; Hays, 2015; Stansbury, Harley, King, Nelson & Speight, 2012). Researchers suggest that the Black pastor is perceived as a respected community leader who is firmly embedded within the African American community, where they acquire a significant degree of community admiration, influence, respect, and civic responsibility that justifiably classifies them in a unique honorable position (Mercer, 2013). The purpose of this research study was to explore through a correlation, quantitative methodological study utilizing the Demographic Data Questionnaire, The Mental Health Counseling Survey (MHCS) and The Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), how the African American pastor as a leader addresses mental illness with their congregants as well as determine the crucial role the pastor has in assisting their congregants who seek professional help for mental illness. Further, this research assessed the correlation between a Pastor's education and their understanding of mental health and their willingness to refer their congregants to a mental health provider.

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Studies show that African Americans have utilized the Black Church to address many of their multifaceted needs: physical, spiritual, mental, emotional, social, and economic (Hankerson et al., 2013; Rowland & Isaac-Savage, 2014). Historically, African Americans have been known to seek support solely from the Black church and the Black pastor to address those various needs, especially when it comes to their mental and emotional needs. Research indicates the various reasons why African Americans choose to seek help from informal mental health services as opposed to formal mental health services. (Rowland & Isaac-Savage, 2014) There are significant disparities that exist along racial and ethnic lines indicating that minorities have less access to mental health services. The individual's, socioeconomic status, demographic location, and employment status contribute to these disparities hindering the individual's ability to seek formal support (Brown et al., 2014; Williams & Cabrera-Nguyen, 2016). Hankerson et al. (2013) also suggest that there are several barriers that keep African Americans from seeking formal mental health services.

Barriers for Seeking Services

One barrier that keeps African Americans from seeking formal mental health services is the lack of appropriate health insurance coverage to receive adequate psychiatric treatment. This barrier may be a result of urban poverty which is deemed to be a cultivator of mental health issues that keep the African American in a cyclical experience where poverty may create mental health issues, but the individual cannot seek help due to lack of benefits due to their poverty (Anakwenze & Zuberi, 2013). Further, there seems to be a negative stigma that is attached to seeking mental health services (Awosan et al., 2011; Hays, 2015). Consequently, Neighbors et al. (1998) assert African Americans do not seek treatment due to the negative stigma of being labeled as crazy. According to Hays (2015), there is a less than positive experience for African Americans seeking formal treatment where they verbalize a culture of mistrust with a therapist or clinician who is not African American.

There is also the notion that health care providers who serve the mentally ill are culturally insensitive, lack cultural competency and provide inadequate and improper treatment and diagnosis of African Americans seeking support- thus increasing the fear of institutionalization (Hays, 2015; Hovey et al., 2014). Given these aspects, many African- Americans are shown to seek psychological support primarily from their pastor. According to Neighbors et al. (1998), many African Americans continue to view the Black church as a haven for both solace and moral support. These researchers suggest furthermore that the Black pastor is perceived as one of the most respected leaders in the community and is deemed to be entrenched and embedded in the African American community. They further suggest that the Black pastor acquires a significant degree of community admiration, influence, respect, and civic responsibility that justifiably places them in a unique and honorable position. According to Lumpkins et al. (2013), the Black pastor's communication from the pulpit is influential to congregants due to the pastor's

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significant leadership role and what it represents. The authors further indicate the pastor is deemed as a spiritual guide and a trusted servant recognized by members as a true change agent. Therefore, the pastor's guidance, direction and leadership become a vital component in the pastor parishioner relationship. Because the Black pastor is considered an influential leader in the community who is well respected, many African Americans would rather seek psychological assistance from their clergy rather than seek formal mental health services (Hays, 2015). Avent et al. (2015) conjectured, despite the educational background of the Black pastor, many members consider the pastor as a credible and valuable individual who may be instrumental in helping them both psychologically and socially**.** This study therefore assesses the nature of the African American pastor's feasibility to issue mental health counseling, utilize formal mental health services and collaborate and refer their congregants to formal mental health service agencies.

Research Method & Design

The researcher uses a quantitative methodological study approach utilizing the following surveys: (a) The Demographic Data Questionnaire (Plunkett, 2009, p. 149-150), (b) The Mental Health Counseling Survey (MHCS), (Anthony, et al., 2015, pp. 120-121; Wylie, 1984), (c) The Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016). The goal was for these surveys to be completed face to face at the Baptist Ministers fellowship meeting on Monday nights in Greenville, S.C. The meeting meets at Martin Webb Theological Seminary from 7:00pm-9:00pm. The researcher ascertained permission from the Baptist Minister's fellowship president to attend at least three consecutive meetings to secure participants. The first meeting was an informational meeting to share with the pastors about the research. The pastors were asked about completing the surveys in the following two meetings. A letter explaining the nature of the study and appropriate consent forms were brought to the meetings along with the surveys. During the second meeting, pastors were asked to complete the surveys. This process took approximately 45-60 minutes. During the third meeting, any pastors who did not complete the survey at the second meeting were asked to complete the survey in another room away from the regular meeting. After week three, if the researcher does not have the appropriate sample size of surveys, surveys will be administered to the remaining pastor via email. The sample for this study will be comprised from the Reedy River Baptist Association Pastors in Greenville, S. C. This group of pastors also makes up the Baptist Ministers fellowship pastors. The sample size estimated for this study will be approximately 30 pastors from the churches associated and listed within region four of the Baptist Educational and Missionary Convention of South Carolina. This sample size is based upon the number of churches in this region that meets the description of the type of pastor to be surveyed, Black Baptist pastors. A power analysis was completed to determine the sample size. This was done by using the survey system software. With a confidence level of 95%, a confidence interval of 10, which denotes a margin of error of +5 and -5. The margin of population is 30. Based on the calculation from this software, if this researcher receives at least 23-28 surveys back, this should be sufficient to proceed with and complete this research. Also, based on the researcher using three

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different surveys, the number of questions for each survey and with the number of participants, even with a small sample, the researcher will receive an ample amount of data points to substantiate the research study. As indicated, this information is public information on both the Baptist Educational and Missionary Convention of South Carolina website and the Reedy River Baptist Association website. The age range for these pastors is estimated to be from 40 years old to 75 years old. The surveys administered were the Demographic Data Questionnaire (Plunkett, 2009, p. 149-150), the Mental Health Counseling Survey (MHCS), (Anthony et al., 2015; Wylie, 1984) and the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016).

