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"Church-Based Health Programs for Mental Disorders among African Americans: A Review

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Abstract

Objective—African Americans, compared to White Americans, underutilize traditional mental health services. A systematic review is presented of studies involving church-based health promotion programs (CBHPP) for mental disorders among African Americans to assess the feasibility of utilizing such programs to address racial disparities in mental health care.

Methods—A literature review of MEDLINE, PsycINFO, CINAHL, and ATLA Religion databases was conducted to identify articles published between January 1, 1980 and December 31, 2009. Inclusion criteria included the following: studies were conducted in a church; primary objective(s) involved assessment, perceptions/attitudes, education, prevention, group support, or treatment for Diagnostic and Statistical Manual-IV mental disorders or their correlates; number of participants was reported; qualitative and/or quantitative data were reported; and African Americans were the target population.

Results—Of 1,451 studies identified, 191 studies were eligible for formal review. Only eight studies met inclusion criteria for this review. The majority of studies focused on substance related disorders (n=5), were designed to assess the effects of a specific intervention (n=6), and targeted adults (n=6). One study focused on depression and was limited by a small sample size of seven participants.

Conclusion—Although CBHPP have been successful in addressing racial disparities for several chronic medical conditions, the published literature on CBHPP for mental disorders is extremely limited. More intensive research is needed to establish the feasibility and acceptability of utilizing

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church-based health programs as a possible resource for screening and treatment to improve disparities in mental health care for African Americans.

Despite important initiatives to eliminate racial/ethnic disparities in mental health care (1), African Americans, compared to White Americans, under-utilize traditional mental health services (2-5). Discouragingly, the most recent National Healthcare Disparities Report indicates that the gap for depression treatment between African American and White adults is *increasing* (6). Among the many factors that may contribute to African Americans' underutilization of traditional mental health services include stigma of mental illness (7), distrust of providers (8), and barriers to access, like lack of insurance (9). Given the debilitating nature of mental disorders (10), especially among African Americans (11), identifying ways to increase mental health service utilization in the Black community is a vital public health concern.

Church-based health promotion programs (CBHPP) have received growing interest as a way to reduce health disparities among African Americans (12, 13). As defined by Ransdell (14), church-based health promotion consists of "a large-scale effort by the church community to improve the health of its members through any combination of education, screening, referral, treatment, and group support." The Black Church, classically defined as one of the seven predominantly African American denominations of the Christian faith, is a trusted, central institution in many African American communities that has been used as a setting for the delivery of health, social, civic, and political services (15). CBHPP have been used successfully in African American churches to address health disparities for numerous medical conditions such as cancer (16-21), diabetes (22-25), weight loss and obesity (26-31), cardiovascular disease and hypertension (32-35), asthma (36), and HIV/AIDS (37, 38).

DeHaven et al. (39) conducted a systematic review of 53 general health programs in faith-based organizations conducted between 1990 through 2000 to determine the effectiveness of these programs in providing healthcare services. Importantly, they concluded that faith-based programs can improve health outcomes. However, only two of the articles in the review identified mental illness as the study's primary focus. In one of these studies (40), all of the participants were White, and in the other, the ethnicity of participants was not specified (41).

The invaluable role of pastoral counseling and African American clergy as "gatekeepers" for mental health referrals has been described in detail previously (42-47). The therapeutic function of Black Church services has also been reported previously (48-53). However, these prior studies do not fall under the rubric of CBHPP, because they either focus exclusively on the activities of clergy or describe in general terms how the church can be a place of healing for members. Given the success of CBHPP in addressing health disparities for medical conditions among African Americans, we feel that a review of CBHPP for mental disorders is warranted. Thus, the purpose of this report is to conduct a systematic review of studies involving CBHPP among African Americans to assess the feasibility of utilizing such programs as a potential resource to reduce racial disparities in mental health service utilization.

