

**A MANUAL TO SUPPORT CLERICAL INTERVENTIONS FOR AFRICAN
AMERICAN WOMEN WITH DEPRESSION**

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Abstract

Many cultural factors influence how African American women experience and manifest depression, as well as how they seek treatment for it. Many rely on their clergy for support. Through review of current research and best practices literature, strategies African American clergy can use to provide culturally appropriate treatment to African American women with depression were identified and compiled into an outline to develop a counselling manual. The proposed manual was developed with a focus on the unique cultural concerns of African American women, and Africentric worldview. The outline describes empirically supported interventions in language that is easily understood by clergy, counsellors, and laypeople. The development of such a manual should increase the culturally appropriate resources available to African American women battling depression, and pave the way for future collaboration between counsellors and clergy in developing culturally appropriate interventions. For this proposed manual, African American and Black women are defined as female descendants of Africans brought to the United States in slavery, and that align themselves with this cultural group.

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Chapter 1: Introduction

Depression is a serious illness that is much more debilitating than occasionally feeling sad (American Psychological Association [APA], 2009; National Alliance on Mental Illness [NAMI], 2009). Indeed, it is considered the greatest non-fatal disease burden and fourth leading cause of disability for women around the world (World Health Organization [WHO], 2000). Depression is often a chronic illness (Miranda, Chung, Green, Krupnick, Siddique, Revicki, & Belin, 2003), but the onset may not be obvious because it can be a gradual process (NAMI, 2009). However, once depression has developed, disturbances in mood, concentration, sleep, energy level, interests, appetite, social behaviour, while developing feelings of worthless, excessive guilt, and recurring thoughts of death or suicide (APA, 2009; NAMI, 2009) show a marked change in personality.

Narrowing the global focus, approximately 7 million women are diagnosed with depression each year in the United States alone (Carrington, 2006). Even though depression is considered the central illness robbing American women of their well-being (U.S. Department of Health and Human Services [USDHHS], 2000), and is highly treatable, it remains a frequently undiagnosed and untreated illness (Carrington, 2006; Simpson, Krishnan, Kunik, & Ruiz 2007). Furthermore, American women are a diverse demographic, and the prevalence of depression in African American women within that demographic is unclear because their experience of depression has not been widely studied (Braithewaite, Taylor, & Treadwell, 2009; Carrington, 2006; Hunn & Craig, 2009; Jackson, 2006, Payne, 2008). The few studies that have compared experiences of depression between African American men, African American women, and White men and White women suggested that African American women are more likely to experience the most chronic and most severe

depressive episodes than the other groups (Braithewaite et al., 2009). Since depression is such a common and complex mental health illness (Hall, 2009), and there is an expected population shift to half the American population being made up of racially diverse people within the next 50 years (WHO, 2000), it is imperative to branch out from Eurocentric definition and treatments of depression to one that accommodates African American women.

Gaps in Current Research

Few treatment models for depression have focused on the experience of depression for African American women (Jones & Ford, 2008; Simpson et al., 2007), and the scant research that does investigate the experience of depression is typically focused on White, middle-class, American, Protestant males (Heath, 2006). This is both unfortunate and negligent because depression affects morbidity and mortality of all people who suffer with it. Therefore, it is critical for counsellors to move toward a method of practicing that accurately explores and assesses mental health in specific populations (Heath, 2006). Given that the symptoms of depression for African American women are connected to their feelings of loss of control and an inability to cope with their lives, a strengths-based approach would be particularly useful in helping clinicians understand how African American women's ability to function competently in dealing with their oppressive realities that often lead to depression (Jones & Ford, 2008).

Mental health professionals use their skills and experience to help clients achieve lives of improved functioning and fulfillment, but there are times when alternate skills, training, and support are necessary (Franklin & Fong, 2011). It is suspected that African American women with depression either delay or avoid seeking treatment for depression in traditional mental health settings, which leaves many researchers believing they may

be seeking support from African American clergy (Jackson, 2006; Payne, 2008). The religious influences of African American women shape their understanding of both depression, and how to overcome it (Payne, 2008). Churches have a great opportunity to reach out to the African American women who are hurting, and there is research indicating that African American women with depression are seeking support from religious leaders (Franklin & Fong, 2011). By exploring how African American women experience depression, and the role African American clergy play in treating it, culturally appropriate interventions for depression can be developed to share with African American women.

Role of Clergy in Treating Depression in Other Cultures

Importance of involving clergy. Even though depression is widely considered a major yet preventable problem in the United States, many people eschew treatment from mental health professionals in favour of confiding in their clergy (Farrell & Goebert, 2008; Payne, 2009). Clergy hold a unique position of being trusted, accessible healers across cultures, and are typically the first responders to personal crises (Payne, 2009). For example, clergy handle pre-marital and marital counselling, weddings, Christening ceremonies and baby dedications, funeral arrangements, and bereavement counselling. Thus, clergy are very familiar with handling the emotions that accompany life transitions or struggles, and may very well be the first people outside of family to be aware of the symptoms of depression in their congregants (Milstein, Manierre, Susman, & Bruce, 2008; Payne, 2009). In addition, clergy expect to see their congregants often, and often know multiple generations within a single family. By virtue of these extensive, lifelong relationships, clergy often have more comprehensive information about their congregants

and their family histories than do mental health professionals (Milstein et al., 2008). Therefore, it is likely clergy hold more intimate and holistic views of their congregants than most mental health professionals too.

It is not uncommon for religious Americans to conceptualize depression within a religious framework that differs from the perspective held by mental health professionals (Neighbors, Musick, & Williams 1998; Witherspoon & Arnold, 2010). According to Neighbors et al. (1998), most religious people with depression do not seek treatment for it; rather, they learn they have it when seeking assistance for other health issues. However, Neighbors et al. (1998) go on to say that religious people who do seek treatment for depression go to one common professional: clergy. When congregants meet with clergy, they receive the understanding they are looking for, and are therefore not motivated to seek support for depression elsewhere. Because research indicates that most people are seeking assistance for depression from clergy, there is a question about whether members of the clergy are adequately trained to treat it (Farrell & Goebert, 2008).

Knowing that depression is prevalent in the United States, and the volume of religious people that seek support from depression from clergy is large, it is important clergy are able to treat it (Franklin & Fong, 2011). Some psychologists have recommended that clergy and mental health professionals collaborate in depression care (Milstein et al., 2008), but it can be difficult for clergy to decipher when people are depressed because the belief systems of clergy may be different than those of mental health professionals (Franklin & Fong, 2011). In a survey done by Farrell and Goebert (2008), clergy typically did not refer congregants expressing classic symptoms of

depression or suicide to mental health professionals or physicians because clergy members' ability to identify serious mental illness was lacking. These researchers suggested this finding speaks to the need for mental health providers to ascertain how clergy understand depression, and provide further knowledge as needed. However, Farrell and Goebert (2008) cautioned mental health professionals from belittling faith-based explanations of depression to avoid alienating clergy, and shutting down this sharing of knowledge.

There are potential benefits to collaborating with clergy too. Working with clergy could actually reduce clinicians' professional burden (Milstein et al., 2008) because clergy are more accessible than mental health professionals time-wise and economically (Neighbors et al., 1998). Also, their role as frontline responders to personal crises means clergy serve as natural advocates within a community, and constitute a cultural bridge between people and professionals (Kramer, Blevins, Miller, Phillips, Davis, & Burris, 2007). In addition, faith-based communities may improve the knowledge base of the public about depression and its treatments by sharing this knowledge in their continued contact with people (Kramer et al., 2007). For these reasons, it would be valuable to find ways to develop faith-based interventions for clergy. As this relates to African American women specifically, African American clergy would be able to draw upon powerful cultural resources, traditions, narratives, and viewpoints not available to most mental health counsellors (Paukert, Phillips, Cully, Romero, & Stanley, 2011; Williams & Frame, 1999).

Ascertaining how clergy define depression. Just as worldview shapes clients' explanatory beliefs about depression, so do the worldviews of clergy. Consequently,

clergys' definitions of depression can both facilitate and hinder treatment for their congregants depending on if they hold similar explanatory beliefs as their parishioners (Kramer et al., 2007). Payne (2008, 2009) observed that White American Christian clergy more readily agreed with the statement that depression was a biological mood disorder, but African American Christian clergy more readily agreed that depression was a sign of personal weakness, sinfulness, or hopelessness resulting from a lack of trust in God. Research also shows that African American women hold similar views of depression as African American clergy (Payne, 2009). This is an especially important point when counsellors keep in mind that clergy are often the first person contacted many women with depression.

To help clinicians understand how African American clergy conceptualize depression, Payne (2008) coded ten sermons randomly selected from African American Christian clergy in the United States. These sermons were coded in response to these research questions of how they discuss symptoms of depression, what words they used to name it, and the beliefs around treatment. The coding of these sermons showed that terms like "crazy" were used when discussing mental health, but the terms "mental health" or "mental illness" were never used. Also, the clergy publicly encouraged a reliance on Jesus over secular resources to achieve wellness. Furthermore, the clergy of these sermons used a multiplicity of terms to discuss depression, rather than using the word depression itself.

To be clear, the intention of this study was not to denigrate African American clergy but to emphasize how vital it is to understand the explanatory beliefs of clergy and parishioners toward depression. Researchers need to converse with clergy in non-

threatening, non-judgmental discussions to gain an understanding of these faith-based explanatory beliefs of depression. Clergy are highly skilled professionals with numerous cultural resources at the ready (Flannelly, Stern, Gosta, Weaver, & Koenig, 2006; Paukert et al., 2011; Payne, 2008). The goal is not to re-educate clergy, but to create a rapport in which both sets of professionals assist each other for the sake of the clients.

Ascertaining how clergy view people with depression. As mentioned earlier, some African American clergy view depression as the result of personal weakness, sin, or lack of faith. This in turn influences how these clergy view their congregants that are depressed. In Payne's (2008) research, it was found that active praise was an essential part of the religious experience, and people who are non-responsive to charismatic worship services are thought to be hostile. People with depression may struggle in energetic worship services because they do not have the energy to engage in the fervour. Thus, they may be labelled as hostile, or blamed for their negativity. Such assumptions may hinder congregants with depression from seeking help even from clergy because the cultural stigma of depression is being reinforced (Payne, 2008).

Ascertaining the views clergy hold of treatment. Many clergy feel inadequately trained in recognizing and treating depression, they often proceed to do so because parishioners are reluctant to seek help for depression elsewhere (Farrell & Goebert, 2008; Neighbors et al., 1998). In addition, many clergy view themselves as capable as mental health professionals to treat people with depression because they have more comprehensive knowledge of their parishioners as compared to mental health professionals. (Neighbors et al., 1998).

In determining how to counsel African American women with depression, African American clergy engage in a filtering process in which they attempt to differentiate whether parishioners are experiencing mental health crises, life or social crises preceded by major stressors, or spiritual crises. At some point, they then determine whether individuals need to heal through spiritual interventions like prayer, worship, and scripture readings, or intensive counselling with clergy (Kramer et al., 2007; Neighbors et al., 1998). There are also some definite, unwritten “do’s” and “don’ts” in regards to formal treatments. Payne (2008) found that the rules of don’t trust White healthcare, don’t be counted amongst those called “crazy”, don’t be weak, don’t cry, and don’t take medication publicly were heavily emphasized for African American women, but reliance on Jesus and the church family is stressed as acceptable. While many mental health professionals would balk at this process, it does blend secular and spiritual interventions in a culturally acceptable manner while holding depression in a religious framework rather than a medical one (Kramer et al., 2007; Neighbors et al., 1998). Therefore, it should not be assumed by mental health workers that African American clergy will automatically refer parishioners with depression to them, but rather it should be assumed that it is the responsibility of African American clergy to treat African American women with depression.

One way to develop culturally appropriate treatments for African American women with depression would be to examine how clerical support networks function in the African American culture. Neighbors et al. (1998) noted that in the African American culture, social networks involve a lot of trust, and are not as heavily influenced by age factors as in other cultures. Therefore, folk remedies and indigenous therapies passed

from generation to generation, and African American clergy have been informal, indigenous healers for African American women for centuries. By involving them in the treatment of depression for African American women, the culture as whole may benefit as new, faith-based interventions for depression trickle down through support networks and generations (Kramer et al., 2007; Milstein et al., 2003; Neighbors et al., 1998; Payne, 2009).

Using Rabbis as an example of how clergy work with mental illness. Flannelly et al., (2006) conducted a meta-analysis of 21 articles pertaining to how rabbis engaged in mental health care with their depressed parishioners. Overall they found similar themes that have been discussed already. Namely formal and informal contact rabbis have with members of their congregations allows them establish long-term relationships with families, and the many opportunities they have to observe changes in behaviour early on. They are also hold a unique position of trust in their faith communities, and have more freedom to support parishioners in a culturally appropriate context. Also, Jewish people feel more comfortable receiving care from a professional who is educated about Jewish culture and practices.

Flannelly et al. (2006) go on to explain that because parishioners come to them to disclose personal problems, they are in an ideal position to recognize and treat mental illnesses like depression. However, they do caution that as in other denominations, rabbis need support to treat depression. Most of their research indicated that rabbis wanted more knowledge on depression, also that mental health professionals needed more knowledge of religious explanations of depression. To start that sharing of knowledge, Flannelly et al. (2006) suggested that mental health professionals spearhead educational programs

about depression specifically oriented towards rabbis and other clergy. Doing so would give rabbis a chance to incorporate the values of the Jewish with depression interventions.

In sum, the articles addressed the need for collaboration between rabbis and mental health specialists, and given the important role that religion has in the lives of many people, mental health specialists should recognize the importance of treating mental health problems in a spiritually sensitive manner. Thus, by working together, rabbis and other mental health professionals can improve the health of parishioners with depression.

Ascertaining the specific role of African American clergy. Payne (2008) noted that religious communities are a source of support for most African American women. For African American women who do not find much welcome in the wider society of the United States, religious communities may be the only places they feel accepted and valued. Payne (2008) also highlighted that the Africentric worldview of African American women leads them to attribute a high level of importance of defining depression in a religious framework. African American clergy are firmly embedded within African American culture in a way that mental health professionals will never be, and it is time to work with that fact rather than against it (Neighbors et al., 1998). In addition, religion remains a pillar in the African American community, and represents more than a place of worship. Indeed, it stands as a testament of the survival against the centuries-old discrimination and marginalization African American women have had thrust upon them (Witherspoon & Arnold 2010). Thus, African American clergy have the most influence on the help-seeking behaviors of African American women with

depression. Much research remains to be done to support African American with depression. It is time for faith-based, culturally appropriate interventions for depression to be placed in the hands of African American clergy so they can be shared with African American women with depression (Flannelly et al., 2006; Jackson, 2006; Neighbors et al., 1998; Payne, 2008).

