STANDING IN THE NEED OF PRAYER:
BELIEFS ABOUT DEPRESSION AND TREATMENT HELD AMONG AFRICAN AMERICAN CHRISTIAN WOMEN

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ABSTRACT

Standing in the need of prayer: Beliefs about depression and treatment held among African American Christian women

This exploratory study utilized a quantitative approach to examine beliefs about depression and treatment held among African American Christian women. The convenience sample consisted of 106 African American Christian women from three Boston area churches. Standardized instruments included Center for Epidemiological Studies- Depression Screen (CES-D), Robinson Resistance Modality Inventory (RRMI), and the Shepherd Scale (SS). The non-randomized Beliefs about Depression and Treatment (BHBI) was also utilized. Results from the Center for Epidemiological Studies Depression Scale indicated that depression was prevalent in the sample (n= 64). Results from MANOVA and Rasch Rating Scale Models indicated that education, age and psychological resistance had a statistical and significant relationship on beliefs about the origins and existence of depression. This sample of women were found to be optimal resistors as scored from the Robinson Resistance Modality Inventory (n=82). The sample was also found to be highly evangelical Christians as measured by the Shepherd Scale. BHBI subscale revealed that study participants believed that the existence and origins of beliefs emanated from brain changes, an abuse history, a sickness needing treatment, and a health condition. Prayer and psychotherapy were reported as the most acceptable forms of treatment for depression.
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CHAPTER ONE
Introduction

because she didn’t know any better
she stayed alive
among the tired and lonely
not waiting always wanting
needing a good night’s rest


This chapter presents the statement of the problem, background of the problem, the rational and research significance, description of the study, the major research questions and operational definitions. The chapter concludes with a summary and overview.

Statement of the Problem

Despite advances that have been made to address the need for culturally relevant mental health models, there is limited understanding of the interaction of Christianity and depression in African American women. Persistent cultural and religious messages of long suffering and strength through adversity are one factor that explains this lack of engagement with external mental health services.

African-American Christian women’s beliefs in depression as a specific ailment similar to high blood pressure or diabetes remains under researched in the psychological literature (Keith, 2003; Banks-Wallace, 2000). The psycho-social history of racism and gender oppression when added to a personal belief that with prayer and belief in Jesus that all things “work together for the good” creates a belief orientation that heavily perpetuates reliance on the self and prayer (Robinson-Wood & Braithwaite-Hall, 2005). This scriptural teaching instructs believers to have faith that the final outcome to a problem or situation will be positive and in her best interest (Cook & Wiley, 2000). These dynamics decrease the likelihood that a black Christian woman would seek out treatment for depression, something that she may not believe is real (Simon,
Help seeking behaviors among African-Americans is often framed in participation rates relative to service utilization (Taylor et. al, 2004; Caldwell, 2003; Taylor et. al, 1999). Limited research studies have examined whether black Christian women who perceive or diagnose themselves as having a mood disorder, like depression, interprets their condition to be spiritual in nature and thereby necessitates a spiritual guide as opposed to a mental health clinician (Gazmarian et., al 1995). Additionally, these women would not know about the availability of different treatment types since they have not been involved in the traditional mental health delivery system (LaRoche & Turner, 2002; Surgeon General Supplemental Report, 2001).

Prayer is the primary coping mechanism used by African American Christians (Robinson-Wood & Braithwaite-Hall, 2005; Conner, 2004; Long Cudjoe, 2004; Hackney & Sanders, 2003; Hunt & Hunt, 2001; Brome, et al. 2000, Cook & Wiley, 2000; Chatters et. al, 1999; Ellison, 1993; Wimberly, 1991; Bryant, 1991). It is unclear under what condition a Black Christian woman would deem acceptable to engage a response beyond prayer as a means for the alleviation of depressive symptoms. She may perceive any action outside of prayer or a spiritually grounded response as moving her away from the centrality of God’s presence in her life (Singleton, 2003; Cook & Wiley, 2000). Furthermore, in Black Christian worship and expression continuing to “pick something up”, that is to still hold onto the problem’s relevance to one's life, indicates a lack of spiritual maturity. As a result, believing that a depressed mood will simply pass creates a dynamic of passivity. Spontaneous faith healing can and does exist (Levin, 2000). However, the role of prayer ought to be a mechanism through which communion with the Creator provides courage for the woman to actively contend with resolving/alleviating her depressive mood. Black Christians often believe that prayer is the active response (Conner, 2004;

At times the Holy Spirit, (third person of the God head- Father, son, Holy Ghost) can and does impart spiritual insight and guides actions to deal with the pressing concern. Black Christians also believe that the search for problem resolution or symptom reduction can also be found in the Bible. This process, prayer and Bible reading may then be supplemented or enhanced with pastoral counseling (Boyd-Franklin, 2003). This three part process has tremendous benefits, yet some significant limitations. African American Christian women use Jesus as their anchor and organizing force for their lives. Identification with the suffering and redemption of Jesus is significant in their culturally influenced spiritual development (Taylor et. al, 2004; Black, 1999).

The communally focused nature of African descended people indicates the significance of relational connections in the development of their racial, gender and cultural identity (Constantine, 2004). This network and community conveys the value placed on persistence, perseverance, and the management of adversity. As a consequence, this silent suffering that emanates from a mood disorder like depression gets sanctioned almost as a birthright that assumes suffering to be synonymous with being a Black woman (Beauboeuf-Latontant, 2007, hooks, 1993). The connection of God, scriptures and the Holy Ghost are standing resources/guides that are ever present for the believer. Within the context of this religious/spiritual environment, the pastor becomes the significant human being that guides and supports growth, knowledge, and problem/situational resolution (Taylor et. al, 2004; Weaver et, al, 2003; Wimberly, 1991).
The minister’s presence in the lives of parishioners is significant as a gatekeeper and a means of support outside of the church context (Taylor et. al, 2004; Cook & Wiley, 2000; Wimberly, 1991). Though imbued with spiritual gifts and insights, this person is still human, vulnerable and subject to limitated skill training in counseling and treatment (Cook & Wiley, 2000). So to assume that this person can do all things is placing and erroneously expecting too much from one individual. One cannot assume that a pastor can treat chronic health issues like diabetes or hypertension. This same logic holds for the understanding, diagnosis and treatment of depression. It is not prudent to expect that a pastoral guide simply by virtue of his/her position can not only understand the depth and impact of emotional and psychological problems, but can also effectively support and counsel the person living with this mood disorder (Cook & Wiley, 2003; Peterson, 2002). African Americans and their utilization of organized helping institutions (e.g. hospitals, schools, mental health entities) reflects a history of distrust, oppression and lack of racial and cultural knowledge that has impacted full participation within these systems (Hodge, 2002; Constantine et. al, 2001, Surgeon General Supplement, 2001, Black, 1999). African American Christian women’s perceptions of and experiences with accessing care, inclusive of clinician’s training and competence needs to be explored to further understand mental health concerns among this understudied group (Caldwell, 2003; Williams & Williams & Morris, 2002; Alvidrez, 1999; Sue, 1992)

In summary, the interplay between Christian beliefs, suffering as emblematic of black identity, and psycho-social gender variables influence the African American Christian woman’s belief about depression and treatment outside of the realm of prayer. This is the significant issue and problem that will be examined in this research study.
Background of the Problem

The “strong black woman” is the ultimate idealized descriptor for the African American female (Beauboeuf-Lafontant, 2007). It is presumed that this woman has the capability to persist and “show strength” through all manner of personal, familial, communal, and societal struggle. She persists while maintaining a presentation of the self as unaffected by the human experiences of fear, need, or fatigue or rejection often manifested by lack of self care, and ignoring actual emotional or physical conditions (Romero, 2000). The U.S. Census Bureau (2004) reports that of the nearly 294 million people in the U.S., more than half are women. There are 48 million women of color in America. In this group, Black or African American women compose 39% or roughly 19 million of the population. For many of these women religious and spiritual beliefs are a central organizing force in their lives (Constantine et al. 2004; Cook & Wiley, 2003; Lincoln & Chatters, 2003). These beliefs grounded in Christianity provide the value system and socializing force that is used for coping and managing the daily challenges of life (Boyd-Franklin, 2004).

The National Urban League’s State of Black America (2007) report focused on a collective portrait of the Black male, which has a direct impact on African American women. The collective picture of Black male unemployment, underemployment, incarceration, mortality through violence, low college graduation rates, and negative stereotyping permeates the individual, familial, communal and societal progress of the black community. These men are the brothers, sons, husbands, fathers, lovers, uncles and friends of the 19 million black women in this country. Mather et. al, (2005) indicates that 42% of female headed African American households with children live in poverty. Black male and females (42.2% for males, 40.8% for females) are more likely than whites (38.3%) to be unmarried, divorced (9.4% black males, 13.3% black females) and (whites 5.9%) (Administration for Children & Families, 2002). As a result, the
contemporary daily life for many African-American men and women is experienced through the persistent assaults of racism, sexism, classism and economic oppression (Keith, 2003). The impact of these collective assaults along with individual functional abilities creates outcomes that manifests in mood, personality, and communal disorders (Jones et. al, 2007; Kessler et al. 1994).

Williams and Williams-Morris (2000) explore three key mechanisms through which racism impacts mental health and function. First, societal institutions can lead to truncated socio-economic mobility, differential access to desirable resources, and poor living conditions that can adversely affect mental health. Secondly, experiences of discrimination can induce physiological and psychological reactions that can lead to adverse changes in mental health status. Lastly, the acceptance of negative cultural stereotypes can lead to unfavorable self-evaluations that have deleterious effects on psychological well being (Williams & Williams-Morris, 2000).

*Psycho-Social Influences of Depression*

Kessler et. al (1994) findings from the National Comorbidity Survey (NCS) report that 50% of African Americans, as opposed to 31% of Caucasians associated major discrimination (i.e. hassled by police, fired from job) as being linked to major depression and psychological distress. Though African American women have lower rates for clinical depression (10.99%) than white females (12.68%), their one year prevalence rates are higher than African American males (4.99%) and white males (7.62%). Further, African American women have the highest one year prevalence of dysthymia of any one race/gender, as well as the highest one year prevalence for mania, simple phobia, agoraphobia, post traumatic stress disorder, and schizophrenia.

Major depressive disorder or clinical depression is one of the most commonly occurring mood disorders in the general population and among African American women (Brown & Keith, 2003; Kessler et. al, 1994). The causes are multiple and interrelated. For some persons, social
and environmental factors like major stressful life events may precipitate clinical depression (American Psychological Association, 1994). Genetics may factor significantly and/or the interplay with medical conditions or changes in the central nervous system, which can often be the result of substance or medication use. A diagnosis of clinical depression requires at least five specific symptoms during a two week period, one of which must be a depressed mood or loss of interest or pleasure in the usual activities of life, and the presence of these symptoms must represent a change from previous functioning. Other symptoms may include significant weight loss or gain, insomnia or hypersomnia, fatigue or loss of energy, psychomotor retardation, diminished ability to concentrate or think, and recurrent thoughts of death or suicide (DSM-IV).

Findings from the National Mental Health Association (NMHA, 1996) indicate a persistent lack of clarity regarding the symptoms, definitions, and progression of depression among African Americans. In particular, 63% of African-Americans believed depression is a personal weakness. Roughly 40% of the sample would not seek treatment because of denial, 38% would not seek treatment because of shame or embarrassment. Only 30% believed that depression was a health problem.

Not believing in depression as a health problem has profound implications for African American women. Depression manifests differently in its expression across race and gender groups (Brown & Keith, 2003; Gazmarian et al., 1995). Depression gets evaluated from European American perspectives and diagnostic norms (Warren, 1995). Consequently, certain symptoms are not recognized, suffering continues, and escalates, thereby increasing the risk of serious medical and psychological ailments such as alcoholism, hypertension, hanges in the immune system, heart disease, breast cancer, and Type II diabetes (Surgeon General, 2001). Symptoms in African Americans are often somaticized in the form of headaches, crying fits,
angry outbursts, busyness, social withdrawal, substance abuse, poor self-care, and the masking or denial of symptoms (Boyd-Franklin, 2003; Singleton, 2003; Schreiber et. al, 2000).

Psychosocial influences of depression in African American women encompass socialization, racial and gender identity, spiritual beliefs, health and wellbeing, and socioeconomic status (Beauboeuf-Lafontant, 2007; Robinson-Wood & Braithwaite-Hall, 2005; Williams & Williams-Morris, 2000). The intersection of race and gender in African American women’s lives creates a clear challenge in the research literature as this intersectionality (Robinson, 2005) often gets demarcated into the study of race or gender (Banks-Wallace, 2000). As a result, the psycho-social influences presented follow the same pattern. The womanist conceptualization is one of the few theoretical frameworks that explicitly merges the race and gender of the African-American woman placing centrality on racial consciousness and self-healing (Banks-Wallace, 2000; Warren, 1995).

Wang et. al, (2000) examined data from the Mid Life Development in the United States (MIDUS) indicated that clinical depression occurs more frequently (18.9%) among younger (18-44) than older African American women (3.8%). The highest rates occur among those aged 20 to 29 years old. Clinical depression is significantly lower among married African American women than among those who were not married (i.e. separated, widowed, or never married). Jackson (2003) notes that social class factors into the well being of married black women. Educated black women are not as happy as their peers with less education, particularly if their experience results in additional schooling not translating into higher income. Black women who work in service occupations (Riley & Keith, 2003) seem to be at a psychological disadvantage than full time housewives. The husband’s attitudes toward gender roles influence the behavior and adaptations of wives and their resultant well being. Furthermore, Jackson (2003) concludes that the amount
of money contributed to the household income reduces the rate of marital conflict between African American wives and their husbands. The work environment for both professional and non-professional employed black women is filled with experiences of discrimination, subtle or overt, which often deplete their self-confidence and spirit (Riley & Keith, 2003). Turner (1997) contends because racism and sexism are so closely intertwined black women often go through the mental gymnastics of deciding “which is it this time?”. There is a persistent process of mental gymnastics occurring on a daily basis wherein the woman is constantly decoding which type of discrimination lies behind which interaction, and then deciding whether or not to respond, how to respond to feeling overwhelmed by those strong feelings (p.166).

Lane et. al. (2004) argue that since 1996, the War on Drugs governmental policies targeting crack cocaine when coupled with the “three strikes you’re out” guidelines have resulted in a tripling of the African American male prison population and the doubling of female headed households. Simultaneously, the government has aggressively focused on the promotion of marriage among poor women even while social policy and violence have created a shortage of available men. This in turn has influenced absentee fathers, disjointed families, competition and adaptation among black women and limited economic self-sufficiency. Not surprisingly, lower socioeconomic status has been indicated to be a risk factor for depression and other affective disorder (Jackson, 2003).

Developmentally, black women have integrated traditional male roles of achievement, autonomy, and independence with the more traditional female caretaking and nurturing roles (Hill, 2002; Turner, 1997; Greene, 1994). Brown and Cochran (2003) note that for some Black women having multiple social roles may allow them to balance stresses and rewards among their various roles. Most notably, midlife and older African American women who are unmarried,
unemployed, and provide care for others may face economic hardship. In addition, these women are at particular risk for higher levels of depression (Brown & Cochran, 2003).

Black women’s identity and self-perception (Robinson, 2005; Brice, 2003; Jenkins, 2000; Hill, 2002; Black, 1999; Thomas; 1998; Watt, 1997; White, 1994) is intertwined with stereotypical images of their identity (Jones & Shorter-Gooden, 2003; Abullah, 1998; Shorter-Gooden, 1996), and biased designations of physical beauty including hair, skin color (Keith & Thompson, 2003; Banks, 2000; Ward, 2000) sexuality (Newman, 2000; Reid, 2000; Wyatt, 1997) and sexual orientation (Greene; 2000, 1994). Womanist theory explicitly merges race and gender for African-American women with a focus on racial consciousness and self-healing (Banks-Wallace, 2000).

Socializing Impact of Christianity

The multiple social roles that Black women undertake on behalf of personal, family, and community obligations are often not by choice (Brown & Cochran, 2003; Romero, 2000; hooks; 1993). Although feelings of competence and mastery can emerge, depleted energy, fatigue, and selflessness often result (Walker, 2004). It is partly from this constellation of variables, economic issues, societal racism, sexism and the Christian socialization of longsuffering that the archetype of the strong black woman emerges (Boyd-Franklin, 2004; Bryant, 1991). Limited attention has been paid to the relationship among slavery, Christianity, gender, identity, and the ways African-American women engage the world and make meaning out of their existence (Banks, 2000). Slavery informed the development of African American Christianity and provides a context for understanding contemporary manifestations of the Christian religion. (Coleman, 2002; Hunt, 2001; Johnson et. al, 2000; Ellison, 1993; Gilkes, 1998; Akbar, 1984).
The fundamental tenets of Christianity as practiced by Black women play a key role in behaviors, attitudes and beliefs about mental health (Conner, 2004; Coleman, 2002; Brome, 2000; Cook & Wiley, 2000; Dílìou, 1998). The Black church has always been in the vanguard of providing leadership in many dimensions of Black people’s lives (Boyd-Franklin, 2003; Gilkies, 1998; Lincoln & Mamiya, 1990). However, clergy training, educational achievement, and years in ministry and their combined impact on perceptions and beliefs concerning depression and treatment warrant further examination (Taylor, et. al, 2004, Wimberly, 1991). Women ministers have increased significantly in certain denominations of the black church. Gender similarity between clergy and parishioner regarding beliefs about depression and treatment are important to research (Cook & Wiley, 2000). Related to this issue is whether denominational affiliation impacts the beliefs held by African-American Christian women about depression and treatment. An examination of the potential role that structural influences have on individual beliefs has been researched (Boyd-Franklin, 2003; Taylor, 2000; Taylor et. al, 1999, Wimberly, 1991; Lincoln & Mamiya, 1990) but not in the understanding of depression.

Christianity in the Lived experience of African-Americans

Spirituality matters in the lives of African-American Christian women (Robinson & Braithwaite-Hall, 2005; Taylor et. al, 2004). Spirituality and its force in promoting healing (Liebert, 1996; Wimberly, 1991) lends direct and positive benefits. These include: creating personal understanding and a sense of interconnectedness (Washington, 2001), decreasing isolation (Snorton, 1996), reducing stress and anxiety (Simon, 2007), promoting release of guilt and forgiveness (Brome et. al, 2000; Robinson, 2000), increasing self-esteem (Butts, 2001), supporting meaning making (Moon, 2002), providing a guide for decision making (Brown et. al, 2001), giving place and sense of agency in the world (Bryant, 1991), facilitating the ability to
manage ambiguity (Black, 1999), building inner strength and lessening pathologys (Singleton, 2003) providing a mechanism for reframing present challenges (Black, 1999), and promoting dreams and aspirations (Lincoln & Chatters, 2003; El-Khoury et. al, 2004, Swinton, 2001). These benefits are significant in that they are a direct act of pushing back against the significant psychic, emotional, economic and physical forces of oppression and marginalization.

The manner in which identity development and cultural dynamics inform spirituality are important for the understanding of Christianity in the lives of African-Americans. The historical context of the Black religious tradition from African indigenous religious practices to its maintenance through the enslavement experience provides insight into how spirit has been a sustaining force for people of African descent (Cook & Wiley, 2000; Lincoln & Mamiya, 1990). The transformation of Christianity into a Black cultural phenomenon has created a socialized reality that is unique and distinct (Richardson & June, 1997). The Black church has been/is an avenue for the political, the artistic, the musical, the academic and the economic (Reid, 2003; Cook, 2000). It serves as an instrument for skill development and for the integration of different socio economic classes (Lincoln & Mamiya, 1990). As an entity, it provides a therapeutic context for belonging and identity formation for many (McRae et al. 1999). Simultaneously, there are structural dynamics that mirror the limiting and oppressive constructs of the larger white society. These can include gender stratification, hierarchical structures of power, economic and psychological exploitation (Boyd-Franklin, 2003).

Even with these persisting structural dynamics, the power of the Black church continues to sustain and empower especially as it supports the process of making meaning out of life and provides a potent counter to the struggle with marginalization and white supremacy. In terms of affiliations of African-American religious, the following outlines the major Christian
denominations: Baptists, African Methodist Episcopal, United Methodists, Nondenominational, Church of God in Christ, Seventh Day Adventist, Pentecostal Assemblies, Catholics, and Jehovah’s Witnesses (Boyd-Franklin, 2003).

_Spirituality and Therapy_

Christianity is expressed in storefront churches, the Mega Church, television broadcasts, self-help books, retreats, churches based on specific ministry personalities, private homes, and increasingly in workplace organized groups. African-American expression of Christianity (Coleman, 2002) is often evidenced through prayer, meditation, attending worship services, music, fasting, dress, structured ritual participation, Bible study class, reading the Bible, healing experiences of the body and emotions, being caught up in the spirit, testifying, and titles and methods of reference to one another, such as brother and sister. (Cook & Wiley, 2000) There are often structural and ritualistic expressions that inform the identity and spiritual development of the individual. These have important implications for therapeutic work.

Governing tenets, structural realities, and behavioral mandates of religious sects combine to create an environment where acceptance of others outside of one’s specific group creates tension, hatred, superiority and oppression if a power stance is used (Kass & Lenox, 2005). As a result of this history, there has developed a belief that spiritual matters are a private issue best kept in the context of religious practice or private lives (Spilka et al., 2003, Jones, 1994). The politically guided separation of the secular from the spiritual or religious perpetuates discomfort with spirituality in non-spiritual contexts (Suess et. al, 2002; Peterson, 2002; Helminiak, 2001; Cook, 2000; Pargament, 1997).

African-American Christianity can be strength in the lives of people, serving as a coping mechanism, stress reducer, sense of belonging, cultural affirmation, and connection with a
Supreme Being. When spirituality becomes an obstacle, it is often when used to occupy time, maintain an external appearance of religiosity, increase lack of tolerance of others’ beliefs, limit critical thinking, abuse power and position, and perpetuates patriarchy and gender stratified roles (Taylor et. al, 2004). Clearly, clinicians’ understanding of their clients’ spirituality and how it is manifested through organizational affiliations is a component of multicultural competence (Hodge, 2002; El-Khoury et. al, 2004; Queener, 2001). In addition, clinicians need knowledge of when spirituality becomes a problem in clients’ lives (Robinson & Braithwaite-Hall, 2005; Boyd-Franklin, 2003; Swinton, 2001; Wimberly, 1991) and the comfort and skill to explore this challenge with the client.

Many African-American women manage to mask their internal pain (Beauboeuf-Latontant, 2007; Schreiber et. al, 2000), yet it manifests in high blood pressure, exhaustion, and depression (Singleton, 2003). For these women the challenge of legitimizing their suffering comports with the notion of the longsuffering Christian (Carlson, 1988). For many black women, internal distress is a sign that something is out of balance and not an indication that psychological support is needed (Surgeon General, 2001). Hence the indigenous community healer becomes the first line of outreach, namely ministers, pastors, spirit guides, prayer warriors, family and friends (Constantine et al., 2004).