The participants self-identified as African American senior level pastors or clergy. The parameter of age criterion for this study was 18 years of age or older, and the participant should be capable of reading the material and understanding the basic nature of the study. The survey asked engaging questions of the pastor surrounding the use of formal mental health resources in their community as noted in the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016).

Due to the unique and challenging responsibility of the Black pastor, this chosen research method and design was deemed most appropriate. Submitting surveys face-to-face created a personal touch and engagement where the researcher explained the nature of the study. The use of an online survey tool is only submitted to pastors via email who were unable to attend one of the survey meeting times. This research design is suitable to respond to this study's purpose, which is to explore how the African American pastor as a leader addresses mental illness with their congregants. The purpose will further examine the pastor's formal use of mental health services thus assessing whether the pastor educational level supports their making appropriate referrals to formal mental health agencies.

Results were computed by the researcher using the R Project software for statistical computing. SPSS for Windows was utilized to help with data analysis. According to Gaffney (2016), it is also vital for surveys that are ineligible or incomplete to be discarded and not included in the data analysis and outcomes of the study. The results from the final analysis will hopefully significantly contribute to both the theological and psychological fields of study. The merging of these two schools of thought may aid the pastor as well as the health care professional in understanding both the spiritual and psychological needs of the individual thus developing a healthier collaboration between the two (Rowland & Isaac-Savage, 2014; Stansbury, et al., 2012).

Operational Definitions of Variables

This study utilized a descriptive quantitative correlational research approach. The objective is to explore the possible relationships between the African American pastor's education level and their ability to understand the mental health issues of their

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congregants as well as assess their willingness to refer their congregants for mental health services. It further determined the pastor's relationship with mental health referral agencies as it relates to the pastor's ability to refer congregants for services.

Table 1

Description of Research Variables with Corresponding Operational Definitions and Variable Measures

Research Variable	Operational Definition	Variable Measure
Pastor's Understanding of Mental Health	This variable is based on their self-report understanding of common mental health practices and issues from a scale	Mental Health Counseling Survey (MHCS)
Pastor's willingness to refer their congregants	This variable is based on their self-report indicating their willingness to refer their congregants for mental health treatment	Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS)
Pastor's ability to refer congregants	This variable is based on their self-report indicating their ability to refer their congregants for mental health treatment	Mental Health Counseling Survey (MHCS) Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS)

Table 2

Research questions and their corresponding measured variables

Question Number	Dependent Variable	Independent Variable
1. What is the association of a Pastor's education on their understanding of mental health?	Pastor's Understanding of Mental Health	Pastor's Education

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2. What is the association of a Pastor's education on their willingness to refer their congregants to a mental health provider	Pastor's willingness to refer their congregants	Pastor's Education
3. What is the association of the Pastor/Mental Health agency relationship on a pastor's ability to refer their congregants to mental health services?	Pastor's ability to refer congregants	Pastor/Mental Health Relationship

The Mental Health Counseling Survey (MHCS) was initially developed in 1984 (Wylie, 1984). It was later revised in 2015 (Anthony et al., 2015, pp. 120-121). This survey is an eleven-question survey that asks the clergy various questions surrounding the following:

- Describing the characteristics of congregants who seek counseling
- Check list of issues that the congregant might be seeking help for
- The number of congregants counseled and for what mental health issue?
- Rank in order of importance as to why the congregant seek help from the clergy as opposed to the mental health professionals
- What are the cues that denote a congregant needs help?
- Checklist comparison of professional counseling and spiritual counseling
- Are congregants referred?
- Factors that influence decision to refer
- Experiences in counseling and doing a better job
- Opinion pertaining to formal training in counseling being appropriate for Clergy (Anthony et al., 2015, pp. 120-121).

This study hypothesized that the more formal education the pastor has, the more that pastor will utilize formal mental health services in the community. It further assessed the pastor's relationship with mental health agencies as it relates to the pastor's ability to refer congregants for services should they need it.

Validity and Reliability

According to Heale and Twycross (2015), validity is defined as "the extent to which a concept is accurately measured in a quantitative study" (p. 66). Reliability, the authors' state "relates to the consistency of a measure" as well as the "accuracy of an instrument" (p. 66). Leedy and Ormrod (2013) indicate the following as it pertains to validity and reliability. The "validity of a measurement instrument is the extent to which the instrument measures what it is intended to measure" (p. 89). Reliability they state, "is the consistency with which a measuring instrument yields a certain, consistent result

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when the entity being measured hasn't changed" (p. 91). Therefore, the validity of a project indicates whether or not the information the researcher is receiving measures what the researcher wants as the outcome; thus, will it accurately reflect what the researcher wants it to reflect in the data sheet. Moreover, the reliability of the project should therefore indicate whether or not the project is reproducible where the researcher can receive the same results multiple times in a row.