Rationale for the Importance of Developing a Manual

The Diagnostic and Statistical Manual of Mental Disorders-TR, fourth edition (DSM-IV-TR; APA, 2001) emphasizes the universality of depressive symptoms while neglecting to identify culture-related symptoms (Waite & Killian, 2007). Failing to incorporate worldview into the diagnostic process leads many people to think treating depression is a standard practice that crosses cultures smoothly (Hunn & Craig, 2009). Although specific universal criteria are used to diagnose depression, gender and sociocultural dimensions influence how African American women experience and manifest depression, and how and from whom they seek help for overcoming it (Chung, Jones, Jones, Corbett, Booker, Wells, & Collins 2009; Hunn & Craig, 2009; Waite & Killian, 2007).

It is suspected that more African American women struggle with depression than White women and women of visible minority groups (Carrington, 2006), but rates of clinical treatment for them are the lowest of all visible cultural groups in America (Das, Olfson, McCurtis, & Weissman, 2006; Simpson et al., 2007). Vontress, Woodland, and Epp (2007) asserted both psychological problems and solutions emerge from the culture in which people live, which means that the influence of culture must be acknowledged in order for African American women to receive accurate diagnoses and treatment of depression (Carrington, 2006). Waite and Killian (2007) added that culturally appropriate interventions are needed to

address the unique health needs of African American in relation to depression.

Typically African American women are the most comfortable around others of their own race (Das et al., 2006), particularly their clergy (Waite & Killian, 2009). Clergy are viewed as the nurturers of their parishioners (Chung et al., 2006), so it is acceptable for African American women with depression to bear their struggle to clergy because they are helping clergy fulfill their nurturing role (Ojeda & McGuire, 2006). African American clergy also have some distinct advantages over most mental health professionals when it comes to understanding depression in African American women. For example, they have the same worldview of African American women (Kohn, Oden, Munoz, Robinson, & Leavitt, 2006). Most important though, they already have the trust of African American women, an efficacious ingredient for any successful treatment (Waite & Killian, 2009). Through review of current research and best practices literature, the goal of this project is to identify strategies African American clergy can use to provide culturally appropriate treatment to African American women with depression, and propose an outline for a counselling manual explaining the collected strategies.

Existing research shows that depression interventions can benefit African American women if those interventions are placed in the hands of African American clergy because clergy are usually the first and only people African American women with depression will seek support from (Ojeda & McGuire, 2006; Schulz, Israel, Gravlee, Mentz, Williams, & Rowe, 2006). Therefore, rather than trying to force African American women with depression to seek out mental health professionals, it makes more sense to place appropriate depression interventions in the hands of the African American clergy (Jones & Ford, 2008). The purpose of outlining this manual is two-fold. First, it is to address the needs of African

American women with depression in accessing culturally appropriate support. Second, the aim is to provide culturally appropriate depression interventions to African American clergy because they are the people African American women are most likely to turn to in times of distress. The development of such a manual will hopefully increase the resources available to African American women battling depression, and pave the way for future collaboration between counsellors and African American clergy in developing culturally appropriate interventions. Through a review of current research and best practices literature, the goal of this project is to identify strategies African American clergy can use to provide culturally appropriate treatment to African American women with depression.

For this proposed outline of a manual, African American women are defined as female descendants of Africans brought to the United States in slavery, and that align themselves with this cultural group. In addition, religion can best be understood as shared set of beliefs and practices developed in a community of people who have similar understandings of the transcendent. These beliefs and practices are designed to mediate the community's relationship with the transcendent (Hodge and Bonifas, 2010). In this proposed manual, religion refers to Christian denominations in the United States.

Chapter 2: Literature Review

There is no doubt that depression is a major mental health issue African American women face, but current research is usually involves White women, and most treatments are based on norms of health for White men (Heath, 2006). Although the feminist perspective in psychology challenges cultural ideologies that universalize traits of women, it neglects to integrate the diversity of the African American female experience (Jones & Ford, 2008). For instance, traditional feminist models have mirrored the characteristics of educated White women, and they use language that applies these characteristics to all women (Jackson, 2006). Thus, African American women's experiences are viewed using a perspective that may account for gender, but overlook the implications of culture in psychological wellbeing (Schulz et al., 2006).

The experience of being both African American and female is unique, and truly understanding the sociocultural factors that influence African American women's life experiences is essential to understanding the context in which their mental health is shaped (Chung et al., 2009; Heath, 2006; Hunn & Craig, 2009). In this literature review I will discuss a few of these sociocultural factors: characteristics of African American women, effect of Africentric worldview on help-seeking behaviour, impact of cultural history on the etiology of depression, current cultural stressors, multiple familial roles, strong black women, racism and discrimination, culturally bound symptoms, culturally appropriate interventions, and the role of religion. By doing so, I will demonstrate that African American clergy can be a better fit for treating depressed African American women than mental health counsellors at times.

Characteristics of African American Women

There are many reasons for African American women with depression to seek support from African American clergy instead of counsellors. Post-slavery issues of racism and oppression continue to influence the social and economic standing of African American women, who are still, in the 21st century, at the bottom rung of the hierarchical ladder economically, socially, and politically (Hunn & Craig, 2009; USDHHS, 2000). Vontress, et al. (2007) assert more than 250 years of enslavement, prejudice, and discrimination has resulted in a race specific chronic depression characterized by hostility, anger, and self-hatred. Specifically, they suggest African American women with depression have internalized the pervasive rejection, hatred, and discrimination historically heaped upon them by the dominant White culture of America.

Furthermore, Heath (2006) noted that a lack of cultural awareness plagues the mental health field in terms of some counsellors developing patterned responses to all clients with depression without taking culture or gender into account. She explained that African American women already face gender and class disadvantages, so the adoption of patterned responses can result in African American women with depression being denied access to appropriate treatment because they are being treated according to Eurocentric norms of health. In her research, Carrington (2006) found that mental health professionals who use patterned responses with African American women with depression are more likely to misdiagnose depression as schizophrenia, and over-medicate them rather than delve into their reality, a finding echoed in Vontress et al.'s (2007) research. It is understandable then that African American women avoid mental health professionals (Etowa, Keddy, Egbeyemi, & Eghan, 2007).

Yet, African American women with depression do not seek help for depression from family and friends either (Etowa et al., 2007). Some research indicates that depression is just not understood in the communities of African American women (Etowa et al., 2007; Vontress et al., 2007). More research indicates that African American women do understand it, but believe it is not an appropriate topic of conversation because it is only an emotional issue which is not as important as physical ones (Waite & Killian, 2007). Still, more recent research suggests that indeed African American women understand depression very well, but they avoid discussing it because there is a cultural taboo about African American women going ‘crazy in the head’ (Neighbors et al., 1998, p. 761). Even if African women with depression do reach out to family and friends for support, there is a high likelihood of the women’s depressive symptoms being attributed to physical health problems due to either a lack of awareness of what depression is, or the cultural stigma surrounding mental illness (Stansbury, Brown-Hughes, & Harley, 2009). Shying away from discussing of depression with their family and friends means African American women with depression are usually just left with the option of approaching their clergy for support.

In addition to these reasons for African American clergy being the best option for African American women with depression, they have an advantage over mental health professionals. African American women with depression can engage in particular self-destructive coping mechanisms that African American clergy may be quicker to identify than mental health professionals would. For example, Waite and Killian (2009) found that many African American women with depression demonstrated self-destructive behaviours such as overeating, consuming too much alcohol, and shopping excessively.

While anyone of any cultural group could demonstrate these same behaviours as a part of a myriad of disorders, Waite & Killian (2009) found them to be a unique feature to African American women with depression. Furthermore, African American women have a unique language to describe the experience of depression. Therefore, African American clergy with their shared cultural norms may be quicker to identify these behaviours as coping mechanisms for depression than mental health professionals may be.

Waite and Killian (2008; 2009) also found that African American women with depression recognized they were emotionally drained, but they frequently ignored these symptoms because of the need to manage the more urgent physical needs of their families. They also found that the African American women in their study believed depression was an intrinsic weakness to be ashamed of, and that only African American clergy with their cultural similarity and assurance of confidentiality should know of such a weakness. For the women in these studies, the risks of not providing for their families by prioritizing their emotional needs and of being seen as weak to others meant that being vulnerable to their clergy was the only acceptable option for seeking help for depression.

One factor that some African American women and African American clergy share to give clergy this advantage over counsellors is an Africentric worldview. Neblett, Hammond, Seaton, & Townsend (2010) studied the Africentric worldview extensively, and found that African Americans with this worldview value religion, and view life's challenges as opportunities to turn to the Lord for strength. This more recent study corroborates the findings of previous research regarding the Africentric worldview. Previous research has also established this holds true for African American women across the United States, regardless of urban or rural location (Simpson et al., 2007; Stansbury et

al., 2009). As it applies to African American women with depression, the Africentric worldview can act as a buffer from more severe depression by giving them a framework to view obstacles as opportunities for showing spiritual or religious strength. In reference to African American clergy, the Africentric worldview gives them common ground with African American women with depression, and they can use it to encourage proactive behaviour. In essence, an Africentric worldview creates a positive a framework for African American women to be hopeful about the range of available coping resources for dealing with a stressful situation (Neblett et al., 2010).

Effect of Africentric Worldview on Help-Seeking Behaviour

The unique perspective—or worldview—of a cultural group influences the etiology of depression, as well as treatment options (Arthur & Collins, 2010; Brown, Abe-Kim, & Barrio, 2003; Waite & Killian, 2007; Waite & Killian, 2008). In addition, the worldview of a cultural group influences how much members of that group normalize the symptoms and experiences of depression, and whether health is viewed as a holistic measure that incorporates well-being (Brown et al., 2003). For African American women, the experience and symptoms of depression have been normalized to the point that many consider it a natural, expected part of life (Primm, Cabot, Pettis, Thi Vu, & Cooper 2002). In addition, this normalization is often passed from generation to generation, leading African American women to make their decisions about recognizing and treating depression based on the denial of care that shaped their ancestors' lives (Nicolaidis, Timmons, Thomas, Wahab, Mejia, & Mitchell 2010). Unfortunately, very little research specifically addressing African American women's health has been undertaken from the perspective of African American women, creating the dire situation that most health

professionals do not understand the needs of this group (Etowa et al., 2007). However, with population trends indicating a growing increase in diversity, it behooves clinicians to acknowledge that the Eurocentric views traditionally used in care may not be appropriate to use with African American women with depression (Carrington, 2006).

The Africentric worldview held by African American women also emphasizes collectivism (Heath, 2006; Neblett et al., 2010). This worldview can be found to some extent among most African American women (Townsend, Hawkins, & Batts, 2007), and in fact African American women tend to emphasize that their lives are not lived as discrete individuals, but as members of families and communities (Etowa et al., 2007). Due to its emphasis on interconnectedness and cooperative effort, most people would expect that African American women would seek out treatment for depression to keep the health of their families and communities intact, yet that is not the case. Because of their collective identity, African American women have a significant sphere of collectively defined responsibilities, and they feel obligated to protect the collective group from any negative situation that could harm its solidarity, such as showing weakness, or relying on outsiders (Carrington, 2006). The nondisclosure of depression and its symptoms because of socialization and culture has far-reaching implications for treating depression in African American women (Hunn & Craig, 2009); mainly that breaking from the collective group is seen as a betrayal of their responsibility to protect it (Das et al., 2006). Therefore, mental health professionals should not expect African American women to seek treatment for depression from them.

This does not mean African American women with depression never seek out professional help. Rather, when they do seek treatment for depressive symptoms, they are

just looking to people other than mental health professionals (Etowa et al., 2007; Thomas, Witherspoon & Speight, 2008). Trust in the professional—whether counsellor or African American clergy—shapes the degree to which African American women will follow through on treatment recommendations. When considering historical medical discriminatory practices, such as the Tuskegee experiment that involved the unethical denial of treatment to African American subjects infected with syphilis, it seems reasonable for African American women to distrust large institutions and professionals (Hunn & Craig, 2009). Even with the same recommendations, African American women with depression are much more likely follow through on suggestions for managing depression when the suggestions come from their African American clergy as opposed to mental health professionals (Chung et al., 2009; Townsend et al., 2007). This is part of why African American clergy should be provided with the tools needed to support African American women with depression (Chung et al., 2009; Neblett et al., 2010).

The Africentric worldview is also shared generationally (Neblett, et al., 2010). In their research, Vontress et al. (2007) noted that this worldview has its roots in slavery, and suggested that the survival skills learned in that era are transmitted from one generation to the next. Therefore, if matriarchs found strength to survive slavery and oppression by leaning on spiritual leaders, then their descendants do the same today.

Impact of Cultural History on the Etiology of Depression

The cultural history of people informs and defines their perceptions of illness, including the expression of its etiology, symptoms, and the acceptability of having it. Understanding the cultural history of African American women is critical to understanding what depression is like for them. African American women were brought

to the United States as slaves destined for lives of hard labour and survival (Carrington, 2006). The effect of slavery across generations, and subsequent civil rights movements mean African American women have had uniquely different life experiences than any other cultural group in the United States (Hunn & Craig, 2009). These experiences socialized African American women to work hard, and keep complaints quiet for fear of abuse or punishment. Additionally, African American women developed a necessary paranoia to be on guard at all times to enhance their chances of surviving (Hunn & Craig, 2009). Vontress et al. (2007) underscore the impact of cultural history by pointing out that for many generations, being singled out meant severe, sometimes fatal treatment for African American women. Therefore, African American women experiencing depression often hide their symptoms from others, and carry on as though nothing is wrong in order to blend in with the crowd.

Furthermore, the oppression African American women experienced was structured by continual racist perceptions of gender roles. Historically, the relevance of race, ethnicity, and cultural identity has been subordinate to gender (Heath, 2006). Gendered racism suggests that African American women are subject to unique forms of oppression due to their simultaneous “Blackness” and “femaleness.” Gendered racism has had a pervasive effect on the psychological distress of African American women, even in the presence of coping mechanisms (Thomas et al., 2008).

