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A Rural African American Faith Community's Solutions to Depression Disparities

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Abstract

Objective—The aim of this study was to explore how a rural African American faith community would address depression within their congregations and the community as a whole.

Design and Sample—A qualitative, interpretive descriptive methodology was used. The sample included 24 participants representing pastors, parishioners interested in health, and African American men who had experienced symptoms of depression in a community in the Arkansas Delta.

Measures—The primary data sources for this qualitative research study were focus groups.

Results—Participants identified three key players in the rural African American faith community who can combat depression: the Church, the Pastor/Clergy, and the Layperson. The roles of each were identified and recommendations for each to address depression disparities in rural African Americans.

Conclusions—The recommendations can be used to develop faith-based interventions for depression targeting the African American faith community.

Keywords

African Americans; depression; faith; health disparities

Epidemiological studies indicate that African Americans have lower prevalence rates of depression than Caucasians (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005). However, African Americans diagnosed with depression are more likely than Caucasians to experience a severe and prolonged course of illness (Williams et al., 2007), resulting in increased disease burden and disability. Yet despite the disability experienced by African Americans living with depression, they are less likely than Caucasians to report depressive symptoms and seek treatment of depression (Das, Olfson, McCurtis, & Weissman, 2006). Thus, finding strategies to reduce the rates of depression among African Americans is important.

African Americans living with depression experience depression stigma and other barriers, which prevent access to formal mental health services (Department of Health Human Services [DHHS], 2001). Further, even with advances in decreasing racial disparities in access to quality mental health services (U.S. Census Bureau, 2010; DHHS, 2001), underutilization of formal mental health services by African Americans remains a problem (Padgett, Patrick, Burns, & Schlesinger, 1994; Thomas & Snowden, 2001). Quality improvement programs have been shown to be efficacious and cost-effective; however, they do little to address the perceptual barriers experienced by African Americans, including stigma. Thus, improving the quality and quantity of services provided will not eliminate racial disparities in depression outcomes.

Connection of Faith and Depression among African Americans

The literature suggests that African Americans rely on faith, spirituality, and religiosity to manage depressive symptoms (National Mental Health Association [NMHA], 2004). Indeed, religious beliefs have been found to be an important factor in how African Americans perceive emotional distress and treatment of depressive symptoms (Neighbors, Musick, & Williams, 1998). Further, a sizable body of the literature indicates that African Americans are more likely to attend church and receive informal supports from church-based networks when experiencing distress (Boyd-Franklin & Lockwood, 2009; Mattis, 2000; Taylor, Chatters, & Levin, 2004).

Using Faith and Collaborating with the Faith Community

As African Americans are more likely to use religion to make sense of their depressive symptoms (Neighbors et al., 1998) and use church-based supports for coping, collaborating with faith communities may be useful for eliminating racial disparities in depression. In regard to the physical health, church-based interventions have successfully increased health screenings and have also been effective in promoting healthy behaviors among African Americans. The literature is sparse, however, on faith-based programs that address mental health concerns, and no programs have addressed depression among rural African Americans (Hankerson & Weissman, 2012).

Before developing faith-based interventions for depression in African American communities, research is necessary to determine the most effective ways to engage the community in discussion about depression. Therefore, the present study examined how a

rural African American faith community describes solutions to depression barriers and treatment disparities.

Research question

The purpose of this study was to explore how a rural African American faith community would address depression within their congregations and the community as a whole. Therefore, this study posed the research question “What are a rural African American faith community's solutions to address depression disparities?” The goal of the study was to identify how a rural African American faith community would confront depression disparities to subsequently develop a faith-based intervention for depression.

Methods

Design and sample

This qualitative study is based on the principles of community-based participatory research (CBPR) (Minkler & Wallerstein, 2008). This approach is especially important because engaging the rural African American population in research has been historically more difficult than with other populations (Hatchet, Holmes, Duran, & Davis, 2000). This framework guided the study and provided a starting point for building effective partnerships to develop intervention approaches tailored to the needs of African Americans with depression.

