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Ministers' Perceptions of Church-Based Programs to Provide Depression Care for African Americans

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ABSTRACT *African Americans, compared with white Americans, underutilize mental health services for major depressive disorder. Church-based programs are effective in reducing racial disparities in health; however, the literature on church-based programs for depression is limited. The purpose of this study was to explore ministers' perceptions about depression and the feasibility of utilizing the church to implement evidence-based assessments and psychotherapy for depression. From August 2011 to March 2012, data were collected from three focus groups conducted with adult ministers (n=21) from a black mega-church in New York City. Using consensual qualitative research to analyze data, eight main domains emerged: definition of depression, identification of depression, causal factors, perceived responsibilities, limitations, assessment, group interpersonal psychotherapy, and stigma. A major finding was that ministers described depression within a context of vast suffering due to socioeconomic inequalities (e.g., financial strain and unstable housing) in many African American communities. Implementing evidence-based assessments and psychotherapy in a church was deemed feasible if principles of community-based participatory research were utilized and safeguards to protect participants' confidentiality were employed. In conclusion, ministers were enthusiastic about the possibility of implementing church-based programs for depression care and emphasized partnering with academic researchers throughout the implementation process. More research is needed to identify effective, multidisciplinary interventions that address social inequalities which contribute to racial disparities in depression treatment.*

KEYWORDS *African Americans, Church, Depression, Mental health services, Community-based participatory research*

INTRODUCTION

Major depressive disorder (MDD) is one of the most disabling and prevalent psychiatric disorders in the USA.[1] Epidemiological studies show that 14–17 % of Americans are diagnosed with MDD at some point in their lives.[1,2] African Americans, compared with white Americans, have slightly lower or similar rates of lifetime MDD.[2–4] Nevertheless, African Americans with MDD have a more persistent and debilitating course of illness relative to their white counterparts.[3,5]

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Despite national initiatives to reduce racial disparities in mental health care,[6,7] African Americans continue to under-utilize mental health services compared with white Americans.[8–11] Factors associated with these disparities include stigma of mental illness,[12] lack of access,[13] financial cost,[13], and distrust of providers.[14] Given the disabling nature of MDD and enduring racial disparities in care, identifying alternative treatment strategies is a pressing public health priority.

Research suggests that community-based interventions hold promise for reducing racial disparities in depression treatment.[15,16] The Black Church, classically defined as the set of seven predominantly African American denominations of the Christian faith,[17] is a prominent, easily accessible, and trusted institution in many African American communities.[17,18] The Black Church has a history of confronting racial disparities by providing health and social services to community members.[17,19] Church-based health programs are designed to provide measurable benefits to individuals through education, screening, and treatment.[19,20] Such programs have effectively improved health outcomes for cancer screening,[21–23] dietary change,[21,24–28] weight loss, [21,26,28,29] smoking cessation,[30] and diabetes treatment.[31] However, the literature on church-based programs for mental disorders is limited. Our group conducted a systematic review of church-based programs for mental disorders among African Americans and found only eight empirical studies.[32] Depression was the primary outcome in only one of these studies.[33]

Clergy provide an invaluable role in the US mental health care delivery system.[34] Findings from the National Comorbidity Survey, a nationally representative general population survey of 8,098 adults in the USA, show that a higher percentage of people sought help for mental disorders from clergy (25 %) compared with psychiatrists (16.7 %) or general medical doctors (16.7 %).[34] African American ministers, in particular, are considered trusted "gatekeepers" for referring community members to mental health professionals.[35,36] Neighbors et al. found that 50 % of African Americans utilizing only one source of mental health care sought help from clergy providers.[35] Despite the indispensable mental health services provided by African American ministers, qualitative data about their roles in depression care are scarce.[37] Focus groups are an effective qualitative research method for investigating complex behaviors and can help identify emerging issues for intervention planning.[38,39]

Thus, the purpose of this study was to conduct focus groups with ministers from one of the largest black churches in the US to learn their views on depression and the feasibility of implementing church-based programs for MDD. We specifically sought to understand the minister's perspectives on distributing a validated depression screening assessment[40] to parishioners in the church. We also explored the ministers' opinion about conducting an evidence-based treatment for MDD, interpersonal psychotherapy (IPT) delivered in a group,[41–43] at the church. This intervention was selected because it has been shown to be effective among similar populations,[44,45] including two studies conducted in groups with community members in rural Uganda.[46–48]

METHODS

Sample and Recruitment

All study procedures were approved by the Institutional Review Board of the New York State Psychiatric Institute. This study was conducted at a predominantly African American, Methodist denomination, mega-church in New York City. Mega-churches

are defined as having at least 2,000 worshippers throughout the course of a weekend. As such, there are over 1,200 mega-churches in the USA.[49] Persons identified as ministers (n=65) at the church were eligible to participate in the focus group study regardless of race/ethnicity or gender. Additional inclusion criteria were age 18 years and older, English speaking, and able to give informed consent. Exclusion criteria included inability to provide signed informed consent and any significant medical condition compromising ability to participate. Men and women were recruited equally.

