NO LONGER SILENT: AFRICAN AMERICAN WOMEN SPEAKING UP
ON DEPRESSIVE SYMPTOMS AND RELIGION

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NO LONGER SILENT: AFRICAN AMERICAN WOMEN SPEAKING UP
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Dissertation

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ABSTRACT

The primary purpose of this qualitative study was to give voice and meaning to women experiencing depressive symptoms and struggling to maintain their faith, beliefs, and trust in a historical place of asylum. Six African American women who had experienced depressive symptoms in the past four years were recruited from local Black churches in the northeast Ohio. Three research questions guided data collection and analysis: 1) What are African American women’s experiences related to mental health in the African American church; 2) What are African American women’s experiences related to depression in the African American church; and 3) How do African American women view the role of the church in coping with depressive symptoms? Participants revealed depressive symptoms of anger, isolation, pain and hurt, sadness, tearfulness, and withdrawal. At times they felt lack of support from church in the areas of finances judgment, mistrust, lack of inclusion, and rejection. Data analysis revealed that the protective factors African American women use to cope with depressive symptoms in the church fit a womanist perspective. Each participant used prayer, individually selected gospel music that communicated a specific message to the heart, finding mentorship with women in the church with a like mind, and reading the Word of God to develop a direct spiritual relationship to decrease depressive symptoms.

Keywords: African American women, religion, depressive symptoms
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To God be the Glory for the things He has done to make this dream a reality.

Amen.
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CHAPTER I

THE PROBLEM

Introduction

An estimated 19 million people in the United States experience depression each year (Ward, 2007). In any given one-year period 15% of women suffer from a depressive illness (American Psychiatric Association, 2000). Depressive illnesses often interfere with normal functioning and cause pain and suffering not only to the individual but also to those who care about them. Women are twice as likely as men to experience depression (APA, 2000; Waite, 2008; Ward, 2007). The life-long prevalence rate of depression among women is 12.6 compared to 6.3 among men (Ward, 2007). When looking specifically at racial and ethnic minorities, African American and other minority women are at a higher risk for depression than white women (Colbert, Jefferson, Gallo, & Davis, 2009).

In the last decade, researchers exploring the role of religion and healing, coping and overall well-being have found that symptoms of depression in African American women in the religious arena have significantly increased (Carrington, 2006; Jang & Johnson, 2004). Some studies indicate that African Americans are reported to present with more depressive symptoms than other groups but have less access to mental health services, are less likely to receive the help they need, and receive less favorable treatment.
when diagnosed (National Institute of Mental Health, 2005; United States Department of Health and Human Services, 2001; Waite & Killian, 2008). African American women are often identified as a group at a high risk for depression (Cochran & Mays, 1994; Warren, 1997). There is a paucity of research focused on depression in African Americans in general and even less on African American women specifically as it relates to the impact of religion on mental health in this population.

Chronic depression can destroy the religious connections the individual has with her church family as well as her immediate family members (Neighbors, Musick, & Williams, 1998). Historically, it has been a taboo for African American women with a deep religious faith background to seek mental health services (Jang & Johnson, 2004; Koenig, McCullough, & Larson, 2001; Myers, 1988). Some individuals believe that to seek help signifies a lack of commitment and belief in their religious preference (Mattis, 2002). Their well-being is compromised by the fear of being labeled and judged as being spiritually weak.

African American women are more at risk for depression because of their double minority status of being black and female (Woods-Giscombe’ & Lobel, 2008) within a predominantly white culture that has a history of oppression and racism. Other oppressions can be found in the healthcare system, educational system, economic system and social resources (Carrington, 2006; Colbert et al., 2009; Jang & Johnson, 2004). According to Ward (2007), women of color are overrepresented in the population of depressed individuals but their use of mental health services is lower than that of white female counterparts due to lack of access to health insurance and a greater dependence on public health services.
There are medications and psychological therapies such as cognitive/behavioral, talk or interpersonal that can ease the pain of depression. But how are such remedies viewed by African American women from a religious and historical background? Emotional wholeness, psychological strength, and resilience are central to African American women’s historical struggle. Studies have demonstrated a link between religious practices of African American women and physical, psychological, and spiritual well-being (Carrington, 2006; Colbert et al., 2009; Hunn & Craig, 2009; Mattis, 2002; Waite & Killian, 2008).

Researchers have also been interested in the psychosocial factors of depression since the late 1950s and 1960s. Psychological research into depression has addressed etiology, pharmacological treatments, and treatment measures and scales to measure levels of depression. The psychosocial research has primarily focused on diagnosis, counseling services, and therapeutic treatments. Hunn and Craig (2009) and Colbert et al. (2009) have added race and gender to psychosocial factors of depression. There is little empirical data on African American women as a unique and diverse group, and the incidence of depressive symptoms in this population is unknown (Brown & Topcu, 2003; Kohn & Hudson, 2002; Mills, 2000). Researchers in various fields have begun to consider the role of religion on the outcomes of individuals experiencing depressive symptoms (Aaron, Levine, & Burstin, 2003; Abernathy, Houston, Mimms, & Boyd-Franklin, 2006; Baetz, Griffin, Bowen, Koenig, & Maroux, 2004; Brodsky, 2000; Brown, 2006; Gill, Minton, & Myers, 2010; Jang & Johnson, 2004). Previous research on mental health found that people who are actively involved in religion or religiously committed
are less distressed than those who are nominally religious or not religious at all (Mirowsky & Ross, 1986; Sherkat & Ellison, 1999; van Olphen et al., 2003).

Affiliation and participation in religious groups have offered African American women opportunities to increase social ties, increase social support, share their feelings, and receive the encouragement needed to reduce symptoms of depression (van Olphen et al., 2003). Evidence suggests that religious involvement is a protective factor for African American women. This is done through encouraging behaviors that reduce health risk and positively influence mental health through encouraging emotions (van Olphen et al., 2003). Findings across studies on African American women who do not use religion as a form of support have identified ethnic social support as a mechanism associated with better mental and physical health. Ethnic social support can include affiliations with sorority groups, extended family, friends and mentors. Ferraro and Koch (1994) found that social networks and organizational participation outside of religious circles have been identified as having a positive influence on health and well-being. Researchers have only recently begun to document the role of social support in the health and well-being of African American women. Other forms of coping utilized for depressive symptoms include increased physical activity, volunteering services, and private expressions of faith through prayer without being associated with any religious institution (van Olphen et al., 2003).

There are currently few studies that have been conducted with African American women regarding depression. The treatment of depression and other mental health disorders in African American women continue to plague the U.S. mental healthcare system (Hunn & Craig, 2009). The misdiagnosis and the underdiagnosis of depression in
African American women are evident due to the lack of culturally competent practice with the women who present with depressive symptoms (Hunn & Craig, 2009). In a study conducted by Jones and Ford (2008), a consistent shortcoming in the study of depression in African American women is the culturally inappropriate strategies utilized to meet the specific needs of the women. Health beliefs about depression among African Americans vary. African American women’s expression of depressive symptoms may be culturally related and treatment of depression and the willingness to apply culturally relevant treatment influences what African American know and believe about depression (Waite & Killian, 2008). Relatively limited attention has been focused on African American women by previous researchers studying the relationship between religion and depression given that African American women report higher levels of strain or stressors and distress than do other ethnic groups (Mirowsky & Ross, 1986). Religiosity among African American women is of special relevance due to the higher levels of religious involvement and the symbolic centrality that religious institutions, especially churches, have within many African American communities (Jang & Johnson, 2004).

As interest in developing culturally relevant frameworks for understanding African Americans has increased over the past two decades, religion has been recognized as a cultural construct with implications for African Americans’ stress experiences and mental health outcomes (Hatter & Owens, 1998; Myers, Sweeney, & Witmer, 2000). According to Myers (1988), worldviews vary across cultural groups and determine how individuals perceive, view, think, feel, and experience the world. African American women as a cultural group experience the world through family, friends, church
(religious association), and clergy interventions (Gibbs & Fuery, 1994; Myers, 1988; (Neblett, Seaton, Hammond, & Townsend, 2010).

“Crisis of faith” is a phrase commonly applied to periods of intense doubt and internal conflict about one's preconceived beliefs or life decisions (Strandberg, 2008). This internal conflict frequently leads to symptoms of depression which can create a decrease in the individual's level of functioning. A crisis of faith can be contrasted to simply a period of doubt that demands reconciliation or reevaluation before one can continue believing in whichever tenet is in doubt or continuing in whatever life path is in question (Douthat, 2007) i.e., the crisis necessitates a compromised decision: either sufficiently reconcile the cause of doubt with the belief or decision in question, or drop the belief.

Religious doubt could lead to anxiety and depression over the doubter’s supposed eternal future. Religious leaders, especially African American religious leaders, understand that religion is a key resource for members of African American communities attempting to cope with stress and distress (Neighbors et al., 1998; Trader-Leigh, 2008). The friends and relatives of these women also experience distress over the depressed state of the individual. While many religious adherents derive happiness from their religion, some religious beliefs may cause unhappiness to some of its followers (Ellison, 1993). Some beliefs that may cause unhappiness in followers are perceived lack of supportiveness, condemnation theory and chauvinism within church roles. Ellison (1993) found that life satisfactions among younger African Americans of higher SES exhibit a direct positive relationship to depressive symptoms related to religious beliefs. Religious practices are ways to cope with depression through externalization of feelings, giving
meaning to depressed mood and finding healing through the internalized relationship with God (Smith, McCullough, & Poll, 2003).

**Background of the Study**

Having or expressing a belief in or respect for women and their talents and abilities beyond the boundaries of race and class: "Womanist . . . tradition assumes, because of our experiences during slavery, that black women already are capable." (Alice Walker, 1983)

**Womanist Theory**

The term Womanist was developed by author Alice Walker in 1983. Alice Walker defined womanism as “Empowerment through interpersonal connection to resist oppression within and outside the church that causes depression and a reduction in religious engagement.” Womanism is derived from the folk culture of African American women with its commitment to survival and wholeness of self. Womanist models reflect integrated analyses of race, gender, class, and sexual orientation while addressing African American women’s lives more holistically than do Afrocentric and feminist models (Williams, 2005). Black feminist/womanist theological scholarship pays particular attention to Black women’s roles in church history and to their particularized readings and uses of Biblical texts (Gilkes, 2001).

The lack of attention to everyday realities of African American women and other women of color and the lack of understanding of the full dimension of oppression of African American women require an insightful inquiry into their history. African American women’s coping mechanisms for oppression, abuse, poverty, relationships, family, and life are focused on the church, their spirituality and religious practices (Greer, 2011). Historically, African American women have relied on faith and religious practices
to cope in challenging situations and environments, and the development of identity for African American women is also connected in faith and religion (Howard-Hamilton, 2003). Based on traditional African cultural patterns of spirituality, communalism, emotional expression and interdependence, there is a belief that these cultural patterns serve as protective factors for African American women against negative psychological effects (Williams, 2005). A relatively recent theoretical development, African American feminism or “womanism” offers an alternative to Afrocentric and feminist approaches to understanding African American women (Williams, 2005). One theory that may hold more relevance for African American women is Janet Helms’ Theory of Womanist Identity Development (cited in Ossana et al., 1992). This is also the theory that has been used most widely in the study of gender identity formation in African American women. Helms’ Womanist model describes the development of women in search of their gender identity. The stages describe women’s development as they move from an acceptance of societal definitions of womanhood to their own definitions and beliefs about the roles of women. No studies were found, however, focusing on Helm’s Womanist model and theories of racial identity that are not considered stage-wise theories.

It appears that racial identity and gender identity are critical components of identity development for African American women. Hemmons (1974) posited that the women’s movement did not specifically address issues central to the concerns of Black women, and Kelly (1994) reiterated that contemporary feminism fails to be relevant to young Black women’s lives. In fact, recent theories and treatment approaches that include traditional feminist approaches place little, if any focus on issues of race. Consequently, some African American women totally reject the term feminist, preferring instead to use
the term womanist to describe their commitment to womanhood and the Black community.

Womanist theology attempts to help Black women see, affirm, and have confidence in the importance of their experience and faith for determining the character of the Christian religion in the African American community. Emotional wholeness, psychological strength, and resilience and their centrality to African American women’s historical struggles are the core of womanist theory (Williams, 2005). Womanist theology challenges “all oppressive forces impeding Black women’s struggle for survival and for the development of a positive, productive quality of life conducive to women’s and the family’s freedom and well-being” (Walker, 1983, p. 18). Modes of psychological resistance to oppression identified in womanist discourse include reliance on women-centered networks of emotional support and care giving, spiritual faith, and a healthy construction of self (Boyd-Franklin, 2003; Collins, 1990).

Womanist theology opposes all oppression based on race, sex, class, sexual preference, physical ability, and caste. The Womanist strategies of integrating race, cultural oppression, class, gender, and sexual orientation to holistically address the African American woman’s life experiences increase community building, self-determination, compassion, and empowerment through interpersonal connection (Cannon, 1988). Thus, it is thought that Womanist theology may be more appropriate or relevant to the experiences of African American women.

**Philosophy Guiding the Research**

Qualitative methodology places a “high value on the investigation of the individual’s experience” (Jarvis, 1996, p. 6) and is a method of listening to hear and
understand the voice behind quantitative research. Qualitative methodology helps to learn
about people “embedded in the context of their lived understandings” (Carter, 1989, p. 66). In qualitative research the researcher is the instrument and data collection is an
interactive process between the researcher and the participant (Morrow & Smith, 2000; Patton, 2002). In this study, the qualitative case study approach was used to increase the
interactive process between the researcher and the participant while gaining a better understanding of the individual’s lived experience.

The importance of the role of religion in the African American world view has been researched connecting various variables and factors. However, little research has been conducted that examines religion related to lived experience of African American women experiencing symptoms of depression in the church. Given the shifting demographics of people of color in the American population with cultural values and value systems being weakened, looking into the reality of African American women will help us to understand their needs, stressors, situations, and struggles maintaining the connection to religious roots as a source of strength. The present research attempts to investigate the lived experience of depression in African American women in context of their religion.

There has been a paucity of studies that have been published focusing on depression in African American women related to religion. It is my intent to further investigate the lived experiences of African American women in the church who have previously experienced depressive symptoms and the role of religion. The present study focused on African American women who have experienced depressive symptoms within the past four years as measured by the BDI II. They may have had either a past diagnosis
of depression from mental health providers, by self-report or who are identified by other females involved in their lives. The specific aim was to hear their stories through their lived experiences regarding symptoms of depression in the context of religion.

The goal of this study was to allow the voices of African American women who experience depressive symptoms in the church to be heard within this social construct and to provide insight into protective factors African American women utilize in coping with symptoms of depression as they engage in religious activities and involvement in the church. Some of its tasks were excavating the life stories of women of African descent in the church and understanding the "languages" of Black women.

The intersect of African American women experiencing symptoms of depression in relation to religion can be theorized using this diagram.

Figure 1. The interconnected relationship of each construct identifies focus of research study.
Purpose of Current Study

The current research was a qualitative, phenomenological investigation exploring the lived experiences of African American women who are active churchgoers and the relationship among religiosity and depression. The primary purpose of this study was to give voice and meaning to women experiencing depressive symptoms and struggling to maintain their faith, beliefs, and trust in a historical place of asylum. The African American church has focused on civil rights, social justice, community development, public education, meal service, and other services that provide for the overall well-being of its members (Ferraro & Koch, 1994). The secondary purpose of this study was to provide insight into protective factors African American women utilize in coping with symptoms of depression as they engage in religious activities and involvement in the church. Qualitative studies are needed to help elucidate results and interpretations of quantitative studies that have been conducted on the relationship between religion and depression. Also this qualitative investigation may help mental health professionals and clergy more fully understand the effects of depression among African American women seeking asylum in the church using their religious beliefs and practices.

Researcher Stance

When conducting qualitative research, the researcher is the instrument in the interactive process of data collection. The process of data collection can be skewed by biases of the researcher if proper precautions are not taken to control for and restrict these personal biases. Providing pertinent personal and professional information about the researcher helps to maintain the creditability of the study as documented by Patton (2002, p. 56). It is my goal to share my experiences as a religious African American woman in
the church interacting with my peers and the struggles and victories we share as a community of believers. I am actively engaged in women’s groups and auxiliaries in the church practicing my spiritual gifts and talents with other women with whom I frequently interact.

Professionally, I am a Licensed Professional Clinical Counselor –Supervisor. It is known in my community of believers that I present at various women’s functions as an expert on depression in women. On several occasions after a presentation women would approach me both privately and publicly to ask questions, tell me their stories, and to seek guidance on specific situations in their lives that has caused them to feel sad, distressed, helpless, and hopeless within the church setting.

During my life’s journey, I had the opportunity and privilege to live in Nigeria, West Africa for most of my adult life. During this time I learned the meaning of community, family, collective experience, spiritual roots, and religious heritage. I was a part of a community of women who generously shared ideas, gifts, talents, resources, and material and financial wealth with each other without feeling forced or pressured but felt obligated and compelled to pass on whatever knowledge they had gained or support they had received from the group to other women in the community as the need arose. The theories of collectivism and womanism resonate with me due to this experience. As a youngster growing up in America, I remembered the church I was raised in following these same principles of giving to enhance the nurturance and growth of every individual in the church community. The women in the church at that time acted as mothers, teachers, aunts, counselors, and mentors to all girls and young women regardless of maternal ownership. There was no fear of betrayal, no mistrust, no gossip, no hoarding of
property or position but a communal distribution and contribution of the collective wealth.

As women in the church shared their stories with me, I began to discover the loss of the spirit of Agape unconditional love and communion in the present day religious experience. Women today, who are actively engaged in religious practices and involved in church activities, come to seek my guidance and counsel for what was once the role of the elder women, “mothers” in the church home environment. I began to question the role of the Black church in meeting the needs of many women who faithfully attend and support this historic place of asylum. As my professional experience increased and my roles in the church decreased, I began to understand the dilemma of this population of women. Returning to the United States after living in Nigeria for over 18 years and my religious experiences, I understood what these women were feeling and experiencing. Where was the support and encouragement from the women leaders in the church? Where was the nurturing and guidance expected from the leaders and elders in the church? Where is the education for survival in an often hostile environment outside of the church doors? Where is the family who will receive the broken in body and spirit and love them no matter what? Why are so many women depressed and experiencing symptoms of depression in the church? To explore these questions for myself and to hopefully find answers, I examined African American women’s history to reach answers for the present.

Over the past several decades, social norms and expectations for African American women have changed dramatically. We were once permitted to stay at home or work part-time and care for our children while our spouse carried the financial burdens of
the family. Today, the roles in the African American family have shifted with more women acting as heads of households and being required to provide for the needs of her family. The shift has prompted African American women to go to college campuses to ensure they have an opportunity to increase their professional and career development and financial stability. The theoretical development of the womanist philosophy that encourages empowerment of African American women to resist all forms of oppression has helped me to understand the struggle of African American women. Womanist theory is committed to the survival and wholeness of self and family.

As a Professional Clinical Counselor, I have learned to listen to the stories of women experiencing depression related to a variety of life circumstances ranging from relationships with significant others, their children, families, poverty, health issues, feelings of disappointment and betrayal to lack of support and nurturance while engaging in religious practices. Philosophically, I feel equipped to undergo a qualitative investigator methodology to document, research and share the lived experiences of African American women experiencing depressive symptoms while engaged in religious practices. I have experienced depression while religiously engaged and sought asylum in the historical place of asylum. I live a personal position as an insider to the experience of so many women who “fall away” from the faith due to unmet emotional, spiritual, and sometimes financial needs.

Extant literature on depression, African American women, and religion has established a positive relationship between the constructs with religion acting as a buffer for psychological well-being (Jones, 2004; Jones & Ford, 2008). Spiritual and religious beliefs, values, behaviors, and practices are woven into the fabric of this culture, their
personal development and their world view. Research extending over a 20-year period indicates that the clergy is the most frequently sought source for help with problems related to psychological distress (Chalfant et al., 1990). Contrary to existing literature, my current experiences, and from the current reports of African American women I work with both professionally and as part of the church community, there is a need for current studies to be conducted through the womanist lens reflective of the present condition of the church as it impacts today’s struggles of African American women. Research studies with African American women could also provide insight into the protective factors used by African American women in relation to their religious experiences. The historical place of asylum, a place to articulate suffering, a place to locate persecutors, and a place to validate African American women’s experiences in America, the church environment appears to be “falling away” from its original role. A few studies have been conducted that explored religious variations in symptoms of psychological distress and depression among African American women with inconsistent results (Ellison, 1993). I hope to develop a deeper understanding of this phenomenon by exploring the lived experiences of African American women experiencing depressive symptoms in the context of their religion.

**Significance to Counseling**

The majority of people in the world identify with some religious belief and most people in North America see religion as part of the larger picture of living their lives (Elkins, Hedstrom, Hugh, Leaf, & Saunders, 1988; Hill, 1972; Jones, 1991). A perception has existed about psychotherapy that the field holds little interest in religion, but some shift is occurring (Neighbors, 1985; Neighbors & Jackson, 1984; Neighbors et al., 1998;
Ward & Heidrich, 2009). In fact, new research is beginning to consider how therapists can include religion in therapy for the benefit of students, clients, and even the larger community around them. The increasing interest and changing perception have stimulated a growth in research on religion in counseling practices (Cornish & Wade, 2010). The challenge for therapists is to develop culturally competent variables sufficient enough to integrate knowledge of cultural differentials in the treatment and care of African American women for whom religion is important.

A study by Pate and High (1995) reported that 75% of those involved in counseling believed that spiritual and religious issues were somewhat to very important to daily functioning. Further, Hickson, Housley, and Wages (2000) reported that religious interventions in mental health therapy were either important or vitally important. These studies, among others, have shown that there is importance to implementing religious practices when working with women experiencing symptoms of depression. Specifically, incorporating discussions about religion into conversation with African American women to increase expression of thoughts and feelings in therapeutic sessions is beneficial. The governing bodies of the counseling profession support the discussion of these beliefs in counseling. Despite these efforts, spiritual and religious material continues to be neglected in counselor training programs (Cox, 2013).

**Definition of Constructs**

**African American Women**

In an attempt to keep up with changing social opinion, the United States government officially classified black people (revised to black or African American in 1997) as a person having origins in any of the black racial groups of Africa. The U.S.

African American women can be described as women of black African descent and those who self-identify as African American. This current designation not only reflects a historical lineage, but it also establishes an identity that is rooted in cultural and ethno-geographic origins, rather than skin pigmentation as defined by United States politics and policy.

