CE 2.5 contact hours

EQUIPPING African American Clergy TO RECOGNIZE Depression

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ABSTRACT: *Many African Americans (AAs) use clergy as their primary source of help for depression, with few being referred to mental health providers. This study used face-to-face workshops to train AA clergy to recognize the symptoms and levels of severity of depression. A pretest/posttest format was used to test knowledge (N = 42) about depression symptoms. Results showed that the participation improved the clergy's ability to recognize depression symptoms. Faith community nurses can develop workshops for clergy to improve recognition and treatment of depression.*

KEY WORDS: *African Americans, clergy, depression, faith community nursing, mental health*

The cost of depression in the U. S. is staggering. The incidence of major depressive disorder (MDD) is 6.7% in persons 18 and older and is the leading cause of disability in ages 15 to 44 (Anxiety and Depression Association of America, 2016). Depression is a serious medical illness, affecting more than 19 million American adults annually (Mental Health America, 2016a).

More than 80% of people with depression can be treated successfully with medication, psychotherapy, or a combination of both, but many are untreated. Unfortunately, in the African American (AA) community, depression often goes untreated, due to a lack of access or reluctance to seek mental health services, along with a lack of understanding of depression (Mental Health America, 2016b).

DEPRESSION IN AFRICAN AMERICANS

Over 10.4% of AAs, 12.9% of Caribbean Blacks, and 17.9% of non-Hispanic Whites have had an MDD at some point in life. However, among participants with depression, the rate of chronicity and severity of depression was highest in Black groups: 56.5% in AAs and 56% in Caribbean Blacks, compared with 38.6% in Whites (González, Tarraf, Whitfield, & Vega, 2010; Lincoln, Taylor, Watkins, & Chatters, 2011; Williams et al., 2007).

Cultural background plays a role in how symptoms of depression are presented, recognized, interpreted, and treated. Research indicates that the impact of depression on AAs may be greater than that in the general population, due to a lifetime of adversity, stemming from long-term racism, discrimination, and low socioeconomic status (Hammond, 2012; Pratt & Brody, 2008). Although education and socioeconomic advantage tend toward a protective effect on mental and physical health outcomes, these advantages are thwarted in the presence of discrimination (Hudson et al., 2012). The rate of chronic depression is higher among AAs and more severe than in Whites (Mental Health America, 2016b), and older AAs express significantly more depressive symptoms than older Whites, even after controlling for gender, education, and income (Skarupski et al., 2005).

According to Mental Health America (2016b), approximately 63% of AAs believe that depression is a personal weakness; only 31% believe depression is a *health* problem. Thirty percent of AAs have said they would handle depression themselves, and 20% said they would seek help from family and friends. However, 66% believe that faith and prayer would successfully treat depression. Sclar et al. (2012) and Dobransky-Fasiska et al. (2010) identified mistrust of institutions, cultural insensitivity, and stigma as the primary barriers that keep AAs from seeking mental health treatment and, instead, relying on family, friends, and the religious community.

An important consideration in diagnosing depression in AAs is the awareness that the presenting symptoms may be culturally bound. *Culturally bound symptoms* are explained through cultural expressions and understanding that are usually seen in only that particular racial or ethnic group (American Psychiatric Association, 2013;

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Carrington, 2006). Culture-bound symptoms seen among AAs may include somatization, isolated sleep paralysis, an experience of dizziness, and sudden collapse or seizure-like symptoms, referred to as *falling out* (Paniagua & Yamada, 2013). Frequently, these symptoms are inaccurately assessed because of a lack of understanding of the cultural mores and folkways of expressions of AAs. This inaccuracy in assessment can lead to delays in seeking and receiving treatment.

HELP FROM FAITH LEADERS

African Americans' strong reliance on faith is evident from numerous studies. Research on religious coping reported that over 90% of AAs believe that prayer is important in dealing with stressful life events versus 66.7% of Whites (Chatters, Taylor, Jackson, & Lincoln, 2008; Jones & Ford, 2008; Nadeem, Lange, & Miranda, 2008). Sixty-three percent of AAs reported that they use prayer or other spiritual practices as a complementary and alternative medicine for mental disorders (Colbert, Jefferson, Gallo, & Davis, 2009; Woodward et al., 2009).