Spirituality can be utilized to treat various emotional and psychological problems (Conner, 2004; Brown et. al, 2001, Brome, 2001; Butts, 2001; Constantine et. al, 2000; Robinson-Wood & Braithwaite-Hall, 2005). Therapists’ biases and discomfort warrant consideration (Sharanske & Perry, 2005; Sullivan, 1998). They can either support the healing of Christian clients or minimize and discount the central role that faith has in people’s lives (Sharanske & Perry, 2005; Queener et. al, 2001, Robinson, 2000; Sullivan, 1998).
Various treatment modalities that incorporate spirituality have proven to be effective with African-Americans (Meinert, et. al, 2003; Walker, 2002; Moore et. al, 2000; Brome, 2000). Some of these modalities include but are not limited to spiritual/religious history, spiritual genograms (Hodge, 2001) and timelines, utilizing rituals (Moore & Skeete, 2000) in the therapy or suggesting rituals as an intervention tool for the client. Stage theory has suggested that the level of spiritual development of the client is best served if the clinician is also at that level or higher. This in turn assists in the clinician’s capacity to interpret the particular stage for and with the client. Spiritually integrated interventions have been successful when working with inner-city youth (Cook, 2000, Pearce et al. 2003), substance abusers (Washington, 2001, Brome, 2000, Potts, 1991), AIDS grief work (Moore& Skeete, 2000), domestic abuse survivors (El-Khoury et al., 2004) and incest survivors (Robinson, 2000).

**Research Gaps**

There is limited empirical research that examines the role of religious beliefs among African American Christian women who experience depression and choose to seek treatment outside of the religious community. The role of the black church as a significant social, emotional and economic and support base assists in understanding the centrality that the black Christian church has played in the socialized and present experience for African Americans (Lincoln & Chatters, 2003). The minister and his or her presence in the lives of the parishioners is significant as a gatekeeper and a means of support outside of the church context (Taylor et al., 2004; Cook & Wiley, 2000; Wimberly, 1991).

African Americans and their utilization of organized helping institutions (e.g. hospitals, schools, mental health entities) reflects a history of distrust, oppression and lack of racial and cultural knowledge that has impacted full participation within these systems (Hodge, 2002;
Constantine et al., 2001, Surgeon General Supplement, 2001; Black, 1999). African American Christian women’s perceptions of and experiences with barriers to accessing care, inclusive of clinician’s training and competence needs to be explored to further understand mental health concerns among this understudied group (Caldwell, 2003; Williams & Williams, 2002; Alvidrez, 1999; Sue, 1992).

Statement of the Problem

Despite advances that have been made to address the need for culturally relevant mental health models, there is limited understanding of the interaction of Christianity and depression in African American women. Persistent cultural and religious messages of long suffering and strength through adversity may factor into this lack of engagement with external mental health services.

African American Christian women’s beliefs in depression as a specific ailment similar to high blood pressure or diabetes remains under researched in the psychological literature (Keith, 2003; Banks-Wallace, 2000). The psycho-social history of racism and gender oppression when coupled with a personal belief that with prayer and Jesus all things work together for the good (Cook & Wiley, 2000) decreases the likelihood that a black Christian woman would seek out treatment for depression, something that she does not believe to be real (Simon, 2007). Prayer has been relied on as a primary source of coping with and remedy for life challenges (Conner, 2004; Long Cudjoe, 2004; Hackney & Sanders, 2003; Hunt & Hunt, 2001; Brome, et al., 2000; Cook & Wiley, 2000; Chatters et al., 1999; Ellison, 1993; Wimberly, 1991; Bryant, 1991).

Help seeking behaviors among African Americans is often framed in the rates of their usage of mental health services (Taylor et al, 2004; Caldwell, 2003; Taylor et al., 1999). However, it is unclear what creates the distinction between a person naming their distress or
malady as being the result of a mood disorder or originating from spiritual sources. This difference would necessitate the need for a mental health clinician as compared to a spiritual guide (Gazmarian, et al., 1995). Additionally, it is unclear how an individual would know about the availability of treatment modalities if she has not been involved in the traditional mental health delivery system (LaRoche & Turner, 2002; Surgeon General Supplemental Report, 2001).

**Potential Benefits of the Study**

The potential benefit of this study is to better understand beliefs about depression and treatment in a sample of African-American Christian women in the Boston area. Women will be surveyed from an African Methodist Episcopal, Baptist and non-denominational church. In-depth interviews with the senior pastors of these three churches will be conducted. African-American Christian women’s knowledge of the availability and suitability of therapeutic treatment outside of the church context is an understudied area of psychology. It has implications for the intersections of gender, race, and spirituality in the identification and treatment of depression. It will better inform whether the centrality of prayer is as significant the literature indicates. The research will identify variables that influence mental health service utilization in addition to prayer. This may help in de-stigmatizing and enhancing sensitivity to spirituality/faith in multicultural therapeutic environments.

Participation in the research will expose the women and the clergy to the symptomatology, progression and treatment modalities for depression. It may challenge some women to recognize and acknowledge that they or their loved ones may be living with some form of depression. Pastors may discover that there are limitations in their training, and resultant skill set in appropriately counseling women with depression. The clergy may also more intentionally explore the scriptural foundations of Christianity and its teachings about depression.
The women and pastors will have updated listings of local and national resources dealing with depression and mental health.

Knowledge of the lived experience of African-American Christian women can inform the training of clergy, counselors, academics and providers. More than 87% of African-Americans populate the urban areas (U.S Census, 2000) where there is an increased need for support services to mitigate the damaging effects of population density, poverty, limited employment and education (National Urban League, 2007). The majority of African-Americans are Christians who may no longer practice within a faith system but have been socialized in Christian ethics, values, and belief systems. In simpler terms, an understudied yet important segment of the population’s voice would be heard and better understood.

There is limited outreach from the counseling profession to the religious/spiritual communities (Queener et al., 2001). Given the history of racism and cultural exploitation, there exists a persistent distrust of the established white institutions and their lack of competence in dealing with issues pertaining to communities of color (Taylor et al., 2000). The lack of clinicians of color in the counseling profession also impacts the human capacity needed to lessen the sensitivity towards spirituality in multicultural therapeutic environments (Constantine et al., 2004).

This study could further expand models of spiritual development that incorporates multiculturalism with African American women’s responses to depression. Counselor education programs need to better integrate spirituality into the curriculum and make the explicit connections between therapy and spirituality. Robinson-Wood and Braithwaite-Hall (2005) assert that there are important commonalities between spirituality and therapy that include the use of a scared healing space, narrative discourse, and a focus on personal reflection, growth and
awareness. These areas of convergence point a path for the future for continued research and professional practice in spirituality and mental health.

The practical basis of this work stems from the fact that depression and other forms of mental illness exist among human beings. African-American Christian women are not immune from the emotional, psychological dysfunction and distress that emanate from a White male dominated society where oppression and marginalization are persistent. This reality when added to genetic predispositions, environmental factors, higher rates of poverty among Blacks and traumatic life events contribute to distress and cases of physical and mental illness. African-American Christian women need therapists who are aware, competent and conversant in the particular concerns that their faith brings to the psychotherapeutic relationship.

Research Questions and Hypothesis

Research Question 1: What is the prevalence of depression among African American Christian women?

Hypothesis One: There will be a low prevalence of depression in a sample of African American Christian women.

Research Question 2: What is the relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women?

Hypothesis Two: There will be a positive relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women.

Research Question 3: What is the relationship among psychological resistance, conservative Christian views and African-American Christian women’s beliefs about the existence and origins of depression?
**Hypothesis Three:** There will be a positive relationship among psychological resistance, conservative Christianity, and beliefs about the existence and origins of depression in African-American Christian women.

**Research Question 4:** What are the mental health treatment types that African-American Christian women believe treat depression?

**Hypothesis Four:** There will be a variety of mental health treatment types that a sample of African-American Christian women believes treat depression.

**Operational Definitions**

The variables are defined as follows:

_African American Christian_ – an individual whose belief in Jesus Christ is rooted in the traditions of the descendants of Africa. Individuals believe that Jesus is the son of God, there is life after death and that a moral code of living comes from the Bible the word of God. The expression of this spirituality is manifested in a way of adapting to life challenges with a persistent drive toward liberation and wholeness. (Cook & Wiley, 2000; Richardson & June, 1997).

_Beliefs_ - often derived from schemas are cognitive structures that serve as a basis for screening, categorizing, and interpreting experiences. They can be negative or positive based on how the individual manifests them in their cognitive and behavioral responses.

_Depression_ - a disorder of mood characterized by sadness and loss of pleasure and interest in usually satisfying activities, a negative view of the self, hopelessness, passivity from poor
concentration, indecisiveness, anger, irritability, suicidal intentions, appetite changes, weight loss, sleep disturbances, fatigue, headaches, and other physical symptoms. Causes range from chemical imbalance in the brain, family history/genetics, stress or trauma, loss, substance abuse, physical conditions, and negative attitude. Depression creates a disruption in the natural processes that create balance. This is manifested in distress that can impact cognitive, emotional, behavioral, physical, and spiritual dimensions of the individual. In addition, depression has culturally adaptive presentations.

*Treatment* – interventions aimed at the remediation and/or alleviation of cognitive, emotional and behavioral problems. The goals are 1) to increase adaptive functioning, 2) enhance learning, and 3) teach and promote the use of preventative strategies as appropriate.

*Womanist* - derived form Alice Walker’s (1983) perspective that the experiences of black women are significantly different from those of white women so that a term other than feminism is needed. The word womanist is considered to be more reflective of both language and ideals of the Black community. Womanist ideology/theology not only proceeds from the context of the suffering and experiences of African American women’s experience, but also brings together the issues of race, sex, and class. The dimension of class is particularly informative since most Black women have been poor. The womanist uses a coping style that includes “expecting the worst”, finding sustenance in the presence of God, “sparing others” from her pain, and deriving a sense of empowerment from the African American church’s affirmation of woman’s strength (Snorton, 1990). This style emerges in response to a culture that both praises and criticizes the African-American woman for her strength.
Chapter Summary and Review

Chapter one presented the statement of the problem. The background of the problem was divided into three sections- 1) psychosocial influences of depression, 2) the socializing role of Christianity, and 3) the lived experience of Christianity. The potential benefits of the research were detailed. The chapter concluded with the research questions, hypothesis and operational definitions.

To capture the essence and synergy of spirituality in the lives of African people, Mary McCloud Bethune’s words close this chapter.

*Herein dwells the still voice to which my spiritual self is attuned. I find also, that I am equally sensitive to any outside obstructions that would mar this harmony or destroy this fortress. Therefore, as I come face to face with tremendous problems and issues, I am geared immediately to these spiritual vibrations and they never fail me. The response is satisfying, though the demand may call for greater courage and sacrifice. This power of faith which is my spiritual strength is so intimately a part of my mental and emotional life that I find integration and harmony ever present within me…and my happiness within is a fortress against doubt and fear and uncertainty* (Wade-Gayles, 1995, p.294)

Chapter 2 provides a review of literature related to beliefs held by African-American Christian women about depression and treatment.
Chapter Two

Review of the Literature

Introduction

Distinctions between spirituality and religion are discussed and beliefs linked to Christianity are reviewed. Exploratory pathways provide an exploration of African American Christian women’s beliefs about depression and treatment. They guide the presentation of the literature review and are identified as African worldview, the tenets of the Black church, spirituality and well being, psychological health of African American women as well as ecological variables, gender, and mental health. Finally, the theoretical frameworks of this study, multicultural psychology and constructivism end this chapter.

Spirituality and Religion

Distinctions and Commonalities

Standard definitions for spirituality and religion do not exist. Spirituality is an inner well spring of energy having the capacity to sustain our active participation in the whole and ever evolving human and ecological systems (Chatters et al., 1994). This perspective points to the universality of this experience and its connection to all things. According to Potts’ (1991), spirituality is a belief that a sacred force exists in all things. Ingersoll (1995) described seven dimensions of spirituality: 1) one’s conception of the divine or force greater than oneself, 2) one’s sense of meaning or what is beautiful, worthwhile, 3) one’s relationship with Divinity and other beings, 4) one’s tolerance or negative capacity for mystery, 5) peak and ordinary experiences engaged to enhance spirituality (may include religious rituals or spiritual disciplines), 6) spirituality as play or the giving of oneself, and 7) spirituality as the systematic force that acts to integrate all dimensions of one’s life.
In research conducted on spirituality with African-American women who were recovering addicts Mattis (2000) urged sensitivity and caution when working with this topic. She cautioned researchers to measure spirituality in terms of: 1) the extent to which individuals believe in a transcendent dimension of life; 2) the relational aspect of spirituality -self, others, God, spirits; 3) the extent to which individuals attempt to discern and live in accordance with the will of God or a Higher Power and; 4) the extent to which individuals have internalized beliefs and values that are demonstrative of the active presence of the divine in the life of the individual.

Religion is a hierarchical structure that allows for the practice of one’s connection to a Higher Power. It is often governed with explicit rules and tenets. There is typically a method of socialization that involves processes, beliefs, habits, attitudes, conduct and values. Religion may encompass the supernatural, the non-natural, atheism, deism, finite and nonfinite deities and practices, beliefs and behaviors that defy definition and circumscription (Spilka et al, 2003). For some it is the means through which spirituality can be discovered. It is possible to self define as being a spiritual person and not a religious person. There has been ongoing research in the connection between religion and well being (Pargament 1997; Ellison & George 1994; Idler 1987). Pargament (1997) posits important consequences of this connection of religion and well being. These include 1) religion provides a sense of comfort in times of trouble; 2) the integrative aspect of religion gives access to a large network of potential support providers; 3) religious norms discourage behaviors that might lead to health problems; and 4) religious beliefs furnish a cognitive framework through which people can better understand the meaning of pain, and suffering.

There are important distinctions in the meaning making process inherent in the construction and expression of religion (Park, 2005). The distinctions include global meaning and meaning
making. “The global meaning systems are usually unwittingly, acquired from the surrounding culture (including parents, media, and other cultural agents) and through accumulated personal experiences. Regardless of their awareness of global meaning, however, it exerts powerful influences on people’s thoughts actions, and feelings, and gets translated into their daily lives through interpretations (the ways that they understand daily occurrences as well as major life events) strivings or personal projects (smaller, more concrete goals that people pursue on a daily basis, derived from their longer term, more abstract higher order goals), and a sense of well being and life satisfaction” (p.298). The meaning interpretation process gets amended, challenged or expanded during times of crisis or life altering circumstances (Taylor, Chatters & Levin, 2004; Park, 2005; Pargament; 1997). What typically unfolds is the belief that the sacred is seen actualizing its will in particular life scenarios, then what was once perceived as random, nonsensical and tragic is changed into something else: an opportunity to appreciate life more fully, a chance to be with God, a challenge to help others grow, or a loving act meant to prevent something worse from happening (Pargament, 1997; p.223). This process underscores the ways that depression often gets re-interpreted for African American Christians.

Beliefs of Christianity

The foundational beliefs of Christianity are that Jesus Christ is the son of God, was born of the Virgin Mary, suffered death on the cross in redemption for our sins and was resurrected on the third day. The scripture declares that God so loved the world that he gave his only begotten son that who so ever believeth in him shall have everlasting life (John 3:16, KJV). Through the acceptance of Jesus into one’s heart and life the believer is afforded the promise of eternal life
The trinity is defined as God the Father, God the son and God the Holy Spirit (Long Cudjoe, 2004). The Bible is the record of God’s word, laws and commands. The only way to salvation is confession of one’s sinful nature and the asking of the saving grace of Jesus to enter into one’s heart (Wimberly, 1991). Believers are asked to invoke the indwelling of the Holy Spirit which is the Comforter that enters into the being of the individual. The Holy Spirit is the ongoing presence of the living God that guides and directs thoughts, beliefs, and behaviors and intervenes on behalf of the “child of God” (Long Cudjoe, 2004). Significant to Christian faith is a theodicy that emphasizes evil and sin. The core beliefs in Christian theology are mankind’s fall from grace and the promise of redemption. The fall from grace is connected to the original sin of the original man. This aspect of Christianity becomes operationalized as the method to explain why bad things happen. Hence the presence of sin explains the state of bad things in the world (Richards, 2005; Lewis, 2004, Musick, 2000).

African American Christians will often explain life’s challenges as God’s will being made manifest or more simplistically as the consequence of sin or sinful behavior. Evangelical Christianity is a distinct culture within Christianity of which African-Americans and the poor are significantly represented (Hodge, 2003). These individuals manifest a Christianity that encompasses vibrant worship, Biblical teachings, and a mandate to spread the gospel and convert others to Christianity. These are groups that have traditionally been denied access to power. Without understanding the behavioral norms, Biblical imperatives and power structure, personal bias will interfere with effective service delivery (Belaire & Scott Young, 2002; Bassett et. al, 1981).

Carlson (1998) suggests that there is a pervasive myth within the Christian faith that Christians should not have emotional problems. He contends that many believers may not only
deny their problems but are also intolerant of those that have emotional difficulties. The emotional–health gospel assumes that if you have repented of your sins, prayed correctly, and spent time reading and studying God’s Word, you will have a sound mind free of emotional problems. Hence emotional problems are re-defined as character problems of which the remedy is further sanctification. Carlson further stresses that spirit filled Christians are often ashamed of their inability to conquer their internal maladies and typically find little solace in preachers providing healing (using touch through the hands as believers receive healing for various conditions through God’s power) for a specific disease without any public acknowledgment of the progressively debilitating course of chronic depression. Bad theology, poor scriptural knowledge and limited exposure to the ameliorating effects of counseling and psychopharmacology, mis-guided notions about the origins of mental illness all combine to influence this pervasive mindset within many Christian believers. This dynamic when combined with historical mistrust of a perceived insensitive mental health community, further exacerbates the problem and leaves persons suffering through their depression in silence.

After examination of the psychological literature Kass and Lenox (2005) delineated five key conceptualizations that unfold during the spiritual maturation process. Though this is a generic process, its tenets hold true for the Christian development process. These include: 1) maturation and conceptual processes that shape religious meaning – cognitive learning, moral decision making and ego formation. 2) Adherence to a moral and behavioral framework that contributes to social justice and individual well being. Here the focus on the role of moral and behavioral codes within the individual gets reinforced by the larger community of adherents. 3) The maturation of God’s representation. The work of spiritual growth manifests in the ways that the individual represents God and makes meanings and interpretations from that imagery.
Culture, socialization and individual experiences impact the representations from being distorted or caring and benevolent. 4) The capacity for core religious experience underscores the growth of the individual to have an awareness of God that has been internalized. These core religious experiences emanate from: a) a distinct event and a cognitive appraisal of that event, which results in personal conviction of God’s existence; and; b) the perception of a highly internalized relationship between God and the person. Contemplative practices aid in the depth of these core experiences. 5) Participation in developmental challenges of the human cycle as vehicles for spiritual growth. Essentially, the individual matures through life experiences both developmentally and spiritually as he/she reacts, responds and adapts to the internal and external challenges (Kass & Lennox, 2005).

Oser and Gmunder (1991) as cited in Kass and Lenox (2005) posit that in early developmental stages, individual’s see God as the sole cause of their problems. Later they replace God’s agency with their own. Finally, they develop interdependent explanations, affirming personal agency while recognizing interdependence with God and other people. (p.187). There are limitations in applying this process to African American Christians. Though logical in its explanation, many African American Christians may have evolved to develop interdependent explanations for their problems, but perhaps as a result of larger socio-cultural dynamics and their individual particulars, never fully release that sense of God’s supreme agency in their lives. Thus, it becomes easier to release the problem’s origin to God rather than to assume responsibility for his/her role in the development and persistence of the problem.

**Exploratory Pathways**

*African Worldview*

In his groundbreaking text Afrocentricity (1988) Molefi Asante asserts that there is a
three tiered process for examining an African-centered world view. They are the existence of an African Cultural System, the juxtaposition of African and American ways and finally the values derived from the African-American experience. There are countless subsets of tribal groups and ethnic affiliations that would fall into the definition of Africa [an]. For the purposes of this exploration it is important that this word convey a region and a collective of people. The distinctions between different regions could offer some qualitative distinctions but in general, it is the history, development, contributions and unique way of doing and being that emanate from the African continent.

An African-centered world-view places the centrality of Africa and its descendents in the Diaspora at the core of a value driven method and system of living, learning and developing. The collective is at the core of this belief system (Manning et. al, 2004; Thompson & McRae, 2004; Boyd-Franklin, 2003; Cook & Wiley, 2000; Asante, 1988). This means that the individual does not take precedence over the collective. Connected to this collective is the power of the spirit as being a real and tangible part of the individual. As a result, spiritual engagement is neither strange, an aberration to the norm, or indicative of an unstable person, when viewed through the concept of African-centeredness. This view values a connection with nature as opposed to a control over things natural. The European worldview rewards control and domination and creates an inherent alienation from spiritual and moral development. In the African worldview the expectation of doing for the community or the collective is foundational.

The pursuit of individual goals is expected and often at the expense of the collective, in contemporary society. The African world-view believes that individuals are creations of God. There is acknowledgement and reverence for the divine. This divine power then imbues the individual with gifts, talents and abilities which are to be used ultimately for the good of the collective (Akbar, 1984). In the utilization and perfecting of these gifts and imbued talents, there
is an expectation that one will be living a moral life that is in line with intellectual, physical development. Morality and justness are emblematic of a human being, and not an indication of something that one becomes. African centeredness (Carruthers, 1984), challenges the individual in the collective to strive for balance and live a life that in essence is holistic, not one that separates and pathologizes, but instead regenerates and renews in body, mind and spirit. Anthropologists and genetic experts have unequivocally determined that the original man and women are African. Remains of early man, predecessors of homo sapiens were found in the Ethiopian region of Africa dating back nine to twelve million years old. The oldest fossilized form of a human outside of Africa was found in Java and found to be 500,000 years old. Even with these scientific facts and historical study of ancient African civilizations, white supremacy and global domination and oppression has been fundamental to the development and expansion of Western civilization. Christianity has been a significant part of this expansion that has impacted the African in America.

African worldview is central to understanding African identity and engagement in the world (Myers, 1988; Akbar, 1984). An exploration of the African worldview evolves into the examination of the enslavement period in America and its legacy in the establishment of the Black Church. The tenets and belief systems of Christianity emerged from an African ethos and psyche. The impact of the Black Church cannot be minimized as a central socializing force for Black people in America, irrespective of individual religious beliefs. Most persons of African descent have been socialized in some aspect of the black church by virtue of generational influences and kinship networks. Participation in mainstream and/or evangelical sects of Christianity may influence a woman’s beliefs regarding depression and treatment.
African-American Christian Church- Origins & Contemporary Practices

MAAFA or black holocaust was unprecedented in the history of the world (Asante, 1988). Over the span of 400 years, millions of Africans were taken and enslaved many with the complicit assistance of other Africans. This tearing apart of kinship, tribal and language groups has been reproduced in the experience of the lived African experience in America. The death of millions of African people whose bones lie somewhere on the bottom of the Atlantic Ocean are testament to the communal spirit of African people. Family lines were broken and interrupted. The tortured and defiant spirits of the ones who leapt to their physical death provide insight into the power of resiliency and resistance. European Americans used the objectification of Africans as the means through which they perpetrated this evil and abhorrent system of inhumanity. European Americans elevated their personhood as the moral and physical ideal and relegated Africans to property, abuse, and violence. In essence they had to create a distorted mental apparatus to maintain such inhumanity (Akbar, 1984). The moral and religious authority was available and used as a resource and justification for the perpetuation of this genocide. Much of the moral authority emanated from the Christian church.