**Black Church**

The term **black church** or **African-American church** refers to Christian churches that minister to predominantly African-American congregations in the United States. Throughout U.S. history, religious preferences and racial segregation have fostered development of separate black church denominations. After slavery was abolished, freed blacks continued to establish separate congregations and church facilities, creating communities of worship in culturally distinct ways. In addition, segregationist attitudes in both the North and the South discouraged and, especially in the South, prevented African-Americans from worshiping in the same churches as whites. The majority of African Americans are Protestant of whom many follow the historically black churches. According to a 2007 survey, more than half of the African American population is part of the historically black churches.
Depression

The term depression can be defined as a feeling of sadness and dejection resulting in an impairment of daily functioning (APA- DSM-IV TR, 2000) exhibited as social withdrawal, decrease in motivation, lessened sex drive, sleep disturbance whether insomnia or hypersomnia, an increase in feelings of anxiety, irritability, and anger. Depression can be defined as an illness that involves the body, mood, and thoughts. Depression is not a sign of personal weakness or a condition that can be willed or wished away.

Religion

Larson, Swyers, and McCullough (1998) defined religion as “subjective feelings, thoughts and behaviors that arise from a search for the sacred.”(p. 22). Religion is often associated with the individual’s level of adherence to the doctrines, beliefs, and ritual practices of religious institutions and level of organizational religious involvement. Religion is an organized approach to human spirituality which encompasses a set of narratives, symbols, beliefs, and practices. Religion can be defined as the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred that may also include a search for non-sacred goals such as feelings of identity, belonging, or wellness within the context of that sacred search (Cornish & Wade, 2010). Religion is associated with activities in a formal, structured religious environment for validation and support from people with the same values and beliefs. These often have a supernatural or transcendent quality that give meaning to the person’s experiences of life through a reference to a higher power.
The History of African American Women and Religion

Throughout the history of African American women, the struggles for acceptance and belonging within the church has been documented (Beauboeuf-Lafontant, 2005, 2007; Boyd-Franklin, 1991; Brodsky, 2000; Moore, 1991). The history of religion and African American women is an interwoven tapestry of their encounter with mainstream America and the Black church as development and change occurred. African American women of all religious denominations have always relied on their faith in God and themselves to overcome obstacles and barriers in their lives. The beginning of organized religion in slave camps on plantations of the South over two hundred years ago has been the guiding force in the lives of most African American women and men. The church offered a place to articulate suffering as well a forum to advance educationally, politically, socially and economically (Collier-Thomas, 2010). Religion and religious involvement shaped and informed the lives of African American women creating a forum for political activism as well as create an opportunity for the development of organizations where their voices could be heard. Emboldened by their faith, African American women with a resilient spirit set out to fight against racism, sexism, and poverty using the network of organizations established on religious foundations.

African American women have always had to cope with racism and sexism as they sought to find a place in the religious arena (Collier-Thomas, 2010; Gilkes, 2001)). Religion has always been a source of extraordinary resilience for African American women in their efforts to survive and advance in a culture that is often hostile and resistance to gender and race advancement (Collier-Thomas, 2010; Moore, 1991). Their daily life experiences reflected the struggles heard in all aspects of their lives. As a result
of migration, varying denominations of religious groups multiplied throughout cities in the western and northern regions of the United States. African American women were no longer restricted to the southern regions of the United States and pursued areas that would allow them to have substantial roles in the church. New patterns of worship and an expanded base of religious institutions became the norm in northern urban black America (Collier-Thomas, 2010). Religion served as a source of oppression as well as a needed resource to fight for equality differentiated by mostly by geographical and class differences. The church was the foundation and stepping stone for African American women preparing them for roles such as missionaries, teachers, educational program coordinators, and leadership training institutes building emotional wholeness and resilience mentally and philosophically for equality in the church and society (Collier-Thomas, 2010). Even though the organizations were under the influence of the organizations’ leaders and church laws, the opportunity to be involved in these forums afforded African American women a means in which to construct their identities while merging their religion beliefs, their daily experiences and community living into their reality. The religious organizations created a central location to speak collectively on issues of race and gender which are relevant to the womanist identity of love of the spirit, love of folk and love of the self.

According to Bettye Collier-Thomas (2010), numerous studies have considered the importance of race, class, and sex to African American women’s history but few have perceived religion or spirituality as significant factors in the shaping of African American women’s thoughts and actions, nor the historical factors that have impacted the lives of this population of women. Studies on religion and African American history have
provided insight into the lived experiences of the African American women omitting the internal struggles faced on a daily basis which may have created depressive symptoms.

**Research Questions**

1. What are African American women’s experiences related to mental health in the African American church?
2. What are African American women’s experiences related to depression in the African American church?

The central research question for this study is:

3. How do African American women view the role of the church in coping with depressive symptoms?

**Summary**

The current research regarding African American women, religion, and depression examined the lived experiences of this group of women through the lens of Womanist theory. Alice Walker, who is known as the mother of womanism, reminded us that African American women carry a burden of responsibilities related to race, gender, and other culturally specific psychosocial stressors (Walker, 1983). This study hoped to capture and explore some of the culturally specific stressors that contribute to symptoms of depression in this population of women. Another objective of this study was to increase knowledge on effective multicultural interventions to utilize with African American women. To accomplish this end, several open-ended research questions were designed to gather information on the experiences of these women. The researcher used a non-dominant research voice.
This research study was organized into six chapters. Chapter I provided a brief introduction to the problem along with definitions of variables to be studied. Chapter II provided appropriate background information for the research through a review of the current research on African American women, religion and depression to. Phenomenological methods were used to collect and analyze data. To obtain in-depth information, qualitative research design and methodology was used to identify and select participants and to describe the data collection and the data analysis process presented in chapter III. Results of the study and meanings derived from the analysis of the data are presented in chapter IV followed by a discussion and recommendations for future research in chapter V. Chapter VI presented the researcher’s journey.
CHAPTER II
LITERATURE REVIEW

African American Women and Mental Health

African American women face a diversity of mental health issues and concerns as they are continuously attacked and confronted day after day due to their racial, historical, cultural, and economic position in American society (Matthews & Hughes, 2001; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Societal factors have proven to be the most salient influences on the mental health and well being of African American women, despite medical science endeavors seeking to identify biological and genetic determinants of mental health and illness (Brown, Abe-Kim, & Barrio, 2003).

Previous research on mental health has shown that African American women are more distressed than others, especially whites, due to their more frequent experiences of strain or stressors, including racism and economic disadvantage, largely caused by their relatively disadvantaged social status, such as income, education, employment, and neighborhood residence (Mirowsky & Ross, 1986; Schultz et al., 2000). Being targets of both racism and gender stigma, African American women must also contend with the discrimination emanating from body image that may further increase mental health concerns. Psychosocial stressors that overwhelm this population of women may further increase the erosion of the role religion and spirituality play in their lives (deGroot, 2001).
Researchers have found positive effects of religion on various mental health outcomes (Jang & Johnson, 2003; Johnson, Thompson, & Webb, 2002; Koenig et al., 2001; Regnerus, 2003; Sherkat & Ellison, 1999). Some studies suggest that African American women have different views about the etiology and treatment of mental health problems as importance is attributed to religion and spirituality in treating and understanding the cause of mental health issues (Mays, Caldwell, & Jackson, 1996; Regnerus, 2003).

Current utilization of mental health services is disproportionate in terms of race, culture, and gender (Ward & Heidrich, 2009). Explanations in the literature concerning African American women and mental health include the stigma associated with mental illness, their lack of trust in the healthcare system, their lack of access to needed services, and their denial that a mental health problem exists (Carrington, 2006; National Mental Health Association, 2002; Nelson, 1997; Ward & Heidrich, 2009). People of color constitute the fastest growing population in the United States (U.S. Bureau of the Census, 1998). The President’s Commission on Mental Health (1978) identified social inequalities that are faced by women of color result from gender, ethno-racial discrimination and oppression which increases the need for exploration on their mental health outcomes (National Institute of Mental Health, 2005).

One group in need of exploration is African American women (Mays, 1985; Mays et al. 1996; Mays & Comas-Diaz, 1988) given the magnitude of stress that they experience which may increase their vulnerability for developing psychological illness (Jackson & Sears, 1992). Though mental health professionals are more likely to interact with women than men, as women are more inclined than men to recognize and label
feelings of distress as emotional problems and seek help (APA, 2000; Smith et al., 2003), to date, the distinctive concerns of African American women have not yet been priorities in multicultural research (Frame, & Williams, 1996). According to Caldwell (1996), the mental health issues of African American women in particular must be addressed to attain equality among the races in access and use of mental health services and diagnosis.

Eugene (1995) has proposed a model of mental health for African American women that incorporate the Black church. In particular, she indicated that the Black church assists African American women with maintaining their mental health by providing a therapeutic community that allows for (a) articulating suffering; (b) locating the persecutors (i.e., prayer allows them to disclose their troubles with others and to ask for collective support); (c) providing an asylum for Black women to release their frustrations and pain without judgment (i.e., express extreme emotionalism without negative evaluation); and (d) validating Black women’s experiences in America. The clergy in the Black church are mentioned most frequently as a source of help for general psychological distress but it is expected that they will quickly refer depressed individuals to more appropriate mental health services (Chalfant et al., 1990).

African American Women and Depression

The historical and contemporary contexts of oppressions and resistance for African-American women, African-American communities give sense and meaning to one’s life into Black women’s spaces where one can know who we are when we are most us. (C.L. Wise, personal communication, February 2012)

Depression comes in different forms just like other illnesses such as diabetes or heart disease. Major depression occurs several times in a lifetime and is manifested by a combination of symptoms that significantly interfere with daily functioning. Clinical
Depression or Major Depressive Disorder (MDD) is diagnosed when an individual experiences a severely depressed mood that includes five or more primary clinical depression symptoms that cause impairment in usual functioning nearly every day, during the same two-week period. Clinical depression (also called major depressive disorder or unipolar depression) is a state of intense sadness, anhedonia (the absence of pleasure or the ability to experience it), or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living. Clinical depression implies a formal psychiatric diagnosis based on a systematic comparison of the individual’s mental health history and his or her signs and symptoms with predetermined criteria (APA, 2000). The person with clinical depression finds that there is not always a logical reason for his/her dark feelings. A depressed person may feel any or all of the following emotions: anger, irritability, hopelessness, fear, anxiety, fatigue, numbness, confusion, worthlessness, or shame.

Mental health professionals have avoided detailed discussions of diagnosis, symptoms, and prognosis (Brown & Schulberg, 1998). Depressive symptoms can be detected by psychometric instruments designed to screen and assess for depression. Any diagnosis of depression must be in accordance with standardized DSM–IV-TR criteria. There are three primary types of depression: Major Depression – also known as unipolar or clinical depression; people have some or all of the depression symptoms listed below for at least two weeks or as long as several months or even longer. With Dysthymia, the same symptoms are present; however, they are usually milder, but last at least two years; and Bipolar disorder which is characterized by cycling mood changes (APA, 2000).
Depression is one of the most ancient and common diseases of the human race and its burden on society is impressive (Bertol, D’Ilario, Ruffo, Di Virgilio, & Rizzo, 2000). It is the most pervasive psychiatric problem observed in primary care settings throughout the world (Endler, Macrodimitris, & Kocovski, 2000). In 1999, depression was listed as the world's leading disability, and its economic costs are $35 billion dollars a year in the U.S. alone (Linsenmayer, Scheffrahn, McLain, & Brenner, 1999). The current estimated economic burden of depression from treatment cost, mortality, and lost productivity exceeds $43 billion a year (Pinus, 2001; Scanlon, 2002). Depression can be manifested both physically and psychologically but the roots of depression can be psychosocial, situational, and spiritual (Brown, Brody, & Stoneman, 2000).

Major depression affects approximately 18.8 million American adults or about 9.5% of the U.S. population age 18 and older in a given year (Endler et al., 2000). National Depression and Manic Depression Association statistics (obtained from www.ndmda.org) suggested that two thirds of these people are never treated. Approximately 80% of people experiencing depression are not currently receiving any treatment (Kessler et al., 2003). The National Depression and Manic Depression Association reported that by the year 2020, depression will be the second most common health problem in the world even though it is one of the most treatable illnesses with 80-90% of affected individuals finding relief.

Depression imposes a large societal burden. A recent study sponsored by the World Health Organization (2004) and the World Bank found depression to be the leading cause of disability in the United States. Depression is the leading cause of mental illness for women (Peden, Rayens, Hall, & Grant, 2005). According to estimates by Greenberg et
al., (2003) in the year 1999 patients affected by depression were estimated to be approximately 11 million in the U.S. Most (71%) of these patients were women. The primary reason for this phenomenon is that women tend to focus more on their problems (Kessler et al., 2003). Other reasons for a higher depression rate among women are the greater number of women in poverty, sexual abuse, fertility problems, and a general lack of assertiveness (Linsenmayer et al., 1999). One fourth of all women experience depression but only one fifth of this identified population of women is treated for it (Kessler et al., 2003). Over their lifetime about 12% of women will have some form of clinical depression (Kessler, Chiu, Demler, & Walters, 2002).

According to Smith et al. (2003), depression and depressive symptoms are among the most common of all mental disorders and health complaints with a higher prevalence in women. Women are at significantly greater risk than men to develop Major Depressive Episodes at some point during their lives, with the greatest differences found in studies conducted in the United States and Europe. Studies indicate that depressive episodes occur twice as frequently in women as in men (Kessler et al., 2002). Other research has found that women are not more vulnerable to depression than men but simply express or label their symptoms differently (The National Institute of Mental Health, 2005). The lifetime risk for Major Depressive Disorder in community samples has varied from 10% to 25% for women and from 5% to 12% for men.

In women, the cases of depression are similar to many of those experienced by men, but women appear to experience more external stressors than men (Nolen-Hoeksema, 2002). Poverty and economic inequality are predictors of depression in women (APA, 2000; Belle & Doucet, 2003; Brown et al., 2003) and women experience
depression about twice as often as men due to hormonal factors (Waite, 2008; Ward, 2007). Many factors unique to women are suspected to play a role in developing depression. Some research on depression has focused on understanding these factors, including reproductive, hormonal, genetic or other biological factors; abuse and oppression; interpersonal factors; and certain psychological and personality characteristics (Beauboeuf-Lafontant, 2007; Cochran & Mays, 1994; deGroot, 2001; Jackson, 2006; Warren, 1997) but the specific causes of depression in women remain unclear.

In any given one-year period 15% of women suffer from a depressive illness (American Psychiatric Association, 2000). According to The National Institute of Mental Health (2003), depression is likely to have multi-facets that can be understood interacting with social factors and multicultural content. African American women with economic and social stressors may be at risk for longer periods of depressive symptoms (deGroot, 2001). Early research on African American women has indicated that they may delay treatment or withdraw from treatment early because their ethnic, cultural, and/or gender needs are not recognized (Cannon, Higginbottom, & Guy, 1989, Warren, 1997). Among African American women, it is common for depression to go undetected and/or undertreated (Jackson, 2006). While African American women are often identified as a group at high risk for clinical depression, they are also depicted as delaying or not seeking treatment for depression (Akbar, 1991; Barbee, 1992; Ward & Heidrich, 2009). Though research has identified that more than one quarter of women will experience depression in their lives, as few as 7% of black women will receive treatment (Beauboeuf-Lafontant, 2007). Beauboeuf-Lafontant (2005) reported that African
American women struggle with depression in their daily lives yet continue to project the image of the ‘strong black woman’ which is limiting rather than empowering.

Depression is an increasing problem for African American women. Depression represents a considerable health burden for African American women with a one year prevalence rate ranging from 2.2% to 3.1% among African American women (de Groot, 2001). African American women are often identified as a group at a high risk for depression (Cochran & Mays, 1994; Warren, 1997). A recent study conducted by the California Black Women’s Health Project (1978) found that 60% of African American women have symptoms of depression. Depressive symptoms if not checked or identified may escalate into clinical depression, which can erode the quality of life for African American women (Warren, 1997). “Depressed African American women may perceive themselves as being devalued within American society and may have fewer support systems to buffer stressful conditions” (Carrington, 2006, p. 114). Women who have low self esteem, who view themselves with pessimism, or who are overwhelmed by stress are prone to depression (Carrington, 2006). Difficult relationships, financial problems or any stressful change in life patterns can trigger a depressive episode. Many women also face additional stressors such as responsibilities at home and work, single parenthood, and caring of children and aging parents. African American women experience these stressors in addition to being a minority.

Depression is often unrecognized in women of color as they are culturally and emotionally distinct from mainstream. African American women are viewed as being multiply victimized by having to endure a combination of racism, sexism, and poverty (Davis, 1998; Gibbs & Fuery, 1994; Kasturirangan, Krishman, & Riger, 2004; Mitchell et
Women of color are exposed to racism, sexism, and oppression within the dominant culture and within their own ethnic and racial communities as well, which is translated into oppressive reactions that increase depression and depressive symptoms (Lorde, 1994). This situation does not exist among women from the dominant group. African American women may become depressed in response to their stressful psychosocial environments (Barbee, 1992; Brown et al., 2000) in an attempt to survive and advance in society. Multiple effects of psychosocial factors particular to African American women may also increase depression as the cumulative stress and stressors erode the strength and resilience of this group of women (Woods-Giscombe', 2010).

The President’s Commission on Mental Health (1978) stated that the social inequalities faced by women of color result from both gender and ethno-racial discrimination and oppression. African American women face “a range of cultural imperatives and psychological realities that may challenge, facilitate, or undermine their development and adaptive functioning” (Greene, 1992, p. 89). “The conflicts often evolve into the struggle that women of color have with the devaluation of their realities and sometimes with the internalization of such experiences in negative self images” (Comas-Diaz & Greene, 1994, p. 219). African American women must address the daily, mundane life stressors that all women face, in addition to the stressors of racism, poverty, and discrimination. Low self esteem is an issue articulated by African American women.

Among African American women, depression could be undetected because a depressed mood is not as blatant as other signs of the disorder that might be more manifest in the cognitive dimension (Brown et al., 2003; Brown & Schulberg, 1998). African American women reportedly manifest more depressive symptoms than their
White counterparts, but these differences dissipate when socioeconomic status is considered (Beck, Steer, & Brown, 1996; Kessler et al., 2002; Kessler et al., 2003). African American women are at a higher risk for depression, primarily because of overrepresentation in the nation’s lower SES group (Kessler et al., 2003; Tomes, Brown, Semenya, & Simpson, 1990). The experience of poverty (Myers & Gill, 2004) including low income, low educational attainment, fewer career options, chronic unemployment, substandard housing, unsafe living environments, social stigma, and lack of access to health and mental healthcare may be responsible for the higher risk for depression in African American women.

Challenges to mental health as a consequence of poverty can be identified as low self-esteem, low sense of control, chronic stress, negative coping behaviors, substance abuse, victimization and depression, and the stigma of mental illness embedded in some African American communities (Schreiber, Stern, & Wilson, 1998, 2000; Snowden, 2001) contribute to symptoms of depressed mood. “When looking specifically at race and ethnic minorities, African American and other minority women are at a higher risk for depression than white women” (Ward, 2007, p. 265).

The buffering hypothesis (Cohen & Willis, 1985) states that there are many psychosocial factors related to depressive symptoms indicating that the negative association of religious involvement and depression is even stronger for people who have recently undergone high amounts of life stressors. Studies as far back as the late 1880s have pointed to religion as a possible influence on the occurrence and severity of depression (Koenig et al., 2001). Several influences have been found that potentially connect religion/spirituality with depressive symptoms. The variables include genetics,
developmental influences, social support, substance use, appraisal of life events, and ways to cope with stress.

**African American Women and Religion**

Individuals who are experiencing high levels of depressive symptoms may find a lack of pleasure in former religious involvements, which may over time erode their public and even private engagements with their religious faith (Smith et al., 2003). Depressive symptoms may include a lack of energy or a physical disability. People who normally engage in religious practices may find themselves unable to engage in religious pursuits making them appear less religious on many metrics that assess for religiousness (Smith et al., 2003). Depressive symptoms apparently prompt some African American women to seek comfort in their religion (e.g., by attending religious services or reading Holy Scripture). Religious involvement may afford women opportunities for social support, which has been found to protect against depressive symptoms (George, Larson, Koenig, & McCullough, 2000; Koenig et al., 2001). Higher levels of depressive symptoms in African American women who experience feelings or thoughts of lack of support and care from their closest form of social and spiritual support may significantly decrease their active involvement in the roles they play within the church (Smith et al., 2003).

Religion has been recognized as having an important relationship with mental health status suggesting that religion is just as likely to be positive as well as a negative factor in predicting mental health (Hill et al., 2000). To conceptualize the problem, African American women struggle to maintain sound mental, emotional, and religious health in a culture that is historically oppressive. Many scholars have noted that
Religiosity is an inherent and central aspect of African American culture and worldview (Hill, 1972; Jones, 1991).

Religiosity is a difficult term to define as most theorists agree that it is an outward or external expression of the inward spiritual system (Elkins et al., 1988; Myers et al., 2000; Westgate, 1996) whereas spirituality is internal. Aspects of religiosity cannot be studied as a one-dimensional variable but has components of daily spiritual experiences, meaning, values, beliefs, private religious practices, organizational religiousness, religious support, religious coping, forgiveness, religious history, commitment, and religious preferences (Gill et al., 2010). Additional components of religiosity include spiritual maturity and religious commitment. Several studies by Myers et al. (2000) revealed higher levels of spiritual wellness among African Americans who are religious than among European Americans.

Religion has been identified by a number of researchers and scholars as a fundamental attribute of the African American personality (Akbar, 1991; Myers, 1988; Phillips, 1990). Through the study of religious traditions and the study of self concept, scholars have found that religious traditions among persons of African descent provide a central organizing framework for how Africans know themselves, solve problems, and feel connected to each other (Moore, 1991). Religion, as the cornerstone of the African American personality and as being essential to the recovery of African American women’s spirituality, significantly contributes to those assumptions about self, others, and self-world relationships.

Taylor, Chatters, Jakody, and Levin (1996) found that African Americans attend more religious services, read more religious material, and seek comfort through religion
and spiritual activities more often than Whites. African Americans turn to religion or some type of religious activity to cope with stressful life events (Abernathy et al., 2006; Jang & Johnson, 2004). There is a perception of well-being that comes from being in religious communion with God and the sense of purpose and life satisfaction that accompanies that communion (Myers et al., 2000). For the African American, religion has been recognized as being the foundation of one’s core existence, the source that provides strength (Akbar, 1991; Dessio et al., 2004; Hill et al., 2000; Mattis, 2002; Myers, 1988).

Religion is an organized approach to human spirituality which encompasses a set of narratives, symbols, beliefs, and practices (Abernathy et al., 2006; Carrington, 2006; Hackney & Sanders, 2003). These approaches often have a supernatural or transcendent quality that give meaning to the person’s experiences of life through a reference to a higher power. Religion is behavioral patterns to identified practices of religious expression within a specific religion. Batson and Ventis (1982) asserted that religion is whatever we as individuals do to come to grips personally with the questions that confront us while we are alive because as humans one day we will die. Religiousness has often been associated with the individual’s level of adherence to the doctrines, beliefs, and ritual practices of religious institutions and level of organizational religious involvement.