Gendered racism socialized African American women to put the needs of others before their own (Magnus, Shankar, & Broussard, 2010). They were always acutely aware of their roles as mothers, homemakers, and providers, and felt guilt when engaging in activities to promote self-development (Carrington, 2006). Even today role conflicts

between personal developmental needs, family survival needs, and performing collective responsibilities often result in guilt and depression in African American women (Magnus et al., 2010). This context has an inevitable impact on their own health and well-being, as well as the health and well-being of their loved ones (Etowa et al., 2007) because choosing personal development exposes them to contempt of their community (Grote, Bledsoe, Wellman, & Brown, 2007; Magnus et al., 2010).

Brown et al., (2003) noted that women explore illness by referencing it to prior experiences with illness, but also look to their social network for meaning and acceptable coping strategies. African American female socialization incorporates the values of both traditional African culture as well as those of the dominant culture, but unfortunately many African American women in large urban areas where their social networks are becoming spread out, even absent. However, positive perceptions of African American women among African American women are associated with reports of fewer depressive symptoms. Similarly, African American women who believed that others view African American women more positively also report fewer depressive symptoms (Settles, Navarrete, Pagano, Abdou, & Sidianius 2010). Thus, although African American women use other African American women as an important reference group for their expression of depression, they remain influenced by the attitudes and opinions of the broader society. It has been suggested that the mechanism behind this context is that positive perceptions of race are related to higher self-esteem, a protective factor from depression (Settles et al., 2010). Consequently, helping African American women with depression to improve their own perceptions of African American women may be an avenue to mitigating their depression.

Every culture also develops its own language over time. Miscommunications between African American women with depression and mental health professionals have the potential to lead to misunderstandings, misdiagnoses, inappropriate treatments, and premature termination of treatment by African American women with depression due to feeling misunderstood (Das et al., 2006). The implication of this is that having a common language with African American women would aid in detecting and appropriately treating depression (Chung, 2010; Waite & Killian, 2007). For African American women, language plays a pivotal role in their experience of depression. Verbal expressions of feeling evil, walking around in a fog, needing to shake off the devil, crazy, hopeless, being in a black hole, grief-stricken, rejected, sad, upset, fatigued, irritable, out of control, lonely, angry, stressed, out of balance, drowned, and sick are common to African American women with depression (NAMI, 2009; Waite & Killian, 2007; Waite & Killian, 2009).

Payne's (2008) research highlighted how African American clergy already have language in common with African American women. Through coding ten sermons addressing depression by ten different African American clergy, the word "depressed" was mentioned only three times, but emotion-laden phrases including crying and boo-hooing, the bottom falling out, cloudy or rainy days, troubles, weakness, darkness, misery, going through, sorrow, hurt, heartache, pain, time of need, struggling, and burden were frequently used. In particular, the term "survival" for both African American women and African American clergy meant using inner resources—such as faith—to overcome the immense experience of their depression (Waite & Killian, 2007).

Having a common language with African American women usually eliminates the risk of them being marginalized by the people helping them thrive (Carrington, 2006; Waite & Killian, 2007; Williams & Frame, 1999). Allowing African American women to explore and express depression according to their cultural norms empowers them to overcome depression because they are able to safely risk being vulnerable enough to ask for help because they know they will be understood (Carrington, 2006; Williams & Frame, 1999).

Treatment options are also limited by the context of cultural history. African American women, who have lived with the legacy of centuries of discrimination within the United States, may be particularly vulnerable to the effects of discrimination experienced in institutional arenas (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008). African American women have a history of being discriminated against by White people, and are understandably reluctant to ask for help from mental health professionals since most of them are White (Settles et al., 2010). Indeed, Nicolaidis et al., (2010) found that African American women mistrust Whites in general, and view mental health professionals as “experts” in a racially biased system. African American women are slightly flexible in this regard if mental health staff are also African American (Nicolaidis et al., 2010), but since there are few African American therapists, it is still necessary to put the strategies in the hands of African American clergy because they are culturally acceptable supports for African American women with depression.

Current Cultural Stressors

Stress has been considered a factor in the declining health and the emotional well being of many African American women (Townsend et al., 2007). African American

clergy better understand how chronically stressful the lives of African American women are than do mental health professionals who are usually further removed from the culture (Das et al., 2006; Grote et al., 2007). Chronic stressors represent continuously demanding, or difficult situations that do not change, including discrimination on the basis of gender, race, and other particular cultural circumstances. Mounting evidence suggests that African American women do not habituate either biologically or psychologically to chronic stress (Grote et al., 2007). Rather, chronic stress depletes their biological and psychological resources leaving them vulnerable to deeper depressions (Grote et al., 2007). Since African American women face more chronic stressors than both White women and women of visible minorities (Etowa et al., 2007), a discussion of their chronic stressors is necessary to understand their experiences of depression.

Typically, people face overwhelming stressors that tax their coping skills and resources in an isolated fashion. African American women, however, face a constant stream of stressors due to their social context in America (Braithewaite et al., 2009). A sampling of these stressors includes health and chronic diseases, interpersonal and intimate relationships, family relationships and daily demands, unresolved pain and trauma, confronting negative historical stereotypes and media images about African American women, sociopolitical stressors, economic and financial concerns, community concerns, and handling multiple expectations of others (Braithewaite et al., 2009). In fact, the number of African American families living in poverty is more than double the American national average, and nearly 70% of those families are headed by single mothers (Waite & Killian, 2007). Regardless of socioeconomic, political, familial, or relationship status, African American women are plagued by chronic stress (Das et al.,

2006; Heath, 2006). As Vontress et al. (2007) noted, no amount of research thus far encapsulates how exhausting it is to be African American women in a White men's society.

Socioeconomic and relational issues have some of the strongest impacts on African American women because they are often the heads of their households, caring for extended family members despite their own personal hardships (Waite & Killian, 2007). To survive these demands, African American women tend to minimize their own hardships and health concerns, attempt to handle them on their own (Nicolaidis et al., 2010), and feel guilty if they do not meet their caregiving demands because they are "selfishly" tending to their own needs (Waite & Killian, 2007). Yet quality of life is impacted by medical conditions. According to Magnus et al. (2010), depression is more debilitating than most medical conditions. Therefore, it can be assumed that the quality of life for African American women is significantly impacted because their depressive symptoms can be chronic, and worsen over time.

Obviously inequities surrounding culture, race, and gender are still rampant in the United States (Witherspoon & Arnold 2010). Treatment efforts for African American women with depression need to address their quality of life as well as the debilitating symptoms and repercussions of depression (Simpson et al., 2007). In addition, it should not be assumed that financial security and professional accomplishments for African-American women protect them from depression and its damaging emotional effects (Williams & Frame, 1999). In short, there needs to be a promotion of overall wellness for African American women, and African American clergy are poised to be the best resource for that promotion (Braithewaite et al., 2009).

Multiple familial roles. With an increasing separation and divorce rate among African Americans, women play several indispensable familial roles. These include holding one or more jobs, attending to household chores, and nurturing children (Jones & Ford, 2008; Vontress et al., 2007). However, the responsibility of all these roles creates frosty relationships between opposite-sex partners even when men are in the home because African American women are socialized to rely only on themselves (Hunn & Craig, 2009). People that are trained to rely only on themselves often find it difficult to rely on someone else. The constant reality of African American men leaving families through separation, or divorce, plagues African American women with an overwhelming self-reliance to manage all of life's responsibilities on their own (Kohn et al., 2006).

Divorce and separation are not the only reasons American women are juggling multiple familial roles. The United States incarcerates more people than any other country in the world, with incarceration rates for African American men being disproportionately high compared to White men and all visible minorities (Hunn & Craig, 2009). According to Vontress et al. (2007), approximately one in three African American men will be incarcerated in state or federal correctional facilities during their lifetime, compared with approximately one in twenty-five for White men. This is a longstanding trend. For more than a century, African American men, who comprise approximately less than 12% of the U.S. population, have consistently accounted for at least 20% of the population held under the control of the nation's criminal justice system (Vontress et al., 2007). In addition to coping with the absences of significant males in their lives, African American women must also deal with the emotional fall-out of husbands, partners,

brothers, sons and fathers that return home from prison psychologically scarred (Vontress et al., 2007).

The life experience of African American women also includes the high mortality rates of African American men. African American men have a shorter life expectancy than men of all other races in the United States (Hunn & Craig, 2009). The psychological impact attributable to high death rates of husbands, sons, brothers, fathers, and other male family members cannot be ignored when looking at depression in African American women. To experience this higher rate of traumatic loss and grief jeopardizes the psychological well-being of African American women. As Etowa et al. (2007) found, the constant worry about their children's safety and future, satisfying their families' basic needs without much economic or emotional support from partners, and catering to the needs of their communities while denying their own personal traumas is likely to result in many African American women developing depression. In addition, Etowa et al. (2007) highlighted that many African American women are chronically grieving the loss of their male loved ones through incarceration or death.

What may be considered depression by both healthcare professionals and the women themselves is often the consequence of multiple social roles leading to stress (Grant, Jack, Fitzpatrick, & Ernst 2011; Heath, 2006; Williams & Frame, 1999). Clearly, the implication is that African American women expect—and are expected to—reliably manage all familial duties (Hunn & Craig, 2009), and the weight of this cumulative stress cannot be underestimated (Jones & Ford, 2008).

Strong Black Women. The presence of a stigma about mental illness is also dependent on cultural norms. A negative stigma of mental health exists in many cultures,

including African American, and this stigma encourages women with depression to suffer in silence, without hope of life being any different (Chung et al., 2009; Franklin & Fong, 2011). As this stigma applies in the world of African American women, depression is not a topic readily discussed or even acknowledged even when it is suspected that a woman is not fully healthy (Waite & Killian, 2009). Many African American women believe depression is just stress that does not warrant any attention at all. If it does, it is only because a woman is physically and mentally weak (Neblett et al., 2010). This belief, known culturally as being a Strong Black Woman (Jones & Ford, 2008; Nicolaidis et al., 2010; Waite & Killian, 2009), contradicts the etiology held by the majority of Americans that depression is caused by a chemical imbalance in the brain (Schulz et al., 2006). The necessity of being Strong Black Women also means that chronic poor health, a lack of motivation, or need for help in managing life challenges are overt indicators of African American women's weak character. Many African American women believe they are not susceptible to depression because of the cultural belief that depression stems from having a weak mind, poor health, a troubled spirit, and lack of self-love (Waite & Killian, 2008). This leads African American women to exert enormous efforts to keep their composure at all costs, avoiding any hint of vulnerability publicly. Ultimately, the notion of Strong Black Women rewards women for being stoic about their suffering (Waite & Killian, 2007).

The pervasive taboo of emotional weakness reinforces the cultural expectation of being Strong Black Women, raising feelings of embarrassment and shame that African American women with depression must also suppress (Givens, Katz, Bellamy, & Holmes, 2007; Waite & Killian, 2007). Beauboeuf-Lafontant (2007) and Waite and

Killian (2009) identified that when African American women are depressed, the Strong Black Woman image they employ limits expressions of frustration, exhaustion, and depression. The image of the Strong Black woman is a barrier to both recognizing depression and seeking care (Nicolaidis et al., 2010). African American women are considered the strength of their families, which contributes to their struggles with depressive symptoms and holds them back from seeking help (Heath, 2006). Often their own family members minimize their health concerns, and encourage them to handle issues on their own (Thomas et al., 2008; Townsend et al., 2007). Minimizing struggles with depression, as well as continued selfless behaviour, entrenches African American women into familiar social expectations that render them unable to voice critiques of their environments, ask for help, and/or take their personal feelings and experiences seriously (Waite & Killian, 2009). Ultimately African American women accept the symptoms as normal responses to everyday stressors; thus they tend to ignore the symptoms, and the circumstances associated with them (Etowa et al., 2007).

Furthermore, being Strong Black Women means depression is not widely discussed among the support networks African American women either (Carrington, 2006). Some believe it is not a topic of daily conversation because they are too busy coping with everyday survival to worry about emotional issues (Etowa et al., 2007). Others have unrealistic notions of being strong due to the stigma associated with being weak (Simpson et al., 2007). Even physical weakness is frowned upon for African American women (Settles et al., 2010). Susceptibility to disease and illness increases as depressive symptoms increase, but the cultural stereotype forces African American women to stay strong, work hard, take responsibility as head of household, and function

as the primary wage earner (Waite & Killian, 2009). African American women exert great effort in appearing composed, cheerful, strong, and in control (Carrington, 2006; Etowa et al., 2007; Townsend et al., 2007). Thus, African American women are more likely to develop a personality and behavioural pattern that is characterized by strength and capabilities, and accept life's ups and downs as the products of their unalterable destiny (Jones & Ford, 2008; Settles et al., 2010).

Even if African American women are aware that they are depressed, they are still reluctant to ask their support networks for any type of assistance because the expectation of reciprocating the help received from network members can be demanding, time-consuming, and emotionally exhausting (Heath, 2006). Indeed, Hunn and Craig (2009) found that only it was only through confronting the denial of depression that African American women with depression would acknowledge feeling a lack of energy, or other classic symptoms of depression. Even so, the only acceptable form of finding relief for these women would be going to church to turn to the Lord for help.

Clearly, the stigma of depression for African American women is just one of many barriers to mitigating depression for them. Connecting with other African American women in sisterhood means most Black women shy away from seeking outside help for depression (Waite & Killian, 2007). Rather, they tend to group together in mutual support, but without discussing their emotional needs as fits being Strong Black Women (Nicolaidis et al., 2010). Dailey and Stewart (2007) believe this leaves African American women in the predicament of either having to suffer with depression alone, or seek professional help and risk being ostracized from their support network. Even when African American women are brave enough to seek help, they face other barriers to

receiving that help. Often there is a stigma or lack of trust with mental health professionals, little or no insurance coverage for mental health services, no funds of their own to cover services, and a lack of culturally aware professionals (Braithwaite et al., 2009; Chung et al., 2009). Fortunately, some research identifies a culturally appropriate treatment option: clerical support (Jackson, 2006).

