Alternative Mental Health Services: The Role of the Black Church in the South

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Objectives. This study determined the extent to which churches in the South were providing mental health and social services to congregations and had established linkages with formal systems of care.

Methods. A computer-assisted telephone interview (CATI) survey was conducted with pastors from 269 Southern churches.

Results. Black churches reported providing many more services than did White churches, regardless of urban or rural location. Few links between churches and formal provider systems were found, irrespective of the location—urban or rural—or racial composition of the churches.

Conclusions. Results are discussed in terms of the potential for linking faith communities and formal systems of care, given the centrality of the Black church in historical context. (*Am J Public Health.* 2002;92:1668–1672)

The Black church has served a dominant role as an informal social service provider throughout its history,[1,2] and its utility as an entry point for formal services has been the topic of considerable research.[3,4] Studies suggest that churches provide a wide range of prevention and treatment-oriented programs that contribute significantly to the psychological and physical well-being of their congregants. Services provided include substance abuse assistance as well as health screenings, education, and support.[3,5]

The church and individuals associated with it have often been identified as valuable counterparts in attempts to link formal and informal systems of care for the benefit of underserved or marginalized persons.[3–6] This association is prompted, in part, by studies documenting the utility of lay persons, natural helpers, and especially religious leaders in the treatment of mental illness in a variety of settings.[7–9] The focus on religious leaders has grown out of findings that paraprofessional counselors are often as effective as professionals in fostering positive change in recipients of services.[9,10]

The importance of the Black church has been documented in 4 areas of community medicine: primary care delivery, community mental health, health promotion and disease prevention, and health policy.[11] This documentation highlights the church's potential as a valuable collaborator with formal care systems to maximize preventive and treatment-oriented services. Eng et al.[5] documented the development and impact of church health care programs in which pastors asked congregants to identify confidants within the congregation who could serve as health advisors. These "natural helpers" received training on resource mobilization, preventive and primary self-care skills, organization of educational and service-oriented activities, and interaction with health professionals. The roles of lay advisors were shaped by the needs and opinions of the congregation and were successful in fostering social support, linkage with formal care systems, and promotion of general well-being.[5] The roles of churches and the religious community in general, however, have been much less frequently described in the mental health literature.

In the early 1970s, rural individuals became more widely recognized as an underserved population despite myths regarding the superior quality of rural life. This recognition grew out of investigations of psychiatric utilization and morbidity in rural areas; these investigations continue to evolve and contribute to the understanding of rural–urban differences in mental health status.[2] Problems endemic to rural mental health service delivery are attributable to social, economic, and geographic factors. Investigation of the relative contribution of these factors has been complicated by the difficulty in disentangling the effects of poverty from effects of race and social isolation associated with rural life in the South. In addition, when treatment is received, the quality of care typically is suboptimal, particularly among minorities.[12,13] Although this situation is discouraging, it is hardly surprising given that most rural counties lack even a single doctoral-level mental health professional and that only 3% of licensed psychiatrists practice in rural areas.[14]

The interaction between race and attitudes greatly affects an individual's decision to seek mental health care. Furthermore, there is theoretical interest in the ability of White professionals to provide services to Black consumers. Early theorists argued that White service providers had limited ability to be of help to Black consumers because of their lack of understanding of Black culture, history, and the experiences of Blacks living in a largely White society.[15] This position implied that Blacks are less likely to trust White therapists and to seek their services, and thus it is in the best interest of Black consumers to receive services from Black therapists. One study confirmed that the majority of Black clients indicated a preference for Black therapists. However, that preference was based on judgments of professional competence and attitudes in addition to cultural and racial compatibility.[16] Interest in this line of research continues to grow in light of findings that Blacks are less likely than Whites to use outpatient mental health services even when the effects of socioeconomic status and insurance coverage are held constant.[17] These findings reinforce the need to consider cultural and attitudinal differences as well as systems-level barriers as alternative explanations of utilization patterns.