Religion must be considered to completely understand the whole person (Akbar, 1991; Dessio et al., 2004; Myers, 1988). A vast number of Americans maintain active religious beliefs and practices as evident by the number of churches, mosques, cathedrals, and synagogues in any given community. Religion is an organized system of beliefs,
practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and (b) to foster an understanding of one’s relation and responsibility to others in living together in a community (Abernathy et al., 2006; Carrington, 2006). Anthropologists have long noted that one of the primary functions of religion is to increase intragroup solidarity and cohesion (Durkheim, 1965; Rappaport, 1985; Strawbridge, Shema, Cohen, & Kaplan, 2001).

Religion involves a form of worship that has specific behavioral, denominational, and systematic doctrine attributes. Most traditional religions require sacrifice of their followers, but in turn, the followers may gain much from their membership therein. Thus, they come away from experiences with religion with the feeling that their needs have been filled. In fact, studies have shown that religious adherents tend to be happier and less prone to stress than non-religious people (Colbert et al., 2009; Stringer, 2009; Waite & Killian, 2008). The relevance of religion in the life of African American women on psychological norms of their culture influences the well being of the individual (Brown, 2006; Colbert et al., 2009; Stringer, 2009).

Each religion asserts that it is a means by which its adherents may come into closer contact with God, Truth, and Spiritual Power. They all promise to free adherents from spiritual bondage and bring them into spiritual freedom (Ashing, Padilla, Tejaro, & Kagawa-Singer, 2003; Bartel, 2004). It naturally follows that a religion which frees its adherents from deception, sin, and spiritual death will have significant mental health benefits. Abraham Maslow's research after World War II showed that Holocaust survivors tended to be those who held strong religious beliefs (not necessarily temple
Religion has historically been the primary means by which African American women cope with stressors in their lives from economic stress, psychological stress, societal stress, and physical stress to oppression and discrimination within society (Ashing et al., 2003; Blaine & Croker, 1995; Dillard, 2008; Eugene, 1995). Studies as far back as the 1800s have significantly advanced our understanding of the role of religiosity in physical and mental health status, life satisfaction, social support, and a host of other variables. The Black Church in the African American experience has undoubtedly contributed to the religious formation of African American individuals (Lincoln & Mamiya, 1990). Historically, the Black Church has been a place of worship, a setting for emotional expressiveness and a place to gather to socialize as a family (Boyd-Franklin, 1991; Moore, 1991; Taylor et al., 1996).

Religious activities have been identified in the literature as traditional means of coping among African American women and in the African American community as a whole (Brown, 2006; Colbert et al., 2009; Jang & Johnson, 2004; Mattis, 2002; Stringer, 2009; Watlington & Murphy, 2006). Many African American women rely on prayer, the Bible, and the church community to meet their daily needs (Abernathy et al., 2006). Prayer, spiritual rituals, participation in religious services, reading of Biblical scriptures and connection with spiritual mothers in the church have historically been paramount in the survival of African American women.

Mattis (2002) identified religiosity experiences interconnect with other factors such as biological, social, and psychological mechanism that influence outcomes. Social
influences that help frame views of depression for many African American women are religious beliefs, prayer, and spirituality (Carrington, 2006; Cooper, Brown, Vu, Ford, & Powe, 2001). Forty-three percent of African American women use religion, spirituality, or prayer for relief of health symptoms (Dessio et al., 2004). Religion involves an identifiable group that supports and prescribes the search for the sacred (Abernathy et al., 2006).

According to Eugene (1995), “there are very few appropriate settings where one (a Black woman) can go to discuss one’s personal problems” (p. 65). The historical and contemporary contexts of oppressions and submission for African American women give sense and meaning to their life. “A connection with the church provides African American women with a forum to express and process what it is that is causing them to suffer, with less fear of repercussion, shame, or punitive damages for sharing personal problems openly” (Brome, Owens, Allen, & Vevania, 2000, p. 473). Religious beliefs and practices have been shown to influence African American people’s understandings of forgiveness, liberation, hope, justice, salvation, the meaning and purpose of life, and their responses to oppression (Lincoln & Mamiya, 1990).

Taylor and colleagues (1999) credit African American women’s religiosity with gender socialization. African American women exhibit greater interest in both organized and non-organized religion activities and possess subjective religiosity to a greater extent than white participants or African American men (Brown, 2006). This population of women engages in relatively high levels of involvement in religious institutions, especially black-controlled churches, which continue to play a vital role in most African American communities (Ellison, 1993; Sherkat & Ellison, 1999). The most consistent
finding regarding the coping experiences of African American women is that religion holds a central place in these women’s coping repertoires (Mattis, 2002). African American women use formal religious involvement and private devotional practices (e.g., prayer) to negotiate a range of adversities including race, class, and gender oppression, family and parenting stress, financial stress, illness, psychological distress and a vast array of daily hassles (Brodsky, 2000; Mattis & Jagers, 2001). Regardless of their level of involvement in organized religious life, African American women tend to use prayer as the primary means of coping with hardship (McAdoo, 1995; Neighbors et al., 1998). Religion has played a powerful role in African American women’s efforts to negotiate and make meaning to struggles they face related to the larger sociopolitical environment (Mattis, 2002).

Evidence from a significant body of research suggests that religious involvement is a protective factor for better mental and physical health despite differences of samples, designs, methodologies, measures of religious involvement, health outcomes and population characteristics (van Olphen et al., 2003). Religious involvement may positively influence mental health through social support, social ties and interactions. In terms of coping for African American women, few researchers have focused on African American women coping behaviors (Oakley, Song, & DeBose-McQuirter, 2005) other than use of mental health services. Information related to other coping behaviors such as primary care providers, medications, pastors, informal support, social services, avoidance and internalization have not been explored. More recent research on coping has focused on religious coping when dealing with stressful situations. Ellison and Taylor (1996) and Taylor, Mattis, and Chatters (1999) found African Americans (90.4%) reported higher
use of religious coping compared to Whites (66.7%). Other studies to date regarding how religion helps some African American women and not helped others have not been located in the literature.

The origins of religion for persons of African descent remain interconnected to individuals who have been displaced to other continents and regions in the world. Furthermore, religiousness has been shown to affect the physical and psychological well-being of African American women, their healing practices, and their efforts to cope with adversity (Taylor et al., 1999). These findings suggest that religiosity, defined as the active participation in beliefs and practices that increase presence of the belonging and connectedness, influences virtually every domain of the African American woman’s life. Religion has an important relationship with mental health and psychological well being. In many religions, prayer and spiritual practices teach that the individual and God should work cooperatively to prevent and cure illness often relying on prayer, meditation, or other forms of religious healing practices (Poloma & Gallup, 1990). Religion and religious practices are identified as having positive psychological outcomes (Colbert et al., 2009; Waite & Killian, 2008; Watlington & Murphy, 2006). Religious involvement may afford people opportunities for social support, which have been found to protect against depressive symptoms and negative forms of religious coping, such as blaming God for life’s problems or avoiding problems through religious activities that may also predict mental illness as opposed to mental health (e.g., Pargament, 1997).

Although religion has been established as a coping mechanism for stressful life circumstances for people in general (Koenig et al., 2001; Koenig et al., 1997), few studies have been conducted that explore the link between depression and religion to African
American women. Cashwell and Young (2005) reported that internal beliefs are difficult to define given that it is both universal (e.g., 96% of the American population report a belief in God) and highly personal, but religion and religious activities have been shown to be an effective means of coping for women recovering from breast cancer (Ashing et al., 2003) and other life stressful events and situations. A study conducted by Dessio et al. (2004) to describe the prevalence and patterns of use of religion among African American women for health reasons found that African American women utilized religion most often for serious conditions such as cancer, heart disease, and depression.

Ethnic differences related to factors used to identify religiosity were explored in a study by Miller, Gridley, and Fleming (2001) indicating that African American women identified a connection with God, satisfaction with God and day-to-day living, future/life contentment, personalized relationship with God, and meaningfulness of purpose, while Caucasian women identified more with religious factors such as religious well being, life satisfaction/purpose and future as salient. Ethnicity makes a difference in how religion affects individual’s lives (Gill et al., 2010). Because religion in the African American population is the “whole of life” (Frame & Williams, 1996), each person is viewed as a spiritual being in a spiritual world. Blaine and Croker (1995) stated that religion helps African American women cope as well as identify spiritually to their roots and postcolonial heritage. “We have spiritual and cultural memories of our unique and collective ways of being on this earthly journey” (Dillard, 2008, p. 29) that opens to the spiritual nature which continues to link African Americans to spiritual and religious practices.
The inner experience of spiritual feelings and awareness is an integral part of the everyday religious and spiritual lives of African American women (Underwood & Teresi, 2002). These findings support the acknowledgement by counselors of the importance of the African American church as an avenue of social support and coping in the African American community (Bibbins, 2000). Research has documented that African American women tend to use religious leaders for mental health problems (Chalfant et al., 1990; Ward, 2007), but there currently appears to be a stigma attached to African American women who claim strong connectedness to religious beliefs and practices, expressing symptoms of depression. African American women have been viewed historically as strong individuals who can persevere under dire circumstances (Heron, Twomey, Jacobs, & Kaslow, 1997) relying on their strengths of strong kinship network, solid work ethic, value of achievement, and deep sense of spirituality to decrease feelings of hopelessness and increase hopefulness.

The sociopolitical context of African American women’s lives forced African American women to take on roles of mother, nurturer, and breadwinner out of social and economic necessity during and after legalized slavery (Greer, 2011). However, many African American women continue to internalize the stereotype of the ubiquitous strong matriarch; “in the tradition of the mammy, she acknowledges no personal pain, can bear all burdens, and will take care of everyone” (Greene, 1992, p. 152) and consequently, many African American women feel deficient if their own burdens are too heavy and resist asking for help in a place that has historically served as a place of refuge. Woods-Giscombe’ (2010) found that emotional suppression by African American women might place their health and well-being at risk.
The religious heritage of this group of women can often be a hindrance to their help seeking behaviors when they are experiencing symptoms of depression (Ferraro & Koch, 1994; Greer, 2011; Neighbors, 1985; Neighbors & Jackson, 1984). According to Larson et al. (1998), “more longitudinal research with better multidimensional measures will help further clarify the roles of these [religious] factors and whether they are beneficial or harmful” (p. 22). Banks-Wallace and Parks (2004), examined the meaning and function of religion for a group of African American women and found religion was a cornerstone in many participants’ daily lives by influencing decision making and behaviors across many realms. “Religion reconsider[s] the traditions, practices, scriptures, and theologies with a special lens to empower and liberate African American women” (Walker, 1983, p. 12). African American women have been known for their strength and resilience in the personal and societal challenges (Greer, 2010) often using religion.

**African American Women, Depression, and Religion Intersect**

Symptoms of depression in African American women in the religious-spiritual arena have significantly increased in the last decade according to recent findings by researchers exploring the role of religion and spirituality in healing, coping, and overall well-being (Baetz et al., 2004; Brome et al., 2000; Gill et al., 2010). Culturally inappropriate and inadequate counseling services, cultural differences, lack of resources, and the paucity of research related to the specific needs of African American women are a few of the barriers these women face in receiving effective treatment for symptoms of depression. Some scholars have asserted that a lasting effect of institutional racism has been the reluctance of many African Americans to seek mental health and medical care.
African American women historically engage in religious and spiritual activities as a means to cope with the stressors of daily life (Mattis, 2002). However, measuring religion and religiosity is a challenge because of the complex multidimensional character of the constructs (McNulty, Livneh, & Wilson, 2004). As has been documented, the need for religious communion with a body of believers gives African American women hope, calm, peace, and strength. This supportive environment is where she goes to relieve her burdens, find confidence and empowerment, nurturance, support, and faith to continue her journey in life. The treatment and prevention of depression in African American women requires researchers “to examine strategies that are culturally congruent, positive mental health paradigms that stress the strengths of clients and recognize deficits in the community” (Jones & Ford, 2008, p. 134). The cultural legacies of women of color, including African American women, often emphasize interconnectedness with each other as well as collective interactions in worship, family, group, and community. African American women make diverse choices in coping, functioning and empowering or disempowering themselves in their communities. Many look to a source of comfort and/or nurturing that only their community or family of origin can offer (Boyd-Franklin & Lockwood, 1999). Akbar (1985) wrote that derivatives of the African worldviews may be observed in the statement “I am because we are,” which emphasizes the importance of the African American woman’s need to connect with their spirituality and religious practices while having flexible gender roles in the family and community. Boyd-Franklin (1991) observed that strong kinship bonds are perhaps the most enduring legacy of
African heritage which can be seen in connection to the “church family” concept for acceptance, approval, support, and validation in African American women.

**Womanist/Black Feminist Theory**

*It is this articulation of suffering through music and speech which seems to have a major therapeutic function within the womanist and larger Black community.*

(Toinette Eugene, 1995, p. 61)

Current research has begun to highlight some of the unique clinical concerns of Black women (Boyd-Franklin, 2003; Jackson & Greene, 2000; Jones & Shorter-Gooden, 2003). One consistently highlighted shortcoming is that current counseling frameworks are culturally inappropriate or inadequate to meet the specific and unique needs of African American women (Atkinson, Morten, & Sue, 1998; Chaing, Hunter, & Yeh, 2004).

Traditional feminist theories may not be effective in explaining the gender identity development of African American women because gender does determine one’s status in society. Janet Helms’ Theory of Womanist Identity Development described the development of women in search of their gender identity. Helms’ stages describe how women in general development as they move from an acceptance of societal definitions of womanhood to their own definitions and beliefs about the roles of women. Stages in the Womanist model are labeled as Pre-encounter, Encounter, Immersion-Emersion, and Internalization just as the stages of the Racial Identity Development model by Cross. Several descriptive studies have been conducted on African American women that indicate significant positive relationships between higher stages of Womanist identity development and self-esteem (Helms, 1990). African American women may recognize racism before sexism. Helms’ stages of Womanist identity development and Cross’
stages of racial identity development both identify the goal of reaching an optimal level of development. Very little qualitative research exists on whether race or gender is more salient for African American women who are religious and are experiencing depressive symptoms.

The Helms (1984) womanist model purported that during stage one, Pre-Encounter, the woman, aligning her views with societal ideals about gender, conforms to societal norms. Theoretically, during this stage a woman not only thinks but also behaves in ways that devalue women and value men. Encounter, stage two, occurs when novel information or experiences emerge in the woman’s awareness. As a result, greater salience of the meaning of being a woman, she begins to question previously accepted values and beliefs. Subsequently, in search of positive self-affirmations of womanhood along with an intense affiliation with other women, the transition toward stage three, Immersion-Emersion, begins. During stage three a noted investment in the idealization of women and the rejection of perceived male-supremacist views of women is apparent. Through this lens all that is social, political, and psychological is critically filtered. Finally, processing and claiming a more positive view of what it means to be a woman, the boundaries along with the external definitions of womanhood give way allowing the woman to fully incorporate into her identity her own unique panorama. Helms and Cook (1999) pinpointed this experience as congruent with Internalization, the final stage of womanist identity development. What follows then, according to Helms, is a flexible personal ideology that may or may not involve identifying as feminist or adopting feminist beliefs, and characterizes a “healthy” development in terms of womanhood. Whatever role she may choose for herself the woman comes to value herself as a woman.
Research into identity development models suggest that African American women are less likely than White women to identify as feminists. Myaskovsky and Wittig (1997) found that African American women and other women of color were far less likely than White women to identify publicly as feminists. Although African American women may support the women’s movement, they are not likely to identify with being feminist as the women’s movement did not specifically address issues central to the concerns of African American women. In fact, recent theories and treatment approaches that include traditional feminist approaches fail to be relevant in lives of African American women.

Consequently, some African American women totally reject the term feminist, preferring instead to use the term womanist to describe their commitment to womanhood and the Black community. Black feminist writer Alice Walker (1983) first used the term “womanist” to describe a distinct interpretation of feminism. According to Walker, one is a womanist when one is “committed to the survival and wholeness of entire people, male and female” and addresses the notion of solidarity of humanity. Therefore, womanist may be more appropriate or relevant to the experiences of African American women in the society. Although the womanist identity model was not based upon the womanist theory, per se, the fundamental ideologies are quite similar. It follows that African American women may be more likely to identify with womanist statements than feminist ones.

Womanism can be a useful paradigm to address the needs of African American women as it is a “cultural perspective that places the issues that Black women face in a cultural and historical context” (Abernathy et al., 2006, p. 102). The etiology of depression in African American women can be explored using a Womanist/Black feminist perspective to gain a better understanding of the intersection and influence of
race, gender, and religion in the lives of African American women experiencing symptoms of depression (Jones & Ford, 2008). The expression “womanist” refers to the willful behavior of Black women who are often socialized to be competent, self-reliant, and responsible (Bell & Nkomo, 1998; Gibbs & Fuery, 1994). A womanist is “traditionally capable” (Walker, 1983). Womanist/Black feminist offers a model for practice that addresses the simultaneity of oppression that African American women experience and provides a framework for understanding modes of empowerment that the women cultivate for psychological survival (Collins, 1990; Taylor, 1998).

Womanism may serve as a framework for understanding the psychological needs of African American women (Abernathy et al., 2006). Womanist/Black feminist theory provides a more salient way to account for how the cumulative effects created by the multiple role conflict experienced by African American women can result in emotional isolation and symptoms of depression (Jones & Ford, 2008). Traditional feminist models have failed to integrate diversity and the unique experiences African American women face and have universalized all women’s experiences. Traditional feminist perspectives were developed to challenge gender cultural ideologies and mirror the characteristics and ideologies of White women (Comas-Diaz & Greene, 1994). Theorists and researchers have increased their efforts to transcend universalizing, hierarchical and dualistic limitations to be more inclusive of race and class in the development of the Black feminist or "womanist" perspective (Brown, 1994; Comas-Diaz & Greene, 1994; Landrine, 1995). Due to the shared oppression of both African American men and African American women, some African American women totally reject the term
feminist, preferring instead to use the term womanist to describe their commitment to womanhood and the Black community (Simpson, 2008).

Womanist perspective reflects integrated analyses of race, gender and class (Collins, 1990; Greene, 1992; King, 1988; Simpson, 2008) and offers a model that simultaneously addresses oppression of the African American women’s life experience. The core of Womanist theory is developed around an emphasis on emotional wholeness, psychological strength and resilience and these constructs’ centrality to African American women’s historical struggles with oppression, racism, and sexism instead of individual psychopathology. Hooks (2005) stated that rather than view depression as stemming from personal deficits that are inherent in African American women’s nature, Womanist theory sees racialized and gendered social roles as encouraging African American women to avoid acting assertively, decisively, and placing their own needs at the forefront of their social-psychological well-being. Sometimes it is difficult for many African American women to love themselves as they do not have time or fail to take time to care for themselves or are faced with various issues that increase feelings of self-hate, low self-worth or lack of empowerment (Abernathy et al., 2006; Jones & Ford, 2008). By helping African American women “recognize the internalization of socially constructed identities that contribute to their depressive symptoms” (Williams, 2005, p. 77), they may be able to separate the personal from the contextual and successfully remove or adapt unhealthy elements of their lives.

Womanist strategies of spiritual agency, community, self-determination, and empowerment through interpersonal connection as key modes of resistance (Cannon, 1988; Williams, 2005) may decrease depression and depressive symptoms in African
American women. Tyler (2005) proposed a psychosocial competence practice framework which is grounded in the Womanist perspective to identify and treat depression in African American women. Tyler’s concept is consistent with newer concepts in mental health on well-being reflecting on the presence of skills, knowledge, and qualities that encourage interaction and effective functioning within the individual’s environment instead of pathology.

Womanist theory provides a culturally relevant way to assist African American women who are suffering from disorders like depression in integrating their multiple identities and relieving their symptoms (Jones & Ford, 2008). Pulitzer Prize winner, Alice Walker, identified a womanist to be a Black feminist or a feminist of color as she equated “womanist to feminist as purple is to lavender” (Abernathy et al., 2006, p. 102). One distinguishing factor between womanism and feminism is that feminism focuses on women’s rights, while womanism is the “commitment to the survival and wholeness of an entire people, male and female”, with a comprehensive focus of womanism identifying a womanist as one who “loves the Spirit, loves folks, and loves herself” (Walker, 1983, p. 12). This triad reveals the three most important concerns of African American women; it represents the spiritual, communal, and internal dimensions that must be addressed in mental health (Abernathy et al., 2006). The concept of womanism allows many women of color to connect with feminism while affirming themselves as black within the African American community.

The history of African American women is laden with struggles for survival, identity and protection of and support for her family (Simpson, 2008). Historically, African American women have been overlooked in the research by mental health
professionals and other researchers assessing depression related to the context of religion. Understanding the intersect of depression, religion, and African American women may assist mental health professionals in developing cultural competence in the treatment of depression disorders within a cultural context. Previous research on African American women and depression has failed to take into account the role of religion and religious beliefs in the development of culturally competent interventions. Therefore, it is now imperative that researchers begin to build from scratch culturally relevant theories of the causation, course, and treatment of depression in African American women (Simpson, 2008). There is little empirical data on African American women as a unique and diverse group and the incidence of depression and depressive symptoms in this population is virtually unknown (Brown & Topcu, 2003; Ford, 1999; Kohn & Hudson, 2002; Mills, 2000). The implementation of the concepts of Womanist theory into the study and treatment of depression in African American women needs to be explored/ researched in an attempt to increase positive mental health outcomes for this population while developing culturally competent and effective treatment modalities that take into account the whole experience of the African American woman.
CHAPTER III

METHOD

Research Design

The role of religion in the lives of African American women experiencing symptoms of depression while actively connected to and engaged in church and religious organizations were explored using personal narratives and interviews. There has been a paucity of research on African American women for several reasons: trust, access to mental health services, and not being informed of opportunities to participate in studies relevant or specific to their need (Aaron et al., 2003; Abernathy et al., 2006; Boyd-Franklin, 2003; Brown & Topuc, 2006; Carrington, 2006.) Accessing women from local churches may reduce the gap on the lack of research related to this population and increase the participation, authenticity, and validity/trustworthiness within studies on African American women in general. Much of the research about mediating factors of religion on African American women experiencing symptoms of depression has been quantitative in nature with a paucity of research conducting investigations using a qualitative approach that considered the lived experiences of African American women in the church who have experienced depression and depressive symptoms.

The idea of telling an informant’s story is not new to qualitative sociologists studying narratives. The systematic interpretation of the informant’s interpretation of events by researchers gives meaning and value to lived experience of the informant.
Qualitative interviews using the narrative approach “is not narrative but question and answer exchanges, arguments, and other forms of discourse” (Reissman, 1993, p. 3). Narrative analysis requires attention to subtlety, nuances in speech, organization of a response, local contexts of production, and social discourses that shape what is said and what cannot be spoken (Reissman, 1993, p. 67). The history of qualitative research methods can be traced to anthropology in the 1900s as a means to connect artifacts and relics discovered during digs to the daily living experiences of various cultures.