The study setting is a community located in northeast Arkansas, near the borders of Missouri and Tennessee, in the Mississippi River delta region. The African American population of the community (33.7%) is higher than in other Arkansas communities (U.S. Census Bureau, 2010). The director of the Progressive Life Center, Johnny Moore, Jr., served as a collaborating partner, key informant, and guide for the research team. The center is a nonprofit organization serves as an outreach ministry of PromiseLand Church and is located immediately behind the church.

Recruitment of participants was purposeful; key persons in the African American faith community were identified and invited to participate. A group of pastors, a group of parishioners interested in health, and a group of men who had experienced symptoms of stress and/or depression comprised the participant pool. To be included, pastors needed to be English-speaking, the primary pastor of a predominantly African American Christian church in the community for a minimum of 1 year, or a named representative. The second group were parishioners, to be included they had to be English-speaking men or women, 18 years and older who attended a predominantly African American Christian church in the county and were interested in improving the health of their congregation. The final group was African American men who were English-speaking, 18 years and older and self-reported having experienced stress or depression symptoms in their lifetime.

Institutional review board approval was obtained from the University prior to recruitment. The community partner completed the protection of human subjects training and facilitated participant recruitment. Twenty-four (24) participants participated in focus groups. The first

group, pastors, were all married African American men with an average age of 52 (40–70 years). Their average length in the ministry was 21 years (5–48 years) (Table 1). The second cohort, parishioners, included 7 women and 4 men. The average age was 35 years (24–46 years). The Christian denominations represented included Pentecostal, Baptist, and non-denominational. Over half (55%) of the parishioner participants had never been married (Table 2). The third group included four African American men. Their average age was 43 years (34–57), and all had at least a high school education (Table 3).

Measures

The primary data sources for this qualitative study were focus groups, which provided an “insider” point of view. The focus groups were conducted at locations convenient for participants: restaurant, a local church, and a community organization. The participants were informed of their rights, including the right to withdraw from the study at any time. Prior to the focus group discussions, participants were given a demographic questionnaire to complete. The focus groups were facilitated by the lead author and digitally recorded. Sessions lasted on average 60 min.

The focus group questions were based on the literature and findings from previous studies (Holt & McClure, 2006; Kramer et al., 2007; Stansbury & Schumacher, 2008). In addition, because the faith community is known for providing services to community, it was important to obtain an understanding of the faith community's assets and services as they relate to depression and depression care. The first three focus groups were designed to collect initial data about the community and the beliefs of residents. Focus group questions included “What health programs, counseling, etc., do you offer to your parishioners with depression?” “If you could offer services to prevent or cope with depression in your congregation, what would they entail?” After the first three focus groups, subsequent focus groups included preliminary results and participants were asked to comment on them.

At the conclusion of each focus group, participants were thanked for their time and participation, and given a gift card as a token of appreciation. Immediately following the focus groups, the lead author took time to reflect on what was learned from the session and wrote field notes. The digital recordings were transcribed and reviewed for accuracy prior to analysis. The transcribed data excluded any identifying information, ensuring confidentiality.

Analytic strategy

Morse, Barrett, Mayan, Olson, and Spiers (2002) proposed that rigor in qualitative research includes investigator responsiveness, methodological consistency, sampling adequacy, an active analytic stance, and saturation. In this study, analysis occurred concurrently with data collection, increasing the refinement of interviewing foci as data were crosschecked with developing patterns. The lead author, who is an experienced qualitative researcher, conducted all of the focus groups, increasing rigor by providing consistency in interviewing style and technique. Transcripts were reviewed by three experienced qualitative researchers, who provided verified of concepts and categories. Qualitative data collection, coding,

analysis, and interpretation were integrated to ensure that the interpretation of findings was grounded in the data.

The verbatim transcripts of focus groups and field notes were entered into a qualitative analysis and management software package (Ethnograph 6.0; Qualis Research, Colorado Springs, CO, USA). This enabled the authors to mark blocks of text with codes, explore relationships among and between codes, and compare participants and groups. The lead author and an experienced qualitative researcher reviewed the transcripts and field notes and developed an initial set of inductively derived codes with definitions. The lead author and two other authors verified code words and definitions. The transcripts of subsequent focus groups and interviews were jointly coded to ensure that definitions captured the meanings of the text and were mutually exclusive. Definitions were revised as necessary to improve coding reliability and consistency. This process also enhanced consistency in coding. After the initial coding, codes were collapsed into more general related constructs and aggregated into broad themes.