Historically, the Black church has provided an array of community services to its congregants, including social welfare, education, civic activity, political organization, recreation, counseling services, and health promotion (Lincoln & Mamiya, 2005). The church has provided counseling and relief for the social stressors unique to the Black community. Unlike traditional healthcare, counseling from clergy does not require health insurance or payment. Studies support the involvement of pastors in counseling AAs in need of mental health help, as a natural extension of an existing relationship (Hankerson & Weissman, 2012). The AA pastor plays a pivotal role in identifying the spiritual, physical, and emotional needs of their congregants. Their commitment to community service has fostered a level of trust that supersedes traditional barriers to care. For these reasons, the pastor often is the first professional contact for congregants in a time of need and is the point of entry for referral to healthcare service providers (American Psychiatric Association Foundation [APAF], 2016).


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When mental health problems arise, many turn to a faith leader for help (APAF, 2016). This is especially true for AAs, who are more likely to contact their clergy than a mental health professional (Anthony, 2007). Past research has shown that AAs who saw clergy first were less likely to contact a mental health professional, were more satisfied with the help they received from clergy, and more likely to refer others to clergy than to mental health professionals (Wang, Berglund, & Kessler, 2003). However, it is not clear if the congregants received adequate mental health services from clergy.

African American clergy have an impressive history of service within the Black community, which extends well beyond religious concerns into social, political, civic, and educational arenas. However, programs that address the area of mental health are notably lacking. Given their education and access to mental health resources, AA clergy can perform a pivotal role in recognizing, counseling, and appropriately referring depressed parishioners for the help they need.

African American congregants expect their clergy to assume role(s) that provide support and solutions for their problems, including depression (Brown & Adamczyk, 2009; Kessler et al., 2005). Based on U.S. prevalence rates, it is safe to assume a church congregation has the same mental health illness rates as any other institution, yet clergy's lack of formal training and experience in mental health issues is a concern (Williams, Gorman, & Hankerson, 2014). Clergy need to be able to differentiate between problems that they are qualified to respond to, and those that warrant consultation from mental health professionals (Farris, 2007). Without special training, clergy may be ill-equipped to deal with a mental illness, such as depression. The issue for AAs is that the delays in treatment are associated with a prolonged, and potentially costly, recovery, and impact on family and work. Overall, data support that whether care is inaccessible or not accessed, untreated depression in the AA population correlates with negative outcomes.

The purpose of this study was to explore the effectiveness of a face-to-face depression training workshop on the ability of AA clergy to understand

the causes of depression and recognize depression symptoms and severity. The overarching goal is to provide an alternate resource and eliminate barriers for depression care in the underserved AA population.

TRAINING CLERGY TO ADDRESS DEPRESSION

In a survey of AA clergy, Anthony, Johnson, and Schafer (2015) found that in the 4-week period prior to the study, participants ($N = 65$) had counseled 243 congregants with depression symptoms. Of that group of depressed congregants, 41 expressed suicidal ideations, and 195 had complaints of anxiety. Only 62% of the clergy reported that they were able to recognize the signs of depression; 48% referred depressed congregants to mental health professionals, due to their discomfort and lack of proficiency in addressing this issue.

The prominence of the Black church within the AA community provides the ideal point of contact to address these mental healthcare needs. The AA clergy's lack of formal training in recognizing and addressing mental health issues, particularly depression, demonstrates the need for more research and training in these areas. The specific aims of the present study were to: 1) improve the AA clergy's ability to recognize depression symptoms, and 2) explore, through pre- and post-workshop surveys, the impact of the depression training workshop on the clergy's ability to identify depression symptoms.

Using a quasi-experimental design with a timed series pre- and post-test format, data were collected from participants in a depression training workshop, and at 1-, 2-, and 3-month time periods following completion of the workshop. The Depression Attitudes Questionnaire (DAQ) (Botega & Silvera, 1996; Haddad, Menchetti, McKeown, Tylee, & Mann, 2015) was administered to the participants. A personal data form was used to collect socio-demographic information.