The Black Church is a distinct form and expression of Christianity and exists as a historical, social, economic, political, and psychological force (Taylor et. al, 2004; Boyd Franklin, 2003; Chatters, 1999; Lincoln & Mamiya, 1990). It was birthed from the enslaved African’s adaptation of the slave master’s religion. In the mid 1600’s the European church attempted to Christianize enslaved Africans in an attempt to “save their souls”. Christianity was used for social control, to produce obedient and docile slaves (Lincoln & Mamiya, 1990). However, an adaptation process unfolded through which an invisible church emerged where persons met in secret for singing, preaching, storytelling, and praying (Coleman, 2002; Cook &
As a result, African spirituality became a tangible process through which community was maintained, liberation fostered, and oppression mediated. Jesus became an identified figure of freedom and liberation because of his persecution, suffering and resurrection (Cross, 2003). This promise of resurrection gave hope, power and a reason to preserve through all things (Lincoln & Mamiya, 1990).

Several of the prominent arguments surrounding the roots of African-American Christianity are espoused by Vaughn (1997). These include the belief that Africans were stripped of their culture through the process of enslavement, whereas others assert that African customs were adapted into the slave masters rituals such as the infusion of emotionality and the call and response. Naming Africans with “Christian” names also created an external mechanism through which internal adaptation occurred over time. Given that slave owners profited from work groups that functioned effectively, Sobel as cited in Vaughn (1997) details the significance that this provided in that like tribal groups became the norm through which plantation planter groups prospered. Therefore, it was possible for the strong cultural identity of these Africans to be preserved such that they could be infused with the introduction of Christianity. Christianity became the benchmark of the enslavement and acculturation process for Africans in America. Coleman (2002) details the similarities between the vibrancy of African-American worship service and its foundation in the West African Yoruba tradition. This research confirms the belief in the African roots that remained even after the indoctrination into the white European religion of Christianity. Similarities include the processional, shouting, dancing, being caught up in the spirit (an experience being connected to God’s presence through strong emotion’s and altered states of consciousness) and the recessional and benediction.
The impacts of slavery on Southern agrarian life on the contemporary patterns of black religiosity in comparison to white Americans are explored by Hunt and Hunt (2001). The semi-involuntary thesis indicates that segregation especially in the rural South has historically: 1) constrained the religious practices of African-Americans to segregated churches, 2) isolated them from broader public institutions, 3) increased their reliance on religious institutions and practices, and 4) made their church participation patterns particularly reflective of broader community pressures.

A comparative analysis was done of data taken from the General Social Surveys between 1974 and 1994. The sample consisted of 18,995 respondents, of whom 86% (16,315) were white and 14% (2,680) were black. The data was divided into distinct sub regions of the country. The results indicated that African-Americans continued to show higher levels of religiosity compared to whites nationwide as evidenced in higher overall church attendance, church affiliation and activity membership. Additionally, findings illustrated that African-Americans have higher religious involvement in the urban South and markedly lower involvement in the urban North. The authors expand on the multiple implications for the African-American community where the role of church culture, identity, status from church affiliation and access to resources is crucial for advancement and empowerment especially in poor environments that need the role models and skills that middle class African-Americans provide. The black middle class have an important impact on the psychological and economic development of low income blacks.

Different denominations and religious groups are represented in African American communities (Boyd-Franklin, 2003). These include Baptist, African Methodist Episcopal, Jehovah’s Witness, Church of God in Christ, Seventh Day Adventist, Pentecostal churches, Apostolic churches, Presbyterian, Lutheran, Episcopal, Roman Catholic, Nation of Islam and
other Islamic sects. Additionally, there are traditional African religions whose tenets and beliefs are often affiliated with their tribal groups. Baptist and African Methodist Episcopal represent the largest proportion of members. Denominational affiliation though present, does not have as abiding impact in the expression of Christianity. Many African Americans have remained in congregations within which they were raised. Further, “membership in an independent African American church or in an predominantly African American mainline Protestant, Catholic, or Pentecostal church may be a haven from the bicultural existence with which African Americans must cope in the larger society” (Cook & Wiley, 2000, p.376). At times distinct and conservative practices that relate to drinking, smoking, praying, public behavior, dress codes, and dancing may cause conflict among children, adolescents and family members who may experience these practices as too constricting and old fashioned (Boyd-Franklin, 2003).

In addition to denominational affiliation, there are other important factors that guide the understanding of the contemporary African American church. (Boyd-Franklin, 2003; Wimberly, 1991). The Black family is the primary unit of the church. Women represent the largest segment of the church body (Taylor, Chatters & Levin, 2004; Cook & Wiley, 2000; Lincoln & Mamiya 1991). Typically men are in leadership positions and women are in supportive roles. Among the lower socio-economic classes, teenage black males are often socialized by their male role models to view too much church involvement as a sign of weakness or an absence of machismo (Lincoln & Mamiya, 1991; p.305). The absence of a larger presence of black men in church are influenced by a convergence of sociopolitical factors such as rates of homicides, military service, incarceration, educational drop outs, unemployment, drug addiction and homelessness (Urban League, 2007; Cross, 2003; Jackson, 2003; Hill, 2002; U.S. Department of Health and Human Services, 2000; Williams & Williams-Morris, 2000, Dittus et. al, 1997).
Congregations that adhere to stricter Biblical interpretation may be governed in a hierarchical fashion where male leadership mirrors the scriptural imperative that God ordained that men be the head of the church and in their homes (Jackson, 2006; Young et. al. 2003; Cook & Wiley, 2000). Toward that end, the pastor, typically but not always male, exerts great influence over the lives of the congregants and the larger community. These individuals are the first line of contact for parishioner life challenges, family disputes, social needs, financial concerns, medical crises and spiritual difficulties. (Cook & Wiley, 2000). Boyd-Franklin (2004) notes that African-Americans have traditionally sought out pastors for counseling due to both their sacred revered position of the person and the long standing mistrust and stigma associated with mental health treatment entities. African American pastors are very direct in their relationships with their congregants. As a result, individuals may expect professional therapists to conduct themselves in a similar style (Wimberly, 1991). In a survey of 99 pastors (Young, Griffith, & Williams, 2003), two fifths identified the presence of individuals whom they considered dangerous to others. Sixty-eight could identify a mental health facility or mental health professional that they would feel comfortable making a referral. However only a quarter reported having made a referral to a social worker, emergency department, or public health agency. Close to half of the pastors agreed that people with severe anxiety or depression can cure themselves if they “put their mind to it”. Among the causes of mental illness listed were stresses of living (90%), unhealthy early family relationships (85%), absence of a “right relationship with God” (72%), and biological reasons (60%). Sixty percent indicated that stunted spiritual growth or un-confessed sin were causative factors.

Many Christian denominations have been historically suspicious of counseling because of their organizing belief that “all you need is Jesus”. This belief expects that the power of faith and
belief in the Lord is enough to solve all of an individual’s problems. The increase in seminary training of pastors and the entrance of women into ministry who previously had careers in mental health fields has begun to change this dynamic (Cook & Wiley, 2000). Mainline Protestant and Catholic denominations tend to be most open to counseling because of the influence of larger white denominations. The Church of God in Christ and mainline Pentecostal and Holiness churches tend to hold the most conservative attitudes towards counseling (Cook and Wiley, 2000).

The most creative forms of ministry in black communities are being carried out by a better educated clergy at the large urban churches (Lincoln & Mamiya, 1990). Further the researchers observe that the Black Church is the only institution where one out of every four or five practitioners has graduated from professional school. As a result, increasing levels of education among black people will need to be met by their intellectual peers in the ministry even as the church contends with the needs of the unchurched and the poor. The research does not indicate whether or not the Northern or the Southern churches have a more educated congregation. One could assume that the preponderance of many colleges and universities in the Boston area would increase the likelihood that there would be educated congregations in that region. These research findings suggest that there are subtle shifts that have been taking place within some Black churches as a result of societal advancement of African American women. It appears that the adherence to strict interpretation of Biblical mandates may not provide for the creativity and expansion of ministry work that addresses the mental health needs of parishioners. Though the literature cites the role of the pastor as key, it remains vague whether generational issues, age, type of college training may influence the distrust that some ministers have towards external community health organizations.
In addition, the contemporary African-American church also can engage racial liberation through multiple mechanisms. These can include the worship service, social action initiatives and political affiliations. Some churches create their own schools as a direct response to the anti-religious and Western focused ideals of many secular institutions. Congregations that have an explicit connection to their African roots may participate in traditions such as adorning the Church with African art, displaying depictions of Jesus as a black man, dressing in African clothing, and preaching liberating messages that decry racism and white supremacy. (Cook & Wiley, 2000). The neo-Pentecostal movement that began in the mid-80’s (Lincoln & Mamiya, 1990) has continued to flourish into the 21st century (Emmanuel Gospel Center Research, 2006). This movement characterized by worship with elements connected to Pentecostal churches (e.g., speaking in tongues, presence of the Holy Spirit, prophetic ministries) has been most evident in the African Methodist Episcopal denomination (Long Cudjoe, 2004).

Taylor, Chatters, & Levin (2004) extensively detail the far reaching impacts of religion in the lives of African-Americans. Data from the National Survey of Black Americans (Taylor & Chatters, 1986a, 1986b, 1988) investigated issues of church based social support networks on the social, psychological and physical health of African Americans. Some important findings highlight that: women pray 85% more than men, prayer is a regular form of spiritual expression, prayer serves as a coping activity and can be used to mask problems, ministers are often the first point of outreach contact for personal and familial problems, church members provide social support and can create difficulties when there are negative interactions, regular church attendance and activities can serve as a mediator for depressive symptoms and can have a positive impact on physical health. Their findings again affirm the centrality of prayer in the lives of African Americans. It is unclear when prayer is perceived as being a part of a coping
strategy and not the coping strategy. Granted each individual is unique, but it may be possible to better understand the variables that influence the progression of prayer as a masking strategy to one that promotes outreach for added support. These researchers are unique in the explicit focus on religion in the lives of Black people. The depth of their work had been instrumental in the expansion of this area of inquiry. They are sociologists and not in the psychological arena.

African American Church and Community Collaboration

Liberation movements that had origins from the Black Church context include the underground railroad, abolitionists, back to Africa, arts renaissance, historically black college formation, civil rights movement, housing integration, armed forces integration, educational desegregation, and economic empowerment (Lincoln & Mamiya, 1990). The social service and social provider role of the church has been instrumental for the educational, economic, and civic advancement of many African-Americans. At times this community support role has been separate and at times in collaboration with local, state and federal entities. There are difficulties that can emerge from these collaborations. For example, Charitable Choice is a faith-based federally sponsored initiative aimed at the utilization of the religious community to provide a wide array of social service programs (Kennedy & Bielefeld, 2002). There exists in these types of programs great confusion for public managers, state coordinators, and local municipalities ranging from the definition of “faith-based” to what constitutes a religion. African-American pastors in urban areas have voiced concerns about hiring credentialed staff, and meeting the mandates of the program while maintaining their unique Christian mission. Given that class and race are integrally woven into these congregations, the requisite monitoring and evaluation practices take on heightened significance. Linkages between colleges and churches have been limited yet provide interesting possibilities for enhancing academic knowledge, documenting
best practices and meeting the particular needs of the Black community. Project DIRECT was a federally funded community-based health initiative at the education and prevention of diabetes (Reid et. al, 2003). Participatory leadership, goal development, community involvement were interwoven with the master’s level training program so that practitioners in training would have real practical application of course material. The outcomes provided for culturally appropriate and relevant programs aimed at the reduction and prevention of a chronic disease impacting the African-American community. This program also highlights the importance of skill development and enhancement as the Black church actively engagement complicated social and community health problems.

Weaver et, al. (2003) note the significance of clergy as frontline mental health workers. Data cited from the U.S. Department of Labor data from 1998 indicate that some 300,000 Protestant pastors, 49,000 Catholic priests and 4,000 Rabbis consistently devote 15% of their working time to pastoral counseling. This totals approximately 138 million hours of counseling annually, a volume that is equivalent to each of the approximately 100,000 members of the American Psychological Association delivering 26.5 hours per week. In an extensive review of twenty years of professional literature on the collaboration between clergy and mental health professionals, the authors detailed the following significant findings: the need for greater collaboration with African-American clergy, heightened needs for older adults, the uneasy relationship between psychology and religion, limited training in mental health programs, and lack of personal religious affiliation for mental health workers. This last finding corroborates the research examining Christians who hesitate to seek mental health counseling because of the belief their spiritually will not be an active part of the process and that the clinician will be neutral if not resistant to the topic because of its lack of importance in his/her own lives (Belaire
& Scott Young, 2002). The previously cited study of Young, Griffith & Williams (2003) indicates more is needed beyond community collaboration with African American clergy. Many need skill enhancement to better understand the symptoms, course and treatment of mental illness.

Social and Psychological Health

The third pathway focuses on the social, psychological, and physical health of African-American women. The social and psychological health of Black women is a persistent process of survival and adaptation within a dominant culture that affirms neither their race nor gender. As a result, African-American women have utilized a variety of strategies to mediate the ongoing assaults of marginalization and oppression. The overlay of socio-economic influences informs the impact, success and longevity of these strategies. Yet, the primary coping strategy used by many African American women is spirituality and religious connection. Though beneficial in many ways, the literature also indicates that there can be negative outcomes associated with spirituality and religious connection as the primary coping tool.

Beliefs about healing are important for understanding the significant role faith plays in the lives of Black Christian women. In an survey that examined spiritual practices and beliefs related to healing, findings revealed that respondents who were female, African-American, Evangelical, poor, sicker and less educated believe that God acts through physicians to cure illness and that God’s will is the most important factor in recovery (Mansfield, Mitchell & King, 2002). Results affirmed that religious faith in healing is prevalent and strong in the southern United States and that there is a strong belief that God acts through doctors. Based on the underutilization and mistrust of psychiatrists and psychotropic medication (Jackson, 2006), this research confirms the persistent bias and stigma surrounding mental health issues. The shame of
stigmatization limits the capacity for African-Americans to seek out resources and in turn works on the managing the presenting concerns alone, through faith, family and friends (Boyd-Franklin, 2004).

African-Americans turn to emergency room staff and primary health first in their response to emotional distress. The difficulty lies in the capacity for medical professionals, especially primary care physicians to assess symptoms for depression that are more culturally specific than the DSM-IV specified listing (Meinart et. al, 200303). This belief in God acting through doctors gets diminished when emotional and psychological health issues are the present. Spirituality as a dynamic buffer in the lives of Black women was detailed in the work of Mattis (2000). She notes that spiritual life and secular life are interwoven into the lives of African-American women. This is noteworthy because women may not share this interwoven reality with mental health professionals because it is so fundamental to the way that they engage and live in the world. Similarly, clinicians may not explore this aspect of the client if there are not evident markers of spirituality like significant church attendance or involvements. The importance of maintaining connectedness mitigates against poor health. Black women are more vulnerable to physiological and psychological deterioration because they are continually exposed to external stressors such as racism and sexism, which can become internalized. The internalized stressors can have a deleterious impact of self-esteem, identity, perceptions of beauty, relationships, aspirations, social skills, negative cognition, and self-hatred (Jones et al, 2007; Jones & Shorter-Gooden, 2003; Banks, 2000; Edmondson Bell& Nkomo, 1998). As a result, their spiritual beliefs may have also become internalized to counteract this vulnerability. Since internalized stress creates agitation, disrupts the immune system and produces stress related difficulties, then
religion provides a healthy coping strategy through which this dynamic can be managed if not altered (Taylor, 2004).

Levin and Chatters (1998) indicated that religious involvement has preventative and positive therapeutic effects on mental health outcomes. However, it was noted that when religion is used as a means to an end, such as emotional or social support or social status, it is negatively associated with mental health. In contrast, when religion is used as a guide for life, there is a positive association with mental health. In a study with women (n=1,236) Lincoln & Chatter (2003) examined the relationship between non-organizational religious involvement (i.e., private religious behaviors), stressful life events and psychological well being. Results indicated that life stressors experienced have detrimental consequences for the psychological well being of African-American women. In addition, African-American women who are more involved in non-organizational religious pursuits experience higher levels of psychological well being than women who are less involved. These pursuits such as Bible reading, prayer and meditation afforded the women to be active participants in the management of their life stressors. This research also confirms the positive benefits of spiritual practices that are not connected to an organized religious body, which at times can create additional challenges for some individuals who have difficulty adapting to the structure, hierarchy and explicit norms often present in organized religious systems.

African American women yearn for connection, and interconnection as a deliberate means of negotiating the challenges inherent in their marginalization (Beauboeuf-Lafontant, 2007; Walker, 2004; Turner, 2003; Jenkins, 2000; Wyatt, 1997). hooks (2002) shares that most women search for love hoping to find recognition of our own value. It may not be that we do not see ourselves as valuable; we simply do not trust our perceptions. In a description of the spiritual
process that emanates from this yearning for connection, Bryant (1991) explains that through prayer she can discover the best way to sister somebody. “I can sister a sister by walking with her while she’s struggling. I do not carry her. When she begins to require me to carry her; I recognize that she has not accepted responsibility for her gift. And the best thing I can do for the both of us is to let her go”…” a woman who has not married belief and behavior will remain unchanged. She will be quoting scripture, but she will be the same. She will be going to more church services, but she ain’t changed. Her interior world is still wrought with divisions” (p.133)

The literature indicates the presence of socializing processes taught often by the mother to the daughter. The intent is to create a proactive response to the persistent devaluing messages and experiences of racism and sexism. This process called armoring is often systematic in the nurturance, socialization and raising of children (Bell & Nkomo, 1998). Through case narratives of women from families of support and nurturance, and families of struggle and stress the researcher’s detailed specific distinctions in the ways armoring was presented and validated. In this study, women raised in families of support and nurturance were from two parents, solidly middle class family systems that also included siblings, grandparents, and extended family members. Their narrative analysis indicated two aspects of armoring: 1) being responsible and 2) developing courage. The analysis of their narratives revealed the two key components of armoring becoming self-reliant and being strong. Though armoring was revealed to be an adaptive psychological buffer that mitigates racism and sexism, it appears that socio-economic class is a salient factor in the process. The focus of this dynamic centered on creating adaptive responses to scarcity in meeting basic needs. This issue of being and staying strong becomes a persistent theme in the mental health of African-American women. Of note was the impact of economics on the narrative stories and the ways that being strong unfolded – either from a
position of strength in response to life or simply from a reactionary position that was further exacerbated with family instability and crisis. This armoring process asserts the agency of Black female identity and action. The qualitative focus of this research provides a distinctive process of extricating the lived reality of Black women’s lives and delineating the components of this psychological experience that gets operationalized through behavior and action. Moreover, these findings underscore the importance of utilizing multiple methods of inquiry to understand phenomenological realities in the lives of people of African descent (Quimby, 2006).

**Depression**

Lack of adequate and sufficient research on African Americans contributes to the problems of misdiagnosis, under-diagnosis, and under-treatment of depression in African American women (Carrington, 2006). Most of the mental health research on African-American women has focused on forms of psychological distress or mental health problems, which generally exhibit sub clinical symptoms that do not meet the DSM threshold or criteria for a diagnosis of mental disorder (Brown & Verna, 2003). Further, African American women have historically not been included in large controlled trials in sufficient numbers to generate data that are generalizable to larger populations of African American women (Carrington, 2006). Hence the presence of depressive symptoms is the most commonly used indicator of psychological distress. Research indicates that when compared to African-American men and Whites, African-American women are more likely to have high levels of depressive symptoms sufficiently high for a clinical diagnosis of depression (Jonas & Wilson 1997, Gazmararian et. al, 1995). In fact, the rate of depression in African American women is almost 50% higher than that of Caucasian women. Analysis of the National Comorbidity Study indicates that the most prevalent lifetime disorders among African-American women are major depression, and anxiety disorders- simple
phobia, agoraphobia, social phobia, and post traumatic stress disorder (Brown & Keith, 2003). In comparison to other groups, Black women have the highest twelve month and lifetime prevalence of simple agoraphobia, and PTSD (post traumatic stress disorder). With regard to PTSD rates, the exposure and witnessing of persistent neighborhood violence and unsafe environment presents a distinct course through which PTSD can evolve. In addition, African-American women have higher lifetime rates of MDD (major depressive disorder) than males, but lower rates then White women.

Black women living below the poverty level have the highest rate of depression for any racial/ethnic group (Women of Color Data Book, 2006). Clinically, depression is described as a mood disorder with a collection of symptoms persisting over a two-week period. These symptoms must not be the result of the direct effects of alcohol or drug abuse or other medication use. However, clinical depression may occur with these conditions as well as other emotional and physical disorders such as hormonal, blood pressure, kidney, or heart conditions (American Psychological Association, 1994). To be diagnosed with clinical depression, an African American woman must have either depressed mood or loss of interest or pleasure as well as four of the following: 1) depressed or irritable mood throughout the day (often everyday), 2) lack of pleasure in life activities, 3) significant (more than 5%) weight loss or gain over a month, 3) sleep disruptions (increased or decreased sleeping), 4) unusual, increased, agitated or decreased physical activity (often everyday), 5) daily fatigue or lack of energy, 6) daily feelings of worthlessness or guilt, 7) inability to concentrate or make decisions, 8) recurring thoughts or suicidal thoughts.

Depression manifests differently for many African-Americans when compared to the typical prescribed symptoms as outlined in the clinical manifestation listing in the DSM-IV.
Somaticization of mental and emotional distress is far more common in persons of color (LaRoche & Turner, 2002) and consistently manifested in African-Americans (Shorter-Gooden, 2003). Clarification of the role of cultural context in psychiatric diagnoses is critical to the diagnostic process and accurate diagnosis (Quimby, 2006). Screening of African American women for depression in an urban hospital indicated a comorbid presentation that included post traumatic disorder, substance abuse disorders, and generalized anxiety disorder (Lawson & Carrington, 2006). Depressive symptoms for African-American women may be demonstrated through ongoing busyness, devoted caring taking of others, limited self care, irritability, angry outbursts, and low-self-esteem that negatively impacts receptivity to help from others (Brown & Keith, 2003; Warren, 1994). Findings from the National Mental Health Association (NMHA, 1996) indicate a persistent lack of clarity regarding the symptoms, definitions, and progression of depression amongst African-Americans. More specifically, 63% of African-Americans believed that depression is a personal weakness. Roughly, 40% of the sample would not seek treatment because of denial, and 38% would not seek treatment because of shame or embarrassment. Only 30% of the respondents believed that depression was a health problem (NMHA, 1996).