Results

Three explicit themes were derived from the data on the roles of the church, the pastor, and the layperson in relation to depression. In addition, the participants provided recommendations for addressing depression problems and disparities in the rural African American faith community (Table 4).

Role of the church

The church was defined as more than a mere building or place of worship. Rather, the church was considered the collective “Black Church”, the persons who made up a specific congregation, and an institution. Three distinct roles were identified for the church when addressing depression: (1) address man in a holistic approach, (2) provide a support system, and (3) provide information, referrals, and health services. The holistic approach to man was described as not only providing church goers with spiritual guidance, but also recognizing that social issues, health conditions, and other variables can affect a person. Some participants felt that churches in the area should be involved in providing health-related information. There was agreement among participants that the church, God, and spirituality are important. There was also recognition that “preaching” health, and wellness, and having a healthy congregation are important, and the church should play a role in making the members healthy.

As a Black church, what we can do is to deal with the holistic approach of man, and to educate our people that it's not all about spirituality, that it's also about the natural man. (Pastor)

It's no harm in having a [physically] healthy membership. (Parishioner)

Participants thought that a second role of the church is to act as a support system for those who are in need. They include not only members of the church, but the community as a whole. The church was viewed as a place to provide support for those who are in need.

Distress and stuff like that...in the black church they feel like the church ought to be the place that they can come and get help. (Pastor)

That [the church] should be a place where you go and can feel some of that weight lifting off of you. (Parishioner)

Participants said the third role of the church as providing information, referrals, and health services. Some participants said that the church had been addressing depression for many years, although the church did not always refer to it as “depression”. Rather, the church spoke more to the stressors of life, emotions, and using prayer and strength through God to overcome them.

My opinion the church has always speaking on depression. Not directly calling it what it is; but in that vicinity of depression, they've been speaking on it. (Pastor)

Other participants however, felt that it was the church's responsibility to do more for persons at risk and those experiencing depression. The church should provide parishioners and the community the resources needed to reduce depression risks and recognize depressive symptoms earlier. One participant felt that health programs were needed in rural communities and should be addressed in churches.

If you go to a more metropolitan area then you would see ministries that would do that [provide health programs]. Around here is something that would be very much needed and helpful. (Parishioner)

The participants identified four key recommendations for the church in regard to depression: (1) develop a faith-based intervention to give persons in the church the tools they need to manage depression, (2) address the needs of men differently from those of women, (3) change depression terminology, and (4) educate the community about depression. For some participants, concerns about confidentiality and privacy were more important than seeking treatment. Therefore, they felt a faith-based intervention teaching self-management approaches would be most appropriate.

I think learning the [stress management] techniques, all the techniques, because some can do one and some can do another, but these have been proven techniques over time that these will work and relieve stress. (Pastor)

It was also suggested that a program in the church should give persons the tools they need to identify and address depression.

It [depression] is going to drive them down, but we as a church have to do all that we can to help get them back up. The church's involvement, we've been doing greater later. We weren't doing it all earlier, but now you've got more churches participating in health symposiums, situations, and studies like this. (Pastor)

A second recommendation was that church should address the specific needs of African American males.

I think it's a challenge for the church to get particularly minority men involved and committed. If that commitment takes place, I think it's life changing. (African American male)

One pastor described his all-male Bible study:

We divided up the men, because we discovered that you cannot have the men and women in the same Bible study...It allowed the men to be men and to talk on that level, and where other men, we understand. (Pastor)

Many of the other pastors and other male participants supported the idea of an all-male setting. They felt that men would be able to put their guard down a little more without the presence of females. It was thought that men would develop camaraderie, which would lead the men to express themselves and share their experiences.

It's such a blessing and such a help to the men to be able to open up...what it does is it creates a bond, even amongst the brotherhood. (Pastor)

The participants noted the need for more African American men to attend and participate in church to address issues such as depression.