Racism and discrimination. African American women with depression likely carry deep wounds from oppression and racism (Hunn & Craig, 2009), and many of them find it difficult to pin-point the precise cause of their depression due to pervasive incidents of oppression (Etowa et al., 2007). For example, situations of racism at work prevent Black women from receiving due recognition and promotion, fuelling feelings of worthlessness (Hunn & Craig, 2009). In spite of the multigenerational struggle of African Americans for equal opportunity, they still encounter many frustrations getting and keeping jobs, and advancing in them (Etowa et al., 2007; Vontress et al., 2007). In general, female African American employees are distressed most by supervisors whom they perceive to be inconsiderate and unfair, and it is understandable that the workplace is an uncomfortable environment for African American women who may have had little opportunity to relate to White authority figures as equals and colleagues (Vontress et al., 2007).

As previously mentioned, African American women experience what is known as gendered racism (Vontress et al., 2007). Gendered racism is a form of oppression that occurs because race and gender intersect (Thomas et al., 2008). This means everyday stressful incidents of discrimination such as being mistaken as clerks or cleaning staff when in professional buildings, or being sexually harassed, being called names, and

hearing jokes related to being an African American women cannot be separated into acts of oppression that relate to just gender or race (Burgess et al., 2008). African American women experience some forms of racism that are similar to those experienced by African American men, and some that are experienced by White women. However, African American women are subjected to a unique form of discrimination due to being both African American and female in a culture that favours White males.

African American women identify anger and frustration—and ultimately depression—as the result of instances of prejudice that unjustly rob them of their entitlement, especially at the peak of their experience, skills, and career (Waite & Killian, 2009). Being denied higher paying jobs elevates the stress of being financial providers for their families as well, compounding the chronic stress of African American women. In addition to this is the jeopardy of being a woman in a sexist society (Waite & Killian, 2008). Obviously African American women are dealing complicated forms of racism and discrimination that present unique challenges to self-worth, value, and esteem of African American women with depression (Settles et al., 2010).

Nicolaidis et al. (2010) collected extensive data pertaining to how the legacy of discrimination African American women carry shapes their help-seeking behaviour for mental health concerns. They interviewed eighty-three women, all of whom indicated that they had a general mistrust of White professionals, and all of whom expressed a preference for working with African American counsellors. Furthermore, the majority of the women interviewed said they would not participate in any type of clinical treatment for depression unless their therapist was also African American. Gender of therapists however, was not a concern for the women though.

Nicolaidis et al. (2010) also found that the women in their study were extraordinarily wary of most depression treatments and providers associated with White systems of healthcare. The women described negative experiences of the healthcare systems such as providers not spending enough time with them, not respecting their intelligence, not providing adequate explanations, and breaking their trust even when they described classic White symptoms of depression: sadness, anhedonia, hopelessness, social isolation, guilt, loss of energy, and suicidality. In addition, they struggled to follow through with treatments that clashed with their cultural worldview. Obviously conceptualizing African American women's within a Eurocentric worldview is often limiting and ineffective (Williams & Frame, 1999).

The women involved in this study explained that they wanted to take care of their depression on their own both because of the cultural norm of being Strong Black Women, but also because White clinicians tend to right off that explanation. This negation further alienates African American women with depression from mental health professionals. In fact, African American women with depression tend to report a greater number of depressive symptoms and rate them as more severe when mental health professionals make offensive or uninformed comments (Jackson, 2006). However, when a collaborative approach to healthcare is used with professionals African American women already trust, like African American clergy, their depressive symptoms do lessen (Simpson et al., 2007; Waite & Killian, 2008).

Culturally Bound Symptoms

Individual clients have their own thoughts and views about depression, but such opinions may differ from those held by mental health professionals due to lack of

understanding the cultural forces that shape symptomology between clients and clinicians (Waite & Killian, 2007; Waite & Killian, 2009). Clarification of the role of cultural context is critical in understanding how to recognize symptoms of depression in African American women (Carrington, 2006). African American women usually display only physical symptoms, or somatisation, in response to depression as opposed to emotional ones because physical illnesses are slightly more acceptable than mental ones in their culture (Brown et al., 2003; Carrington, 2006; Hunn & Craig, 2009; Simpson et al., 2007; Vontress et al., 2007). However, that does not mean their experiences of depression are any less debilitating than those of other women.

Displaying only physical symptoms of depression is an unfamiliar pattern to most mental health professionals because in the United States because diagnostic criteria for depression is based on White male health norms. A significant proportion of African American women who present with chest pain without cardiac origin do have significantly high levels of chronic stress (Das et al., 2006). In addition, many energetic self-destructive behaviours common to African American women are chalked up to biological rather than psychological distress because clinicians are trained to screen for low mood and lack energy which run counter to the symptoms manifested by African American women with depression (Hunn & Craig, 2009). Furthermore, health-related anxiety can also trigger periods of depression in African American women (Burgess et al., 2008). They tend to experience depression as chronic physical pain, which in turn deepen the depression because they cannot see an end to this pain since topical treatments are not alleviating their physical symptoms (Etowa et al., 2007). This creates a vicious cycle of chronic stress leading to chronic physical pain, and that in turn exacerbates the

chronic stress, which further builds because of the cultural ideal of being Strong Black Women prevents them from expressing their suffering (Carrington, 2006; Etowa et al., 2007). Hypertension can also mask depression in African American women (Carrington, 2006), as can numbness in limbs and abdominal distress (Jackson, 2006). Even sleep paralysis, or dizzy spells that lead to collapsing (known culturally as “falling-out”, Carrington, 2006, p. 783) are indicators of depression for African American women. Finally, according to the NAMI (2009), feelings of hyperirritability or acting out on repetitive harmful impulses are common symptoms of depression for African American women.

As previously discussed, the way African American women communicate these symptoms to mental health professionals when they do seek help is also culturally bound. In studies of African American women, Waite and Killian (2007) found that the words women used to communicate the physical symptoms of depression were significantly influenced by social and cultural experiences. Without an understanding of the history, language, and values of a culture, mental health professionals will be at a major disadvantage in assessment and treatment (Jackson, 2006). However, African American clergy are well aware of the history, language, and values of African American women, making them ideal candidates for treating it.

Culturally Appropriate Interventions

Though depression has been identified as a costly major global public health problem with broad social, economic, and personal consequences, appropriate and effective treatment is anything but global. Among African-American women, depression is often not detected because the symptoms differ from those of majority White culture;

as a result, they often do not receive effective treatment (Carrington, 2006; Townsend et al., 2007). Due to the chronic nature of depression and its tremendous costs, it must be understood and treated within a socio-cultural context if it is to be cured at all (Waite & Killian, 2009). Despite the widespread assumption that psychotherapeutic treatments for depression can be universally applied equally to all racial and ethnic groups, research shows this not the case. Indeed, what research does show is that African American women are an underserved and understudied group (Carrington, 2006), leading to inequities in treatment with widespread ramifications (Simpson et al., 2007). This point is particularly salient when the increasing rate of suicide among African American women is considered (Joe, Woolley, Brown, Ghahramanlou-Holloway, & Beck, 2008; USDHHS, 2000).

Part of what influences the acceptability and efficacy of depression treatments are the beliefs and attitudes cultures hold about the illness itself by underpinning both the interpretation of abnormal emotional experiences, and the appropriate responses to them. For example, Waite and Killian (2008) assert that the cultural stigma of depression in the African American community acts as a barrier to accessing any kind of treatment for it, as does the limited knowledge about its etiology. In later research Waite and Killian (2009) clarified explanatory models of illness, including stigma, are not consciously created; but rather absorbed as part of day-to-day life. As it pertains to African American women, some do not know their abnormal emotional experiences are indicative of depression. To best serve African American women with depression, it would be beneficial to remove the barriers exist that prevent them from receiving clinical treatment by providing clergy with faith-based interventions (Waite & Killian, 2009).

Understanding socio-cultural context of depression allows clinicians to anticipate which treatments will be appropriate African American women with depression (Givens et al., 2007; Waite & Killian, 2008). Nicolaidis et al. (2010) highlighted how the complex cultural history of violent experiences at the hands of White culture has encouraged African American women to espouse the opinions of elders in their communities, instead of current medical opinions. As acceptable as this form of help-seeking is, access to elders is dwindling. Therefore, developing faith-based interventions for African American clergy to use with African American women with depression is of utmost importance.

Research must also address the validity and reliability of psychodiagnostic instruments (Hunn & Craig, 2009). By exploring psychometric equivalence of diagnostic tools used across diverse populations, therapists and their clients can be sure that similar concepts of illness (Dailey and Stewart, 2007), and have confidence that results lead to the right treatments. An example of such work being done involves the Beck Depression Inventory-II (BDI-II). Joe et al. (2008) found evidence to support the dimensionality, internal reliability, and convergent validity of the BDI-II in a sample of African American participants who recently attempted suicide. Although this finding is promising, it has only been replicated in African American people who have attempted suicide, not with those that are depressed without suicidal ideation, or are suicidal but have not attempted, not with African American women with depression specifically. Clearly much work remains to be done in creating culturally meaningful diagnostic tools.

Pharmacological treatments are common treatments for depression too; however, African American women are often not receiving the full benefit of these treatments

(Jackson, 2006; Joe et al., 2008). One reason for this is that African American women are significantly less likely than White women to receive an antidepressant prescription because of how differently depression manifests in African American women than White women (Simpson et al., 2007).

Furthermore, African American women rarely visit professionals with the ability to prescribe medication, so there is little data that examines the response and metabolism of antidepressant medications by African American women (Das et al., 2006; Jackson, 2006). In a meta-analysis of the meagre information that does exist examining the effects of imipramine in African American women with depression, common side effects such as dry mouth, increased sweating, dizziness, tremors, and nervousness were reported more frequently by African American women than White women (Jackson, 2009). Jackson (2006) also found African American women with depression had hardly any remission of depressive symptoms with citalopram, whereas most White women experienced remission of depressive symptoms with minimal side effects.

This is a topic of concern even gender-wise because women have slower gastric emptying times than men across cultures, resulting in a delay of medication reaching the small intestines where absorption occurs. The subsequent slower absorption rate of medication leads to delayed peak blood levels of the medication, and possibly a lower peak blood level in women overall (Jackson, 2006). Jackson (2006) also asserted that since African American women have higher rates of diabetes, cardiovascular disease, newer depression medications that have been associated with hyperglycemia, dyslipidemia, and weight gain are inappropriate in regard to race. Das et al. (2006) corroborated these results in their study, and went on to point out that poor remission

rates of symptoms, health concerns, and side effects prompt African American women with depression to discontinue medication without informing their practitioners. Since there is little data examining how African American women metabolize antidepressants, and the data that has been collected is showing negative repercussions of using medication to treat depression, writing prescriptions is not a culturally appropriate intervention (Sleath et al., 2006).

Even when depression is correctly diagnosed in African American women with depression, they are less likely to accept medication as an acceptable treatment than White women (Jackson, 2006). Nearly all of the women in the research done by Nicolaidis et al. (2010) had negative experiences with counselling, but overall they held more positive attitudes toward counselling than they did to antidepressants. In fact, all of the women were strongly opposed to antidepressants citing fears of addiction, nor did they feel they had enough information about antidepressants to use them properly, a finding echoed by Primm et al., 2002. Surprisingly many of the women in Nicolaidis et al.'s (2010) study had used antidepressants with success, but always with the caveat that medication had been a last resort for them. Jackson (2006) suggested that although African American women are reluctant to use antidepressants, a previous positive response to some form of pharmacological treatment, or severe symptomology could encourage some African American women to try medication. In addition, a lack of available alternative treatments pushes some African American women into using medication to treat depression (Jackson, 2006).

Vontress et al. (2007) acknowledge that drugs may provide relief from depression, but assert it is not lasting understanding or healing because medication does

not address the vast socio-cultural issues heaped upon African American women. They maintain that effective interventions for depression should be holistic, and address these social factors. Primm et al. (2002) tried to address these socio-cultural factors in an education videotape called *Black and Blue: Depression in the African American Community*. The video features African Americans who have experienced depression, African American health professionals, and an African American member of the clergy. According to Primm et al., (2002), the purpose of the videotape is to emphasize the importance of early recognition and treatment of depression, discuss its standard treatments and how to access them, increase awareness of the negative consequences of untreated depression, and teach relatives and friends how to support depressed loved ones. In addition, the tape includes the culturally specific messages that religion is a part of healing from depression, antidepressants are not addictive when used correctly, and that depression is an illness rather than a character weakness. The participants in Primm et al.'s (2002) research reported that they had a much better understanding of depression after watching the tape, as well as much less judgement against people who do have it. Most significantly, the participants felt the video helped them see depression as an illness, not a punishment from God for a lack of faith, and felt hopeful that African American clergy would be willing to discuss depression with them in a nonjudgmental manner because an African American clergy person was included in the video.

Stress management training is another common aspect of treating depression. This psychological intervention enhances the ability of people to cope effectively with stressors. Although the use of stress management training or psycho-educational interventions has grown, there has been a call for the development of gender specific,

faith-based interventions that address the unique needs of African American women (Townsend et al., 2007). Typically stress management treatment plans include advocacy and facilitation of access to services to enable people to better manage chronic stressors in order to reduce their depressive symptoms, but all too often the most damaging social stressors for African American women are outside their control (Grote et al., 2007). In addition, these stressors are chronic, not fleeting (Das et al., 2006). Failing to consider the lack of control over the stressors means stress management training becomes an exercise in futility for African American women, and only sets them up for feeling helpless (Kohn et al., 2006; Nicolaidis et al., 2010).

According to Hunn & Craig (2009), culturally competent interventions for depression mean that professionals have a solid understanding how clients' cultures influence its etiology and treatment options; two influences African American clergy already understand about African American women. Also, interventions to assist African American women to recover from depression must have a strength-based, African American feminist dimension for them to be effective (Etowa et al., 2007; Jones & Ford, 2008). With the current demand for cost-effective and quick treatment approaches, it is important to understand the kinds of interventions that work for African American women (Kohn et al., 2006).

The interventions of depression for African American women should be viewed from a strengths-based perspective that calls attention to positive resources they have (Grote et al., 2007; Jones & Ford, 2008). One of the most effective and studied ways of providing accurate diagnoses and treatment for depression for African American women is creating a trusting a relationship with African American communities (Chung et al.,

2006; Chung et al., 2009; Jones & Ford, 2008; Townsend et al., 2007). Simpson et al. (2007) found this holds true for African American women in both urban and rural areas across the country. Trust shapes the willingness African American women have in discussing their emotional needs, and adhering to treatment offered to them (Waite & Killian, 2008). Building a professional rapport with clients and demonstrating sensitivity to clients' beliefs regarding treatment for depression supports the development of mutual and genuine trusting connections. African American clergy have behaviours that minimize the reservation of African American women to be open about emotional needs, and can communicate the respect and encouragement they need to overcome depression (Hunn & Craig, 2009; Waite & Killian, 2008).

