IN THE PASTOR’S STUDY: A GROUNDED THEORY ANALYSIS OF AFRICAN AMERICAN BAPTIST MINISTERS’ COMMUNICATION ON MENTAL HEALTH AND ILLNESS

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ABSTRACT

Jeannette H. Porter: In the Pastor’s Study: A Grounded Theory Analysis of African American Baptist Ministers’ Communication on Mental Health and Illness
(Under the direction of Brian G. Southwell)

African Americans are much less likely than the general population to seek mental health services but are 20% more likely than Whites to report serious psychological distress. In the Black community, the Black church is extremely important in providing information as well as validation for the experiences and decisions of its members; what Black pastors say, matters.

Guided by the Reasoned Action model, a series (n=41) of in-depth interviews of Black Baptist pastors on their mental health communications yielded six broad findings:

1) The Black Baptist church operates in the Biblical, Institutional and Social/Cultural dimensions; it can be pastor-led, deacon-led or congregation-led.

2) Stigma in the congregation and community against mental illness constricts pastors’ willingness to recommend specialty health services. Sources of stigma include:
   a. A belief that “God will solve all the problems”;
   b. A belief that good Christians don’t have these problems, with the corollary that those who do are flawed Christians, violating the concomitant imperative to appear well; and or
   c. A belief that to be well is to be in control; the mind as a site of resistance.

3) The response to “troubles” and mental health issues is framed in terms of faith but frequently pastors recommend worldly action.
4) Pastors interviewed understood mental health issues as biomedical in their cause, with the possibility of associated trauma. Referral practices and terms varied.

5) Many pastors are aware of a gap in their knowledge of mental health and mental illness, which constrains their engagement with these issues.

6) “Sick pastors make sick people in the pews”: pastors stressed by the need to take on congregants’ troubles in addition to their own, are particularly hampered by the cultural imperative to appear flawless because of their leadership positions; hence they maintain a stigma-driven silence on their own mental health, contributing to the stigma-driven silence in the church.

Empowered pastors emphasized pastoral transparency with respect to mental health as theologically and managerially critical to the survival and growth of the African American Baptist church and the wellness of its congregants.
May suffering be lessened.
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CHAPTER I: Introduction

On February 7, 2017, Sybrina Fulton and Tracy Martin were featured on The 1A, a National Public Radio current events show. The occasion was the release of their book, five years after the murder of their son, Trayvon Martin. Host Joshua Johnson asked them how they were doing.

“I am doing fairly well,” Fulton [replied on air]. “I’m trying to keep myself busy and my mind occupied with positive thoughts and positive things.” (Fulton, 2017)

In their book, Fulton had written:

The day after the verdict was a Sunday. I got up and I went to my church, Antioch Missionary Baptist of Miami Gardens.
I just thought it was important, especially on this Sunday…. I knew God would give me unyielding spiritual strength….
I sat through the service praying, grieving, giving thanks to God and trusting that He would, as always, guide my path.
Then I went home, back to my purple bedroom. That numb feeling had returned. (pp. 323-4)

The “numb” feeling is a classic symptom of clinical depression, which is completely understandable. Sybrina Fulton had lost her 17-year-old son to a violent death that did not have to happen, had to fight to have the killer indicted and tried, and watched the legal system free her son’s killer. But Fulton did not consult a mental health professional—at least, she did not discuss doing so in her interview or in her book. Instead, like many, many black people before her, Sybrina Fulton went to church, she went home, and the next day she got up and endured: “…The next morning only brought more of the same….” (Fulton & Martin, 2017)

African Americans are one-third to one-half as likely to consult specialty mental health helpers as the population overall, even when disparities in insurance availability are accounted
for (Fiscella, Franks, Doescher & Saver, 2002). In 1985, Neighbors documented the propensity of African Americans in distress to seek help first from neighbors and then from faith leaders (“ministers”). In her distress, Sybrina Fulton did what the majority of churched African Americans (which is the majority of African Americans) do when presented with a personal hardship; she sought solace in her faith. Her book does not say whether or not she spoke to her minister about feeling “numb”. Thirteen days after the acquittal, she gave her “first major speech after the verdict” in front of 6,000 people at a National Urban League meeting in Philadelphia, saying: “…I was determined that the audience wouldn’t see the broken Sybrina. I was determined to show them the woman that had once been broken but who had somehow been able to get back up,” she wrote (p. 325). She began her remarks:

Let me start off—because I have to put God first. I need to tell you my favorite Bible verse is Proverbs three, verses five and six, and it says, “Trust in the Lord with all your heart and lean not unto your own understanding. In all your ways acknowledge Him, and He shall direct your path.”

…Let me just say that I stand here before you today, only through the grace of God, only because of the spirit that lives within me… Because, as a mother, Sybrina couldn’t do it. Sybrina could not lose her baby… (p. 325-6).

It is plain that Fulton frames her pain and her coping strategies through the lens of her faith.

Monica Coleman was actually a minister in training, a graduate student at Vanderbilt University in Nashville, when she sought help from a credentialed female pastor at a black church (Coleman, 2016). She had been in therapy on and off since her teens for major depression, of which her family had a history going back at least three generations. As a student at Vanderbilt, she was raped, and had (and understood that she was having) post-traumatic stress disorder as a result of the attack. Coleman describes her meeting with the black woman pastor:

I gave a short version of [my] story. “Earlier this year I was raped. I’m still post-traumatic.” …

[The pastor] began to share with me. She … said that she knew what I was going through. She was also a survivor. Of childhood sexual abuse.
I felt my muscles relax; my shoulders shifted down. My comfort became audible. “Yeah?”

“Yes. Now let me tell you,” she continued. “Depression is a tool of the enemy. Cast it out in the name of Jesus.”

My shoulders tensed up again…. I heard the sentences I wanted to say in my head: “Are… you… serious?! I’m not possessed by some demon. Casting out will not help. I… am… a… victim… of… rape. I’m not supposed to be okay!”

Is this what ministers tell people? Is this what they tell people like me who finally muster up the courage to share? That it’s our fault? That the devil is making us sad? That taking blame onto ourselves or doing some kind of exorcism will heal us?! Do they preach this to people?! (p. 180-181).

In this case, a black woman took her mental health concerns to the pastor of a black church. She framed her concerns in psychological language (“post-traumatic”) and received strictly faith-based advice.

The reason this is important is that the African American church occupies a central role in the norming processes of African American life (C. E. Lincoln & Mamiya, 1990; Taylor, Chatters, & Levin, 2004). People do not make decisions to seek health care—or any kind of decisions-- in a vacuum. One of the most established models of people’s decision-making processes is the Reasoned Action approach (Fishbein & Azjen, 2010). According to this theory, people base their decisions in part on the norms of their relevant communities. In the black community, the black church is extremely important in providing information as well as validation for the experiences and decisions of its members, and even for the communities in which those members live. Black pastors tend to be highly regarded, even revered (W. L. Collins, 2015). What they say, matters.

Mental illness is plainly a serious and under-addressed problem in the United States, and is still less addressed in many African American communities. African Americans with mental illnesses come to doctors’ offices later in the course of their illnesses and more disabled than European Americans (Bailey, n.d.; Riolo, Nguyen, Greden, & King, 2005; Robins & Regier,
1991; D. R. Williams & Earl, 2007). Alegria et al. (2008) found that in a national survey, blacks diagnosed with depression were almost 20 percentage points more likely than whites to have not accessed any mental health treatment in the past year. Fiscella, Franks, Doescher, and Saver (2002) found that even among the insured, African Americans have only one-third the use of mental health services of the overall population.

Related literature covers the models pastors use to understand mental illness (Leavey, Loewenthal, & King, 2016), Black pastors’ perspectives on pastoral care and counseling (Stansbury, Harley, King, Nelson, & Speight, 2012), licensed professional counselors’ perceptions of pastoral care in the Black community (Jackson, 2015), Black pastors’ perceptions of mental health services (Brown & McCreary, 2014), the culturally-specific (and universal) barriers to effective congregational counseling (Armstrong, 2016), reasons why pastors should learn about mental illness in seminary (Capps, 2014), the huge healthcare role that clergy play in responding to mental disorders in the U.S. (Wang, Berglund, & Kessler, 2003) and particularly among African Americans (Young, Griffith, & Williams, 2003), scope and efficacy of faith-based mental health interventions among African Americans (Hays & Aranda, 2016), and ministers’ perceptions of such programs for depression (Hankerson, Watson, Lukachko, Fullilove, & Weissman, 2013). Even with this abundance of literature, there is little discussion of what African American pastors say to their congregants on this topic. Pastors create and maintain norms in part through their communication. What are they communicating?

The purpose of this dissertation is to find out what black pastors tell their congregants when congregants come to them with mental health/illness concerns. Because it matters what Black pastors say, it matters whether or not pastors can and do recognize valid mental health/illness concerns when they are presented to them, and it matters what advice they give. In
short, when African Americans go to their ministers with possible mental health concerns, what happens in the pastor’s study?
CHAPTER 2: Literature Review

African Americans experiencing troubles seek help from their neighbors and families, and from their religious institutions (Lukachko, Myer, & Hankerson, 2015; Neighbors & Jackson, 1984). African Americans seek mental health help at a rate from one-third to one-half the rate of the population overall (González et al., 2010; Hankerson et al., 2011; Neighbors et al., 2007; Wang et al., 2005). The purpose of this study was to inquire as to the nature of the communication African Americans had with their pastors on mental health and mental illness. When African Americans go to their pastors for help, what do the pastors say?

To answer this question, we need to:

- examine the development of mental health care in the United States and the role that race played (and plays) in it;
- define Black and African American for the purposes of this study;
- review the development and incidence of the Black Church;
- review the model of behavior—the Theory of Reasoned Action—that helps explain why factors such as subjective norm perceptions and confidence in being able to act constrain communication behavior on this topic; and
- review the existing knowledge of the role of Black pastors in health care in general and mental health in particular.

Then we will be able to inquire about the nature of the communication Black pastors are having with their congregants about mental health.

The History of Psychology in America: Supporting the Racial Order

The mental health establishment in the United States has, historically, rarely been a therapeutic space for Blacks. Anti-Black ideology is woven into the very fabric of psychology history and practice (Byrd & Clayton, 2002; Guthrie, 2004; Smedley, Stith, & Nelson, 2003). The infamous Tuskegee experiments are a touchstone in the Black community for distrust of
medical authority (Bailey, n.d.). How then should African Americans approach an entire medical discipline that made its intellectual bones on “proving” the inferiority of African Americans?

**Care of the mad.**

Before there was psychology or psychiatry, there were insane or “mad” people. In the United States (the only nation with which this study is concerned), care of these people in colonial times was the responsibility of individual towns and cities. From 1825 to 1850, roughly, care of such persons became the responsibility of the various states in asylums built for the purpose and led by physicians who came to specialize in diseases of the mind (Grob, 1994). In 1844, 13 of these physicians came together in Philadelphia to found the Association of Medical Superintendents of American Institutions for the Insane, the forerunner of the modern powerful American Psychiatric Association (Grob, 1994).

When Blacks were admitted to such facilities, they were generally segregated. “The most significant differentials in care and treatment were clearly a function of race,” Grob says, but clarifies: “Such practices, however, were rarely justified by theories that purported to relate race and insanity” (Grob, 1994, p. 88). Rather, concerned for the credibility of their institutions, superintendents followed community norms. Prior to 1850, psychology and psychiatry were not yet well enough developed to contribute to the racism of the time; rather, they reflected it. Their contributions were coming, midwifed by the era of scientific racism.

The causes of insanity were held to be “physical”—as perhaps a lesion on the brain or a blow to the head—or “moral”. Moral causes “appeared to be amenable to human interventions and thus preventable” (Grob, 1994, p. 60).
Scientific racism and psychology.

Richards (2012) traces scientific racism’s roots to the 1770s, with the rise of Western fascination with the idea of characterological manifestations of physiognomic traits. Phrenology (the “science” of predicting character from the pattern of the skull) was perhaps the best-known example of this idea. The “rooting of culture in biology,” as Richards puts it (p. 9) was accelerated by the publication of Darwin’s Origin of Species (1859). As Europeans staked claims to more and more of the (previously inhabited) globe, the notion that they were superior to the people they were dispossessing and exploiting was a convenient rationalization for their actions.

Physical anthropologists were in the vanguard of “scientists” bringing to light various anatomical differences that could be measured and compared. The “races” of Europe—Celts, Nordics, Slavics, Mediterraneans, etc.—were compared and rated, but the real differences were among the ideal European type and “Negroes.” “A low brow, a protruding jaw, a flat nose and small skull possessed psychological meanings that were felt to be self-evident, almost matters of direct perception” (Richards, 2012, p. 18). It did not matter that these traits were not universal in people of African descent. They became part of the medical/psychological literature and were held to mean that

Negroes: (a) matured earlier than whites, (b) were less individually varied than whites, (c) were rigid and unadaptable in habit and lifestyle, (d) were, on average, smaller-brained, especially the frontal lobes, (e) were more impulsive and emotional than whites and (f) performed best on ‘lower’ level functions, such as sensory acuity and imitation… [A]ll this research was on something which was not there (Richards, 2012, p. 19).

Francis Galton (who believed a phrenologist who told him he was better suited to travel than to study) was a founder of American psychology, introducing the concepts of “nature versus nurture” and eugenics (Fancher, 2004; Richards, 2012). His attitudes towards race were what might be expected of a well-to-do White man of his time (1822-1911), and they hardened during
his youthful travels in Europe, the Middle East and Africa. Based on his experiences, he wrote an 1865 article, “Hereditary Talent and Character,” in which he wrote about the psychological differences among different ethnic and racial groups and his belief that they were transmitted by heredity (Fancher, 2004). Ruth Schwartz Cowan (1977) is quoted in Fancher (2004) on this paper: “Rarely in the history of science has such an important generalization been made on the basis of so little concrete evidence, so badly put, and so naively conceived” (p. 65).

Galton read Letters on Probabilities by the Belgian statistician L. A. Quetelet (1849) near the end of the 1860s; it introduced him to the concept of the normal distribution (Fancher, 2004). Reinforced by numbers, he turned his 1865 paper into the 1869 book, Hereditary Genius, in which he made “the first attempt at quantifying racial differences of a psychological kind” (Richards, 2012, p. 21). His chapter, “The comparative worth of different races,” became a central text of his movement to improve humanity through encouraging the increased breeding of “superior” races, which were infallibly European. (It is only fair to note that Galton promoted increased breeding on the part of “superior” races, or positive eugenics. The elimination of “inferior” races, or negative eugenics, was a logical consequence but not his contribution.) In 1888 Galton invented the basic techniques for calculating correlation coefficients as part of his work on quantifying the degree of resemblance between twins (Fancher, 2004). His disciple Karl Pearson refined and elaborated his techniques, many of which (e.g., Pearson product coefficient, chi-squared test, etc.) are still used today.

Herbert Spencer (1820-1903), the man who actually coined the phrase “survival of the fittest,” published The Principles of Psychology in 1855 and a second volume in 1870 (Richards, 2012). He believed the “primitive,” i.e., non-European, brain was not able to handle modern life. His writing codified all of the “observations” made earlier of non-European people and also
explained that “lower races” lived in “wretched” conditions because they made their conditions wretched. He also wrote that, in Richards’ words, “associative connections established in an individual’s lifetime bring about neurological changes, which are then transmitted to offspring” (p. 24). However, in the 19th century context, this was only an argument for the eventual extinction of the primitive races, not a reason to improve primitives’ living conditions. By the end of the 1880s, Spencerian reasoning underlay many anti-Negro publications (Richards, 2012).

G. Stanley Hall (1844-1924), co-founder of the American Psychological Association, believed in “lower races” and that they were lower because they were “the world’s children and adolescents” (quoted in Richards, p. 26). Such people might be the future, in Hall’s view, but the future was not then. “He felt the Reconstruction experiment to have been mistaken and… endorsed segregated education and limitation of the non-white franchise…. Hall… played a major role in determining psychologists’ orientations toward ‘Negro education,’ the context in which… empirical race differences research first flourished” (Richards, p. 28).

These three men worked in the post-Civil War United States, shaped it and were shaped by it. There had not been much work on the mental health of African Americans until this point; Grob (1994) states that outside the South the population of mentally ill Blacks was so small as not to excite much interest. Within the antebellum South there were such phenomena as Samuel Cartwright’s drapetomania (compulsive running away of slaves) and dysoesthesia oetiopoca (disregard of property rights, breaking of tools), which need no explanation with a 21st century understanding (Richards, p. 36). Yet, these “illnesses” are early foreshadowings of the way America’s medical establishment would deals with some of the human health manifestations of oppression; label it an illness and assign it a punitive “cure.” As an example, Jonathan Metzl (2009) detailed the explosion of schizophrenia diagnoses among African Americans at a
Richards explains that by 1910 the post-Civil War question of what to do with African Americans was urgent:

Psychology offered an ideologically ‘neutral,’ respectably scientific, route for readdressing the intractable difficulties [of the ‘Negro Question’] from a new angle—one that located the source of the problem safely at the individual psychological level, in the ‘Negro’ psyche itself (p. 77).

So from the beginning of the 20th century, much of psychology lent itself to an episodic framing of the whole race question in the United States, allowing itself to be used to blame the victim instead of to indict the institution.