Methods

We systemically searched MEDLINE, PsycINFO, CINAHL, and ATLA Religion databases for articles that were published in peer-reviewed journals between January 1, 1980 and December 31, 2009. The following search terms, separately or in combination, were used: black / African American, church, church-based, faith-based organization, pastor, clergy,

pastoral counseling, minister, mental health resource, mental health service, mental illness, depression, domestic violence, violence, drug use, substance use, treatment, and *therapy*. Inclusion criteria for this review were as follows: studies were conducted in a church; primary study objective(s) included assessment, perceptions/attitudes, education, prevention, group support, or treatment for Diagnostic and Statistical Manual (DSM)-IV mental disorders (including nicotine related disorders) or their correlates (suicide, trauma, etc.); number of participants was reported; qualitative and/or quantitative data were reported; and African Americans were the target population.

After excluding duplicate articles, our initial search produced 1,451 studies subject to examination. Titles and abstracts were initially examined to identify studies that met our inclusion criteria. In instances where the race/ethnicity of participants was not reported, we attempted to contact the corresponding author to obtain this information. This search strategy yielded 152 articles available for formal review. We also hand checked bibliographies from articles identified from our search and prior review articles (39, 54-56) to find an additional 39 studies. In total, 191 articles were eligible for formal review.

The formal review process involved reading the article in its entirety. Studies that focused exclusively on pastoral counseling and those in which all participants were pastors/clergy were excluded. Descriptive studies, studies not reported in English, and those not conducted in the United States were also excluded. After these exclusions, eight studies remained for inclusion in the present review (57-64).

Results

Only eight articles met our inclusion criteria. Four studies were randomized controlled trials, two were open trials, and two were observational studies. The majority of these studies (n=6) were designed to test the effects of a specific intervention, one involved a support group, and one involved focus groups. Total number of participants for all eight studies was 910, but range of participants in each study varied considerably, from 7 to 453. Most of the studies (n=6) targeted adults. The psychiatric disorders addressed most commonly were substance related disorders (n=5). Only one study focused on depressive and anxiety symptoms, but it had only 7 participants. Table 1 summarizes the CBHPP included in this review.

Among the randomized controlled clinical trials, Marcus et al. (64) conducted a faith-based intervention to reduce substance abuse among African American youth. Participants (n=61; 54% female) included adolescents who were recruited from two local churches. The intervention, Project BRIDGE, involved risk prevention alternatives and in-depth information about substance abuse. The control group endorsed significantly more use of marijuana (p=.024) and more use of any drugs (p=.011) in the past 30 days compared to the intervention group. Use of any drugs was reported by 18.5% of the control group and by none of the BRIDGE participants. The authors concluded that the church based intervention was successful in preventing illicit drug abuse among youth.

Schorling et. al (59) conducted a randomized controlled trial to determine if smoking cessation interventions delivered through a coalition of Black churches would increase the smoking cessation rate of church members. Participants (n=453; 49.6% female) were drawn from two rural Virginia counties and were randomized by county. The intervention involved smoking cessation counseling and distributing devotional booklets at churches. There was significantly more progress along the stages of change from baseline to follow-up assessment among participants in the intervention group compared to the control group (p=.

03). Schorling et al. concluded that smoking cessation interventions for African Americans can be implemented successfully through a coalition of Black churches.

Stahler et al. (61) also utilized a coalition of Black churches to provide mentors and settings for a faith-based intervention, Bridges to the Community, to treat African American women with cocaine abuse or dependence. Study participants (n=18; all female) lived at a residential treatment program. The Bridges intervention consisted of interactions with a church mentor and group activities at a nearby church. Significantly more women receiving the Bridges intervention remained in the residential program compared to those women in the Control group at both three-month (p=.04) and six-month (p=.02) follow-up assessments. Urine samples testing drug use at six month follow-up revealed that 75% of participants in Bridges versus 30% of participants in the Control group gave clean urines (p=.05). The authors concluded that utilizing Black churches to enhance efforts of residential drug abuse treatment appears feasible.

Voorhees et. al (58) conducted a randomized controlled trial to study smoking quit rates and progression along the stages of change for smoking cessation. Participants (n=292; 71% female) were recruited from 22 churches in East Baltimore, Maryland. Churches were randomized to either an intensive culturally sensitive, spiritually-based intervention (N=11 churches) or a minimal self-help intervention (N=10 churches). At one-year follow-up assessments, positive progress along the stages of change was highest among Baptist churches in the intensive intervention. Baptists in the intensive intervention were 3.2 times more likely to make positive change progress compared to the other groups (p=.01). Voorhees and colleagues concluded that the spiritual nature of the intensive intervention along with the structural factors of specific denominations (i.e., Baptist) make the church a feasible setting in which to develop health promotion and disease prevention strategies for underserved African American populations.