Black women’s depression when studied from a culturally, racially and gendered strength discourse indicates that women silence their internal needs and drives (Beauboef-Lafontant, 2007). Given that white women are viewed as weak, then the opposing strong Black woman construction fosters a racial and cultural adaptation of being female. Through interviews with 44 Black women, the researcher distilled the potential relationship between constructions of strong Black womanhood and the experiences of silencing and selflessness on women’s experience with depression. The findings indicated that the presumed capability to persist through demonstrable struggle while maintaining a presentation of the self as unaffected by the human experiences of
fear, need, or fatigue often manifests in lack of self care, and the ignoring of actual emotional or physical conditions. A repeated refrain from the participants was that the women rarely saw the strong Black women in their families “fall apart” (p.39). Assistance was perceived as a sign of weakness with an association of a woman without struggle as being “white” or not really “black enough”. Additionally, the respondents described a separate self distinct from the external strong image that had limitations, vulnerabilities and needs. The process of “shifting” between environments and expectation leaves the Black woman lacking and confused about her authentic essential self (Jones & Shorter-Goodeen, 2003). The maintenance of this external wall was managed at times through prayer, shopping, eating, and drinking to excess. Beauboeuf-Lafontant (2007) indicated that sister circles have indeed been a consistent strategy for coping for Black women. However, if women cannot work through their shame of the need for validation, authentic sharing, and self-care, then these groups of family and friends may simply reinforce the persisting dynamic. Lastly, the researcher concludes that the strength discourse normalizes struggle, selflessness, internalization strategies that compromise the health of Black women.

Responses were similar for Black West Indian Canadian women who embraced being strong and suffering in silence as the norm and expectation of being a Black woman (Scheiber et. al, 2000). As a consequence, providers of healing and support for Black women must be cautious in the use of being strong as a healing mechanism among depressed Black women. “Embracing the same behaviors that occasioned the depressive episode would lead not to healing but to a “pseudo recovery” characterized by presenting an image of composure to others in an effort to keep things stable and familiar” (p.46). Similarly, the implications of this strength mindset factors into the therapeutic alliance. This pervasive Black female identified trait can get projected onto and impact therapy when the Black female client expects her African American
therapist to mirror and exemplify this ideal and does not (Romero, 2000). Saussy & Clarke (1996) examines the origins of depression in women’s repressed anger at the persistent expectation of care of everyone else at the expense of her needs and the silencing of her voice. Depressed persons are driven to please others. Consequently they lose touch with themselves, neglecting to listen to their own wishes and blaming themselves for their unhappiness and lack of fulfillment (p. 117).

There have been limited longitudinal studies examining Black women’s health. The Black Women’s Health Study (BWHS) is an unprecedented ongoing prospective ten year old cohort study designed to examine risk factors for major illnesses in African American women. The baseline questionnaire was mailed in 1995 to 59,000 black women. It is an NIH funded joint initiative between Boston University and Howard University Medical Schools. Noteworthy is the perspective on a wholistic view of women and the multiple variables that influence and maintain health. Findings have provided new insights into chronic health issues like high blood pressure, diabetes, lupus, nutrition and contraceptive use. Specifically their work on depression began with participants in the 2005 survey (73%) who were asked about religion and spirituality in their lives. Ninety-three percent report that religion or spirituality is involved in their coping. Ninety percent consider themselves to be moderately or very religious or spiritual. Eighty-nine percent of the respondents pray at least once a week and forty-five percent report that they attend church at least once a week. These results further demonstrate the salience of prayer and spirituality as the source of coping for Black women.

Additionally, the BWHS has reported (Williams, et. al, 2004) that the Centers for Epidemiologic Studies Depression Scale, a 20-item instrument (CES-D) Scale was found to be a reliable measure for use with African-American women (coefficient alpha=.741). The CES-D
measures four types of depressive symptoms (depressed mood, somatic complaints, interpersonal difficulties, and absence of positive experience). Results from a survey of 40,403 women ages 22-74 indicated that compared to older women, younger African American (60 and younger) may have difficulty distinguishing between emotional and physical distress when reporting depressive symptoms. Scores on the CES-D differed by age, educational attainment, marital status and occupation. Women with less than a high school education had higher mean scores, while women with schooling beyond college had the lowest scores. Lower depression scores were noted among women who were married and among those working in professional or managerial positions. The results regarding occupation type and depression risk contradict others research that indicates depression being higher for women in service and professional occupations (Jackson, 2003). The finding of women younger than 60 having difficulty distinguishing between emotional and physical distress raises the issue of somaticization of depressive symptoms. Older women may have simply learned to interpret their distress differently than their younger counterparts. A narrative study of elder poor Black women indicated that their reliance on spirituality was the major way that they made it through significant life challenges (Black, 1999). These older women may also attribute their physical distress to the process of aging and maturation.

One of the few studies to examine the familial context in the etiology of depression was investigated in the work of Constantine (2006). The research explored to what extent does parental attachment mediate the relationship between perceived family conflict and depression in a sample of 283 African American female adolescents. Findings revealed that there was a direct effect of perceived family conflict on depression, and the relationship between perceived family conflict and depression was partially mediated by parental attachment. As a consequence
perceived family conflict predicts depression partially through its indirect effects on parental attachment. Constantine highlights the importance of examining the socio-emotional experiences of African American female children and adolescents and its impact on attachment development. She notes that “the cultural values of many African-American adolescents (e.g., communalism, interpersonal harmony, respect to elders, etc.) could mute the expression of overt family conflict in many African American families and could play a role in overriding mainstream American developmental conceptualizations of adolescents’ development of autonomy and independence from their families” (p.700). Previous research has been cited detailing the process of armoring (Edmondson Bell & Nkomo, 1998) in the socialization of Black children; girls in particular. It is likely that the level of parental attachment and conflict may interfere with the armoring process that becomes part of the psychological resources for Black children.

Additional research exploring gender differences in early risk factors for adolescent depression was studied by Lyons et. al, (2006). The sample was 85 low income African American and Latino kindergarten through fourth grade students (35 boys and 50 girls). This study tested the Nolen-Hoeksema and Girgus (1994) model that proposed that risk factors for depression are more common in girls than boys in childhood. Specifically, the following three risk factors are more prevalent in girls than boys before adolescent. These are negative 1) attributional style, 2) poor body image and 3) identification with a stereotypically feminine gender role. Measures were used that assessed depression, attributional style, sex role orientation, body self image, and stressful life events. Results indicated that there were no sex differences in rates of depression for school age as well as no sex difference in stress for school-age children in this study. Findings failing to support the model were that girls reported a more
positive attributional style than boys. Also, identification with a feminine gender role was not associated with other problems such as poor body image, but instead was linked with positive attributional style. Several conclusions were proposed for the findings. Of note, was that a poorer body image and a stronger feminine gender role identification, but not a negative attributional style, can predispose girls them for depression in adolescence. As a result these predisposing factors may be latent in childhood because the stress of adolescence has not yet interacted with them to engender depression.

Ward (1996) asserts that African American girls may have a broader concept of femininity that is more in line with the African American cultural premium placed on women’s competence, resourcefulness, versatility, and connection to family and community. Further, Ward notes that “in communities that face racism, an important aspect of socialization is learning when to attribute lack of success to personal responsibility and when to attribute it to social forces (e.g., racism), thus helping children to avoid blaming themselves for victimization” (p.653). Hence the study supported elements of the Nolen-Hoeksema and Girgus’s (1994) diathesis stress model by pointing out the existence of some early risk factors for girls among low-income, primarily African American urban children. The socialization of young black girls includes the understanding that it is important that they rely upon themselves as they learn how to take care of others (hooks, 1981). Boyd-Franklin (2003) reiterates the importance of understanding the context of the cultural adage “that black families raise their daughters and love their sons”. This distinction does not mean that black families do not love their daughters but rather try to compensate for the intense discrimination against black males in society by trying to protect them within the family.
Depression within the context of spiritual care is discussed in the work of Liebert (1996) and Saussy & Clarke (1996). Liebert (1996) contends that the issue of women’s spiritual care must be set within the context of women within a particular culture and time. She notes that “the consequences of treating women as if they were merely appendages of men rather than persons in their own right are amply chronicled in women’s tendency toward silence, invisibility, passivity, inability to trust their own experience and authority, feelings of low self-esteem, depression, and alienation from church and society” (p.259). Further, the authors assert that depressed women are done a disservice when their depression is treated from a purely intra-psychic perspective while ignoring the overarching system that breeds and perpetuates a power differential in which women never “catch up” no matter how their situation improves. This focused attention on the dynamics of how gender informs power and position in relation to the African American Christian experience. The evolution of the organized church emanated from a place of racial oppression, with the focus on the issues germane to the whole Black community (Walker, 2002; Gilkes, 1998; Lincoln & Mamiya, 1990). This partly explains the lack of attention paid to the emotional and psychological health of Black Christian women.

Acculturation and its connection to depression in women of African descent was explored in a study (n=9,151) conducted in California by Miranda et. al, (2005). The differences in the prevalence of depression, somatization, drug and alcohol use in disadvantaged young black women from the US, the Caribbean and Africa were compared. Most women in the study were young, with 95% of the sample younger than 43. Compared to US born black women, the immigrant women were slightly older, had more children, were better educated, more likely to be married, to be uninsured, to live in their own apartment or home, but less likely to be employed full time. Rates of somatization were similar across the three groups. Immigrant status did relate
to likelihood of major depression even after controlling for other demographic factors. It appeared that rates of probable depression are related to the length of time in the U.S. for immigrants. The researchers postulate that this difference may be related to differential exposure to risk and protective factors. As a result depression rates increase with time spent in the U.S because growing up in the U.S. may expose women to chronic stressors. Therefore, better understanding the protective factors for immigrant’s mental health over time, as well as understanding how increased time in the U.S. may be related to increases in depression, could also provide important information about factors that could decrease the incidence of depression.

Service utilization factors significantly into the psychological health of African American women. Mays, Caldwell and Jackson (1996) indicated that when Black women perceived their problems to be severe, they sought professional mental health services. Black women in the 35-54 age range used mental health services more than any other age group, and women in the South were less likely to use private therapists than were women in other parts of the country. In addition, they noted that women who viewed themselves as “not at all religious” reported the most severe problems, and they tended to use community mental health centers more than any other type of professional service. These results are certainly consistent with previously presented research on the mediating effects of religion on psychological and health function.

There are important considerations that explain the rate and degree to which Black women utilize mental health services (Caldwell, 2003). These services included ministers, private therapists and community mental health centers. Though health insurance has historically been a barrier for service use, even women with insurance had low rates of service use (Jackson, 2006). The analysis indicated that women who used ministers as a mental health resource, had less income, were married, attended church more regularly, and viewed themselves as religious
In comparison, women with more financial resources tended to use private therapists. When examining the overlap between women who sought assistance from ministers and outpatient mental health services, the issue of whether ministers may be a barrier to seeking out mental health services surfaced. Many ministers may not be familiar with the referral process or the network of support that is available in the community (Queener, 2001; Taylor et. al, 2000).

The notion that “God will not give you more than you can handle” is a commonly held belief by many African-American women. While it affirms the power of the individual with God’s support to deal with life’s challenges, it implicitly minimizes the role that help seeking can play in the resolution of the issues at hand (Romero, 2000). African American pastors may lack adequate information or understanding of mental illness. In one study (Young et. al, 2003) 50% of 99 pastors surveyed believed that people with severe anxiety or depression can cure themselves if they “put their mind to it”. Further in this study middle aged woman, those with lower self-esteem, and those who were unmarried sought support from outpatient mental health services. These results highlight the role that ministers play as a first point of contact for many Black women who are experiencing psychological distress.

Treatment strategies for depressed African American women need to be based on a wholistic conceptualization. African American women’s psychological and physiological health cannot be separated from their ethnic and cultural values. As a result professionals providing treatment need to understand and incorporate appropriate cultural strengths and values in order to provide competent care. Boyd-Franklin (2003) notes that the grief and mourning period in the black tradition focuses greatly on the immediate experience of grief. There is great attention to the family from the church family with a focus on the funeral or home going service. “It is expected that after this brief period of mourning, family members are expected to “get on with
life”, “be strong”, and “wipe away the tears”. Further when this significant loss has occurred, family members are particularly vulnerable to depression, psychosomatic complaints and acting out or conduct disordered behavior in children and adolescents (p.137).

Primary care providers who routinely address the wide spectrum of women’s wellness are more likely to screen for and treat depression (Meinert et. al, 2003). However, Jackson (2006) contends that since somaticization is common for African Americans, if a doctor does not routinely screen for depressive symptoms an underlying diagnosis may be missed. In a study comparing self-perceived and professionally diagnosed physical and mental conditions in underserved populations, depression was the most frequently reported undiagnosed chronic condition (Bazargan-Hejazi, & Baker, 2005). African Americans, who were 50% of the study participants, were asked to report chronic medical conditions and whether or not physicians had diagnosed these conditions. The gap between reporting a diagnosis and having that diagnosis was greatest for depression. The actual therapy process needs to be understood (Singleton, 2003) so that the woman feels empowered and in control of this new undertaking, thereby minimizing shame and stigma (Boyd-Franklin, 2003; Caldwell, 2003; Jones & Shorter, 2003; Alvidrez, 1999; Helms, 1999). Taking a cultural assessment in conjunction with a history and physical supports this wholistic perspective. This assessment highlights what is important to this woman in her cultural, racial and ethnic background (Hodge, 2002). Exploring her attitudes about depression provides an opportunity for psycho-education by sharing information about the combination of factors that cause depression, particularly debunking the myth of personal weakness (Singleton, 2003) or the personal strength of the strong black woman (Schreiber et. al, 2000). Self-help groups like the national Black Women’s Health Imperative foster social and professional resources for its members (White, 1994). Advocacy and activism can be valuable
strategies to promote healing for women. These strategies deconstruct internalization of the larger societal context associated with depressive symptoms (West, 2002) and utilizes anger as an instructive medium for change (Saussy, 1996). Information regarding nutrition, light exposure, exercise, and relaxation modalities can be included. Individual and/or group therapy increases self-knowledge, enhances understanding of depression and self-esteem, and create appropriate alternatives to managing life stressor (Surgeon General Supplemental Report (2001).

African Americans prefer counseling over medication for depression. Even when the diagnosis of depression was clarified, African Americans were less likely to fill prescriptions and take anti-depressants (Jackson, 2006). The longstanding bias and racist practices associated with mental health treatment has created persistent mistrust of medication use (Keith, 2003; Surgeon General Supplemental Report, 2001). Psychopharmacology should include education in both the evaluation and treatment phases of intervention (Comas-Diaz, 1995). It is particularly essential to clarify how the use of home remedies and herbal supplementation may create medication interactions and dosage effectiveness. Further, there are differences in the absorption, metabolism, and excretion associated with gender differences. Women have a higher percentage of body fat, experience monthly hormonal changes, and have slower gastric emptying cycles that result in delays of medication reaching the small intestines where absorption occurs (Jackson, 2006). The stigma of mental illness and the reliance on spirituality, and spiritual leaders further contribute to this dynamic (Young et. al, 2003). In addition, mis-diagnosis or under-diagnosis of psychiatric conditions has further exacerbated in this issue (Constantine et. al, 2004; Caldwell, 2003; Singleton, 2003; Boyd-Franklin, 2003; Comaz-Diaz, 1995, Gazmariian et. al, 1995).

Race and Gender Convergence
The convergence of race and gender development is best exemplified in the womanist framework. The civil rights movement and the feminist movement highlighted the persistent tension inherent in black women working toward racial and gender equality. The tension focused on two issues – a stress upon the continued need for racial unity in a white society and puzzlement as to why more black women had not joined the feminist movement. During the civil rights movement black women were often relegated to support roles while black men were in evident leadership positions. White racism, it is argued, produced a stereotyped emasculation of the black male, therefore black men should be supported in leadership positions (Lincoln & Mamiya, 1990; p.301). Womanist ideology is a product of the Black Nationalism inherent in black liberation theology focused on black feminist concerns. The term womanist is derived from Alice Walker’s perspective that the experiences of black women are significantly different from those of white women so that a term other than feminism is needed. The word womanist is considered to be more reflective of both language and ideals of the black community.

Womanist, from womanish, (Opp. of “girlish”, i.e., frivolous, irresponsible, not serious). A Black feminist or feminist of color. From the Black folk expression of mothers to female children, “Yous acting womanish,” i.e., like a woman. Usually referring to outrageous, audacious, courageous, or willful behavior. Wanting to know more or in greater depth than is considered “good” for one. Interest in doing grown-up things. Being grown up. Interchangeable with another black folk expression: “You trying to be grown.” Responsible. In charge. Serious. (Alice Walker, 1983; p.xi)

Womanist ideology/theology not only proceeds from the context of the suffering and experiences of African American women’s experience, but also brings together the issues of race, sex, and class. The dimension of class is particularly informative since most black
women have been poor. Snorton (1990) reframes the notion of the African American woman matriarch to that of the womanist, a more positive liberating image. The womanist uses a coping style that includes “expecting the worst”, finding sustenance in the presence of God, “sparing others” from her pain, and deriving a sense of empowerment from the African American church’s affirmation of woman’s strength. This style emerges in response to a culture that both praises and criticizes the African-American woman for her strength. Little research exists that identifies the use of the womanist framework in psycho-education or other therapeutic interventions.

**Resistance**

Robinson and Ward (1991) initially developed the theory of Resistance for Black adolescent girls. Suboptimal and optimal strategies were included. Optimal resistance is operationalized as optimal behaviors and attitudes that occur with greater frequency than suboptimal attitudes and behaviors. Suboptimal resistance is operationalized as behaviors and attitudes that occur with greater frequency than optimal behaviors and attitudes. One of its primary goals was to help Black women identify, name, and resist conditions that press down on their lives and contribute to feelings of being oppressed and depressed. Optimal or healthy resistance is linked to the seven principles of the Nguzo Saba, a Swahili term for “first fruit” (Pack-Brown, Whittington-Clark, & Parker, 1998).

In response to race riots, Dr. Malauna Karenga created Kwanzaa during the 1960s as a guide for African Americans to live by. Within the last three decades it has become more popular. Within African psychology, theorists have examined the ways African Americans cope and optimally resist living in a society that has historically valued male and white hegemonic notions of power. Myers’ (1988) Theory of Optimal Psychology is based on an
Afrocentric worldview. In communicating the basic assumptions of her theory, she makes a comparison between a sub-optimal and an optimal worldview (Myers et. al., 1991). The sub-optimal worldview is parallel to the separation of spirit and matter. Self-worth is based on external validation; peace is found outside of oneself and existence is based on what can be seen and measured. The optimal worldview parallels the Afrocentric value system which recognizes a connection between spirit and matter. Self-worth is placed on intrinsic value. In the optimal worldview, the “self ... is seen as multidimensional encompassing ancestors, those yet unborn, nature, and community” (p.56).

At the foundation of Myers' (1988) theory, is the individual search for self-knowledge. The motivation to search for self-knowledge is to live the set of conditions called optimal. The optimal conditions are a life “yielding peace, joy, harmony, and the increased well-being of the whole” (Myers et al., 1991). In Resistance theory, optimal resistance reflects an awareness of environmental stress and institutional oppression that press down on and depress Black women’s lives. The avoidance of negative and depressive thought patterns that directly impact behavior and emotional states is critical to optimal resistance. Optimal resistance is characterized by a reliance on multiple resources: psychotherapy, pharmacology, exercise, community and spiritual resources that may be in the service of preventing depressive symptomatology and/or effectively intervening.

While resistance theory does not purport that Black women who optimally resist will avoid depression, optimal resistance supports health and healing. Suboptimal resistance is associated with a disempowered state that is linked to a strong tendency to depression, feelings of inferiority, insecurity, less gratification, and more pain (Robinson & Kennington, 2002). Suboptimal or survival-oriented resistance refers to short-term dysfunctional cognitive
and behavioral adaptations to chronic stress and/or depression. Short-term adaptations do not serve women well in the long run although they tend to have immediate or short-term numbing, soothing, and/or pleasure inducing effects. See Figure 1 for a summary of optimal and suboptimal resistance.

**Figure 1 Suboptimal and Optimal Resistance**

<table>
<thead>
<tr>
<th>Suboptimal Resistance</th>
<th>Optimal Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation from others or inability to be alone</td>
<td>Umoja—Unity with others across race, gender, class, and age</td>
</tr>
<tr>
<td>Chronic feelings of irritability, worthlessness, pessimism about one’s life and future</td>
<td>Kujichagalia—Incorporation of a healthy identity</td>
</tr>
<tr>
<td>Excessive caregiving and responsibility to “fix” things</td>
<td>Ujima—Healthy reliance on self and others</td>
</tr>
<tr>
<td>Inability to ask for help, inability to say no to others’ requests</td>
<td>Ujaama—Sharing fiscal and human resources</td>
</tr>
<tr>
<td>Feeling like one is always under a black cloud. Chronic feelings of fatigue and “being tired”</td>
<td>Nia—Having a sense of purpose</td>
</tr>
<tr>
<td>Passive coping; Lack of insight into problem solving</td>
<td>Kuumba—Creating new and empowering ways of being in the world</td>
</tr>
<tr>
<td>A pervading sense that things are not going to change; a passive belief that God will take care of everything</td>
<td>Imani—Trust that life gets better and that the universe is benevolent</td>
</tr>
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</table>

**Social Issues**

The myth of the “strong Black woman” has its origins in the enslavement period. Abdullah (1998) contends that this Mammy stereotype endures in our contemporary life. The enslavement process required the black woman to disconnect form her fundamental self and in its place to elevate the sexual, psychological and physical needs of the slave master above her own. This image endured from slavery and beyond. This internalized concept of the self transferred across generations and through inter and intra group dynamics. This presentation of the selflessness of many black women factors into coping styles, mental health status and the
capacity to authentically clarify the needs of the Black woman. Romero (2000) posits that the SBW (Strong Black Woman), depending on how well she has developed coping skills may present as either inflexible and close-minded or as poised and competent. She may not understand why others see her as so together when internally she feels anxious and depressed. This idealized persona gets challenged, impacted and buffeted in the social roles that occupy her life.

Parenthood, marriage and employment are the most commonly examined social roles in the research literature (Brown & Cochran, 2003). Two theoretical frameworks guide the understanding of the impact of roles in women’s lives Hong & Seltzer, 1995 as cited in Brown & Cochran, 2003). The role enhancement hypothesis asserts that multiple social roles provide meaning and purpose for daily living. In contrast, the role strain hypothesis indicates that multiple roles cause overload or strain as a consequence of incompatible or a large quantity of role demands. Employment is consistently the most significant predictor of mental well being of women. The researchers investigated social roles in a sample of 547 African-American women, 55-64 years of age. Findings indicated that the African-American women who are engaged in more than one social role report better mental health in terms of fewer depressive symptoms. Of the five social roles examined (i.e., spouse or partner, employee, care provider, grandmother, and volunteer), the role associated with the least depressive symptoms for African-American women was employment. Women with no social role were those with the highest level of depressive symptoms. The authors contend that these women are likely to be socially isolated and have fewer sources of social support than women with at least one social role. Though these findings indicate employment as the role least associated with depression the research indicates the tremendous stressor that it occupies in the lives of Black women. Women in service positions as
well as those in professional jobs are at risk for depression (Jackson, 2003; Keith, 2003). Yet, economically, black teenage girls and older black women are one of the poorest groups of women in America. African-American women with the lowest incomes report the highest levels of depressive symptoms, (Gazmarian, James, & Lepowski 1991). The rates of self-reported depressive symptoms were similar for poor African-American and White women. However, African-American women of higher incomes had significantly more depressive symptoms than did White women with comparable incomes.