In 1910, Howard Odum (1884-1954), a student of Hall, wrote the monograph, “Social and mental traits of the negro. Research into the conditions of the negro race in Southern towns. A study in race traits, tendencies and prospects.” Richards describes the 300-page opus as the “first US Race Psychology text…almost devoid of academic references, it seemingly consists of an unremitting, uninhibited, and relentless outpouring of racial bile” (p. 91 and 89). Mayo in 1913, Strong in 1913 and Ferguson in 1916 all purport to examine Black and White academic achievement on “scientific” tests and all reach essentially the same conclusion: “The negro has not shown the same capacity as the white when put to the test of psychological or educational experiment, and the racial differences revealed have been considerable” (Ferguson, 1916, p. 25, quoted in Richards, 2012, p.98).

Huge disparities in school furnishings, funding and teacher preparation, not to mention vastly inferior living conditions are not taken into account in these “scientific” studies. Many more such studies are performed along these lines in the decade 1910-1920. In some cases
performance is indexed to gradations of skin color, with the lighter-skinned students always more proficient. Such results are linked to the “negro’s lack of foresight, improvidence, emotional volatility and sexual immorality” (Richards, 2012, p. 98).

**World War I and testing.**

The 1917 American advent of World War I and the U.S. military’s need to rapidly assess and place 1.7 million recruits into ranks and tasks appropriate to their abilities accelerated the development of the testing industry (Byrd & Clayton, 2002). Richards states that historians of psychology call this moment the discipline’s “coming of age,” in which “U.S. psychologists established their professional credibility with fellow scientists, the military and politicians for the first time” (Richards, 2012, p. 100). The resulting *A Study of American Intelligence* by Carl C. Brigham (1923) was used to demonstrate the inferiority of southern European immigrants to northern European immigrants and the inferiority of African Americans to both, increasing (if that were possible) fears of race-mixing and strengthening support for Jim Crow policies. Brigham recanted the paper in 1930 but by then restrictive immigration policies had been enacted and Jim Crow was so strongly entrenched as to seem immovable.

During the 1920s psychology’s development as a discipline as well as post-Great War civil rights agitation and the flowering of the Harlem Renaissance led to more attention to environmental conditions. The Chicago school of sociology and Boasian anthropology were also furnishing data that tended to diminish the credibility of race psychology. “Internally it was the eventual admission (with varying degrees of reluctance) that the methodological and conceptual difficulties were insuperable that led to [race psychology]’s abandonment” (Richards, 2012, p. 141).
20th century progress.

Explaining the discrediting and fall of hereditarian race psychology, Guthrie (2004) places more agency in the hands of emerging 20th century Black colleges and the Black academics who staffed them. Contrary to the drumbeat of difference being emphasized in the German-influenced psychology departments of many White universities, Black schools taught their students about the similarities among different groups and emphasized the role played by the developmental barriers endemic to African Americans in America. Lack of resources at every level made it difficult for undergraduates interested in the field to become practitioners or teachers, but some few persevered. The American color line greatly inhibited Black practitioners from treating Whites, but World War II and Truman’s integration directive brought hundreds of thousands of African Americans into the military’s orbit, and the need to sort and direct them explains why Guthrie cites the military as “perhaps the first large recognized body to designate [Black] individuals as clinical psychologists” (p. 141), followed by the Federal civil service. Slowly African Americans in the human development fields of teaching and psychology developed and organized, culminating in the 1968 founding of the National Association of Black Psychologists by a group of about 200 African American members of the American Psychological Association.

Guthrie quotes a 1968 press release from the new group:

The Association [of Black Psychologists] charged that APA through inadequate positive measures condoned the white racist character of the American Society and failed to recognize the new Black movement as the most promising model for solving problems stemming from the oppressive effects of American racism. (p.148)

Since that seminal moment the Association of Black Psychologists has grown to more than 1400 members (Association of Black Psychologists, n.d.) but, perhaps more important for
the development of the discipline overall, the APA has slowly recognized a role in increasing ethnic and racial representation in the profession. The 1993 vision statement of the APA’s Committee on Ethnic and Minority Affairs reads in part, “that APA's membership and leadership will reflect the composition of society” (APA Committee on Ethnic Minority Affairs, 1993). That was a quarter-century ago, but it is at least a goal.

In the meantime, there has been a vigorous debate on how to achieve a multicultural psychology and serve a multicultural population (e.g., Sue (1998)). However, only 2% of psychiatrists identify as Black, while Blacks are 20% more likely than the general population to experience serious mental health problems (Bailey, n.d.) and are one-third to one-half as likely to actually seek specialty mental health help. This pattern leads to questions of how African Americans make decisions on their mental health care. This inquiry starts from a model known as the Reasoned Action Approach.

The Reasoned Action Approach

In 1967 Fishbein, drawing from Dulany’s theory of propositional control (1968) proposed that “intentions are the immediate antecedents of behavior and that intentions, in turn, are function of attitude toward the behavior [in question] and the sum of normative beliefs weighted by motivation to comply…” (Fishbein & Azjen, 2010, p. 13). This was the start of 45 years of work on the prediction and change of behavior. Together with his graduate student Ajzen, they later added the concept of a subjective norm to represent perceived social pressure, arguing that, this higher-order normative construct was determined by underlying beliefs. In their second joint book (1980) they began to refer to their theory as a theory of reasoned action, adding “background factors such as demographic, personality and other individual difference variables” (p. 14). and arguing that such factors could “influence behavior indirectly by influencing the
behavioral and normative beliefs that a person might hold” (p. 14). In 1985 and 1988, “Ajzen introduced the construct of perceived behavioral control as an additional predictor of both intention and behavior,” and called the resulting schema the Theory of Planned Behavior.

An NIMH conference in 1991 with Albert Bandura, Marshall Becker, Martin Fishbein, Frederick Kanfer and Harry Triandis resulted in agreement on eight “key variables that were assumed to underlie behavior” (Fishbein & Ajzen, 2010, p. 14). In 2001 Fishbein and Ajzen began to work together again, and published the latest iteration of their work in 2010 in the volume *Predicting and Changing Behavior: The Reasoned Action Approach*.

As shown in Figure 1, the model posits the actor’s attitude toward the behavior to be a function of *behavioral beliefs*; the actor’s subjective norms are now influenced by *normative beliefs*; and the actor’s perceived behavioral control is now influenced by *control beliefs* (Azjen, 2012).

“The starting point of our analysis is a particular behavior of interest to the investigator. It is therefore of utmost importance that the behavior under consideration be clearly identified and properly operationalized,” Fishbein and Ajzen (2010, p. 16) warn. The particular behavior of interest here is black Baptist pastors’ conversations with congregants on the subject of mental health and illness. I operationalize it not only by recall of conversations, which Southwell and Yzer (2007) warn can be problematic, but by posing hypothetical situations for pastors to respond to in an interview setting.
This theoretical approach emphasizes the importance of understanding what others think and do as an influence on one’s own decision-making. This model also suggests that without the skills to perform a behavior, a behavior is not likely to be performed.

In many African American communities, the church is a strong source of the behavioral, normative and control beliefs as identified in the Reasoned Action behavior model (Levin, Chatters, & Taylor, 2005; Rowland & Isaac-Savage, 2014). Neighbors’ and Jackson’s 1984 work states that 18.9% of African Americans in their sample who needed mental health help sought it from a minister, whereas just 4% went to a mental health center and 5% contacted a psychologist or psychiatrist. Pastors are simultaneously the source and recipient of these norming behaviors, making an investigation of their beliefs and behaviors a rich study. Southwell and Yzer (2007)
describe Yzer, Siero and Buunk’s 2001 work as “specifically highlight[ing] the conversational norms—or perceptions that important others value and condone talking about a particular topic—play in encouraging talk” (p. 436).

Is there One African American Community?

“Those who wish to draw precise racial boundaries around certain groups will not be able to use science as a legitimate justification,” said Collins and Mansura (2001, p. 221) of the Human Genome Project. This research does not attempt to do so. The “community” of interest for this research is those people who identify themselves as African American or Black, and who attend, belong to and pastor churches in the General Baptist State Convention of North Carolina. (This definition does not address the possibilities of such individuals as Nkechi Amare Diallo, née Rachel Dolezal, a woman who chooses to identify herself as Black although she is the biological child of parents who identify as White. Diallo chooses to align herself with the cultural constructs of American Blackness, and it is a conversation among those constructs that I am interested in examining.)

The African American Church: Backbone of a Community

In the history of African American chattel slavery, Christianity has played many roles. Indeed, the bringing of Christianity to the peoples of Africa was considered a justification for slavery at several times during the transatlantic slave trade (Raboteau, 2001). Another of Christianity’s prime functions in the antebellum United States was social control; slaves were encouraged to identify with the Old Testament’s long-suffering Hebrews and serve loyally in this life to earn a place in a perfect Heaven (Erskine, 2014; Raboteau, 2001).

Erskine (2014) detailed the interrelationship of African traditions with European and American economics and politics that led to the syncretic nature of the black church. Despite the
animistic, polytheist traditions Africans brought with them to the Western Hemisphere, Christianity was well established among the American slave population by the revival movement known as The Great Awakening of 1740 (Moore, 1991). Frazier’s landmark 1964 book, *The Negro Church in America*, locates the first black church in America in Savannah, Georgia, the “First Colored Baptist Church” in 1779. Moore (1991) states that by 1793 Africans (free and enslaved) made up an estimated one-quarter of the Baptists in the United States. The first independent black church, the African Methodist Episcopal Church denomination, was established in 1794.

Wingfield (1988) states, “because blacks were denied the opportunity, during and after slavery, to participate fully in the social affairs of the country, the black church came to represent the only vestige of the so-called freedoms guaranteed other Americans by the Constitution” (p. 128). Moore (1991) concludes: “The independent church led the way for Africans to exercise control over one aspect of their lives. Structures were developed, property purchased, community behavioral standards established, social and religious agendas were set, and leaders emerged” (p. 156). Rowland and Isaac-Savage (2014), Erskine (2014), Raboteau (2001), C. E. Lincoln and Mamiya (1990), Frazier (1974), Cade (1934), Pius (1911) and Whitted (1908) are clear that, as the black church has evolved and grown, its influence over the African American community has remained. Moreover, they make it clear that the black church has a unique relationship to its community; it is a backbone, a touchstone of cultural identity.

In North Carolina, black Baptists came together to form their first association in 1867, the General Association of the Colored Baptists of North Carolina, after the 1865 conclusion of the Civil War (General Baptist State Convention of North Carolina Inc., n.d.). According to the North Carolina Department of Natural and Cultural Resources, the withdrawal of black Baptists
from the greater denomination “stemmed from strong white opposition to social equality and the desire by both races for separate churches” (North Carolina Department of Natural and Cultural Resources, 2014). J.A. Whitted’s 1908 *A History of the Negro Baptists of North Carolina* describes the 30 years after 1867 as “a period of construction” (p. 37). However, by 1882 the group represented 800 churches which comprised more than 95,000 members (DNCR, 2014). The organization went through several name changes, settling in 1929 on the General Baptist State Convention of North Carolina, the name used today (GBSCNC, n.d.). The group has supported Shaw University, the oldest historically black university in the South, since its inception (Pius, 1911; Whitted, 1908). Today the GBSC’s member churches have more than 500,000 congregants (GBSCNC, n.d.).

In 2014 the Pew Research Center polled 35,071 Americans, including 1,916 who identified as members of historically Black Protestant denominations-- 1,180 of whom were Baptists-- on the role of religion in their lives (Pew, 2015b, p. 122, 144). The greatest single black denomination was Baptist (Pew, 2015a). Three-quarters of all African Americans polled said that religion was “very important” to them; that number was only 49% for whites and 59% for Hispanics (Pew, 2015b, p. 46). Eighty-five percent of members of historically Black Protestant churches said that religion was “very important” to them, a higher percentage than any other denomination except Jehovah’s Witnesses (Pew, 2015b, p. 46, 11). Also, that number had not dropped from the last such poll in 2007; it stayed steady. Among the members of historically Black Protestant churches:

- 80% said they prayed daily (p. 13).
- 58% said they participated in prayer or scripture study groups monthly or more often (p. 75).
- 89% said that religious institutions bring people together and strengthen community bonds (p. 30).
- 53% said they attend services at least once a week (p. 38).
• 47% said they rely on religious teachings for moral guidance, while 41% relied on practical experience (p. 64), bearing out the 1984 findings of Neighbors and Jackson. Just 4% of those in historically black churches relied on science for guidance in questions of right and wrong. (Pew, 2015b, p. 65).
• 72% said they belong to a local house of worship (p. 73).

In short, African Americans are more involved with religion than whites or Hispanics and they are extremely attached to and influenced by their religion communities. Rowland and Isaac-Savage (2014) describe the Black church as “a major agent of cultural transmission and a powerful agent of healing” (p. 1093-4). Collins, in an article entitled “The Role of African American Churches in Promoting Health,” (2015) called the African American church a “trusted organization” within the African American community and observed:

Pastors can serve as catalysts for behavioral and social change due to their influence and position as key leaders within religious institutions…. In his or her trusted roles…[both] congregational members and those in the community may seek the pastor’s advice and wisdom on issues ranging from personal angst to holy concerns. (p. 194, 195)

The preeminence of Baptists within the Black Protestant community and of the denomination within the state of North Carolina, means that a study of North Carolina Black Baptists’ conversations about mental health and illness means that this study examines a strong source of normative behaviors for half a million people. Furthermore, the results may well hold for much of the Bible Belt and for populations elsewhere in the United States, due to North Carolina’s contribution to the first and second Great Migrations.

The Black Church and Black Mental Health: What We Know

Taylor, Ellison, Chatters, Levin and Lincoln (2000) summarize four reasons for the centrality of pastors to African American mental health care:

1. The pastor is “a pivotal figure in the church.”
2. Ministers have many roles, “particularly as agents of health-related behavioral change.”

3. Ministers “often function as gatekeepers to formal mental health services”

4. Ministers are “sometimes the first and only professional that individuals encounter” (p. 74).

Neighbors, Musick and Williams (1998) described black clergy as “the best hope for bridging the gap between the black community and specialty mental health” (p. 774). Generally speaking, Southwell and Yzer (2007) stated, “We can expect information to spread most quickly when established social connections exist among members of a population” (p. 430).

Related literature covers the models pastors use to understand mental illness (Leavey et al., 2016), Black pastors’ perspectives on pastoral care and counseling (Stansbury et al., 2012), licensed professional counselors’ perceptions of pastoral care in the Black community (Jackson, 2015), Black pastors’ perceptions of mental health services (Brown & McCreary, 2014), the culturally-specific (and universal) barriers to effective congregational counseling (Armstrong, 2016), reasons why pastors should learn about mental illness in seminary (Capps, 2014), the huge healthcare role that clergy play in responding to mental disorders in the U.S. (Wang et al., 2003) and particularly among African Americans (Young et al., 2003), scope and efficacy of faith-based mental health interventions among African Americans (Hays & Aranda, 2016), and ministers’ perceptions of such programs for depression (Hankerson et al., 2013).

A 2010-2013 content analysis of 21 South Carolina African American churches’ health messaging found that mental health messages were the second most frequent type of message, behind cancer and ahead of heart disease (Harmon, Chock, Brantley, Wirth, & Hébert, 2016). These authors said, “These findings point to the need for more work in this area, which is of
apparent interest to churches but is not well understood by practitioners and researchers” (p. 1422). Hankerson and Weissman (2012) found only eight studies of church-based health programs for mental disorders among African Americans in a review of literature from 1980 through 2009, and concluded that more intensive research in this area is needed.

Payne (2009) reported the results of a 2006-7 survey of Protestant pastors’ perceptions of the causes of depression, tabulated by race and religious affiliation. “Little, if any, research has been done to determine what clergy views are about handling specific issues such as depression” (p. 356); her research aimed to fill that gap. She found that African American pastors more readily agreed that depression was “hopelessness that happens when one does not trust God,” as opposed to a “biological mood disorder.” The reverse was true for white pastors. Socioeconomic status did not explain the variance; nor did gender, age or pastoral counseling training. While these findings are interesting, and may well dovetail with the results of the study proposed by this document, these findings do not obviate the need for the research being proposed herein. For one thing, more than half (56%) of those who did not respond to Payne’s survey were pastors of churches in predominantly African American areas. For another, it was a closed-ended survey, not allowing pastors to speak to the nuances and subtleties of their beliefs and their practices. Payne herself did not think her survey was the last word on the topic: “It is extremely important that researchers continue to engage in empirical studies on the important topic of how clergy define and treat depression” (p. 364). The study being proposed by this document does just that. Furthermore, it tests clergy knowledge about mental health by describing two hypothetical congregant situations (depression and schizophrenia) without identifying them by diagnosis. It accounts for the socioeconomic status of a church’s actual membership, not just its location.
(worshippers may travel to a family church even after they have moved to a different area), and locates the church in a rural, suburban or urban area.

The question of what Black ministers know about mental health (their mental health literacy, after Jorm et al. [1997]) was raised in a 2008 paper reporting on a qualitative study of nine ministers with congregants 60 and older by Stansbury and Schumacher. Respondents had some ability to recognize specific disorders or types of distress, had some knowledge of how to seek mental health information, some positive beliefs about professional assistance, and some knowledge and beliefs about risk factors and causes. Interestingly, “educational levels did not differentiate mental health literacy” (p. 136).

The question of what Black ministers are telling congregants about mental health was raised in a 2015 paper that reported on consensual qualitative research with eight pastors in North Carolina. Avent, Cashwell, and Brown-Jeffy (2015) used purposive and snowball sampling to reach their sample through personal emails. They asked many of the same questions this study is concerned with, such as: how often do congregants disclose mental health issues? How do you respond to those disclosures? What factors influence pastors’ decision to refer members to mental health services outside of the church? Seven of the eight pastors said they dealt with mental health issues “every day”; some used clinical language such as “paranoid schizophrenia, autism” and some used the congregation’s language: “going through” (p. 38). Five participants attributed anxiety and depression to “spiritual causes,” such as “lack of faith, spiritual warfare, neglecting the spiritual, unanswered prayers, and demonic possession” (p. 43). “Only two of the eight participants noted psychological approaches as an independent coping method” (p. 39). Participants advocated for Christian counselors when speaking about referrals outside the church. Half spoke about the stigma within the community attached to seeking
mental health help, and three spoke of African American culture and coping strategies being different from those of other groups.