The three survey instruments the researcher is using for this study, were all evaluated for their validity and reliability and were used in previous study's. The Mental Health Counseling Survey was "adapted from the Health Counseling Competencies Needed for Ministers Survey designed to determine the competencies ministers need to feel competent in counseling congregants" (Anthony et al., 2015, p. 122; Wylie, 1984). This instrument was also used in a study where the researcher wanted to determine the African American clergy's competence and their ability to recognize and address issues of depression with their congregants. The study further aimed to identify the clergy's skill set through training to determine if the clergy would recognize the congregant's issue of depression. The findings indicated the more educated and trained the clergy was, the better they were at recognizing and perhaps referring their congregants for professional help. Many did however state they needed more training in the area of learning about depression (Anthony et al., 2015).

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH-SF), has also been used in past studies. "This scale originally looked at the effects of social class, educational level, religion, and college major regarding the attitudes toward seeking professional psychological help scale" (Gaffney, 2016, p. 53; Fischer & Turner, 1970, p. 86). In a study conducted by Gaffney (2016), the researcher assessed the African American Pastor's attitudes toward seeking professional psychological help. This study looked at the association between the African American pastor's theological belief, their education level, their personal experience with mental illness and the pastor's attitude toward congregants seeking professional psychological help. The findings indicated "theological belief has a direct impact on pastor's attitudes toward seeking professional psychological counseling" where the education and personal experiences had no impact (p. 72).

Elhai et al. (2008) further examined the reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale short form. According to their findings, "The ATSPPH-SF evidenced adequate internal consistency. Higher scores (indicating more positive treatment attitudes) were associated with less treatment-related stigma, and greater intentions to seek treatment in the future. No associations were found for mental health impairment or depression" (p. 320). Because both instruments have been replicated in multiple studies where the concepts appeared to be accurately measured with a consistent measure, this indicates a high level of validity and reliability.

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Findings

The reader will notice a smaller sample indicated in this research versus what the power analysis deemed as sufficient. As previously mentioned in chapter three, a power analysis was completed to determine the sample size. This was done by using the survey system software. With a confidence level of 95%, a confidence interval of 10, which denotes a margin of error of +5 and -5. The margin of population is 30. Based on the calculation from this software, if this researcher receives at least 23-28 surveys back, this should be sufficient to proceed with and complete this research. However, due to several unsuccessful attempts to collect data from participants who met criteria, the researcher was only successful at collecting the following:

A. Eighteen surveys were collected for the Demographic Data Questionnaire (Plunkett, 2009, pp. 149-150).
B. Seventeen surveys were collected for the Mental Health Counseling Survey (MHCS), (Anthony et al., 2015, pp. 120-121; Wylie, 1984).
C. Fifteen surveys were collected for the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016).

The data collection process began on August 12th, 2019, approximately one month and ten days after the researcher received IRB committee approval. An initial email with the 'Letter of Invitation to participate in the Study' was sent to 25 pastors. Attached to the email were the surveys. Participants were asked to complete the surveys and they were issued a deadline to distribute the surveys back to the researcher. Two weeks later on August 26th, and August 27th, 2019, another 30-60 emails were distributed to participants with 30 sent on August 26th, 2019. Another 30 pastors and clergy were sent emails. The emails sent on August 27th were 30 different pastors and clergy asking for their participation. The researcher also met two consecutive Monday evenings at the pastor's/minister's fellowship. This time was used to explain the importance of participation in the research process as well as answer any questions that needed to be answered. At each meeting there were approximately 25-30 clergy present. Over the course of several months, the researcher also sent follow-up emails, made follow-up phone calls to participants, and asked to meet with participants. It is estimated by this researcher from the various attempts, that approximately 100-125 clergy were reached and encouraged to complete the three surveys. However, after several attempts to garner more participation, the researcher was not successful in meeting the proposed sample size. The following is a breakdown of survey responses:

- Eighteen Demographic Data Questionnaire (Plunkett, 2009, p. 149-150).
- Seventeen Mental Health Counseling Survey (MHCS), (Anthony et al., 2015, pp. 120-121; Wylie, 1984).
- Fifteen Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016)

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A consultation was held with the dissertation committee, and it was agreed that the researcher should proceed with analyzing the data using the surveys that were collected.

Demographic Profile

The demographic profile of the participants is indicated as follows in the following pie graphs:

Figure 1

Race

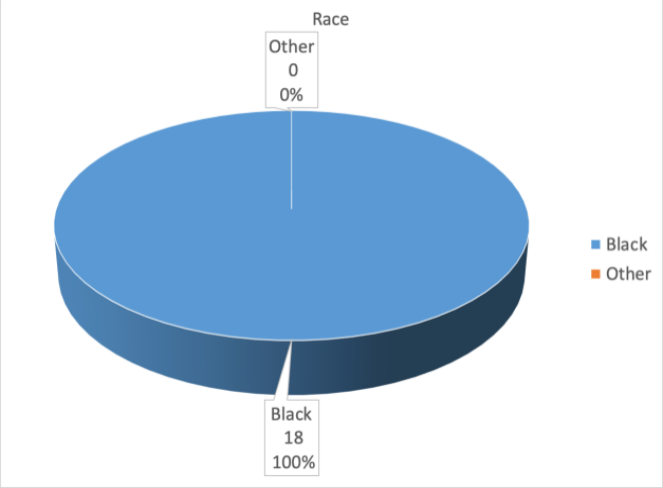

Figure 2

Marital Status

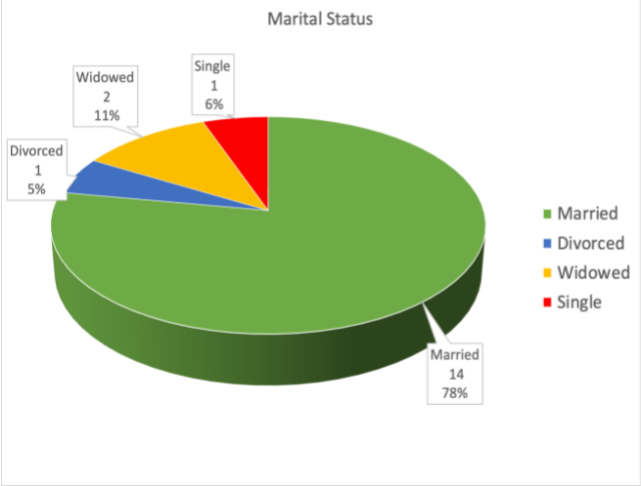

Figure 3

Gender

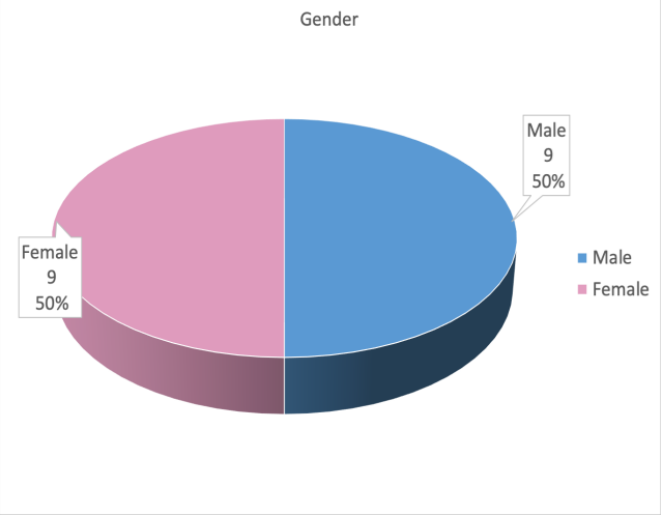

Figure 4

Annual Income

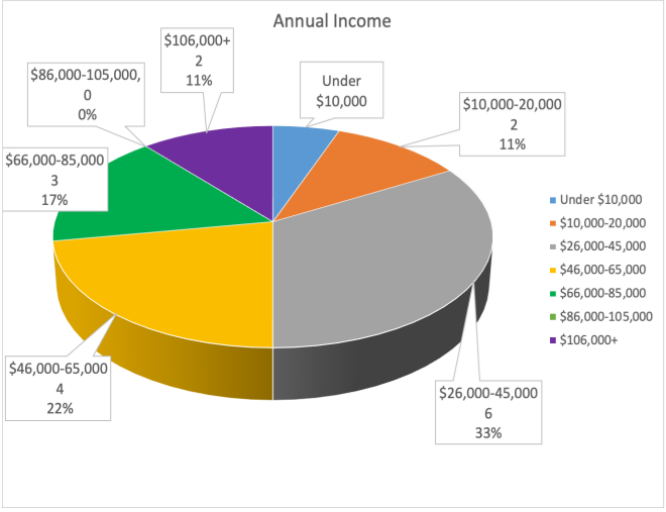

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Figure 5

Denomination

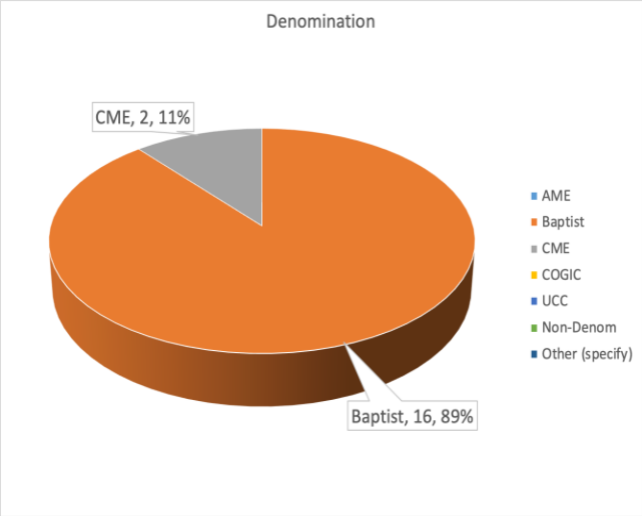


Figure 6

Engagement in Professional Relationship w/ Counselor

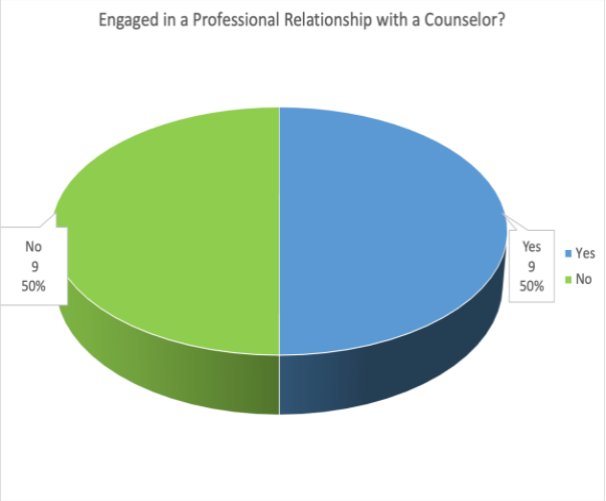


Figure 7

Received Counseling from a Pastor

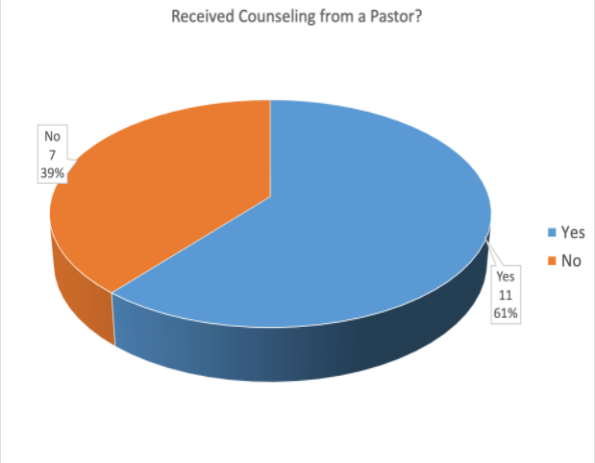
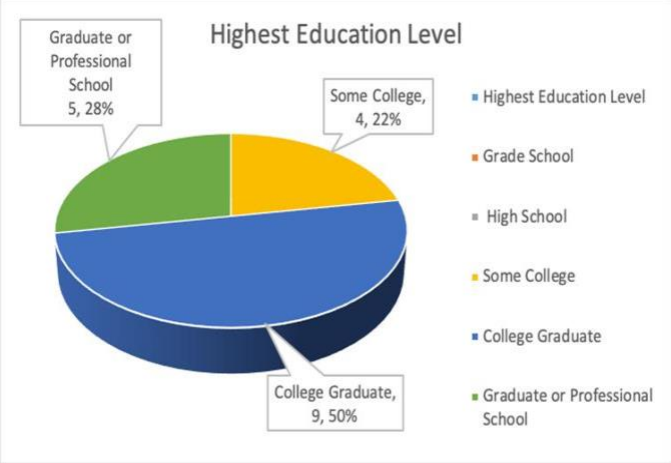


Figure 8

Highest Education Level



Therefore, the demographics noted from the Demographic Data Questionnaire (Plunkett, 2009, pp. 149-150) indicates:

Race: Of the 18 participants that completed the survey, 100 % or all 18 participants identified their race as being Black (see Figure 1).

Marital Status: Of the 18 participants that completed the survey,

- 78% or 14 participants indicated they were Married.

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- 5% or 1 participant indicated they were Divorced.
- 11% or 2 participants indicated they were Widowed.
- 6% or 1 participant indicated they were Single (see Figure 2).

Gender: Of the eighteen participants that completed the survey, 9 identified as male and 9 identified as female (see Figure 3).

Annual Income: Of the 18 participants that completed the survey,

- 5.6% or 1 participant indicated having an income less than $10,000.
- 11% or 2 participants indicated having an income between $10,000-$20,000.
- 33% or 6 participants indicated having an income between $26,000-$45,000.
- 22% or 4 participants indicated having an income between $46,000-$65,000.
- 17% or 3 participants indicated having an income between $66,000-$85,000.
- There were 0% participants who had an income between $ 86,000-$105,000
- 11% or 2 participants indicated having an income of $106,000 or more (see Figure 4).

Denomination: Of the 18 participants that completed the survey, 11% or 2 participants identified as Christian Methodist Episcopal (CME), while 89% or 16 identified as Baptist (see Figure 5).

For the following question: Have you ever been involved in a professional relationship with a licensed counselor/psychologist/psychiatrist/social worker for a personal problem?

- 50% or 9 participants indicated Yes- they have been involved in a professional relationship.
- 50% or 9 participants indicated No- they have not been involved in a professional relationship (see Figure 6).

For the following question: Have you ever received counseling from a pastor or other clergy person for personal a problem?

- 61% or 11 participants indicated Yes- they received counseling from a pastor or other clergy person.
- 39% or 7 participants indicated No- they have not received counseling from a pastor or other clergy person (see Figure 7).