**Methodology**

The term *qualitative* implies an emphasis on examination of the processes and meanings but not measured in terms of quantity, amount, or frequency which is the principle philosophy of quantitative research (Labuschagne, 2003). The great strength of qualitative research is that it attempts to depict the fullness of experience in a meaningful and comprehensive way (Riessman, 1993). Qualitative philosophy is meaningful in that it is an individualized approach to understanding social constructs in a scientific manner. It is a personal enquiry into the experiences that give meaning to the participant’s reality (Meloy, 2002). A qualitative approach offers a unique contribution to the emergence of new and unexpected understandings about depression and religion among African American women. The data collected in qualitative research are not an impersonal numerical collection of facts, but the researcher becomes personal with the interchange occurring within the environment, self, and the participant (Riessman, 1993).

A holistic case study approach informed the design, methods, and data collection method of this study. Understanding social life from the natural science methods of quantitative analysis is limiting and requires the use of qualitative research methods to
investigate the life story and experiences of the participant (Riessman, 1993). Qualitative approaches tend to treat fellow humans as people rather than objects (Wolcott, 2001). Even though traditional approaches to qualitative analysis may generalize experiences by examining pieces of the response out of context, the overall question and answer discourse tends to examine the participant’s experience, analyze it, and give voice to the experience. Using the qualitative research interview, which is a structural approach to analyzing data, it is possible to assess for inequalities in the participant’s life experience that will not be identified with the quantitative approach. Qualitative research then is most appropriate for those projects where phenomena remain unexplained; where the nature of the research is uncommon or broad; where previous theories do not exist or are incomplete (Patton, 2002); and where the goal is deep narrative understanding or theory development (Hammersley & Atkinson, 1983). Qualitative methods for data collection typically include participant observation, open-ended or semi-structured interviews, and qualitative content analysis of documents.

Racial oppression, gender discrimination, disempowerment, cultural variation, and sociopolitical history experiences were made evident through the language and descriptive accounts presented in qualitative enquiry. The qualitative researcher deals with the ambiguity of language and may find it difficult to be objective or neutral. Meaning is ambiguous because it arises out of a process of interaction between people: self, teller, listener and recorder, analyst and reader (Riessman, 1993). Qualitative researchers often seek to depict other’s experiences but act as if representation is not a problem (Reissman, 1993), but representational decisions cannot be avoided and must be confronted. Reissman (1993, p. 10) identified a five level representation process in
narrative research processing: attending, telling, transcribing, analyzing, and reading to produce a narrative. Limitations in representation by the narrative for research practices occur as meaning derived from representation is ambiguous due to the fluid and contextual nature of meaning.

There are several strategies for collecting empirical data for qualitative research. Wolcott (2001) conceptualized the qualitative approach as a tree with roots penetrating deep into the everyday events of the participant’s life. He labeled experiencing (participant observation), enquiring (interviewing) and examining (archival research) into three categories which form the roots for qualitative research. The core of which is participants’ observation which employs a wide array of techniques utilizing not only everyday nature of the data but the everyday nature of the way we go about collecting data (Wolcott, 2001, p. 92). The data collected are verbal, nonverbal behaviors, nonnumeric, and visual documentation gathered through interviews and/or observations. The authorial voice is critical in qualitative research (Wolcott, 2001).

The case study definition begins with the scope of a case study. A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when boundaries between phenomenon and context are not clearly evident (Yin, 2003). The case study inquiry copes with the technical distinctive situation in which there will be many more variables of interest than data points.

Case study is a distinct form of empirical inquiry but has been viewed as less desirable than either experiments or surveys due to traditional prejudices against the case study strategy. Concerns that have prejudiced the case study research are: (a) lack of rigor with investigators being sloppy, not following systematic procedures, biased views
influencing direction of findings; (b) case studies provide little basis for scientific generalization; and (c) case studies take too long and result in massive unreadable documents (Yin, 2003, p. 10). Case study = exploratory, experiments = explanatory or causal inquiries. The case study should not be confused with a specific method of data collection that requires field experience and detailed observation. Yin (2003, p. 9) identified that the most important step to be taken in a research study is to define the research questions. For the case study a “how” or “why” question is being asked about a contemporary set of events, over which the investigator has little or no control. There are four conditions needed to develop the design quality of a case study for trustworthiness: internal and external validity, construct validity, and reliability. In the qualitative paradigm to ensure “trustworthiness,” the criteria are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). External validity for the qualitative researcher can be termed transferability, the degree to which the research results can be transferred or generalized to other settings. Reliability is based on repeatability or being able to replicate the same results if the same phenomena is observed twice. In qualitative research the term used to account for ever-changing context within research is dependability.

**Research Questions**

1. What are African American women experiences related to mental health in the African American church?
2. What are African American women experiences related to depression in the African American church?
3. How do African American women view the role of the church in coping with depressive symptoms?

Participants

The sample selection was not random but a purposeful selection in that participants must meet preset criteria for participation. In qualitative research a small sample size is utilized to gain deeper and richer depth of study. A minimum of six participants were recruited from several local African American churches of various denominations. If saturation was not reached with this number, then the sample size would increase by increments of one until saturation (no new data are emerging from interviews) was reached. All participants were women between the ages of 18 years old and 65 years old who self-identify as African American and who report church attendance from three to five times a month. The age limit category allowed for adequate inclusion of women who may have been consistent in the religious area over a significant period of time. Church attendance for this same group of three to five times a month was used to measure their level of religiosity for this study. This group of African American women experiencing the same phenomenon may increase a deeper understanding of the cultural context and experiences that are particular to this group and may contribute to constructs of interest.

Instruments

The study was conducted using three instruments: a demographic questionnaire, The Beck Depression Inventory–II, and a series of interview questions. The instruments were used collectively for data analysis.
Demographic Questionnaire

Demographic information for the participants was collected using a questionnaire to collect only data that the researcher found to be useful information for this particular study. Demographic questions included race, gender, age, level of religiosity, educational history, marital status, and mental health history (see Appendix D).

Beck Depression Inventory-II

The Beck Depression Inventory-II (BDI-II) was used for triangulation of data (Appendix E). Triangulation with the BDI-II in the study was used to increase dependability and creditability of the data by asking the same question in multiple ways so the informant reflects upon her experiences for a longer period. The data gathered from the BDI-II was used to corroborate the depressive symptoms reported by the participants needed to qualify them as having experienced moderate levels of depression in the past four years. Participants in this study must have a score of 20 points of higher on the BDI-II to participate. A moderate level of depression is a score between 20-28 points on the BDI-II. A score of 28 or higher is indicative of severe depression. Those individuals who score above 28 on the BDI-II were provided with referral information to mental health agencies within the community for further assessment and treatment. The BDI-II can be completed in 5 to 10 minutes if self-administered or 15 minutes if the participant is interviewed. A reading level of at least fifth to sixth grade is necessary to understand the questions.

There is no evidence that the BDI-II is more valid or reliable than other depression scales. The current version of the questionnaire is designed for individuals ages 13 and over and is composed of items relating to symptoms of depression such as
hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.

The BDI-II is a 21-question multiple choice self-report inventory published in 1996 in response to the American Psychiatric Association's publication of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV-TR) which changed many of the diagnostic criteria for Major Depressive Disorder. The BDI-II’s 21 questions are answered on a scale value ranging from 0 (low depression) to 3 (maximum depression). According to the BDI-II Manual (Beck et al., 1996), the cutoffs used differ from the original with 0–13: minimal depression; 14–19: mild depression; 20–28: moderate depression; and 29–63: severe depression. Higher total scores indicate more severe degrees of depressive symptoms.

The BDI-II reflects the two identified components of depression: the somatic/affective component and the cognitive component and is separated into two subscales. The purpose of the subscales is to help determine the primary cause of a patient's depression. The BDI-II is positively correlated with the Hamilton Depression Rating Scale with a Pearson r of 0.71, showing good agreement. The test was also shown to have a high one-week test–retest reliability (Pearson r = 0.93), suggesting that it was not overly sensitive to daily variations in mood. The test also has high internal consistency (α = .91).

The instrument remains widely used in research; in 1998 it had been used in over 2,000 empirical studies and continues to be utilized at present. Studies that have used the BDI-II with current sample participants are limited. However, a few that have been documented include studies conducted by Wheatley (2009), Houri, Kaslow, and Thompson (2005), Simpson, (2008) and Warren, (1997). The African American women’s
levels of depressive symptoms in these studies were measured by the self-reported 21-item Beck Depression Inventory-II (BDI-II), a revised version of the Beck Depression Inventory-I (Beck et al., 1996). The BDI-II was designed to standardize the assessment of the presence and severity of depressive symptoms in order to monitor change in symptomatology over time, to record the illness, or to describe the symptoms (Beck et al., 1996).

In the study conducted by Mascaro, Arnette, Santana, and Kaslow (2007) the BDI-II was used to measure depressive symptoms of 46 low-income, African American women aged 19-51 who were survivors of IPV, with coefficient alphas ranging from .87 to .93 over the four assessment points. Two studies in which all the subjects were African Americans (Dutton, Mitchell & Haywood, 1996; Gary & Yarandi, 2004) used the BDI-II. The Cronbach’s coefficient alpha for the original study of 206 African American women was .91 (Gary & Yarandi, 2004). The Cronbach’s coefficient alpha for a study involving 220 African Americans (50% African-American women) was .90. (Dutton et al., 2004). These were the only studies which had more than a 10% representation of African Americans and which used the BDI-II to detect depressive symptoms.

Other studies that utilized the BDI-II focusing on African American women and depression (Blanchard, 2009; Houry et al., 2005; Kneipp, Kairalla, Stacciarini, & Pereira, 2009; Mascaro et al., 2007; Simpson, 2008; Wheatley, 2009) found that the BDI II is comprised of two symptom dimensions and has a high degree (0.94) of internal reliability and construct validity within each of the factors. One study found that with older African American women “pessimism” loaded most high on the cognitive factor (.81) (Gary & Yarandi, 2004) and “past failure” was the most salient in psychiatric outpatients (.81, .71).
(Beck et al., 1999; Steer, Ball, Ranieri, & Beck, 1999). For this research, the BDI-II will only be used in triangulation of the data.

**Reliability.** The BDI-II has been found to have a good reliability, with split-half reliability coefficient of .86, and the test-retest reliability coefficient of .75 (Beck et al., 1988). In two studies using the BDI-II to detect depressive symptoms, in which all the subjects were African American, the Cronbach’s coefficient alpha was .91 with 204 participants and .90 in the study involving 220 African American participants (Wheatley, 2009).

**Validity.** There has been limited validity with the BDI-II, but indications are that it has strong validity comparable to that of the BDI-I (Wheatley, 2009). The BDI-II showed good convergent and discriminate validity when compared to a similar depressive symptom instrument, the Hamilton Psychiatric Rating Scale for Depression (.71). The psychometric characteristics of the BDI-II test-retest correlation of .93 ($p < .001$) in a study of college students was significant (Beck et al., 1996). The correlation between the BDI-I and the BDI-II is .92 supporting the convergent validity of the BDI-II (Dozois, Dodson, Ahnberg, 1998). The construct validity of the BDI-II was, as in the original study, .93 with 210 participants. Concerning discriminate validity, the BDI-II was more highly correlated with scores on the depression subscale of the SCL-90 than on the anxiety subscale of the SCL-90 (Beck et al., 1988).

In terms of internal and external validity for qualitative research, there is an argument for different standards of judging the quality of research (Trochim, 2006). Traditional qualitative-oriented research focuses on the concepts of internal and external validity. According to Trochim (2006), the purpose of qualitative research is to describe
or understand the phenomena of focus from the participant’s perspective as they are the only ones who judge the creditability of the research results during a member’s check follow-up interview. Qualitative research involves establishing that the results are believable from the perspective of the participant in the research. External validity for the qualitative researcher can be termed transferability, the degree to which the research results can be transferred or generalized to other settings.

External validity can be guaranteed by a comprehensive description of the research context and assumptions that are central to the research. In the qualitative research process, the researcher becomes personal with the interchange occurring within the environment, self, and the participant. Essentially, as the researcher in this study, journaling immediately after each interview will help to guarantee reliability and external validity by describing the change that occurs in the research setting such as the participant’s body language, tone of voice, expression of feelings, and verbal expressions.

**Quantitative research.** In quantitative research, reliability is based on repeatability or being able to replicate the same results if the same phenomena is observed twice. In quantitative studies, truth is often assessed by how threats to internal validity are measured. The true score theory in quantitative research tries to get around the fact that we are measuring two different phenomena since we cannot measure the same thing twice in qualitative research.

**Qualitative research.** In qualitative research the term used to account for ever-changing context within research is dependability. The research describes the changes that occur and these changes affect the research approach to the study. The researcher is the tool in qualitative research and each researcher brings a unique perspective to the
study. To assume dependability and confirmability, the researcher in qualitative research documents the procedures for checking and rechecking the data throughout the study. After the study, a data audit will be conducted that examines the data collection process and analysis procedures for the potential of researcher bias or distortion of data.

The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes; the participants are the only ones who can legitimately judge the credibility of the results. A member’s check will best assist the researcher with credibility or true value of research data. According to Krefting (1991), true value is usually obtained from the discovery of human experiences as they lived and perceived by the participant.

**Interview Questions**

To begin the interview process, a list of questions was developed with the womanist theory in mind. Womanist theory looks at the paradigm that addresses the needs of African American women related to a cultural perspective that places the issues that these women face in a cultural and historical context. The articulation of suffering through speech with a trusted individual seems to increase empowerment that the women cultivate for psychological survival (Woods-Giscombe’, 2010). African American women are often socialized to be competent, self-reliant, and responsible even under oppression. The core of Womanist theory is developed around an emphasis on emotional wholeness, psychological strength, and resilience. This womanist lens decreases the pressures to
avoid acting assertively, decisively, and placing their own needs at the forefront of their social-psychological well-being.

1. Tell me about your experience with the African American church.
2. Tell me about your role(s) in the African American church.
3. Tell me about your positive experiences within the African American church.
4. Tell me about your negative experiences within the African American church.
5. How did you cope?
6. What helped?
7. What do you feel helped you through the (situation, event, period of sadness, anger, disappointment)?
8. What was the overall impact of the church on your religious practices?
9. What do you want me to take away from this interview?

Data Collection/Procedure

Semi-structured or guided qualitative research interviews were used to define and express the construct of depression as it relates to experiences of African American women in religion. The interviews attempted to ensure the development of a comprehensive view of the role of religion in African American women who have experienced depressive symptoms. Hitchcock and Hughes (1989) preferred the semi-structured interview format because it allows the interviewer to further develop and expand upon particularly interesting responses, and in the best-case scenario, develop a kind of relationship with the participant, where negotiation, discussion, and expansion of responses can occur. Semi-structured interviews should be organized so that the participants, while answering specific questions, feel free to augment the conversation
with what they consider valid, if uncovered information. Participants in the study completed a demographic questionnaire, engaged in an interview and scored 20 points or above on a completed BDI-II that was used for triangulation of collected data.

Participants for this study were recruited from four churches in an urban section of a city located in the Northeastern part of the United States. Church leaders of the randomly identified churches were approached and asked if research could be conducted with women in their congregation (Appendix A) during a woman’s function or after a church service. The women were then informed of the study through a verbal presentation conducted by this researcher to solicit participation (Appendix B). The participants may also self-refer or referred by other women in the church who are concerned or involved in their lives relative to expressions of depressive symptoms.

The women were given a number to contact the researcher by phone if they were interested in participating in the study. During the phone interview, if any woman reported experiencing suicidal thoughts or feeling severely depressed, she was given a list with referral information to mental health therapists in the area and the local emergency room (Appendix E). Being experienced as a Licensed Professional Counselor, the researcher was able to facilitate referral of perspective participant’s to therapists of choice if depressive symptoms present during phone interview. If interviewee expressed severe depressive symptoms, she was not considered for the study. The first six participants to meet criteria established for participation were included in the study. A standby list was developed with three to four names and contact information for women who met criteria and would like to participate if any of the initially selected women dropped out of the study for any reason.
During initial phone contact the criteria for participation was established. The criteria for inclusion into the study were (1) being an African American; (2) being female; (3) between ages 18-65; (4) identify as religious (attend service three to five times a month); and (5) self report of moderate levels of depressive symptoms. If criteria for participation were met, any questions or concerns the prospective participant might have were answered and a date and time for a face-to-face interview were established.

The face-to-face interview was conducted at the respective places of worship for each participant and took up to 60 minutes to complete. During the individual face-to-face interview, the researcher explained the research study to the women, provided a copy of the informed consent form (Appendix C) for signature, and a demographic questionnaire (Appendix D). The signed informed consent was collected before each individual interview began. Because of cultural sensitivity and stigma toward mental health, especially toward African American women who attend church and are religious, participants were informed of the depression scale component before beginning the process. A full description of the BDI-II and instructions for its use was explained before completion. The participant may withdraw from the study at any time during the research process.

The interviews were conducted by this researcher who is an African American Licensed Professional Clinical Counselor. Data were collected using two methods of recording: an audiotape recorder and a computer software program, Dragon, on a portable computer that converts voice to text. Participants spoke into the digital audio taping device while the computer program ran simultaneously. The researcher maintained a journal after each interview to reflect thoughts, feelings, ideas, and hypothesis generated.
by contact with the participants. This process of reflective analysis eliminated researcher bias by separating her own experiences from those of the participant.

Individual interviewing methods were utilized to encourage participants’ in-depth descriptions of depression and religious beliefs and practices. The interview questions were designed to facilitate discovery of how participants’ experiences in the church influence their perceptions and behaviors regarding depression. Interviewing is asking questions and receiving answers with one person asking and listening and the other responding (Sadler-Gerhardt, 2007). The questions on the interview guide were constructed to allow for flexibility of responses while yet providing a measure of structure for responses. Active listening was used to encourage dialogue and to clarify statements to draw out meaning that may be embedded in the participant’s response. This approach in interviewing may increase case study tactics for quality design conditions of the case study research design identified by Yin (2003). The interviews were conducted in a confidential setting that is free from distraction and possible influences on participant.

During the interview process, each participant was permitted sufficient time to express and explore thoughts and feelings. A Member Check, which is a second interview to enhance the understanding of the results of key findings, was scheduled within 30 days after the initial interview to summarize the content of data that had been gathered to ensure participant’s perspective was fully understood. A Member Check is also beneficial to triangulate all data.
Data Analysis

To analyze data, each participant’s audiotape was transcribed verbatim and compared to voice-to-text conversion transcription to establish accuracy. Each participant’s voice was configured from speech to text using the software designed to assist with the transcription process. Content analysis of the raw data was facilitated with the use of V-Vivo or similar software to identify patterns and commonalities across responses and to manage data related to depression, religion, and being an African American woman or any other themes that may emerge during the content analysis process. Categorizing and coding of data were based on words, phrases, themes, and concepts that emerge related to intersect of research. The point of data saturation ended the coding process as no additional themes or concepts emerge.

Triangulation of the Data

Triangulation of data is critical to the quality of qualitative research, particularly creditability. Triangulation is the convergence of multiple perspectives of data to confirm and ensure that all aspects have been investigated to minimize distortion from a single source or a biased researcher (Knafl & Breitmayer, 1989). Triangulation was assessed using the three preliminary ways in which data were collected for processing and analysis: the data provided by the BDI-II, data collected from participants during the interview process, and the journal maintained by the researcher. The data gathered from the BDI-II were used to corroborate the symptoms of depression reported by the participants’ need to qualify them as experiencing or having recently experienced moderate levels of depression. A score on the BDI-II between 20-28 points was indicative of moderate levels of depression. The journal maintained by the researcher
increased the information base for data collected during the study reflecting on participants’ emotions and expressions of verbal and body language. Subjective meaning and perceptions of the participants are critical and the researcher is responsible for accessing these.

In this study the researcher maintained a double role, a clinical counselor and a doctoral researcher. Therefore, it is important to be aware of and to reflect on the possible influence these two roles may have on the study. One of the ways researchers can describe and interpret their own behaviors and experiences within the research context is through journaling (Krefting, 1991). Journaling reflects the thoughts, feelings, ideas, and hypothesis generated during contact with research participants (Lincoln & Guba, 1985). Documentation of these thoughts and feelings increases the researcher’s awareness of biases and preconceived assumptions. Entering these data immediately following each interaction with research participants reduced the influence of the researcher’s own background, perceptions, and interest.

The use of a journal will increase rigor in qualitative research (Krefting, 1991) by assessing trustworthiness, enhancing creditability, and reducing researcher bias. Rigor is supported by using audit trails, member checks, memos, and other tangible evidence. All these verification strategies help to ensure rigor in qualitative research (Creswell, 1997). Freedom from bias in the research process increases neutrality which is the degree to which the findings are solely from the participant and conditions of the research and not biases, motivations, or perspectives of the researcher (Guba, 1981).
CHAPTER IV

RESULTS

In this study the qualitative research paradigm was used to better express the aims of this research. Labuschagne (2003) and Mattis (2002) identified that qualitative research is complex history and tends to mean different things to different people. It focuses on understanding, interpreting, and finding meaning rather than predicting and generalizing ((Lincoln & Guba, 1985). The purpose of this research was to allow African American women to give voice and meaning to their experienced depressive symptoms while struggling to maintain their faith, beliefs, and trust in a historical place of asylum.

The research was conducted in the participant’s religious environment in hopes of increasing comfort, trust, and support of participant. The churches used in the study represent a subset of the Black Church. They included a Holiness church, a Church of God in Christ (C.O.G.I.C.), a Baptist church, and a nondenominational church. All the leaders in these churches are male leaders. This study focused on the mental health of African American women. With all the church leaders being male, there may be issues related to patterns of communication between genders and understanding the meaning behind nonverbal communication that affect mental health.

The researcher is not an expert and the research was based on a not-knowing attitude but with an attitude that was open to learn from the participant. To maintain the chain of evidence in telling the participant’s story and to increase the chances for sound
and credible interpretation of the data, the data sources included the BDI-II, the personal interview of each participant, the immediate journaling of the interviewer after each interview to include verbal and nonverbal methods of communication of participant, careful transcription of interview focusing on the participant’s tone of voice and reflecting on body language in the moment, and maintaining a reflective journal during the transcription process. A member check was also implemented so participants could confirm and verify data analysis on themes that emerged from the interviews and to expound upon existing themes if needed. The use of multiple sources to obtain data was implemented to achieve a comprehensive understanding and interpretation of the data.