None of these printed papers included the interview guides or instruments, making it difficult to evaluate the studies more fully. The Stansbury and Schumacher study concerned clergy knowledge, while the Avent, Cashwell and Brown-Jeffy study concerned clergy practice. This study concerns both clergy knowledge and practice, using intensive interviews to provide data to answer the question: How do African American Baptist pastors communicate with their congregants about mental health and illness? The next chapter discusses the methods this study used.
CHAPTER 3: Methods

The research question here—How and what do Black Baptist pastors communicate with their congregants when those congregants consult their pastors with a possible mental health or illness concern?—in the context of Blackness, faith and the concept of mental health, was always a qualitative question to me (Denzin & Lincoln, 2011; G. Williams & Elliott, 2010). From the beginning I conceived that eventually a large-scale quantitative survey might be designed based on the issues raised in the present study, but the present study was always intrinsically qualitative.

The highly private nature of the communication in question meant that observation was vanishingly unlikely. Instead, I opted for interviews with the pastor half of the conversational dyad. In an effort to elicit the strongest data possible, I based the questions both on recalled (anonymized) conversations and on hypothetical situations based on the pastor’s experience. The interview instrument is attached as Appendix 2.

I began the study referring to “ministers” and learned in the course of it that a “pastor” is a very different thing. Pastors are the caretakers of their congregations. Ministry is what an ordained individual can do anywhere. Pastoring is a relationship. As Dr. Dickerson of Orange Grove Missionary Baptist put it in our interview:

See, my idea of pastoring is more than just the title. It's more just than standing up preaching, it's more than leading a church. A pastor has to understand his people. And if we don't understand our people, I don't think you're pastoring. …I think you just a preacher. …And I think it's a tremendous difference. Between me preaching to you and being a pastor to you. And a pastor to me is that, when you finish your Ph.D. you walk across at UNC, I'm sitting there cheering you on [claps hands]. That's a pastor, to me. …As a pastor I'm involved with your joy. My idea [of a pastor]. I'm involved with your hurts. Involved with your pains.
With your celebrations. … Involved with you as a person. And just that to me it's a total involvement with a person. …Pastors build a relationship with people. ... You're accessible to me.

All of the personnel I spoke to were the pastors of their congregations except for three: one was a deacon, one was the head of a congregational care ministry within a church, and one was a medical service provider. Deacon Jenkins was referred to me by the pastor of his church, and Dr. Smith was referred to me by a pastor who thought that a medical service provider’s perspective would be valuable. Those two interviews were not coded for this study.

The African American Protestant church is still a highly sectioned enterprise. Wishing to conduct a study with the highest degree of explanatory power possible, I chose to look at the denomination representing the biggest single chunk—a plurality—of African American church members: Baptists. Constrained to the state of North Carolina by resources, I chose to look at the membership of the General Baptist State Convention of North Carolina, an organization whose website states that it represents more than half a million worshippers. Furthermore, under previous leadership, the GBSC had chosen to partake in health-related research (Holmes, 2004).

(This decision turned out to be practical in one other regard: I observed that members of the GBSC train ministers who become pastors to congregations all across the country. The organization’s motto is “Christian Education, Missions, Benevolence.” Two of those three result in replication of the organization’s practices, so what GBSC pastors do in North Carolina can influence what happens elsewhere.)

Armed with University of North Carolina at Chapel Hill Institutional Review Board study approval, I emailed the GBSC staff requesting use of a statewide mailing list. Executive Secretary-Treasurer Dr. Haywood T. Gray informed me that the use of the list for non-GBSC business was prohibited. However, he explained, the membership of the convention is divided
into regional associations, and several of these associations posted their membership lists online. Three of these associations were within driving distance for me: the East Cedar Grove, New Hope and Wake Associations. A small amount of typing resulted in a pool of 125 addresses. I postal-mailed the recruitment letters (text in Appendix 1) on a Friday and Saturday in May 2017 and began receiving calls to set up appointments for interviews on the following Tuesday. Ultimately, I had 41 interviews, an excellent response rate of 33.6%. These interviews were centered on the North Carolina Triangle—Raleigh, Durham and Chapel Hill, but ultimately I interviewed pastors as far northwest as Roxboro and as far southeast as Zebulon.

Generally, I responded to responses to me, but there were two categories of pastor for which I attempted further recruitment: those whose websites indicated an entrepreneurial or prosperity gospel approach, and women. I made several phone calls and sent several emails to a church whose website seemed to me to promote a prosperity gospel approach, because this approach was in the popular press (e.g., Glaude, 2014) as being an increasingly attractive approach for Protestants, though not so much with African American Baptists (Walton, 2014). I also made several phone calls and sent several emails to the five women pastors on my list because I wanted to be sure I secured at least one woman’s input, as women have always been the lay backbone of the African American church and are now joining its clergy. I was unsuccessful at securing a pastor explicitly positioned in the prosperity gospel perspective, but I did interview one female pastor and one female minister; their interviews were coded and are included in this text.

I arranged interviews via phone (voice, voicemail and text) and email. I requested to meet with pastors at their churches, in order to get a sense of the size and feel of the organizations they led. In two cases I met pastors at their homes, at their request. Due to time constraints I quickly
abandoned any attempt to attend worship services at each church and instead asked pastors about the characteristics of their congregations. Just being in the church buildings proved informative: were they older or younger buildings? Large or small? Technologically challenged or fully equipped? Built for the congregation or inherited? Light and airy or walnut-paneled with stained glass? On large rural or suburban plots, or snuggled into urban spaces? Or dominating urban spaces? Temporary new quarters or old family churches? Depending on the time I visited, was the building busy or quiet? Some of these answers say more about the wealth of the church than anything else, but I did not encounter any glaring disconnects between the feel of the spaces and the pastors’ descriptions of their institutions.

I began each interview by expressing a request to audio-record the interview, so that I could concentrate on the exchanges rather than taking notes. All participants but one agreed to be recorded; for that one interview, I took voluminous notes. In each case I then went over the IRB-mandated consent form, which I presented on carbonless duplicate; I emphasized that participants could refuse to answer any question for any reason, and that they could request the recorder be turned off at any time. Participants signed the consent form, I counter-signed, and gave them the original copy. Once the recording started, my first question was always an offer to use a pseudonym for the participant. I offered a list of possible pseudonyms to jump-start their thinking, but emphasized that the choice was theirs. Participants who chose pseudonyms are indicated in this text with an asterisk in the listing of participants, and their churches are not identified except by description as relevant.

While I started each interview with the intention of closely following the interview instrument, I was flexible when pastors introduced new aspects and considerations (Weiss, 1994). If pastors answered a question before I asked it, I did not re-ask it. Interviews ranged from
35 minutes to more than two hours, with a mean recording length of 1 hour 7 minutes. This mean underestimates the amount of time spent in interviews because in several cases pastors disclosed information after I turned the recorder off. In at least two cases, this information was significant, and I captured it via written notes.

In one case I was directly asked, as a precondition for the interview, whether I was a Christian. In several other exchanges the topic came up. In each case I was truthful, and disclosed or volunteered that while I was raised culturally as a Protestant, and I do believe that a historical figure named Jesus was crucified and died for the sins of many, I am unchurched. However, because of my membership in the African American community (I am and appear as a Black woman) and previous work experience in a faith-influenced non-profit and as a newspaper reporter, I have some familiarity with the ways and behaviors of the Black church. Therefore, in this study I had an outside-insider status (Cowling & Lawson, 2016; Pelias, 2011). Interestingly, no-one asked me about any experience I might have with mental illness. While I do have family experience with mental illness, I was not asked.

It was not possible to observe an actual interaction between a pastor and congregant on the topic of mental illness; recollection was the closest I could approximate while observing the conventions of the privacy of clerical communication. However, people forget, and change things in the process of recollecting them. The hypothetical portion of the interview was designed to address this weakness in the research design. By giving pastors the opportunity to respond to a scenario that could quite conceivably point to mental illness without actually mentioning such diagnoses as “depression,” “mental illness,” or “schizophrenia,” I hoped to find out both what pastors thought and how they would act on what they thought.
The interview instrument’s flow was influenced by my background as a newspaper reporter. By beginning with a question that could not have a wrong answer (“What is the big idea of your ministry?”) and progressing to fact-based and familiar topics (“How many members on a typical Sunday? Do your members walk or drive to church? How far? What is the gender and age spread of your congregation?” etc.) I developed rapport. My early question presentation and body language was meant to call for approximations, rough numbers, not census figures.

I then asked the pastors to tell me about their preparation for ministry, without implying that there was a “right” answer, and asked them to describe their role in their church. Then and only then did I approach the topic of mental health, first using the term “troubles” found in the literature [e.g. Neighbors et al. (1998)] and in the culture. The three hypothetical scenarios were symptom-based, as a congregant might present to the pastor. (The symptoms came from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition.) Finally I used the actual term “mental illness” in the last few questions. Although my recruitment letter mentioned “mental health,” my goal with this flow was to ease over the hackles that might have been raised by diving into a stigma-laden topic at the top of the interview.

I did my best to ask questions and quickly stop talking, the better to capture pastors’ responses. However, particularly in the interviews coded for this study, the responses tended to call forth answering responses and questions from me, turning a one-way information stream into a two-way conversation. In effect, I memoed and coded during the interviews themselves, which in some cases is captured in the quotations I have chosen to include. I did my best to squelch this tendency as soon as I became aware of it in the moment, but in some cases it resulted in exchanges so rich that I cannot regret it. As the literature review section in the last chapter showed, there is not a lot of published work about the texture of pastor-congregant exchanges on
mental health, and in the case of the African American community, this question turns out to have theological implications I did not expect. The pastors were kind enough to lead me to what I believe is a new vein of inquiry, and I followed.

At the close of every interview, I offered each participant a $25 Amazon gift card, explaining that while I could not possibly pay pastors what their time meant to me, I could indicate my gratitude with such a token. If they demurred, I said that pastors probably knew someone who could use the card if they could not. Of the 41 interviews I did, 8 refused the gift card, saying generally that they understood that graduate students were on a tight budget and telling me to use it where it might do me good.

Once interviews were recorded, I uploaded the recordings to the online automated transcription service Trint. Trint provided a time-coded but rough transcription of each interview. Listening to these recordings and re-reading these transcripts several times (as in what Kreiss calls “living with my data” [2016, p. 233]), I performed a constant comparative analysis of those interviews (Glaser & Strauss, 1967). That is, I examined and re-examined what the pastors had told me, analyzing inductively and deductively, tracing emerging themes and their links (Reed, 2004). This analysis and my field notes highlighted 10 interviews that represented the points made in all 41 interviews (Emerson, Fretz, & Shaw, 2011). I could not have been said to reach saturation after any one of the 10, but by the 41st interview I had a range of points that those 10 represented well. As expected, those 10 taken together provided significant conceptual data (Small, 2009). I listened to those 10 interviews several more times, correcting transcripts (which included removing non-meaningful vocalizations), taking notes and initial or open coding of this sample according to the following prompts:

- What process(es) is at issue here? How can I define it?
- How does this process develop?
• How does the research participant(s) act while involved in this process?
• What does the research participant(s) profess to think and feel while involved in this process? What might his or her observed behavior indicate?
• When, why, and how does the process change?
• What are the consequences of the process? (Charmaz, 2014)

During this process in particular I memoed, and selected quotations that illustrated the points made. I then aggregated those codes into focused codes in accordance with the precepts of grounded theory (Charmaz, 2011, 2014; Holton, 2010; Thornberg & Charmaz, 2013). I continued to pull significant quotations from the transcripts to illustrate theoretical codes. Throughout, I kept returning to the research question: How and what do Black Baptist pastors communicate with their congregants when those congregants consult their pastors with a possible mental health or illness concern? I then folded notes, memos and codes into this text. I did this by hand; I did not use coding software. Figure 2 is a summary of the process. The next chapter details my findings.
Figure 2. A diagram of the study's workflow.
CHAPTER 4: Findings

My major findings from the 10 coded interviews (and the 31 more that I executed and analyzed) fell into 6 themes, which are summarized here and discussed in more detail below.

1) The Black Baptist church is not a monolithic body. Two pastors each gave it a triune nature on different axes—origins and leadership. These distinctions matter greatly to the consideration of the findings that follow.

2) Stigma in the congregation against mental illness, actual and perceived, constricts pastors’ willingness to recommend specialty health services, no matter who is leading the church. Three possible explanations for this stigma are presented.

3) The response to “troubles” and mental health issues was always framed in terms of faith (e.g., “I will pray with her”) but frequently the pastors’ responses contained recommendations for worldly action, sometimes a good deal of it.

4) Notwithstanding the faith framing of the response, pastors interviewed had a definite understanding of mental health issues as biomedical in their cause, with the possibility of associated trauma. Referral practices and terms varied.

5) Many pastors are aware of a gap in their knowledge of mental health and mental illness, which constrains their engagement with these issues.

6) “Sick pastors make sick people in the pews.”

In every case, it should be noted, I asked pastors to speak on behalf of themselves. The statements here should not be taken to express the views of whole congregations or the
Missionary Baptist tradition except where that is explicitly stated. (The Salvation Statement, Articles of Faith and Covenant of the Missionary Baptists are included in Appendix 3.)

**Coded Interview Participants**

Asterisks indicate pseudonyms, used at the request of the participants.

- Rev. Dr. Tonya Armstrong is the head of the Ministry of Congregational Care and Counseling (MC3, as it is known) at Union Baptist Church, one of Durham’s leading churches with an average Sunday attendance of about 6,000 people over several services. She is “Reverend” in this context (master’s degree in theological studies from Duke University) and has also earned a doctorate in clinical psychology from the University of North Carolina at Chapel Hill, so in the text is referred to as Dr. Armstrong.

- Dr. Herbert Dickerson is the Senior Pastor of Orange Grove Missionary Baptist Church in Durham, which has an average attendance between 900 and 1200 between two Sunday services. He holds a master’s degree in religious arts and a doctorate in theology, both from Jacksonville Theological Seminary in Florida.

- Rev. Mark Gibson is bi-vocational, serving as the Senior Pastor of Redeeming Love Missionary Baptist Church, located on the developing edge of Raleigh, with an average Sunday attendance of 350 to 400 people. He is also the Dean of Student Development at Wake Technical Community College. In addition to his master’s in student personnel services, he has earned a master’s degree in divinity from Shaw University and is now working on a doctorate.
• Pastor H* leads a small urban congregation with approximately 60 to 70 individuals in the pews on any given Sunday. He is bi-vocational, with a bachelor’s degree.

• Dr. Kenneth Hammond is now Pastor Emeritus of Durham’s Union Baptist Church, though he was Senior Pastor at the time of his interview. He was for many years bi-vocational, including his time as the first African American Director of Student Affairs at East Carolina University. Union’s Ministry of Congregational Care and Counseling was established on his watch. He has a master’s degree in education from East Carolina University, a master’s of divinity from Shaw University and a doctor of divinity from Apex School of Theology.

• Dr. Dumas Harshaw is the Senior Pastor of First Baptist Church, one of Raleigh’s leading African American churches. With nearly 50 years in ministry (36 as a full-time pastor), he holds many degrees, including a doctorate in ministry from Claremont Seminary and a Ph.D. from Claremont Graduate University.

• Rev. Louisa Peters* is the pastor of a historic family church in a Triangle-area bedroom community. The church averages about 175 people in attendance on Sundays. She has a master of divinity degree from Duke and is working on a doctorate at seminary.

• Dr. Andrew Reed* is the pastor of a historically important and activist church with an average Sunday attendance of approximately 250 in a university area in the Triangle. He holds a doctorate in ministry.

• Dr. Joe Stevenson is the pastor of Macedonia New Life Church, on the developing edge of Raleigh. The church has an average Sunday attendance of
850. Dr. Stevenson holds two master’s degrees, one of which is in pastoral counseling and care, and a doctorate in ministry, all from Ashland University in Ohio.

- Rev. Norman York* is the pastor of a historic rural church on the edge of a growing town, with an average Sunday attendance of 200. He is bi-vocational, self-employed in the financial industry.

**The Church is More than One Entity**

Before discussing the conversation as described by these representatives of the Black Baptist church, two essential observations must be made about the Black Baptist church, directly from the observations of participants.

Dumas Harshaw, who pastors one of the leading Black churches in Raleigh, First Baptist, is an informal student of the North Carolina pastorate, because he is not from North Carolina. He had almost a quarter-century of ministry in California and then international mission experience before arriving in Raleigh in 1996, when he realized he had to learn how things are done in Raleigh. I realized during data analysis that I identified with his outside-insider status (Cowling & Lawson, 2016). This may have been one reason that his interview was outstandingly rich for me, conceptually.

Dr. Harshaw said he conceives of the church as a triune entity: the Biblical church, the institutional church and the cultural church:

The Biblical church is the foundation that's the authentic church. With all of its problems, it wasn't perfect but then eventually it's institutionalized, it becomes married to government or it becomes separated from other aspects of the church through doctrines like whether to baptize a child as an infant … or whether to sprinkle them or whether to, you know, immerse them as Baptists-- all of that nonsense that separates us. And so you have all these institutions that exist, and still the symbols are powerful and they still relate to the source, but they've gotten so far away from the source, that's one thing. And then when I look at the black
church …. [it] has a culture of how we function and rules and codes and those kinds of things and still it's all in the name of God and it's in the name of Christianity. But sometimes a cultural church is more related to culture than it is to Christian or to the Bible.

