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Spirituality and religious coping in African American youth with depressive illness

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Abstract

The research team completed a secondary data analysis of primary data from a 2 phase depression treatment engagement behavioral trial to assess African American adolescents reported experiences of spiritual and religious coping when dealing with depression. The team utilized data collected from twenty-eight youth who participated in focus groups or individual interviews. Qualitative data were analyzed using thematic techniques for transcript-based analysis to identify the key patterns and elements of the study participants' accounts and to extract 6 primary themes. The main themes are reported in this manuscript and include; "Religion as Treatment Incentive", "Prayer & Agency", "Mixed Emotions", "Doesn't Hurt, Might Help", "Finding Support in the Church", and "Prayer and Church: Barriers to Treatment?" Overall, the data suggested that religion and spirituality play a key role in African American adolescents' experiences of depression. As well, it is surmised that these factors may be important for improving treatment seeking behaviors and reducing racial mental health disparities in this population of youth.

Keywords

Religion; spirituality; African American youth; treatment engagement; health disparities; adolescent depression

Introduction

In the latest update to the Diagnostic and Statistical Manual of Mental Disorders (the DSM V published by the American Psychiatric Association (2013), what were formerly known as Mood Disorders were reclassified as Depressive Disorders. Notably, depressive illness

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comprises the only mental health condition classified among the top 5 causes of disability worldwide by the World Health Organization (2012). Once considered the domain of adults, research over the past 30 years has identified the impact of depressive illnesses on children and adolescents (Author, 2015; Author, In Press; Author, 2015; Stein et al, 2010).

Depressive illnesses are associated with high levels of impairment and distress in youth and given the lifetime prevalence of depression (12 to 15% adolescents aged 15 years and older) along with estimates of depressive illness of close to 8% for youth aged 12 to 17, the public health significance of this illness is evident (Centers for Disease Control, 2012; Kessler, Chiu, Demler, & Walters, 2005; Merikangas, He, Brody, Fisher, Bourdon, & Koretz, 2010). In teens, research indicates that depressive illnesses are associated with poor physical health, educational deficits, suicidal ideation, poorer quality of life and interpersonal impairment (Brook, Stimmel, Zhang, & Brook, 2008; Horwood et al, 2010). In general, depressive illness creates significant burdens for youth and their families causing negative impacts in academic performance, peer and familial relationships and quality of life.

Racial disparities exist in the treatment of adolescent depression with African American adolescents demonstrating significantly lower rates of mental health service utilization and reporting lower quality of care compared to their white peers (Author, 2015; Author, 2011b; Cummings & Druss, 2011; Garland, et al., 2005; Tanielian et al, 2009). It has been suggested that stigma, mistrust of providers, under-diagnosis or misdiagnosis of depression are important barriers to care via their significant documentation in the research literature (Chandra & Minkovitz, 2007; Murry, Heflinger, Suiter, & Brody, 2011; Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005). Even when controlling for socioeconomic variables like annual family income, African American youth still underutilize mental health services compared to whites (Author, 2004; Author, 2012).

Religion and spirituality may be culturally congruent mechanisms for reducing African American treatment utilization disparities for depressive illness. Given the high degree to which diverse African Americans/Blacks (including Caribbean Blacks, Continental Africans and varied socioeconomic groups) report religious affiliation and activities, religion and spirituality may be particularly salient for this population. Recent studies from Pew Research indicate that, "African Americans are markedly more religious... than the U.S. population as a whole" (Pew Forum on Religion & Public Life, 2009) with a full 87% engaging in formal religious activities like prayer and religious service attendance (Pew Forum on Religion & Public Life, 2009, p. 1). Though Pew indicates that, in general, younger persons report less religious affiliation than older persons, roughly two-thirds of all Millennials still report a specific religious affiliation and In addition, African American Millennials report the highest religious affiliation when compared to their peers of all other racial groups except Latinos (Pew Research Center's Forum on Religion & Public Life, 2012; Pew Research Center's Forum on Religion & Public Life, 2010). Moreover, among Protestants (i.e. the denomination with which most Christian African Americans are affiliated), African American youth report higher participation in Black churches when compared to other racial groups (24% vs. 14-17%).