A client's racial identity has been shown to be a major factor in predicting the success of establishing a positive therapeutic relation-

ship.[18–23] Racial identity means more than recognition of one's racial background; it includes a sense of the impact of race on intrinsic and interpersonal development. Practitioner cultural competence involves a recognition and acceptance of nonnormative behaviors in minority populations. The importance of therapist sensitivity and cultural competence is underscored by the cultural responsiveness hypothesis,[24] which asserts that the efficacy of psychotherapy is a function of a therapist's ability to communicate an understanding of cultural background. Lack of cultural responsiveness may account for observed racial differences in help-seeking, diagnosis, and premature termination of treatment. Blacks are more tolerant of psychological distress, less likely to initiate treatment, more likely to receive diagnoses of schizophrenia and psychosis, and more likely to terminate treatment prematurely than White counterparts.[24–27]

Holistic understanding of psychiatric morbidity and service utilization is fostered by examination of individual-, interpersonal-, and systems-level factors. Factors at the individual level include client characteristics that predict service utilization and treatment outcomes. Individual-level factors have been the subject of considerable research and include race or ethnicity, religiosity, beliefs about mental health (e.g., stigma), and coping styles.[17,28] At the interpersonal level, social support, stigma, and social distance influence willingness to initiate treatment and success in adhering to treatment recommendations. Social support in rural areas is central to the management of mental illness, in part because of limited access to specialty services, which is reflected in networks of informal care providers that are common in rural areas. Extended family, neighbors, and clergy often serve as alternatives to costly or inaccessible inpatient and outpatient services.[11] The effectiveness of natural helpers in promoting positive change in mental health has been documented by several researchers.[8,9]

The social support provided by natural helpers in rural Black communities is motivated by shared beliefs about mental illness and the health care system. Stigma is clearly a powerful predictor of poor utilization of care that exerts influence at both the individual and the interpersonal level. Stigma may increase reliance on social support, informal care networks, and self-reliance and also decrease the probability of a search for formal services. This hypothesis is supported by a study of help-seeking for depression that found that Blacks tolerated higher levels of psychological distress due to stigma and fear of hospitalization.[29] Those fears and tolerance for distress result in help-seeking from specialty providers only in extreme situations, which may explain the increased emergency mental health service utilization and decreased levels of case management and outpatient services among Blacks compared with Whites, Asians, and Hispanics.[27] Fear and stigma may lead rural Blacks to minimize symptoms and rely on informal support systems, frame symptoms in somatic terms, and seek ambulatory and emergency care.[30,31] Neighbors observed that poorer Blacks were more likely than wealthier Blacks to experience severe physical, interpersonal, and emotional problems. Despite suffering greater severity of emotional problems, Blacks were 15% less likely than Whites to seek help for emotional problems than for economic, physical, or interpersonal problems.[30] Furthermore, the likelihood of many rural Blacks to seek professional assistance is limited by geographic and economic barriers that they face.

In the present study, we hypothesized that rural churches would provide fewer social and mental health services than their urban counterparts and that they would have fewer links with formal systems of care.[1,2] Because of the centrality of the church in the Black community and the historic exclusion of Blacks from other formal service systems (e.g., schools, hopsitals), we hypothesized that Black churches would provide more social and mental health services but would have fewer links with formal systems of care than White churches.

METHOD

Pretesting and Development

The survey instrument was developed and pretested for use with the Computer-Assisted Telephone Interview (CATI) system. Respondents were asked for information about church-level demographics (location, size of congregation, racial composition of congregation, church denomination, average attendance at weekend services, number of services held each week, annual church budget, and date the church was founded). Respondents were asked what problems they considered to be of primary importance among church members and specifically whether they had ever dealt with depression, delusions, paranoia, dementia, Alzheimer's disease, nervous breakdowns, or attempted suicide in members of their congregations. Respondents also were asked to assess the degree to which the church offered support services to address these problems and the types of links that existed with local hospitals, physical or mental health care providers, and support services such as Alcoholics Anonymous. Questions were asked about the number of referrals made to and from these support services and providers.