An examination of racism on everyday quality of life for Black women in a combined sample size of 812 women affirmed that racial discrimination is a part of the daily existence for African-American women (Brown et. al, 2003). Everyday types of discriminatory experiences were associated with higher levels of psychological distress among African-American women. Most of these experiences were based in the workplace. More routine experiences like verbal insults, poor service, and disrespect are distinct from major discriminatory acts like loss of employment due to race. When the incidences were prolonged and intense, participants reported increase in depressive symptoms. Those strategies and adaptive responses to discrimination that are most beneficial to the psychological health of African-American women remain unclear. Similar results were noted for a college-age sample (Jones et. al, 2007) which explored the impact of race-related stress, racial identity attitudes, and mental health in black women.

An inherent psychological challenge for Black women in employment is the experience and impact of racism and sexism. Garcia et al (1997) describe the profound anger that many African-Americans experience as a consequence of white racism. This anger can be manifested in many ways but rarely gets focused on the “white power structure”, the place from which the institutionalized obstacles emanate. As a consequence, that anger is often mis-directed and
manifests in lowered self-perception, tenuous interpersonal relationships, health problems and limited effective coping strategies. The desire for advancement and achievement is often intertwined with conflictual feelings such as the fear of the losing oneself, alienation from one’s history, blackness and linkage to family (Turner, 1997). As a consequence many women experience a dynamic called shifting (Jones & Shorter-Goode, 2003). This defines the ongoing internal, invisible process of rapid adaptation that black women use to negotiate worlds and relationships with white women, black men, and other segments of her community. The resultant impact over time, though clearly a survival mechanism, can wreak havoc on the woman’s sense of her authentic self. Black women’s identity development is integrated with the traditional male models of achievement, autonomy and independence and the more traditional female caretaking and nurturing roles as the norm.

Research on marital status and/or intimate partnerships on the psychological health of African-American women yield conflicting outcomes. The issue is best understood from a host interrelated factors. These include but are not limited to: mate selection, mate availability (Lane et. al, 2004), perceptions of beauty, gender expectations (Poran, 2002; hooks, 1993; Parker, 1995), stereotypes (Cole & Zucker, 2007; Greene, 2000; Banks, 2000; Abdullah, 1998), incarceration, the impact of incarceration on women and children (Keith & Thompson, 2003), the financial state of women prior to partnering, and the presence of abuse/domestic violence (West, 2002).

Greene (2000) notes that the meaning and reality of being an African-American who is lesbian or bisexual requires a careful exploration of the impact of ethnic identity, gender, lesbian sexual orientation, the intra-psychic dynamics and interactions with others. The nature of the traditional gender-role stereotypes within African-Americans, the role and importance of family
and community, and the role of religion and spirituality in the lives of African-Americans are also salient factors. (p.85). Many racial and ethnic groups call homosexuality a “white problem” and lesbians of color may face rejection or exclusion in their racial communities for engaging in a “white” form of sexuality (Greene, 1994). Hence, lesbians of color face triple jeopardy from the effects of racism, sexism, and heterocentric bias. Peplau, Cochran and Mays (1997) as cited in Tucker (2003) detailed the results of a study of 723 gay Black men and lesbian women. Results indicated that African-Americans were more likely to have a partner of another race. In addition, neither men nor women prioritized finances or attractiveness in the mate selection process. These results runs counter to the priorities that are often present in the initial selection process in heterosexual African American women (Lane et. al, 2004; Poran, 2002).

Health Issues

The Centers for Disease Control (2005) data indicates that in comparison to white women, African-American women more regularly are dealing with chronic health problems such as high blood pressure, diabetes, and heart disease. The Black Women’s Health Imperative notes the increasing rates of colorectal cancer in black women, along with the long standing chronic illnesses that are often perpetuated through generations of black women and their families. The diagnosis of new HIV cases finds the major group to be black women. A causative factor in these alarming numbers lies in the black communities’ discomfort with actively engaging sexuality discourse and information in homes, churches, and educational institutions. It also is indicative of the role that sexuality plays in the social communal identity of the black community. Given that these new cases emanate from heterosexual transmission, it is exemplar of the persistent homophobia and hidden shame/powerlessness and duplicity of black gay men. Though there are
strong religious/Christian morals that undergird the fabric of the black community there is a persistent role that sex (Newman, 2002; Greene, 2000; Wyatt, 1997) has been used as a way to mark inclusive. African American women are more likely to believe in chance for good health, or to depend on powerful others for their health (Barroso et al, 2000). As a result, this belief promotes passivity, lack of proactive health behaviors and the reliance on God and prayer to cope when bad things occur.

The Surgeon General Report of 2001 clearly indicates that there are striking disparities for minorities in mental health services. These disparities manifest in racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care, and when care is provided it more likely to be poor in quality (p.3) The cumulative impact of this dynamic is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity. Additionally, persons of color are overrepresented among this country’s high need groups such as homeless and incarcerated persons. These sub-groups have higher rates of mental disorders than do there persons in the larger community. The report further highlights the issues of access, cultural stigma; cost, clinician competence, and distrust of treatment are all part of the bigger picture impacting this public health problem. African-Americans have the lowest suicide rates of all groups. Their utilization of mental health services is persistently low. Typically, it is through the emergency room, their primary care providers.

A longitudinal study of black women and health where physical activity and the prevention of depression in were examined indicated that on average, inactive women had the most depressive symptoms (Wise et. al, 2006). Utilizing participants (ages 21 to 69) from the Black Women’s Health Study (n=35,224) the researchers noted that vigorous physical activity in
adulthood was inversely associated with depressive symptoms. The biggest decrease in the odds of depressive symptoms was observed among women who were active in both high school and adulthood. Women who were active in high school only or adulthood only still had significantly lower odds of depressive symptoms relative to women who were never active. Walking for exercise was not associated with risk of depressive symptoms overall, but there was evidence of a weak inverse association among obese women. Although obese women were less likely to be active in general, those who were active were more likely to engage in walking as opposed to vigorous physical activity. The findings conclude that the causal association of walking to fewer depressive symptoms in obese women may have important public health implications, because few obese individuals appear able to perform or sustain high levels of physical activity. Next were the group of women who had been inactive but who exercised now. Women who exercised when they were in high school and still exercised had the fewest depressive symptoms. The researchers concluded that even inactive women can reduce their risk of depression by taking a variety of exercise types (Wise et. al, 2006). Obesity is a serious health problem in the Black community. The findings are important for the development of community based strategies to deal with this chronic disease. Women need to be aware that movement will not only help lose weight and increase their help but it can promote better mental health in the process.

Spirituality, Health and Wellbeing

In the lives of African American women, spiritual life and secular life are not separated, but are intertwined in African American communities (Mattis, 2000). The individual’s need and realization of connectedness contributed to health. As a group, African American women are more vulnerable to physiological and psychological deterioration because they are
continually exposed to external stressors such as racism and sexism, which may become internalized. As a result, their spiritual beliefs may have become internalized to counteract this vulnerability. Internalized stress keeps the mind agitated, throws off balance, and disrupts immune system functioning and produces stress related disorders. Religious involvement such as religious attendance, private piety, and meditation may counteract the adverse effects of stress on feelings of self-esteem or mastery (Taylor et al, 2004). By establishing a relationship with God, a sense of unconditional acceptance and guidance by a higher force may develop in the individual, which in turn fosters peace and reduces stress.

Levin (2001) outlines seven key principles that are foundational to the understanding of theosomatic medicine, the ways that faith and belief systems impact the spirituality-healing connection. Principle one – religious affiliation and membership benefit health by promoting healthy behavior and lifestyle. Principle two – regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation. Principle three- participation in worship and prayer benefits health through the physiological effects of positive emotions. Principle four- religious beliefs benefit health by their similarity to health –promoting beliefs and personality styles. Principle five- simple faith benefits health by leading to thoughts of hope, optimism, and positive expectation. Principle six- mystical experiences benefit health by activating healing bio-energy or life force or altered state of consciousness. Principle seven- absent prayer for others is capable of healing by paranormal or by divine intervention.

These principles become important for understanding African-American Christian women’s beliefs about depression. The religious and often cultural commonalities that bring people together may be mutually beneficial, similar to the function of self-help groups. By sharing similar experiences and engaging in activities, individuals eventually talk about
difficulties, exchange ideas, or pray for each other which creates validation from the group. In turn the participants may not only be helping themselves but others as well through sharing and actively engaging in coping. Isolation that often escalates into more negative states such as depression and hopelessness is reduced (Taylor et al., 1999).

Findings from a study of 137 immigrants from 17 countries (Walsh, 1998) indicated that blood pressure was lower for immigrants that were affiliated with and attended church regularly. Walsh theorized that religious participation united adherents into a single moral community and may have been particularly useful for immigrants struggling to come to terms with the profound life stressors that accompany immigration. However as the acculturation process unfolds it appears that the protective factors of one’s cultural identity can become compromised as the stresses from living in a race/class conscious America becomes part of daily living (Miranda et al, 2004) Religious coping can be defined as the use of cognitive or behavioral techniques stemming from one’s religion or spirituality. Coping may include prayer, meditation, confession of one’s sins, and seeking comfort in God (Taylor, et al, 2004; 1999; Walsh, 1998. Prayer for African-Americans is the primary source of religious expression in the public or private setting (Taylor et, a., 2004). Spilka (2005) delineates the four forms of prayer forms as: colloquial, petitionary, ritual, and meditative. Petitionary prayer is the most widely used form. It is the prayer of the believer to God for whatever is needed. Intercessory prayer for self and others can be included in this category. Ritual prayer stresses the ceremonial quality of order and regularity in prayer pattern and content. Meditative prayer focuses on the desire for experiential communication with the deity.

Musick (2000) studied life satisfaction in a group of black (n=537) and white (1,215) persons, utilizing instruments that measured ubiquity of sin, church attendance, conservative
protestant denomination, stressors, and interpersonal distrust, and demographics. Blacks reported higher levels of ubiquity of sin, and church attendance, and are more likely to be affiliated with a conservative protestant denomination. Life satisfaction was positively associated with education, family income, and church attendance is negatively correlated with distrust and stressors. The differing results for whites included the association between ubiquity of sin and life satisfaction was negative and significant. Additionally, conservative Protestants tend to report higher levels of ubiquity of sin and lower levels of life satisfaction. In essence, these persons may perceive that they consistently fall short in their desire to live a sin free life. Given the preponderance of African-Americans in conservative Protestant denominations, this research provides additional corroboration for the role of exploring denominational affiliation and the salience of the ubiquity of sin for its adherents.

**Spirituality and Clinical Contexts**

African-Americans have an appreciation for and reliance on things spiritual in nature be it singularly expressed through Christianity (Richards & Bergen, 2004; Brome, 2000; Cook & Wiley, 2000; Black, 1999) or experienced through a more existential connection to the world without a theistic orientation (Richards, 2005; Sharanske & Sperry, 2005; Constantine, et, al., 2004). Therefore using spirituality in therapeutic intervention can be beneficial to the needs and issues of the client (Boyd-Franklin, 2003; Butts, 2001; Queener, 2001; Robinson, 2000; Constantine et. al, 2000. Walker (2002) who is an African-American pastoral counselor developed a model for pastoral counseling with African-American women. She posits that the there is a tendency for some African-American women to develop a divided, distorted and destructive sense of self. This stems from internalized images of the self or of God that distorted. Cook and Wiley (2000) note that depression; addiction and addictive behaviors, sexual abuse and
incest and homosexuality are clinical and social issues that therapists may commonly encounter in working with individuals from African American churches. The authors assert that though these issues are not more prevalent in the Black community, the religious context, spiritual traditions and beliefs influence the course, recognition and treatment of these concerns.

The private spiritual life when combined with the socialized religious background and the academic training of an individual clinician greatly influences his/her competence and comfort to with include spirituality within the counseling process (Hall, 2004; Moon, 2002; Helminiak, 2001; Miller, 1999; Ingersoll, 1994). Kahle & Robbins (2004) indicate that for many clinicians there is deep seated fear about being authentic on a topic due in large part to unresolved personal beliefs. As a result, they contend that clinicians become comfortable with the process of learned avoidance, since it is not actively taught in graduate school, evaluated in clinical settings, or an expectation of the client. The APA (2004) guidelines outline the ethical goals and aspirations for practicing clinicians. It extensively details the extant that cultural diversity and difference occupy in the culturally competent provision of mental health care. Spirituality and religion are a part of the large umbrella outlined in the codes. So, to not explore this domain does not honor the essence of the code.

Hathaway (2004) suggests that for persons who are Christians and psychologists it is possible to be faithful to ones Christian beliefs. The notion of “faithful comprehension” is proposed as a type of naturalistic epistemology where our models of knowledge have to follow from, or describe, our natural examples of knowledge formation. The author further asserts that Christian psychology is at best an interpretive vision that holds the spiritual in parallel to clinical judgment. He reasons that the Holy Spirit is an active person in the counseling process. This type of clinical process is hard for those who stand outside of the Christian belief system and find it
impossible to reason that something that cannot be externalized has validity and importance. Yet it provides an acknowledgement and legitimization to Christian psychologists who desire to not only provide excellent therapeutic work, but in so doing hold Jesus Christ as an active agent in the healing discourse and psychological process (Johnson, 1997). There exists a philosophical division between Christian psychologists. There are Christian clinicians who practice psychology using the Bible as their guide for treatment and problem resolution. They believe this work to be their vocational ministry as they contribute to the furthering of God’s kingdom on earth. Another perspective contends that all persons are God’s creation and as a result, whenever a member of God’s creation is supported to a place of healing and wholeness, then God is glorified regardless of the person’s belief in Christ (Johnson, 1997).

**Clinician Training in Spirituality and Multicultural Issues**

The continued subjugation and marginalization of persons of color in society occurs in therapeutic contexts. There has been a persistent disconnect and long protracted history of the empirical study of religion and spirituality in psychology (Ebaugh, 2001). The counseling profession is not immune from the deleterious effects of white supremacy, class elitism and clinician bias (Constantine et. al, 2007; Constantine et. al, 2000; Arredondo & Perez, 2003, Brown & Keith, 2003; LaRoche & Turner, 2002; Simoni et. al, 1999; Helms, 1999). Issues that are central to the lived experiences of persons of color are often positioned from the margins of the counseling profession. The active work of inclusivity of people of color and other marginalized groups has caused the counseling profession to expand models, practices, and competencies. People of African descent are intrinsically rooted in spirituality as a fundamental manifestation of their cultural identity and socialization (Conner & Eller, 2004; Wade-Gayles, 1995; Wimberly, 1991; Akbar, 1984). The expression may be different in respective groups, but
many Native Americans, Latinos, Asians, and African-Americans hold spirituality, religious beliefs and expression as significant in their lives. Given this reality, it is perplexing that clinicians and therapeutic environments that purport to value diversity do not as a regular course in their therapeutic practice offer or engage spirituality as a basic item that is integrated in the overall scheme of assessment, treatment planning and implementation. A part of this intrinsic sense of spiritual rootedness for persons of color is the manner in which spirituality is intertwined into the socialization and lived expression.

Many clinicians are poorly trained to competently infuse issues of spirituality into the therapeutic relationship (Robinson & Morris, 2000). Most counselor training programs have limited academic coursework that addresses these issues (Weaver et. al, 1998). Cashwell and Young (2002) found that 23 out of 94 Council for Accreditation of Counseling and Related Educational Programs (CACREP) surveyed offered a specific course on spirituality and religion in counseling. The Summit on Spirituality which occurred in 1995 outlined nine competencies that clinicians should master to effectively engage spirituality in therapy. 1). Explain the relationship between religion and spirituality, including similarities and differences. 2). Describe religious and spiritual beliefs and practices in a cultural context. 3). Engage in self-exploration of his/her religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of his/her belief system 4). Describe one’s religious and/or spiritual belief system and explain various models of religious/spiritual development across the lifespan 5). Demonstrate sensitivity to and acceptance of a variety of religious and/or spiritual expressions in the client’s communication 6). Identify the limits of one’s understanding of a client's spiritual expression, and demonstrate appropriate referral skills and general possible referral sources 7). Assess the relevance of the spiritual domains in the client’s therapeutic issues; be sensitive to and respectful
of the spiritual themes in the counseling process as benefits each client’s expressed preference 9). Use a client's spiritual beliefs in the pursuit of the client’s therapeutic goals as benefits the client’s expressed preference. (Cashwell & Young, 2002)

Out of those programs only competencies 1, 3, and 6 were the major focus of academic work. Therefore, one has to wonder how and through what mechanism clinicians are expected to develop comfort and capacity to engage this issue. Additionally, the personal bias and limited awareness can interfere with the clinician’s capacity to engage the client (Robinson-Wood & Braithwaite-Hall, 2005; Keith, 2003; Sullivan, 1998). If there are unresolved obstacles and painful experiences that the clinician has not processed he or she will not integrate spiritual themes into their therapeutic work (Tisdale et. al, 2003). It is impossible to bring someone to a place where you have not ventured. It is possible to explore the spiritual with clients (Hodge, 2002; Constantine et. al, 2000). This exploration must be rooted in a strength based perspective and not from an orientation of pathology. Personal disclosure can be extremely useful as an intentional technique for building rapport and trust with multicultural clients (Boyd-Franklin, 2003; Cook & Wiley, 2000; Helms, 1999).

Weaver et al., (1998) notes that between 1991 and 1994 in seven APA journals that there were less than 3% of quantitative studies that included a religious or spiritual variable. Additionally, whereas 95% of the general public expresses a belief in God, only 43% of APA members do. In addition the researchers indicate that psychologists indicate a lower level of religious involvement than do other groups of mental health professionals such as psychiatrists, social workers, or marriage and family therapists (Weaver et al., 1998). The integration of multicultural and social justice in clinical and research has underscored the significance of nine specific social justice competencies that Constantine et. al (2007) proposes as important for
counselors and psychologists to consider as they work with increasingly diverse populations in the United States.

Concomitantly, the bias in the psychological field to a Western empirically based notion of treatment persists. Things that are phenomenological in nature and derived from the qualitative sphere are still not as valued and legitimized in the profession (Hallsten, 1999; Neimeyer, 1998; Hoffman, 1990). Derived from the Western tradition of psychoanalysis, Freud was preoccupied with the question of religion and the psychological origins of God. He made a connection between the individual’s relation to the father and the elaboration of the idea of God. Freud called religion a cultural neurosis. All aspects of religious life were illusions, fulfillments of the oldest, strongest and most urgent wishes of mankind to have the illusion of safety amidst feelings of helplessness (Sorenson, 2004). Because spirituality is not easily quantifiable and fits into the phenomenological experience of individual’s, there has been a long standing bias targeting the legitimacy of these constructs. Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. This is at the core of the African-American engagement of the spiritual. It may be the inner small voice, a mystical experience, unexplained healing, and an unshakable faith in the divine (Wade-Gayles, p.3)

Theoretical Orientations

Multicultural Psychology

Multicultural psychology provides a context for understanding the racial, ethnic, and gendered experiences of African-American women (Robinson, 2005; Reynolds & Constantine, 2004; Helms, 1999) particularly its expansion into the arena of social justice. Constantine et. al, (2007) notes that social justice reflects a fundamental valuing of fairness and equity in resources,
rights, and treatment for marginalized individuals in society because of immigration, racial, ethnic, age, socioeconomic, religious heritage, physical ability or sexual orientation status groups.

Professional and academic psychology is embedded within a White European worldview. As a direct result of the sociopolitical forces of the 1970s, multicultural psychology sought to expand professional and academic psychology relative to initially people of color and eventually to women, people with disabilities, and sexual minorities (Constantine, et. al, 2007, Arredondo & Perez, 2003; Sue et. al, 1992). Multicultural counseling refers to five major cultural groups in the United States and its territories: African/Blacks, Asians, Caucasian/Europeans, Hispanic/Latinos and Native Americans or indigenous groups who have historically resided in the continental United States and its territories (Robinson & Morris, 2000).

Over several decades there has been a marked increase in the graduate education (Simoni et. al, 1999) and predoctoral programs that report requirements related to the study of racial and ethnic minority groups (Constantine & Gloria, 1999). Discrete competencies have been outlined and adopted by the professional counseling organizations- the Association for Multicultural Counseling and Development of the American Counseling Association and the American Psychological Association (APA, 2003; Arredondo & Perez, 2003). These competencies include: 1) counselor awareness of own assumptions, values, and biases; 2) understanding the worldview of the culturally different client; and 3) developing appropriate intervention strategies and techniques. In total these competencies encapsulate three dimensions of beliefs and attitudes, knowledge and skills.
Constructivism

Several tenets describe constructivism (Gergen 1985). Included is the way professionals’ study the world is determined by available concepts, categories, and methods. Many of the concepts and categories people use in scholarship and everyday life vary considerably in their meanings over time and across cultures. As a result, Constructivism emanates from a theoretical conceptualization known as postmodernism. Central to this overall framework is the inner reality of the individual in the context of a socially constructed reality. A defining tenet of postmodernism is the belief that knowledge is power and hidden concepts may exist in a theory or text that justifies the use of power (Simon, 1994). Power concepts may allow those who possess knowledge to devalue, subjugate, and otherwise victimize those who do not possess such knowledge. Further, postmodernists assert that all methods of studying reality and all claims of truth are merely socially constructed conventions and reflect the shared values of those utilizing those conventions. Descriptions and explanations of the world are themselves forms of social control and have consequences. Deconstruction or the analysis of the hidden element of power inherent in all organized systems supports individuals to make better choices about their actions. Power cannot be avoided, but increased awareness can reduce the chance of being abused by it (Anderson, 1997).

Constructivism explores the manner and process sees through which we make meaning out of our world. Given that discourse and narrative are essential in the multicultural framework, the connection to social construction and the formulation of beliefs and corresponding behaviors have a natural association. Reality as we know it is socially constructed through interactions with others. Hoffman (1990) notes that when we view our experience of the world and communications through the lens of “the map is territory,” we can imagine that perhaps our maps
are the basis of understanding our worlds, experiences, and communications with others. Yet, individual maps may not represent our experience or the world around us. The process of giving our maps a reality check usually involves conversation and comparing our experience with others. Social constructivism argues that a real world cannot be known with an objective certainty, but places the individual in a discursive interaction within the world of people. Therefore, one’s identity or self becomes created in an ongoing process, in ongoing discourse, with others, while at the same time the processes of observation/perception and meaning making are occurring (Neimeyer, et. al, 1998).

Race as a social construction has impacted individuals, families, communities and the practice of counseling (Pope-Davis & Liu, 1998). Constructivism assumes no sense of pathology and takes into account ecological variables that influence an individual’s life (Neimeyer, et, al, 1998) As a result, therapy takes on heightened importance as that individual hears and engages the client in her experience of telling her personal narrative, creating a pathway to emotional and psychological healing (Andersen, 1997; Lyddon, 1995). Hallstein, et. al. (1999) indicates that it is crucial that postmodern theories incorporate strong feminist ideals given the far reaching impacts of femininity and womanhood in society.