Researchers have examined religion, spirituality and coping among youth with interesting results. Mahoney and colleagues describe a construct called sanctification or "an aspect of

life [with] divine character and significance” (Mahoney, Pendleton, & Ihrke, 2006, p. p 354). Molock and colleagues (2006) discovered that among African American youth, girls may utilize this concept of sanctification more than boys for coping. Specifically, girls in their sample reported a greater propensity for working in conjunction with their higher power than boys, who were more likely to report using a self directed coping style (i.e. less reliance on a higher power). Further, the researchers identified the positive benefits for collaborative coping and negative impacts of self-directed coping including associations with greater hopelessness and suicidal behaviours, findings that have been replicated in racially diverse populations of youth (Shannon, Oakes, Scheers, Richardson, & Stills, 2013; Terreri & Glenwick, 2013). In general, African Americans are reportedly more likely to use religion and spirituality as coping resources when facing health challenges and are more likely to report experiences of positive health outcomes attributed to their religious practices including prayer (Gillum & Griffith, 2010; Holt, Roth, Clark, & Debnam, 2014).

Religious forms of coping are also reported by youth and young adults with evidence to support their benefits for health concerns, including mental and behavioral health. For example, high religiosity and spirituality are reported to have positive associations with reduced depressive symptoms and higher self-esteem (Hovey, Hurtado, Morales, & Seligman, 2014; Regnerus, 2003; Weber & Pargament, 2014).

Recently, researchers have capitalized on the benefits of religious and spiritual preferences of African Americans by incorporating them into mental health treatment engagement strategies. Along these lines, *Faith Based Mental Health Promotion (FBMHP)* (a term attributed to Author of X University) promotes African American faith communities as first line, culturally relevant intervention agents that can support improvements in knowledge and awareness of adolescent depression, understandings of appropriate and effective treatments and increases in clinical care engagement (Author, 2012; Author, 2012). New research has expanded FBMHP to African American adults (Hankerson & Weissman, 2012; Williams, Gorman, & Hankerson, 2014).

To date, just a few studies have explored religious/spiritual coping for adolescent depression. For example, while an emerging body of research indicates the receptivity of African American youth to addressing their health care needs in faith settings, other research indicates that church organizational infrastructure (e.g. leadership hierarchy and messages that promote prayer over help-seeking) may be a barrier to professional clinical care (Author, 2011; Author, 2010; Desrosiers & Miller, 2007; Molock, Matlin, Barksdale, Puri, & Lyles, 2008). We sought to expand the knowledge base in this area by examining the interplay of African American youth depressive illness, religious and spiritual beliefs and practices and coping. We define religiosity as an individual's degree of adherence to the beliefs, doctrines and practices of a religion including church attendance, prayer, and other activities (Mattis & Jagers, 2001) and spirituality as emotional well-being, peace and comfort derived from belief in a higher power (Cotton, Larkin, Hoopes, Cromer, & Rosenthal, 2005).

Method

Study design

We used data from The AAKOMA Project, a multi-phase clinical intervention development study for depressed African American adolescents and their families. Research on The AAKOMA Project has been reported elsewhere, including intervention development, baseline data and outcomes (Author, 2012; Author, 2011a; Author, 2010). Our study sample included a socioeconomically diverse group of participants between the ages of 11 and 17 years who self-identify as Black/African American (non Latino) from the southeastern United States. Sample youth came from rural, urban, and suburban settings and had parents with a range of education levels. In fact, over half of the families in our sample reported managerial and professional occupations; approximately half reported annual family incomes greater than or equal to \$50,000.00 USD and almost half reported parental completion of college and/or graduate school.