Education: Of the 18 participants that completed the survey:

- 22 % or 4 participants identified as having some college
- 50% or 9 participants identified as being college graduates

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- 28 % or 5 participants identified as having graduate or professional degrees (see Figure 8).

In summary, the figures noted from the Demographic Data Questionnaire (Plunkett, 2009, pp. 149-150) shows overall for the surveys collected that all participants were African American with half of the population being male and half females. The majority, about 78% indicated they were college graduates. Most were of the Baptist denomination and most earned an annual salary between $26,000 and $45,000 dollars. About half of this population indicated they engaged in a professional relationship with a counselor, while the other half indicated they did not engage in a professional relationship with a counselor. Finally, most participants indicated they received counseling services from a pastor.

For the Mental Health Counseling Survey (MHCS), (Anthony, et al., 2015, pp. 120-121; Wylie, 1984) and the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS), (Fisher & Turner, 1970; Gaffney, 2016) the data was computed by the researcher using both “R” and “R-Studio” Software.

Further Analysis of Data/Results

Mental Health Counseling Survey

Seventeen participants completed the Mental Health Survey. The questions on the survey generally are only analyzable qualitatively or by using frequencies (i.e., counts of how many people responded a particular way). Questions for which responses allowed for numerical/statistical analyses were analyzed in that way (e.g., Question 3).

Describe the characteristics of congregants who seek counseling from you.

Thirteen out of 17 participants indicated that congregants who sought counseling were adults (i.e., 18 years of older). Four participants indicated that they had been approached by younger individuals for counseling (one participant indicated 8 years and older, one participant indicated 12 years and older, and two participants indicated 16 years and older). Three participants indicated that they had been approached by males; 11 participants indicated that they had been approached by females. Eleven participants counseled individuals, 8 counseled couples, 5 counseled families, 6 counseled parents/children (3 participants counseled all groups)

Do any of your congregants seek your help when dealing with the following issues?

Congregants sought help about: grief, depression, anxiety, suicidal ideation, and other miscellaneous concerns. Four participants said that congregants had sought help for all four of the issues (i.e., grief, depression, anxiety, and suicidal ideation). One participant was approached by congregants by the first 3 issues on the list (i.e., not on dealing with suicidal ideation).