This approach to data analysis is founded upon an inductive method of research. The inductive method of research asserts that conceptual understanding of the data emerges from the immersion of the researcher into all aspects of the data gathering process, rather than just from preconceived theories founded on speculation. The goal of data analysis in this study was to examine the participant’s experience to develop themes across interviews and create a unified voice for all participants.

The participants’ interviews were transcribed to reflect the rich and meaningful data gathered on the phenomena being studied. The transcribed interviews were used to identify emerging themes from the religious experiences shared by these women. To ensure confidentiality and protect the identities of the participants, pseudonyms were used throughout the research. This section presents the findings from the interviews conducted on six African American women. Each interview is discussed separately, then collectively in a comparative analysis. The names of the participants were changed to maintain their anonymity. Table 1 lists brief descriptions of each woman interviewed.
### Table 1

Description of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Education</th>
<th>Marital stat</th>
<th>Employment</th>
<th>Church involvement</th>
</tr>
</thead>
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<tr>
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<td>BA</td>
<td>Single</td>
<td>Employed</td>
<td>Inactive</td>
</tr>
<tr>
<td>Allison</td>
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<td>MBA</td>
<td>Married</td>
<td>Employed</td>
<td>Inactive</td>
</tr>
<tr>
<td>Charnette</td>
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<td>Associate</td>
<td>Single</td>
<td>Unemployed</td>
<td>Inactive</td>
</tr>
<tr>
<td>Candi</td>
<td>57</td>
<td>HS</td>
<td>Separated</td>
<td>Unemployed</td>
<td>Active</td>
</tr>
<tr>
<td>Lou Lou</td>
<td>60</td>
<td>HS</td>
<td>Widow</td>
<td>Unemployed</td>
<td>Active</td>
</tr>
<tr>
<td>Emily</td>
<td>29</td>
<td>Ms.+</td>
<td>Married</td>
<td>Unemployed</td>
<td>Active</td>
</tr>
</tbody>
</table>

**Participant #1**

Courtney is a 34-year-old bank manager with a bachelor’s degree. She attends church three to five times a month, is a Christian, and single. Courtney has never been diagnosed with depression but reports “speaking to someone” about her depressive symptoms. Courtney scored over 20 on the BDI-II which is a criteria for participation in the study. A score between the range of 20-28 is indicative of moderate levels of depressive symptoms. She reported growing up in the church all her life with her immediate and extended family members without having options or choices as whether she should attend church or when she was to attend church services. Courtney was not actively engaged in church roles or activities but had a good relationship with other church members and felt comfortable being in the church. She holds a BA in Human Resources and is planning to continue her academic pursuit as her finances improve.
During data analysis several themes emerged for Courtney. The primary theme was her religious stance. In this context, religious stance can be defined as her attitude, beliefs, and practices toward Christianity. Central tenets to the Christian faith are believing the gospel and the teaching of hope through the messages in the Bible. The following themes emerged in the analysis of Courtney’s religious experiences shared in her interview.

Courtney’s religious stance was a prominent theme in her experiences within the African American church. For example, she stated:

I am a Christian woman and I believe what I believe and I'm solid; I'm solid in what I believe. Even though I didn't agree with the values of the church leader, my core values were already formed. I believe that at the end of the world I will, there's a heaven and I will be there.

Another example was:

I'm a Christian and I believe in the word of God. It’s not about the leaders of the church or the church members or what happens at the church. It’s all about you. No one can change your mind, no one can change your heart, no one can change the way you feel. . . . Church is all I know.

The depressive symptoms such as Courtney’s feelings of sadness, isolation, and withdrawal also emerged as a theme. Depressive symptoms as documented in the DSM-IV-TR are feeling sad or empty, diminished pleasure in activities, isolation, withdrawal, low self esteem, feelings like being punished, hopelessness, low energy, and depressed or irritable mood.

I feel sad much of the time; I feel like crying, but I can’t. I have thoughts of killing myself but would never carry them out. I have been going through some bouts of depression and I'm a little worried to talk about it because the church sometimes makes you believe that what you are feeling is wrong and that prayer can fix everything. There’s always going to be gossip.

Courtney shared how she was impacted by her grandfather being a pastor and raising the family to be religious by attending numerous weekly church services
without options to do other things she would have enjoyed outside of the church. Courtney talked about experiencing depressive symptoms while engaged in religious activities but felt she could not seek help in the church. She has a strong religious and spiritual identity but feels she is still alone in finding the help she may need with life’s challenges and problems. She identified a lack of support from her church due to mistrust, social isolation, and judgment. Issues related to the lack of support stem from not trusting her pastor to convey messages to individuals that are congruent with the Word of God as written in the Bible. She shared feelings of social isolation by not connecting with church members in a place where she grew up and knows the life events of most people who attend. Courtney felt she was judged by others in her Christian walk if she lived her life a certain way Monday through Saturday and presented herself differently on Sunday.

During Courtney’s second interview, she was more introspective and seemed calmer, less anxious and more engaged in the dialogue. She expounded upon the questions asked in an open manner with more detail creating an opportunity for the researcher to gather additional data that was not represented during the first interview. In the second interview, new rich detailed information emerged from the exploration of her story which contributed significantly to the data. In her first interview she focused on her family but was unable to share what effect the presence of her family attending the same church had on her. Courtney was withdrawn and isolated in her home church refusing to participate in religious activities on any level. During her second interview she initially stated “I don’t have a why” for not joining in activities or engaging with groups. But while sharing her story the second time, she was able to
state that “fear of being judged” by family members and the familiarity with the pastor and other church members prevented her active engagement in religious activities. Her thoughts and feelings on religious activities within the church setting transferred to her current church but during the second interview, she was able to understand why.

Courtney also shared a mechanism for coping with depressive symptoms that was not shared in her initial interview. She listens to Gospel music and “opening my heart to religion” has reduced her depressive symptoms. Another topic that surfaced during the interview is her focus on the new pastor’s appropriated method of communicating with the congregation. She does not feel threatened by the pastor and feels she can trust him and his teaching on Christianity which are in tune with her religious stance. “I actually listen to the Word now whereas before I would be on my phone texting, not listening, just sitting.” Courtney feels she has a better understanding of the leadership role in communication which has reduced her feelings of anxiety and increased her feelings of happiness.

The researcher used the BDI-II, reflective journaling, and participant responses to triangulate data. The participant appeared confident in the interview but during transcription and reflection, it was more apparent that the participant was holding back on some of her responses. An emerging theme was a lack of support. She indicated a lack of trust for church leaders and members, non-inclusion and feeling judged if she verbalized her depressive symptoms. She reported sadness, disappointment in herself, and feeling like she was being punished. Her statements that identified themes for her experiences were consistent with other data gathered by the BDI-II and the researcher. During the follow-up interview, Courtney continued to express sadness and that the
church members and pastor could not help. “You have to get through and do it yourself.” Courtney’s responses are discussed in detail in the comparative analysis section with other participants to best answer research questions.

**Participant #2**

Allison is a 31-year-old African American female with a Master’s degree in education. She is currently married. A few years prior to this interview, Allison was a single mother. She attributes the experience of having a child out of wedlock to her loss of support, love, and care from her church family. Before becoming a single mother, Allison attended church with her family a few times a week and was actively engaged with other youth in the church. She considered herself a part of her church family with the elder women, missionaries, and women in the church who were a little older than herself. When she became pregnant, feelings of belonging changed. During this period in her life, she reported isolation, rejection, and victimization from those she loved in her church home. Currently, she attends various churches three to five times a month seeking a church home and identifies as a Christian. She reported she has never been diagnosed with depression and has never sought any treatment for depressive symptoms. Allison scored over 20 on the BDI-II. A score of 20-28 on the BDI-II is indicative of moderate level of depressive symptoms. During data analysis several themes emerged. The following themes emerged in the analysis of Allison’s religious experiences shared in her interview.

Allison’s shared her lack of trust and support. Trust is the belief that someone or something is reliable, good, honest, effective, a reliance on the character, ability and strength of someone; confidence in and dependence on assistance in the future. Support is
to bear all or part of the weight, to hold up, give assistance to or enable to function or act.

These themes were prominent in Allison’s experiences within the African American church, however, in a negative connotation. She experienced a lack of trust and support when she felt she needed it most. She felt judged, mistrusted, rejected, and socially isolated as a single mother after the birth of her child. For example, she stated,

As a teenager, I participated in the choir and as an usher but when I became pregnant as a single mother I felt so disconnected. Lack of support from the church members I think. There was a lack of trust perhaps. I felt judged maybe. A lot of different emotions. Just not feeling part of the church family and any trust or assistance from mostly the women in the church. They would maybe not speak to me or maybe perhaps from what I remember not involve me in a lot of different activities; uhm. and after a while I just felt distant from it.

Allison went on to state,

Well, I would say after that experience I distanced myself from the church. And not feeling welcomed or supported, or loved I distanced myself and haven’t, haven’t been the same since. Even, even when I tried to go back and try to reconnect, I just haven't really found, I guess, the right church family that I can reconnect and feel safe with.

Another example:

Church and the church family relationships are important for women and important for all women at all stages of their lives, and uhm, even as they grow into mature adults, those relationships are important and vital for continued growth. And with those missing, there is always going to be a gap.

Allison’s responses on the BDI-II reflected her affect and tone during the face-to-face interview. The researcher observed participant to be sad, not interested, discouraged, and lethargic. During reflective journaling and transcription of her interview, there was evidence of long-term depressive symptoms in her religious experiences. There was evidence of social isolation, hurt, sadness, and withdrawal during data analysis. Allison used present tense verbs indicating there is still pain and sadness in her religious pursuits and statements that indicated a lack of religious well-being in a secure church family. In
the follow-up interview, the participant’s voice was sad. She stated, “It’s just one of those days.” She reported nothing had changed and the themes identified by the researcher from data analysis were correct. The participant did not want to continue a dialogue to further explore her symptoms and the role of religion in her life and kept the communication short and to the point responding only to what the researcher requested or stated. At the time of the follow-up interview, it was suggested to the participant that she use the mental health referral list left with her during the first interview. After confirming themes and data with the participant, the researcher documented additional thoughts and feelings on the participant to include a possible increase in depressive symptoms. While reflecting on the interviews with Allison, it became apparent there was an increase in sadness and lethargic mood even though she continues to attend church services.

During Allison’s second interview, she was a bit more engaged and less officious than during the initial interview. Her tone was more engaging and she shared a bit more of her story in detail. Allison reported that since the last interview she is:

Attending Sunday service, um, more often, looking for mentors and talking to people um, in the workplace and in my social life that are heavily involved in the church and just kinda seeking their opinions on the church that they attend. It’s just getting a little bit more reconnected.

On her depressive symptoms, she stated:

I haven’t found anything that helps me cope yet. Again, maybe just attending services more. umm listening to gospel music more um, Music is a good, a good coping mechanism for me, so um, I’m still trying out different things.

Allison feels having strong relationships with Christian women is fundamental to growth and development. On her relationship with trusting women in the church again after being hurt, rejected, isolated, and ignored, she stated:

just that I do believe that, um, church is a good place for women to, uh, get fellowship as well as develop in their Christian lives. I do want that to change,
um, just taking baby steps towards that by attending service more, talking to other women that are not at my church, but they are saved, um, just kind of seeking, uh, their opinions and mentorship in terms of fellowship.

Another theme that emerged from Allison’s interview is the need for supportive leaders in the church to help women reduce depressive symptoms while engaged in religious practices. Defined, a supportive leader is someone who cares about those under his leadership by listening to and helping out when help is needed to prevent stress and frustration. A supportive leader provides clear guidance and coaching to eliminate obstacles that can impede success in reaching a goal.

I would say more maybe support, um, not so much, I would say support and leadership mainly support from the leadership of the church: How do they, um, live their lives, how do they um recognize and relate to you as a, as a church member. Um, how do they try to get you engaged and involved. Um, if they aren’t doing that, that can bring some frustration and stress with one that is trying to be more engaged with the church. So, I, I guess all of it really comes back to just support, but support, in particular, uh, from the leaders.

Participant #3

Charnette is 48 years old, single, never married, and a student in a local college. She attends various churches three to five times a month and identifies as Christian. Charnette reported growing up in the church and serving on various ministerial committees and in many leadership capacities from youth to adulthood. She reported being a “multi-tasker” working on the missionary board, a minister, choir director, a kitchen worker, Sunday School teacher, and a youth director. She shared how she experienced rejection, isolation, disappointment, and mistrust in the church after many years of selfless service after the death of her mother. Charnette reported she has never been diagnosed with depression and has never been in any treatment for depressive symptoms. Charnette scored over 20 on the BDI-II which is a score indicative of
moderated depression symptoms. At the time of the interview, Charnette was still seeking a permanent church home. During data analysis several themes emerged. The following themes emerged in the analysis of Charnette’s religious experiences shared in her interview. One theme was depressive symptoms which include anger, pain, hurt, isolation, sadness, and withdrawal. The prominent theme emerging from Charnette’s story was depressive symptoms due to economics and pretense which may significantly contribute to and influence her depressive symptoms. Being on a fixed income, her economic status is below the poverty threshold for a single individual. Poverty is a lack of the usual or socially acceptable amount of money or material possessions. This measure recognizes poverty as a lack of those goods and services commonly taken for granted by members of mainstream society.

Charnette’s feelings of betrayal of not “being a mover and a shaker,” “a have not” in the church dominated her story. She stated:

if you are of low economic status, the church tends not to give you things that you need when you have a need. It was also peer pressure for me in African American church. I became a chameleon. I did what they did. I would merge with people that you would call a mover and a shaker. But what I found out emerging with movers and shakers, you also find other people that's in that particular group that's also chameleons.

Another theme emerging from Charnette’s interview was lack of trust. She stated:

I believe that there is a lack of trust in the African American church and I have experienced it all of my life and I know people look at that and say “well, are you trustworthy?” Yes, I am trustworthy but if you put your personal life in the hands of somebody that is the next person according, that’s closest to God, you would think that you've that would be a trust factor but it is no trust.
Another theme emerging theme was strong religious stance as a Christian.

Charnette stated:

If you keep your focus on God, you could be healed of every situation. But you cannot look to people for help. You have to look to the Lord for help because it's never going to come from people in the church. The church is not designed to help people; it's only designed to raise money. I am so glad that I do know the Lord. I don't live for the church now. I live for God. Study the Word and know it for yourself cause you will find a lot of things that they tell you “do as do and do as I say” does not even coincide with the word of God because God is love and that's the bottom line.

Triangulation of the data identified Charnette to be angry, socially isolated, hurt, sad, and withdrawn. Charnette’s responses on the BDI-II, the researcher’s reflective journaling, and the participant’s interviews were congruent with the data analysis findings. The themes that emerged reflected the participant’s depressive symptoms while actively engaged in the church and the loss of identify to fit in with others. Trying to fit in with others affected her mental health in the church family “peer pressure.” The lack of support experienced by Charnette while actively engaged in the church included denial of financial support, being judged by SES, mistrust of leaders and members, rejection, and social isolation. She reported feelings of hopelessness, sadness, guilt, and feelings of being punished. During the interviews, the sound of her voice, the flat affect, and the expression of being excommunicated from God “backslidden” attributed to the data analysis results.

In her follow-up interview, Charnette agreed with the findings and stated:

That is precisely what I wanted to share so others can be prepared or discuss with their pastors or church members before it becomes an issue and they too backslide. When I looked back over certain things, I realized I was a multi-tasker in the church out of a sense of duty and to try to fit in, which wasn’t going to happen without money.
Her religious experiences seemed to focus on outward rituals and routine practices as a lived reality which she discovered after she was denied needed financial assistance to bury her mother who sent tithes to the church even though she was not a member.

**Participant #4**

Candi is 57 years old, separated, and has an associate’s degree in the helping profession. She attends church over three times a month in the same church for the past 18 years and identifies as a Christian. She is actively engaged in her church as a choir member, a deaconess, an usher, and a hospitality aid. Candi shared her love and support for her pastor and her struggles with other church members based on finances, gossip, and lack of acceptance. Candi reported that she has been treated for her depressive symptoms in the past. “I took medication before for my depression when I was really bad” but is currently not on a prescription. She scored over 20 points on the BDI-II in a range indicative of moderate level of depressive symptoms. During data analysis, several themes emerged from Candi’s interview that may significantly contribute to her level of depressive symptoms. The following themes emerged in the analysis of Candi’s religious experiences during her interview. The prominent theme emerging from Candi’s story is depressive symptoms related to economics and pretense from others within the church family. Candi is on a fixed income for disability and functions in the poverty level of economics for an individual. Poverty is a state of privation or a lack of the usual or socially acceptable amount of money or material possessions. This measure recognizes poverty as a lack of those goods and services commonly taken for granted by members of mainstream society.
Candi reported feelings of isolation in her church based on lack of finances. “I feel that things are in groups, you know the ones that have and have not. The ones that have usually don’t mingle with the ones that don’t have.” She reported feeling left out since she is on a fixed income and cannot afford to engage in the social outings with others or dress according to their expectations. “That costs money.” She also experienced isolation as, “families stick with families instead of just like everybody being together as one.”

Additional significant information emerging from Candi’s experiences in the African American church was pretense. Candi stated:

I hate to see people go to church and act like they are all into it and when they get out they criticize people. For example, somebody is talking, they might not even be talking about you, but you take and turn around and make it about you to make other people try to gang up on this group, I don’t feel that that’s right.

Another theme emerging with this participant was a strong Christian religious stance. Her religious stance as a Christian is evident in reading the Bible and a strong prayer life.

I feel that I am a strong person and I believe in God. I try not to let anything discourage me or put me back to where I was . . . like back in the street and doing things I know I wasn’t suppose to do. I pray that God will change their hearts. I just pray that one day they will see that it’s not all about me. It’s about us.

Candi became tearful during the interview and wanted the researcher to be sure to share her experiences within the African American church “because it might help somebody out there like me and needs help to get through.”

Candi’s responses on the BDI-II, the researcher’s reflective journaling, and the participant’s interviews were congruent with the data analysis findings. She was sad and tearful during the interview, expressed feelings of hurt, pain, social isolation, and
becoming withdrawn from others. The themes that emerged reflected the participant’s depressive symptoms while actively engaged in the church and trying to fit in with others. The theme of lack of support emerging from the data was evident by feeling judged by church members, mistrust of members, and rejection. Candi’s religious experiences seemed to focus on staying positive with a strong prayer life to get through the struggles of the religious experience. She loves the people of the church and prays for them to seek a closer connection with God and not let others’ behaviors pull them into a negative place or return to a past that may lead to destructive behaviors. Candi reported feelings of sadness, discouragement, failure, hopelessness, feelings of guilt, and feelings of being punished. During the interviews, her voice was shaky and she cried as she shared her experiences. Her affect, nonverbal communication, and the thoughts of her past contributed to data analysis outcome. As I reflected on the face-to-face interview with Candi, the reflective journaling during transcription, and the BDI-II, all the data were congruent with research findings. In her follow-up interview, Candi agreed with research findings and stated, “Please share it all. Like I said, maybe it will help someone get through a rough spot or at least get people to know what they are doing wrong and how it hurts somebody else’s growth in the church and in God.”

During the second interview which was conducted by phone, Candi was in a good mood. She was not tearful and her voice was steady and happy. She openly responded to follow-up questions and shared a more in-depth and interactive approach toward the data collection process than displayed during her initial interview. Over the phone, Candi spoke with confidence and possibly felt more anonymous as she responded without hesitation on topics that previously caused her to shut down in her communication. I felt
closer to her during this interview than during the initial interview as she was able to laugh, relax, and express herself freely. She continued to share her negative experiences within the church in more detail as it relates to finances and rejection. Candi, being on a fixed income expressed:

It makes me not want to participate as much and I don’t, I like, I like going to church but sometime I just don’t have that drive to go because I don’t wanna feel like I’m like pushed to the side. It makes me feel real out of place and withdrawn, and I try to fit in and you know, laugh about it but sometimes it hurts down inside. It’s, the hurting part is like feeling rejected, you know like being rejected from the ones that are well off. You know like trying to say hi and to hold a conversation and they be just like give you a real quick answer and you know you can really tell that they don’t want to be bothered with you or that they don’t have time for you and then when they do something, they always do it with the people that’s in their corner, not the ones that don’t have.

She also expressed feelings of rejection from the elders and other leaders of her church in her time of need. An example of a negative experience from the leaders was when she was seeking assistance. She shared:

I when I first started going, I was, like real deep in it and anytime I needed something or needed to talk to anybody, I would go to the head of the church, not the pastor, but sometimes the ministers or whoever, and they would like um, like, they, I’m not going to say that they put you off on another auxiliary or anything like that, but it seems like what I would ask for or what I would say it seems like it would get to somebody within the church and I don’t feel like that was right, so now if I have a problem or something, I just go the lady of the church, the first lady, and I know she don’t like spread or really talk, you know like, I’m gonna say it like this: go to the missionary board. I don’t like being passed around. If I come to you I expect you to help me. I don’t want to be passed around.

She expressed a lack of trust with church leadership and her confidentiality was breeched exposing her needs to too many other individuals. The broken confidence increased Candi’s depressive symptoms in the church. She stated:

Because they always say they have to talk to the board members. No they don’t! They don’t have to talk to the board members, just give me a yes or no or give me something and don’t put my business in no group. Because if I wanted that I would have went to the front of the church and said that. So, that’s the way I feel.
You’re the head of the church and you have some kind of pull or whatever, don’t keep sending me to different people cause I’m not going to do it, I’m not gonna do it.

During this interchange with Candi, two new topics of data emerged. First is the role of leadership and its effect on her feelings of trust, confidentiality, and support. The other significant contribution to the data that emerged is the presence of her family members in the church that helps her to cope when she would have otherwise stayed away. The presence of family as a support helps with challenges she may face with other individuals and with coping with depressive symptoms. When asked why she was currently attending church, the same church, where she is experiencing feelings of separation and isolation, Candi responded, “some of the members are, you know, I connect with, and then I have family there.”

**Participant # 5**

Lou Lou is a 60-year-old widow who is retired. She has a high school diploma and became employed right after graduation from high school until her retirement. She identifies as a Christian and attends the same church more than three times a month. Her roles in the church are many. She reports being the hospitality president, being in the choir, a deaconess, and on the executive board of the church. She also volunteers on various committees and in most church events. Lou Lou has a long standing history in her church for over 24 years of service. She especially enjoys working with hurting women in the church as a confidant and support. Lou Lou reported she has been diagnosed with depression in the past after the death of her husband and has been in treatment and has taken medication for her depressive symptoms. Lou Lou scored over 20 on the BDI-II which is in the moderate range for depressive symptoms. At the time of the interview,
Lou Lou reported she is not happy with her church but will remain there until God tells her to go to another place. During data analysis using the participant’s personal interview, BDI-II scores, and reflective journaling, several themes emerged. The following themes emerged in the analysis of Lou Lou’s religious experiences shared in her interview. The prominent theme emerging from Lou Lou’s story was lack of support. Support can be defined as to bear all or part of the weight, to hold up, give assistance to or enable to function or act. Lou Lou experienced a lack of support when she felt she needed it most.