We utilized standard qualitative focus group and individual interview procedures with the adolescents for baseline data collection. All focus groups were co-led by two trained facilitators and always included the Principal Investigator (author). The PI or a trained postdoctoral fellow completed all individual interviews using questions developed by the PI and 2 expert qualitative health researchers. The questions followed the general theme of describing African American youth experiences with and knowledge of depression, depression treatment and mental health in African American peers. Sample question prompts included, “When you hear the words “emotional problems”, “behavior problems” or “mental illness” what comes to mind? Have you ever personally known a friend or teenager (or maybe even you) who you think might be depressed?”

The following qualitative data are from the 28 youth, 21 of whom participated in focus groups and seven of whom participated in individual interviews. All data were de-identified prior to analysis and were properly vetted by the Georgetown University Institutional Review Board (IRB).

Data Analysis

Following, we provide a brief description and review of the methods used to support qualitative rigor (Author *et al.*, 2011a; Author *et al.*, 2011b; Author *et al.*, 2010). We used transcript-based analysis including the coding of all primary transcripts (i.e. those from the focus groups), follow-up transcripts (i.e. member checking interviews with randomly selected focus group participants), and participant written response notebooks (collected during the primary focus group meetings). These multiple sources of information represent best practices in qualitative research to support methodological rigor and accuracy of information (Cohen & Crabtree, 2006). We also used a Constant Comparative Approach (i.e. “look for statements and signs of behavior that occur over time during the study,” (Dye, Schatz, Rosenberg, & Coleman, 2000 p. 2) in order to generate significant themes. We employed thematic data analysis, which focuses on generating identifiable themes and patterns of behavior based on the report of key informants (Aronson, 1994). Finally, we

utilized Grounded Theory to generate an explanatory theory of processes as they occurred in their natural environments (Starks & Brown Trinidad, 2007).

The PI trained four independent coders including two bachelors level psychology graduates, a doctoral sociology student, and a postdoctoral research psychiatrist. This team of five trained coders individually performed open coding (i.e. grouping together concepts and identifying major concepts and recurrent ideas) then discussed their coding choices (i.e. why they assigned particular themes to sentences or portions of the transcripts) with 1 assigned coding partner. When patterns of convergence emerged (i.e. sections of transcripts were coded similarly), the dyads discussed the similarities and agreed upon terminology for themes. These processes are consistent with open coding practices and allowed the team members to maintain fidelity to primary analysis goal (i.e. ensuring that each allowed themes from the transcripts to emerge independently without a prior hypotheses) (Starks *et al.*, 2007).

Multiple methods ensured that we addressed analyst, data and source triangulation to establish the reliability and validity of the research findings (i.e. multiple sources of data, identifying key informants, data checking with key informants, comparing findings across team members, creating graphic and tabular models of the data) (Cohen *et al.*, 2006). Study validity was addressed in data collection via a random sample of 2-4 members of each focus group participating in a re-interview approximately 4 weeks after initial participation aligned with member checking procedures. Reliability was addressed via inter-rater agreement as described above. We developed an initial codebook according to methods outlined in *Team-Based Qualitative Analysis* (MacQueen, McLellan-Lemal, Bartholow, & Milstein, 2008) resulting in axial codes (broad easily identified themes based on repetition by participants) and complex codes (abstract themes based on evidence of significance as reported by the participants) (Author, 2011). The primary themes reflect full agreement by all coders while the secondary themes reflect agreement between three of the five coders.

Primary Themes

The research team identified six primary themes, which we illustrate with direct quotes following.

Religion as Treatment Incentive

Youth in the study identified religiosity as supportive of individual mental health treatment seeking and stated that they received religious messages admonishing negative thoughts and behaviors like self-harm and recommending therapy as a viable alternative:

“I think that...religion might help somebody go to a counselor or therapist because um...what if something within their religion might be telling them that how maybe if they were thinking of hurting they self or killing their self, um, then like their religion might be telling them to do otherwise, so they need a counselor...”

In this example, the participant articulates how the mores of religion may advise against self-harm while suggesting care-seeking options. In the area of spirituality, another teen

expressed that even when one seeks help from the higher power, additional support via external clinical care may be a reasonable.