I interviewed Dr. Harshaw a third of the way through my 41 interviews and mentioned his observation to many of the pastors I interviewed subsequently. All agreed with his observation. The influence of pastors in the Black church partakes of this triune nature, just as does the outsize influence of the Black church on the African American population as a whole. It is outside the scope of this study to determine which portion of this influence is the greatest; at this juncture it is important to note that the forces here, while discussed in the context of a faith organization, are more than only spiritual.

The second essential observation of the Black Baptist church came from Rev. Norman York, pastor of an aging, historic rural-suburban church. In his 20 years in ministry, he said, he had observed that churches were driven either by their pastors, their deacons or their pews, meaning their congregations. This means (among other things) that the Black church cannot be dropped as a black box into a health messaging campaign. Research is always important in strategic communication, but to maximize the effectiveness of such a campaign the designers need to know whence the authority flows in the particular church(es) with which they wish to work. That is, if a health message is to be transmitted using the borrowed validity and authenticity of “the church,” whose validity is being borrowed: the pastor’s, the deacons’ or the congregation’s? If the last, whom in the congregation? Does this mean that tailoring is more important than targeting in this space (Hawkins, Kreuter, Resnicow, Fishbein, & Dijkstra, 2008)?

This study was conceived and executed in the belief that the Black Baptist church is a top-down, pastor-led institution. Chapters 5 (Discussion and Policy Implications) and 6 (Limitations and
Suggestions for Future Research) revisit the implications of deacon- and congregation-led churches.

**We Don’t Talk About This**

Stigma contributes to silence on many health care topics (Boudewyns, Himelboim, Hansen, & Southwell, 2015). Every pastor interviewed agreed that African Americans in general and African American Baptists in particular tend to silence on the topic of mental health and mental illness, heavily influenced by that stigma. During our interview I told Dr. Harshaw that I had heard from 30 of the 125 pastors to whom I’d written requesting interviews, and asked if it was fair to assume that the 90 or so who had not responded (as of that date—the number of interviews was eventually 41) were of the mind that “we don’t talk about this”; that is, that African Americans do not discuss mental health and mental illness openly. Dr. Harshaw responded, “Without a doubt.”

Three aspects of the institution and culture of the Black Baptist church emerged as drivers of that silence.

**First: “God will solve all the problems.”**

Dr. Harshaw observed:

You know I would say from my limited experience and getting to know so many of the pastors across the decades and some of the leading pastors, you know, fortunately, Christian ministers in the 20th century and again in the 21st-- … some of them or of that group the fundamentalists believe that God will solve all the problems you know and then with some of that, you know, you don't talk about the issues. Now some of the kind of holiness Pentecostal groups they'll talk about in sermons and deal with it. But, but in terms-- and some of them truly believe that the Holy Spirit or just the blood of the Lamb are just what the Bible says handles all of that. Let's take a pedophile, or let's just take a chronic alcoholic, and they believe that they just get the word of the Lord, the Holy Spirit. That that's all they need. So, you know, people in [the mental health] profession are useless to them. I mean they don't even you know they don't condemn them but they don't acknowledge them at all because they feel like, you know, the Word handles everything.
At least one pastor of the 41 I interviewed, when asked about his approach to the issue of mental health and illness among his congregation, gave it as his opinion that what his congregation wanted from him was exegesis of the Word. If he spent his time in prayer and study, he said, his interpretations and explanations of the Word would satisfy his congregation’s needs. It should be added that his was a large church with an active diaconate, who were more active in handling congregants’ daily needs.

**Second: Good Christians don’t have these problems.**

Louisa Peters, pastor of an old family church (“family church” meaning a church populated by successive generations of relatively few families) on the suburban-rural interface of the Raleigh area, amplified the reasons for silence on mental health and illness among believers:

…we have so spiritualized our emotional and mental health that people think that there's a huge stigma. That there is a shame attached to a mental or emotional struggle. And so because of that they will not come forward because it means either you don't trust God enough. It means maybe you're not really saved…. It means that there's something wrong with us spiritually…. It's so loaded with shame and weakness. And for people whose faith sustained them in the belly of slavery and through Jim Crow-- If my faith can get me out of the chains of slavery then surely my faith can unshackle me from depression. Surely if it can't then the problem has to be me, because pastors are never depressed. Look at them…. I am bad. I’m preventing God from healing me.

In a community that believes that defines itself through the seeking of salvation, which believes that “nothing prevents the salvation of the greatest sinner on earth, but his own determined depravity and voluntary rejection of the Gospel; which rejection involves him in an aggravated condemnation” (National Baptist Convention, n.d.), the failure of a believer to heal could be seen as a critical, a mortal personal flaw.
This interpretation—which is more institutional and cultural than Biblical, to use Dr. Harshaw’s analysis—means that the appearance of wellness is critical to congregants’ social standing. Rev. Gibson stated:

We have a lot of folks who are silently dying in our pews, because of just the thoughts that are running rampant in their minds because of what they dealt with, whether it's at home, whether it's a war, whether it's in the community, whether it’s even here in church. And so I think that the misunderstanding or miseducation that a lot of pastors have when it comes to this-- not just pastors but church officials in general-- is that what doesn't appear to be wrong isn’t wrong. And what I've said this morning is, on Sunday we become masters of Maybelline, and we know how to make our faces up so we look blessed all while inside we're crying. It's a torturous storm that's brewing on the inside of us all.

Subsequent interviews agreed with the importance of appearance.

**Third: The mind as a site of resistance.**

An alternate but related explanation was presented by Andrew Reed, the pastor of a historical church in a university area. He delves into another reason, a little more secular, which partially explain the unwillingness of many Blacks to even entertain the “psych” prefix:

…due to our journey everything has been a mental attack on us so we guard our minds and we don't want to let people in because of our historical journey, even, you know, beyond us hundreds of years ago, so anything psychological-- We feel like the thing that's kept us strongest… is our ability to control our minds. Even if we were in slavery we had control of our minds. And you know so we feel like the whole giving people access to what's buried deeply within our psyche is like-- that's giving up our control.

As discussed in the literature review and detailed in Wingfield (1988) and Moore (1991), the Black church has been a fortress of self-control on a battlefield strewn with painful examples of colonized domination; to be a member of the Black church was to assert control over self and life. So for all these reasons—the primacy of the Word, the importance of demonstrating salvation, and the drive for self-control—the first thing to know about mental health and mental illness in the Black Baptist church is that “we don’t talk about it.”
Several of the 41 pastors I spoke to had intimate personal examples of this silence, including one longstanding pastor of a church in a leadership role in his area. His wife was diagnosed with schizophrenia and bipolar disorder and refused to let that be known, despite being active in the congregation. When she was ill, she did not even wish to appear on the church’s prayer list. Not even in death did the family disclose her condition. Another pastor with whom I spoke said he had been “in therapy for anger issues,” yet when I asked if he had any experience with mental health issues, he said, “No.”

Granted, some pastors had personal experience of mental health issues—most often complications of depression and/or addiction—with which they struggled, for which they sought biomedical treatment, and which they disclosed to their congregations. Some even preached and ministered out of their own personal experience, treating it as a teaching opportunity. These ministers, however, were the exception.

**Faith Framing, Worldly Action**

Without exception, every pastor said he’d pray with congregants who came to him with “troubles.” Indeed, Dr. Stevenson referenced Matthew 9:35 when asked to summarize the big idea of his pastorate: “Jesus went through all the towns and villages, teaching in their synagogues, preaching the good news of the kingdom and healing every disease and sickness.” (New International Version)

But several pastors cited James 2:17, “Faith without works is dead.” (New International Version) In response to the interview questionnaire’s first scenario (based on DSM-5 criteria for depression) Dr. Reed explicitly stated,

[Mary]’s got to unpack. And she's got to come up with a plan. And you know me praying with her, that ain't gonna cut it. I'm sorry…. Yeah, I'm going to pray with her and I'm going to pray fervently with her. But you know even in the book of James, you know, my Bible tells me that I'm just not going to quickly pray on
somebody just to send them away and make them feel like they've had a interaction with, with me and everything is going to be all right. Now you need prayer and you need a plan of action because if you don't have that plan of action you're going to be right back here next week and it’s probably going to be worse.

Rev. Peters agreed:

I'll just go to my Creator and, you know, I am a believer. Yes, God does heal, sometimes miraculously. That's true whether it's a mental health issue or a physical health issue. Sometimes God heals miraculously and we just can't explain it. But usually he does keep putting instruments in your path.

Dr. Dickerson took it a step further: “I believe prayer change things, I believe prayer is good. But I also believe that if you are supposed to be on your medicine and you ain't taking your medicine, we need to get you some help to get you on your medicine. We need to get you to a doctor.”

In some cases, seminary training was to be used to provide modern context for the literal interpretation of the Bible. As Dr. Reed explained,

You know, the Bible addresses a lot of mental illnesses and a lot of social ills that that would make people classify you as having mental issues. And then you have to unpack it in a way that is not offensive, because the church went on this rampage of calling everything a demonic spirit and spirit. And we take it out of context because what was labeled as a spirit then might not be the same interpretation in 21st century terms, so you know you unpack it in a way and that's what school did prepare me for, how to deal with a biblical text.... They called it a spirit because that was their context in which they dealt with. And you kind of break that taboo.

Also, the helping professions were seen as gifts of God, to be used as other gifts are meant to be used. “Nobody can call [the power of prayer] into question,” Dr. Harshaw said, “but part of the answer for that prayer is God will put you in the place of people who can help you because that’s how they’ve been trained.”
Biomedical Understanding, Careful Referrals

All the pastors cited in this study had at least a partially biomedical understanding of mental illness. In some cases they thought there were conflating issues, such as trauma or inheritance. In response to scenario two, which was based on the DSM-5 evaluating criteria for schizophrenia, Dr. Reed said:

My notion would be some form of schizophrenia in a sense. Again that's just a very novice attempt. Just because of who I've worked with in the past… But I also know that there that something traumatic has happened in every one of those persons’ lives that I've worked with to get them to that point and there's something that's thrown them off.

Many referred to the need for medicine or medication and suggested that it was appropriate to see a doctor. Many of the more rural pastors responded to the hypothetical scenarios by saying they’d recommend the congregant contact their general practitioner or primary care doctor or practitioner. One pastor explained that specialists of any kind in rural areas were hard to access both geographically and financially, so congregants were more likely to actually follow up on referrals to more easily-accessed GPs and PCPs. Another common referral term was professional. When pressed, several pastors said they would recommend a counselor. However, words starting with the psych prefix were assiduously avoided. Rev. Gibson explained the aversion in terms similar to the aversion to the whole mental health conversation:

The connotation that [psych] has, particularly in the African American community, is ‘You must be out of your mind. You must be crazy.’ And so for me to seek any psychiatric help, I’ve lost who I am, I’ve lost my identity. Historically we’ve lost all we had anyway—the one thing I want to be able to keep is my self-dignity. I don’t want to be viewed as though I can’t even control that. And so the [prefix] psych has a connotation within the community that, ‘I lost it all.’

Of all the pastoral interviews coded from churches that did not have an explicit mental health ministry in place, only Dr. Reed’s—who had an earlier career as a case manager in the
mental health system—Rev. Peters’ and Dr. Harshaw’s, showed any comfort with the actual concept of a psychologist or psychiatrist. Even then, Dr. Reed had a careful approach for introducing the psych words to congregants:

… I never say you gon’ go crazy, I say you will feel like you're about to lose your mind, you know, you just gon' lose it all, and I say you got to get yourself back on kilter. And I tell them and I give them my limits at that point. ‘You know as a pastor I don't have the credentials to go but so far, I can give you all the spiritual support. But, you know, would you consider exploring some other options as it relates to just really unpacking what were your thoughts?’…Then I just lay out the whole scope of psychologists without even using that word… talking with someone who can just kind of again, and not judge you. ‘You want to be-- you ever talked to somebody who never judged you?’ ‘Yeah!’ ‘How'd that make you feel? Free?’ ‘Yeah!’ ‘Why? Why'd you feel like that?’ ‘Because I mean I just felt like I could talk and flow and just-- really just tell it all in one sitting.’ ‘Yeah, that's it.’ And then you know once I asked those leading questions you know I usher them, well, this is what you're telling me you need. You tell them you need to talk with a life coach or, you know, we may call them a counselor you can call it anything you want to. But, you know, this is what they do and this is why they're good at it. And this is the way their ears are trained to listen…. So that's how I lead into this, and it's a long road to get there. But … I think it's worth the journey because if I go all the way right here and I get you to see my point, and it took me 20 minutes to get here … as opposed to 15, I'll take the 20-minute route and make you feel comfortable with it.

*Freedom* is an important component in the process above; freedom from being labeled, freedom from being judged. Once freedom is assured, the process of seeking help can start. This is an interesting analogue to the relationship of African Americans to the historical development of psychology in the United States.

It is also interesting to note that the Dr. Reed has here described the task of “educator” in the most ancient and literal sense: *ex-*, the Latin prefix meaning *out of*, and *ducare*, meaning *to lead*. In the conversation above, Dr. Reed is literally leading his congregant out of ignorance or ambivalence to knowledge. Once that congregant knows what a psychologist really does, he or she can freely decide whether or not he or she wants one.

A little later in that conversation, Dr. Reed referred to “vetting” helping professionals
before referring congregants to them. “They’re almost looking for me to cosign them, because I’m really what hope looks like to them. So they’re depending on me to say, ‘Yeah, I think this is a good move for you.’ So they need that validation from me.” This is an important function of the pastoral counseling or educative process; letting congregants know not only what such professionals do, but that they are okay to associate with. Okay in the eyes of the pastor; okay in the eyes of the church; okay, period.

The importance of this is proven in the inverse by another pastor from one of Raleigh’s large churches who observed to me: You know, if I think something should not be happening in the congregation or the church, I don’t have to preach against it. All I have to do is not mention it. If I just don’t talk about it, it will eventually fade away. (This obviously doesn’t work on everything; sin persists. But the point remains.)

Dr. Dickerson, while not detailing his successes in getting members to access mental health services on their own, emphasized strongly that no such work was possible outside of a trusted relationship. Within the bounds of the pastoral relationship, which he described as one of caring and involvement (see p. 25), established trust could be leveraged to convince a congregant to approach his or her doctor or even a mental health services provider.

On the other hand, Pastor H, leading a small and relatively impecunious congregation, actively disavowed the referral role, saying that his members would have to decide for themselves if they wanted to pursue mental health services. “We try to defuse the situation as much as we possibly can,” he said, “so that way keeps it from having it come to us…. We try to make sure that the information needed is already there.” Scarcity of resources was a frontline issue for him; he was one of the few pastors to question why mental health issues should be
addressed in the church at all, when its focus was designed to be theological: “We are tired…. Let everybody do what they do well.”

Other, more resourced pastors described strategies in between, such as: giving a congregant a phone number to call, alerting the service provider to expect the call, then following up a day or two later to find out if the call had been made. Several pastors expressed a wish or intention to establish relationships with community care providers, either to provide trusted access or even financial support for congregants who might not be able to afford the care (or who perceived that they couldn’t afford it).

**Not Enough Knowledge**

Just about every pastor expressed the need for more training about mental health. Those who didn’t either had degrees in counseling, or were fairly explicit about feeling that their congregations didn’t want that type of care from them at all.

Universally, pastors expressed that seminary did not prepare them for the human needs of their congregations. Dr. Dickerson even suggested, half-joking, that he needed to invent some kind of school that pastors would attend after Bible school and before seminary to “learn about people.” Dr. Harshaw, on the other hand, was not amused:

I would say that those ministers, some of them don't know. They honestly just don't know. And then you've got so many people now going into ministry who have had no mentors. You know the old wisdom is not anywhere around them and if they used the Internet for that they're getting just a bunch-- some of it's good and some is just a bunch of crap.

When to attempt to handle congregants’ issues internally and when to refer out to helping professionals was also a fraught issue. Dr. Gibson emphasized the split: “You’ve got to know what’s pastoral and what’s professional.”
Dr. Reed, who had some mental health service provision experience, referred to “red tape” and “being allowed” to broach certain topics. However, when asked how he’d advise the mother of a young man acting in a manner consistent with schizophrenia, he emphasized that his opinions were “novice,” based on what he’d seen while working in the case management setting, and that he would have to consult with psychologist and psychiatrist “colleagues.”

Armstrong (2016) points out that clergy lacking training in pastoral counseling or pastoral psychotherapy “may attempt to address complex clinical issues on their own. Significant feelings of overwhelm or burnout and the exacerbation of parishioners’ symptoms are common results” (p. 120).

Dr. Harshaw was blunt in his condemnation of the cultural imperatives that contribute to the muddling of the line: “The institutional church and the cultural church… allow sick people to stay sick in the name of God and to pray over stuff that needs to be clinically addressed.”