Lou Lou reported that her depressive symptoms appeared after the death of her husband and the church where she has been a member for the past 24 years failed to assist her emotionally, spiritually, or financially. She stated:

I am a tithe payer. When my husband passed, I saw a different side of the church that just really really discouraged me. There was no counseling for grieving widows. When he passed I was just thrown to the side. A lot of times people put the church down and me being on the other side, I would always try to . . . build the church back up but when it happened to me I was just torn completely apart. I wanted to give up, I wanted to leave the church but God never let me lose my praise.

Another emerging theme was trust. Trust is the belief that someone or something is reliable, good, honest, effective, a reliance on the character, ability and strength of someone; confidence in and dependence on assistance in the future. Lou Lou has been an actively engaged member of her church holding leadership roles but on occasion her trustworthiness is questioned. She stated:

The latest hurtful and negative experience that I had was after a church regional breakfast. I was collecting items you know after the breakfast, collecting items that I had taken to church from my home to decorate the hall back to my car. The pastor and one of the elders come running out to my car taking the box from me. I said “that’s okay” but he insisted. I opened the trunk of my car and the pastor took the box, put it in the trunk and he started digging, going through the box like I was stealing. I have been here for 24 years, if you don’t know me after 24 years, I
don’t believe you will ever know me and just to belittle me like that. I was just so angry.

Another theme emerging was the participant’s strong religious stance on Christianity. She reported that through all the issues of nonsupport, false accusations, and other hurtful situations she still has God. She stated:

Some nights I couldn’t sleep. I just cried and prayed, crying and praying then the Lord will lead me to what is needed to help me. When I am so angry and saying what I was going to do or say, the peace of God will come over me and I just continue to talk to God.

Lou Lou’s responses on the BDI-II, the researcher’s reflective journaling, and the participant’s interviews were congruent with the data analysis findings. The themes that emerged reflected the participant’s depressive symptoms while actively engaged in the church and the lack of nonsupport from leaders and fellow church members. Lack of support was identified as denial of financial assistance during grieving period, mistrust from her pastor, rejection, and being judged. Her religious experiences began as positive experiences when she was working and her husband was alive. She was active in several areas and enjoyed working with other women in the church who were hurting or had problems that they struggled to deal with on a daily basis. After the death of her husband her roles changed in the church and a new lived reality was discovered after she was abandoned and challenged on her trustworthiness.

Lou Lou reported feelings of sadness, discouragement, loss of pleasure in things previously enjoyed, disappointment, and feelings of isolation which are indicative of depressive symptoms. During the face-to-face interview and the follow-up interview, the sound of her voice, the flat affect, and tearful expressions contributed to the data analysis results. While sharing her experiences, Lou Lou used present tense verbs which indicated
she was still feeling the hurt, pain, and disappointment from her experiences. The researcher’s reflective journaling while transcribing the interview showed consistency in the data. The participant’s words, expressions, and scores reflected the pain she continues to carry while actively engaged in religious practices.

In her follow-up interview, Lou Lou re-emphasized the need for confidentiality and requested that her statements be reworded to increase anonymity. She agreed with the researcher’s findings and stated:

There is so much more I would like to express but I think you got the point and just tell people that things have to change if the church is to survive. Our pastors have to be there and be open to helping widows, single mothers, ladies coming off drugs or in remission and down on their faith, that they are still human and still loved. Show some encouragement. Women are hurting in the church and at home. Stop making it worse for them. We gather for a reason and a season. Don’t continue to discourage people cause in God’s eyes we are all the same.

To continue gathering data to enhance the story of the participant’s experience of depressive symptoms while actively in the church, a second interview was conducted after the follow-up interview, member check. During the second interview, the participant continued to share her feelings of anger, hurt, pain, disappointment, and grief. New themes that emerged for Lou Lou during the interview were church leadership in regards to gender issues and the role of women in the church as support. Lou Lou shared times when she felt invalidated when she presented her ideas to leadership on ways to increase participation of all the women in the church not just the wealthy ones. An example of her experience with this was:

A lot of time like women in the church they have different ideas on everything; because you’re a woman, you’re shot down until, you know, they whoever their administration is decides, you know, maybe . . . let’s take that idea just fix it up a little bit and then it would be their idea. They did a lot of that and I, I believe that I did implicate um what’s the word, initiate quite a few things in the church concerning, you know, women . . . but when I brought it up, it wasn’t used, but
after I quit stop doing, you know, stop doing what I was doing then it was implicated, even as far as, um, women’s conventions and things, they still wanted the women to come all dressed up, um, retreats and stuff. A lot of women couldn’t afford that. So the ones that couldn’t afford it didn’t go. So, there go a group that’s left out. And I care for the group that’s left out. So I went to them and I said: “Um, I’ve been on another retreat with another different organization and the women, it’s a retreat, so you know, relax. I said “How come we can’t wear casual, even jean suits or whatever for the retreats?” “No, No, No, No, No”. Knocked it down. But then, what, a year later, “OK, dress down for retreats”. You know?

Another gender issue for women in her church using her word, was:

Chauvinist. Under that man “you don’t do what I do, You do what I tell you to do”. They took the key from me they said no ladies would have a key again except the first lady and she would have only the key to her office. To get into the church and get into her office.

In her first interview, Lou Lou spoke of retiring to give more of herself and her time to the church. During her volunteer service she began to experience a different side of her church and the leadership within. She expressed it this way:

Eager to retire and have all that free time you know to be available to work and volunteer in the church and work in the community and do different other things, and once I retired and started asking to do things in the church, uhm, I was just like uhm, okay , when I first retired it was like open arms, but then after I was there for awhile, you know it started getting shady, and people you know that administrative, administrative people, you know, you know started doing a lot of talkin’or whatever. . . . They began to say I was giving away too much food, and just making up all kind of stuff. So, it really you know put me down in a hole. And you know I told them that the two hours I stayed for the food bank, it wasn’t their time, it wasn’t my time, it was God’s time. That I volunteered those two days a week for two hours, to stay there whether 1 person came or whether 20 came, I just you know gave that time to God. And you know they just started treating me so bad, I just quit. And you know I felt really, really bad because you know people would talk about the church all the time and I would always defend. Oh no you got to be taking the pastor wrong or, you know, you got to be this deacon or this trustee wrong because they are really not like that. Tremaine Hawkins wrote a song, “I didn’t think it could be until it happened to me.” And just a whole lot of different things that made me really depressed and when my husband, the next thing my husband passed, now he paid tithes, I paid tithes. And when it came to doing the program, they wanted me to pay for them to type up the program and everything. that really got next to me. I got depressed, I was stressed out and I said I was gone quit. I just got really, really depressed after my husband
passed. And oh yeah, they wanted to charge me, charge me, umm, $200 to make programs. So I got really, really mad with that.

I saw a lot of things that, I saw a lot of politics and things that was going on you know that I knew, I come from a Christian background okay, so just like in Titus it says what you learned as a child and I umm knew what I learned as a child was strong Word in my soul and in my spirit and in my heart. And some of the things were just not right and they want to call it, call it, you know that I was a rebellious person and all this kind of stuff but no I just have a heart for hurting people. and you know that’s what that was. They play politics in the church so much and then a lot of members leave and you know join, you know or start their own little church, you know, uh, that’s scattering.

Umm I don’t know, his leaders, I don’t know. I guess he has too much trust in his leaders that weren’t right and telling him lies and he began to you know, I guess began to believe the lies because I guess that was the way I felt I was being treated.

Participant #6

Emily is 29 years old, married, and has a working professional degree in medicine. She attends church over three times a month in the same church and has a good relationship with a few women in her church. She identifies as a Christian. Emily is actively engaged in her church as a praise dance choreographer, a church office administrator, and a social coordinator for the youth. Emily shared feeling of love and support from her pastor, his wife and “just a very, very, very few women” in her church. Emily reported that she has been treated for depressive symptoms in her late teenage years and is currently not on a prescription. She scored between 20-28 points on the BDI-II, which is within the moderate range for depressive symptoms. During data analysis several themes emerged from Emily’s interview. The following themes emerged in the analysis of Emily’s religious experiences shared in her interview. The prominent themes emerging from Emily’s story were support, acceptance, and strong faith and beliefs. Support can be defined as to bear all or part of the weight, to hold up, give assistance to
or enable to function or act, acceptance is the act of accepting something or someone, the quality or state of being accepted, and the religious stance of Christianity as evident by her strong faith, beliefs, reading the Bible and prayer contributed significantly to the findings. She stated:

I have had a good experience with the African American church because I have had a chance to build some relationships . . . with a few women who have been there for me. In my deepest, deepest need God has always moved a few women there who don’t know me . . . come up and hug me, tell me everything’s gonna be all right, encourage me, and extend a loving hand towards me.

Another example of the support from women in her church was advice and guidance provided related to her marriage, being withdrawn, and social isolation. Emily reported:

I am sort of a shy person, they were constantly calling me and asking me to do things to get out, enjoy them. I sought counseling (marriage) with the first lady and she was very, very helpful. The church can be there for you and sometimes it can’t. I haven’t had an experience where anybody has repeated any of the problems that I’ve had.

Her strong faith was evident by

My relationship with Christ has kept me going through all my stages of sadness and depression. Not really any of the like the religious phony things that, that people do to keep you going. Having it on the inside is the part that really keeps you going because when you have a relationship with Christ then, which is the church within you. You are the church and the body is the temple of Christ.

Data that emerged from Emily’s interview were depressive symptoms not related to her church experience but to issues in her home that affected her involvement with her church family. She shared, “I get depressed, irritated, and agitated when my husband doesn’t support me emotionally. That really like gets me so irritated, like the fullest extent and saddened, agitated, and really depressed. Just really mad.”
Emily’s responses on the BDI-II, the researcher’s reflective journaling, and the participant’s interviews were congruent with the data analysis findings. Emily’s nonverbal communication and her flat affect contributed to data analysis outcome. As I reflected on the face-to-face interview with Emily, the reflective journaling during transcription, and the BDI-II, all the data were congruent with research findings. The BDI-II indicated sadness, isolation, and withdrawal symptoms. During the interview, Emily expressed feelings of anger, sadness, hurt, pain, and social isolation and becoming withdrawn from others. The emergence of depressive symptoms was not related to her experiences with the church but in her marital relationship which manifested in her interactions within the church. She presented at church with a flat affect and sad countenance which prompted others to extend a friendly hand, provide words of encouragement, and reach out to include her in various activities.

During transcription and reflective journaling the participant’s depressive symptoms while actively engaged in the church were evident. Some feelings of being judged and mistrusted also emerged as Emily had very few relationships in the church and was apprehensive about engaging in conversations with others.

The themes of support and acceptance in the church emerged from the data analysis evident by Emily’s inclusion and positive relationships. Her religious experiences seemed to focus on her relationship with women in the church and a strong prayer life to get through the challenges of her marital relationship. She reported a connection with a few women in the church and with her pastor for support.
In her follow-up interview, Emily agreed with research findings from the data analysis and added, “I knew my marriage has a lot to do with my emotional state and how it affects me at church but again, I am in denial. I want to also add that . . . never mind.”

After the follow-up call to Emily, a second interview was scheduled to continue to gather data related to her experiences in the church. During the second interview, Emily was open to going deeper into the experiences within the church that caused her to experience depressive symptoms while actively engaged in the church. One of the questions focused on trust as Emily is reported to be guarded and withdrawn. Emily quickly let me know the church has been a support for her, especially the women in the church. She stated:

I would say just one person I could completely confide in, or I didn’t really need to confide in her because she was able to just look at me and tell I needed some kind of support. There were about four women, I would say, in the . . . and three others that, there must be this thing on my face that’s, um, very expressive cause they always knew and . . . God would just tell them to come over and give me a hug and say whatever I, say the words that I needed to hear to become stronger. So those women I could confide in, but mostly the other three women, um, I was very, very close with. I confided with them a lot. Um, but there was still some limitations except for one who knows completely everything, um, that I have ever felt.

I learned a lot from uh, the women that I came in contact with, um, the women that I worked with. The church really helped me too, those women supporting me, um, has pretty much helped me to stay here, or helped me to develop mentally or professionally, um, yeah. I could always go and just, cause the door is always, pretty much always open and there’s always someone there to uh, pray with me if I need it or if I just called in, and say “I’m not happy” or if I called and said “Something’s going on” or, if I call and say, “uh, “Put me on the prayer list,” um, they’re always there to talk about it with me and pray with me and, you know, check up on me to be sure I’m ok.

Since Emily verbalized finding peace, safety, support, and comfort within her church, the researcher asked Emily to share the source of her depressive symptoms. She
shared her family of origin was not loving or supportive leading her to contemplate
suicide and left her feeling rejected, incompetent and unwanted. Here is her response:

I think I would say my depressive feelings um originated within my family. Um, yes, so it started there. And, I have had, um, a lot of problems with my family, with my Mom, with my sisters, um, career life, with boyfriends or male significant others. That’s where a lot of my depression came from, from the fact that I didn’t feel like I was loved, or I didn’t feel like I was wanted. But then, when I went to church, you know, I had those women who would love on me and hug me and tell me that they love me and gave me words to let me know that I was valuable and they took an interest in me. So, that’s why I say I haven’t had a bad experience yet, because they’ve always been there for me. My experiences from outside the church with like family or friends or other things that tend to, uh, what’s the word?: transfer over . . . so because of past experience that I learned to create a barrier, that way I don’t get hurt. I didn’t want to get hurt as well in another area that I was already comfortable with.

**Triangulation of Data**

Triangulation is a technique in qualitative research to increase dependability and creditability of the study. In this study using multiple sources, the BDI-II, a reflective journal maintained by the researcher and the affect of the participants were used for triangulation of the data. The six participants all completed the BDI-II and scored within the range of 20-28 which is indicative of a moderate level of depressive symptoms. During the face-to-face interviews the affect of all the participants was congruent with the scores recorded by the BDI-II. Emily’s score was closer to the severe range than all other participants but her affect was most positive. The emotions that dominated each participant’s experience were captured by the researcher through being attentive and proactive during the interview. During the second interview, some of the same questions used in the initial interview were asked in multiple ways to assist the participant in reflecting on her experience and provide a deep, richer narrative of her experience. Some
of the participants were able to consider unresolved issues in their lives and felt empowered through self-reflection as reported by Emily and Courtney.

The reflective journal maintained by the researcher documented the levels of congruence in affect of the participants and the BDI-II scores as well as the researcher’s thoughts and feelings after each interview and during transcription of the collected data. The reflective journal was also useful in the audit trail to make clear the steps taken during the data collection process and to note any changes made to the original methodology protocol.

**Comparative Analysis: Giving Harmony to the Voices**

The participants in this study are African American women who are attending the African American church while experiencing a moderate level of depressive symptoms. An attempt was made to bring all their experiences together to hear the harmony in their voice. The goal was to develop a broad, new rich insight into understanding African American women, religion, and depressive symptoms. Currently there is a dearth of qualitative literature that compares and analyzes this voice. Qualitative researchers code in order to get past the data record, to a category, and to work with all the data segments about the category. Analytical coding is central to qualitative inquiry as it allows for the emergence of themes from the interviews. In this comparative analysis of the six interviews, the differences and similarities are discussed as well as draw attention to issues in the historic place of asylum for African American women in particular and African American women as a whole. The women in this study have all experienced depressive symptoms in a religious context. The general themes across the experiences of each participant are listed in the conceptual schema table below.
### Table 2

**Depressive Symptoms and Support**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Depressive Symptoms</th>
<th>Support Inside Church</th>
<th>Support Outside Church</th>
<th>Lack of Support+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courtney</td>
<td>A, I, S, W</td>
<td>No</td>
<td>Yes</td>
<td>M, R, J</td>
</tr>
<tr>
<td>Allison</td>
<td>I, P, S, W</td>
<td>No</td>
<td>Yes</td>
<td>J, M, R, S</td>
</tr>
<tr>
<td>Candi</td>
<td>I, P, S, T, W</td>
<td>Yes</td>
<td>No</td>
<td>F, J, M, R, S</td>
</tr>
<tr>
<td>Loulou</td>
<td>A, I, P, S, T, W</td>
<td>No</td>
<td>Yes</td>
<td>F, J, M, R</td>
</tr>
<tr>
<td>Emily</td>
<td>A, I, S, W</td>
<td>Yes</td>
<td>No</td>
<td>J, M</td>
</tr>
</tbody>
</table>

*Note.* Depressive Symptoms

A = Anger  
I = Isolation  
P = Pain, Hurt  
S = Sadness  
T = Tearfulness  
W = Withdrawal

Lack of Support

F = Financial  
J = Judgmental  
M = Mistrust  
S = Social/lack of inclusion  
R = Rejection

All participants experienced feelings of isolation within the church. Emily’s experiences with isolation were due more to her feelings of low self-esteem related to her family of origin than issues within the church related to support or lack of support. All participants experienced withdrawal from activities and participation within the church due to lack of support in the areas of feeling judged and mistrust. Four of the six participants found support outside of the church and two participants found support within the church.
Table 3

Interactions With the Church

All participants identified aspects of their relationships with their leaders and other members of the church to be positive or negative. Two of the six participants experienced a negative relationship with their church leaders and the church members, while the remaining participants varied in their experiences leaders and members. All participants found their religious stance of Christianity which included reading the Bible and prayer as a source of hope to cope with depressive symptoms whether church relationships were positive or negative.

The themes of participant coping across participants are prayer and reading the Bible on a regular basis to get them through the negative experiences they encounter both inside and outside of the religious context. The church provided a sense of hope when trying to cope with depressive symptoms. Whether the relationships they encountered within the church were negative or positive, attending church while experiencing symptoms of depression seems to help the women cope.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Church Relationships</th>
<th>Spirituality</th>
<th>Church Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative</td>
<td>Positive</td>
<td>Prayer</td>
</tr>
<tr>
<td>Leader</td>
<td>Members</td>
<td>Leader</td>
<td>Members</td>
</tr>
<tr>
<td>Courtney</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Allison</td>
<td>Yes</td>
<td>Yes</td>
<td>----</td>
</tr>
<tr>
<td>Charnette</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Candi</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lou Lou</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Emily</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The major theme that emerged from the data was that all participants in the study use prayer and the Word of God (Bible) Christianity to try to find comfort during trying times. This method of individual self-comfort and encouragement provided a temporary relief and direction when experiencing depressive symptoms. Lou Lou, for example, described how she fervently prayed to find an answer during a period of grief when she felt the church had “thrown (me) to the side. One night I couldn’t sleep good, couldn’t sleep for a long time. I just cried and prayed. Crying and praying then the Lord led me to help outside of the church.”

Courtney’s experiences focused on her beliefs in the Word of God after losing trust in her pastor.

I am a Christian, I believe in God, I believe in the Bible, knowing that what I believe is what I believe and no one can take that from me. I’m solid in what I believe. I am sad sometimes but I am able to get out of it with prayer and with my faith by myself.

Another participant, Allison, said “my relationship with God helped me cope” when she was rejected by her church family as a single mother. The use of prayer and the Bible was also evident in Charnette’s story as she quoted scriptures to express her knowledge of the Bible after being rejected by church members and denied financial assistance to bury her mother. “The Bible says, ‘Look to the hills from whence cometh your help.’ I have faith in God not in people; I am rooted and grounded in the Word and I know God as my personal Savior for myself. Study the Word and know it for yourself.”

Candi shared, “I believe in God, I pray that God will change their hearts and just pray” after experiences with church members that left her feeling isolated and rejected. Emily found prayer and reading her Bible “as well as just hugging someone else” helps when
she is feeling down. “I think being able to pray and read my Bible has helped me a lot. When you have a relationship with Christ, the church is within you.”

**Depressive Symptoms**

The experiences related to depressive symptoms of African American women who are religious was another prominent emerging theme in this study. The DSM-IV-TR list several criteria to describe and define symptoms of depression. No individual reported being currently depressed but all of the participants used language which was reflective of depressive symptoms. Lou Lou’s interview reflected anger, isolation, sadness, insomnia, and emotional hurt and pain, becoming withdrawn losing interest in previously enjoyed activities. Courtney spoke about anger, sadness, suicidal ideations, isolation and being withdrawn from church activities and roles. Allison expressed feelings of sadness, isolation, emotional hurt and pain and withdrawal. Charnette experienced anger, isolation, emotional hurt and pain, guilt, sadness, worthlessness, social isolation, and withdrawal. Candi’s experiences left her with depressive symptoms of emotional hurt and pain, sadness, tearfulness, isolation, social withdrawal, and feelings of helplessness. Even though Emily’s sadness was not identified with religious activity, her symptoms included anger, isolation, withdrawal, and sadness.

The depressive symptoms experienced by the participants resulted from relationship issues and lack of support while engaged in religious practices. A qualitative study conducted by Sadler-Gerhardt (2007) on the lived experiences of women surviving breast cancer, found the African American participant in the study experienced feelings of disappointment, rejection and felt shunned by her church family due to her illness. Church relationships were categorized based on church leader and church members’
positive or negative relationship (see Table 3). A negative relationship emerged in the study with a positive relationship with the church leader leading to feeling supported in the church environment. Participants who could go to their pastor for advice or shared problems or concerns felt support in the church even though there was a negative relationship with church members. Emily was comfortable with interactions with her pastor and Candi “could go to him for anything I need or I could talk to him.” Participants who had a negative relationship with their pastor did not feel support in the church. Lou Lou expressed her pain in the present tense when she shared her pastor did not trust her after 24 years of service by following her to her car and searching through her personal belongings “to just belittle me like that”; also “to be thrown to the side” during her period of grief without counseling or financial support. Her anger was rooted in being a tithe payer and not receiving any type of support when it was needed. Lou Lou wants to be elsewhere but will wait until God leads her there. Charnette’s negative experience within the church also began during a period of grief. She was a tithe payer for 12 years contributing 10% of her income and contributing 10% of her mother’s fixed SS income “faithfully.” When she asked for assistance, it was denied. She became disillusioned and lost trust in her pastor. “The church is a place of refuge. And if you look up the word refuge, that means you are encamped about, you should be able to come to the place where you dwell on a weekly basis month by month, year to year to at least get some type of assistance.” She also mistrusted her pastor’s confidence. “(He) make sermons and preach over the pulpit everything about you, everything about your personal life.”
Relationships with members in the church were also inversely related to positive and negative feelings of support. Emerging themes indicating lack of support fell into five categories: financial, judgmental, lack of trust, lack of inclusion, and rejection. In Charnette and Lou Lou’s case both were denied financial support and assistance from their church homes when they lost a loved one to death. Charnette and Candi experienced rejection and lack of inclusion due to low economic status and had to act “like a chameleon” to fit in with the “have and have nots.” In all cases, the participants felt they were being judged by church members which resulted in being guarded, inactive, lack of participation in church activities, and being withdrawn. As the participants experienced feelings of judgment real or perceived, the issue of mistrust became apparent as they all voiced being abandoned by the church family in times of need. Allison when she became a teen mother; Charnette when she discovered other members modified their behaviors also just trying to fit in; Candi as she overheard other members talking about other members to create division in the church and Emily due to experiences within her family of origin. Emily in her own way did not voice mistrust but her actions indicated such when she stated “very, very, very few women” and withdrawal from out of fear of “lack of acceptance and being judged.”