Study participants were recruited from a convenience sample during the ministers' regularly scheduled, monthly administrative meeting on 11 June 2011. The research team gave a detailed power-point presentation that described the study objectives and process for conducting the focus groups. A total of 32 ministers initially agreed to participate in the study. However, eleven of these ministers decided not to participate due to scheduling conflicts, resulting in 21 of 32 eligible ministers who ultimately participated (65.6 %). All ministers who participated provided signed informed consent. No demographic information was collected from the ministers who did not participate in the focus groups.

Procedure

A semi-structured, open-ended question guide based on the study objectives was developed. Prior to conducting the focus groups, researchers modified the question guide based on feedback from members of the church's Health Ministry, a committee of congressional members who promote health-related activities at the church.[50] The final question guide is shown in Table 1.

Each of the focus groups (n=3) was facilitated by the primary investigator, an African American male psychiatrist. All focus groups were conducted on-site at the church in the pastoral library between 13 August 2011 and 10 March 2012. The number of participants in each focus group ranged from three to ten ministers. The group facilitator initiated the open-ended interview; however, the specific content and order of the discussion was driven by participants' responses.[14,51] Research assistants took detailed field notes to record the flow of discussion, seating arrangement, and nonverbal gestures of participants. Each focus group lasted 90 min and was audiorecorded. Each minister received a $30 fee upon completing the study.

Immediately after each focus group, investigators met to review field notes, comment on group dynamics, and download the audio-recording to a password protected laptop computer. Each focus group was then transcribed verbatim into Microsoft Word. Identifying information was removed from all of the transcripts to protect confidentiality of the participants. Members of the research team received a copy of the transcript to review prior to commencing data analysis.

Data Analysis

Data from the focus groups were analyzed via methods of consensual qualitative research.[52–54] This analytic process involves three essential steps: (1) identifying domains—topics used to group data, (2) developing core ideas—summary of the data that captures what was said in few words and greater clarity, and (3) a cross-analysis—used to construct common themes across groups.[53] Two researchers coded all of the transcripts and identified domains. Discrepancies were argued to consensus among research team members through discussions led by the primary investigator. A senior investigator, who has extensive experience conducting focus groups with African Americans and analyzing qualitative data,[55–58] served as external auditor to ensure that raw data had been coded accurately. We identified three overarching

TABLE 1 Question guide utilized for minister focus groups

Tell me a little about your responsibilities as a minister
How long have you been a minister?
What does the term "depression" mean to you?
Do you believe depression is a disease?
What factors do you believe contribute to depression?
Do you believe other factors contribute to depression? (Biological, psychological, spiritual (i.e., sins), and others?)
What are the main mental health/emotional concerns or issues of members in your church?
What do you consider mental/emotional distress (impairment)?
How do you identify if a member is in distress?
If a member comes to you in distress, how do you help them?
Do you believe you can help a church member who is in mental/emotional distress?
How do you determine if a church member needs help for depression outside of the church?
If a church member needs help for depression outside the church, how do you determine the type of help they need?
How do you make a referral?
To whom/where do you refer them? (Social worker, psychologist, psychiatrist, primary care doctor, or others?)
Do you believe some psychological problems require medications?
If so, what disorders require medications?
What are your views on people who take medications for depression?
Do you believe that some members avoid seeking help for depression?
If members avoid getting help for depression, why do you think that is?
Do you believe it would be a good idea to distribute a mental health survey about depression to members in your church?
What do you believe would be the challenges of distributing a mental health survey in your church?
How do you overcome these challenges?
How do you keep material confidential?
How do you present a research study to a church congregation?
Do you believe it would be a good idea to conduct group therapy for depression in your church?
What do you believe are the challenges of conducting group therapy for depression in your church?
How do you overcome these challenges?
How do you keep group material confidential?
How do you deal with legal problems related to treatment?

themes: concept of depression, ministers' role in depression care, and church-based depression services. After conducting cross-analyses across the three focus groups, eight primary domains emerged.