Although alternative treatments are limited in availability, Nicolaidis et al. (2010) found that African American women desired to have depression care programs facilitated by African American people that had both overcome the same barriers of depression they faced, and would act as advocates for them in navigating what is perceived as a White healthcare system. The women also wanted depression care to address their real-life issues, and focus on interventions that encouraged healing through art, crafts, journalling, and religious activities instead of talking or medication. Most of all, they wanted the information they would learn about depression to be available to family and friends, so they could be supported in their journey of improving their mental health instead of remaining isolated. Regardless of what treatments are used, the least damaging labels of depression should always be used African American women so they are not marginalized more than they already have been (Vontress et al., 2007).

Brown et al. (2003) outlined several factors that must be incorporated for success to an option. First, an understanding of the cultural context of depression, and its disabling effects on African American women is essential. As discussed earlier, African American women's experience of depression is shaped by their cultural identity, culturally sanctioned expressions of distress, explanations for depression, and culturally relevant psychosocial factors. Second, somatic complaints should be recognized as potential manifestations of psychological distress. Third, the effect of multiple risk factors, such as life stress, health problems, and multiple family roles, as well as the various dimensions of social stress resulting from minority status needs to be accounted for. Fourth, it is important to recognize how strongly African American women identify with the Africentric worldview to determine if more traditional or independent treatment options should be explored. Every African American woman is a distinct individual with her own ideas and opinions, and it would be a mistake to assume that all African American women think, feel, and express identically. Fifth, gain a thorough understanding of how African American women explain depression, and what they believe is causing their emotional distress. Sixth, validate experiences of racial discrimination. Seventh, spirituality—which will be discussed in-depth later on in this literature review—should be regarded as a crucial cultural resource in reclaiming sound mental health. Following these recommendations may be a hefty order for counsellors not connected to the African American community, but since African American clergy are already intimately connected to the community, these recommendations can easily be added to how they interact with their female African American parishioners with depression.

The African American church has long been a refuge and sanctuary from the oppression African American women face in the United States (Hunn & Craig, 2009). Research has found that African American women have unique coping processes anchored in religious rituals, including prayer, so accessing their clergy in order to cope with depression is a logical intervention for African American women (Thomas et al., 2008). Beyond the role of religion—which will be discussed shortly—African American clergy have race, cultural history, and sometimes even gender in common with African American women. Das et al. (2006) found when treating depression, having race in common between the treating professionals and clients is likely to lead to successful treatment of depression for African American women. One reason for this is African American women trust others with shared experiences, mutual empathy and, supportive listening, which is how African American clergy tend to relate to their parishioners (Townsend et al., 2007). Therefore, after generations of impersonal and dehumanizing treatment by Whites, African American women need support people that understand their culture and its development, and are willing to develop personal relationships with them (Jackson, 2006; Settles et al., 2010). This in turn creates a feeling of safety for African American women, a safety in which they might allow themselves to be vulnerable and willing to receive help for emotional needs (Chung et al., 2009; Settles et al., 2010).

Since African American women consider depressive symptoms to be an indication of a lack of faith (Primm et al., 2002; Waite & Killian, 2008), it is clear that improving depression treatment for African American women means involving people that are both African American and deserving of their respect (Dailey & Stewart, 2007; Nicolaidis et al., 2010; Primm et al., 2002). African American clergy already have both

of these characteristics. While many researchers call for clinicians to improve their relationships with clients of other cultures by examining their own values, experiences, and expectations, African American clergy already have similar worldview and realities of African American women (Williams & Frame, 1999). In addition, religion and prayer are significant influences listed by African American women to cope with and manage depression (Witherspoon & Arnold, 2010). Because African American women with depression have developed adaptive practices that enhance their ability to cope with depression through strong ties to the African American clergy, it is reasonable to assume that treatment provided by African American clergy would support African American women better than traditional treatments alone (Waite & Killian, 2007; Witherspoon & Arnold, 2010).

Role of Religion

African American women have developed strong collective communities, and adaptive beliefs to enhance their survival through a reliance on each other and community leaders (Carrington, 2006). Since African American clergy are considered to be in the ranks of community leaders, the influence of religion in the African American women's repertoire of survival strategies cannot be undermined. The African American church has a long and powerful history that cannot be ignored. Hunn and Craig (2009) provided a timeline of its history, briefly discussed here.

It began in the mid-1700s as an underground meeting of slaves, where for over 100 years, they created their own religious culture that resembled without replicating the Christianity of their White owners. As a result, the African American church served as a place of safety while instilling dignity and self-esteem. From the mid-1800s through the

civil rights movement of the 1950s, the African American church served as a place of safety from the effects of Jim Crow laws, and fought systematic discrimination. During the civil rights movement, the church became a pacesetter for the freedom and liberation movement. The African American church and its clergy continue to be paramount in the spiritual, social, political, economic, and psychological preservation of African Americans.

Hunn and Craig (2009) went on to outline that the potential of the church as support and treatment for African American women experiencing depression is understudied, but it is obvious the African American church and its clergy are a major emotional resource for them. Even today when some African American families have moved to mostly White neighbourhoods, it is common practice for them to attend church in former neighbourhoods for the emotional and cultural understanding that can only be found with African American clergy (Vontress et al., 2007).

Religion plays a central role in the lives of many African American women, and powerfully influences virtually all aspects of their lives (Brown et al., 2003; Moon & Shim, 2010). It is a resource from which African American women draw their personal strength, identities, and basis for decision-making and behaviour (Jackson, 2006). In general, most African American women feel that internal strength rooted in God provides an element of assurance for them to feel better (Waite & Killian, 2009; Williams & Frame, 1999). During several focus groups of African American women, both Etowa et al. (2007) and Waite and Killian (2007) found the main coping technique of African American women with depression was turning to the Lord. Accumulating evidence is beginning to corroborate this theme by documenting the positive influence that religion

has on the health of African American women, and highlight the comfort they feel in seeking direction from African American clergy (Dailey & Stewart, 2007). According to Carrington (2006), almost 85% of African American women describe themselves as “fairly religious” or “very religious”. Carrington (2006) goes on to note that prayer is a common coping response for African American women in distress. These findings strengthen the argument that African American clergy should be given tools and strategies to treat depression because their female parishioners already have a longstanding reliance on them to provide guidance and support

In a survey conducted by Jackson (2006), African American clergy revealed frequent encounters with African American women suffering from depression. Of the 99 African American clergy surveyed in New England, two-thirds of them reported involvement with suicidal persons. Two-fifths of the clergy identified individuals with severe mental illness in their congregations, and 63 of 99 pastors had personally counselled individuals whom they considered dangerous to others. Though 68 pastors were able to identify a mental health agency or professional who they would be comfortable referring patients too, only a quarter reported having made referrals. Almost 50% of the pastors agreed that people with severe anxiety or depression could cure themselves if they “put their mind to it.” When asked to rate the contribution of various items to the cause of mental illness, 90% of the pastors identified stresses of living, and 85% cited unhealthy early family relationships. A lack of a “right relationship” with God was cited by 72%. While approximately 60% identified biological issues as a causative factor in mental illness, the same percentage listed stunted spiritual growth and/or unconfessed sin as causative factors as well. Because African American clergy are aware

that a significant portion of their female parishioners are depressed, and that it is most likely they will be the ones providing support, then it only makes sense to provide faith-based depression interventions to them (Townsend, et al, 2007).

Summary

According to Carrington (2006), the most relevant definition of depression is not necessarily an exhaustive list of textbook symptoms, but an acknowledgement that it is the result of a complex interaction of sociocultural factors. By discussing just a few of these factors, I have demonstrated that there is complex intersecting of sociocultural factors specific to African American women that increases their odds for developing depression. Research about treating depression in African American women is scarce, highlights how sensitive the topic of depression is for them, and the strength of their desire to keep depression private (Jones & Ford, 2008). Therefore, putting interventions in the hands of African American clergy will provide a way for African American women with depression to access healing resources in a culturally appropriate manner.

Chapter 3: Methodology

This project is based primarily on the critical review and integration of literature gathered from diverse yet complementary sources. These sources include research journals, government publications, religious articles and books, and reports from international health organizations. By compiling this research into one manual, African American clergy will have access to all of it in one resource.

Literature Sources

Scholarly sources of literature for this manual outline included peer-reviewed journals, and authoritative books grounded in research. To broaden perspectives on cultural manifestations of depression and methods of clerical support, non-scholarly sources also were utilized. Thus, also referenced are edited religious books with articles and chapters written by individuals of diverse backgrounds and opinions who are knowledgeable about clerical explanations of depression, and possible treatments for depression by clergy. In addition, relevant literature was gathered from public sources such as websites of authoritative government offices.

For socio-cultural relevancy and currency, most of the literature was selected based on its context, date of publication, and location of publication. Although American literature produced within the last decade was preferred, for an historical perspective on development in the experiences of African American with depression and clerical interventions for depression, some literature was included that did not meet this criteria. In addition, some literature was included primarily because it extended the discussion of depression in African American women with new perspectives and applications. By utilizing a breadth of information sources, a more inclusive and richer understanding of

the experiences of depression for African American women and its appropriate treatments was obtained.

Research Databases

The methodology employed for this manual followed a systematic search strategy to locate information regarding depression for African American women and African American clerical support. A comprehensive search using electronic databases from the University of Lethbridge were used for this search, including PsycInfo, PsycARTICLES, MEDLINE, ScienceDirect, Wiley Online Library, Ovid HealthSTAR, PsychiatryOnline, and SAGE Journals Online. In addition, a Google Scholar search was used to find relevant literature beyond the university's library. Only literature from 1998 to 2011 was included. The search terms included *African American women, Black women, depression, depression treatment, health belief, clergy, African American clergy, pastors, etiology, coping, therapy, antidepressants, stigma, and strengths-based approach*. This preliminary search was followed by a search for specific peer-reviewed sources based on the references in the articles retrieved through the electronic searches. When selecting the peer-reviewed sources, there was a specific emphasis on understanding how African American clergy explain depression, examining views related to cause and etiology of depression, and gathering information about which effective treatments for depression African American clergy are willing to use. In addition, only research regarding major depressive episodes was included.

Limitations and Constraints

As in all research endeavours, this project has inherent limitations and constraints. One overriding limitation is the literature, given the current underdevelopment in

research on African American women with depression, and clerical support provided by African American clergy. Since there was such a limited amount of research to draw on, I carefully extrapolated the data using information from research included in the literature review to create the proposed manual. When reviewing the data, I used a coding system to sort it into clerical explanations of depression, cultural explanations of depression provided by African American women, treatment options, and etiology. Coding is the process of combing the data for themes, ideas, topics, and then sorting similar passages of text into a smaller number of categories. Coding data makes it easier to make identify any patterns in large quantities research, and organize it into a meaningful application (Marshall & Rossman, 2011). The codes, or categories, are given meaningful names that indicate the concepts that tie similar passages of text together. As researchers read through data, the number of codes evolves and grows as more topics or themes become apparent. The list of codes will thus help identify the patterns contained in the data. While coding may be considered a subjective form of compiling research, it involves the close reading and careful analyzing and extrapolation of the data (Marshall & Rossman, 2011). In the case of this project, the data was sorted into broad codes of depression, clerical, African American women, and African American clergy. More extensive coding and analysis of the data further sorted the codes into narrower categories, resulting in the specific chapter titles and subchapter headings. This extensive coding resulted in the main sections of this manual outline.

A second limitation of creating this project could be my own worldview and cultural experiences. This project is focused on how African American clergy can treat African American women with depression, and on the rationale that they are in the best

position to do so. Even though I am a woman and can relate to some of the literature that identifies barriers to treatment to African American due to their femaleness, I am not African American. Therefore I have no personal experience to the life experiences and barriers to treatment that arise to the racism and discrimination African American women with depression face in seeking treatment. In addition, I have never had a major depressive episode either, but have seen major depression and its impact on members of my family. However, being a devoutly religious woman I believe every person is a child of a Divine Creator, and should be treated as such. Also, seeing firsthand the effects of depression in my loved ones, I would hope that clerical support would be available to women of all cultures, nationalities, ethnicities, colours, races, religions, marital statuses, sexual orientations, physical and mental abilities, ages, and socioeconomic statuses. No characteristic of any woman should bar her from receiving the help she needs to live her life effectively.

Explanations of Depression

In pursuit of learning how African American clergy define depression, I found only three studies that directly involved African American clergy sharing their views of depression. All three involved questions along the lines of: What does the word depression mean to you? What do you think is the cause of depression? Tell me more about how you handle grief and loss the church? Using open-ended, qualitative questions allowed clergy to begin a dialogue with mental health researchers about how cultural context factors into their explanations of depression (Payne, 2008).

First, Young, Griffith, and Williams (2003) conducted face-to-face interviews with 99 African American clergy in the New Haven area of Connecticut. In their work,

they made sure to conduct each interview in each participant's setting of choice, and employ open-ended questions. One trend highlighted in these interviews is that clergy were aware their parishioners of low socioeconomic status needed more clerical support than those who had more resources at their disposal. Although a number was not specified, clergy who headed poor congregations spent nine hours per week counselling parishioners, compared to six hours spent by clergy of working or middle class congregations. In a further break down of the data, 39 clergy reported their congregations included individuals with depression, 67 reported counselling suicidal individuals regularly, 38 reported spending more than one-tenth of their pastoral counselling time performing crisis intervention, and 14 reported that they conducted such interventions at least half the time. While this particular study did not separate congregations into demographics, it does provide a glimpse into the awareness clergy are of the needs facing their African American parishioners, some of whom are women.

Young et al. (2003) also asked clergy the clergy participating in their study to identify what they thought caused depression. Chronic stress was the most common theme, brought up by 89 clergy. Family relationships and disruptive social forces were also common themes, 84 and 59 clergy discussing each topic respectively. These are topics discussed in the literature review as causes of depression as well, but from data provided by African American women. In a different direction though, 72 clergy felt that depression was caused by not having a good relationship with God, 61 believed that depression stemmed from stunted spiritual growth, and 59 said it was rooted in unconfessed sin. Interestingly, 29 clergy said they believed depression had nothing to do with unconfessed sin. From this data, Young et al. (2003) suggested that even though

nearly three-quarters of the clergy believed depression was rooted in a poor relationship with God, nine out of ten pointed to stresses in living, and almost as many mentioned unhealthy early family relationships. From this data, they concluded that using clerical interventions African American parishioners with depression would be appropriate, as long as clergy validated the negative impact chronic stressors had on their parishioners too.