“Sick Pastors Make Sick People in the Pews”

Part of what may inhibit pastors from seeking outside help for their congregants may be the significant pressure from the congregants themselves on the pastor to be, or at least look, perfect. Dr. Joe Stevenson, senior pastor of Macedonia New Life Church on the southern edge of Raleigh, explained the mechanism behind that pressure:

The people in our pews, for the most part, will never rub shoulders or sit at the table with presidents or governors or lawyers of renowned status or entertainers. The most important person in that community is the pastor. And all of that comes to play in the congregation because he or she is the voice for that community. And that individual stands, that individual is really, has really postured themselves as the chief within that church. …The perfect pastor is the epitome of success, for the most part, within the context of that community…. And if that individual is not able to find a safe place, doesn't have someone to hold them accountable, then they will break down emotionally, which affects them physically which of course affects them emotionally and psychologically.
Dr. Harshaw described in more detail how that pressure can imperil a pastor’s ability to help his congregants, and even hurt his congregants:

We need each other and God has created this sense of community and relationship where you can't be holy and delivered, and then not deal with your relational reality around here, with this in your home and your marriage with your children with your friends and with your enemies who used to be friends…. A lot of [pastors] don't go there because then some of them got so much stuff. …You know there's people in ministry who have been through all kinds of stuff. And you never know what happened…. It won't be in their testimony and they just repress it and, you know, ‘God delivered me’-- so they can't be helpful for the people who are out there struggling. You know that everything doesn't happen instantaneously, but they're not acknowledging that. All they're doing is praising God above it. And they're being blessed in God's use, and all that good stuff. But the health of the congregation and the church is not happening because we're still living in deception. As if all of us who gather on a Sunday morning have victory over everything! We've got all kinds of issues and you're going to die with some of them. The strength comes with knowledge of who we are and knowing that God loves us still and the Lord is working with it.

Dr. Stevenson described healing as the focus of his ministry:

[The Black church does] a great work in preaching. We do a great work in the black church in teaching; but the healing component for the most part— psychologically, emotionally and spiritually-- we tend to not do so well in that area. So I've made it my focus and ministry to address that as best as I can.

In particular, he said, he works with pastors:

The largest bulk of what I do for the most part, interestingly enough, is with pastors and ministers who are emotionally or spiritually depleted… There are a lot of pastors and ministers that are incredibly emotionally distraught. More so, sick pastors make sick people in the pews. If the pastors and ministers are healthy, the congregation is healthy.

Both the congregation and the pastor experience what Rev. Peters called “the communal shame” of the appearance of less-than-perfection in the cultural church. It takes a strong-minded leader (in a pastor-led church!) to be willing to diverge from that culture. Dr. Dickerson and Dr. Reed both said they’d made teachable moments out of their own work on their own mental health. Dr. Dickerson said:
I told them one Sunday, just like you go every year you get a physical checkup? You ought to at least go every one or two years to get a mental checkup. I tell 'em. And I had to have something major to happen in my life for me to go and sit down with a psych-- counselors. And I found that a counselor can make you see. Other things that you didn't see…. I think that's one of the critical things that we miss sometimes, is that, if you are professionally trained to do this, then why shouldn't I--? I shouldn't feel like I'm so above this that it never happened to me. That I can't come down and say, this is what I'm going through. Even though we have had some of the same courses, that's your specialty.

(Note that even in the context of advocating transparency, Dr. Dickerson hesitated to say “psychologist” or “psychiatrist.”)

Dr. Reed said he preaches on his own ongoing work:

When I’m more explicit about it I preach about me going to my counselor because I teach about that…. And I minister about it, yeah….. [Y]ou kind of break that taboo. And as a pastor there’s a point of transparency that you have to have with your members, so with me, I had panic attacks. I had major panic attacks and the way I combatted it was not only through prayer, but by putting in the work. I have faith in God but I know God without works is dead. I had to put in some work. I went to counseling. I told my people that I went to counseling. I was out sharing the milestone journeys and I was giving them nuggets from my sessions, you know, and I may even use some of those things where I am permitted to, as it relates to just, you know, some strategies. But yeah, just being transparent and telling.

The word that Dr. Reed used—transparent—came up with Dr. Harshaw, Dr. Stevenson, Rev. Gibson, Dr. Dickerson, Rev. Peters and many other pastors. In Chapter 5, Discussion and Policy Implications, we will unpack the importance of transparency to a synthesis of theology and health messaging with radical policy possibilities.
CHAPTER 5: Discussion and Policy Implications

This chapter discusses and develops the findings set forth in the previous chapter; takes a close look at one church’s management of the African American Baptist mental health conversation; and uses that look to project some policy implications for mental health communication in Black Baptist churches in general.

I began this study with a clear concept of the Black Baptist church as a major cultural and institutional influence in African American life. Looking at mental health messaging within this institution, I expected this study to remain a cultural and institutional artifact. But in the words attributed by the internet to Albert Einstein, “If we knew what it was we were doing, it would not be called research, would it?”

In listening to the pastors, minister, deacon and doctor who responded to my query, I learned that there is a strong theological component to this communication, when it takes place. There is a theological justification, even an urgency, for pastors to be open and intentional about the mental health of their congregations and their own. Pastoral transparency is the courage—the freedom—to appear broken before one’s congregation, colleagues and community.

Theologically speaking, pastoral transparency is the willful identification with the imperfect human aspect of the savior figure. This might seem an easy sell in a Christian congregation, but the institutional and cultural aspects of the African American Baptist worship enterprise, as set forth by Dr. Harshaw and Dr. Stevenson, mitigate that ease. Pastors, ministers, deacons, elders—all are under tremendous pressure to appear upright, saved and excellent. Rev. Gibson explicated the internal dialogue from his own struggles:
When my ex-wife wanted us to go [to our bishop for counseling], I said “I’m not going to do it. I don’t want the bishop to think of me like that. I mean, I’m one of his armor bearers. I’m on the national committee. You can’t take this stuff there. This will destroy me.”

But there is a strong identification of judgement with ownership, a concept with sharp echoes in many African American communities when applied to people. The relationship, the agency which allows judgement is similar to ownership. Rev. Gibson explained:

We see transparency as leading to vulnerability because we’ve spent so much time—I mean black folks have spent so much time having to just build walls to present ourselves as human. I mean we had to armor ourselves just to go out the front door. So that process of doing that constantly means that it’s very difficult for you to be transparent with other people.

So in this context, the cessation of judgement—which is God’s function in Christianity, not humans’—is the casting off of ownership by institutional and cultural strictures. Dr. Stevenson said:

In my opinion, transparency releases you. Transparency frees an individual or persons from the tyranny and the pressure that society forces individuals to walk in. When I render myself transparent, you can’t hurt me…. Which is why we have such an affinity for Christ because I don’t have to live that—I don’t have to lie. I am not able to live that existence. I’m only able to do that through Christ.

(Incidentally, that leads to the rejection of the politics of respectability, which as recent events have clearly shown, has not been successful for African Americans in the long run.)

Pastoral transparency provides pastors with the relationship that makes them an effective support system for their congregants and allows pastors to be in real relationship with sources of support for themselves. And pastoral transparency includes transparency on mental health issues. As Dr. Harshaw said:

You may need to sit and talk to someone, even though you’re a pastor of the Holy Ghost. Even though you’re a deacon or even though you’re the soloist of the choir, even though, you know, you’ve been raised in a Christian home. There’s still some issues that you may have to deal with and you can’t deal with by yourself by just praising the Lord and in your prayer.
Pastoral transparency provides congregants a model of a relationship in integrity with the Scriptures in which they say they believe. This renews the institution and the culture, creating and strengthening relationship in the church and community in Christianity.

When this does not happen—as now, in many congregations—the church is weakened.

Rev. Gibson explained:

Culturally… lot of people have been hurt in that church. And I don’t want to just leave it at, folks have been hurt by the church. Sometimes a church is hurt by folks. ‘I’m not going to come over here and give all that I have to the church. Because we feel as though it’s all gone to the pastor.’ You know, those kinds of statements and so the church suffers.

In an organizational schema, the sum of much increased pastoral transparency approaches institutional transparency: the courage and freedom to admit flaws and to seek to amend, secure in the support of a community. I asked Dr. Reed about a statement I heard from another pastor, that his congregation was heavily invested in that pastor’s uprightness and appearance. Dr. Reed responded:

Not to be judgmental, but those churches, I would classify them as on life support. And the reason they're on life support is if they keep that as their method of, their methodology, they will never grow that church beyond who they have, because millennials are looking for transparent, real organizations to be a part of. They don't have time to waste with facades and they don't have time to waste with what I guess we historically call the hypocritical-type thing. They know we have issues. They know people who know us. They might know us and they might know more about us than we realize. So that would be a bad taste in a millennial's mouth. And it will stink in their nostrils and that's why they might not come. And if they do come it might be because of coercion, or being forced to come, but the first opportunity that they get to, to ship out and sail out, they will. Because again they are looking for realness. Just be real.

This is a model for the future of the Black church; taking hold of roots in the Scriptural beliefs that made the church a strong and functional body and rejecting the cultural and institutional encrustations that are keeping it from growing and evolving to meet the needs of
new generations. In this model, the pastorate communicates on mental health issues to wield transparency to interpret Scripture for the present and future, embracing God-given knowledge for the reduction of suffering.

Dr. Reed continued, referencing the Black church’s dilemma of an aging population that’s not being replaced:

Just be real, because church to me-- I was always taught that church is a hospital. You know, church is not a country club. You know, it's not a social club. A church is a hospital. People are hurting, they come to be uplifted, informed, empowered, healed. You know, we call it delivered. I mean people are coming with issues and everybody has issues. And I preach that, as part of my, you know, my philosophy. Everybody has issues. Just because you have money, you have issues. You've got issues and your money cannot always buy you out of issues, and matter of fact it may create even more issues than you may be aware of. So, you know, again that commonality putting everybody on the same plane. There are silk stocking, silk stocking churches. And that's, that's their paradigm and that's what they hold fast to. And if that's them, that's fine. But you know it depends on who your target is. And my target is to again create the intergenerational church, you know, and I press people, you know, hey, don't you forget your testimony. Don't forget who you used to be. You know people need to hear your story because they're not going to come to church. And the only way you could influence them to even consider God is through your testimony, so that you don't forget who you are and where you've come from, and you remind them that you're not where you still desire to be. You're a work in progress. And that's how the attorney can minister to the, you know, the ex-felon and the felon can minister to the attorney because they have that commonality. You know, yeah, I made some mistakes, still making mistakes, you know and I, I've even put it out like this: you know some of my favorite preachers, they say yeah, I was born in a church. Born on the front pew and I sinned in the church and that's where I did my dirt because church was all I knew. So, you know, with that being said, you know, this whole notion of, you know, creating this perfect environment-- I just don't feel-- this is me personally-- I just don't feel that that's what people are looking for nowadays. Not in my opinion. Just so, so my, my take on that is, I think they're on a downward slope and I think at some point that that pastor of that church or those pastors of those churches have to come to the reality of what's going to make the church flourish and flow with them and beyond them, because if not the church is goin' die.

Dr. Dickerson, asked what course of action he would recommend to a young pastor starting out who wanted to address mental health in his congregation, recommended: “Teach
them about being holistic.” Rev. Gibson, asked the same question, responded: “I think we start by, number one, being true to ourselves. And being true to ourselves means that we learn to communicate.”

“The issue is that humanity needs partnership,” Dr. Harshaw stated unequivocally:

And there are times in life where you cannot do it by yourself and the knowledge and theoretical knowledge of the Bible and knowing that God is able is not sufficient. Not because it isn’t sufficient in itself but because God created us to be a community… which for me, then, drives the point home that God does solve everything but he solves it with all of us. You know when you're young and you're praying: ‘Lord I want to be used, I want to impact the world for you, I want to glorify your name.’ So what's the first thing God does? If he answers that prayer he gets you involved with broken people who you really don't want to be bothered with. Okay, but he's answered your prayer. You said you want to be used. What's that? What, a TV show? You know what it is. Makeup? And cameras? Give me a break. No, that's not what he's talking about. He's talking about them as soon as He answered the prayer. You want to deal with the brokenness of your family or the brokenness of your friend or your friend comes out: ‘My boyfriend just broke up with me, I want to commit suicide.’ And then when you mature in Christ, you understand that that was the answer to your prayers. You said, ‘Lord, I really want to be used.’ You mean to stand up in a pulpit with a robe on, holding some big old Bible with a big cross around your neck and be featured, the featured speaker? Is that what you mean by being used? No, no. If you're not going to stay there long, you can come and preach and leave and like an evangelist. But if you come and stay, the first thing you got to deal with as pastor is the brokenness of the church, and the broken people will make their way to your office and make their way onto your prayer list. You keep saying, ‘Lord, use me,’ and God keeps sending you all these problematic people. And you say, ‘What's going on? I really want to get them out of the way, I want to be used’ and God says, ‘Yeah, it's about people.’ That's what it's all about.

Dr. Stevenson went further, calling for a “cultural hermeneutics to Scripture.”

Hermeneutics is defined in Denzin and Lincoln (2011) as “An approach to the analysis of texts that stresses how prior understandings and prejudices shape the interpretive process” (p. 16). Dr. Stevenson defined his use of the term as allowing the Scriptures to speak to [our] Blackness. As opposed to a Eurocentric understanding of what Scripture means to you. Because for the most part a huge amount of what we respond to comes out of a Eurocentric interpretation. Which may even be somewhat responsible for some of our mental challenges.
In his hermeneutics, suffering is pointless; pain has a purpose. It is redemptive. Creating and embracing authentic and culturally honest hermeneutics would replace the Eurocentric understanding now undergirding the politics of respectability that is pushed on African Americans in church and out, for reasons that have nothing to do with theology and everything to do with supporting the existing power structure. In a White-focused religion it is acceptable for Black folks to suffer endlessly as a by-product of White supremacy. Dr. Stevenson seeks to convert that suffering to pain, which is a functional message in an injured organism. Pain is lessened and hopefully eventually eliminated when healing is complete. Today many African Americans say “We’re fine because we know God,” while masking suffering. Rejection of culturally and institutionally sanctioned suffering in favor of acknowledgment of personal pain will allow African Americans to grasp God-given tools for healing—like the mental health paradigm and its associated professionals and practices. It will turn mental health care into an act of resistance.

The integration of a mental health vocabulary with the pastoral and ecclesiastical experience gives congregants additional tools with which to address their pain in a setting where their pain is validated. Following on the symbolic interactionist argument (Blumer, 1969) that people conceive of future acts in words, the Reasoned Action Approach (Azjen, 2012) posits that cultural influences can shape and place those words. Pastors can be impactful and responsive sources of those words. In the words of Dr. Reed, “Pastors provide hope, until [congregants] can get help.” Renewed and healthier, congregants deliberately engaging with their mental health and illness issues are more fruitful members of their churches, better able to help themselves, their church families and their pastors. Ultimately they renew and extend the institution: “a visible church of Christ, a congregation of baptized believers, associated by covenant in the faith and
fellowship of the gospel… exercising the gifts, rights, and privileges invested in them by
[Christ’s] work” (National Baptist Convention, n.d.)

The pastors’ descriptions of the Black church as given in their interviews have serious
implications for what the mental health message is and where and how it’s placed. The existing
health messaging literature tends to assume a pastor-led institutional/cultural church. But as Dr.
Reed asked, “What if my schedule is bombarded? What if I’m out of town on a conference?... I
need to create some [mental health] EMS people…. I’ve got to get people equipped to give hope
until help arrives.” Regarding the health of the congregation, there’s a need for distributed care.

Orange Grove Missionary Baptist and many other churches use deacons to do this,
although Dr. Dickerson, Rev. Peters, Rev. Gibson and many other pastors stated that in the end,
many if not most congregants with mental health “troubles” do end up in the pastor’s study.
Nearly all the reviewed relevant literature focuses on the pastor-congregant relationship. As one
of the Baptist church’s “only scriptural officers” (National Baptist Convention, n.d.). deacons are
plainly a first line of response for congregant troubles, and communication and training for
deacons certainly deserve more study.

However, as this study focuses on the pastor-congregant communication, I continue this
section with a look at the history and function of the Ministry of Congregational Care and
Counseling (MC3, as it’s known) at Durham’s Union Baptist Church, one of the largest Black
Baptist churches in the Raleigh-Durham-Chapel Hill Triangle and the largest church visited for
this study. It has a membership roll of 7,000 people over five counties in central North Carolina.

This section is informed by two interviews. First was a 44-minute interview with Kenneth
Hammond, now Union’s senior pastor from 1991 to August 2017, who made the decision to hire
a psychologist and begin the MC3 program. Dr. Hammond has a master’s degree in education
and additional certifications in counseling, and was the first African American Director of Student Affairs at East Carolina University. He explained: “So in a sense I became the African American ombudsman. Everybody was like, ‘Go see Dr. Hammond.’ So you just take on some of these responsibilities in terms of counseling kids and those kinds of things.”

Second was an 84-minute interview with the psychologist Dr. Hammond hired, Tonya Armstrong, the founding supervisor of Union Baptist’s MC3 (as well as the dean of the Counseling Studies department at the Apex School of Theology and the CEO of The Armstrong Center for Hope, a multi-disciplinary private mental health and wellness practice). With a doctorate in clinical psychology and a master’s degree in theological studies, nearly her entire career has unfolded at the intersection of faith and mental health.