“You could just talk to God or your Buddha or whoever but then on the other side and might feel like Buddha or whoever is not interested in your [sic] your, uh, you acti [sic], not interested in you for help and then that is when you have to go into, uh, against reality and try to get help.”

Consistently, the teens in the study indicated that they received messages about self-care for emotional concerns within the faith community setting.

Prayer & Agency

Although the teens identified prayer as important, sample participants note the importance of individual initiative for change (i.e. Prayer and Agency). Agency has been defined as, “the sense of responsibility for one's life course, the belief that one is in control of one's decisions and is responsible for their outcomes, and the confidence that one will be able to overcome obstacles that impede one's progress along one's chosen life course” (Côté & Levine, 2014, p. 145). Youth who reported these feelings appeared to pair prayer with an intrinsic motivation to act on perceived needs as noted in these examples from two youth:

“They think that just by praying everything is going to go away, but sometimes you have to do something yourself.”

“I think they think by praying that might solve all their problems, which I'm not saying it doesn't and I'm not rejecting people praying or anything like that but I do think God gives us people here to help us. And I don't think a lot of people realize that.”

In both examples, the youth express the importance of taking initiative to seek help outside of prayer. Youth acknowledge the import of prayer for addressing problems, and they understand the power of active self-care.

Mixed Emotions

Study youth also expressed contradictory feelings about receiving emotional support from faith community members whom they sometimes experienced as disingenuous. For example, one youth stated,

“Cause they'll tell you, they'll tell you [sic] ‘Oh, we wouldn't judge you on that blah, blah, blah, blah, blah,’ and then they come right back around and they judge you on it and they're doing the same thing”.

Another youth further illustrates such mixed feelings by indicating,

“yeah, there are certain people who you can talk to about things and there are certain people you can't talk [to].”

Conversely, sample youth reported that there are often people in their faith communities from whom they can obtain support. For example, one respondent indicated,

“They accept the fact that you're going through some things and they're going to help you.”

For some youth, their mixed feelings about seeking help within the faith community, weighed heavily upon whom they decided to trust as evidenced following:

“certain people I just don't talk to, because I, I don't feel that trust is there. But I got, um, people that I can go to and I know automatically that I can trust them. So, if they ask me ‘what's going on?’ I'd be, like, ‘I don't want to talk about it right now,’ but they know something is up, because they know me.”

It is their varying experiences and mixed messages from adults and faith leaders that contributed to youth ambivalence towards help seeking within the faith community setting.

Doesn't Hurt, Might Help

Even though sample youth expressed mixed feelings and some uncertainty about help-seeking within the faith settings, the youth generally reported that the benefits of receiving help in faith settings (and reliance on their faith) outweighed the costs. For example, when one teen was asked why African American youth seek help from people within their faith communities the teen responded:

“Um, because like encouragement. How they know things, like, you know, why's and stuff and again, then again, I would sometimes go to my mom because like, that would be...I mean, like, um, like you were saying, like they know, they been through the same thing.”

In this example, the teen articulates the importance of receiving encouragement from the church community based on authority figure's lived experience. Supporting this idea, a teen in an individual interview was asked if he/she felt that faith or religion influences a teen's decision about clinical care and she responded *“It might help more than likely, yeah.”* When asked if he/she could recall individuals in his/her faith community discussing therapy for mental illness she responded, *“Yeah...encouraging them to go”*.

Overall, youth in the study reported that their faith communities provided a safe and secure environment that increased their willingness to confide in faith community leaders for emotional concerns and the likelihood that might consider outside clinical care when encouraged by their faith communities.

Finding Support in the Church

Most study participants reported on the importance of having a trusted authority figure as a confidant, including faith leaders. It is through these relationships that many youth found a pathway to considering external support. For example, one teen noted,

“I would go to her [Godmother] because she's a minister, and like when she was young like back in the day, like, she did some stuff, like, I'm not going to say what it was but she, she did some stuff. But then she was like, God delivered her from stuff, and, like, if she can go through something that bad and then be where she is

today then I know I can make it with the little stuff that I'm going through. You know what I'm saying?"