Participants were recruited through seven local, leading AA ministerial associations, in a moderate-size, Midwestern city. The investigators met with association leaders to describe the research study and invite their participation. On the date of the training workshop, the investigators again described the study and explained the Informed Consent Form. Clergy interested in participating in the study signed the form, which included a request for contact information for follow-up evaluations. All participants received a copy of the signed consent forms for their records. This study was approved by the Institutional Review Board at the University of Cincinnati.

DEPRESSION TRAINING WORKSHOP

The Depression Training Workshop, developed by the research study team, consisted of these modules: overview of depression; depression in AA children and adolescents; depression in adults and older adults; bipolar disorder in AAs; and suicide issues with AAs. In each module, topics included the origins of depression, diagnostic criteria, epidemiology of depression, behaviors frequently seen in AAs who are depressed, cultural beliefs and barriers that prevent AAs from seeking care from mental health professionals, risk factors, and treatment options (Table 1). The training was lecture-based, using visual tools and interactive discussions. The workshop lasted three hours and was offered on two occasions. Workshop content was reviewed for accuracy and cultural appropriateness by an interdisciplinary panel of three doctorally-prepared AA mental health professionals. Participants received gift cards worth $15.00.

The DAQ is a self-report instrument with a 5-point Likert-type answer format from *strongly agree* to *strongly disagree* (Table 2). The questionnaire is comprised of core categories that focus on knowledge and attitudes about depression, specifically the nature of depression, treatment options, and professionals' reactions to depressed persons. This tool is useful in examining professional individuals' views and understanding of depression and for evaluating training that addresses attitudes toward depression.

Prior to the start of the depression workshop, the clergy introduced themselves and shared what they hoped to get out of the training. All participants stated they had been approached for help by congregants who stated they were depressed, or by their family members. The majority of participants stated that over the past 3 to 5 years, they had been approached more frequently for help. Few had had formal training in recognizing and assisting depressed congregants.

Data from the pre- and post-tests were coded and entered into the SPSS software program by the principal investigator and statistician. All data were entered twice; the sets of data were compared to verify accuracy. Descriptive statistics were used to describe the sample. An Alpha level

Table 1: Topics in African American (AA) Depression Training Workshop

	Origins of Depression in AAs	Diagnostic Criteria	Epidemiology	Risk Factors	Treatment Barriers	Treatment Options
Overview of Depression	X	X	X	X	X	X
Childhood & Adolescent	X	X	X	X	X	X
Adulthood Depression	X	X	X	X	X	X
Depression in Older AAs	X	X	X	X	X	X
Bipolar Disorder in AAs	X	X	X	X	X	X
Suicide in AAs	X	X	X	X	X	X

Table 2: Questions from attitudes and knowledge about Depression Questionnaire

D1: Please check the box that indicates how strongly you agree or disagree with the following:
Depression is a real disorder
Depression can be treated
Use of antidepressants can change someone's personality
The causes of depression are unknown
If someone is suffering from depression, it is his/her own fault
If you are suffering from depression, you have to pull yourself together for getting over it
Antidepressants have side effects
Antidepressants are addictive
D2: To what extent do you agree or disagree that the following are a cause of depression?
Wrong lifestyle
Problems with others
Disorder of brain
Fate
Heredity
Environmental poisons
Influence of media (e.g., TV, newspapers, movies)
Today's achievement-oriented society
Loss of self-discipline
Weakness of character
D3: Which symptoms of depression do you think are usually seen in depressed people?
Compulsive grooming
Physical complaints (e.g., trouble sleeping)
Hallucinations
Feelings of guilt
Loss of pleasure
D4 How successfully can depression be treated by the following (very successful—not successful)?
A family doctor
Psychiatrist
Psychotherapist
Pastor/Minister
D5: To what extent do you agree or disagree that the following are effective ways to treat depression?
Talk to friends
Take a vacation
Take sleeping medications
Contact a psychiatrist
Contact a family doctor
Pull yourself together
Eat chocolate or sweet things
Light therapy
Take antidepressants
Be more active (e.g., sports)
Contact a nonmedical person
D6: Please check the box that best describes your level of agreement or disagreement with the statements about suicide:
People who talk about suicide do not commit suicide.
It is always possible to help someone who thinks about suicide.
People who take their lives are mentally ill.
There is a risk of causing a person to think about suicide if you talk about it.
Once a person thinks about suicide, they cannot stop thinking about it.
Suicide happens without a warning.
Once a person decides to take his own life, no one can stop him/her.
Many suicide attempts are made out of revenge or to punish someone.
I would consider suicide if I had a severe, incurable disease.
If someone wants to commit suicide, it is their business, and we should not interfere.
I am prepared to help a person in a suicide crisis by making contact.
D7-A Has anyone in your family or a friend ever thought about or attempted suicide?
Yes_____ No_____
D8-A Has anyone in your family or a friend ever been treated for thinking about or attempting suicide?
Yes_____ No_____