RESULTS

Sample Characteristics

The mean age of ministers (n=21) was 54 years (SD=11.6), and the majority of ministers were female (85.7 %). In terms of racial/ethnic self-identification, 17 ministers were African American, two were Jamaican, one identified as "Other," and one did not respond. Most of the ministers were married (52.4 %) and had a master's degree or higher (57.1 %). Characteristics of the participants are shown in Table 2.

TABLE 2 Characteristics of minister focus group participants (n=21)

Minister characteristic	*n* (%)
Age (mean (SD))	54 (11.6)
Gender	
Women	18 (85.7)
Men	3 (14.3)
Ethnicity[a]	
African American	17 (81.0)
Jamaican	2 (9.5)
Other	1 (4.8)
Marital status	
Married	11 (52.4)
Never married	5 (23.8)
Separated/divorced/widowed	5 (23.8)
Education	
High School	1 (4.8)
Some College	1 (4.8)
Completed College	7 (33.3)
Master's Degree or Higher	12 (57.1)

[a]One participant did not respond

Concept of Depression

Definition Ministers defined depression as a common and serious problem among African Americans that occurs in a context of vast suffering. Women and youth were cited as high-risk groups for becoming depressed. A common description of depression was a feeling of being "hopeless" or "helpless." People with depression were described as "trapped" or "stagnant." One minister defined depression as follows:

> "It's various degrees, levels, but the easiest working definition for me is a negative triad – negative view of self, negative of others, and negative view of future and world. Everywhere I look; everywhere I see; it doesn't look good."

Most ministers asserted that depression is a disease, although support for this definition was not unanimous. Other ministers argued that only "some depression" constitutes a disease state. Surprisingly, only one minister defined depression solely in reference to God, describing depression as:

> "…a greater opportunity for the depressed person to work on the relationship with God, and for God, in return, to meet the needs that the depressed person has…"

Identification Duration and severity of symptoms were proposed as ways to distinguish depression from transient periods of sadness or "environmental" stress. Many ministers also identified various types of depression, such as "seasonal depression" and "dysthymia." Several ministers identified people with depression as crossing a threshold:

> "Whereas the person who is really depressed and actually struggling doesn't even know where to start; that not being able to see your way out of it. The duration and that person's reaction to what they are in, I would say are ways to distinguish."

Causal Factors Though many causes were listed, socioeconomic conditions and conflict in interpersonal relationships were named as the main causal factors for depression. Specifically, financial hardship, unstable employment, broken family systems, and loss of a loved one were named as factors causing depression. One minister stated that the primary mental health concerns facing church congregants were:

> "…not having money, not being able to meet your obligations, [and] having people want to take your house because you can't make the payment."

"Life circumstance" and "stress" of the being African American in the USA were also described as factors contributing to depression. Ministers illustrated how the adverse effects of institutional racism, political policies, and unfavorable environmental conditions contributed to depression:

> "Effects of slavery, then white supremacy, racism, and all things that we talk about in the black community; all that we have to deal with in our community is systemic. So, even though you may play by all the rules, and you may get the degrees and do everything that's required of you, and then you don't get that payoff in the end, you can go into a state of depression."

Ministers stated that biologic factors such as low serotonin levels, sleep deprivation, and "chemical issues" can lead to depression. Many cited "trauma," particularly childhood trauma, as causing depression. Crises of identity were cited as major causes of depression among adolescents.

Minister's Role in Depression Care

Perceived Responsibilities Ministers stated that they have multiple responsibilities in providing depression care. The ministers currently utilize prayer, "faith healing," and quoting Scriptures to counsel congregant members. The ministers outlined a process by which parishioners in need can speak briefly with a minister immediately after the main Sunday service. Providing short-term counseling to parishioners who are experiencing psychological distress and referring parishioners to mental health professionals were also identified as ministers' responsibilities. A summary of these responsibilities is:

> "…to stop the bleeding and use discernment and be able to give them [parishioners] direction. I believe, we all believe in Biblical principle, but we have to use practical application. You have to use discernment and know when this is out of your hands and you guide them off and give them recommendations to get themselves practical, clinical help."

Limitations The ministers reported that time constraints and lack of a formal procedure for counseling and referring parishioners are factors currently limiting their ability to provide depression care. Ministers felt like they were "barely scratching the surface" of the real issues causing a person distress. Ministers acknowledged it was difficult to assess a parishioner thoroughly:

> "I found myself as a new minister, being sort of overwhelmed with that, because my heart was aching for them [parishioners]. It was not very much that I could really do in terms of just prayer and listening; kind of talk and console and make a referral."