Chapter Summary

This chapter began with a presentation of the distinctions between spirituality and religion. It then reviewed the beliefs of Christianity. Exploratory pathways provided an exploration of African American Christian women’s beliefs about depression and treatment. These pathways guided the presentation of the literature review and are identified as African worldview, the Black church, spirituality and well being, psychological health of African
American women as well as ecological variables, gender, and mental health. Finally, the theoretical frameworks of this study multicultural psychology and constructivism ended the chapter.
Chapter Three
Methodology

Introduction

This chapter presents a detailed description of the methods and instrumentation used in this investigation. Psychometric properties are provided for each measure. It also includes a review of the sample, the research design, the data collection procedures, and data analysis used.

Participants

This study was approved by the Northeastern University Internal Review Board’s Office of Human Subject Protection. The research utilized a convenience sample of three predominantly Black churches in the Boston area (African Methodist Episcopal (AME), Baptist, and non-denominational). There were a total of 106 African American Christian women surveyed (African Methodist Episcopal = 43, Baptist = 23, and non-denominational = 40).

Research Design

The research used a descriptive quantitative design, utilizing surveys to investigate levels of Christian beliefs, the prevalence of depression, psychological resistance, and beliefs about depression and treatment for depression among African-American Christian women. The demographic data requested was as follows: age, place of birth, city of residence, ethnicity, social of family of origin – poor, low-income, middle-income, upper-income, number of people in the home, number of persons requiring dependent care, sexual orientation, marital status, years married/divorced/widowed, number of children, highest level of education completed, current occupation, annual income, number of years a Christian, frequency of church attendance, prayer and Bible reading frequency, number of years a member at current church, number of
activities/ministries currently involved, location of residence, living arrangements, place of birth of respondent, and place of respondent’s mother and father.

Instruments

The constructs being measured for this study are attitudes regarding depression and treatment, levels of conservative Christianity, psychological resistance, and depression.

Attitudes about depression and treatment

The Braithwaite-Hall Beliefs Inventory is a non-standardized measure that asked respondents to complete answers to questions that examine their experiences and attitudes about depression and treatment (medication, psychotherapy, nutritional counseling, exercise, meditation, group counseling, shock therapy, Bible reading, prayer, and fasting). There are several subscales in the BHBI. A BHBI subscale (items #8 and #12) examines beliefs about the existence and origins of depression. Another subscale (BHBI items #16 and #17) examines beliefs about treatment for depression. This information was developed by the researcher. See Appendix A.

Conservative Christianity

The Shepherd Scale developed by Bassett et. al, (1981) was derived from Biblical principles to measure conservative evangelical Christianity and to differentiate Christians from non-Christians. The scale is divided into a belief component that measures agreement with Christian doctrinal statements and a Christian walk component that measures Christian lifestyle characteristics. It was standardized on white adults over the age of 18 who were living in the mid-South and actively practicing Christians. It identifies high, moderate, and low levels of conservative Christianity. Bassett et, al (1981) had no set cut off for identification of low- high
levels. As a result, Belaire and Young (2002) utilized median scores to separate their respondents \( (n=100) \) into either a moderate or highly conservative group. There are 38 items based on a 4 point Likert-type scale, ranging from 1=not true, 2=generally not true, 3=generally true, and 4 = true. Examples include ‘I believe I have a personal presence of God in my life’ and ‘I believe that everyone’s life has been twisted by sin and the only remedy to this problem is Jesus Christ’. Scores range from 38 to 152 with higher scores conveying greater strength of evangelical orientation. Basset et. al (1981) reported a reliability coefficient of Cronbach’s alpha of (.86). Pecnik and Epperson (1985) reported a Cronbach’s alpha of (.94) for the instrument. Its construct validity has been shown by correlating it with other validated measures of religiosity, such as King and Hunt’s (1975) composite religious scales \( (r=.65) \) and Glock and Stark’s (1965) Dimensions of Religious Commitment \( (r=.41) \).

**Psychological Resistance**

The Robinson Resistance Modality Inventory (RRMI) assesses psychological resistance employed by Black women to counter racial discrimination. The measure was developed by Dr. Tracy Robinson-Wood. See Appendix B. Twenty questions (2, 3, 6, 8, 9, 11, 13, 15, 17, 19, 21, 23, 25, 26, 28, 31, 32, 35, 36, 40) reflect suboptimal resistance when answered with high scores: (3) I agree with this statement, or (4) I strongly agree with this statement). Optimal resistance is reflected when a respondent answers any of these questions with: (1) I strongly disagree with this statement, or (2) I disagree with this statement. The range for this scale is 20-80. The mean suboptimal resistance score in preliminary studies with 72 Black women was 39.30, standard deviation was 7.6. The alpha coefficient was (.75).
Twenty questions (1, 4, 5, 7, 10, 12, 14, 16, 18, 20, 22, 24, 27, 29, 30, 33, 34, 37, 38, and 39) reflect optimal resistance when answered with high scores: (3) I agree with this statement, (4) I strongly agree with this statement. Suboptimal resistance is reflected by low scores (1) I strongly disagree with this statement, (2) I disagree with this statement. The range for this scale is 20-80. The mean optimal resistance score in preliminary studies with 72 Black women was 64.5, standard deviation of 7.97, alpha (.72).

The initial sample for the Robinson Resistance Modality Inventory (RRMI) was 72 Black women ages 18-25 recruited from the greater Boston area. The majority of the sample was attending a private, urban-situated University in Boston, Massachusetts. Black women were defined as women of African descent who were native to the United States, biracial/multiracial women of African ancestry who identify as Black, and women of African ancestry who identify as Black and were born outside of the United States, such as in Haiti, other parts of the Caribbean, and the African continent. Preliminary data indicates that Boston is an ideal place to recruit ethnically diverse Black women given that 1 in 4 Black people in Massachusetts is foreign born. Within group differences can be investigated.

An exploratory principle components factor analysis was performed on all 40 items of the RRMI. The procedure yielded 13 components with eigenvalues of greater than 1.0. A screen plot indicated that four components were interpretable. The Varimax with Kaiser Normalization rotation method was used. Extraction communalities or estimates of the variance in each variable accounted for by the components were provided. All of the extraction communalities were high (.597 -.900). This is an indication that the extracted components represent the variables well. The four factors accounted for 41% of the common variance. Reliability coefficients were computed to determine their acceptability. Moderate to
strong correlation coefficients were desired and needed for a psychometrically sound instrument, (a minimum of .68 was regarded as acceptable). Reliability coefficients for the RRMI were .73.

**Depression Screen**

The Center for Epidemiologic Studies Depression Scale (CES-D) is a 20-item instrument used to assess depressive symptoms in community samples and population based studies. It was developed by the Center for Epidemiologic Studies, National Institute of Mental Health (Radloff, 1977). The CES-D measures four types of depressive symptoms (depressed mood, somatic complaints, interpersonal difficulties, and absence of positive experiences). Respondents were asked to rate each item, indicating the frequency experienced during the previous week on a 4-point scale ranging from ‘rarely or none of the time’ to ‘most or all of the time’. The measure includes such items like ‘I felt sad’, ‘I felt lonely’, ‘I felt depressed’, and ‘I enjoyed life’. Total scores range from 0 to 60. Scoring is weighted based on the frequency of the item. The higher scores indicate the presence of more symptomatology. A score of 16 indicates the possibility of depression and a score of 23 or higher indicates clinically significant levels of depression. The instrument has been found to be a reliable (Radloff, 1977) measure in the general population (coefficient alpha= .85). Williams et. al, (2004) in a study with 40,403 black women had a reliability alpha of (.74) indicating that the relationships among the four factor structure (depressed affect, positive affect, somatic complaints, and interpersonal complaints) vary by age for black women. The variation in score totals based on race and ethnicity point to the importance of further examination of specific items measured by the CES-D to provide a detailed evaluation of which items actually contributes to total scores (Boutin-Foster, 2008).
Procedures

The research proposal was submitted for approval to the Internal Review Board of Northeastern University. In 2006, a meeting was held with Rev. LeRoy Attles the senior pastor of St. Paul AME Church in Cambridge, MA where the researcher has been a member for 23 years. Given the nature of the subject matter and the Black church’s historical resistance to mental health issues outside of the realm of spiritual counseling, it was important that the researcher get advice about the surrounding churches and the openness of senior clergy to allow research with congregants. A list of churches was generated. Rev. Attles followed up with calls and letters to the identified churches.

Phone conversations occurred between the researcher and the senior pastor from each of the three churches to arrange a time to clarify the survey process. A description detailing the survey goals and process was forwarded by e-mail to the senior pastor. At the in person meeting, the senior pastor gave the researcher the signed copy of the informed consent/permission for his congregation to participate in the study. In all instances, it took considerable time to secure a phone meeting with each senior pastor due to scheduling and availability issues. In person meetings then took place to further clarify the research goals, agree on the process for survey completion, and to collect the signed informed consents /permission for the congregation to participate in the research. These signed consents were forwarded to the Internal Review Board.

The actual survey completion occurred on multiple dates for each church. Research with church congregants (Taylor et. al, 2004; Queener & Martin, 2001) indicates that using a previously scheduled time with the survey as an add-on works best. Surveying may take place during bible study, a missionary or young adult meeting or choir practice. There was an increase in completed surveys when the pastor made an announcement from the pulpit while the researcher was
attending the church service. Bulletin inserts, as well as list serve reminders were also important strategies used to get women to participate in the study. The data were collected after Sunday services, during women’s fellowship, homeless women’s shelter fundraiser, missionary meeting and through referrals by other research participants. Participants were given the preferred option to complete the surveys at the church. If the participants’ time was limited, a stamped pre-addressed envelope was given out. A drop off box was developed for two of the churches (A.M.E and Baptist). The largest church (non-denominational) opted to have the participants leave the completed sealed envelopes at the receptionist station. She would then forward them to the women’s ministry coordinator.

All of the instruments were put in one large envelope. The demographic information survey was printed on yellow, blue and green paper with each color distinguishing a specific denomination e.g. (yellow- AME, blue- Baptist, green- non-denominational). This was to aide in the sorting of responses from each church. The researcher began with a welcome and thank you to all present. In some churches the coordinator of the program introduced the researcher and then the data collection proceeded as outlined. An overview of the research, informed consent and survey components were provided. There was a prayer offered by the researcher who was present throughout the survey process. Meditative music played in the background until all individuals completed their surveys. Information detailing mental health resources including community health center, national hotlines, websites, referral numbers from national organizations, and scriptures related to depression were available on a table for women to take with them. When each woman turned in a completed survey, the researcher gave her an inspirational book mark as a token of appreciation. An offer was extended to the coordinator and
pastor for the researcher to return to share the findings of the research with the participants. All survey packets were kept in a locked file cabinet in the researcher’s office.

Data Analysis

Classical Method

In order to generate appropriate statistics to answer the research questions and to test the statistical hypotheses below, Likert-style survey instruments were administered to a convenience sample of African American Christian women. Traditionally, responses from Likert-type questionnaires are added and divided to produce sums or means and standard deviations. But because the responses are nothing more than ordinal numbers, they are inadequate for inferential statistical analysis when used in the classical way.

Rasch Rating Scale Model

The following statement indicates the inherent challenges when applying traditional approaches:

Parametric statistical tests, which use means and standard deviations (i.e., which require operations of arithmetic on the original scores), ought not to be used with data in an ordinal scale… When parametric techniques of statistical inference are used with such data, any decisions about hypotheses are doubtful. Probability statements derived from the application of parametric statistical tests to ordinal data are in error to the extent that the structure of the method of collecting the data is not isomorphic to arithmetic (Siegel, 1956, 26).

This researcher added to the classical data analysis the Rasch rating scale model, which has revolutionized the way that scholars analyze data of an ordinal nature. The Rash model is ideal for extracting data from the survey instruments used in this study. The model enables the researcher to test if items in an instrument form a unidimensional variable, it calibrates the magnitude of differences among items on an interval scale, and it measures each person on the newly created variable (Fox and Jones, 1998). Importantly, it transforms ordinal data to log odd
ratios or logits, and by so doing, it places them on an interval-level scale, thus enabling statistical tests to be conducted with real interval data. Moreover, unlike traditional analysis which produces a single measure of reliability and of validity, the Rasch model not only generates these, but it also produces a measure of reliability and validity for every Likert-type statement in a questionnaire. One of the strengths of the model is that it is “sample free”, in that it does not depend upon the necessity of a probability sample for its results to be valid.

A theoretical requirement of Rasch modeling is that a unidimensional trait or underlying construct is being measured, such as anxiety, depression, or self-esteem. This means that, conceptually in this study, women’s responses to all the ordered items are influenced by one dominant trait, and that trait can be represented by a single number. This unidimensionality enables a mapping of the items in a hierarchical way such that the items of least “endorsability” are located at one extreme of the map, and those items of most “endorsability” are at the other extreme. Both women and survey statements or items can be located along one continuum or construct on the same map.

The problem with using raw scores in the traditional analysis of rating-scale data is that one routinely mistakes the distances between fractions or percentage scores as having direct meaning, when all that one may infer from these data is the ordering of the persons or the items. A more efficient way is to better represent the relative distances between the raw scores by transforming the score from a merely ordinal scale to its natural logarithm to produce logits. The logit is thus a unit of measurement with interval level properties. Since logits can have negative values, in this study logits are all rescaled to range from 0 to 100.

Statistical software packages used to analyze the data include SPSS (Statistical Package for the Social Sciences), SAS (Statistical Analysis System) and Winsteps (a Rasch-model
computer program for rating-scale data analysis). SPSS was used to capture the data in a single database from the survey instruments described above. Winsteps enabled the researcher to critically analyze the set of ordinal scores from the survey instruments to determine the optimal set of response categories, produce overall and individual measures of reliability and validity of every statement in an instrument, rank the statements hierarchically, determine the meaningful distances between items on the construct’s scale, and produce an interval measure of the construct for each respondent. These will be utilized to produce descriptive and inferential statistics, including logistic regression to test the relationship between a dichotomous outcome variable and an interval-level independent variable.

In conclusion, the data analysis will be a combination of the two methods – the classical presentation and the Rasch Rating Scale Models. The classical data analysis will be utilized to create means, medians, and percentages. The Rasch Rating Scale Model analysis will employ the use of re-scaled raw data that into logits and analyzed through person-item maps and inferential statistics.

Research Questions and Hypotheses

Research questions define the nature and scope of a research project. They serve to focus the researcher’s attention on certain issues, they influence the scope and depth of the research, they serve as guides to certain research strategies and methods of data collection and analysis, and they set expectations for outcomes. The research hypothesis is a general statement of what the researcher predicts.

**Research Question 1:** *What* is the prevalence of depression among African American Christian women?
**Hypothesis One:** There will be a low prevalence of depression in a sample of African American Christian women.

The CES-D will be scored and the mean frequencies analyzed to determine the prevalence of depression in the sample.

**Research Question 2:** What is the relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women?

**Hypothesis Two:** There will be a positive relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women.

Multiple regression analysis will be used to test the relationships between the independent variables of income, educational level, age and the dependent variable of beliefs about the existence and origins of depression (BHBI subscales item #8 and item #12).

**Research Question 3:** What is the relationship among psychological resistance, conservative Christian views and African-American Christian women’s beliefs about the existence and origins of depression?

**Hypothesis Three:** There will be a positive relationship among psychological resistance, conservative Christianity, and beliefs about the existence and origins of depression in African-American Christian women.

Multiple regression will be used to test the relationship between the independent variables of psychological resistance, conservative Christianity and the dependent variable of beliefs about the existence and origins of depression (BHBI subscales item #8 and item #12).
**Research Question 4:** What are the mental health treatment types that African-American Christian women believe treat depression?

**Hypothesis Four:** There will be a variety of mental health treatment types that a sample of African-American Christian women believes treat depression.

The responses will be scored and the mean frequencies analyzed to determine the mental health treatment types that women believe treat depression. A person-item map will present their selections through this Rasch Rating Model format.

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**Chapter Summary**

This chapter has outlined the sample, research design type, measures and instruments, procedures, and data analysis used in the research study.
Chapter Four

Results

Introduction

This chapter presents the results of this study which examined the beliefs about depression and treatment in a sample of 106 African-American Christian women. As noted in Chapter 3, both Classical Theory methods as well as Rasch Rating Scale Theory Models were used to analyze data collected for the study. As such, results are presented within the framework of both Classical Theory and Rasch Theory. The findings are organized in four major sections. First, demographic characteristics of the sample are presented using descriptive statistics. Second, specific findings related to the Braithwaite-Hall Beliefs Inventory (BHBI) are presented. Third, descriptive results of the Robinson Resistance Modality Inventory (RRMI) and the Shepherd Scale are detailed. The chapter ends with a presentation of the findings related to the research hypotheses.

Section One- Demographic Characteristics of the Study Sample

The demographic results are presented in tabular format. This information details the ethnicity, religious designation, marital status, age, household income, number of children, and indicators of Christian involvement.

Table 4.1 indicates that African-American/Black constituted the largest percentage of the sample. The Baptist church had the least participation in the study. Marriage was or has been a part of the lives of the majority of the women. However, almost half of the women had never been married. The average participant was a woman in her mid-forties who had two children and earned about $80,000 per year. These women have been a Christian for an average of thirty years with a standard deviation of sixteen years.
Table 4.1  

*Demographic characteristics of participants*  
(N=106)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>African-American/Black</td>
<td>93(88)</td>
</tr>
<tr>
<td>Bi-racial/Multi-racial</td>
<td>8(8)</td>
</tr>
<tr>
<td>Religious Designation</td>
<td></td>
</tr>
<tr>
<td>AME Church</td>
<td>43(40)</td>
</tr>
<tr>
<td>Baptist</td>
<td>23(22)</td>
</tr>
<tr>
<td>Non-Denominational</td>
<td>40(38)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>45(42)</td>
</tr>
<tr>
<td>Currently married</td>
<td>40(38)</td>
</tr>
<tr>
<td>Divorced</td>
<td>12(11)</td>
</tr>
<tr>
<td>Widowed</td>
<td>6(6)</td>
</tr>
<tr>
<td>Separated</td>
<td>2(2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>47</td>
<td>48</td>
<td>14</td>
</tr>
<tr>
<td>Income</td>
<td>$81,294.56</td>
<td>62,000.00</td>
<td>93,651.03</td>
</tr>
<tr>
<td>Number years Christian</td>
<td>29.7</td>
<td>30</td>
<td>16.45</td>
</tr>
<tr>
<td>Number of Children</td>
<td>2.1</td>
<td>2.0</td>
<td>1.43</td>
</tr>
</tbody>
</table>

Table 4.2 highlights the living environment for study participants. Women lived predominantly in a house or apartment. Over half of the women lived with a partner/husband, or with friends or relatives. Approximately the same percentage of women living alone also lived with friends/relatives. Almost half of the women lived in the Roxbury, Dorchester, and Mattapan areas of Boston which are predominantly African-American neighborhoods. Close to sixty percent of the women have children, which is higher than the percentage of women with marriage as part of their history. Although women reported that as many as four (4) persons were dependent on them for care, no question asked about the ages of these persons. As a result, no conclusion can be made about whether these women were caring for minor children and/or aging parents.
Table 4.2  Demographic characteristics of participants  (N=106)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lives in house or apartment</td>
<td>99</td>
<td>(97)</td>
</tr>
<tr>
<td>Lives in predominantly AA neighborhood</td>
<td>49</td>
<td>(46)</td>
</tr>
<tr>
<td>Lives with partner/husband</td>
<td>34</td>
<td>(32)</td>
</tr>
<tr>
<td>Lives with friends or relatives</td>
<td>25</td>
<td>(23)</td>
</tr>
<tr>
<td>Lives alone</td>
<td>26</td>
<td>(24)</td>
</tr>
</tbody>
</table>

| Parental Status- Dependent Care |    |     |
| Women without children | 41 | (39) |
| Women with children | 63 | (59) |
| Women with 1 child | 13 | (12) |
| Women with 2 children | 24 | (23) |
| Women with 3 children | 18 | (17) |
| Women with 4 children | 9  | (8.5) |
| Women with 6-7 children | 2  | (2) |

Table 4.3 reports the socio-cultural backgrounds of participants. These women represented a group that is well educated, with approximately 60% having earned at least one college degree. Only seven women did not receive any training or further education beyond the high school diploma. The largest category was for women who had bachelors or masters degrees. Fourteen women held terminal degrees. Their commitment to educational attainment appeared to affirm the values of their family of origin. The majority of the women came from middle income or working class families. The numbers of women from poor and upper income families were the same (n=8). Overall, a majority of the women had immigrant histories. Either the women or their parents were born outside of the United States. The locations of their birth were in the West Indies and Africa. Only forty-seven women (34.89%) were born in Massachusetts.
Table 4.3  
(Demographic characteristics of participants  (N=106)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Levels</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduated High School only</td>
<td>7</td>
<td>(7)</td>
</tr>
<tr>
<td>Completed Specialized Training Post High School</td>
<td>10</td>
<td>(9)</td>
</tr>
<tr>
<td>Completed some college</td>
<td>8</td>
<td>(7)</td>
</tr>
<tr>
<td>Completed Associate of Arts Degree</td>
<td>6</td>
<td>(5)</td>
</tr>
<tr>
<td>Currently Enrolled in Graduate School</td>
<td>3</td>
<td>(3)</td>
</tr>
<tr>
<td>B.A., B.S., degrees</td>
<td>25</td>
<td>(24)</td>
</tr>
<tr>
<td>M.A., M.S., or Ed.M. degrees</td>
<td>25</td>
<td>(24)</td>
</tr>
<tr>
<td>Ed.D., J.D., M.D., Psy.D., Ph.D., or Pharm. D. degrees</td>
<td>14</td>
<td>(13)</td>
</tr>
<tr>
<td><strong>Social Class of Family of Origin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>8</td>
<td>(7)</td>
</tr>
<tr>
<td>Working Class</td>
<td>34</td>
<td>(32)</td>
</tr>
<tr>
<td>Middle Income</td>
<td>48</td>
<td>(45)</td>
</tr>
<tr>
<td>Upper Income</td>
<td>8</td>
<td>(7)</td>
</tr>
<tr>
<td><strong>Place of Birth/Family Heritage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Massachusetts</td>
<td>47</td>
<td>(35)</td>
</tr>
<tr>
<td>Born in West Indies</td>
<td>16</td>
<td>(16)</td>
</tr>
<tr>
<td>Born in Africa</td>
<td>3</td>
<td>(3)</td>
</tr>
<tr>
<td>Mother Born in Massachusetts</td>
<td>19</td>
<td>(18)</td>
</tr>
<tr>
<td>Mother Born in West Indies/Caribbean</td>
<td>28</td>
<td>(26)</td>
</tr>
<tr>
<td>Father Born in Massachusetts</td>
<td>9</td>
<td>(8)</td>
</tr>
<tr>
<td>Father Born in West Indies/Caribbean</td>
<td>25</td>
<td>(22)</td>
</tr>
</tbody>
</table>

Table 4.4 captures information on the religious practices of the participants. The women publicly demonstrated their Christianity through weekly church attendance. Their personal Christian practice was indicated by daily prayer and Bible reading. Their involvement in a wide variety of church ministries was a consistent part of the lives of these women. Forty-seven women (44%) were a part of 1-2 church ministries.