of 0.5 was used to obtain statistical significance. Confidentiality was maintained by assigning an identification number to each participant.

A total of 42 AA clergy attended the 3-hour workshop ($N = 42$). Participants were from a midsized, Midwestern city, with a 44% AA population. Nineteen were male, and 23 were female; 55% ($n = 23$) were married. Almost two-thirds had earned degrees from the associate to doctorate levels (Table 3).

The DAQ was administered at pre- and post-depression training workshops; and at 1-, 2-, and 3-month postdepression training sessions. Data were analyzed, using software with bias-corrected accelerated (BCa) bootstrapped *t*-tests to reduce the impact of nonnormality, heterogeneity of variance, and other violations of assumptions for the traditional *t*-test.

SIGNIFICANT LEARNING

Analyses revealed that responses on the questions, "*Which symptoms of depression do you think are usually seen in depressed people*?" and, "*How successfully can depression be treated by the following: (family doctor, psychiatrist, psychotherapist, and pastor)*"? were significantly different between pre- and post-intervention, and at 1-month follow-up ($p = .022$ and $p = .045$, respectively). In addition, this second question showed the only significant difference at the 3-month follow-up ($p = .044$).

Further analysis revealed that the intervention group only differed from baseline to post-intervention on causes of depression; commonly observed symptoms of depression how successfully depression can be treated by family doctor, psychiatrist, psychotherapist, or pastor; and effective ways to treat depression. No significant differences were found on any of the other subscales at pre- and posttraining or at the 1-, 2-, or 3-month follow-up.

Significant changes were found between baseline and post-intervention scores on "*To what extent do you agree or disagree that the following are causes of depression?*" There was agreement

among participants that fate (p = .048), heredity (p = .038), environmental poisons (p = .027), and today's achievement-oriented society (p = .031) were contributors to the development of depression.

Significant changes in "*Which symptoms of depression do you think are usually seen in depressed people?*" were found between pre- and post-intervention (p = .002). Participants were able to identify specific symptoms of increase in physical symptoms; trouble sleeping and hallucinations showed significant changes following the workshop (p = .003 and p = .001, respectively).

Participants viewed family physicians, psychiatrists, and psychotherapists as being more successful in treating depression than ministers. They agreed that taking sleeping medications, contacting/seeing a psychiatrist, pulling yourself together, use of light therapy, and taking antidepressants were effective ways to treat depression.

Of practical importance, there was a significant change among responses to the statement, *Suicide happens with warning*, between the pre- and post-depression training intervention (p = .026).

Table 3. Participant Demographics (N=42)

Gender	
Male	19 (45.2%)
Female	23 (54.8%)
Marital Status	
Married	23 (54.8%)
Widowed	2 (4.8%)
Single	7 (16.7%)
Divorced	7 (16.7%)
Other	3 (7.2%)
Age Range	
	43–78 years
Education	
Doctorate	6 (14.3%)
Master's degree	7 (16.7%)
Bachelor's degree	12 (28.6%)
Associate degree	6 (14.3%)
Completing graduate degree	2 (4.8%)
Completing undergrad degree	1 (2.4%)
Church training/Certificate	6 (14.3%)
Denomination	
Baptist	21 (50%)
Non-denomination	17 (18%)
Other	12 (13%)

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Unlike traditional healthcare, counseling from clergy does not require health insurance or payment.

Many stated that they now felt equipped to address depression symptoms related to situations such as death of a family member, job loss, and illness; however, they recognized that more severe cases of depression were beyond their expertise.

Findings in this study bear on the diagnosis and treatment of depression in AA congregants. Participants stated that they would use what they had learned in caring for their congregants with depression symptoms. Additionally, follow-up administration of the DAQ revealed knowledge retention about depression symptoms at 1-, 2-, and 3-month post-training.