Due to lack of knowledge about mental illness, some ministers expressed concern over the possibility of doing more harm to depressed parishioners than helping them. Some ministers admitted feeling "unequipped" to handle severe cases of depression. Conversely, many ministers could not describe a systematic process by which to refer parishioners to a higher level of care outside the church:

> "I'm just not aware of … some processes, a procedure to follow, if there were someone to see these individuals. But as an individual minister, I don't know if I'm the right person."

Feasibility of Church-Based Depression Services

Assessment Ministers stressed the importance of keeping responses on the depression screening instrument anonymous and brief. The ministers' major concerns with the health survey were how it would be distributed and why socioeconomic data were being collected. Ministers objected to distributing the survey to congregants during Sunday services, because they thought it would disrupt the flow of service and might cause respondents to falsify results due to social pressure. Instead, they suggested distributing the assessment in "smaller settings" like the church choir or Men's Bible Study. Ministers and academic researchers collaborating to distribute the screening instrument and reporting the results back to the church were deemed crucial to gain the trust of parishioners:

> "You have a team of ministers that have signed up for this, maybe put us in rotation to go out and support you or whoever is going to be handing them out, so we can explain it. So it's a familiar face, it's not like outsiders coming and using us as guinea pigs …"

> "And so you definitely want to give them the results, so that they are part of the process, and they understand the results. Because you are actually educating people when you give them results."

Group Interpersonal Psychotherapy Ministers asserted that Group IPT would be feasible to conduct in a church building. The ministers equated Group IPT to a support group, "Grief Share," which is currently conducted weekly at the church:

> "We do Grief Share, as a Christian-based, grief support group. People were very open, and not that we have any clinicians in there, but the program was developed by some clinicians and by some Christians. And I think it's very helpful, and it's a safe space for people that are going through clinical issues or grief to interject how they really feel …"

However, protecting parishioner's confidentiality and protecting the church against liability were identified as the main challenges to providing Group IPT in the church. A minister summarized these risks:

> "… someone may breach that confidentiality. There may be some devastating effects behind that, because if the person is already depressed and now you expose them, and they may do something even worse to themselves or someone else, which would leave the church open to liability."

Stigma Stigma cut across all of the over-arching themes, i.e., concept of depression, ministers' role in depression care, and feasibility of church-based depression services. Ministers suggested that depression may be more stigmatized in the church community than the lay public due to parishioners' concern that depression signifies an erosion of one's relationship with God and failure to be a "good Christian." For instance:

> "When people are transparent, they're not made to be comfortable to be transparent, because either they are ostracized or either they're labeled, or either they don't have enough faith, or they're not spiritual enough. So, people have learned to play the church game."

The stigma associated with depression was cited as a barrier in the ministers' ability to have a prominent role in care. Ministers suggested that identifying depression in a parishioner would be met with resistance:

> "It's very hard for people to accept. When people come to you, for you to say, you know, 'Are you experiencing depression?' They don't want to hear that."

Due to the stigma associated with psychotherapy, one minister suggested calling the group intervention, "Coping with the Vicissitudes of Life." Ministers asserted that changing the name would help with recruitment, because "if you say anything about group therapy, they (community members) are not coming."

DISCUSSION

The ministerial focus groups presented here represent the first phase of a study designed to address racial disparities in depression treatment via church-based programs. The second phase of the study involves distributing a depression screening assessment among parishioners.[40] The final phase involves conducting IPT in a group at the church.[41,46,47] Since African Americans have higher rates of church attendance and religiosity compared with other racial-ethnic groups,[59,60] church-based programs may reach a large cohort of African Americans who currently do not utilize mental health services.[15,16,49]

Overall, the ministers were enthusiastic about expressing their perspectives on depression and stated that providing church-based depression services is feasible. A pathway of care representing our major domains is illustrated in Figure 1. The

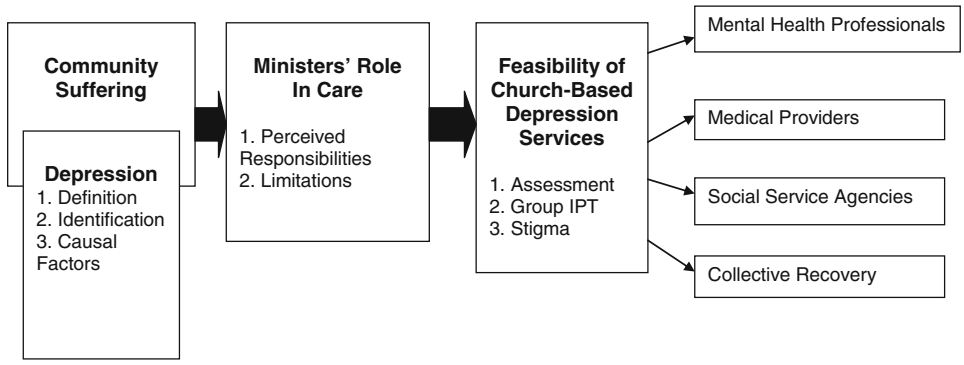

FIGURE 1. Pathway of depression care that summarizes results of ministers' focus groups.