In another example, a teen expresses how self-disclosure, or the lack thereof, impacts the relationship between teens and faith leaders.

"Even though it may seem that they don't have any problems, but then when they really talk to you they, they do. But then it comforts you because every time they see you they got a smile on they, their face. So that means that when you, um, even though you going through something just like they're going through something, you can still be happy and have a smile on your face".

Sample youth also reported feeling support from faith community adults for seeking specialty mental health care.

"...the people there kind of...try to...convince people to go to the counselor if they are feeling bad about they selves. They would try to do what is best for you, so...if you didn't want to go to therapy, they would probably try to convince you to go..."

Overall, the youth in the sample reported feeling encouraged by faith community members and having the sense that these were individuals with whom they could relate when self-disclosure occurred.

Prayer & Church: Barriers to Treatment?

Although, prayer and church were reported to provide overall positive benefits, study youth also reported that the, sometimes, rigid ideals and values held within faith communities could be a hindrance. For example, sample youth stated:

"I think that especially ... religious black people or Christian Black people are usually like, okay, 'All you have to do is take your troubles to God and he'll deal with it' and "...I think that people, teenagers especially, don't get help because of what other people say about you know, how you should pray and all that 'well, you don't need no drugs because all you gotta do is pray'".

"I think that faith has a big part in impacting teens' decisions when it comes to seeing a therapist, they solely depend on God sometimes if they are Christians and say they don't need help."

Another barrier, referenced under "Finding Support in the Church", was teens' perceptions of faith community leaders as unrelatable because they do not share personal struggles. Youth in turn become fearful of self-disclosure themselves for fear of being judged.

"When I look at people in the church, like, ministers or whatever, I see, I see, like, like, some – yeah, like they don't have no problems or whatever and then, like, if I go talk to them...it's like, okay, I'm different."

Overall, youth describe the contradictory messages they sometimes receive from faith community members.

Discussion

Essentially, the data derived from the sample highlighted African American youth's mixed feelings about the interplay of religion, spirituality and faith communities with the needs of depressed teens. They described feelings of ambivalence about how they are received in faith settings and by faith community members and discussed the mechanisms that drive and impede their help-seeking for depression.

One recurrent idea was prayer; a mechanism that researcher have examined in relation to health outcomes and coping. Pargament (1997) provides an excellent framework for religious coping via three proposed mechanisms; self-directed, deferring, and collaborative. These mechanisms are quite relevant for the youth of our study in that our sample teens clearly described their use and perceptions of positive community regard for prayer as a form of collective coping. In this vein, our themes of “Religion as Treatment Incentive and Finding Support in the Church” highlight the importance of collective coping via prayer and “Prayer and Agency” as a form of prayer coupled with personal initiative. Given this, our research team suggests a few ways in which prayer might be incorporated into clinical work and research with African American teens.

For example, recent research has examined the intersection of prayer with health coping including a measure called, RCOPE (Pargament, Feuille, & Burdzy, 2011) Using the RCOPE measure, a team of researchers discovered that negative religious coping, which they characterize as, “spiritual tension, conflict and struggle with God and others,...negative reappraisals of God's powers (e.g., feeling abandoned or punished by God),...spiritual questioning and doubting, and interpersonal religious discontent.” (Pargament et al., 2011, p. 58) is a strong predictor of poor health outcomes, like negative adjustment after a health event (Ai, Seymour, Tice, Kronfol, & Bolling, 2009). Conversely, positive religious coping is associated with positive health outcomes like managing stress, a positive outlook post health events and better social support (Pargament *et al.*, 2011).