In an open trial, Brown et al. (62) conducted a three-year study to provide training and technical assistance to Black churches to develop and implement substance use prevention programs. The majority of the research activities – quarterly training workshops, cluster meetings, and technical assistance – took place in a church setting. Participants' (n=14; no demographic information provided) pre and post study scores indicated that there was a statistically significant increase in their knowledge of developing research proposals (p=.003), recruiting and training volunteers (p=.012), and substance use prevention programming (p=.001). A majority (69%) of participants surveyed reported that they provided abuse prevention programming at their church as a result of the intervention. Brown et al. concluded that churches can effectively implement substance abuse prevention programming.

Mynatt et al. (60) conducted an open trial of group psychotherapy at a church to reduce depressive and anxiety symptoms, hopelessness, and loneliness among African American women. The 12-week intervention, INSIGHT therapy, is a cognitive behavioral therapy (CBT) approach designed specifically for women (65, 66). Women (n=7) were recruited by announcements in the church bulletin. Mean length of depressive symptoms among study participants was 10 years. Median post-treatment scores on the BDI-II and State Anxiety Inventory were less than pre-treatment scores. Significant changes in depression were observed when analyzing data with paired t-tests (p=.02). Mynatt and colleagues concluded that developing culturally acceptable interventions that reduce risk of anxiety and depressive disorders among African American women is paramount.

In an observational study, Molock et al. (63) utilized clinical vignettes to explore perceptions of help-seeking behaviors among African American adolescents when faced

with a suicide crisis. Participants (n=42; 62% female) included adolescents (ages 12-18 years) who participated in 90-minute, co-ed focus groups conducted at two local churches. Approximately 76% (32/42) of the participants knew of at least one peer who had either attempted or completed suicide. Nearly all participants reported that it was important for suicidal individuals to get immediate help. However, very few selected mental health professionals as helpers. Youth were open to community-based programs located in schools, churches, or other community settings. Molock and colleagues concluded that suicide prevention programs for African Americans should include an educational component and that youth may be distrustful of formalized mental health care providers.

Pickett-Schenk (57) conducted educational support groups on mental disorders for African American families. Participants (n=23; 83% female), who had a family member with mental illness, attended support groups held at a metropolitan church. No treatment was provided to participants in the support groups or directly to their family members as part of the study. Pre-study outreach activities conducted at the church included providing educational booklets on the causes and treatment of mental illness, a telephone hotline for crisis intervention services, and a half-day workshop on mental illness. Nearly all (91.4%) of the participants reported that the groups had greatly increased their understanding of the causes and treatment of mental illnesses and 69.6% felt that support group participation greatly increased their morale. Pickett-Schenk concluded that church-based support groups provide families of persons with mental illness with valuable knowledge and emotional support.

Discussion

The current body of literature on church-based health programs for DSM-IV mental disorders and their correlates among African Americans is sparse. Our review covers a 30 year period and yet we only identified eight studies for inclusion in this report. The majority of studies described in this review focus on substance related disorders, making it difficult to make inferences about church-based health programs for other mental disorders. However, the Black Church is a prominent, trusted institution in many African American communities that already provides “de facto” mental health services for many of its members (67). Since African Americans have higher reported rates of church attendance and religiosity than other racial/ethnic groups (68, 69), the Black Church may be uniquely positioned to overcome barriers like stigma, distrust, and limited access that partially contribute to racial disparities in mental health service utilization. Driven by the results of this review, we identify themes in church-based health programs for mental disorders and suggest areas of future research.