pathway emphasizes how ministers' role as "gatekeeper" can be leveraged to refer parishioners to church-based depression screening and Group IPT, mental health professionals, other medical providers, and social service agencies. To better equip them in their gate-keeping role, we suggest that ministers be formally trained about the signs and symptoms of major depression.[49,61] Such training was successfully used to educate clergy in a domestic violence preventive program.[61] Educating ministers and having them disseminate that knowledge to community members could help reduce some of the stigma associated with depression. We also suggest that clergy develop a formal, systematic process for documenting which parishioners are referred to mental health professionals. A crucial part of this process would involve building trust between ministers and local mental health providers.

An important finding was that ministers described depression within a context of vast suffering in the African American community. Consistent with prior studies, ministers attributed depression among African Americans to harsh socioeconomic conditions.[37,62–64] As such, interventions that solely target depressive symptoms may be insufficient to address the broader issues of chronic stress and suffering.[62] More research is needed to identify effective, interdisciplinary interventions which address the numerous factors contributing to suffering in many African American communities.[58,65] One possible solution is to promote "collective recovery," a process of rebuilding social connections in under-served communities that lead to individual and group recovery.[65,66] Collective recovery was effectively utilized in New York City to help communities cope with the aftermath of the terroristic attack of 9/11.[66]

The ministers viewed the screening assessment as a way to educate parishioners about the symptoms of depression. Ministers emphasized the importance of collaborating with academic researchers to distribute the assessment to parishioners in small group settings. By administering the survey in smaller groups (i.e., the church choir), ministers would be able to more easily address parishioners' concerns about the need to collect socioeconomic data. They also stressed the necessity of getting buy-in from the lead pastor and identifying members of the ministerial staff who would consistently advocate for implementing the assessment.[67] Garnering support of key intra-organizational leaders is highly correlated with the success of church-based health programs.[32,67–70]

Regarding IPT in a group, the ministers emphasized similarities between Group IPT and a grief support group which is currently conducted at the church. Group IPT provided in a church can appeal to African Americans' cultural preferences for depression treatment. For example, African Americans in clinical samples express a preference for psychotherapy over taking medications to treat depression[71] and are three more times likely than white adults to cite spirituality as an extremely important part of depression care.[72] The ministers' major concerns about conducting Group IPT were about the possibility of breaching confidentiality and liability against the church. To protect participant confidentiality and reduce stigma, ministers recommended that Group IPT be conducted at a church building located one block away from the current main sanctuary. Collaborating with community members to identify flexible ways to deliver Group IPT was successfully completed among community members in Uganda.[73] In addition to these recommendations, it appears prudent for churches and researchers to consult with legal experts prior to implementing evidence-based psychotherapy on church grounds.

We must acknowledge the study's limitations. First, our findings may have limited generalizability to other settings. Our study was conducted with a relatively small sample (n=21) of highly educated ministers from one church that has over 2,000 members in an urban setting. Future studies should be conducted with a greater

number of churches that vary in size, level of minister education, and geographic location. Second, we assessed ministers' perspectives about a specific depression screening assessment and treatment. As such, we cannot comment on the ministers' perceptions of utilizing other depression assessments or interventions. Third, since the primary investigator was also lead facilitator of the focus groups, participants' may have been subject to desirability effects.[74,75] Prior to conducting the study, our team decided that the risk of possible desirability effects would be outweighed by the benefit of the primary investigator's visibility and engagement with the ministers throughout the study, leading to a more trusting relationship. Building trust is an essential process of community-based interventions.[76–78]

In conclusion, reducing racial disparities in depression care is a multi-layered problem, for which there is no single solution. We recognize that there may be vulnerable populations (i.e., black adolescent males) that are unlikely to be reached by church-based mental health programs.[32] However, African American ministers play an essential role in providing mental health services to underserved communities. Partnering with church leaders via principles of community-based participatory research[68,76,78] appears essential for implementing and testing church-based depression services. Additional research is needed to develop interdisciplinary, collaborative interventions to address the socioeconomic factors that contribute to suffering and mental health disparities among African Americans.

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