We constructed 4 scales to measure the number and type of mental health services offered through the church and calculated 2 variables to measure referrals made to and from the church. The first scale, *Problems*, measured the degree to which respondents had dealt with various mental health problems in their congregational communities in the past 2 years. A score was calculated for whether the respondents had dealt with (1) depression, (2) delusion or paranoia, (3) dementia or Alzheimer's disease, (4) nervous breakdown, (5) suicide, and (6) other mental health problems. Possible scores ranged from 0 to 6, with the total mean for the sample being 2.92 (SD = 1.74).

The second scale, *Programs for Adults*, measured the total number of mental health programs offered through the church. A score was calculated for whether churches offered programs for (1) alcohol and substance abuse, (2) marital counseling, (3) sex education and counseling, (4) domestic violence counseling, and (5) sexual assault counseling. Possible scores ranged from 0 to 5, with the total mean for the sample being 2.59 (SD = 1.34).

The third scale, *Programs for Children*, measured the frequency of support services offered specifically for children. A score was calculated for whether churches offered (1) weekly programs, (2) monthly programs, (3) group meetings several times a year,

(4) individual conferences, (5) family conferences, and (6) other support services for children. Possible scores ranged from 0 to 6, with the total mean for the sample being 1.14 (SD = 1.57).

The fourth scale, *Programs for Teenagers*, measured the frequency of support services offered to teens. A score was calculated for whether churches offered (1) weekly programs, (2) monthly programs, (3) group meetings several times a year, (4) individual conferences, (5) family conferences, and (6) other support services for teenagers. Possible scores ranged from 0 to 6, with the total mean for the sample being 1.37 (SD = 1.55).

We measured the exchange of referrals between the church and formal health and mental health services by means of 2 variables. *Referrals In* reflected referrals made to the church that originated from formal care providers. The distribution of scores ranged from 0 to 4, with the mean for the sample = .85 (SD = 1.16). *Referrals Out* measured the number of referrals made by the church to formal support services. The distribution of scores ranged from 0 to 4, with the mean for the sample = 1.05 (SD = .89).

Sampling Design and Method

For our purposes, the South was defined as Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. To locate rural Black churches, a cluster sampling technique was used by which geographic regions with known demographics were selected and a sample of churches drawn from within those regions.

A total of 2867 churches were targeted for contact from the national listing. Attempts to contact 2657 of these churches resulted in 269 completed interviews. There were clear differences in interview completion rates among the church categories. White churches in urban areas were the easiest to reach, with about 6 such churches targeted for every completed interview. For urban Black churches and rural White churches, the ratio of targeted to completed interviews was approximately 8 to 1. Rural Black churches were the most difficult category to reach, with about 14 churches targeted for each completed interview. This result was due in part to a slightly higher rate of refusal among rural Black pastors to complete interviews, although locating accurate telephone numbers and actually reaching someone was by far the greatest barrier. These churches generally had no full-time staff on the premises.

TABLE 1—Distribution of Churches in Final Sample, by Church Type

Church Type	n	Percentage
Rural Black	131	48.7
Rural White	43	16.0
Urban Black	50	18.6
Urban White	45	16.7
Total	269	100.0

A useful feature of this sampling was that the White churches were drawn from the same geographic areas as the Black churches. In other words, the study did not compare White churches in suburban areas to Black churches in the inner city or more remote rural areas. Rather, the churches were all from the same set of zip codes, and the White churches were drawn from a subset of the zip codes that supplied our Black church samples. Black churches were oversampled for use in analyses not presented here.

RESULTS

The first step of our analysis involved calculation of descriptive statistics for the entire sample and for major subgroups. Respondents represented a total of 269 churches, of which 181 were predominantly Black and 88 were predominantly White. Of the total, 95 churches were located in urban areas and 174 in rural areas. Among total respondents representing urban White churches (45), urban Black churches (50), rural White churches (43), and rural Black churches (131) (Table 1), 231 were pastors or ministers, 10 were deacons, and 28 had other leadership positions within their churches. All of the 269 respondents classified their congregations as Protestant. Of these, 87 were Baptist, 76 were one of the various independent Protestant denominations, 57 belonged to the Church of God, and the remaining 49 were Methodist.