A common element in many of these studies was that church-based interventions for mental disorders were culturally tailored to emphasize Black culture and spirituality. In a study on smoking cessation, Voorhees et al. (58) distributed audiotapes of gospel music and booklets with Biblical scriptures. Stahler et al. (61) developed a faith-based intervention for women with cocaine addiction that stressed Black culture and a spiritual worldview. In view of James Jackson's hypothesis (70) that many African Americans may smoke cigarettes, drink alcohol, and use drugs to cope with the chronic stressors of racism and harsh living conditions (e.g., poverty, poor housing, and crime), utilizing culturally modified interventions via CBHPP may have a greater impact on reducing substance related disorders among African Americans than traditional interventions.

Conversely, many churches may struggle with addressing moral issues, like illicit sexual and criminal activity, associated with substance use disorders (71, 72). These conflicts may limit the ability of CBHPP to provide comprehensive services to all participants with substance related disorders. When potentially controversial issues are the main focus of CBHPP, Thomas et al. (72) suggest that secular agencies and public health professionals can be

utilized to provide appropriate resources. Additionally, researchers can collaborate with church leaders to frame the topic in a manner that is congruent with doctrinal tenets of the church (71, 72). The successful implementation of CBHPP in the studies described in this review suggests that Black churches can be used as a setting in which to address sensitive issues like substance related disorders.

The one study focusing on depressive and anxiety symptoms was an open trial that only included 7 participants (60), which limited the study's power to detect statistically significant differences in outcomes. Participants reported lower depressive and state anxiety symptoms after completing the study. Given this one study and its small sample size, it is clear that research on CBHPP for depression is currently under-developed. Acknowledging this limited body of evidence, we suggest that CBHPP for depression could satisfy cultural preferences for depression treatment among African Americans. For example, African Americans in primary care settings express a preference for counseling over taking medications to treat depression (73) and are three times more likely than Whites to cite intrinsic spirituality (i.e., prayer) as an extremely important part of depression care (74). Future studies should examine African Americans' attitudes about the feasibility and acceptability of providing church-based depression care.

Only two of the studies targeted adolescents (63). Molock et al. (63) focused on suicidality and help-seeking behavior, while Marcus et al. (64) conducted a church-based intervention for substance related disorders. Both studies suggested that community based resources may be more acceptable to Black adolescents for mental health care. Although these studies are encouraging, more research is needed to address suicidality and substance use among Black teens. From 1980 to 1995, the suicide rate increased by 119% for African Americans age 10-19 years, driven largely by a 214% increase in completed suicides in males (63, 75). Since adolescent males have lower rates of church attendance than adolescent females (76), CBHPP are likely insufficient to singularly address the mental health needs and reduce suicide rates among Black males. We propose that future studies should examine the feasibility of utilizing CBHPP among Black teens, while also exploring other community based venues as possible resources in which to engage African American adolescents in mental health care.

Methodological insights from several studies highlighted the importance of collaborating with the church community. In two studies, investigators developed a coalition of Black churches in which pastors collaborated with researchers on ways to best engage their congregants as study participants (59, 62). Marcus et al. (64) explicitly utilized principles of community-based participatory research (CBPR), where members of the target population are engaged in the entire research process from planning, implementation, analysis, and evaluation (77). A recent review concluded that CBPR has "great potential for helping reduce mental health treatment disparities among minorities and other underserved populations" (78). Church-based, collaborative research processes could help build trust and reduce stigma associated with research that is especially strong in the African American community (8, 79-81).

Our study must be assessed in light of several limitations. First, we did not include descriptive articles, but only articles that reported qualitative or quantitative data. This eliminated articles that described collaborative efforts between mental health professionals and churches (82). Second, several of the intervention studies had a small number of participants that limited their ability to detect statistically significant differences between study outcomes. Third, due to the limited number of studies included in this review (n=8) and different types of data, we did not conduct a meta-analysis to assess the effectiveness of

these studies. Fourth, as all of the studies were conducted in Christian churches, we cannot comment on the presence or absence of CBHPP among other religious groups.