The practical application of this knowledge might include the efforts of a practicing clinician, comfortable with collaborative religious coping, inviting a teen to share the lessons learned from peers and faith leaders that would support his/her continuation in treatment. For example, an oft-stated colloquialism in Christian Black churches is “God helps those who help themselves” and such a tenet might be very useful for supporting treatment engagement by a teen. Additionally, it might also be useful for a clinician to encourage a teen patient to take lessons learned through mindfulness or CBT in treatment out into his/her faith community. When done carefully and with all of the appropriate considerations for confidentiality and privacy, these techniques might yield a multi-faceted benefit by a) culturally encapsulating clinical techniques outside the session to normalize them for the teen, b) encouraging the use of techniques learned in session outside of the clinical encounter, therein reinforcing the practical use of the skills in daily life, c) supporting the use of social support and collaborative coping and d) reframing evidence based approaches to fit the cultural norms of the population. Such an approach might have the added benefit of helping a clinician demonstrate cultural competence.

Youth also described that they are sometimes encouraged to “pray to fix everything” an ideal that seems well aligned with the concept of deferential or deferring religious coping. Unfortunately, in the context of mental health, this approach may have detrimental impacts. For example, studies indicate that a deferring approach to health concerns is one aspect of negative religious coping (e.g. “ my suffering is God's retribution for my sins”), which is associated with poorer psychological adjustment to stress and other health outcomes (Ano & Vasconcelles, 2005; Pargament *et al.*, 2011). In essence, while a deferring approach might alleviate depressive symptoms temporarily (i.e. “Let go because this is part of God's plan”), it may not serve an adolescent's immediate needs for relief from depressive symptoms and in turn may delay the onset of care.

Generally speaking, it may be more helpful for African American teens (with the propensity for religious coping) to develop an active religious or spiritual coping style to encourage practical steps to alleviate their depressive symptoms. In this regard, a clinician might explore with an African American teen how he or she views deferring coping and whether or not he or she observes this in the messages received at home and in the faith community. In doing so, the clinician can ascertain whether or not additional clinical strategies are needed to help the adolescent patient understand and reframe such messages into his or her clinical treatment plan. For instance, using some of the techniques of Motivational Interviewing, a clinician might work on “rolling with resistance” to active coping and explore the pros and cons of how a deferring coping might impact the process of recovery from depression.

The African American youth in our sample discussed their perceptions of the helpful aspects of their own religious/spiritual practice in relation to seeking support for depression as well as the support they feel from some leaders in the faith setting. These sentiments are well aligned with the positive regard held toward the “Black Church” among African Americans. In fact, the centrality of Black churches in social activism and social justice movements historically solidifies their positive status within the culture (Berkley-Patton et al, 2010; Harley, 2005; Young, Griffith, & Williams, 2003). As it relates to clinical service provision, clinicians working with African American youth and families might inquire at intake about familial involvement with their personal faith communities. In doing so, a clinician can actively support this important relationship and build rapport with a teen and family in a culturally congruent way.

Limitations and Future Research

The research study presented provided important examples of the mechanisms employed by African American youth that may increase and hinder depression coping and treatment seeking via specialty mental health care.

Though this research study is innovative and has not been widely represented in the research literature in the past, it is important to acknowledge the small sample size of the study. Though the sample was small, it was more socioeconomically representative than is typically the case in child and adolescent mental health research, which tends to focus on highly impoverished Black youth. However, because of the wider representation of socioeconomically diverse African Americans in this study, it provides a strong starting point upon which to build future research.

Given the limited evidence base for depression treatment among African American youth, future research should examine the utility of FBMHP as a support for depression treatment. Though religiosity (via regular practice) and spirituality are neither identical nor universal among African Americans, both are culturally congruent. For example, it has been reported that mental health benefits may be generated from one's commitment to core beliefs (i.e. spirituality) and not solely church attendance (i.e. religiosity) (Greening & Stoppelbein, 2002). Therefore, researchers might separately examine the mechanisms of change of spirituality and religiosity for depression awareness and treatment among African American teens.

Overall, an emerging research base supports the import of religion, spirituality and the potential for FBMHP in African American teens and families (Author, 2013). Additional research can develop the evidence base for FBMHP and illuminate the mechanisms of change to support African American youth and families in improving depression (and other mental health) treatment utilization via religion and spirituality.

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