**Case Study: Ministry of Congregational Care and Counseling**

Dr. Armstrong located a good deal of MC3’s DNA in two senior pastors at Union Baptist, whom she described as “counseling-minded”; Rev. Dr. Grady D. Davis, who pastored Union Baptist from 1964 to 1990 and under whom she grew up; and Dr. Hammond. Dr. Armstrong herself studied psychology and music as an undergraduate and credited Dr. Davis with influencing her choices as early as 12:

…Under Dr. Davis when I grew up here, I had a vague awareness that he actually had his Ph.D. in psychology but I didn't have the sort of wherewithal as a young child to think, Well, why is he a pastor? Or, what does he do in psychology? Like I never thought to ask him that question before he died. But I think I was always aware that that was a part of his training. I don't ever remember having that experience where I felt psychologized, or felt like he was psychologizing people, but he just loved people and he was a great encourager of people.... Honestly I don't really know how he translated his psychology training into what he did, but it helped to set the tone for the culture [at Union Baptist]. And then with Pastor Hammond being here and being counseling minded and even having had experience with counseling at ECU, he was open enough, number one, to counseling. And number two…. not only did he come here open to counseling just in terms of who he is as a person and a professional, but he's also a pastor who's taken some risks.
Dr. Armstrong acknowledged that the installation of a mental health ministry could be seen as risky in an African American Baptist church, and her view was echoed by that of other pastors to whom I spoke. Dr. Hammond didn’t seem to think of it in those terms; he described the Union congregation as “expect[ing] to be challenged” and “embrac[ing] differences.” He described his thought process in reaching the decision to begin MC3:

Simultaneously, after one year of working [at ECU] I was called to pastor. And it became clear to me that what I was seeing and what I perceived to be the reality is that the issues that congregants presented with-- were presenting with then and going forward-- would be issues substantially beyond the scope of what most pastors should be dealing with. Because the reality is probably 80% of pastors I would never send-- I would never go to for counseling or send somebody to for counseling. Not because they're not good people; they just don't have a skill set. Most pastors who counsel, at least in my view, you know, take sort of a, you know, a biblical perspective: OK, let's pray about it. Let's go through the Word and see what that Word says about it. The reality is psychotherapy is what these folk are needing. They don't need to know that Jesus will fix it. They know that. But it ain't fixed. And so I then enrolled-- well, in seminary, came out of seminary and then I enrolled in a master's program in counseling. And it reinforced my belief system that, you know, we needed people with more training.

Having grown up at Union, Dr. Armstrong was finishing her doctorate in clinical psychology at the University of North Carolina at Chapel Hill in 1998 and “started having some conversations with [Dr. Hammond] about what it would look like for me to use my gifts and my training in a church setting.” At the same time, Dr. Hammond was in the process of adding to Union’s membership, which went from 1500 to 7000 under his leadership. With those kind of numbers, Dr. Armstrong explained,

…he wanted the emphasis to be on the care that the congregation was providing and not the care the pastor would provide, which I think is especially important in the context. With such a large population, the 6000 of us can’t all be looking at the pastor to, ‘Come by my bedside, come take care of my depression.’

(Indeed, Dr. Dickerson at Orange Grove opined: “I think any time a church gets over 200 members, it’s difficult to keep up with them.”)
In 1999, Union first implemented Stephen Ministry, a “one-to-one lay caring ministry… which equip[s] and empower[s] lay caregivers—called Stephen Ministers—to provide high-quality, confidential, Christ-centered care to people who are hurting” (Stephen Ministries, n.d.). Dr. Armstrong, functioning as a deaconess, attended her first Stephen Ministry training in 1999. The program is rigorous (Dr. Armstrong half-seriously described the manual as weighing “33 pounds”) and has been implemented in more than 12,000 congregations in more than 170 Christian denominations (Stephen Ministries, n.d.). There is more descriptive material about Stephen Ministries in Appendix 4.

Stephen Ministries’ web site describes its program as being “appropriate for people experiencing grief, divorce, cancer, hospitalization, physical rehabilitation, long-term care, chronic illness, terminal illness, job loss, loss of a home, military deployment, the onset of a disability, loneliness, spiritual crisis, or other life struggles” (Stephen Ministries, n.d.). Many of these conditions can co-occur with mental health diagnoses, and in some cases might even precipitate mental health crises, but they are not mental health disorders in and of themselves. Dr. Hammond and Dr. Armstrong thought the Stephen Ministry program was working well but was not sufficient. Dr. Hammond expounded:

There was a belief on my part that there needed to be additional layers of therapeutic support for congregants because when you look at data, data suggests that, at least at that time, African-Americans were least likely to get mental health services because of the stigma. If you go get mental health services, if you see a counselor, you crazy. So they weren't going outside. Even if they worked on a job and they had employee assistance benefits, they just wouldn't use them. What we found is that if they were going to use [a counselor] they might be more likely to do it within the confines of their faith community.

(Dr. Hammond’s finding—that congregants would be more likely to seek mental health services within their church—has been explicitly borne out in the experience of MC3. Dr.
Armstrong estimated that “30 to 40 percent” of the clients MC3 sees do not reference their faith in their discussions with her:

**Jeannette Porter:** So in those 30 to 40 percent of cases, it is the existence of MC3 and a trusted institution, that brings them here, as opposed to necessarily a theological trustworthiness.

**Tonya Armstrong:** Yeah. Right, right. … I've not heard a lot of people say that, but now that you mention it I do think that is sort of implied. There's some conveyed trust that comes just from us being within the black church. This church. Yes.)

In April of 2000 Dr. Hammond brought Dr. Armstrong on board to begin Union’s Ministry of Congregational Care and Counseling. His decision was greatly facilitated by what this study would identify as Union’s pastor-led structure and culture.

The fortunate thing is, very early on I was empowered to be pastor…. Maybe that happened within 45 days of becoming pastor. Which is unique in and of itself. So it was, ‘This is what I want to do.’ And it was, ‘OK, fine.’…. I didn't have to try to...sell it to anybody. I didn't have to make a case study. You know, ‘This is what I want to do.’ ‘OK, let's do it.’

Regarding the choice of Dr. Armstrong, Dr. Hammond observed that the Black church, culturally, puts counselors at a disadvantage in advancing to pastorship:

I'm a little bit crazy in terms of some of my thinking about stuff. …. For example, I don't believe that every call to ministry is pulpit-based. I believe that God affirms callings on individuals that are unique and specific beyond a general call that God places upon all of our lives; that God gives certain individuals with gifts for ministry. But what has happened is most churches have not had a way to validate those gifts and so that person who has a gift and knows that this is my gift-- whether it is teaching, whether it is evangelism-- my gift is not validated unless it goes to the pulpit. So I have to stand up and try to preach and that's not my gift. So I had a conversation with Tonya and she was sharing with me a call around the issue of counseling, and I was in the process of thinking through how could we set up a more formal counseling piece here at the church.

This is undoubtedly correlated with the fact that Black church is known for its charismatic preaching, but not so much for its healing work, as Dr. Stevenson mentioned.
Over the years, MC3 has developed a structure of three licensed professionals—currently a psychologist, a licensed clinical social worker and a licensed professional counselor, supplemented by interns brought on from Duke and other area universities, plus periodic other additions to staff. Dr. Armstrong, as the head of MC3, also supervises the Stephen Leaders (four as of summer 2017) who supervise the Stephen Ministers (seven as of summer 2017). There is also a grief support ministry, which was not active at the time of the interviews.

A typical course of service at MC3 will begin with a congregant filling out a form titled, “Confidential Request Form for Psychotherapy and Counseling Services.” It asks for basic contact information, whether or not the congregant is a member of the church, marital status, emergency contact information and a short summary of why the congregant is seeking “counseling.” The form can be handed to a secretary, left in a response box or slipped under the door to Dr. Armstrong’s office. After she reviews the request, a referral coordinator makes a match with one of MC3’s care givers based on need, specialty and availability, and the first appointment is set up. Clients are generally referred to as “care receivers,” using Stephen Ministry language. Care receivers can meet in Dr. Armstrong’s office in the church or in another building the church owns close by, which is not consecrated. (That “was intentional,” Dr. Hammond said, “because you still got some folk that don’t want to come to the [church] building” for counseling services.)

Church members can see a provider for up to 8 sessions at no cost; non-members, up to four sessions if there is care giver availability. If need persists, either can use their health insurance or pay for further sessions. Dr. Armstrong estimated that two-thirds of care receivers choose to extend and use their insurance for further sessions; the remainder, she said, “are kind of clear that they don’t have the budget or the insurance for it, and so they’re just, like, ‘Let’s
maximize the sessions we have.’” Dr. Armstrong is often called to respond to persons who come
to the church in distress, but MC3 does not provide walk-in services. “Not often, but every now
and then we’ve had to help with getting someone to an in-patient facility,” she said.

Actual sessions tend to unfold according to the usual norms of a therapy session, adapted
to the conventions of the training of the care provider, Dr. Armstrong said. However, there are
some cultural hallmarks to MC3’s overall approach:

… Each of our licensed professionals is trained at a slightly different guild. I tend
to think that we're more alike than different, but I'm trained in psychology, Anita's
trained in social work and Ava was trained in professional counseling. So we
probably all approach the task a little differently. Do I think it makes a big
difference on the outcomes? No, but just in terms of how we sort of frame the
session, structure it, how, you know, one of us might do more listening; another of
us might do more directing. I have found that unlike what we see in the White
media where people go to therapy, ‘How do you feel about that?’ Black folk are
not trying to hear that; they want you to give them answers. So we're actually
trained not to give people answers. We have to sit with people as they figure out
their own answers. Even so it has been a great benefit to be more directive within
therapy. So you don't tell someone what to do but sometimes you have to
structure therapy a little bit more than, you know, oh, lay back on the couch and
talk for 90 minutes and I'll see you in two days. Mm-mmm. We don't have time
for that kind of free association. You know, we have a problem to solve.

Dr. Armstrong observed that there are some topics that are generally extremely fraught
when communicating with her population of African-American Christians. Medication is one,
and labeling is another:

You have to be extremely careful about conversations regarding medication and
it's just kind of ironic to me. … When it comes to medication people will not
think twice-- in my experience, a lot of my clients will not think twice about
taking their metformin every morning. But if you want to talk about the anti-
depressant, it's a completely different conversation. I'm like, OK, let's understand
that this is all biology. This neurology and neurochemistry. Let's talk about
neurotransmitters-- dopamine and serotonin and how the brain responds to
different things. So just having to give that kind of psycho-education is helpful,
but not always completely persuasive, but it helps them to think about it. Because
it's just so ingrained that we don't do medication, even though we do medication
for many other things. We don't do psychotropic medication. So that's a very
careful conversation that I have with over half of my clients.
Actually just conducted a psychological evaluation with someone-- which we don't do at the church, by the way-- when I was at my practice earlier today. And did the interpretive to explain the results, and recognized with this well-educated, highly-- I don't know exactly what his job is but he's in a good paying job and he's well-educated. So he's a solidly middle class black father but [I’m] finding myself saying to him, ‘Your daughter has symptoms of depression and anxiety and yet I was careful not to write that diagnosis in your report because I was not sure how you were planning to use this.’ He said ‘Yeah, 'cause you know how those labels are!’ I was like, OK, I think I chose the right thing. So even at that level of great education you know we're still careful about things like medication and labels and do I really want my child to have this even though the reality is, in terms of resources that are available and getting direction to treatment, getting accommodation in the schools; all of that is there if one can just get past the label. So that's a careful conversation.

As she heads a ministry with Christian caregivers and care receivers, Dr. Armstrong says she does use the language of the Bible:

**Tonya Armstrong:** From a Christian point of view, I think it always helps to have the language ready around Biblical concepts, Biblical figures, understanding even what people might say, like I can do all things through Christ who strengthens me, absolutely. That's in Philippians 4:13. Now let's look at the context of that passage. Paul was in a great deal of suffering when he said that. So he's saying that he can survive the suffering; he's not saying that from a triumphalist point of view that he's victorious because he did everything through Christ. He's saying at the bottom of his valley, that he can do all things. So when we say that, let's be clear what our expectations are. So some of that you know, using-- hearing them say it, but they're saying, What does that mean when we say that?

**Jeannette Porter:** So bringing down even some of the Scriptural shorthand.

**TA:** Yeah. Favor. Being highly favored. Too blessed to be stressed or depressed, mmkay, and so, yeah, we can look at all of those promises in Deuteronomy, when everything that God said wasn't ours. So then if that's not where you are, does that actually mean that you're cursed? Or can we understand life's storms. Can we understand how the disciples went through storms? Even had Jesus right there with them-- who was going to sleep through all that, you know. So there are so many different directions that you can take to help people when they (snaps fingers) give a soundbite to really dismiss or minimize what they're going through is to kind of re-appropriate that.

**JP:** So not only do you want to be able to use that language, but you have to be prepared to unpack it when your clients use it.

**TA:** Absolutely.
The Christian context of the service provision is not a communicative given, however. Dr. Armstrong described her practice:

> Usually I follow their lead so I don't use a lot of that language until I hear them say it. Right. So even here where it might be easy to assume that people are operating at a deeper level of spirituality or religiosity, whatever, you know. I don't make this an overly spiritual experience unless the client says OK, well, I want to talk about the Scripture or-- because honestly I would say at least 30 to 40 percent of people are not using-- how do I want to say this-- they are faithful people; they don't necessarily see faith as having much to do with their problems. And so if they're not trying to sort of see spirituality as a coping resource, that's not going to be my leading card. I'm going to figure out: OK, you're going through these symptoms of a panic attack. So let's talk about what the psychological literature has to say about panic attacks. We can kind of get to what Philippians 4 says about anxiety a little bit later.

So even in faith-provided mental health care, the orientation of the conversation is determined by the client’s/care receiver’s attitude. If he or she frames issues religiously, Dr. Armstrong responds in that frame. If not, she relies on the psychological literature.

Dr. Hammond said that he thought MC3 “has gone far beyond what I thought it would be…. I think probably going forward, what I hope is that more of our congregants and community understand the resource that is available to them, and that we can continue to broaden by adding additional staff to the ministry.” Dr. Armstrong said she thinks MC3 has had “moderate success…. It’s not more than moderate success because stigma is still real.”

MC3 has attempted to address stigma on a church-wide level by including promotional and informational items in Union’s electronic newsletter; posting promotional and informational videos on the church’s website, especially during May, which is Mental Health Month; interacting with other ministries, such as making presentations to the Youth Church, etc. But, said Dr. Armstrong, “the most impactful things are happening one by one,” meaning one person at a time.
Theological and practical conclusions and implications

As argued at the start of this chapter, pastoral transparency with regard to mental health is a challenge, but also a strategy not just for the mental health and wellness of congregants but also for the health of the Black church as a going concern. Sound churches are made sound in part by their skill at developing trust among pastor and congregants, which is an absolute pre-requisite for the mental health conversation. Dr. Hammond, asked how he would advise a colleague who wanted to move a mental health resource into his church community, immediately responded in terms of trust: “Well the first thing I think you have to do is you have to build some trust around what you’re doing.” In the space that trust creates, transformative growth of both the individual and the institution is possible. In Dr. Stevenson’s words, “transparency will allow the power of God to flow through you that will bring healing to so many others.”

In response, I asked, “Why is this so difficult for us?” referring to the African American struggle with mental health transparency. And Dr. Stevenson responded to me: “It's difficult because we are afraid that it looks like vulnerability.” Rev. Gibson was vivid about this:

**Mark Gibson:** We've been so assaulted that we are never able to just be who we are. We're always with our armor, and that keeps us from dealing with the very real problems and griefs and troubles that we have. And we never address them, which means they tend to become toxic, to fester within ourselves. And then we wonder why we’re so angry and so bitter and we are so standoffish and we refuse to get close to people for fear that they'll take over our armor and say we've got wounds.

**JP:** Literally stigma.

**MG:** [Nods] And one of the things that I was teaching on Sunday was, one of the things that happens is the body is reacting to a wound whether we want it to or not. The white cells immediately say it's a cut, we've got to go. And so now you see the pus that comes up and then it scabs over. But it cannot scab over unless it has air to breathe. We have become so, so fitted with this armor… that there is no air that can get into it really help us heal. So what we have a tendency to do is walk around clanking, because of the armor that we have. This ain't the armor of God, the helmet of salvation, the shield of faith and all. Now this is the armor that says I don't want you close to me. And therefore it [does] not flex… We also have a hard time being inter-dependent. Because we can't get close to
somebody with that. And... you'll miss the very person that can help you because you've been hurt so many.

**JP:** Church is a place where this could be reversed.

**MG:** It could be.

Echoing Dr. Reed, Rev. Gibson said, “I call this place a spiritual hospital. Where those who are wounded and hurt can come in.”

Dr. Stevenson was explicit about the role of transparency in this endeavor:

…The transparent path allows individuals to appreciate the genuine authentic person. And the pastor as a person, as one whom God is using. And that nothing is coming from the individual in that sense; it's all of God. So an individual who is able to not only acknowledge a concern, but as I've [cited the work of Henri Nouwen (1979)], is a wounded healer, but is working on it, working on themselves through self-care, through a psychologist or perhaps even a psychiatrist or even a trusted friend, someone who will hold them accountable-- That individual is stronger. Because they're free.

I observed that there is a “paradox here, where the attitude that could really set us free, is kind of crippled” by the cultural church which so many African American Baptists inhabit. Dr. Stevenson took that one step further, citing Scripture to demonstrate the centrality of transparency and acceptance of brokenness to the New Testament message:

And as such the power of God is withheld, or held back, because we are operating out of the cultural-- … not the Biblical. And if we really looked at the Biblical, most individuals that God used were all broken. … Job losing everything he had, but yet no pastor except maybe this one has given Job counseling. Coming out of everything he went through to set Job down to have a conversation with him about how he was doing emotionally. Who sat Bathsheba down and talked to her about the fact that she was a victim of power and abuse of a powerful king? But we look at the cultural aspects and we dance play organ music and we do all of this stuff when in fact the power of God is manifested more so when we see individuals who acknowledge that they're broken.

Dr. Armstrong said:

I think about that notion in 1 Corinthians 12 of us being members of one body. And I think about the need for the hands and the eyes and the foot, the arm to function well in their own roles, in order for the body to function well. So if we're only as strong as our weakest link, and our link is weak because of a mental disorder-- and let me be clear; there are many people who come for help for the
MC3 that are not presenting with a mental disorder, and even when they come, are not necessarily diagnosed with a mental disorder. So people can be depressed and not know it, certainly, but…. Not necessarily disorders. And so when any of that is happening, then it makes the body weaker. Now do people sort of think, ‘Oh I should go for counseling, so I can be a better Sunday school teacher”? I don't think people think in those ways but I do think that the ministry encourages people to come to be helpful in helping the individual, helping that family unit, helping the community, helping this church community to all be stronger in that way. So we're always trying to educate and empower people with skills different ways of thinking about themselves and then it just kind of ripples to the other units and systems that they're in. And that's how we see it really empowering the church.