Experiences of lack of support also resulted in rejection. Whether the lack of support was from the church leader or church members, all participants voiced feeling rejected. The rejection was social isolation, being ignored, abandonment, denied assistance, excluded, and shunned which all resulted in the participant developing depressive symptoms. There was also a lack of inclusion and interaction, being with but not a part of the group, social isolation. At best, the women felt ambiguous about church.
Church helps. Church does not help. The negative experiences of the participants seemed not to outweigh the positive experience of attendance as evident by the women returning to services week after week and year after year.

It is evident that the themes derived from the stories of the African American women participants gave meaning to the relationship of religion and depressive symptoms as well as contributed new insights and perspectives on these concepts. All participants felt the researchers’ interpretations of their story were accurate, true representations of the participant’s experiences and creditable, describing the phenomena of interest from the participant’s perspective. The research questions centered on the experiences of African American women related to mental health in the African American church, their experiences related depressive symptoms in the African American church and how they view the role of the church in coping with depressive symptoms. Based on the research questions being answered by all participants, it seems that the purpose of this qualitative research was fulfilled.

**Summary**

The researcher began this study to answer three research questions. The first question, “What are African American women experiences related to mental health in the African American Church,” was answered by several responses from the participants. The second question, “What are African American women experiences related to depressive symptoms in the African American Church” was answered in detail by all participants. And the last research question which was central to the study was, “How do African American women view the role of the church in coping with depressive symptoms” created a voice from the women that will make a significant contribution to
the field of counseling. The results from the data analysis provided clear answers to the research questions as they relate to mental health, depressive symptoms and the role of the church in coping with depressive symptoms.

Previous research on the role of the church and healthcare practices indicated that the church occupies a central place in the lives of African Americans and religious involvement exerts positive and diverse health benefits for African Americans (Aaron et al., 2003). Other researchers have also indicated that church attendance and involvement in church have a positive effect on participants including improvements in quality of life, greater perceived social support, improved life satisfaction, higher resilience to stress and lower levels of anxiety (Musgrave, Allen, & Allen, 2002; Strawbridge et al., 2001; Taylor et al., 2000). The participants in this research all voiced that they would not give up on seeking comfort in a church home where they can connect, feel safe, trust, and be accepted.

The results of the current research indicated that African American women view the church as a negative place of support for depressive symptoms. The outcome revealed that a lack of trust related to confidentiality, support, advice, guidance, and protection (refuge) is evident in the church. The majority of participants in this study were rejected, isolated, denied support, and judged while actively engaged in religious practices. The resultant behaviors related to the negative experiences of these women are indicators for criteria established in the DSM-IV-TR that represent depressive symptoms. Loss of interest in activities previously enjoyed in the church, anger, hurt, pain, sadness, tearfulness, and becoming withdrawn are just of a few of the indicators. A majority of the participants all voiced that the church is not helping them to deal with depressive
symptoms and sought help and support from outside the church or try to find solace within themselves on an individual level. Only one participant, Emily, found solace and safety in the church with women she could trust and confide in as she reports her family was the source of her depressive symptoms.

Courtney said, “It’s all about you. I have been going through some bouts of depression and a little worried to talk about it because the church sometimes makes you believe what you are feeling is wrong. I am able to get out of it with prayer, with my faith, by myself.” Allison felt “it’s up to the individual to find different mechanisms for coping outside the church with that missing part of their life and continued support and growth.” I believe that part of a woman’s well-being and growth is her relationship with women, the church, and her church home as that carries through from adolescents up through her maturity in life. Charnette, who appeared to be the most hurt and “bruised” from her experiences came to the conclusion that the church teaches that it is a safety net, a place of protection in a time of trouble but found it to be her “greatest downfall” as she currently experiences a negative outlook on the church within herself. “You may be distressed and you should be able to come to this place of refuge.” “The church has caused me to have a grievance and my spirit became grieved. The church is no longer designed to help people, to the degree of as far as counseling and clinical things. People are hurting but help is not available in most of the black churches.”

Candi used her internal strength to cope within the church. “I can’t go to the elders of the church or the members but I love the church. I try not to let nothing discourage me or put me back to where I was in the streets and doing things I know I wasn’t supposed to do.” Lou Lou found that in her time of need to overcome depressive
symptoms while actively engaged in the church, she was “just torn apart, wanted to give up” and leave the church. She sought support and assistance for her depressive symptoms from a clinical professional. Emily was the only participant who found some comfort, guidance, and support with her depressive symptoms within the church. She was able to connect with a small support system of women to get her through.

During the interviews it was also discovered that the presence of family members attending the same church as the participant increased depressive symptoms. Courtney and Emily both found that the presence of family members hindered their religious activity as they felt they were being judged and criticized by them. However, Candi felt the presence of family members in the same church was a source of support for her when she felt rejected by other church members. The age of the participants may be a contributing factor to this outcome. Courtney and Emily are younger women in significant relationships and felt they were judged by family members in the church which inhibited their active involvement in religious activities. Candi is an older, single woman and expressed the presence of her family in her church as a source of support.

After growing up in the church from childhood through adolescence to adulthood, a majority of the women experienced rejection at their greatest time of need. Once actively engaged and involved in several areas of service within the African American church (tithe payer, volunteering, teaching, singing, committees, and more) the women in more advanced stages of life are now withdrawn, isolated, mistrustful, angry and feel rejected. Blind worship changed to “I am smarter” now that they have experienced a different dimension of the church. Several of the participants expressed the leadership of the church must change to be more supportive of the women in the church and
communicate in a more respectful manner to the congregations to ensure members stay involved, encouraged and focused on growing within the church setting. Allison expressed a very clear expectation of how leaders can increase their support for women experiencing depressive symptoms:

In terms of just church leadership. So, um, mainly support from the leadership of the church: How do they, um, live their lives, how do they um recognize and relate to you as a, as a church member. Um, how do they try to get you engaged and involved. Um, if they aren’t doing that, that can bring some frustration and stress with one that is trying to be more engaged with the church. So, I, I guess all of it really comes back to just support, but support, in particular, uh, from the leaders.

Courtney shared this:

There have been many, many times when he’ll have a message and the next Sunday he’ll come up, he’ll come up to the pulpit and he’ll say, “Hey, let me apologize for this, this, this that I said last week. I got a call from someone that said this is what I meant when I said that. I assure you this is not what I meant.” And he’ll say it again whatever it is that he said but he’ll break it down so he won’t leave it to interpretation what he meant. So I like that this person takes responsibility for what he says and responsibility for you misunderstanding and tries to make it as plain, I guess, I guess he says if one person heard me say this that means somebody else probably heard it too, but that’s not what I meant when I said it . . . start over again and make sure everybody understands exactly the words that came out of my mouth.

Candi felt she receives great support from her pastor but his elders which are included in the leadership, create emotional issues for the church members. “I love my pastor, I love the kids, I, I, you know, it’s, it’s a nice church, but some things I just don’t agree with. I just like the church.”

Charnette’s experiences under the leadership at her church has left her in a place both emotionally and religiously where she continues to struggle to return to her level of previous faith and worship.

The Bible says with loving kindness have I drawn thee. If you're not kind, you cannot be drawn and I think that is the problem with the church. That’s what
caused me to backslide. And what I mean by backslide is to leave the church. they take your business and preach it over the pulpit. Which causes people to never to go back.

Lou Lou’s experiences with leadership also focused on the lack of support and encouragement especially toward women that causes the members to church hop or scatter, “scattering,” leave the church, in hopes of finding a place to feel secure, not ignored, disrespected or minimized as women. Lou Lou shared the following on leadership and gender issues:

A lot of time like women in the church they have different ideas on everything; because you’re a woman, you’re shot down until, you know, they whoever their administration is decides, you know, maybe . . . let’s take that idea just fix it up a little bit and then it would be their idea. They did a lot of that and I, I believe that I did implicate um what’s the word, initiate quite a few things in the church concerning, you know, women . . . I gotta make an example outta you,” and he made her sit back down, in front of the whole church.

African American women experiencing depressive symptoms in the church have found that worldly aspects of religion interfere with getting the mental health services they may need. The worldly aspects that are frequently encountered include personality clashes with their leaders and other women in the church, issues related to financial status, lack of acceptance due to financial status, or having a strong opinion on issues that are not popular and blaming the victim. Other worldly aspects include viewing depression and depressive symptoms as a weakness and therefore not being referred to mental health professionals for treatment and education to help relieve symptoms. The women in this study shared themes across their experiences related to church leaders, church members, support, nonsupport, and acceptance. Charnette said “with loving kindness have I drawn thee” which was not the reality for these women. Each individual articulated her struggle with issues within the religious context as documented throughout
this section to increase understanding of the challenges African American women face with depressive symptoms and religion.

The consistent response for these women faced with mental health challenges included withdrawing from participation in once enjoyed religious activities as is the case with all six participants, or withdrawing attendance from the church and seeking membership in another church after shopping around several churches. Lou Lou called this “scattering.” All of the women voiced feelings of deep hurt, resentment, demoralization, and anger in response to being ignored or denied needed assistance in their times of deepest need viewing the religious arena to be hypocritical.

The themes that emerged demonstrating what helped these women to cope are prayer, listening to music, and reading the Word of God. Each person found words from a gospel artist that soothed them and helped them relate to their current situation telling them they are not alone in the struggle but to continue to seek God and not give up or give in to the vices of men. The researcher found that the women’s source of strength is in being spiritual instead of religious. Their coping was individualistic. Each participant used prayer, individually selected gospel music that communicated a specific message to the heart, finding mentorship with other women in the church with a like mind, and reading the Word of God to develop a better direct spiritual relationship with Him to decrease depressive symptoms than looking to leaders and members to relieve symptoms.
CHAPTER V
DISCUSSION

The primary purpose of this study was to give voice and meaning to women experiencing depressive symptoms and struggling to maintain their faith, beliefs, and trust in a historical place of asylum. The researcher tried to capture the stories behind the voices of African American women who are experiencing depressive symptoms while actively engaged in the African American church. The voices of six participants were heard through in-depth interviews, by researcher’s interpretations of the participant’s stories, researcher’s reflective journaling, a member’s check to verify the interpretations for accuracy and conducting a second round of interviews with additional questions to increase the richness of the data. The participants articulated in-depth information regarding their experiences within the African American church as well as their experiences with depressive symptoms outside of the church that impacted their experiences. The themes were analyzed and discussed in a way that the participant’s voice could be heard in a current context of the phenomena being studied. This chapter provides a brief discussion of the methodology for the study, the purpose of the study, implications for practice, strengths of the study, limitations of the study, and recommendations for future research.

There was a paucity of research focused on depression in African Americans in general and even less on African American women specifically as related to the impact of
religion on mental health in this population. Qualitative methodology was used to explore experiences of African American women and the relationship between religiosity and depression. Six participants for the study were recruited through presentations conducted at local churches in the Northeastern region of the United States. African American women who experienced depressive symptoms were eligible for the study. Criteria for inclusion into the study were (1) being an African American; self-report (2) being female; (3) between ages 18-65; and (4) identifying selves as religious (attend service three to five times a month). The women were interviewed individually face-to-face and by a telephone interview. The data were transcribed by the researcher and coded for themes.

The researcher sought to answer three research questions used as the basis for the study.

**Research Questions**

1. What are African American women’s experiences related to mental health in the African American church?
2. What are African American women’s experiences related to depression in the African American church?

The central research question for this study is:

3. How do African American women view the role of the church in coping with depressive symptoms?

Extant literature on depression, African American women, and religion has established a positive relationship between the constructs with religion acting as a buffer for psychological well-being (Jones, 2004; Jones & Ford, 2008). Researchers have found positive effects of religion on various mental health outcomes (Jang & Johnson, 2003;
Johnson, Thompson, & Webb, 2002; Koenig, McCullough, & Larson, 2001; Regnerus, 2003; Sherkat & Ellison, 1999). Individuals who are experiencing high levels of depressive symptoms may find a lack of pleasure in former religious involvements, which may erode their public and even private engagements with their religious faith (Smith et al., 2003). Higher levels of depressive symptoms in African American women who experience feelings or thoughts of lack of support and care from their closest form of social and spiritual support may significantly decrease their active involvement in the roles they play within the church (Smith et al., 2003). Evident in the results from this qualitative analysis supports prior research findings. The women in this study who reported experiencing feelings of lack of support and care from their church leaders and members withdrew from most collective or group religious activities and relinquished their roles of service within the church.

The central research question “How do African American women view the role of the church in coping with depressive symptoms?” was answered. Previous research suggested that religious involvement is a protective factor for better mental and physical health despite differences of samples, designs, methodologies, measures of religious involvement, health outcomes, and population characteristics (van Olphen et al., 2003). Religion and religious practices are also identified as having positive psychological outcomes (Colbert et al., 2009; Waite & Killian, 2008; Watlington & Murphy, 2006). Prior literature indicated religious involvement may afford people opportunities for social support, which has been found to protect against depressive symptoms.

In this study, several of the participants did not engage in religious activities as a means of social support due to a lack of trust, lack of financial support in times of need,
and lack of support in times of trouble. The negative experiences within the church voiced by most of the participants may have exacerbated their depressive symptoms. All participants were experiencing pre-existing conditions such as death of a loved one, poverty, family relations, and issues related to self-esteem. Not feeling supported by the church and members within the church increased the depressive symptoms of the women in this study.

The women in this study utilized opportunities of corporate or united worship, worshiping as a body with like believers, to strengthen feelings of inner peace while experiencing depressive symptoms related to their experiences in the church. Research findings by Greer (2011) indicated that African American women have been known for their strength and resilience in the personal and societal challenges often using religion. Many African American women rely on prayer, the Bible, and the church community to meet their daily needs (Abernathy et al., 2006). The current research substantiates some of the findings from previous research on the coping techniques use by African American women to meet their daily needs. African American women in this study used individual prayer time, reading the Bible, and Gospel music to cope with challenges experienced within the church.

Little is known about the relationship between religious participation and depressive symptoms in African American women, but some of the findings in this study indicated that the previous literature on the clergy as a resource for psychological distress is outdated. Chalfant et al. (1990) found that the counseling role of clergy is by far the most popular source of help for individuals seeking personal help. However, the historical function of pastors as psychological help providers has been absorbed by other
members of the church, or the individual with a psychological need will develop coping mechanisms to utilize outside of the church such as individual prayer, reading the Bible, and listening to Gospel music to self soothe as was found in this study.

The participants shared that it is not the participation or engaging in religious activity which helps to improve mental health status and the quality of life for African American women experiencing depressive symptoms but simply attending church, reading the Word of God, individual prayer time, and listening to Gospel music. The prevalence of religious participation seemed to negatively impact African American women experiencing depressive symptoms as issues related to trust, lack of support, feeling judged and rejected surfaced as reasons for withdrawal and isolation from active religious participation in the church setting.

Women who were once actively engaged in activities such as singing in the choir, being deaconesses, heading or working with the hospitality department, volunteering time, and teaching Sunday school classes ceased from these activities due to their negative experiences with church members and the leaders in church. Regardless of the level of corporate involvement in religious activities, African American women tend to use individual, private prayer time as the primary means of coping when faced with adverse situations associated with the church. African American women use formal religious involvement and private devotional practices (e.g., prayer) to negotiate a range of adversities (Brodsky, 2000; Mattis & Jagers, 2001). In every case within this study, the women used their Christian faith, beliefs, and practices to cope individually while still attending services in an unsupportive environment.
Integrating the Womanist theory concepts of womanism into the findings of this research is imperative to identify who is the African American woman. According to Alice Walker, a womanist is someone who loves the Spirit. The findings from the current study can be integrated with the womanist theory through all six participants. Each participant sought individual prayer time to commune with her inner spirit to bring her peace when faced with negative experiences both within and outside of the church. The time devoted to prayer and seeking God through His Word was a means to connect to the Spirit which shows the love for the Spirit above all things. The belief and the faith that this communion brought the participants contributed to their increased resilience and emotional wholeness.

Alice Walker continued to define a womanist as someone who loves folks. The participants in the study sought relationships with the folks in their congregations whether they were accepted or rejected. Despite negative experiences, all the participants showed a love and need for inclusion among their people. The women in this study continued to attend services week after week and year after year for the fellowship and communion with fellow believers and to feel connected with others. Through the tears, heartache, rejection, disappointment, and pain each African American woman continued to love and hoped to receive love back from her folk.

A womanist is also someone who loves herself. This concept of womanist theory may not be as easy to identify with the findings as the other concepts of womanism but never giving up on herself by continuing to include herself in sometime hostile environments increased the level of resilience and her survival. Building resilience to get through difficult times shows a love for the self. By never giving up on her church or her
people within the church, the emotional wholeness of the participants was enhanced showing a love for herself. In this study all of the participants displayed emotional wholeness, psychological strength, and resilience as they continued to be religious. The level of religious activity declined significantly but the African American woman remained. A womanist is someone who loves the Spirit, loves folks and loves herself which was substantiated in the findings of this study utilizing the Womanist philosophical approach.

**Implications for Counseling**

The current study contributes to the knowledge base of diverse counseling strategies for counselors-in-training and Clinical Counseling Professionals by informing them of the importance the role religion and relationships within the African American church has on African American women. Counselors-in-training working with African American women could include as part of their internship seeing clients who are religious in their church setting. The intern as well as the client would develop a deeper level of trust and respect for the role of religion and the church family in the counseling process. Religiosity among African American women is of special relevance no matter the levels of stress or distress they are feeling.

The increasing interest and changing perception have stimulated a growth in research on religion in counseling practices (Cornish & Wade, 2010). Counselors need to understand that the church is the foundation stone for African American women who have been indoctrinated in the church since childhood and feel compelled to attend even though they are often unhappy with the human interactions within their place of worship. Understanding the functions of religious participation (attending church) for this specific
population opens the doors for counselors to explore from a cultural perspective the ways in which African American women use religious practices to challenge ideas about their experiences and depressive symptoms. Counselors also can use these findings to understand religion’s positive relationship to mental health outcomes as clients identified coping strategies (strengthening their relationship with God through prayer and reading of the Bible) to assist them through their depressive symptoms while holding on to their religious heritage.

African American women tend to report higher levels of distress and stress than other groups and may deny a problem exists. The religious beliefs of this specific population of women who present for treatment of depressive symptoms have sometimes been identified as a barrier to treatment by counselors. By understanding the religious denial process utilized by African American women to cover mental health issues, counselors can challenge the client to identify what is working for them and how they can more effectively utilize their religious beliefs to become whole.

There is a history of mistrust with most mental health services provided by counselors; and counselors must be able to understand the African American woman, her history, her challenges, her beliefs, and her religious community to meet her and know her where she is. The mistrust stems from historical studies conducted on people of color which resulted in poor mental health treatment, withholding significant information, and overuse of medications which resulted in institutionalization. These new findings are invaluable in alerting mental health professionals and clergy on the positive association between religious practices and depressive symptoms in this population of women.
The current findings from this study may also assist the clergy and other religious leaders in identifying the need to be more sensitive to the needs of the African American women in their congregations. Mental health education programs targeted toward the African American church leaders have been indicated by the results of these data. A curriculum designed to educate clergy and religious leaders on the changing dynamic of the African American woman due to the demise in the once stable African American family structure will better equip them to lead, advise, and support the African American woman. The curriculum could entail educational presentations by mental health professionals who are experts on women of color to show the many struggles this population face as they try to seek the spiritual. Financial segregation, lack of support, isolation, not being heard, and mistrust of leaders and elders within the church are a few of the issues African American women reported in this study that facilitate depressive symptoms. With proper education on mental health issues, the leaders could encourage mental health services to women instead of viewing depressive symptoms as a sign of weakness or totally ignoring that a problem exists.

The women in this study identified a need for organizational religious involvement among women to serve as a model for mentorship, sisterhood, and support to younger women who may stumble along life’s journey. Recognizing the history that the early church was actively engaged in meeting the needs of its members and the community by providing basic social services, leaders can begin to reestablish these systems within the church, thereby reducing the stressors that increase depressive systems. By being informed about the challenges African American women of all ages face in the religious arena and being proactive in finding positive solutions to meet the
women’s challenges, there is a likelihood leaders may increase stability and reduce “scattering and falling away” in their congregation and empower women, families, and the community in which they may reside.

**Strengths**

The strengths of this research are identified as the method of inquiry, using the qualitative approach which provides a context for participants to be heard in-depth, and the researcher opening dialogues that can lend new insights in the counseling process. The unique characteristics of the six participants’ religious involvement and depressive symptoms suggest that the best avenue for future research studying religion and depressive symptoms among African American women should be a qualitative approach.

Another strength of the study is the researcher’s involvement in the process which allowed the women to feel safe, secure, not judged, confident, and trustful to increase the articulation of their inner voice during the interview process. As a Clinical Counselor, the interpretation of the participants’ stories related to the expression of depressive symptoms can also be viewed as a strength. As a professional counselor, the ability to identify and hear the unspoken meaning behind the words increased the richness and depth of the participants’ experiences.

Another strength of the study emerged during the second interview which was conducted over the phone instead of face to face. During the phone interviews it seemed participants were calmer, more expressive, relaxed, possibly due the rapport that was established between the participant and the researcher during the initial face-to-face interview. Or possibly the participants felt less inclined toward social desirability to put on a performance for the researcher and omit relevant information in order to present in a
more positive light which was actually discovered between the first and second interview of the participants. This is only the researcher’s interpretation or bias as many other factors including the researcher’s possible officious demeanor may have contributed to minimal data collection during the first interviews. In the safety and privacy of their own homes during the phone interviews, participants expressed themselves, their thoughts, and their feelings with a louder voice related to their experiences in the church.

In this qualitative study, the Womanist theory philosophical approach was used as a means to empower the women to express their thoughts and gain insight into their current situations. By having the women directly involved in the qualitative research process of verbally sharing their experiences, they were not simply talked to by the researcher but empowered to speak for themselves which is the main philosophy behind Womanist theory. During the second interview process, it was evident by all the participants the increased feeling of empowerment to become the women they desired to be. They reported a renewed interest in the church, an increase in self awareness as it relates to interactions within the church, and an increase in seeking their own personal counsel (prayer) instead of or in addition to involving others (mentorship/fellowship with other women).