Table 4.4  
(Demographic characteristics of participants  (N=106)

<table>
<thead>
<tr>
<th>Religious Practices</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly church attendance</td>
<td>76</td>
<td>(70)</td>
</tr>
<tr>
<td>Daily Prayer</td>
<td>80</td>
<td>(75)</td>
</tr>
<tr>
<td>Daily Bible reading</td>
<td>37</td>
<td>(35)</td>
</tr>
<tr>
<td>Weekly Bible Reading</td>
<td>12</td>
<td>(11)</td>
</tr>
<tr>
<td>Ministry involvement n=0</td>
<td>17</td>
<td>(16)</td>
</tr>
<tr>
<td>Ministry involvement n= 1-2</td>
<td>47</td>
<td>(44)</td>
</tr>
</tbody>
</table>
Section Two - Braithwaite-Hall Beliefs Inventory

This section presents results from specific sub sections of the Braithwaite-Hall Beliefs Inventory. The tables that follow present results related to: clinical definitions of depression, the woman’s experience with depression, beliefs about the existence of depression, beliefs about the origins of depression, contextual treatment issues, self-care practices, and the BHBI question #25 open response.

Table 4.5 captures women’s belief in the APA clinical definition of depression. The results are a combination of strongly agree/agree and strongly disagree/disagree. Eighty-nine percent (n=94) of the women indicated they believed in the clinical definition of depression. This is the gold standard of depression symptom presentation which is widely used by medical and mental health professionals. Seventy-six percent (n=81) of these women reported that they have been depressed, though fully fifty-six percent (n=59) of the respondents indicated a self diagnosis. There was no question that asked about diagnosis from a mental health professional. So it is unknown what diagnostic process was utilized by the other twenty-one women who did not report a self diagnosis. Lastly, seventy-nine percent of the women reported having had experience with depression through a family member. The composite picture is a sample of women who have had personal experience with depression.
Table 4.5  
*Braithwaite-Hall Beliefs Inventory (BHBI)*  
**Beliefs and Experience with Depression**  
*Descriptive Statistics- Agreement Frequency*  
\[(N=106)\]

<table>
<thead>
<tr>
<th>Belief Statement</th>
<th>SA-A %</th>
<th>SD-D %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe the APA definition</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>I have been depressed</td>
<td>81</td>
<td>25</td>
</tr>
<tr>
<td>I diagnosed myself</td>
<td>59</td>
<td>41</td>
</tr>
<tr>
<td>Family member was depressed</td>
<td>84</td>
<td>19</td>
</tr>
</tbody>
</table>

*Note: Responses based on Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.) Agree and strongly agree, disagree and strongly disagree frequencies were combined.*

Table 4.6 reports on the BHBI subscale (item # 8) which focused on beliefs about the existence of depression. The *strongly agree* and *agree* (SA-A) and *strongly disagree* and *disagree* (SD-D) categories were combined for ease of presentation of results. The percentages are from women’s individual beliefs about the existence of depression. There were nine items in this subscale. The reliability coefficient for this subscale, based on Cronbach’s alpha is .568.

Four items in this subset had agreement by less than 10% of respondents. These items included: depression does not exist (n=8); depression exists because of sin (n=7); depression exists because of being female (n=6); and depression was a sign of weakness (n=4). Next, three items received agreement by more than 10% but fewer than 25% of the women. These items included: depression exists because of lack of spiritual power (n=17), depression is contrary to God’s presence (n=21), and depression is a sign of the devil (n=23). Forty-four percent of the women agreed that depression happens to everyone. This item indicated the most variability in beliefs of the sample. In contrast, seventy-two percent of the women, the largest percentage, agreed that depression was a sickness needing treatment. In summary, these women indicated their belief in the existence of depression and it being a sickness needing treatment. They disagreed in spiritual elements and gender as being sources of its existence.
Table 4.6  
Braithwaite Hall Beliefs Inventory (BHBI) Subscale:  
Beliefs about the Existence of Depression by Percent of Women Agreeing with  
Statements  

<table>
<thead>
<tr>
<th>Belief Statement</th>
<th>SA-A %</th>
<th>SD-D %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doesn’t exist</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>Happens to everyone</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Sign of weakness</td>
<td>4</td>
<td>95</td>
</tr>
<tr>
<td>Part of being female</td>
<td>6</td>
<td>93</td>
</tr>
<tr>
<td>Sickness needing treatment</td>
<td>77</td>
<td>21</td>
</tr>
<tr>
<td>Shows lack of spiritual power</td>
<td>17</td>
<td>84</td>
</tr>
<tr>
<td>Is a sin</td>
<td>7</td>
<td>92</td>
</tr>
<tr>
<td>Sign of the devil</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td>Contrary to God’s presence</td>
<td>21</td>
<td>76</td>
</tr>
</tbody>
</table>

Note: Responses based on Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.) Agree and strongly agree frequencies were combined.

Table 4.7 reports on the BHBI subscale (item # 12) which focused on beliefs about the origins of depression. The strongly agree and agree (SA-A) and strongly disagree and disagree (SD-D) categories were combined for ease of presentation of results. The percentages are from women’s individual beliefs about the origins of depression. There were thirteen items in this subscale. The reliability coefficient for this subscale, based on Cronbach’s alpha is .716.

God’s punishment as the origin of depression received the lowest agreement response (8% of the women). Four items received agreement with a range of 22%-43%. These items included: depression originated from a weak spirit (n=21), Satan’s spirit (n=37), racism (n=44), and sexism (n=43). Four items moved beyond the median of the sample indicating agreement by 54%-70% of the women. These items included: depression originated from guilt over something you should have done (n=52), being overweight (n=63), being human (n=65), and genetics (n=66). The next three items indicated agreement by 73%-88% of the respondents. These items included: depression originated from female hormonal changes (n=74), an abuse history (n=81), and brain chemistry changes (n=86). The last item – depression originated from a health condition - received the highest agreement response by 83% (n=81) women. In summary, these
women agreed that depression originated from a health condition and other physiological reasons and that it also has psychological and emotional origins. There was almost a split in the agreement of the role of racism and sexism in the origin of depression. Finally, responses indicated overwhelming disagreement in the belief that God’s punishment was the origin of depression.

Table 4.7  
Braithwaite Hall Beliefs Inventory (BHBI)  
Beliefs about the Origins Depression by Percent of Women Agreeing with Statements (N=106)

<table>
<thead>
<tr>
<th>Belief Statement</th>
<th>SA-A %</th>
<th>SD-D %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>66</td>
<td>28</td>
</tr>
<tr>
<td>Weak spirit</td>
<td>21</td>
<td>75</td>
</tr>
<tr>
<td>God’s punishment</td>
<td>8</td>
<td>88</td>
</tr>
<tr>
<td>Satan’s presence</td>
<td>37</td>
<td>59</td>
</tr>
<tr>
<td>Guilt over something you should have done</td>
<td>52</td>
<td>43</td>
</tr>
<tr>
<td>Health condition</td>
<td>90</td>
<td>9</td>
</tr>
<tr>
<td>Female hormonal changes</td>
<td>74</td>
<td>26</td>
</tr>
<tr>
<td>Brain chemistry</td>
<td>86</td>
<td>11</td>
</tr>
<tr>
<td>Racism</td>
<td>44</td>
<td>54</td>
</tr>
<tr>
<td>Sexism</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>Part of being human</td>
<td>65</td>
<td>34</td>
</tr>
<tr>
<td>Being overweight</td>
<td>63</td>
<td>31</td>
</tr>
<tr>
<td>Result of abuse history</td>
<td>81</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 4.8 highlights the BHBI results of women’s help seeking history and resources available for depression treatment. The church response to depression indicated that only forty percent of the women have heard a sermon on depression. Table 4.8 reflects that 76% (n=81) of the women indicated that they have been depressed. However, only 15 of these women sought help from her pastor. Further, the response percentages (61%) were identical with respect to their churches offering counseling services and their willingness to use those services.

Results of the contextual treatment issues indicated a major shift from the earlier section in that 70% of the women would use community resources when compared to (61%) that would use church counseling services. There was a nine percentage point shift in the women’s reported
use of community resources for depression treatment in comparison to the use of the churches services. When fifty-six of these women (53%) sought depression treatment outside the church, they encountered only 47% of their counselors not including their Christian beliefs in treatment. This is noteworthy because these women conveyed their limited engagement with church and pastoral counseling services. A majority of responses (74%) and (87%) respectively, indicated that the image of the strong Black women as well as conditions in Black women’s lives contributes to depression. These results speak to the psychological and socio/cultural challenges that Black women encounter. Lastly, thirty-four percent of responses indicated that the identification with Jesus’ suffering is part of what contributes to depression in Black women.

Table 4.8

<table>
<thead>
<tr>
<th>Braithwaite Hall Beliefs Inventory (BHBI)</th>
<th>Contextual Treatment Issues- Agreement Frequency (N=106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Totals</td>
<td>n</td>
</tr>
<tr>
<td><strong>Church Response to Depression</strong></td>
<td></td>
</tr>
<tr>
<td>I have heard a sermon on depression</td>
<td>91</td>
</tr>
<tr>
<td>I sought help from my pastor for depression</td>
<td>98</td>
</tr>
<tr>
<td>My church provides counseling services</td>
<td>97</td>
</tr>
<tr>
<td>Would use church counseling for depression treatment</td>
<td>99</td>
</tr>
<tr>
<td><strong>Contextual Treatment Issues</strong></td>
<td></td>
</tr>
<tr>
<td>I would use community resources for treatment</td>
<td>102</td>
</tr>
<tr>
<td>I have sought depression treatment outside church</td>
<td>97</td>
</tr>
<tr>
<td>Counselors include Christian beliefs in treatment</td>
<td>100</td>
</tr>
<tr>
<td>Image of Strong Black woman part of depression</td>
<td>103</td>
</tr>
<tr>
<td>Conditions in Black women’s lives contribute to depression</td>
<td>103</td>
</tr>
<tr>
<td>Identification w/Jesus’ suffering part of depression</td>
<td>101</td>
</tr>
</tbody>
</table>

**Note:** Responses based on Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.) Agree and strongly agree frequencies were combined.

Table 4.9 presents the BHBI results of the self-care practices of the women in the sample. The strongly agree and agree categories were combined into one agreement rating. The self-care practices that indicated agreement of 90% and above were: going to church; volunteering/helping others; and maintaining healthy relationships. The next set of self-care practices that received
75% agreement were praying regularly, spending time with sister girlfriends, making time for fun and play. The third group representing responses of 50% and above were eating properly, asking for help, getting plenty of rest, daily Bible reading, taking vacations, exercising regularly, setting boundaries and shopping. The lowest percentage of self-care practices was for gardening and taking medicine for a pre-existing condition.

Table 4.9  
**Braithwaite-Hall Beliefs Inventory - (BHBI)**  
**Self-Care Practices - Agreement Frequency**  
(N=106)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Valid Total</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I get plenty of rest</td>
<td>105</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>Pray regularly</td>
<td>103</td>
<td>89</td>
<td>84</td>
</tr>
<tr>
<td>Eat properly</td>
<td>104</td>
<td>80</td>
<td>75</td>
</tr>
<tr>
<td>Exercise regularly</td>
<td>104</td>
<td>69</td>
<td>65</td>
</tr>
<tr>
<td>Set boundaries- say no &amp; mean it</td>
<td>104</td>
<td>69</td>
<td>65</td>
</tr>
<tr>
<td>Ask for help</td>
<td>102</td>
<td>75</td>
<td>71</td>
</tr>
<tr>
<td>Daily Bible reading</td>
<td>101</td>
<td>72</td>
<td>68</td>
</tr>
<tr>
<td>Going to Church</td>
<td>104</td>
<td>97</td>
<td>92</td>
</tr>
<tr>
<td>Spending time w/sister girlfriends</td>
<td>102</td>
<td>85</td>
<td>80</td>
</tr>
<tr>
<td>Spending time w/significant others</td>
<td>90</td>
<td>64</td>
<td>60</td>
</tr>
<tr>
<td>Volunteering/helping others</td>
<td>103</td>
<td>95</td>
<td>90</td>
</tr>
<tr>
<td>Maintaining healthy relationships</td>
<td>101</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>Taking vacations</td>
<td>99</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Gardening</td>
<td>96</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Shopping</td>
<td>100</td>
<td>59</td>
<td>56</td>
</tr>
<tr>
<td>Taking medicine for medical condition</td>
<td>94</td>
<td>38</td>
<td>36</td>
</tr>
<tr>
<td>Making time for fun and play</td>
<td>101</td>
<td>84</td>
<td>79</td>
</tr>
</tbody>
</table>

*Note: Responses based on Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.) Agree and strongly agree frequencies were combined.*

*Braithwaite Hall Beliefs Inventory Question # 25*

The final section of the BHBI for which results are presented is question 25: *What do you want counselors, pastors and medical personnel to know about depression and Black*
women? Approximately 75% of participants (77 women) provided response to this question. The majority of the women wrote two to three sentences. Twenty-nine women had no responses. The responses were analyzed using core elements of the processes described by Moustakas (1994). Often qualitative studies utilize data from focus groups and/or interviews. For this study, this one question response required that the researcher connect meaning based on the lived experience of Black Christian women. This researcher identifies as a member of this population. Therefore, the analysis of their responses emanated from integration of their social/cultural meaning with the personal identification of the researcher.

The process unfolded as follows: first all of the verbatim responses were read multiple times for understanding. An important goal was to give each statement equal value prior to the sorting and reduction process. This is a significant aspect of the process called horizontalization (Moustakas, 1994). Responses that required spelling correction due to input errors were made to facilitate ease in reading and comprehension. This resulted in 125 statements, a sample of which is captured in Table 4.10. These statements were then analyzed for responses that contained the similar wording and content. Derived meanings were then extracted from the verbatim statements. Table 4.11 details the derived meanings that emanated from the verbatim statements. The goal in these initial steps was not to disrupt the original meaning but to discern the meaning by reflecting on the verbatim statements.
Table 4.10  Braithwaite Hall Beliefs Inventory Open Response- Question #25
Sample Verbatim Responses and Their Corresponding Derived Meaning

<table>
<thead>
<tr>
<th>Verbatim Response</th>
<th>Derived Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American women should not feel the need to hide behind the mask of the</td>
<td>Acceptance of vulnerability</td>
</tr>
<tr>
<td>strong Black women.</td>
<td></td>
</tr>
<tr>
<td><em>We are human.</em></td>
<td></td>
</tr>
<tr>
<td><em>Endured a lot.</em></td>
<td></td>
</tr>
<tr>
<td><em>Stop the denial.</em></td>
<td></td>
</tr>
<tr>
<td><em>An understanding of code switching and shifting.</em></td>
<td>Psychological processes AA maneuver through</td>
</tr>
<tr>
<td>*Be aware of environmental/life conditions/cultural issues that might be different</td>
<td>There are unique stressors in AA lives</td>
</tr>
<tr>
<td>for Black women and experienced uniquely. Is important in understanding stressors.*</td>
<td></td>
</tr>
<tr>
<td><em>Because of stress in our lives, we can become strained, but will not open up and</em></td>
<td>Stress creates strain and limits ability to admit need for help</td>
</tr>
<tr>
<td><em>admit that we are human and need help.</em></td>
<td></td>
</tr>
<tr>
<td><em>Because of the status of Black males, the lack of them. Because of that many</em></td>
<td>Status of black men creates burdens for AA women</td>
</tr>
<tr>
<td><em>Black women have the weight of the world on our shoulders &amp; there is nowhere to</em></td>
<td></td>
</tr>
<tr>
<td><em>go with it as other Black women in the same situation or doing worse. We’re all</em></td>
<td></td>
</tr>
<tr>
<td><em>in same boat.</em></td>
<td></td>
</tr>
<tr>
<td><em>Be persistent inquiring about childhood.</em></td>
<td>Persist in understanding childhood</td>
</tr>
<tr>
<td><em>Spirituality plays a great part in healing.</em></td>
<td>Spirituality plays a great part in healing</td>
</tr>
<tr>
<td><em>Black women are strong and carry the burden for the family caring and nursing</em></td>
<td>Strength of Black women</td>
</tr>
<tr>
<td><em>especially for the children.</em></td>
<td>Solo burden for child rearing</td>
</tr>
<tr>
<td><em>It feels like no one cares.</em></td>
<td></td>
</tr>
<tr>
<td><em>We are not stupid weak or children. We are women.</em></td>
<td>Isolation and helplessness</td>
</tr>
<tr>
<td><em>Black women often not willing to talk about depression with family, friends,</em></td>
<td>Need to be taken seriously</td>
</tr>
<tr>
<td>*co-workers. When I tried, I remember being told Black women don’t go to therapy-</td>
<td>Little support to enter therapy</td>
</tr>
<tr>
<td><em>just get over it.</em></td>
<td></td>
</tr>
<tr>
<td><em>Black women are individuals, separate &amp; different from one another. Don’t try</em></td>
<td>Uniqueness of each black woman.</td>
</tr>
<tr>
<td><em>and group us as a Black women’s thing!</em></td>
<td></td>
</tr>
</tbody>
</table>
Next, themes were clustered and created from the derived meaning. This was accomplished by delineating the unchanging items from the derived meaning list. Next, attention was placed on the items that were not repetitive and did not overlap. Then groupings were created from clusters related to relationships, personal experience, processes, and institutions. Nine themes emerged from this clustering process. Table 4.11 provides a sample of three of the nine themes and their associated derived meaning. The following eight themes emerged: uniqueness of Black women, socio/cultural stress, psychological processes, treatment, silent suffering, diagnosis, Black church, and depression. The overall themes are presented within the context of the derived meanings. See Appendix for the complete listing.

Table 4.11  Sample of Three Themes for BHBI Open Response Question #25

<table>
<thead>
<tr>
<th>Theme</th>
<th>Derived Meaning</th>
</tr>
</thead>
</table>
| **Uniqueness of Black Women** | Need to hide behind Strong Black Woman  
African-American women have endured a lot  
Developed from slavery  
Superwoman archetype leads to futility and depression  
Humanity of African-American women  
Uniqueness of each Black woman  
Special resilience  
Pain and suffering carried through the mitochondria  
Groomed to be strong |
| **Socio/cultural Stress**   | There are unique stressors in African-American women's lives  
Solo burden for child rearing  
Stress creates stress and limits ability to admit need for help  
Mental health not embraced by Black community  
Much pressure in the lives of Black women  
Status of Black men creates stress for women  
When men are not in the picture stress increases  
Condescending behaviors with other Black women  
Race issues contribute to depression |

*Overall Themes*
Theme #1- *Uniqueness of Black Women.* Respondents highlighted that Black women’s experiences cannot be compared to others because of the distinct position that they occupy within families, communities and larger society. Their grooming to be strong creates an unusual resilience to life’s challenges. However, this resilience has negative impacts on Black women’s lives. Women noted that the strong Black woman descriptor has an historical context as well as a present day reality. It is part of the ancestral legacy that has been passed down from generations. Women use this stance of strength to hide from being vulnerable. They described this label as both a dynamic and a state of being. Women learn to grow into this persona and then become trapped by its power.

Theme #2- *Socio-cultural Stress.* These women shared that there are special stressors that they go through, especially due to the deleterious effects of racism on black men. This results in women carrying unequal challenges and burdens for children and families. The community resistance to engaging mental health issues further traps many women in cycles of stress and distress.

Theme #3- *Psychological Processes.* Respondents detailed the reality that they experience psychological processes that make it difficult for them not only to reach out for help, but to also acknowledge their authentic selves. This “learning how to lie about feelings” becomes a way of living and ill functioning.

Theme #4- *Silent Suffering.* The connection to wearing a mask of strength was shared as a means through which this silent suffering becomes normal and natural. Several women indicated that when they attempted to reach out for help to family and friends their efforts were minimized and misunderstood. Often, women are trapped in the powerful feeling of shame for needing help.
Theme #5- Diagnosis. The women pointed out that the diagnostic process warrants more than the typical approach because of the mask of strength that is often present for Black women. As a result, the presentation of the woman may seem healthy and without distress. Respondents suggested that physiological changes that happen through menopause need to be part of the diagnostic regimen. Further, they indicated that substance abuse and domestic violence must be actively explored to determine their roles in the woman’s life. Importantly, women noted that really listening to what the woman is saying can provide useful clues in detecting the presence of depression.

Theme #6- Treatment. These women shared that spirituality can be an important resource for the healing of depression. They indicated that simply presenting medication as the only treatment type has fewer efficacies for Black women than if it is part of a multi modal approach. Due to the strong women archetype experienced by many women, they noted that an assertive engaged therapy style hold greater promise for Black women.

Theme #7- Black Church. A persistent response was that the church links depression to power of one’s spiritual strength. As a result, a major paradigm shift is needed to break this negative cycle that appears to keep many women trapped and suffering. Also, it was noted that male dominated churches provide little education on emotional/psychological issues. In general there simply needs to be more conversation and regular engagement of this topic.

Theme #8- Depression. Women shared that depression is common in all women. However, they indicated that the triggers of depression in Black women are different. Furthermore, these triggers, which are often socio-culturally-based, make this deeply rooted ailment difficult to detect.
Section Three - The Robinson Resistance Modality Inventory (RRMI) and the Shepherd Scale (SS): Descriptive Results

The previous sections have presented demographic findings and results from the BHBI. This section reports the findings from two instruments- the Robinson Resistance Modality Inventory (RRMI) and the Shepherd Scale (SS). The results are conveyed in the Classical Theory and Rasch Rating Scale Models. Classical Theory findings are reported in table format. Rasch Rating Scale Model results are explained and presented in a person-item map. Further, the Rasch Rating Scale Model psychometric properties of these items are presented.

Table 4.13 reports the descriptive results for the Robinson Resistance Modality Inventory (RRMI). This data is presented in the Classical Theory format. This inventory is divided into two subsets, which examines women’s psychological responses to counter racial discrimination. Twenty questions report an optimal resistor score and the other twenty questions report a suboptimal resistor score. Overall, there were raw scores missing from approximately 23 (optimal) and 24 (suboptimal) out of the 106 respondents completing the RRMI. The mean score of 65.80 indicated that this sample can be categorized as women who are optimal resistors. The standard deviations for both subsets are similar. However, the standard deviations for both optimal and suboptimal do not indicate that a shift into the other category would be possible. The Cronbach Alpha for the optimal scale is .736 and .536 for the suboptimal scale. This indicates that the results from the optimal scale are an acceptable measure of psychological resistance.