Being able to have that kind of setting where we can admit, we can take the covers off some of the issues that we deal with under the covers. (African American Male)

However, some participants noted that even in an all-male setting, some men might not still express themselves.

So a men's group is gonna' have both types of men there...you would still have men that are willing to release this stuff off their shoulder and some that's just gonna' keep packing it down. (Pastor)

A third recommendation was to change the terminology of depression. In general, participants felt that the word “depression” carried a lot of stigma and using another word such as “stress” would be less threatening. They said that if a program was titled or labeled a “depression” program, then community members would not participate. However, if a less stigmatized word were used to describe the program, people would be more likely to participate.

The word stress carries a lot more cushion. It lets people know, okay, I got something on my back right now, but it ain't beaten me down. When in actuality it really is beating me down. (Pastor)

The participants were in agreement that changing the terminology was not the same as lying or deceiving people. Instead, they felt the change would draw more people to participate in a depression program. They noted that once a captive audience is obtained, they can be formerly educated about depression, including how to prevent, recognize, and treat it.

A final recommendation was to provide general education to the community about depression. The participants did not mention what specific role the church should play in providing this education. However, they believed that educating parishioners and the community about depression would decrease stigma and lead more people to recognize the symptoms and seek treatment.

Role of the pastor

The participants identified three roles of the pastor: (1) provide spiritual guidance and support, (2) preach and minister hope, and (3) recognize depression and take action.

The participants said one of the key roles of the pastor is spiritual guide/supporter. There was agreement among the participants that there is a clear divide between the role of pastor and the role of mental health providers. Although they may both be addressing depression, the pastor primary role is that of a spiritual guide and supporter.

His [the pastor] job is to encourage us, lift us, and pray for us...but he's not a medical doctor...he's not a psychiatrist. He just like a good friend that's in your life.
(Parishioner)

One African American male participant said that he could talk to a pastor about his problems, because he believed he would not be judged.

If you talk to like a pastor or somebody I don't think they would judge you.
(African American Male)

In addition to providing spiritual guidance and support, participants thought the pastor should be preachers of hope.

You're basically ministering hope...that is the hope of Christ. (Pastor)

Although pastors are not licensed to diagnose depression, the participants felt it was important for them to identify persons who might be experiencing depression.

We have to be educated to be able to identify [depression] and then make the right application to that situation. (Pastor)

Many of the clergy participants felt that more educational and training opportunities needed to be available to them to address depression. Therefore, one recommendation was to educate pastors about depression including how to recognize depression and when referrals to mental health professionals are needed. One pastor stated:

I think because we [pastors] are so used to trying to take on the burden and the problem ourselves when we're not equipped to do that...[sometimes they need] to get help outside the ministry. (Pastor)

Although most participants supported education of pastors about depression, one participant felt that not all pastors realized or understood the implications of depression. Therefore, the “buy-in” of those pastors would have to be obtained before they would be open to education.

Unless the ministers are convinced that this [depression] is an issue we need to address, it's going to be addressed the wrong way. (Pastor)

Another pastor noted concern about addressing depression inappropriately from the pulpit, therefore, again stressing the need for adequate education and training.

We [pastors] need to be trained, cuz words hurt, and you've got to be careful what you say and how you deal with these [depressed] people. (Pastor)

One parishioner said that some pastors preached and supported faith alone and should be educated to support other avenues to address the needs of those who are depressed.

A lot of times, you have to defuse a pastor on 'if I pray or lay hands on you, it'll be alright'. (Parishioner)

A second recommendation was to get pastors on board with plans for interventions in the faith community. The support of pastors was recognized as essential for faith-based or church-based depression interventions.

The Bible said that people are destroyed for the lack of knowledge. I think the first step is to try to get leaders involved, and that they have the knowledge to be able to minister to their own people. (Pastor)

The role of the layperson

The layperson was defined by participants as the nonclergy church leaders. Three main roles were identified for them: (1) pastoral supporter, (2) peer supporter, and (3) leader by example. In rural communities, often there is no clergy staff or co-pastor to assist the senior pastor. Many of the pastors in this community were bivocational, often working full-time jobs while pastoring a church. As a result, pastoral support was often needed from others to meet the needs of parishioners. In rural communities, there often is not a clergy staff or co-pastor to assist the senior pastor.