Womanist theory speaks to the empowerment of the individual and collective empowerment of African American women. Individually, the women find strength in being true to who they are regardless of the challenges they may encounter within the church. Collectively, the women are able to identify mentorship to alleviate their mental health needs. The Mental Health America (2006) identified that 63% of the African American population believe depression is a personal weakness. Womanist theory
empowers this population of women struggling to balance home, children, relationships, community, family, school, work, and religious challenges within a collective setting by not allowing themselves to be ignored or minimized. In this research Womanist theology informs the present knowledge about the role of religious activity in greater depth related to the lives and lived experiences of African American women.

Limitations

One limitation of this study is the number of participants used to gather such meaningful data on depressive symptoms and religion. The small sample size reduces the generalizability of the study. Ideally the voice of three to five more women would add more depth and possibly more diverse information on the struggles African American women face in the church.

Another limitation of this study important to note is that the participants may have minimized the extent of their personal experiences due to issues related to faith, loyalty to their church, exposure, fear of being identified in some way, and internal struggles with appropriate sharing of information and trust. All of the participants experienced depressive symptoms related to loss of trust whether within the church or outside of their religious experiences.

A general limitation of the research is the researcher as a tool. In most qualitative studies, the researcher has a passionate interest for all the constructs being studied from a personal perspective. It is very difficult to eliminate bias from qualitative research, but the researcher tried to utilize the best methods possible to remove and hopefully eliminate all bias from the interpretations and results. To enhance the participant-researcher relationship, the researcher made attempts to establish rapport with participants during
the solicitation presentations to encourage participation and while conducting the actual interviews. During the data collection process the researcher reiterated the limits of confidentiality and measures to obtain participant autonomy in order to elicit truthful, accurate, in-depth data. However, in qualitative analysis using self-report data, limitations exist not only in possible researcher bias but also in participants’ need to protect themselves from assumed breach of autonomy or confidentiality.

Another limitation of this study is geographical location. The data collected represented only African American women who reside in a northern region of the United States. African American women in the southern region of the United States, popularly known as the Bible Belt, may have a different cultural perspective due to the presence of historical religious organization that began in the south, family beliefs, and structure or religious stability within denominations. Even though the church denominations in the north and south may be the same, the resultant themes may differ due to geographical cultural differences among African American women.

After the completion of the research, a major limitation found in this study was the homogenous gender of all the church leaders. Historically focusing on gender interactions, leadership roles and subordinate positions within the church, African American women formed missionary societies and women’s conventions as a means to have leadership and power in the church. With the majority of traditional Black church leaders being African American males, it is not easy to find a church led by an African American female.
Recommendations for Future Research

This study was conducted as a new venture to begin a way of accessing information to help pastors, counselors, and counseling students working with African American women who have connectedness with the church. This study is not to ridicule the church but to open doors for a dialogue with women to increase awareness of the prevalence of the silent suffering African American women endure in the religious setting. First, future studies should include the role of the present day pastor in his relationship with women experiencing depressive symptoms in the church setting. Research conducted by Aaron et al. (2003) maintained the church is still a support for physical ailments but mental health and depressive symptoms may be the precipitating factor for these physical ailments.

In this study all the church leaders were male. Future studies on the African American women and depressive symptoms could include a diverse leadership paradigm to discover how pastor gender differences relate to depressive symptom outcomes. With major leadership positions in the church reserved for men, African American women developed associations within the church in an attempt to gain full lay leader and clergy rights. Discussions focusing on African American female pastors regarding needed changes in the traditional Black church may revolve around addressing mental health issues concerns. African American women church leaders could be interviewed to assess whether there are gender issues within their churches that prevent women from voicing their experiences with mental health concerns and seeking help without being made to feel spiritually weak or being embarrassed publicly. The research could also focus on African American women’s willingness to share their depressive symptoms with fellow
African American women who reside in the church leadership role versus African American male church leaders.

Second, there is the need to better understand the value of mentorship and fellowship from older women toward younger women in the church on a woman-to-woman or sister-to-sister dialogue. A tenant of the Womanist theory is community through mentorship. Modes of psychological resistance to oppression identified in womanist discourse include reliance on women-centered networks of emotional support and care giving, spiritual faith, and a healthy construction of self (Boyd-Franklin, 2003; Collins, 1990). When family relationships present as a major contributor to depressive symptoms, African American women look to each other for support, direction, and guidance in their lives and they often find it within the church “godly friends.”

The third recommendation for future research is the effects of the extended family and depressive symptoms while religiously engaged in the African American church. The absence or presence of extended family members attending the same church may have a significant impact on depressive symptoms in African American women who are religious. Younger participants in this study with family members attending the same church expressed an increase in depressive symptoms while religiously engaged. These participants felt they were being judged or criticized for daily life events outside of the church setting and found it difficult to worship with family members present. Also in this study, the younger participants with family members in the same church were withdrawn and not actively due to stressful family relationships.

The fourth recommendations is implementing religious education in the counselor training program to better equip mental health practitioners on effective interventions to
utilize with African American women. African American women can assist counselors in clinical practice to become comfortable with using their cultural background knowledge with interventions to treat women experiencing depressive symptoms with challenges while engaged in religion activity.

This study found that the church and relationships with women within the church are imperative to a holistic approach to life and to African American women experiences. The need for support from the women within the church can reduce depressive symptoms of those women without a supportive family of origin, to assist others through challenges and changes in life without condemnation, through grief, bereavement, financial struggles, and trust issues within relationships to build an active, stronger religious commitment. Several women in this study found that in their greatest hour of need, after years of commitment and service, the church was not willing to help them to meet their singular need whether emotional or financial.

It is recommended that future studies using qualitative research should explore factors that have significantly reduced the role of church leadership in meeting the needs of their members. The migration of religious leaders and societal changes over the last two hundred years could play a significant role in the current changes within the church. Another topic of interest for future studies on African American women experiencing depressive symptoms while engaged in religious practices should focus on the role of family presence in the same church setting. Several participants in this study identified the presence of their family of origin as a hindrance to their religious practices and experiences, while another participant viewed family presence as a support. One factor to explore in this scenario is the age of the participant. Older participants felt the presence of
family members in the same church as a source of support, while younger participants felt the presence of their family of origin inhibited their religious experience.

The research identified prayer as a common coping mechanism in African American women's experiences of depressive symptoms. It is suggested that future qualitative research on prayer and depressive symptoms in African American women be explored. Gospel music as a means of coping could also be researched.

Finally, due to the limitation of geographical restriction on the data outcome a qualitative study of the same constructs could be conducted in the Southern region of the United States to possibly diversify findings. Religion is known to be an essential guiding force for African American women. The religious roots of the African American woman began in the Southern states of the USA in slave communities with the Bible being used as a source of inspiration. In the south there may be stronger established religious organizations and stronger stable family structure for support on salient issues the northern participants did not have. By replicating this study in the south the outcomes may be significantly different.
CHAPTER VI

THE RESEARCHER’S JOURNEY

In the course of researching and writing up this dissertation, I experienced many challenges as well as many victories both personally and professionally. The journey created uncountable sleepless nights, heartbreak, and soul searching before coming to my own place of peace. At times the journey was extremely trying creating emotional, physical, and mental exhaustion taking me to places I did not know existed within me; but I feel the experiences have enriched my life and encouraged my professional growth. At the end of the journey, one of the participants told me she was praying for me and that statement alone encouraged me enough to eliminate my emotional frustration and seek the prize, the completion of this dissertation.

I began the dissertation research process in 2009 with a goal for completion within three years. I am an African American woman and I chose the Womanist theoretical framework as the basis for my study. The Womanist theology purports the empowerment of African American women through interpersonal connections to resist oppression within and outside the church which may cause depression and a reduction in religious engagement. This theory suggests that women of color, especially African American women, have numerous challenges in their daily lives that women of other cultural backgrounds do not experience. During this journey I had to be head of household, a teacher, a professional counselor, a supervisor for counselors-in-training, a
mother, a grandmother, a sister, an advocate for abused children, a spokesperson for women experiencing depressive symptoms, and a researcher. Womanist theory explains the cultural perspective of the ubiquitous Black woman who has to be all and all to everyone in all her roles never showing any signs of weakness or defeat. Womanism is derived from the folk culture of African American women with its commitment to survival and wholeness of self. This theory held true for me during my dissertation process.

The introduction to my research study was a release for me as it afforded me opportunity to express the “why” for this topic of research. The chapter took quite a few months to write as there was a lot of editing needed to narrow down the focus for the study and bring it into perspective. I had to separate the constructs of religion and spirituality as they represent two very different measures. Once I was able to do this, the journey began in earnest. I had to create time daily, often after a full 10-hour work day, to search the archives of data on my topic to begin my literature review. I soon discovered there is a dearth of information on religion, African American women, and depressive symptoms collectively in the literature. Most research has been conducted on spirituality and physical health outcomes but very little on religion and depressive symptoms in African American women while actively engaged in the church. The literature review was my greatest challenge as the literature I found was not representative of the current emotional and mental state of the women I came in contact with on a daily and weekly basis. Womanist theory helped me to understand this phenomenon. Culturally and historically African American women have been conditioned to hold negative emotions inside and deal with them silently, without complaint and alone. Therefore, previous
research did not capture the true story of this unique group of women. I also found during the literature review that most studies conducted with African American women used the quantitative research design, gathering numerical data but not hearing the story behind the numerical values. My purpose in using the qualitative research design was to eliminate the silence and give voice to the women being studied.

I had a clear plan in my mind on how best to construct the method for obtaining the data I needed to research my topic as I had already unknowingly practiced the process as a woman’s event speaker at various churches in the area. It was from this forum that I realized I was not alone in my experiences within the church that created depressive symptoms in my life. I had experienced a brief “falling away” as Charnette called, for many of the same reasons the women in this study fell away from devotion, commitment to their churches, their roles and religious activities. I became sidetracked from the study for almost a year but I never gave up interest or hope of exploring this topic that is very close to my heart. I knew what my cohort of religious sisters/women was experiencing and I felt an obligation within me to tell their stories from their perspective in hopes of reaching those that were not attune to their cry for help. I continued to gather empirical research and tried not be bias or judgmental in the process.

After being away from the study for a while, it felt exuberating to finally begin the data collection process. At first I was anxious because I was not entering the churches as a spokesperson at a women’s program or event but as a researcher, and I felt unsure of what to expect or how I would be received and accepted. The response was quite favorable. I had no resistance from church leaders allowing me to interview their members for the study and the response from the women after the solicitation was even
more favorable. I had no trouble recruiting participants to screen for an interview and some women even provided referral information on other women who might benefit from the study. On the first week of solicitation, I had identified through random but purposeful selection, the participants I needed to begin data collection. Through my professional development as a professional counselor first and a researcher second, I experienced some apprehension within the interview process. I did not want to overstep my boundary as a researcher and become clinical so I failed to obtain adequate data representative of the rich story the women needed to tell. A few of the participants became emotional to the point where I felt I needed to end the interview and provide referral information to a mental health provider in the community. It was not my plan to conduct a second round of interviews but in doing so, I was able to capture additional data to enrich the shared experiences of the women. The interviews went well and I felt confident I could document the lived experiences of the participants with an accurate interpretation of the data.

During transcription, the experiences of the women caused me to do some introspection into my own faith, beliefs, my current role in the church, and my tolerance for patience and understanding. I did not remain in a place where I was disrespected, not trusted, devalued, and minimized. My special participant who was praying for me, Lou Lou, was openly humiliated in front of friends and a church elder but had the strength in God to continue in her ministry. This really challenged my place in God. I may not interact with her again but I feel I have a bond with her in the spiritual realm. I also feel for Charnette; I hope she eventually makes it back into the Arc of Safety within God’s arms. Just hearing the stories of all the participants has challenged me to be a better
Christian like Courtney, not looking to men for strength but by “seek ye first the Kingdom of God and its righteousness and all other things will be added unto you.” To be a better mother and grandmother through reflection on Emily’s experience with her family and to be a mentor within my church to young women who have stumbled along the path of life like Allison and to be cognizant of the role I play in others lives is my goal. Candi is just someone I fell in love with. Her demeanor, her approach to life and wisdom will always be remembered and hopefully implemented into my daily experience.

During this journey my life circumstances changed and I was reluctant to continue the study. I lost all passion to move forward. It took a month or so for me to recover and I feel it was my love for the participants and my promise to relay the message they conveyed from their experiences that pushed me forward to this point. I owe them that much, to put their words in print so the silent voice could now be heard. I did not go through this journey alone. Thank you, ladies, for all you unknowingly taught me and did for me in this portion of the journey of my life.

“Now unto Him who is able to do exceedingly and abundantly above all that we ask or think, According to the power that works in you . . . Unto Him be glory in the church by Christ Jesus to all generations, forever and ever. Amen” (Ephesians 3:20-21).
REFERENCES


Wheatley, M. A. (2009). Personal characteristics, chronic stress, and depressive symptoms in midlife African American women (In partial fulfillment of the requirements for the degree of Doctor of Philosophy Frances Payne Bolton School of Nursing). Case Western Reserve University, Cleveland, OH.


APPENDIX A

REQUEST TO CLERGY FOR MEMBER PARTICIPATION

My name is Doris Atanmo. I am a Licensed Professional Clinical Counselor registered in the state of Ohio conducting research to fulfill the requirements of my Doctoral Degree. My dissertation involves gathering information on depressive symptoms among African American women who are religious. The goal of the research is to gain a better understanding of depressive symptoms among women who attend church 3 to 4 times a month. Historically, this population is known to engage in religious and community activities as a means to alleviate suffering, to have a sense of belonging and acceptance and to increase their spirituality. The research I am seeking to conduct, will give women who have experienced depressive symptoms while actively engaged in religion, a voice to articulate their experiences which will hopefully enable professional counselors to develop an effective treatment plan for these women.

As a researcher, I am seeking an opportunity to conduct a presentation to African American women in your church who may have experienced depressive symptoms in the last 4 years and who may be willing to participate in a confidential interview to share their experiences with me. Research on depression and religion indicates there is often a deep-seeded reluctance to share this kind of personal information for fear of stigmatization, a sign weakness or lack of faith. This same research also indicates that when individuals express their deepest thoughts and feelings in a confidential, unbiased setting, their healing process is more likely to begin.

I am requesting that you allow me to solicit participation for women in your church to participate in my research. I would like to conduct the actual interviews for your member(s) in your church if at all possible.

The information gathered will be used exclusively for research, presentations and publications. All information will be anonymously documented and presented.

Thank you in Advance for your support,

Doris Atanmo, MA.ED, LPCC-S
APPENDIX B

PARTICIPANT REQUEST

My name is Doris Atanmo and I am a Doctoral Candidate in the Counselor Education and Supervision program at the University of Akron working under the supervision of faculty members, Dr. Cynthia Reynolds and Dr. John Queener. I will be conducting a study that investigates the role of the African American church with African American women who are experiencing depressive symptoms in a religious arena. There have been few published studies which explored these constructs as they relate to counseling techniques and counselor education for counseling student on the unique and specific needs of this population of women. There are limited studies that have been conducted specifically with training and development of culturally specific interventions.

The primary purpose of this study is to give voice and meaning to women experiencing depressive symptoms and struggling to maintain their faith, beliefs and trust in a historical place of asylum. The findings of this study will contribute to the limited research on culturally specific interventions needed to support counselor education programs and awareness of the continuous development and effectiveness of culturally diverse treatment.

The participants of this study will be African American women between the ages of 18 and 65 years old who attend church 3 to 5 Sundays a month. Participants will be asked to review and sign a consent form, complete a demographic questionnaire, complete the BDI II and be willing to share their thoughts and feelings in a confidential, private interview. The initial interview may take approximately 60 minutes depending on the participant’s exchange of data. A second interview will be conducted with each participant after the collected data has been transcribed to ensure the researcher documented the meaning intended from participant responses.

The data collection instruments will consist of demographic sheet, interview questions and an inventory to identify depressive symptoms. Participation in the study will be voluntary and the data anonymous. Prior to beginning this research, approval will be obtained from the IRB Committee of the University of Akron and my dissertation committee. Additionally, each participant will receive a $25.00 incentive for participating, which will be given at the conclusion of the second interview held to verify accuracy of information provided by participant.

I appreciate your assistance in this research endeavor and feel the findings will contribute significantly to the counselor education literature. If you have any questions or concerns, please do not hesitate to contact me at the following telephone number and e-mail address.

Sincerely,
Doris Atanmo, Ms.Ed., PCC-S
Ataris57@yahoo.com
330-396-1917.
APPENDIX C

INFORMED CONSENT DOCUMENT

PROJECT TITLE: No Longer Silent. African American women speaking up on depressive symptoms and religion.

INTRODUCTION

The purpose of this form is to give you information that may affect your decision whether to say YES or NO to participate in this research, and to record the consent of those who say YES. The name of this Research Project is “No Longer Silent; African American Women Speaking up on Depressive Symptoms and Religion.

RESEARCHER

Doris M.H. Atanmo, Doctoral Candidate, Ms.Ed, LPCC-S
The University of Akron

DESCRIPTION OF RESEARCH STUDY

Several studies have been conducted looking into the subject of depression and religion among women. None of them have examined the intersect of African American women, depression and religion using a qualitative approach through a womanist theoretical approach.

If you decide to participate, then you will join a study involving research on religion and depressive symptoms in African American women where you will complete two questionnaires: (1) Demographic Questionnaire and (2) Beck Depression Inventory II. If you say YES, then your participation will last for sixty minutes (1 hour) for the first interview. A second meeting lasting approximately sixty minutes will be scheduled to affirm and clarify my interpretation of your responses. Six women between 18 and 25 years old who have experienced depressive symptoms in the past 4 years while attending church 3 to 5 times a month will be participating in this study.

INCLUSION CRITERIA

To be included in the study, during a phone interview, you must indicate that you had experienced depressive symptoms within the past 4 years, you are an African American woman between the ages of 18 and 65 years old and attend Sunday church services 3 to 5 times a month.

If you indicate that you are currently experiencing symptoms of depression, are a male, under 18 years old or over 65 years old or not attending church services 3 to 5 times a month you will not be able to participate in this study.

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RISK AND BENEFITS

RISKS: If you decide to participate in this study, then you may face a risk of discomfort or re-traumatization as you recall information pertaining to your depression. Additionally, as with any research, there is some possibility that you may be subjected to risks that have not yet been identified. The possible re-traumitization of participant may occur during interview due to revisiting events in your life that had contributed to the depressive symptoms.

BENEFITS: There are no direct benefits to research participants outside of knowing that your responses will provide relevant information pertaining to depression and religiosity in AFRICAN AMERICAN women. More specifically, through your participation it is hoped that counselors, therapists and religious leaders will be better informed when working with this population.

COST AND PAYMENTS

The researcher will give each participant a gift card valued at $25.00 for participating in this study. Compensation will be provided immediately after final interview.

NEW INFORMATION

If the researcher finds new information during this study that would reasonably change your decision about participating, then it will be given to you.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications but the researcher will not identify you.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study at any time. Your decision will not affect your relationship with Doris Atanmo or The University of Akron, or otherwise cause a loss of benefits to which you might otherwise be entitled. The researcher reserves the right to withdraw your participation in the study at any time if she observes potential problems with your continued participation.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither The University of Akron nor the researcher are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Doris Atanmo, at 330-396-1917 who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had.
about the research. If you have any questions later on, then the researcher should be able to answer them.

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call my advisor Dr. Reynolds at 330-972-6748. And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

---

**INVESTIGATOR’S STATEMENT**

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, cost, and procedures. I have described the rights and protections afforded human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject’s questions and have encouraged her to ask additional questions at any time during the course of this study. I have witnessed the above signature on this consent form.

---

Thank you for agreeing to participate in this research.

Please continue to next page for first questionnaire.
I would like to start by asking you some background information about yourself that will provide qualifying criteria for your participation in this research.

1. What is your race?
   a. African American
   b. Hispanic
   c. White
   d. Asian American
   e. Native American
   f. Other; _____________________

2. What is your gender?
   a. Female
   b. Male
   c. Transgender

3. What is your age range?
   a. Between 18-25
   b. Between 26-33
   c. Between 34-41
   d. Between 42-49
e. 50 and older

4. How many Sundays do you attend church in a month?
   a. 0 to 2 times a month
   b. 3 to 5 times a month

5. What is your religious preference?
   a. Muslim
   b. Christian
   c. Catholic
   d. Jewish
   e. Other _____________________

6. Have you ever been diagnosed with depression?
   a. Yes
   b. No

7. What is your level of education?
   a. Less than high school
   b. High school
   c. GED
   d. Associate degree
   e. Bachelor’s degree
   f. Master’s degree
   g. Ph.D /Ed.D
   h. Professional school
8. What is your marital status?
   a. Single, never married
   b. Married
   c. Separated
   d. Divorced
   e. Widowed
   f. Partnered
APPENDIX E

REFERRAL LIST OF MENTAL HEALTH PROVIDERS

1. **Family Ties – CG&FS:**
   Contact information: Akron Office (330) 762-2557
   Front Street Office (330) 945-5999
   North Summit Office (330) 733-7993
   Southwest Summit Office (330) 753-1096

2. **Greenleaf Family Services:**
   Contact information: Akron Office (330) 376-9494 (376-9351 – TTY)
   Wooster Office (330) 262-4235 (262-3759 – TTY)

3. **Mental Health America of Summit County:**
   Contact information: (330) 923-0688

4. **Minority Behavioral Health:**
   Contact information: (330) 374-1199

5. **Northeast Ohio Behavioral Health:**
   Contact information: Cuyahoga Falls Office (330) 945-7100
   North Canton Office (330) 494-5155

6. **Portage Path Behavioral Health Center:** Contact information: Akron Clinic (330)
   253-4118
   Barberton Clinic (330) 745-0081
   Stow Clinic (330) 928-2324

7. **Summit Psychological Associates, Inc.:**
   Contact information: Akron (330) 535-8181
   Ravenna (330) 296-3700

8. **University of Akron, Clinic for Child Study & Family Therapy:**
   Contact information: (330) 972-6822

9. **Western Reserve Outreach Center:**
   Contact information: (330) 425-4432
APPENDIX F
IRB APPROVAL LETTER

NOTICE OF APPROVAL

May 1, 2015

To: [Name]
From: [Name]

Subject: Notice of Approval

We are pleased to inform you that your research proposal has been approved by the Institutional Review Board (IRB). Your project is approved for the purpose of investigating [brief description of the research topic].

Approval Date: May 1, 2015
Expiration Date: May 1, 2016
Continuation Application Due: April 27, 2015

Please note the following:

- IRB approval is valid for one year.
- Any changes to the approved protocol must be submitted to the IRB for review.
- All adverse events or protocol deviations must be reported to the IRB.

Please sign and return the attached approval letter to confirm your acceptance of the terms and conditions of the approval.

Sincerely,

[Name]
IRB Administrator

[Signature]

[Date]