There were substantial differences in church size and annual budget. A 2 × 2 factorial analysis of variance (ANOVA) was performed to test differences between Black and White as well as urban and rural churches. For church size, the main effect for racial composition of churches was nonsignificant ($F[1264] = .027$; P = NS). However, the main effect for location was significant ($F[1264] = 35.83$; $P < .001$), with rural churches being substantially smaller than urban churches. The interaction between racial composition of the churches and location was nonsignificant ($F[1264] = .003$; P = NS). For annual church budget, the main effect for racial composition of churches was significant ($F[1249] = 12.34$; $P = .001$), with White churches reporting substantially larger annual budgets than Black churches. The main effect for location was also significant ($F[1249] = 49.81$; $P < .001$), with urban churches reporting substantially larger budgets than rural churches. The interaction between the racial composition of the churches and their location was nonsignificant ($F[1249] = .722$; P = NS). In light of these findings, church size and annual budget were used as covariates in the subsequent analyses.

Next, a multivariate analysis of variance (MANOVA) was performed using the 4 scales (Problems, Programs, Programs for Children, Programs for Adolescents) with church size and budget as covariates. The main effect for location was nonsignificant ($F[6213] = 1.142$; $P = .209$). However, the main effect for racial composition of churches was significant ($F[6213] = 4.53$; $P < .001$), with Black churches offering significantly more services to their congregations than White churches. The interaction between the racial composition of the churches and their urban or rural location was nonsignificant ($F[6213] = .705$; $P = .646$).

For the variables measuring the number of referrals made between the church and other forms of formal support services, no effects were found to be statistically significant. For Referrals In, 82.9% of the churches surveyed reported receiving less than 10 referrals in the past year. Similarly, for Referrals Out, 84.7% of respondents reported making less than 10 referrals to formal support services. However, the modal response for each variable was zero, which

TABLE 2—Univariate Effects From Multivariate Analysis of Variance—MANOVA [(*df* Between Groups/*df* Within Cases), F value]

Variable	Main Effect for Racial Composition of Church	Main Effect for Location	Interaction Effect Between Racial Composition of Church and Location
Problems	(1240), .002	(1240), 1.34	(1240), 2.17
Programs	(1241), 17.82*	(1241), 1.06	(1241), .445
Programs for children	(1237), 12.73*	(1237), .618	(1237), .384
Programs for teenagers	(1236), 9.0**	(1236), 2.04	(1236), 2.88
Referrals out	(1245), .546	(1245), 3.29	(1245), .030
Referrals in	(1235), 1.28	(1235), .136	(1235), .047

*$P < .001$; **$P < .01$.

suggests that all churches generally lack links with formal providers of health and mental health services in either the specialist or generalist sector. The simple effects that make up the multivariate result are given in Table 2.

DISCUSSION

Community organizations including churches provide informal services in the de facto mental health delivery system, particularly in rural areas.[32] The role of churches and pastors in provision of these services is well recognized among lay and professional health care providers. However, the place of the church in the delivery of mental health care is not well understood. Churches occupy a unique position because they offer counseling and guidance along spiritual lines and often provide support in a nonstigmatizing way. Few studies have examined the relative merits of receiving services through churches and how churches link with formal systems of care when congregants need more specialized services.

Some of the difficulty in establishing functional relationships between churches and other providers is structural and has its roots in historic antecedents. In the South, but also elsewhere, churches have been divided along racial and ethnic lines. Black churches are overwhelmingly Black, with few White members, and White churches are equally segregated. Indeed, the integrated church is a rarity. The quasi-political role that churches played during the civil rights movement in the middle part of the last century—often serving as the primary social and political outlet for Whites and Blacks alike—no doubt reinforced this pattern.[33]

A second barrier to establishing relationships between churches and formal providers is incongruent conceptualizations of the nature, cause, and treatment of mental health problems within the framework of religion, as contrasted with traditional mental health services. An environment of distrust between mental health professionals and church leaders has developed. Clergy have not enthusiastically endorsed ideologies expounded by formal mental health providers or referred individuals for formal mental health services. At the same time, mental health specialists have characteristically made little or no attempt to include clergy or church members in their treatment for individual members of congregations when in fact such links could improve outcomes.