In the second study, Kramer et al., (2007) ran focus groups with twelve African-American clergy in central Arkansas. Ten were male, two female, and all had received at least a high school education. Three held a bachelor's degree, six held a master's degree, and one held a doctorate. The focus group was co-facilitated by one of the authors with prior focus group experience, and an African American community minister who agreed to consult on the project. The question for the group was, "What do you think are the most important mental health issues or challenges for your congregation?" Immediately clergy identified depression for women as the primary mental health problem in their congregations, which further strengthens the rationale for this manual. For these clergy, depression was a multifaceted illness influenced by conflicts between biological, psychological, spiritual, cultural, and social beliefs.

As the focus group progressed over its two-hour timeframe, Kramer et al. (2007) learned that the clergy believed faith-based communities play an important role in increasing the likelihood that depressed women will initiate care because women who ascribe to a faith-based belief system often want religion incorporated into their care. For these clergy, a belief in God and support from a religious community was an important part of healing from depression because they act as buffers or sanctuaries from the causes

of depression (this particular point was discussed in the literature review from the perspective of African American women rather than African American clergy.) Finally, the clergy noted they are often the frontline responders to mental health crises for their parishioners because of the trusting relationships they have already developed in their congregations, and the high likelihood that African American women with depression seeking help for depression would be stigmatized in their communities if they went outside their communities for help. Again this was small sample of clergy, but it does confirm two things: one, that clergy are highly aware of how prevalent depression is; and two, that their female parishioners with depression depend on them for support for it. It is important to note that the clergy in this study also indicated they were open to counselling African American women not of their congregation, but no further data indicated how often this actually happens.

In Payne's (2009) research, 51 African American clergy in the state of California were mailed or emailed surveys about the etiology of depression. The vast majority of the clergy indicated they believed depression was rooted in feeling weak while dealing with trials and tribulations, but no specific definition of trials or tribulations was provided. Payne (2009) also noted that all the clergy in this study were open to the idea that depression can be defined on a spiritual basis, and subsequently so could cures for depression. All of the clergy responded they were personally likely to support clerical interventions over medication, and encouraged their parishioners to do the same and come to them for support before anyone else. With that data, Payne suggested that the health beliefs of clergy might have a strong influence on their parishioners with depression, which would include African American women. Payne (2009) also suggested

that African American clergy likely have similar views about the etiology of mental illness issues as the African American population in general. Therefore, if African American clergy and African American women have similar views of depression already, then supporting African American clergy in treating African American women with depression could mean greater access to appropriate interventions for African American women.

A fourth study, involving a focus group of African American women, corroborates the data generated in these three studies focused on the perspective of clergy. Waite and Killian (2009) conducted a focus group five African American women. All five women had been diagnosed with depression, resided in urban centres in the northeast United States, and leaned on African American clergy for help in dealing with their depression. The focus group was led by an African-American researcher, a board-certified psychiatric mental health clinical nurse specialist, and a psychiatric nurse practitioner.

When asked about the prevalence of depression, and its etiology, the women discussed causes of depression like high exposure to chronic stressors like high poverty rates, poor housing conditions, high unemployment rates, frequent traumatic loss of loved ones, and high rates of physical illnesses such as heart disease and diabetes. To them, that meant more African American women had depression than not, but they could not know for sure because it was not acceptable to talk about. These contextual factors echo those discussed in the work by Young et al. (2003), as well as those in the literature review. The women also reported African American women explore depression through their own prior experiences of being unwell, and look to their social network for acceptable

strategies treating it. Therefore, they would not discuss their depression struggle with many people, unless they felt safe enough to be able to express it candidly. Because their clergy provided expectations of confidentiality, they preferred to turn to clergy for help. Taken together this data reiterates that African American women and African American clergy believe depression is an illness created through overwhelming life circumstances, it is a taboo subject in public, and clergy and religious support are necessary ingredients in healing.

Since only four studies directly related to how African American clergy explain depression, or how African American women prefer to be treated could be located, caution must be executed in interpreting the data. However, it does seem clear that African American clergy are aware of depression, and the role chronic stressors can play in its etiology. This is consistent with the etiology model held by African American women. Therefore, both African American clergy and African American women with depression may be on the same page on treatment options as well.

Main Research Questions

Guiding this project *A Manual to Support Clerical Interventions for African American Women with Depression* are the main research questions: “What are the most appropriate forms of support and treatment for African American women with depression, and which of those supports and treatments would be appropriate for African American clergy to apply?” To address this question, the subsequent chapter focuses on three topics related to clerical support for African American women with depression: (a) benefits of creating a manual; (b) practical application of manual; (c) implications of a manual; (d) explanations of cognitive-behavioural therapy; (e) faith-based cognitive-

behavioural therapy; (f) efficacy of faith-based cognitive-behavioural therapy; and (g) cognitive-behavioural techniques that blend with religion. Organizing the material in this manner should make it simple for African American clergy to follow the steps outlined to providing effective support for African American women with depression.

Summary

This chapter on *Methodology* focused on describing the research methodology employed with details about the selection of literature, research limitations, and its organization into a proposed manual of clerical interventions for African American clergy to use with African American women who have depression. Included in this chapter was discussion on the challenge of conducting this project due to the paucity of culturally relevant research for African American women and African American clergy. Furthermore, the need to code the data carefully to create a cautious but supported extrapolation of it may be seen as a subjective exercise to people who believe in objectively explaining data. I also elaborated upon conducting this project as a means of promoting the compiling of few and scattered resources into one resource for African American clergy. This chapter concluded by introducing the main research questions: “What are the most appropriate forms of support and treatment for African American women with depression, and which of those supports and treatments would be appropriate for African American clergy to apply?” Also presented were the main topics for the next chapter, which is the manual itself. The next chapter, *Application*, begins with related literature reviewed with a focus on understanding how African American clergy be effectively support African American women with depression.

Chapter 4: Application

In the literature review, seven factors necessary to treat depression in African American women were listed. To recap, cultural context, somatic complaints, effects of chronic stress, individuality, explanations of depression, experiences of racial discrimination, and involvement of African American clergy who already have connections to African American women and their experiences are considered critical for successful remissions of depression (Brown et al., 2003). The kind of informal, indigenous help provided by African American clergy is extremely important in alleviating the distress that African American women can experience (Neighbors et al., 1998). However, incorporating these seven factors may be easier said than done. Some African American clergy feel their training in pastoral counselling is not adequate to provide support for African American women with depression, but feel they must provide some kind of support because the mental health system is often inaccessible to African American women due to fees and cultural stigma (Farrell & Goebert, 2008; Kramer et al. 2007; Neighbors et al. 1998). Yet even the basic counselling can bring some relief (Moon & Shim, 2010).

African American clergy are interested in furthering their knowledge and training in treating depression for African American women. The African American clergy surveyed by Kramer et al. (2007) and Farrell and Goebert (2008) expressed a desire to engage in training provided by mental health professionals, and incorporate that training into their faith-based pastoral counselling. In addition, some clergy members were more likely to consider shared religious beliefs between the provider and the treatment seeker to be essential (Farrell & Goebert, 2008). In this section, I will identify reasons why

creating a counselling manual for African American clergy is advantageous for African American women. After that I will identify specific interventions African American clergy can use with African American women with characteristics of depression. Finally, I will conclude with the implications developing such a manual may have for both African American clergy, and African American women.

Benefits of Creating Manual

Religion is a significant cultural theme of African American life that has been well documented. It is therefore not surprising that African American clergy play an important role in the lives of African American women, providing counselling and other services for both parishioners and their family members (Farrell & Goebert, 2008). Because African American clergy are usually the first and only people contacted by African American women with depression, and the volume of African American women relying on them for support is staggering (Farrell & Goebert, 2008; Neighbors et al., 1998), it is imperative that this proposed manual compiles interventions for depression appropriate for African American clergy to use with African American women. African American clergy are uniquely positioned to play the role of a primary mental health treatment source (Neighbors et al., 1998). Therefore, a manual such as the one outlined in this project that compiles these interventions in one resource is a vital step towards exploring and ameliorating depression for African American women (Jackson, 2006).

Another reason for compiling these interventions into one resource is the continuity of care African American clergy can provide for African American women with depression. African American clergy expect to see their congregants as often as possible throughout their lives. For example, both Milstein et al. (2008) and Neighbors et

al. (1998) pointed out that African American clergy often know multiple generations within single families, and play an integral and trusted role in those families by officiating milestone events such as christenings, marriages, and funerals. This unique lifetime and generational continuity means African American clergy gather a wealth of comprehensive, holistic knowledge about their congregants, including African American women with depression. With such extensive knowledge and trusting relationships, African American clergy have opportunities to provide healing guidance that mental health professionals may not have.

Practical Application of Manual

Kramer et al. (2007) noted some faith-based interventions African American clergy already use when counselling African American women with depression. These interventions included small group discussions designed to cultivate trusting relationships with God, guided Biblical readings about turning suffering into opportunities for growth, and active attendance of worship services and church activities. In addition, African American clergy often invite trusted family members and friends to participate in these interventions with women who are depressed to create ongoing support outside the church building itself without disclosing the women are depressed.

According to Kramer et al. (2007), these interventions are successful for a number of reasons. On-site support from African American clergy for African American women with depression is more accessible than most counselling agencies because of the flexibility in times that support can be offered. Clerical support is often considered the more affordable option as well because most services are offered pro bono. Most important though, these interventions are successful because it is acceptable for African

American women with depression to reach out to African American clergy for support. It appears then that these faith-based interventions are appropriate for African American clergy to continue to use when supporting African American women with depression.

Young et al. (2003) noted the same successful faith-based interventions in their own research, but added that many African American clergy believed taking the time to listen to their female parishioners with depression is helpful because it validates their experiences of chronic stress. This intervention is in alignment with the suggestion of Brown et al. (2003) to validate the experiences of African American women with depression, especially the experiences of racism that can be a source of chronic stress for them. Young et al. (2003) added that African American clergy also believe in removing as much judgment as possible from any responses they provide to African American women with depression. The African American clergy in their research felt listening and being non-judgmental were successful interventions because it allowed African American women to feel close to their clergy, and establish trust with them. Furthermore, African American clergy often use direct interventions that fit with their role of caretaker to parishioners, interventions that may be inappropriate for most mental health professionals. These direct interventions include providing food, transportation, organizing financial assistance, and initiating employment assistance. These interventions, while not encouraging the introspective interventions favoured by mental health professionals, do relieve some of the chronic stress overwhelming African American with depression. By satisfying these needs, African American clergy are allowing African American women with depression the opportunity to marshal the resources they do have to meet other challenges in their lives.

Kramer et al. (2007) also found that cognitive-behavioral therapy containing religious imagery and messages was an effective method for African American clergy to treat African American women with depression. Building on this research, Milstein et al., 2008 found a unique way for African American clergy to support African American women with depression that bridges their community to mental health professionals, while still avoiding the cultural stigma of seeking support outside the community. In their research, the authors attended monthly meetings of a group of African American clergy. The authors only participated in the group discussions between the clergy if directly asked, and for several months this was as much as they participated. However, slowly the clergy began to trust and respect the authors, so much so that the clergy began to ask for clinical types of interventions that could be integrated into faith-based ones to use with African American women with depression, and learn how they could build bridges between themselves and mental health professionals in their areas. Again, cognitive-behavioural interventions appeared to be favoured over others from other psychological theories due to the overtones of people taking action to resolve their distress. Obviously these are just two studies and cannot be widely accepted as standards of treatment, but they show promise. If mental health professionals can build relationships with African American clergy, then perhaps African American clergy can adapt clinical interventions to faith-based, culturally appropriate ones that will further ease the depression faced by many African American women.

Although this section of culturally appropriate interventions may seem brief, it does provide several efficacious interventions for African American clergy to use, or continue using. They can support African American women with depression by listening

to their stories and experiences, and responding without judgment. They can organize small, on-site discussion groups to encourage women to share how they cope with stress, or develop relationships to God, assign guided Biblical readings, and encourage attendance of church functions. To help African American women with depression attend these activities, African American clergy can invite trusted family members and friends to participate as well without disclosing the depression. In addition, African American clergy can help satisfy basic needs like food and transportation, freeing African American women from some chronic stress. Finally, there is some evidence that integrating cognitive-behavioural interventions into faith-based ones can also help African American women with depression find relief. However, this is only possible after mental health professionals make the effort to build respectful relationships with African American clergy, providing clergy with such tools as their professional relationships grow.

Implications of Manual

The central aim of this proposed manual is to assist African American clergy in supporting African American women with depression. Currently, African American women face an overwhelming stigma to be strong at all times no matter the cost. Consequently, many African American women that are depressed are isolated from treatment because they cannot let their weakness show, nor can they openly seek out treatment (Hunn & Craig, 2009). Culturally competent practice includes acknowledging the role the church plays in the psychological wellbeing of African American women. Since connectedness to church and African American clergy are characteristics typically found in African American women who subscribe to an Africentric worldview, it makes sense to harness these characteristics to treat depression in culturally relevant ways

(Sleath et al., 2006). Efforts to provide African American clergy with ways of providing mental health treatment to African American women with depression—such as this manual—means African American women do not have to endure depression needlessly. Rather, African American women with depression can be effectively treated, and gain the opportunity to engage in life—including its challenges in positive ways—rather than just bearing them, or mechanically going through the motions of meeting the demands of their days.

When culturally sensitive resources such as the manual are made to African American clergy, the implications are potentially far-reaching. The specific outcomes of this proposed manual, namely the increased understanding of clerical support in the treatment of depression, will shift depression treatment strategies in a way that will allow African American women with depression the ability to bolster their well-being without being ostracized from their friends and family (Waite & Killian, 2009). The benefits of improved emotional well-being for African American women will ripple out to family, friends, and eventually the support networks of African American women. It is intended that this manual will assist African American clergy in alleviating the negative characteristics of depression experienced by African American women.