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In the past 4 weeks, estimate the number of people whom you have counseled for any reason:

Participants counseled an average of 2.85 congregants, with the number of counseled congregants ranging between 0 and 8. The standard deviation was 2.29; skewness was .631, indicating the values were moderately positively skewed. That is, most participants counseled 0-4 congregants, fewer participants counseled more than that (2 participants said that they had counseled 5 congregants, and one participant each said they had counseled 6 and 8 congregants, respectively). This suggests that a few participants (those with 5 or more congregants seeking counseling) seemed to have a somewhat more counseling oriented practice, whereas other participants saw fewer congregants or did not engage in frequent counseling practices.

In the past 4 weeks estimate the number of people whom you have counseled for each of the following mental health problems:

Depression. Six participants said that they had counseled one person for depression in the past 4 weeks; two participants both said that they had counseled two individuals for depression, and one participant said that they had counseled four individuals for depression.

Anxiety. Six participants said that they had counseled one person for anxiety in the past 4 weeks; two participants both said that they had counseled four individuals for anxiety.

Suicidal ideation. Three participants said that they had counseled one person for suicidal ideation in the past 4 weeks; one participant had counseled three individuals for suicidal ideation.

Why do you think most people come to you instead of going to mental health professionals for help with depression? Rank in order of importance below (1= lowest, 4 = highest).

Participants indicated that individuals came to them instead of MHPs for depression because:

- Clergy integrate their spiritual values and beliefs into the counseling (*M*=2.6).
- Their spiritual values and beliefs may not be respected by health care professionals (*M*=1.75).
- Health insurance does not cover visits to a mental health professional (*M*=1.44).
- Other reasons such as: trust and family members.

What cues make you suspect that a congregant might be depressed?

- Crying a lot, talking in despair, saying "They Quit"
- Separation, behavior change and sudden withdrawal from others

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- Their body language and extreme interpersonal behavior change
- Distance/Self-Esteem
- Trauma/Withdrawn
- In their spirit, it is noticeable, also their behavior/conduct
- Especially on my worksite when I see an engineer looking and longing for a compass to get along or the individuals seem to start looking about before getting to their physical destination or most will stop by my desk in the interim afterwards
- Isolation. Not Eating
- Sitting alone, wanting to be seen in public because of shame
- Guilt

How does your depression counseling compare to your spiritual counseling experiences? (Check all the answers below that are true for you)

When the question was posed-how does your depression counseling compare to your spiritual counseling experiences? (Check all the answers below that are true for you)

Most individuals checked 1 or 2 items, two participants checked 3 items, and one participant checked 4 items. Two participants did not check any items at all.

Therefore, most of the checks were listed where the clergy indicated 7 checks. This deemed as an indication that their methods used in depression counseling was distinctly different from those the clergy used in spiritual counseling. 5 checks were also noted showing the clergy as using depression counseling that they state is somewhat similar to spiritual counseling. (See Table 3)

Table 3

Differentiating Counseling Experiences

Potential Responses	**Frequency (in # of Checks)**
The methods I use in depression counseling are **distinctly different** from those I use in spiritual counseling.	7
Depression counseling is **somewhat similar** to spiritual counseling.	5
Depression counseling is **somewhat different** from spiritual counseling.	4
Depression counseling is **very similar** to spiritual counseling.	3
Issues brought up in depression counseling **almost never overlap** with those addressed in spiritual counseling.	2

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Depression counseling is **very dissimilar** to spiritual counseling.	2
Issues brought up in depression counseling **are identical** to those addressed in spiritual Counseling.	2
The methods I use in depression counseling **are not different** from those I use in spiritual counseling.	2

Do you refer depressed congregants to any of the following? Check all those that you refer to):

When the question was asked- do you refer depressed congregants to any of the following? Check all those that you refer to:

As indicated prior, the questions on the MHCS survey generally are only analyzable qualitatively or by using frequencies (i.e., counts of how many people responded a particular way). Most or 13 stated they would refer to a Mental health specialist. While 7 would refer to the individual's primary care provider, and 3 would refer the individual to the hospital emergency room. (See Table 4)

Table 4

Referral Frequencies

Referred to:	**Frequency**
Mental health specialist	13
Primary care provider	7
Hospital emergency room	3
Psychiatric hospital	1
Other referrals	Their pastor

What factors influence your decision to make a referral?

- When you know the problem is beyond what I can offer.
- If I feel I am not qualified to deal with the situation we contract a (sic) Counseling Service.
- When congregant refuses spiritual counseling that leads to depression counseling. Or choosing not to accept their faith connection.
- Understanding the actual root cause of the individuals and/or couple's issue.

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- Knowledge.
- If the person shows known signs of harming themselves or others.
- Beyond my reach.
- When I have assessed what issues that I may be able to help with, but I can see the need for other format or beyond my area on counseling, my goal is to get the congregant to their next best suited area.
- When there has not been a breakthrough within a few times of counsel.
- Some people need physical help beyond the church.
- Their Ways

As you think about your experiences in counseling individuals suffering with depression, is there anything that would help you do a better job?

- Educating what cues to refer for further counseling.
- List of counselors in the area and senior population.
- More knowledge on mental health awareness and prevention.
- A professional counselor that is available on call.
- Yes.
- Professional to Assist Clergy.
- Much more training.
- Resources.
- Be able to connect with the congregant before the situation get into full depression, for example, if family members or acquaintances observe better, and recognize there is a problem, sometimes the heavier circumstances can be avoided.
- Becoming involved within a network that provides Updates in methods to bring about change for the better in the congregant.
- Yes.
- Be real and be honest in my life experience.
- Yes, need to get my master's degree

In your opinion, is formal training in depression counseling skills appropriate for clergy?