Not every pastor is fulltime, some work nights, some work days, and that's why I push for the concept of a representative from the church that would possible come and stand in. (Pastor)

Therefore, participants suggested that if a person with depression needed pastoral support and the pastor was unavailable, a layperson should be available to provide the ministerial care required.

The second role identified for laypersons was peer support. It was also recognized that for this role had to be a level of commitment.

It's gonna' help out my community, my church family, possibly even me, then I'm willing to put the commitment forth. (African American Male)

It was also suggested that subpopulations in each congregation might require some sort of support to address their needs. For example, one veteran said he felt more comfortable talking to other veterans about his depression. Therefore, a civilian pastor might not meet his needs.

I'm a veteran and when we go talk about depression we have certain people that are veterans and they feel more comfortable about talking about that certain topic. (Pastor)

It was also noted that laypersons in leadership roles should lead by example. One participant stated that the way a man handles stressors that can lead to depression can be an example to others in similar situations.

Seeing how another male or another person say handles stress, and is able to make decisions and not be riled up or not easy to anger, I think is a good example.
(African American Male)

Among the recommendations for solutions to depression, care was having a mental health provider educate laypersons in churches to help them understand how to provide support and make referrals to professional services if needed.

You need a [mental health] specialist, one that's licensed, that's willing to train the willing individuals in each ministry in the community. (Pastor)

Given costs associated with seeking professional mental health services having mental health services offered in the church could benefit those uninsured or underinsured.

Whenever somebody has a depression issue, they got somebody they can go to. They may not be able to afford the psychiatrist or psychologist, but we got a group that's right there that they can come in. (Pastor)

It was stressed that allowing church leaders the option to identify their own layperson leaders would be culturally relevant and help with the success of the program. This was recommended for several reasons. Primarily, the leader needed to be a respected, trusted member in the congregation, one other congregation members felt comfortable talking to. Second, each church would want to have layperson leaders of their own given their particular church boundaries of ownership. If each church had the opportunity to send a representative to be trained to be a “depression specialist”, then one church would not be favored over another. In addition, this could have a greater impact on the community by reaching families and persons not directly affiliated with a church.

They get the training and take it back into their ministry, then you may see some more collaborations going on for the benefit of the actual community. (Pastor)

Discussion

Participants identified three key players to combat depression in the rural African American faith community: the church, the pastor, and the layperson. Key strategies mentioned as the foundation for interventions to address depression in the rural African American faith community included: (1) provide individuals in the church the tools they need to manage their stress, (2) offer education about depression to the faith community particularly pastors, (3) incorporate the need for confidentiality and privacy, (4) train layperson leaders in the church to be “depression specialists”, (5) gain the support and buy-in of the pastor is imperative in the success of any faith-based depression intervention, and (6) due to stigma, do not call the intervention a “depression intervention”, but use a term less threatening. Most importantly, segmenting the intervention by gender was important for men.

Researchers have previously identified the link between religion and depression, particularly in regard to coping with stress and motivation. This link has been attributed to religious and spiritual activities on the community and individual level (Holt & McClure, 2006; Stansbury & Schumacher, 2008). For that reason, the church has often been thought of as a place to incorporate health-related articles, particularly the rural Black church (Blank, Mahmood,

Fox, & Guterbock, 2002). Unfortunately, limited mental health programs have been integrated into the Black church (Hankerson & Weissman, 2012).

In previous studies (Kramer et al., 2007), pastors have been identified as key persons for parishioners needing care for depression; this finding is consistent with findings of the present study. Their role is often that of caregiver, counselor, and a bridge between secular and spiritual care (Kramer et al., 2007). As noted in the current study, pastors in the rural environment often do not have the time or resources to obtain mental health education. Having laypersons assist the pastor in providing mental health services will ensure the success of the program, without over burdening the pastor. Interestingly, the National Action Commission on the Mental Health of Rural Americans recommended providing adequate training to clergy in local communities in 1988 (Bergland, 1988). Over 20 years later, rural clergy continue to request this training. The current study also identified the role of the church and lay persons as two additional aspects of care for those with depression. Therefore, specific trainings targeting these groups should also be developed and implemented.