Manual Outline for supporting clerical interventions with Cognitive-Behavioural Techniques

A thorough review of the literature revealed that cognitive-behavioural therapy is an empirically validated psychotherapeutic approach to alleviating major depression (Coleman, Cole, & Wuest, 2010; Ellis, 2000). In addition, cognitive-behavioural therapy has also been shown to be effective across cultures in the United States, as well as being

adaptable to specific groups, like Christians (Hodge & Bonifas, 2010). But what is cognitive-behavioural therapy? The purpose of this section of the proposed manual is to provide an explanation of cognitive-behavioural therapy, and of faith-based cognitive-behavioural therapy.

Explanation of cognitive-behavioural therapy. Simply put, cognitive-behavioural therapy aims to change dysfunctional thoughts, emotions, and behaviours through an organized, goal-setting approach. In essence, distorted thinking can lead to emotional and/or behavioural disturbances because thoughts determine feelings and actions. Kendall (2000) explains cognitive-behavioural therapy as an active, structured approach based on the theory that feelings and behaviours are largely determined by the way in which people think about their world and circumstances. A succinct definition of cognitive-behavioural therapy is that the meanings attached to experiences lead people to feel and behave in certain ways in response to those experiences, not the experiences themselves.

The goal of cognitive-behavioural therapy is different from other forms of counselling or psychological support in that prying into people's pasts is not a main component of treatment. Cognitive-behavioural therapy is focused on present circumstances. It is also considered an active approach because the professionals providing support are viewed as having skills and expertise that can alleviate the distress of their clients, and clients must be applying the skills learned in treatment in order to find relief through weekly homework assignments. Even though the professionals are viewed as experts, it falls to the clients to follow-through on their assignments to build the skills necessary to cope with negative circumstances healthfully (Forsyth, Poppe,

Nash, Alarcon, & Kung, 2010). Furthermore, many forms of mental health treatment involve numerous sessions or lengthy treatment times. Cognitive-behavioural therapy, on the other hand, is designed to be brief and time-limited while encouraging people to develop independent self-help skills (Kendall, 2000).

The basic goal of this approach is to help people achieve a remission of their faulty thinking, replace it with rational thinking which leads to adaptive feelings and behaviours, and to prevent relapse. Forsyth et al. (2010) and Kendall (2000) noted that cognitive-behavioural therapy helps people identify, challenge, and correct negative thoughts, allowing them to gain awareness of those thoughts and the opportunity to replace those thoughts with adaptive ones. As this relates to major depression, maladaptive thoughts typically include ones of hopelessness, helplessness, and self-defeat. These thoughts then lead to prominent negative emotions such as sadness, anxiety, or in the case of African American women, irritability. These emotions then lead into behavioural symptoms like withdrawal, lack of initiative, and apathy, as well as changes in sleep and appetite (Forsyth et al., 2010). Coleman et al. (2010) further explained that maladaptive thoughts can be grouped into patterns of dysfunctional attitudes, and these attitudes in turn stem from negative core beliefs. Therefore, depression is rooted in these negative core beliefs. As people challenge their negative thoughts by citing evidence that refutes it and developing more helpful ways of thinking, they are directly altering their negative beliefs, helpful ones (Kendall, 2000). Obviously this takes more than one attempt to create lasting change, but as Kendall noted, practice and repetition are the keys to successfully overcoming depression with cognitive-behavioural therapy.

Finally, Corey (2009) shared several benefits of cognitive-behavioural therapy from a diversity perspective. He suggested cognitive-behavioural therapy is a particularly culturally sensitive method of helping people overcome life's challenges. Counsellors and support people using this approach work together with the people seeking help to explore their worldview and values to gain awareness of their conflicting feelings, and then create solutions within that worldview. In addition, cognitive-behavioural therapy stresses people functioning productively in their communities, and the relationships between members of those communities, such families, congregations, and neighbourhoods (Corey, 2009). This is consistent with the Africentric worldview. Because counsellors with a cognitive-behavioural therapy orientation function as teachers and clients focus on learning skills to deal with the problems of living, it also fits the active and energetic problem solving approach preferred by African American women. The collaborative approach of cognitive-behavioural therapy offers people seeking help for depression structure and guidance, and enlists their active cooperation and participation.

Faith-based cognitive-behavioural therapy. I have previously discussed the importance of religion and the role it plays in the lives of African American women who subscribe to the Africentric worldview. The effectiveness of any approach is based in its level of relevance to the people it is being used with. Therefore, approaches that reflect the perspectives of the people seeking treatment are likely to get better results than those that do not. Cognitive-behavioural therapy is an approach to treating depression that can be adapted to incorporate a religious framework, and it is important to do so because incorporating religion into therapy may make counseling more relevant and attractive to

African American women that may find clinical treatments inappropriate. According to Ellis (2000), the constructive philosophies of cognitive-behavioural therapy are similar to those held by religious people in regard to unconditional self-acceptance, high frustration tolerance, unconditional acceptance of others, the desire for achievement and approval, and self-improvement. He also stated that these similarities between cognitive-behavioural therapy and religion have been empirically proven to be compatible. Hodge and Bonifas (2010) created religious framework for cognitive-behavioural therapy that I will share here.

Hodge and Bonifas (2010) explained that cognitive-behavioural therapy is an effective method for treating depression in many people across cultures, including African American women, but that its efficacy may be enhanced by modifying it with Africentric beliefs, values, and spiritual narratives. They asserted that by doing so, African American women with depression would experience faster recoveries than with traditional cognitive-behavioural therapy, improved treatment adherence, and less risk of relapsing into depression. The basic approach used in religiously-based cognitive-behavioural therapy is similar to traditional cognitive-behavioural therapy: the treating professionals help people identify negative, distorted thoughts, and replace those thoughts with more productive ones. While the cognitive interventions and weekly homework assignments are the same as those used in traditional cognitive-behavioural therapy, religiously-based cognitive-behavioural therapy uses religious rationales and practices drawn from clients' religious traditions (Hodge & Bonifas, 2010). These adaptation of cognitive-behavioural therapy to incorporate religion is basically a three-step process that involves understanding what cognitive-behavioural therapy is, ensuring cultural

congruence by using trusted cultural leaders like African American clergy to create trusting, open relationships with people, and incorporating culturally relevant terms and rationales into cognitive-behavioural therapy interventions (Hodge & Bonifas 2010).

Hodge and Bonifas (2010) went on to explain that using religiously-based cognitive-behavioural therapy may result in faster recovery from depression for African American women because they already believe religion to be central in overcoming depression, and using religious rationales in treatment therefore enhances their motivation to change. It also provides a common language between African American women and African American clergy regarding depression and its treatment, rather than just leaving both groups with a common language to describe depressive symptoms. Hodge and Bonifas (2010) also suggested using religiously-based cognitive-behavioural therapy with African American women might improve treatment follow-through because it provides a “buy-in” element for them through using their worldview and reflecting their values. With culturally appropriate and religiously-based treatment, it is also likely that the support networks of African American women—families and friends—will not isolate them for reaching out, but instead provide friendship and understanding. This understanding will hopefully become an ongoing factor in the support networks of African American women, reducing the risk of relapsing into depression (Hodge & Bonifas, 2010).

Efficacy of religiously-based cognitive-behavioural therapy. As discussed earlier, African American women with depression often goes undetected and untreated for reasons such as stigmatization, healthcare avoidance, healthcare mistrust, psychosocial beliefs, and inaccessibility of resources (Miranda, Siddique, Belin, Green,

Krupnick, Chung, & Revicki, 2006; NAMI, 2009; Nicolaidis et al., 2010). In addition, symptomology of depression in African American women can be quite different than the classic ones described in diagnostic manual. Rather than outwardly presenting symptoms of sadness, worthlessness, and a lack of ambition, African American women usually present energetic symptoms of anger, irritability, and self-hatred (Hunn & Craig, 2009; Kohn et al., 2006)

Yet, even with these differences in symptomology, cognitive-behavioural therapy is an empirically validated, effective treatment for African American women with depression (Coleman et al., 2010; Forsyth et al., 2010; Miranda et al., 2006). In a study done by Miranda et al. (2003), 117 African American women with depression were randomly assigned to various treatment methods. In their study, 34 women received antidepressants to treat their depression, 41 were assigned to cognitive-behavioural therapy groups, and 42 received referrals to community health centres. At six months the results showed that the women who received medication had a higher rate of remission of depressive symptoms than any of the treatment modalities (Miranda et al., 2003). However, at a follow-up one year later, the African American women who had received cognitive-behavioural therapy interventions presented continued effectiveness for African American women with depression equal to the rates of those who had received medication (Miranda et al., 2006). In addition, they showed higher improvements in social functioning than those who had received medication at the one year mark (Miranda et al., 2006).

Kohn et al. (2006) highlighted other benefits of using cognitive-behavioural therapy with African American women with depression. In their research, an adapted

group cognitive-behavioural therapy program specifically created to address the aspects of the African American culture using role-models and anecdotes familiar to the women to explain the concepts of cognitive-behavioural therapy. Therapy modules were made specific to cultural issues and the African American experience. It was determined that a specially adapted treatment program resulted in decreased depressive symptoms (Kohn et al., 2006). Furthermore, a study by Jones (2008) determined cognitive-behavioural therapy in a group setting was particularly advantageous for working with African American women with depression. A group setting allows the women to experience camaraderie and vulnerability in a safe setting. NAMI (2009) advocates for cognitive-behavioural therapy to be used with African American women as well, and indicates a group format may be an effective way to deliver effective treatment. According to NAMI (2009), many African American women with depression minimize or conceal their symptoms, and group programs allow them the chance to proactively building strong support networks that can empathize with their circumstances.

Forsyth et al. (2010) hypothesized that cognitive-behavioural therapy could be effectively applied by professionals other than mental health professionals. Their research showed that not only could cognitive-behavioural therapy be learned by various professionals outside of mental health clinics, but that the professionals who played pivotal roles in lives of people with depression had just as much success in treating depression as mental health professionals. Although this study did not include African American clergy specifically, they do fulfill many of the pivotal roles Forsyth et al. (2010) highlighted in their research. African American clergy encourage their parishioners to complete daily tasks, and have continual contact with their parishioners

designed to uplift them emotionally and spiritually. Previously Stansbury et al. (2009) found African American women with depression in rural communities often do not have as much access to mental health professionals as African American clergy. Given that African American clergy are more accessible to African American women with depression in both rural and urban areas, that cognitive-behavioural therapy can be adapted to meet cultural needs, and cognitive-behavioural therapy can be successfully used by professionals other than mental health ones, it seems logical to provide African American clergy with cognitive-behavioural therapy interventions.

To summarize, cognitive-behavioural therapy has many strengths. It can be customized to African American women with depression to ensure they are getting the most out of their treatment. Many professionals, like African American clergy, can learn it and use it effectively. Its effectiveness across cultures is thoroughly documented, as is its compatibility with religious beliefs. Cognitive-behavioural therapy also stresses focusing on the present instead of delving in the past, which may be more comfortable for African American women, as well as stressing accountability and actively taking control of what factors are within their control. Placing such an effective tool in the hands of African American clergy means that African American women with depression will be able to incorporate their faith into their treatment, and may have access to supports such as childcare and transportation options their churches that may be able to provide (Miranda et al., 2006; NAMI, 2009; Revicki et al., 2005). Based on these findings, cognitive-behavioural therapy interventions for depression are effective for African American women, and can be adapted to be more culturally appropriate while still retaining their effectiveness.

Cognitive-behavioural therapy techniques that blend with religion. Jones (2008) outlined that cognitive-behavioural therapy is designed to help people with depression identify which circumstances in their lives they have control over, and then to prioritize those circumstances so people feel organized rather than overwhelmed. They are then empowered to develop positive life goals by tackling just one circumstance at a time by learning and applying problem solving skills. Problem solving changes the areas of the life that are creating significant stress, and contributing to the depression. Cognitive-behavioural therapy includes an impressive array of therapeutic techniques, and commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing thoughts, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation, mindfulness, and distraction techniques are also commonly included. What follows next is an explanation of some of these techniques, with suggestions for African American clergy on how to incorporate religious aspects into them.

According to cognitive-behavioural therapy, self-talk consists of statements people make to themselves that reflect their self-worth. Hodge and Bonifas (2010) suggested injecting religious content into the commonly used cognitive-behavioural therapy technique of challenging negative self-talk could be an effective way of helping African American women with depression to find opportunities to create positive self-talk. This can be done by creating what Hodge and Bonifas (2010) call a religiously relevant self statement: a statement of self-worth based in the religious traditions of African American women. Hodge and Bonifas (2010) went on to explain that many

African American women believe the Lord offers all people unconditional acceptance, and that each person has intrinsic dignity and worth. Together these beliefs suggest that African American women believe they people have inherent value as children of God, even if the make mistakes. The following self-statement provided by Ellis (2000) demonstrates a self-statement incorporates these beliefs of unconditional self-acceptance and inherent value:

Regardless of my actions or feelings, I always have dignity, worth, and value as a person created in your image. While it is appropriate to evaluate my actions, my actions do not impact my value as one of your children. Even when I sin, you still accept me and love me. As your child, I always have intrinsic worth. Thank you God! (p. 32)

Terms and phrases like those of this provided self-statement may have more impact or logic for African Americans women with depression operating within the context of an Africentric worldview than secular terminology alone (Hodge & Bonifas, 2010). As this pertains to challenging negative self-talk and replacing it with positive self-talk, the negative statements can be disputed with the religious self-statements by encouraging African American women to repeat their self-statements whenever negative ones arise. Hodge and Bonifas (2010) noted that Ellis' (2000) example of a self-statement was constructed in the form of a prayer, and prayer is a common strategy for dealing with problems among devout African American women. Therefore, African American women can also be encouraged to use their regular prayers as an expression of faith, inherent worth, and gratitude to God.

Other research has indicated that bibliotherapy—using assigned readings to teach problem solving skills—can also be a useful, customizable cognitive-behavioural therapy technique for African American women. Jones (2008) reiterated that the realities of African American women encompass the interaction of gender, race, ethnicity, class, religion, and psychosocial forces. Jones (2008) went on to explain that some books and religious texts include themes in which a female African American protagonist develops competence in the face of a stressful situation involving some of the aforementioned factors. Therefore African American clergy can assign certain religious texts and books for African American women to read to give them role-models of success to identify with. In addition, Jones (2008) suggested that this technique could be particularly effective in a group setting. In a group setting, African American women with depression could meet together to share feedback with each other about which themes and characters they identify with, and raise discussions in relation to their personal experiences. Discussing the readings allows African American women with depression to receive support on issues that parallel their own lives in culturally appropriate manner.