This chapter has attempted to talk generally about the imperative for mental health communication within the Black Baptist church for the health of the congregants and the institutional and theological health of the church; and to zoom in on how one church, Union Baptist, manages some of that communication on an individual and organizational level. The next chapter looks at the limitations of this study and some of the many possibilities it throws up for future research.
CHAPTER 6: Limitations and an Agenda for Future Research

This study, like all qualitative studies, has built-in drivers and limitations that were not explicitly included in the research design, but that result from the biases of the researcher and the intersection of the researcher and her participants. This chapter cites some limitations that have emerged throughout the research and discussion processes, with suggestions on how to correct for them with future research.

Limitations

The pool of participants for this study may have been unconsciously limited, as it is possible that my recruitment letter discouraged pastors who just did not want to discuss the topic of mental health or illness; its stigma power cannot be overlooked. Also, my pool of interviews could have been skewed toward those who had the bandwidth to respond to my request. As noted earlier, many pastors in smaller churches are bi-vocational and some lack administrative support to respond to calls and emails from non-members. As mentioned in the methods chapter, I generally responded to responses to my letter; I did not call the entire list of members of the three associations. It is possible that with more follow-up (that is, if I badgered pastors), I might have had more interviews. Or, it is possible that my letter was an excellent sorting engine to find that third of pastors concerned with this subject.

All of the pastors I spoke to expressed some understanding that mental illness has or can have biomedical causes. Several pastors mentioned colleagues who did not share that understanding, who believed in demons, the “laying on of hands,” and anointing with holy oil, and I expected to hear some responses in that vein. However, none of the pastors I spoke to
expressed such beliefs or said they would use such methods. In the 80 or so pastors who did not respond to my request for an interview, there may have been some who would use that approach.

While I interpret Small (2009) as supporting my approach in terms of selection of cases, it is also true that more data would give a bigger picture. My choice not to code every line of every interview was made from resource constraints. These will always exist. But it is tempting to wonder how my conclusions would differ with that kind of exhaustive approach.

Depending on how big you think a megachurch is, I interviewed anywhere from one to five megachurch pastors. However, none of the interviewed pastors framed their responses in the context of the prosperity gospel, so this study does not address that belief stream.

At least two pastors I interviewed had family members with significant mental health challenges. At the suggestion of one I began to ask why pastors were making the time to meet with me. It is possible that my pool of respondents was sensitized to the topic of mental illness, but because I did not ask the question uniformly (I was perhaps one-third of the way through my interviews when I was prompted to start asking), I cannot really know.

As Southwell and Yzer (2007) noted, basing analyses on participants’ recollections of communication is tricky: “Primarily, retrieval almost never results in a perfectly efficient procurement of a single representation” (p. 444). I asked participants to think of “the last such situation, or a typical one.” When prompted, some pastors very readily recalled an interaction with a particular congregant. Others appeared to be generating a response de novo.

I began each interview by asking every pastor to tell me about the big idea of his or her ministry. Some congregations have vision or mission statements that they recite every week; I missed several opportunities to learn more about how the churches saw themselves, currently and aspirationally. Also, while all the churches shared the same creed (National Baptist Convention,
n.d.), provided in Appendix 3, there were differences in the governance of individual institutions which I did not probe.

The governance and hiring policies of individual institutions could also contribute to the decisions of pastors about whether and how to discuss mental health and mental illness. At least one church was governed by a board of directors rather than a trustee board. I missed the opportunity to know whether this was simply a difference in nomenclature or a real difference in approach to governance. A church whose pastor feels passionate about congregants’ holistic wellness and secure in his position is likely to have a very different atmosphere around the mental health conversation than a church whose pastor feels constantly brought up short by his deacon or trustee board.

Following Rev. York’s formula, if the authority of a church flows from the deacons or key members of the congregation, as opposed to the pastor, then this study does not cover critical segments of the conversation, because it focuses on pastor communication. I spoke to only one deacon. More study of deacon-led and congregation-led churches is needed, as suggested in the following section.

Lastly: with reference to the method used for analysis: I had only one coder, myself. A stronger picture would have been generated with a second coder and a calculation of intercoder reliability.

**Agenda for Future Research**

Each of this study’s six findings raises questions about the Black church, mental health communication with and among African Americans, and the intersection of these two phenomena.
The first, the observations of Dr. Harshaw of Raleigh’s First Baptist Church and Rev. York on the various actualities of the Black church, calls forth several questions.

Dr. Harshaw stated that the Black church has three parallel states. There is the Biblical church, that is the church of Scripture. There is the Institutional church, that is the organization and hierarchy that has developed since Jesus’ death. And there is the Social or Cultural church, which is the entity that most members are aware of belonging to.

• Is this trinity understood in the religious or sociological literature? Rev. Gibson, Dr. Stevenson and several other pastors agreed with Dr. Harshaw’s observation, but does the academy understand this? A literature review is needed.

• What are the operationalized hallmarks of each aspect? Do the three aspects co-exist in each currently operating house of worship? Do they compete? A critical re-reading of existing ethnographies might suffice for this and the next two questions, but more likely new ones should be carried out. Because a researcher is asking for entrance and trust in a private space, this could be the work of years.

• What are the norms and modes of control of each and how do they intersect? How do they compare?

• What are the communication patterns and practices of each and how do they intersect and compare?

Rev. York of Chapel Hill had a different trinity. He observed that Black churches can be led by their pastors, their deacons or their congregations, and that the chemistry of each is different.
• How would a researcher identify a church by type? (I can well imagine the great amount of tact needed to develop this instrument.) How would one locate the key informants (Weiss, 1994) in such churches?

• Is this only a Black church phenomenon, or does it refer to Baptists in general? Or Protestants or Christians? Or does it apply to worship organizations broadly, assuming that other such organizations have an analogue for deacons?

A typology (or matrix) crossing these two trinities and looking at the issue of mental health communication at their intersections would be an extremely fruitful scheme for further study. Then, returning to this study’s concern-- mental health (really, any health) messaging:

• what are the implications of these church aspects for such messaging? For instance, what is the source of the most effective normative beliefs? If the church is Biblical, it would seem to be Scripture. If Institutional, it would seem to be precedent. If Social or Cultural, it would seem to be practice. Are these seemings correct?

Also, particularly in view of Rev. York’s conception of the deacon-led church, once one found a pool of them, there needs to be an examination of deacon training to respond to the mental health needs of congregations. Dr. Dickerson at Orange Grove Baptist shared with me a 5.5 by 8.5-inch ring binder with forms in it called “The Deacon Family Ministry Plan,” published by LifeWay Press in Nashville, Tenn., and told me it was part of a training that all Orange Grove’s deacons went through. What does it prescribe? How many churches use it? Who developed it? What was their training? What have the results been?

The second finding, that stigma constrains mental health communication in African American Baptist churches in three specific ways, needs to be tested on a broad scale among
both pastors and congregants, and in other locations. There was a good cross-section of size and type of location (e.g., urban, suburban, rural) among these 41 interviews, but they were all located in one Standard Metropolitan Statistical Area in the Bible Belt. Are patterns the same in Portland? A national survey of mental health communication among African American churchgoers in all their organizational multiplicity should be attempted, because African Americans are consistently shown to be more active in their religious affiliations than other groups (Pew Research Center on Religion and Public Life, 2015b) and it is a firm strategic communication principle to reach people where they are (Rice & Atkin, 2013). Such a survey could also look for correlations between willingness to communicate about mental health and indicators such as income, education, size of congregation and number of hours spent on church or faith activities each week. It is possible that this information could be extracted from a dataset such as the National Survey on American Life; inquiry should be made.

Also, while this study looked at a cross-section of churches in terms of age, location and size, I did not attempt to determine if any of those characteristics were correlated with mental health communication patterns. These possible correlations should be examined, as should the possibility of a relationship between pastor preparation—education and length of service—and mental health communication with the congregation.

Because pastors discussed their mental health communication patterns in the context of un/willingness to engage in that communication, it could be asked: why not use the Prototype/Willingness model to conceive of pastors’ decision process on communication and research potential influences in that context? A dual-process decision-making and execution model (that is, a model that looks at the balance and tension between impulsive/intuitive and effortful/reasoned behaviors), the Prototype/Willingness model could unpack the competing
imperatives in pastors’ decisions to communicate openly, guardedly or not at all about mental health. In the health communication field, the PW model is most often associated with attempts to understand adolescents’ risky health behavior decision-making (Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008; Gibbons, Gerrard, Blanton, & Russell, 1998); but I see no reason why it should not be used to understand the risks pastors calculate in communicating about mental health.

Because pastors located their unwillingness to communicate about mental health in concerns for stigma rooted in African American identity, Comello’s prism theory (Comello, 2013) could be a particularly fruitful frame for future inquiry. This theory looks at identity as a both a moderator and a mediator of communication. In particular, the prism theory suggests that “to influence behavior… communicators should make a desired self-concept accessible, and/or enhance the value described to a self-concept, and then provide messages that link the advocated behavior with that self-concept” (Comello & Farman, 2016). This is a most promising place to test that theory. The idea that resistance is a key element of Black identity—currently resistance to the medical establishment—could be reframed as resistance to tradition in pursuit of wellness for the sake of surviving and thriving. Wright (2014) argues that “acts of resistance are always generative… because acts of resistance bring into being new worlds, they produce new subjects and subjectivities.” Future mental health communication within the Black church could emphasize the Black strength of mind that has been needed for survival in America, and introduce tools to maintain and improve that strength.

The gender divide in the Black Baptist church is marked; most leadership positions are filled by men, but women form the majority of the congregants. Indeed, some pastors interviewed for this study reported a gender split as extreme as 90% female, 10% male. Women
are also more likely to seek mental health help than men are (Ward, Wiltshire, Detry, & Brown, 2013; Wendt & Shafer, 2016). These facts taken together suggest that the Black church is a terrific place to reach Black women; men, perhaps not so much. Dr. Armstrong has recently published a book, “Blossoming Hope: The Black Christian Woman’s Guide to Mental Health and Wellness,” (2018), but where is that work for Black Christian men?

This study focused on patterns of mental health communication in African American Baptist denominations. Baptists are a plurality of African American Christians, but not a majority—they represent about 35% of the 3,394 Blacks surveyed by Pew, while Christians generally were 79% (Pew Research Center on Religion and Public Life, 2015b). The African Methodist Episcopal Church, Catholics and Jehovah’s Witnesses all have significant African American memberships (Pew Research Center on Religion and Public Life, 2015b). The Scriptural, institutional and cultural practices of these denominations cannot be assumed to be identical (or even that similar) to those of Baptists merely because they fall under the umbrella of Christianity. More work is needed on other ways of reaching African Americans on this topic, including the 16% who identified themselves as “nothing in particular” with respect to religion.

The third finding, that pastors frame mental health concerns with a faith lens while advocating worldly action, causes me to wonder if this is an effective practice that should be considered in therapeutic practice with this population. Interviews with African Americans who have recently sought mental health help, asking them what supported/influenced their decision to seek such help, would be ideal. That information could be used to design a survey on the same topic. The answers could inform both pastors and mental health providers about partnerships they might be well advised to enter.
Speaking of the faith lens, in this study I merely transmitted what the pastors I interviewed had to say in that vein. However, it is plain that a great deal of Scriptural exegesis is possible on the subject of mental health help. This is a task for a trained theologian, but the task does await. Koenig’s edited *Handbook of Religion and Mental Health* (1998) gives short shrift—in fact, a paragraph—to African Americans, and none at all to an Afrocentric hermeneutics, for which Dr. Stevenson explicitly called.

Both Union Baptist and Orange Grove have institutionalized systems to begin to address the mental health needs of their congregants within their walls. Union’s is the more formally branded of the two. Since they are both located in Durham and are working with some of the same health system resources, a case study comparing them both with recommendations for churches aspiring to such systems would have tremendous translational value.

Several churches, including Union Baptist, used the Stephen Ministry approach to caring for congregants. It is a “one-to-one lay caring ministry… which equip[s] and empower[s] lay caregivers—called Stephen Ministers—to provide high-quality, confidential, Christ-centered care to people who are hurting (Stephen Ministries, n.d.).” The Stephen Ministries website says that through its programs, “millions” of people have been helped. A search of the PubMed, PsycARTICLES, PsycINFO and ATLA Religion databases for “Stephen ministries” found 3 dissertations and 1 peer-reviewed article. That’s not much research for a program offering what could be called para-psychological services to millions of people. Medical, psychological and religious scholarly attention to this program is needed, beginning with a qualitative approach in part to delineate future research questions.

None of the pastors I interviewed mentioned the Mental Health First Aid approach (Kitchener & Jorm, 2002), which equips ordinary citizens to recognize people in need of mental
health services and respond to them, including helping them to get professional (biomedical and psychological) help. A comparison of the two in a Christian-influenced population could be tremendously productive. Does the faith understanding interact with, support or act against the biomedical understanding?

The fifth finding, that pastors felt they did not have enough knowledge to be as active as they wished to be in promoting mental health and wellness among their populations, calls for questions to be asked of several parties. Pastors should be asked what they’d like to know and how they’d like to learn it. Seminaries and Bible colleges should be asked what they teach, and how they’d like to cover it. Medical schools, social work schools and possibly departments of psychology should be asked if they are open to meeting the pastors’ expressed needs—possibly through continuing education units. Whatever the accreditation process for seminaries and Bible colleges, perhaps a standard for what Dr. Armstrong called psychoeducation should be added. And the question of who is going to pay for this process needs to be addressed; churches do not all have endowments and budget lines, and African American Missionary Baptist churches in particular, with their shallow hierarchies, may not have the kind of financial resources available to, for example, dioceses and presbyteries.

The sixth finding, that “sick pastors make sick people in the pews,” is delicate. Pastors could be asked to take a standardized mental health screening instrument, such as the Kessler-6 or Kessler-10, followed by interviews with those who scored over a certain threshold. Pastors such as Dr. Stevenson who have a reputation for working with wounded healers could be interviewed in depth. I found Dr. Stevenson through a snowball process—I do not know how one would deliberately go about seeking such people. I also hesitate to project what should be asked here, or what we could expect to learn. As mentioned earlier, I spoke to one pastor for this study.
who said he had been “in therapy” but did not acknowledge any mental health knowledge or experience. The interview was short. Either my skills were in abeyance that day, or he was unwilling to talk. Then again, Dr. Reed was very open about his personal mental health work. If nothing else, this study has shown me that where people and mental health are concerned, it is wise to expect the unexpected.

With regard to method, as cited earlier in this chapter, the addition of a coder and the establishment of intercoder reliability according to recent developments in the field of qualitative research (MacPhail, Khoza, Abler, & Ranganathan, 2015) will strengthen the work. The ultimate reinforcement, of course, is member-checking (Y. S. Lincoln & Guba, 1985); future research will include circulating this text to all those interviewed.

This chapter has addressed the limitations of this study and established an agenda for future research on this topic of communication on mental health within the African American Baptist church. The next and last chapter presents my conclusions on this topic.
CHAPTER 7: Conclusions

I began this study quite sure I was addressing a fairly simple cultural phenomenon and feeling equipped to do so. Forty-one interviews later, I can truly say, “It’s complicated.”

The African American Baptist church has monumental achievements to its credit. “It is the only thing we own,” Dr. Stevenson said, and in its role as the only institution in America under sole Black control, it has worked with other Black denominations to keep together the body and soul of an embattled people. Historically, politically, culturally, economically, educationally and socially, it has been at the forefront of the African American freedom struggle.

However, like all institutions, it must renew itself or die. Nothing in nature stays static forever. If nothing else, this study shows that the work continues. Dr. Harshaw’s observation of the church’s triune nature, existing in the Biblical, institutional and social/cultural dimensions; and Rev. York’s observation of its organization as pastor-led, deacon-led or congregation-led, both open new windows onto the possibilities of the church for future collaboration with psychology and psychiatry for the well-being of congregants and pastors alike.

In particular, an understanding of the competing imperatives of the Biblical, institutional and social/cultural aspects of the church can be used to combat congregations’ stigma against mental illness, actual and perceived. A church that can meet congregants’ needs from a spiritual base can free pastors to be transparent, strengthening individuals and institutions to be about the business of their faith. When congregants really are “too blessed to be stressed” and not just invested in looking like they are; when congregants in distress can believe that “God will solve all the problems” and that one of the ways He does is to make doctors available; then
congregants will have the strength and flexibility, the tools to live lives of growth and joy. Participation in the institution of the African American Baptist church will continue to be a source of strength, coming from an interpretation of Scripture that evolves with human understanding. Pain, with its redemptive value, will replace suffering; the human right of self-determination will replace the search for control. At least, this is what I hope.

As this study is firmly grounded in the position that stigma-driven silence on mental health is a problem and seeking mental health help when needed is a positive action, I have valorized pastoral transparency as the way forward for the Black Baptist church, spiritually, medically, socially, educationally, institutionally and culturally. I do not suggest that this will be easy. Two-thirds of those I contacted did not respond. But it is my hope that they may learn from the one-third who did. And the African American Baptist church has long experience with long struggles.