Despite this historic separation, any observation of day-to-day life, particularly rural life, highlights the naturally expanding and contracting patterns of interaction which involve informal networks that frequently include pastors and other church leaders. As mental health services research moves out of its infancy, the myopic view of examining mental health services only through the lens of specialty providers and the formal health care system is changing. This view is slowly giving way to a broadened understanding of how different types of people with varying types of problems seek help.

CONCLUSIONS

The results of this survey of Black and White churches reveal continuing gaps between formal providers and clergy. Black churches were found to provide many more supportive programs than White churches, both in terms of numbers and in terms of types of programs offered. This effect was robust even after controlling for differences in church size and annual budget. The result for rural location was not significant after controlling for large differences in annual budgets and congregation sizes between urban and rural churches.

Linkage between any churches and specialty mental health providers was starkly absent. Clergy reported very little interaction with the formal mental health service delivery system. The formal system of care may not view referrals from clergy in the same way as referrals from other professional groups, and there is anecdotal evidence that some antipathy and mistrust exists between mental health professionals and clergy. Future efforts at building coalitions between providers of health and mental health services and faith communities should focus on this apparent absence of communication. Further research is needed to more fully illuminate the barriers to a more free exchange between these groups.

Although it is not possible to fully construct a data-driven explanation for these findings, we suggest that urban pastors may have more formal education and counseling preparation than their rural counterparts and may be more attuned to dealing with mental health problems. The fact that Black churches provide more supportive programs than do White churches implies that these services may not be as accessible to Black congregation members in the community at large as they are to Whites. It may also be that Black churches have a clearer image of themselves as service providers, and that this image is not dependent on linkage with other agencies. It is also possible that community services that are available to Blacks are less acceptable. It seems clear that Black and White churches perceive their missions differently. The continuing gap in referrals between mental health service providers and clergy high-

lights a potential site for strengthening the linkage between pastors and the formal service delivery system. Black individuals are clearly at a disadvantage if they need mental health services. Rural individuals are reluctant to seek specialized mental health care and appear to be more willing to seek general health care from primary care providers; there are not only few rural mental health specialists but also few supportive programs provided by other community organizations. One approach to improving mental health services for Blacks would be to link pastors and other church leaders to primary care providers, thereby strengthening the capacity for this network to provide effective mental health problem identification and treatment.

Creative approaches to effectively link formal health providers with informal networks are essential to ensure appropriate, accessible, and effective health and mental health care. Enlisting the expertise and complementary service capacity of churches and health providers in the design and provision of community-relevant integrated health and mental health care is a fruitful strategy in these critical times.

Churches in the South are well recognized as central to the social order and character of their region. They are strongholds of cultural and community identity and, because of congregational commitment, hold great promise for influencing the attitudes and behaviors of members. The lack of available services and the stigma associated with mental health problems in rural areas are complex problems. Any solution will require creative partnerships between social organizations, such as churches and formal health care providers, with expertise in providing informal care. ■

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Contributors

M. Blank and J. Fox conceived the study and, together with T. Guterbock, developed the interview. T. Guterbock supervised the data collection. M. Blank and M. Mahmoud analyzed the data. All authors contributed to the conceptualization and writing of the article.

Acknowledgements

This research was completed at the Southeastern Rural Mental Health Research Center, University of Virginia, with support from the National Institute of Mental Health (P50MH49173).

Human Participant Protection

Institutional review board approval for the conduct of this study was obtained through the Human Investigation Committee of the University of Virginia Health Sciences Center.

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