As for examples of readings to assign, Jones (2008) does not outline religious-based ones, and it is my feeling that because African American clergy tend to have close relationships with their parishioners, they would be aware of which texts and stories within those texts would be appropriate to use with African American women with depression. Several suggested books are *Mama*, by Terry McMillan (1994), *Sisters of the Yam*, by bell hooks (1993), *Family*, by J. California Cooper (1991), *Coffee Will Make You Black*, by April Sinclair (1994), and *What Looks Like Crazy on an Ordinary Day* by Pearl Cleage (1992). Jones (2008) warns though that before assigning any readings,

African American clergy should read the literature themselves. This way they can ensure the readings are of an appropriate reading level and length for the women, as well as monitor the readings for graphic content such as sexual abuse that may be too distressing for some women read about.

Some research indicates group work may be an effective method of using bibliotherapy to help African American women with depression overcome it (Jones, 2008; Miranda et al., 2003; Miranda et al., 2006). Group work establishes a context in which participants learn new coping skills from the readings from each other while decreasing isolation by fostering supportive interaction among group members (Jones, 2008). If African American clergy are willing to run bibliotherapy groups as opposed to treating African American women with depression individually, Jones (2008) does provide a few suggestions to making the groups successful.

Groups should consist of only 8-10 members to keep the group small enough to create an intimate, sharing environment, but large enough to ensure group cohesiveness. In the first session, the women should be encouraged to come up with a list norms or expectations everyone can abide by to guide the behaviour of group as weeks go on. These norms are not as firm as rules, but do provide the women to voice their needs immediately in a safe way, and feel respected as the norms are adhered to. Group sessions work best if they are highly structured, with a focus on the assigned readings. However, to prevent intimidating group members from feeling pressured into discussing topics they are not ready to, it is best to begin sessions with less intimate content, and move to more intimate content later on. Moving through material this way also allows the women to gain insight into their personal and environmental stressors and to acquire new

skills such as assertiveness, along with constructive confrontation and negotiation skills that are associated with a healthy sense of self-esteem. Also, to help maintain structure and let group members know what to expect, have the sessions on the same day and time every week. Sessions should also last the same amount of time each week, and the usual timeframe is 90 minutes or 120 minutes, with breaks provided. The role of clergy in these sessions is to be the group leader. Group leaders are responsible to structure the readings and discussions of the group, keep the atmosphere open and safe for intimate sharing, assist in facilitating discussions, and encourage the women to translate their insights into actions (Jones, 2008).

Forsyth et al. (2010) and Miranda et al. (2003) also found that using prepared cognitive-behavioural therapy manuals, such as *Mind Over Mood* could also be viable options for group cognitive-behavioural therapy work. Miranda et al. (2003) emphasized that most manuals are easily adapted to account for minority groups, like African American women, without losing their clarity or effectiveness. In addition, group members can keep the manuals after the weekly sessions are over, and thus have a resource of coping skills in their permanent possession. Using prepared manuals may relieve African American clergy of the large amount of planning that group sessions require because the manuals come with the session agendas already structured, and may therefore be a more viable option for them in regard to time. Of course, as with other materials, clergy should be familiar with the manuals and comfortable with the concepts before using them. Another advantage to prepared manuals is that they can be used in one-on-one settings with African American women who are uncomfortable opening up to a group of their peers, or if there are not enough women to run a group. As Miranda et al.

(2003) noted though, for maximum effectiveness, barriers such as childcare and transportation need to be addressed first to enable the women to attend any session, group, or individual.

Kendall (2000) noted three other cognitive-behavioural therapy interventions for depression that African American clergy can adapt into a religious context for African American women. The first is activity/pleasant event scheduling. In this intervention, the women would be encouraged to change their daily routines slightly in order to participate in a culturally appropriate, uplifting activity. It need not be a lengthy or costly activity, but a simple moment to enjoy, like meditation, praying, or listening to a song. The notion behind this intervention is that when people change their actions, they in turn change how they feel and think. To aid in this transformation, the women can also be asked to add a second intervention to this one: keeping mood logs. In a mood log, the women would track the activities they do every day, and note if each one creates feelings of pleasure, mastery, anxiety, or competence. The women then rate each of those four categories on a scale of 0-10 with 0 being no pleasure, mastery, anxiety, or competence, and 10 being the maximum of those characteristics. These ratings allow the women to track how often they engage in activities that create feelings of anxiety or failure, remind them of how often they may experience enjoyable feelings, or identify the need to incorporate more enjoyable activities as the first intervention suggests.

The third intervention Kendall (2000) mentions is problem solving. Problem solving assists people in recognising the resources they have for dealing with problems. First, the women would be asked to identify what the most critical issue is that needs to be addressed. Next, they would brainstorm all the possible solutions to that issue, and of

course clergy could help brainstorm as well if the women feel stuck. Then the women would map out the consequences of each possible solution, allowing them to identify the best one. This does not necessarily mean the easiest one is best, but the one that is most likely to produce long lasting, positive results in their lives. The next step is to implement the solution, and the final one is to evaluate whether it worked or not. This is simplistic explanation of problem solving, and some solutions will take time to implement, maintain, and evaluate. However, this method of problem solving does enhance people's sense of control over problems, and equips them with a method for tackling future problems (Kendall, 2000).

To summarize, cognitive-behavioural therapy uses many techniques to help people, including African American women, to prioritize concerns and organize methods to manage them. Also, the techniques are easily customized to the specific circumstances of African American women, and can be effectively applied by African American clergy using religious beliefs in them. Perhaps most importantly, the techniques can be used in both individual and group sessions, making treatment for depression more accessible to African American women than other forms of treatment.

Erford, Eaves, Bryant, and Young, (2010) compiled several cognitive-behavioural therapy techniques in their book, *35 Techniques Every Counselor Should Know*, that some African American clergy may find helpful. I will provide a description of three of them. The first technique is cognitive restructuring. The basic assumptions of this approach are that self-defeating behaviours flow from irrational thinking like negative self-talk, and that these self-defeating behaviours can be altered by altering the negative thinking, and can be accomplished through seven steps. First, clergy can gather

background on how the African American women with depression have handled past problems. Second, they assist the women in becoming aware of their thoughts by discussing real life examples that support and challenge their conclusions. Third, they can focus on how the women believe their negative thinking influences their well-being. Fourth, African American clergy can help them evaluate how their beliefs about self and others influence their relationships. Next, clergy can help African American women challenge their irrational thinking and beliefs by applying positive thoughts and beliefs such as the spiritual self-statement shared earlier. Sixth, the clergy review the rational thought process frequently and regularly, still using real life examples to help African American women with depression develop attainable goals. Finally, journalling should be used to track feelings during stressful incidents so clergy can help the women maintain focus on their thoughts, and identify how their thoughts and feelings are connected to take control of them.

Next is a rational emotive behaviour therapy (REBT) technique. As with cognitive restructuring, Erford et al. (2010) point out it assumes emotions are important, and they are created by how people interpret the events in their lives. Again, it goes back to thoughts. To implement this approach African American clergy can use the ABCDE model. The A stands for activating event, the situation that triggers African American women with depression into experiencing depressive symptoms. Erford et al. (2010) suggest that having an understanding of what actually happened in the event, as well as of the women's perceptions of the event are important to point out conflicts in thinking. The B is for beliefs, and clergy can point out the shoulds, musts, and other irrational beliefs in the perceptions of the events, while praising the logical ones. The C stands for

consequences. Usually the consequences are what prompt people into looking for help to begin with. After A, B, and C are assessed, then a dispute (D) of the irrational beliefs involving discriminating between rational and irrational reactions, and finally evaluate (E) how proportionate the reactions are to the actual event (not the perceptions because they may be faulty). At that point, African American women with depression can be asked to brainstorm alternate, more rational ways of understanding the event.

The third technique from Erford et al. (2010) I will share here is reframing. Reframing takes problematic situations and presents them in a new way, allowing people to adopt more positive, constructive perspectives. Reframing changes the conceptual or emotional viewpoint of a situation, and changes its meaning by placing it in another context (frame) that also fits the same facts of the original situations. The goal of reframing is to help people see the situation from another vantage point, making it seem less problematic, more normal, and thus more open to solution. When reframing, it is up to the clergy to offer new points of view to African American women with depression, in the hopes that they will see the situation differently as a result, and as a result act more suitably. The new point of view must fit the situation well or even better than the women's original interpretation. There are three steps African American clergy can use to implement the reframing technique. First, they need to listen nonjudgmentally to gain a complete understanding of the stresses African American with depression face. Once clergy have that understanding, they then bridge the women's points of view to the newer, positive ones they offer. Third, clergy can then reinforce the bridge to healthful points of view by giving African American women with depression homework that challenge them to see problems in a new way. For example, African American clergy can

challenge them to track positive moments in their days, or look for blessings in disappointing circumstances.

Chapter 5: Conclusion

This project on *A Manual to Support Clerical Interventions for African American Women* was conducted as a requirement to complete the Master of Counselling degree through the Campus Alberta Applied Psychology program. This final project culminated in the development of a proposed counselling manual that introduced clerical interventions rooted in cognitive-behavioural therapy appropriate for African American clergy treating African American women with depression. One of the outcomes of this project was increase the interventions for depression available to African American clergy to use when female parishioners seek depression support and treatment from them. The other was to raise awareness among mental health professionals of the culturally bound manifestations of depression in African American women, the culturally acceptable methods of treatment, and the paucity of research regarding the experience of depression in African American women. Integral to this project was an exploration of the influence of sociocultural context, as the history of slavery and oppression has created cultural coping mechanisms for African American women that protected them in times past, and still serve as relevant protective behaviours now (Hunn & Craig, 2009; Vontress et al., 2007). Hence, this project should support more informed and sensitive pastoral counselling practice that contributes to ameliorating the distress of African American women with depression.

For mental health professionals, cautions were raised in defining depression universally, as most research and diagnostic criteria is based on the experiences of White, Protestant males (Heath, 2006). Statistics outlining the anticipated shift in demographics in the next few decades were shared to support this point. It is clear from current

literature that the culture alone can result in barriers that impede both the access to mental health services, and the quality of those services (Jackson, 2006). There is a saying that if all people have are hammers, every problem looks like a nail. Currently the status quo for treating depression (the nail) is for people to seek out mental health practitioners on their own (the hammer), but that fails to account for what treatments are acceptable to African American women due to their unique worldview. Mental health professionals may not be consciously discriminating against African American women with depression, but risk doing so unconsciously by relying on the idea that what works for one client will work for every client. There are still prevailing notions that the experience of depression is universal, as are its symptoms and treatment options. However, women are twice as likely as men to experience depression, and while exact numbers are unknown due to the reluctance of African American women with depression to come to mental health practitioners, it is suspected that a disproportionate amount of them are depressed as compared to both White women and women of visible minority groups (Waite & Killian, 2008). In addition, a systematic review of the literature suggested that a history of oppression of African American women by White people and their institutions has created a sincere distrust of White professionals and institutions, limiting the culturally acceptable manifestations of depression and its treatment options for African American women (Burgess et al., 2008).

However, new research is examining how race influences the treatment process, and how the Africentric worldview shapes the personality of African American women. To enhance the ability of African American women with depression to find relief from their depressive symptoms, African American clergy must have access to the

interventions that merge with their faith-based counselling (Chung et al., 2006).

Fortunately, African American women with depression are being treated in increasing numbers by their clergy (Carrington, 2006). Therefore, this manual emphasizes the validity of the Africentric worldview, along with the acceptability of African American women seeking relief from depression through guidance from their African American clergy (Chung et al., 2009).

Understanding how race and gender influence the etiology of depression, how the Africentric worldview socializes African American women to behave, and how the cumulative effect of chronic stress shapes the personality of African American women with depression are critical to accurate diagnoses and treatment. African American clergy already have this understanding, as well as the trust of African American women and their families. As Moon and Shim (2010) noted, clergy see the families of their parishioners often, know of their comings and goings, are familiar with the family histories of their parishioners, and have access to their successes and struggles that mental health professionals do not. With such familiar understanding and trust already in place, African American clergy are a logical and culturally acceptable group to seek help for depression from, rather than breaking cultural norms that could lead to African American women with depression being ostracized from their support networks. *A Manual to Support Clerical Interventions for African American Women* broadens the accessibility of culturally appropriate treatment options for depression for African American women, consequently giving them more opportunities to learn how to manage their depression proactively.

I expect African American women with depression will benefit from this manual

outline, and its cognitive-behavioural interventions grounded in religion. Culturally relevant activities and content will help maintain and develop their interest in reframing their lives' obstacles into challenges they can overcome, and be rewarded with relief from depression and find greater fulfillment. It is anticipated that African American women with depression who participate in faith-based clerical counselling will feel a decreased sense of isolation, as they will be able to ease their experiences of depression and stoicism by safely and honestly connecting with African American clergy whom they already trust. In addition, it is anticipated that the process of counselling itself will become more concrete because cognitive-behavioural therapy focuses on hands-on techniques that require active participation, rather than vague discussion. Although basic counselling skills such as listening empathically, understanding feelings, and providing encouragement are listed by clergy as important skills to use as well (Moon & Shim, 2010), they do not entirely fit the Africentric worldview. Since the Africentric worldview has a bias toward proactively doing activities that benefit friends and families, African American clergy using concrete interventions honours the Africentric worldview by protecting friends and families from potential discrimination by White institutions, as well as incorporating a focus on taking action.

Mental health professionals involved with African American women with depression are also likely to benefit from the development of the proposed manual. For example, mental health professionals could use the literature review and interventions provided to provide appropriate support and treatment to any African American women with depression that may seek them out for relief. In addition, the interventions are

grounded in a Christian religious bias, making them relevant and adaptable to clients with depression who identify strongly with a Christian denomination.

Prior to creating this manual outline, I know now that I held the faulty assumption that obtaining treatment for depression and adhering to whatever treatment was administered was the sole responsibility of African American women with depression. Further reflection leaves me ashamed that I also assumed I knew how it must feel for them to be battling depression. How could I know what it is like to be in the grips of chronic depression, prevented from asking my friends about it, scared of how to access treatment for it, and then be blamed for my misery? It is no longer acceptable for me to think that way. Although depression is a common and debilitating illness, empowering African American clergy to treat it effectively with culturally appropriate interventions may mean relief for African American women with depression today, and for their posterity as treatment crosses generations. Ultimately, these benefits will also contribute to developing healthier communities and broader sociocultural environment for all.

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