The fact that mental health services in the United States generally are under-available and under-resourced when available at all does not mitigate the findings of this study. According to symbolic interactionism and the Reasoned Action model, freer and more common communication about mental health help-seeking should contribute to increased help-seeking, or increased demand. To the extent that we are a market economy, increased demand should, over time, call forth increased supply. To the extent that the health care market is not a pure laissez-faire market but a heavily managed one, the voices of consumers empowered to improve their health care should weigh in favor of more providers. Also to the extent that the health care market is not a pure laissez-faire market but a heavily managed one, the voices of African American consumers empowered to improve their health care should weigh in favor of more African American providers, as well as consumers. Despite the good intentions of providers
prepared to broach the racial barrier (Sue, 1998), there is no substitute for providers who can share the lived experience of their clients.

Because at the end of the day, it is about voices; voices of African Americans free to express their health needs in the sureness that those needs will be met, voices of Black Baptists confident that their venerable and evolving institutions will support their flawed humanity in pursuit of salvation, in accordance with their Covenant, which was somewhere displayed in every church I visited: “We further engage to watch over one another in brotherly love; to remember each other in prayer; to aid each other in sickness and distress; [and] to cultivate Christian sympathy in feeling and courtesy in speech…” (National Baptist Convention, n.d.); such speech to be heard in—and outside of—the pastor’s study.
APPENDIX 1: Recruitment Letter

Below is the text of the letter mail-merged onto the letterhead of the School of Media and Journalism at the University of North Carolina and sent via postal mail.

May 19, 2017

Rev. First Name Last Name
Name of Church
Church Street Address
City, NC ZIP

Dear Rev. Last Name:

I’m writing to request 45 minutes to an hour of your time as a leader of your faith community.

I am a third-year African American Ph.D. candidate at the School of Media and Journalism at the University of North Carolina at Chapel Hill, working on a dissertation on African American communication about mental health and mental illness. You are surely aware that we as a community rely heavily on our faith leaders in these areas. I am investigating why and how this is so. Your experience in this area would be very valuable to my work.

I would like to come interview you in person. The interview would take an estimated 45 to 60 minutes, as mentioned, and I would need to audio-record it for later transcription. No names or identifying information about your congregants would be asked, and in all reports your name and the name of your church would be changed to a pseudonym that you choose. In appreciation of your time, which I know is highly sought, I can provide a $25 Amazon gift card.

This research project has been approved by the UNC-CH Institutional Review Board as study #16-0805. If you have more questions about the study prior to making a decision, I am happy to provide more information (my contact information is below), or you can contact the IRB directly, anonymously if you wish, at 919-966-3113 or at IRB_Subjects@unc.edu.

If you feel that you are not the best person in your organization for such an interview, I would be so grateful if you could recommend another who might be appropriate.

I will try to reach you in the next week or so to see if this interview can be arranged. If you would like to reach me in the meantime, my phone number is 123-456-7890—feel free to phone or text, or email me at jhporter@live.unc.edu.

Thank you so much for considering my request.

Sincerely,

Jeannette H. Porter
Roy H. Park Fellow, Ph.D. candidate
APPENDIX 2: Revised Interview Instrument

1. Please select a name for yourself to be used when this research is published.

2. Please tell me: what do you feel is (are) the guiding principle(s) of your ministry?

3. Please tell me about your church. If you pastor more than one, please tell me about the one where you spend more/the most time. If someone new wanted information about the church, how would you describe it?

4. Please tell me about your preparation for your current role in your church.

5. Please tell me about your role in your church. Is there such a thing as a typical weekday (not a worship day)? If so, can you describe it? If not, just describe what you do in your own words.

6. What would you say are the most common kinds of troubles that church members bring to you?

7. Understanding that every situation is different, how do you respond to those troubles? That is, what advice do you tend to give in these situations? Walk me through the last such situation, or a typical one.

8. Are there situations where members of your church family don’t come to you and you wish they would? Can you give me an example?

9. Can you tell me about some success stories of troubles resolved among your church members?

10. Have you ever felt the need to refer a church member with troubles to someone outside the church? How did you handle that?

11. Please imagine the three following hypothetical situations and walk me through your response to each:

   A. Mary is 31 years old and has been a member of your congregation since childhood. She comes to you saying she has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. She doesn’t feel like eating and has lost weight. She can’t keep her mind on her work and puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary’s boss, who is concerned about her lowered productivity and has spoken to her about it. Mary is anxious about this but doesn’t know what to do.

   B. Kevin is 24 and lives at home with his mother, Cassandra, who is a member of your congregation. He has had a few temporary jobs since finishing school but doesn’t have a job now. Over the last 6 months he has stopped seeing his friends, and has begun locking himself in his bedroom and refusing to eat with the family.
or to have a bath. Cassandra also hears him walking about in his bedroom at night while she is in bed. Even though she knows he is alone, she has heard him shouting and arguing as if someone else is there. When she tries to encourage him to do more things, Kevin whispers that he won’t leave home because he is being spied on by a neighbor. Cassandra feels certain he is not taking drugs because he never sees anyone or goes anywhere, but she is worried and doesn’t know what to do.

C. Angela is 29 and joined your congregation as a teenager. Her husband Reggie, who joined your congregation when he married Angela, has been unable to find a job for more than a year, and recently attempted to kill himself. Reggie was unsuccessful at this attempt and is home now. He is not considered a danger to himself or anyone else, but Angela is worried about her family’s ongoing situation.

12. Please tell me what you think constitutes mental health, and how you foster that in your congregation.

13. Please tell me what you know of mental illness generally, and how it might affect your congregation.

14. Why did you decide to meet with me and answer these questions, in light of your busy schedule?

15. Would you like to comment or follow up on any of the questions above? Ought I to have asked anything more?
APPENDIX 3: Missionary Baptist Belief Documents

What We Believe

Salvation Statement

In order to obtain true salvation there first must be a sense of trouble, conviction, and condemnation set up by God in the heart of the unsaved person. They must pray and seek God and repent of their sins until they know for themselves that God has forgiven and saved them. Man does not convict them and man cannot tell them when God forgives and saves them.

God is all powerful and can save the soul of one seeking Him any place, any time when God's conditions are met. However, we give opportunity for those desiring to seek and find God to come to the front for prayer. The pew sitting in the front facing the congregation is referred to as the "mourner's bench".

The unsaved person does not obtain salvation simply by "accepting", "believing", "making a decision for Christ", or "being baptized" as many teach today.

It is true that a person must "accept" and "believe" that Christ is who the Bible teaches He is. One must also believe that he is the rewarder of those that diligently seek him. This is a historical belief and is definitely required by one seeking God. When one is saved, he/she receives a new, regenerated soul as stated by Jesus in John chapter 3 and must be under those terms stated to Nicodemus by Jesus Christ, (born again). It is true that a person must "decide" to seek Christ; he/she must be determined to seek until he/she finds Him.

We do not believe in using "Repeat after me" prayers nor in reading scripture passages to them to convince them they have prayed, trusted, or believed. We condemn the practice known as "The Roman Road" and all other "easy believism" practices. These practices substitute a historical belief for a belief from the heart.

We do pray with the person seeking God and we do believe in encouraging them according to the leadership of the Holy Spirit.

When God saves the individual, the individual knows, without anyone telling them - including the preacher, loved ones, or any friend.

Articles of Faith

ARTICLE 1. OF THE SCRIPTURES
We believe that the Holy Bible was written by men divinely inspired, and is a perfect treasure of heavenly
instruction; that it has God for its author, salvation for its end, and truth without any mixture of error for its matter; that it reveals the principles by which God will judge us; and therefore is, and shall remain to the end of the world, the true center of Christian union, and the supreme standard by which all human conduct, creeds, and opinions should be tried.

ARTICLE II. OF THE TRUE GOD
We believe that there is one, and only one, living and true God, an infinite, intelligent Spirit, whose name is JEHovaH, the Maker and Supreme Ruler of heaven and earth; inexpressibly glorious in holiness, and worthy of all possible honor, confidence, and love; that in the unity of the Godhead there are three persons, the Father, the Son, and the Holy Ghost; equal in every divine perfection, and executing distinct but harmonious offices in the great work of redemption.

ARTICLE III. OF THE FALL OF MAN
We believe that man was created in holiness, under the law of his Maker; but by voluntary transgression fell from that holy and happy state; in consequence of which all mankind are now sinners, not by constraint but choice; being by nature utterly void of that holiness required by the law of God, positively inclined to evil; and therefore under just condemnation to eternal ruin, without defense or excuse.

ARTICLE IV. OF THE WAY OF SALVATION
We believe that the salvation of sinners is wholly of grace; through the mediatorial offices of the Son of God; who by the appointment of the Father, freely took upon him our nature, yet without sin; honored the divine law by his personal obedience, and by his death make a full atonement for our sins; that by having risen from the dead, he is now enthroned in heaven; and uniting in his wonderful person the tenderest sympathies with divine perfections, he is every way qualified to be a suitable, a compassionate, and an all-sufficient Savior.

ARTICLE V. OF JUSTIFICATION
We believe that the great gospel blessing which Christ secures to such as believe in him is justification; that justification includes the pardon of sin, and the promise of eternal life on principals of righteousness that it is bestowed, not in consideration of nay works of righteousness which we have done, but solely through faith in the
Redeemer's blood; by virtue of which faith his perfect righteousness is freely imputed to us of God; that it brings us into a state of most blessed peace and favor with God, and secures every other blessing needful for time and eternity.

ARTICLE VI. OF THE FREENESS OF SALVATION
We believe that the blessings of salvation are made free to all by the gospel; that it is the immediate duty of all to accept them by a cordial penitent and obedient faith; and that nothing prevents the salvation of the greatest sinner on earth, but his own inherent depravity and voluntary rejection of the gospel; which rejection involves him in an aggravated condemnation.

ARTICLE VII. OF GRACE IN REGENERATION
We believe that in order to be saved, sinners must be regenerated, or born again; that regeneration consists in giving a holy disposition to the mind; that it is effected in a manner above our comprehension by the power of the Holy Spirit, in connection with divine truth, so as to secure our voluntary obedience to the gospel; and that its proper evidence appears in the holy fruits of repentance, and faith, and newness of life.

ARTICLE VIII. OF REPENTANCE AND FAITH
We believe that repentance and faith are sacred duties, and also inseparable graces, wrought in our souls by the regenerating Spirit of God; whereby being deeply convinced of our guilt, danger and helplessness, and of the way of salvation by Christ, we turn to God with unfeigned contrition, confession, and supplication for mercy; at the same time heartily receiving the Lord Jesus Christ as our Prophet, Priest, and King, and relying on him alone as the only and all sufficient Savior.

ARTICLE IX OF GOD'S PURPOSE OF GRACE
We believe that election is the eternal purpose of God, according to which He graciously regenerates, sanctifies and saves sinners; that being perfectly consistent with the free agency of man, it comprehends all the means in connection with the end; that it is a most glorious display of God's sovereign goodness, being infinitely free, wise, holy, and unchangeable; that it utterly excludes boasting, and promotes humility, love, prayer, praise, trust in God, and active imitation of his free mercy; that it encourages the use of means to the highest degree; that it may be
ascertained by its effects in all who truly believe the gospel; that it is the foundation of Christian assurance; and that to ascertain it with regard to ourselves demands and deserves the utmost diligence.

ARTICLE X. OF SANCTIFICATION
We believe that sanctification is the process by which, according to the will of God, we are made partakers of his holiness; that it is a progressive work; that it is begun in regeneration; and that it is carried on in the hearts of believers by the presence and power of the Holy Spirit, the Sealer and Comforter, in the continual use of the appointed means especially, the word of God, self-examination, self-denial, watchfulness, and prayer.

ARTICLE XI. OF THE PERSEVERANCE OF SAINTS
We believe that such only are real believers as endure unto the end; that their persevering attachment to Christ is the grand mark which distinguishes them from superficial professors; that a special providence watches over their welfare, and that they are kept by the power of God through faith unto salvation.

ARTICLE XII OF THE HARMONY OF THE LAW AND THE GOSPEL
We believe that the law of God is the eternal and unchangeable rule of his moral government; that it is holy, just, and good; and that the inability which the Scriptures ascribes to fallen men to fulfill its precepts, arises entirely from their love of sin; to deliver them from which, and to restore them through a Mediator to unfeigned obedience to the holy law, is one great end of the gospel, and of the means of grace connected with the establishment of the visible church.

ARTICLE XIII. OF A GOSPEL CHURCH
We believe that a visible church of Christ is a congregation of baptized believers, associated by covenant in the faith and fellowship of the gospel; observing the ordinances of Christ, governed by his laws; and exercising the gifts, rights, and privileges invested in them by his work; that its only scriptural officers are bishops or pastors and deacons, whose qualifications, claims, and duties are defined in the Epistles to Timothy and Titus.

ARTICLE XIV. OF BAPTISM AND THE LORD'S SUPPER
We believe that Christian baptism is the immersion in water of a believer, into the name of the Father, Son, and Holy Ghost; to show forth in solemn and beautiful emblem, our faith in the crucified, buried, and risen Savior, with
it's effect, in our death to sin and resurrection to a new life; that it is a prerequisite to the
privileges of a church
relation; and to the Lord's supper, in which the members of the church by the sacred use of
unleavened bread and
the fruit of the vine, are to commemorate together the dying love of Christ; preceded always by
solemn self
examination.

ARTICLE XV OF THE CHRISTIAN SABBATH
We believe that the first day of the week is the Lord's Day, or Christian Sabbath; and is to be
kept sacred to
religious purposes, by abstaining from all secular labor and sinful recreations, by the devout
observance of all the
means of grace, both private and public; and by preparation for the rest that remaineth for the
people of God.

ARTICLE XVI. OF CIVIL GOVERNMENT
We believe that civil government is of divine appointment, for the interests and good order of
human society; and
that magistrates are to be prayed for, conscientiously honored, and obeyed; except only in things
opposed to the will
of our Lord Jesus Christ, who is the only Lord of the conscience, and the Prince of the kings of
the earth.

ARTICLE XVII OF THE RIGHTEOUS AND THE WICKED
We believe that there is a radical and essential difference between the righteous and the wicked;
that such only
as through faith are justified in the name of the Lord Jesus, and sanctified by the Spirit of our
God, are truly righteous
in his esteem; while all such as continue in impenitence and unbelief are in his sight wicked, and
under the curse; and
this distinction holds among men both in and after death.

ARTICLE XVIII OF THE WORLD TO COME
We believe that the end of this world is approaching; that at the Last Day, Christ will descend
from heaven, and
raise the dead from the grave to final retribution; that a solemn separation will then take place;
that the wicked will
be adjudged to endless punishment, and the righteous to endless joy; and that this judgment will
fix forever the final
state of men in heaven and hell, on principles of righteousness.
Church Covenant

Having been led, as we believe, by the Spirit of God to receive the Lord Jesus Christ as our Savior, and on the profession of our faith, having been baptized in the name of the Father and of the Son, and of the Holy Ghost, we do now in the presence of God, angels, and this assembly, most solemnly and joyfully enter into covenant with one another, as one body in Christ.

We engage therefore, by the aid of the Holy Spirit, to walk together in Christian love; to strive for the advancement of this church in knowledge, holiness, and comfort; to promote its prosperity and spirituality to sustain its worship, ordinances, discipline, and doctrine; to contribute cheerfully and regularly to the support of the ministry, the expenses of the church, the relief of the poor, and the spread of the gospel through all nations.

We also engage to maintain family and secret devotion; to religiously educate our children; to seek the salvation of our kindred and acquaintances; to walk circumspectly in the world; to be just in our dealings, faithful in our engagement, and exemplary in our deportment; to avoid all tattling, backbiting, and excessive anger; to abstain from the sale and use of intoxicating drinks as a beverage, and to be zealous in our efforts to advance the kingdom of our Savior.

We further engage to watch over one another in brotherly love; to remember each other in prayer; to aid each other in sickness and distress; to cultivate Christian sympathy in feeling and courtesy in speech; to be slow to take offense, but always ready for reconciliation, and mindful of the rules of our Savior to secure it without delay.

We moreover engage that when we remove from this place, we will as soon as possible unite with some other church, where we can carry out the spirit of this covenant and the principles of God's Word.

APPENDIX 4: Stephen Ministries Information

How and Where the Training Happens
Stephen Minister training:
- takes place in your congregation
- is led by your congregation’s Stephen Leaders
- is typically taught in 20 weekly sessions along with a weekend retreat
- combines pre-class reading, devotions, lecture, video presentation, discussion, and skill practice

What the Training Covers
Initial training takes place before Stephen Ministers are commissioned and assigned to their first care receivers. Continuing education takes place during the months after commissioning.

Initial Training
1. The Person of the Caregiver
2. Feelings: Yours, Mine, and Ours
3. The Art of Listening
4. Distinctively Christian Caring
5. Process versus Results in Caregiving
6. Assertiveness: Relating Gently and Firmly
7. Maintaining Boundaries in Caregiving
8. Crisis Theory and Practice
9. Confidentiality
10. Telecare: The Next Best Thing to Being There
11. Using Mental Health Professionals and Other Community Resources
12. Ministering to Those Experiencing Grief
13. Dealing with Depression: The Stephen Minister’s Role
14. Helping Suicidal Persons Get the Help They Need
15. Bringing the Caring Relationship to a Close
16. Supervision: A Key to Quality Christian Care
17. How to Make a First Caring Visit
18. Follow Me

Continuing Education
19. Ministry to the Dying and Their Family and Friends
20. Caring for People before, during, and after Hospitalization
21. Ministering to Those Experiencing Losses Related to Aging
22. Ministering to Persons Needing Long-Term Care
23. Ministering to Those Experiencing Divorce
24. Crisis of Pregnancy and Childbirth
25. Providing Spiritual Care

REFERENCES