- Of the 17 participants, 15 said that, yes, formal training in depression skills is appropriate for clergy. No participants disagreed, and two participants did not answer the question.
- Very Appropriate, Very Important. This would help with making the proper assessment
- Yes, we all need to be the (sic) knowing the signs can help us all. I'll feel more comfortable with having more training
- I am not a counselor

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(ATSPPHS)/Orientations to Seeking Professional Help Scale

Fifteen participants completed the Orientations to Seeking Professional Help scale (hereafter OSPH scale). The OSPH scale (Fischer & Turner, 1970) consists of 29 Likert style questions, where responses for each item were agreement (coded as a 3), probable agreement (coded as a 2), probable disagreement (coded as a 1), or disagreement (coded as a 0). Higher scores indicate more favorable attitudes toward seeking professional mental health help.

This inventory contains four sub-scales: Recognition of need for psychotherapeutic help (hereafter, Recognition of Need), Stigma tolerance, Interpersonal openness, Confidence in mental health practitioner (hereafter Confidence in MHP). Subscale scores were calculated by summing the appropriate inventory items for each subscale, according to Fischer and Turner (1970). Item scores were reversed for items with negative factor loadings (i.e., see Table 4, Fischer & Turner, 1970). The Total inventory score was calculated by summing the individual sub-scale scores.

Table 5

Summary of sub-scale and Total scale descriptive statistics

Sub-scale	Recognition of Stigma tolerance need		Interpersonal openness	Confidence in MHP	Total
Mean	**18.9**	**10.8**	**14.3**	**21.3**	**65.3**
SD	2.8	2.4	1.7	2.5	6.0
Highest possible	24	15	21	27	87
Lowest possible	0	0	0	0	0
Max	22.0	13.0	17.0	25.0	70.0
3rd Quartile	20.5	12.0	15.0	23.0	70.0
Median	20.0	12.0	15.0	22.0	67.0
1st Quartile	18.0	10.5	13.5	19.5	63.0
Min	12.0	5.0	11.0	16.0	48.0

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Table 5 contains the descriptive statistics for subscales and total scale of the OSPH scale. The mean (average) and standard deviation (a measure of how consistent scores were – lower SDs equal more consistency) are given as the top two rows. The lowest and highest possible scores are given in the next two rows. These indicate the minimum and maximum scores that a respondent might have obtained. As example, for the first column, Recognition of Need for psychotherapeutic help contained 8 questions. The lowest possible score for this scale is 0 (8 items with a minimum score of 0: 8 * 0 = 0). The highest possible score for this scale is 24 (8 items with a maximum score of 3: 8 * 3 = 24). A box plot of the subscale and Total scale scores is given in Figure 1A. This box plot contains the same information as the last 5 rows of Table 3.

One male, number 5, accounts for most outliers (all low values). Aside from this, for the Confidence in MHP and Recognition of Need (for psychotherapeutic help) subscales, respondents scored in the upper half of each scale, suggesting that respondents had relatively high levels of confidence in mental health practitioners and did recognize the need/necessity for psychotherapeutic help. In terms of personal openness, the group scored in the center of the scale. In terms of stigma tolerance, the group mostly scored in the mid-high range of the scale, indicating general tolerance for stigma associated with mental illness.

Figure 9

Subscale and Total scale scores for OSPH scale.

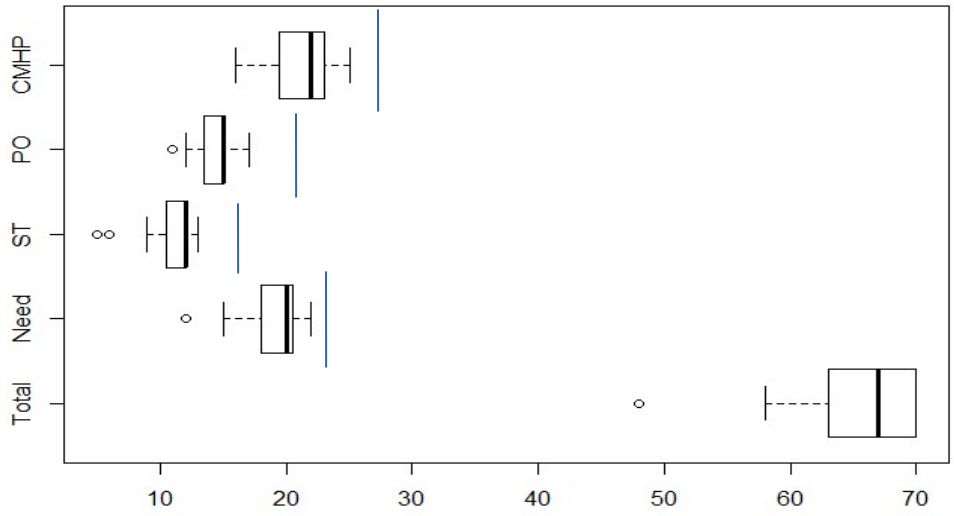

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Table 6

Correlation matrix for sub-scales and Total scores for OSPH scale.

	Recognition of Need	Stigma Tolerance	Interpersonal Openness	Confidence in MHP
Total	**r = .64** p = .01	**r = .88** p = .001	**r = .26** p = .36	**r = .69** p = .004
Recognition of Need		**.31** p = .26	**.14** p = .62	**.04** p = .88
Stigma Tolerance			**.01** p = .96	**.81** p = .002
Interpersonal Openness				**.-24** p = .40

Table 6 contains a correlation matrix for the sub-scale and Total scale scores for the OSPH scale. With the exception of the Interpersonal Openness sub-scale, the subscales all showed statistically significant correlations with the Total score. This is not surprising as the Total score is constructed from the sub-scale scores. Individuals who score high in one sub-scale are likelier to score high in the other sub-scale and Total scale scores.