DISCUSSION

Clergy are in a position to develop long-term relationships with congregants, observing them weekly or more often, which allows observation of behavioral changes. In addition, clergy often are the most trusted persons outside of family and are sought for counseling in situations including illness, death, marriage, depression, and other health issues.

Nurses can partner with church staff and clergy to improve the health of congregants by providing training and education on stress management, grief and loss support, and unbiased health information. Faith community nurses can use an ongoing, faith-based approach to assessing mental health and offering training and intervention. Nurses can invite mental health professionals to church and community workshops and health fairs. Doing so can help develop relationships of trust, respect, and understanding between clergy and the mental health community.

The question of how to differentiate *spiritual depression* from *physical depression* was raised by participants. Spiritual depression has been described as the state or mood when a person feels that God seems far away and is not listening to them (Lloyd-Jones, 2002), and also as spiritual melancholy (Helopoulos, 2014). Spiritually depressed people have lost their zest for life, God, and helping others. Results from the present study suggest that although the training interventions assisted clergy in recognizing the signs of major depression, an uncertainty remained regarding how to recognize spiritual depression. The findings show that this training helped clergy to understand that depression is a medical illness with biological, environmental, and psychosocial causes.

Participants agreed that psychiatry was the discipline that trained practitioners to effectively deal with moderate-to-severe depression, and the clergy expressed a desire to work with a psychiatrist in providing a more holistic approach to mental illness treatment. However, they relayed that mental health professionals (MHPs) were reluctant to collaborate with them in addressing the spiritual and the mental health needs of congregants. Most of

the MHPs participants had come in contact with tended to diminish the importance of addressing spiritual needs, as part of the mental health healing process. In addition, some MHPs interpreted any expression of spirituality as psychosis, without any in-depth investigation or consideration of cultural/spiritual background. In short, clergy felt that their skills and expertise were not valued by the MHPs.

Post-test findings showed that some misconceptions of participants were clarified, such as that sleeping pills and antidepressants are addicting, lead to aberrant behaviors, and have to be taken for life. Participants were happy to learn about nonmedicinal complementary treatments for depression, including exercise and light therapy.

Some participants stated that there was an MHP on their church staff, usually a social worker, trained in mental health. However, congregants were less likely to attend programs that were clearly labeled mental health (i.e., depression, anxiety). Nonthreatening titles, such as *Life Skills* or *Health and Wellness* were better received.

In the AA church, suicide is considered a sin and is highly discouraged and frowned upon. This negative view may account for the lack of acknowledgment that suicide is a problem within the AA community. Because AAs are taught from a young age about the sinfulness of suicide, many clergy do not consider or look for warning signs of suicide in depressed congregants (Joe, Baser, Breeden, Neighbors, & Jackson, 2006).

Although the findings from this small study cannot be generalized, the results provide insight into experiences and beliefs about depression from the AA clergy perspective. These findings suggest that congregants seek clergy for assistance at the point where congregants are more acutely ill and less able to care for themselves. Another explanation is that clergy are more aware of obvious changes in congregant behaviors when they reach more acute stages. Clergy in this study expressed concerns about not knowing when and how to distinguish depression symptoms from medical illness and spiritual intervention. All participants expressed a need for additional training in how to handle congregants with moderate-to-severe depression, as well as other mental illnesses. Suicide is an area in which more exploration is warranted.

CONCLUSION

Study findings show that AA clergy are actively involved in assisting congregants suffering from various levels of depression. It is not clear whether this assistance is the result of intentional effort on the part of the clergy, or if they find that the role of clergy is inherently defined by the needs of congregants. The study results do not indicate long-term changes in attitudes and knowledge about depression. Participants expressed a need for on-going training to increase their confidence in effectively recognizing symptoms of depression and in determining the level of severity. Further, clergy stated they would like to have relationships with MHPs who would be available for consultation and contining involvement with the congregants whom they refer for professional mental health counseling. Other methods of training, which have longer-lasting changes in knowledge and attitudes about depression, should be explored.

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Web Resources

- Mental Health & Faith Community Partnership—https://psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership
- Caring Clergy Project—http://www.caringclergyproject.org

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