Some of the participants in the present study felt it was important to train not only pastors, but also laypersons because many pastors are employed full time while managing a church. Training of clergy and lay health advisors was implemented by Molock, Matlin, Barksdale, and Lyles (2008) as a means to promote suicide prevention among African American youth in African American churches. The lay health advisors provided education to church members, encouraged the exchange of self-care resources, and identified risk and protective factors among the members. Many of their duties were the same as those suggested in the present study.

Although many of the concerns shared by these participants mirror those found in other studies, they represented only a small community. In contrast, the data can be used as a basis for future research studies. These future studies should involve continued collaborative efforts, to establish programs, research, and potential changes in healthcare delivery in communities such as this one. The perspectives of local primary care providers and their need for additional mental health resources should be explored further. The request of pastors for training in mental health disorders and in the ways to make referrals requires collaboration with mental health providers and other supporting resources. Finally, religiosity has been identified as a primary self-help intervention recommended by clergy for dealing with mental illness and socio-emotional problems (Stansbury & Schumacher, 2008). This supports the results of the present study. Therefore, a faith-based self-management and depression education program led by lay health providers should be developed and tested.

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Table 1

Characteristics of Pastors

Pastor	Gender	Age	Education	Marital status	Length of time in ministry	Religion
Pastor 1	M	43	Some college	Married	12 years	Baptist
Pastor 2	M	40	Some college	Married	12 years	Nondenominational
Pastor 3	M	55	Associate degree	Married	28 years	COGIC
Pastor 4	M	44	Some college	Married	9 years	Baptist
Pastor 5	M	44	Bachelor degree	Married	5 years	Pentecostal
Pastor 6	M	48	Associate degree	Married	12 years	Pentecostal
Pastor 7	M	61	Graduate degree	Married	40 years	Pentecostal
Pastor 8	M	61	Some college	Married	22 years	Baptist
Pastor 9	M	70	Associate degree	Married	48 years	Baptist

Table 2

Characteristics of Parishioners

Parishioner	Gender	Age	Education	Marital status	Length of time at church	Religion
Parishioner 1	F	30	Some college	Never married	1 year	Pentecostal
Parishioner 2	F	24	Some college	Never married	<1 year	Pentecostal
Parishioner 3	M	33	Some college	Never married	8 years	Nondenominational
Parishioner 4	M	43	Some college	Divorced	2 years	Unknown
Parishioner 5	F	41	Some college	Married	20 years	Baptist
Parishioner 6	F	25	Some college	Never married	Unknown	Nondenominational
Parishioner 7	F	46	Associate degree	Married	3 years	Nondenominational
Parishioner 8	M	28	Graduate degree	Never married	10 years	Baptist
Parishioner 9	F	25	Some college	Never married	8 years	Baptist
Parishioner 10	M	46	Some college	Divorced	Unknown	Nondenominational
Parishioner 11	F	45	High school	Married	6 years	Baptist

Table 3**Characteristics of African American (AA) Men**

AA male	Gender	Age	Education	Marital status	Length of time at church	Religion
AA male 1	M	57	Bachelor degree	Married	15 years	COGIC
AA male 2	M	34	Bachelor degree	Married	10 years	COGIC
AA male 3	M	35	Some college	Divorced	1 year	Nondenominational
AA male 4	M	45	High school	Married	8 years	Other

Table 4
Roles of the Church, Pastor/Clergy, and the Layperson

	The church	Pastor/Clergy	The layperson
Roles	Holistic approach to man	Provide spiritual guidance & support	Pastoral support
	Support system	Preach & minister hope	Peer support
	Provide health information, referrals, and health services	Recognize depression and take appropriate actions	Lead as an example
Recommendations	Incorporate a program in the church that gives persons the tools they need to manage stress and depression	Educate pastors/clergy about depression	Train layperson members in the church to be “depression” experts
	Address the needs of men differently	Gain the support of the pastors	
	Change depression terminology Educate the community about depression		