Conclusions

Reducing racial disparities in mental health service utilization is an important, complex issue for which there is no single solution. The current literature on church-based health programs for mental disorders among African Americans is extremely limited. Therefore, any conclusions about the role of the Black Church in mental health care should be interpreted cautiously at present. We recognize that there may be large, vulnerable groups (e.g., Black adolescent males) who may not be reached by church based health programs. However, given the success of church-based programs to address disparities for numerous medical conditions, we believe that the Black Church is currently being under-utilized as a potential mental health resource. More intensive empirical investigation is needed to establish the feasibility of Black churches to provide mental health screening, treatment, education, and other services for African Americans.

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Table 1

Church-Based Health Programs for Mental Disorders among African Americans

Study	Demographic characteristics	Number of participants	Measures	Outcomes
Randomized Controlled Trials				
Marcus et al. (64)	Adolescents age 13 to 14 years, 54% female, 98% African American, 2 churches in Houston	61	Alcohol Use, Drug Use, HIV/AIDS Knowledge and Attitudes	18.5% of the comparison group endorsed any drug use compared to none of the intervention group. The comparison group endorsed significantly more use of marijuana than the intervention group (p=.024)
Schorling et al.[a] (59)	Adults mean age 41.8 years, 49.6% female, 100% African American, Coalition of 70 Black churches from two separate counties in rural Virginia	453	Smoking Cessation, Stages of Change, Exposure to the intervention	Intervention was associated with significant progress along the stages of change (p=.03). The cessation rate was higher in the intervention group, but difference was not statistically significant
Stahler et al. (61)	Adults age 18 years and older, 100% female, 94% African American, Residents admitted to a residential treatment program, Cocaine is primary substance of abuse or dependence, 1 church in Philadelphia	18	Treatment Retention at 3 and 6 months post-intake, Treatment attendance, Urine samples to assess drug use	More women receiving the Bridges intervention remained in the residential program at both three-month (p=.04) and six-month (p=.02) follow-up assessments and were more likely to have clean urines (p=.05) compared to women in the Control group
Voorhees et al.[a] (58)	Adults mean age 46.1 years in Intensive Intervention, Adults mean age 47.1 years in Minimal intervention, 71% female, 100% African American, 22 churches in East Baltimore	292	Smoking Quit Rates, Progress along Stages of Change	The intensive intervention group was significantly more likely to make positive progress along the stages of change compared to the minimal intervention group (p=.04). There was no significant difference in smoking quit rates between groups
Open Trials				
Brown et. al (62)	Adults (other demographics not provided) 100% African American, 23 churches	14	Survey of participants, Review of program data	Participants became more aware and knowledgeable of resources and strategies needed to establish substance abuse prevention programs. 69% of study participants implemented a substance abuse prevention program at their church
Mynatt et al. (60)	Adults age 30 to 60 years, 100% female, 100% African American, Stress, Anxiety, or Depressive symptoms, 1 church in Tennessee	7	Frequency of depressive symptoms, Beck Depression Inventory-II (BDI-II), State and Trait Anxiety Inventory (STAI), Beck Hopelessness Scale (BHS), UCLS Loneliness Scale	Clinically important improvements occurred in 7/9 symptoms. Median post-treatment scores indicated significant improvements in depression using paired t-tests (p=.02). There were no significant improvements in state anxiety, trait anxiety, hopelessness, and loneliness following the intervention
Observational Studies				

Study	Demographic characteristics	Number of participants	Measures	Outcomes
Molock et al. (63)	Adolescents age 12 to 18 years, 62% female, 100% African American, 2 Churches in the Mid-Atlantic Study Design: Focus Groups with Clinical Vignettes	42	Problem Recognition, Decision to Seek Help, Selection of Helpers	Youth appeared distrustful with traditional mental health settings. Participants were open to community interventions in schools, churches, or other community settings if helpers were perceived as empathic
Pickett-Schenk (57)	Adults age 35 to 77 years, 83% female, 100% African American, Family members of persons with mental illness, 1 Church in suburban Chicago Study Design: Support Groups	23	Satisfaction with support group, Knowledge of etiology and treatment of mental illness, Understanding of mental health service system, Morale	91.4% of group participants reported greatly increased understanding of the causes and treatment of mental illness mental health system; 91.4% reported greatly increased knowledge of mental health system; 69.6% reported greatly increased morale

[a] Included in review of health programs in faith-based organizations conducted by DeHaven et al. (39)