Aside from the correlation of the Total scale score with sub-scale scores, there were no other significant correlations between sub-scale scores except for one. There was a strong positive correlation ($p = .81$, $p < .05$) of Stigma Tolerance with Confidence in MHPs. Individuals who showed higher stigma tolerance also showed higher confidence in MHPs.

In conclusion, the data analysis found the following:

- For the Mental Health Counseling Survey, as mentioned earlier, the questions on the survey generally were analyzable qualitatively or by using frequencies- thus allowing the reader to determine how the participants answered each question.

This survey however may be assessed more closely in chapter 5 when summarized.

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- For the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS)/Orientations to Seeking Professional Help Scale, due to the quantitative nature of the scale, more conclusions can be evaluated. From the Figure 1. Subscale and Total scale scores for OSPH scale, the following conclusion can be determined from the four sub-scales: Recognition of need for psychotherapeutic help (hereafter, Recognition of Need), Stigma tolerance,

Interpersonal openness, Confidence in mental health practitioner (hereafter Confidence in MHP). As mentioned prior, the sub-scale scores were calculated by summing the appropriate inventory items for each sub-scale, according to Fischer and Turner (1970).

It is concluded from these subscales the following:

- Recognition of Need subscale found clergy scored the maximum score. Therefore, it can be concluded there is a strong recognition by the clergy that there is a need for individuals to receive help and counseling services.
- Stigma Tolerance subscale found clergy scored in the mid- range. So, although the stigma tolerance was positive, it can still be concluded there was an indication that clergy may have a stigma as it pertains to actually seeking mental health services.
- Interpersonal openness subscale found clergy scored in the mid- range. Which may be an indication that although the subscale is positive, there still may be resistance for personal openness.
- Confidence in MHP subscale found clergy scored the highest possible score on this subscale. This indicates clergy having confidence in the Mental Health Practitioner's ability and competence. Every participant scored at the top end of the scale, which again means the clergy is confident in the practitioner's ability to serve their congregants if needed.

Finally, although clergy recognize the need for counseling services and has confidence in the ability of a mental health practitioner, the subscales still conclude there is a stigma surrounding mental health counseling services, and the clergy does not score very high in having personal openness.

Recommendations for Further Research

The hope for this research is that it will contribute to the body of knowledge already in existence. Exploring how the black clergy and the black church address mental health issues, may become an ongoing process in ministry. According to Hayes (2015), it is estimated that over 85% of African Americans state they have a religious belief system where they practice that belief system to cope with stress and grief as well as other mental health issues. Therefore, rituals such as going to church, being active in bible study, prayer, meditation/devotion and talking to their pastor or spiritual leader are

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all vital components for congregants as they are going through their personal challenges.

Based on this, the researcher would propose the following recommendations for further research and development:

1. Expound on this research by examining this phenomenon with a different demographic such as with Caucasian pastors of a different denominations.
2. Expound on this research by examining the tools clergy may need to support them in the area of mental health.
3. Explore opportunities to educate and train clergy members in mental illness and mental wellness to help them better serve their congregants.
4. Identify ways for the clergy members to also assess their own mental health challenges and determine where they too can receive help if needed.
5. Review and describe information in the area of pastoral counseling, biblical counseling, and Christian counseling to clergy members. This can perhaps equip the clergy to better work with their congregants.
6. Develop faith-based conferences, workshops, seminars, webinars, and panel discussions. Or examine those that may already be in existence where both the clergy member and the mental health practitioner can explore healthy ways to collaborate.
7. Develop a resource for healthy communications and dialog for both clergy members and mental health practitioners.
8. Construct a resource manual that would consist of direct referral information for both the clergy members and mental health practitioners.

Further research and development of the resources mentioned may be vital to contributing to the current body of knowledge.

Conclusion

In conclusion, this research study aimed to determine there being a correlation between the clergy members educational level and their ability to understand mental health, make referrals, assess the clergy's mutual relationship with the mental health practitioner- thus encouraging the clergy to make referrals. Based on the results of this research, it appears to support the notion there may be a correlation between the clergy members educational level and their ability to understand mental health, make referrals and develop a collaboration with mental health practitioners- as evidenced by the results from the Demographic Data Questionnaire.

According to the Demographic Data Questionnaire (Plunkett, 2009) that was completed by the participants, 78% identified as being a college graduate or having a graduate or professional degree. It was also highly favored that most of the participants agreed there being a need for congregants to receive help. They also agreed that mental health practitioners had the ability and competence to serve congregants, yet

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most clergy still noted having a stigma as it pertains to mental illness. Most clergy also noted their perspective as it pertains to interpersonal openness being minimal.

Based on these findings, it can be inferred there is an overall agreement that there should be collaboration between clergy and mental health professionals and there is a need for congregants to receive help if needed. Although the original purposes of this study to prove direct correlations as indicated in the research questions was not met, this study did disclose a clearer awareness of mental health issues as it pertains to clergy stigma, and resistance on the part of the clergy displaying personal openness- thus these finding impacting the church and congregants.

It may also be important for both the clergy and the mental health practitioner to assess their personal competency as it pertains to servicing the congregant. In other words, the clergy address the spiritual needs of the congregants and know their limit and the mental health practitioner to address the mental health component of the congregant and know their limits, as well. Developing a bi-directional collaboration between the clergy and the mental health practitioner may be a vital service to make sure the congregant is receiving appropriate care (Avent & Cashwell, 2015 and Plunkett, 2014).

About the Author

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