Table 4.13: Descriptive Statistics for Robinson Resistance Modality* (RRMI) Classical Theory Results (N=106)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Scale</td>
<td>65.80</td>
<td>66.0</td>
<td>6.61</td>
<td>83</td>
</tr>
<tr>
<td>Suboptimal Scale</td>
<td>38.57</td>
<td>38.0</td>
<td>6.07</td>
<td>82</td>
</tr>
</tbody>
</table>
Rasch Rating Scale Model Results for the RRMI

The Rasch Rating Scale Model that is based on modern test theory and is utilized to analyze raw scores from Likert-type questions. The model produces measures for all items, as well as estimates of the necessary psychometric properties of reliability and validity of each item. The analysis not only includes a hierarchical ranking of all the items, but also an indication of the distance between any pair of items on a linear scale. The psychometric statistics show that the indices of reliability for the person were 0.73 and for the items 0.98. The appendix presents data on these additional Rasch results: means and standard deviation of the raw scores, model errors and reliability indices, infit mean square and item summary.

The person-item map of the Rasch Rating Scale Model is presented to amplify the results of how respondents answered the survey questions, with a particular emphasis on the psychological distances present in their response to the items. Figure 4.1 presents a visual demonstration of the location of the 40 items of the Robinson Resistance Modality Inventory (RRMI) and the respondents in a hierarchical order on the same unidimensional continuum. The lower the location of an item (on the right side of map), the easier it was for the respondent to endorse the item with respect to suboptimal and optimal resistance. The $M$ in the center along the line represented the mean of the distribution of the calibrated items; the $S$’s and $T$’s indicated the standard deviation and two standard deviations from the mean, respectively.

Results indicated that 20 of the items fell at or above the mean and 20 below it. The numbers on the left of the map represented the measures which were the positions of the respondents when their scores were transformed to logits (Rasch scale measure) and then put on a scale of 0 to 100. The mean of the items was 45.5 and 49.7 for the persons responding to the
items. The fact that the mean of the items was larger than that of the respondents was an indication that the respondents found it difficult to endorse the items in the instrument. Figure 4.1 showed that most of the respondents’ measures fell around the mean.

The actual item groupings in the person-item map visibly highlight the optimal and suboptimal category responses. The color coded presentation conveys the grouped items that women found easiest and most difficult to endorse. Higher power (optimal) was the response that respondents found the easiest to endorse. This was followed by using past struggles to influence present choices (optimal). The next grouping included pray for strength (optimal), positive role model (optimal), and racial justice (optimal). A noteworthy result was that two sub optimal items- not depending on others to get things done and pressure to look attractive were endorsed in the grouping with all of the optimal items. Overall, the composite group results indicated that the women believed in the ongoing presence of God in their lives, and used prayer as a coping mechanism. These are spiritually grounded means of resistance. In addition, respondents demonstrated a socio/political optimal resistance strategy by their belief that: the past struggles of Black people have given them freedoms today, that they have a responsibility to be a positive role model to Black youth and that Black people are entitled to racial justice. On the opposite end, the sub optimal items that the respondents found the most difficult to endorse, located at the top of the map, was smoke to cope and alcohol to cope.

In summary, the Classical Theory and the Rasch Rating Scale Model results present a sample of women categorized as optimal resistors who utilize the psychological resources of spirituality and racial consciousness to counter discrimination in their lives. Next, results are presented for the Shepherd Scale which measures Conservative Christianity.
Figure 4.1 MAP for Robinson Resistance Modality Inventory

Women - MAP - Item
<more> <rare>
80
+ 28 "Smoke" to cope
+ 15 Alcohol to cope
+ T
70
+ 36 Judge on possession
Classical Theory Results for the Shepherd Scale- (SS)

The results are conveyed in the Classical Theory and Rasch Rating Scale Models.

Classical Theory findings are reported in table format. Rasch Rating Scale Model results are explained and presented in a person-item map. The appendix presents data on these additional Rasch results: means and standard deviation of the raw scores, model errors and reliability indices, infit mean square and item summary.

Table 4.14 reports the descriptive results for the Shepherd Scale (SS) in the Classical Theory format. The instrument measures high or low evangelical Christian beliefs within a
range of 38-152. There were 25 respondents that did not complete the instrument or did not respond to all the items. The highest score for this sample was 147 with a mean of 135. Further, the median for the respondents was 137 which are seventeen points below the maximum score. Therefore, these results indicate that study participants have high evangelical/conservative Christian beliefs.

Table 4.14  \textit{Descriptive Statistics for Shepherd Scale* (SS) - Classical Theory Results}

\begin{tabular}{lccccccc}
\hline
Min & Max & Mean & Median & SD & n \\
\hline
102 & 147 & 135.38 & 137.38 & 12.17 & 81 \\
\hline
\end{tabular}

\textit{Note: *SS measures conservative Christianity. There are 38 items based on a 4 point Likert-type scale Total scores range from 38 to 152 with higher scores conveying greater strength of evangelical orientation.}

\textit{Rasch Rating Scale Model Results for Shepherd Scale- (SS)}

The Rasch Rating Scale Model is based on modern test theory and is utilized to analyze raw scores from Likert-type questions. The model produces measures for all items, as well as estimates of the necessary psychometric properties of reliability and validity of each item. The analysis not only includes a hierarchical ranking of all the items, but also an indication of the distance between any pair of items on a linear scale. The psychometric statistics show that the indices of reliability for the person was 0.87 and for the items 4.14. The appendix presents data on these additional Rasch results: means and standard deviation of the raw scores, model errors and reliability indices, infit mean square and item summary.

The person-item map of the Rasch Rating Scale Model is presented to amplify the results of how respondents answered the survey questions, with a particular emphasis on the psychological distances present in their response to the items. Figure 4.2 presents a visual demonstration of the location of the 38 items of the Shepherd Scale (SS) and the respondents in a hierarchical order on the same unidimensional continuum. The lower the location of an item (on
the right side of map), the easier it was for the respondent to endorse the item with respect to conservative Christianity. The $M$ in the center along the line represented the mean of the distribution of the calibrated items; the $S$'s and $T$'s indicated the standard deviation and two standard deviations from the mean, respectively.

Results indicated that 19 of the items fell at or above the mean and 16 below it. The numbers on the left of the map represented the measures which were the positions of the respondents when their scores were transformed to logits (Rasch scale measures) and then put on a scale of 0 to 100. The mean of the items was 50.5 compared to 64.7.5 for the study participants. The fact that the mean of the persons was larger than that of the items was an indication that the respondents found it easy to endorse the items in the instrument. Figure 4.2 showed that most of the respondents’ measures fell around the mean. The items’ groupings indicated the areas that most define their Christian beliefs and lifestyle. The items lowest on the map, which were the easiest items to endorse, were *personal relationship; personal presence of God* and *God raised Jesus from the dead*. Though there are other items that detailed lifestyle and behavior responses to Christianity, these items were noteworthy because they are the guiding beliefs principles that informed their Christianity.

In summary, the Classical Theory and the Rasch Rating Scale Model results present a sample of women categorized as highly evangelical/conservative Christians. In addition, they indicated that the personal relationship and presence of God in their lives to God, as guided by the belief in Jesus being raised from the dead, were core to their Christianity. These items indicated the fundamental Christian beliefs of this sample. Next results are the four research questions and their related hypothesis.
Figure 4.2  MAP for Shepherd Scale- Conservative Christianity

| Women - MAP - Item | <more>|<rare> |
|-------------------|-----------------|
| 100               | XX +            |
|                   |                 |
|                   |                 |
|                   |                 |
|                   |                 |
| 90                | XXX +           |
|                   |                 |
|                   |                 |
|                   |                 |
|                   |                 |
| 80                | +               |
|                   | X               |
|                   | XX              |
|                   | XXXXX           |
|                   | XXXX S          |
|                   | X               |
Research Questions and Research Hypotheses

This is the final section of this chapter and the findings associated with the four research questions and hypotheses posed are presented. Findings associated with each research question and related hypotheses are presented in turn.

**Research Question 1**: What is the prevalence of depression among African American Christian women?

**Hypothesis One**: There is a low prevalence of depression in a sample of African American Christian women.
Table 4.15 shows the prevalence of depression in the sample of African-American Christian women. While 71% of the women (64) had scores that indicated the presence of depressive symptoms, and less than one-third (29%) had scores that indicated clinical levels of depressions, based on the CES-D scoring manual. These results indicated a high prevalence of depression in this sample of women. Therefore, the hypothesis was not confirmed.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Score Range</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Depressed</td>
<td>(0-15)</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Moderately Depressed</td>
<td>(16-22)</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td>Clinically Depressed</td>
<td>(23-43)</td>
<td>26</td>
<td>29</td>
</tr>
</tbody>
</table>

(CES-D) is a 20-item instrument used to assess depressive symptoms in community samples. Total scores range from 0 to 60. ≥ 16 indicates possibility of depression. ≥ 23 indicates clinical levels of depression. There were 90 valid and 16 missing responses.

Post Hoc Analysis

After the analysis of the first research question was conducted, this researcher was interested in the frequency of the status variables age, marital status, and the depression scores of the research sample. Large and small studies (Brown & Keith, 2003; Williams, et. al., 2004) have reported on the relationship between depression in black women and age.

Table 4.16 presents descriptive data on the cross tabulation of age and depression scores derived from the CES-D instrument. Of the 106 respondents, there were seventeen that had missing responses. Among the 89 valid counts, 26 were classified as Not depressed, 37 as Moderately depressed, and 26 as Clinically depressed. The vertical distributions show the respondents by prevalence of depression. The frequencies showed that between the first group
of *Not depressed* and *Moderately depressed* the highest percentages were among women in the 40-49 group. Among the *Clinically depressed*, the frequencies were the same for four age groups (20-29, 30-39, 40-49, and 50-59). The women who were 60 years and older had the lowest depression scores in the *Clinically depressed* range. In total there were 26 non-depressed women and 63 depressed women.

<table>
<thead>
<tr>
<th>Table 4.16</th>
<th>Crosstabulation of Age and Center for Epidemiologic Studies-Depression Scale (CES-D) Scores <em>(N=106)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group</td>
<td>Not Depressed (0-15)</td>
</tr>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>20-29</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>8</td>
</tr>
<tr>
<td>50-59</td>
<td>6</td>
</tr>
<tr>
<td>60-69</td>
<td>5</td>
</tr>
<tr>
<td>70- over</td>
<td>4</td>
</tr>
</tbody>
</table>

*(CES-D)* is a 20-item instrument used to assess depressive symptoms in community samples. Total scores range from 0 to 60. ≥16 indicates possibility of depression. ≥23 indicates clinical levels of depression. There were 89 valid and 17 missing responses.

A cross tabulation was run to investigate the degree of depression present based on the marital status of the women. Table 4.17 presents descriptive data derived from the scores of the CES-D instrument. Of the 106 respondents, seven did not complete this question. Among the 89 valid counts, 26 were classified as *Not depressed*, 37 as *Moderately depressed*, and 26 as *Clinically depressed*. The frequencies showed that among the first group of *Not depressed* married women had the highest percentage. Never married and currently married women had the highest percentages for the *Moderately depressed* group. Among the *Clinically depressed*, the never married group had the highest percentage. Widowed and separated women had the lowest percentages in the *Clinically depressed* group.
Table 4.17  Crosstabulation of Marital Status and Center for Epidemiologic Studies-Depression Scale (CES-D) Scores (N=106)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Not Depressed (0-15)</th>
<th></th>
<th>Moderately Depressed (16-22)</th>
<th></th>
<th>Clinically Depressed (23-43)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Never Married</td>
<td>6</td>
<td>6.7</td>
<td>16</td>
<td>17.9</td>
<td>17</td>
<td>19.0</td>
</tr>
<tr>
<td>Currently Married</td>
<td>14</td>
<td>15.7</td>
<td>16</td>
<td>17.9</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>3.3</td>
<td>1</td>
<td>1.1</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>4.4</td>
<td>2</td>
<td>2.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>27</strong></td>
<td><strong>30</strong></td>
<td><strong>36</strong></td>
<td><strong>40</strong></td>
<td><strong>26</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

(CES-D) is a 20-item instrument used to assess depressive symptoms in community samples. Total scores range from 0 to 60. \( \geq 16 \) indicates possibility of depression. \( \geq 23 \) indicates clinical levels of depression. There were 89 valid and 17 missing responses.

**Research Question 2:** What is the relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women?

**Hypothesis Two:** There is a positive relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women.

Hypothesis 2 examines the relationship among beliefs about the existence and origins of depression as the outcome or dependent variable, and income, educational level and age as independent variables. This hypothesis was tested utilizing a multiple logistic regression model. The model requires a dichotomous outcome variable and dichotomous, interval or ratio level independent variables. While income and age were collected at an interval scale, education attainment was dichotomous. It was therefore necessary to recode the variable educational level, such that 0 represented a bachelor’s degree or less, and a 1 was the code for a respondent whose education level was postgraduate, to include masters, JDs, PhDs or their equivalent. For this hypothesis, the dependent variable was measured as a subscale of the combination of questions 8 and 12 that comprises 22 items. In order to derive valid measures from the Beliefs subscale, the scores from the 22 items from the Beliefs subscale, the scores from the 22 items in questions 8
and 16 were first calibrated in logit measures. The logit analysis indicated that the person separation reliability, approximately equivalent to Coefficient Alpha, is 0.63. This suggests moderate discrimination between the respondents. In contrast, the item separation reliability of 0.96 indicates that the 22 items create a well-defined variable of beliefs about the existence and origins of depression.

Figure 4.3 provides a visual demonstration of the location of the 22 items and the respondents in a hierarchical order on the same unidimensional continuum. The lower the location of an item (on the right side of map), the easier it is for the respondent to endorse relative to the existence and origins of depression. An additional advantage of the map is that it provides a visual demonstration that meaningful psychological distances exist between the items, and it shows further which sets of items can be considered as clusters. The $M$ in the center along the line represents the mean of the distribution of the calibrated items; the $S$’s and $T$’s indicate the standard deviation and two standard deviations from the mean, respectively. Nine of the items fall above the mean and 12 below it. The numbers on the left of the map represent the measures, and hence the position, of the respondents when their scores are transformed to logits and then put on a scale of 0 to 100. The mean of the items is 49.4 and it is 44.0 for the persons responding to the items. That the mean of the items is larger than that of the respondents is an indication that the respondents found it rather difficult to endorse the items in the instrument. Figure 4.3 shows that most of the respondents’ measures fall around the mean, and that these range from a low of 33.1 to a high of 55.8. The items’ groupings indicated that brain changes, an abuse history, a sickness needing treatment, and a health condition were the primary areas that defined their beliefs about the existence and origins of depression.
Figure 4.4. Person-Item Map of the BHBI

<More depressed> | <Harder to Endorse>

60 +
   | T
59 +
   | 3 Sign of weakness
58 +
57 + 4 Being female  7 Is a sin
56 . + 12 God's punishment
   | 1 Doesn't exist
55 +
   | S
54 +
   |
53 + 6 Lack spiritual power
   | 11 Weak spirit
52 + 8 Sign of the devil
   | 9 Contrary to God's...
51 +
   | T
50 +
   . | M
49 # + 13 Satan's presence
   . | 18 Racism  19 Sexism
48 ### + 2 Happens to everyone
   # | 14 Guilt
47 # S+
   . # |
46 + 20 Being human  21 Being overweight
   ### |
45 .##### + 10 Genetics  16 Female changes
   .##### | S
44 ###### M+
   .##### |
43 .### + 5 Sickness treatment  15 Health condition
   22 Abuse history
   ####|
42 . + 17 Brain changes
   # |
41 ## S+
   |
40 ### +
   . | T
39 . +
38 . +
37 # +

<Less depressed> | <Easier to endorse>

EACH "#" IS 2. EACH "." IS 1.
Hypothesis 2 posits a relationship that regresses beliefs about the existence and origins of depression on income, education and age. The BHBI measures of the depression scale are used as the dependent variable, and the independent variables are age of the respondents and education. Age is a ratio level variable and was used directly in the model. Educational attainment was classified dichotomously, with a 0 code for all below a bachelor’s level, and a code of 1 for all at the master’s degrees or equivalent and higher. Preliminary analysis indicated that the great variability in income relative to depression beliefs showed little relationship and was therefore excluded from the final model. Application of the SAS multiple regression software produced the output in Table 4.18.

Examination of the output in Table 4.18 reveals that the significant F value is an indication of a relationship between beliefs about the existence and origins of depression and age and education, even though the $R^2$ is relatively small at 0.056. The variable age is statistically significant at 0.10 levels, and education is also significant at the 0.05 level. The coefficient for age is interpreted to mean that for an increase in age by 10 years, the belief index of depression (BHBI dependent variable) increased by 4 points. For example, as each woman aged by a decade, she found it more difficult to believe in statements that were shown in the upper section of Figure 4.3. Those statements were that depression was - contrary to God’s presence; sign of the devil; indicates a weak spirit; lack of spiritual power; doesn’t exist; God’s punishment; is a sin; being female; and a sign of weakness. When the value of the education variable for a respondent changed from 0 to 1—or from a bachelor’s level and below—the depression index (BHBI dependent variable) increased by about 1.5 points. Therefore, as a woman achieved higher education beyond the bachelor’s level, her education served to make it more difficult to endorse most of the belief items shown above the mean in Figure 4.3, specifically: contrary to
God’s presence; sign of the devil; indicates a weak spirit; lack of spiritual power; doesn’t exist; God’s punishment; is a sin; being female; and a sign of weakness.

| Variable | Estimated Coefficient | Standard Error | t value | Pr > | t |
|----------|-----------------------|----------------|---------|-------|
| Age      | 0.0417                | 0.0235         | 1.77    | 0.0790|
| Education | 1.3950            | 0.6824         | 2.04    | 0.0435|
| Constant | 41.1852              | 1.3140         | 31.34   | <0.0001|

F Value = 3.04  Pr > F = 0.0522  R2 = 0.0562

**Research Question 3:** What is the relationship among psychological resistance, conservative Christian views and African-American Christian women’s beliefs about the existence and origins of depression?

**Hypothesis Three:** There is a positive relationship among psychological resistance, conservative Christianity, and beliefs about the existence and origins of depression in African-American Christian women.

The dependent variable is operationally represented by a subscale of the Braithwaite-Hall Beliefs Inventory comprised of the items that make up questions 8 and 12. Question 8 consists of 9 belief statements about the existence of depression, and question 12 incorporates 13 belief statements about the origins of depression. (See the BHBI instrument for these items.) The data from the 22 items in the subscale were analyzed with the Rasch Rating Scale Model and the resulting additive linear measures of the individual respondents were rescaled to range from 0 to 100. Similar applications of the rating-scale model to the raw scores of the covariates
(Psychological Resistance and Conservative Christianity) produced interval measures. The relationship between these variables was then assessed with the multiple regression model.

The results from the regression analysis are presented in Table 4.19. The first key statistic examined was the F-test at the bottom of the table. The F-value of 7.09 and its associated p value of 0.0013 indicated a statistically significant relationship between beliefs about the existence and origins of depression (BHBI subscale) and psychological resistance and conservative Christianity, the R² indicated that the independent variables, Psychological Resistance and Conservative Christianity, explained only 12.3 percent of the variance between the dependent and the independent variables.

A review of the last column in Table 4.19 reveals that of the two independent variables, Psychological Resistance was statistically significant at the 0.001 level, while the Conservative Christianity’s p value of 0.1793 signified that it was not. These results indicated that while the independent variables Psychological Resistance and Conservative Christianity jointly have an impact on the independent variable Beliefs about the Existence and Origins of Depression, only the influence of Psychological Resistance was of statistical significance. Essentially, this means that higher psychological resistance scores had an inverse relationship to items that were above the mean on the BHBI subscale. Women who were optimal resistors did not endorse those items. Those statements were that depression was - contrary to God’s presence, sign of the devil, indicates a weak spirit, lack of spiritual power, doesn’t exist, God’s punishment, is a sin, being female, and a sign of weakness. A similar relationship was not indicated between the conservative Christianity scores and the BHBI belief subscales. Therefore, the hypothesis was not confirmed.
Table 4.19  Estimated Coefficients by the Multiple Regression Model of Beliefs about the Existence and Origins of Depression on Psychological Resistance and Conservative Christianity

| Variable                | Estimated Coefficient | Standard Error | t value | Pr > |t|     |
|-------------------------|-----------------------|----------------|---------|-------|-------|
| Psychological Resistance| 0.2296                | 0.0691         | 3.32    | 0.0012|
| Conservative Christianity| 0.0434                | 0.0321         | 1.35    | 0.1793|
| Constant                | 30.820                | 3.5580         | 8.66    | <0.0001|

F Value = 7.09  Pr > F = 0.0013  R² = 0.1230

Research Question 4: What are the mental health treatment types that African-American Christian women believe treat depression?

Hypothesis Four: There are a variety of mental health treatment types that a sample of African-American Christian women believes treat depression.

Table 4.20 lists the results for BHBI Treatment Subscale (item #16) which examined treatment modalities that the women believed in for the treatment of depression. The strongly agree and agree categories were combined into one agreement rating category. There were a variety of mental health treatment types for depression that a sample of African American women believed treat depression. The order of agreement was - prayer, psychotherapy / counseling, Bible reading, exercise, nutritional counseling, meditation, group counseling, fasting, and medication.
Table 4.20  
*Braithwaite Hall Beliefs Inventory (BHBI)*  
*Subset Item 16 – Frequency (N=106)*  
I Believe in the Following Treatments for Depression- Classical Presentation

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Agreement</th>
<th>SA-A</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>Psychotherapy/Counseling</td>
<td></td>
<td>98</td>
<td>92</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td>81</td>
<td>76</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>93</td>
<td>88</td>
</tr>
<tr>
<td>Meditation</td>
<td></td>
<td>87</td>
<td>82</td>
</tr>
<tr>
<td>Group Counseling</td>
<td></td>
<td>87</td>
<td>82</td>
</tr>
<tr>
<td>Shock Therapy</td>
<td></td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Bible Reading</td>
<td></td>
<td>92</td>
<td>88</td>
</tr>
<tr>
<td>Prayer</td>
<td></td>
<td>98</td>
<td>92</td>
</tr>
<tr>
<td>Fasting</td>
<td></td>
<td>72</td>
<td>68</td>
</tr>
</tbody>
</table>

*Note:* Responses based on Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree.) Agree and strongly agree frequencies were combined.

Figure 4.4 presents a Rasch Rating Scale Model visual demonstration of the location of the 10 items and the respondents in a hierarchical order on the same unidimensional continuum. The lower the location of an item (on the right side of map), the easier it was for the respondent to endorse the items that they believed represented options for treating depression. An additional advantage of the map was that it demonstrated that meaningful psychological distances existed between the items, and it shows further which sets of items can be considered as groups. The $M$ in the center along the line represents the mean of the distribution of the calibrated items; the $S$’s and $T$’s indicated the standard deviation and two standard deviations from the mean, respectively. There were 3 of the items that fell above the mean and 7 below it. The numbers on the left of the map represented the measures (positions) of the respondents when their scores
were transformed to logits (Rasch measures) and then put on a scale of 0 to 100. The mean of the items is 44.19 and it is 54.02 for the persons responding to the items. The mean of the items was lower than that of the respondents. This was an indication that the respondents found it rather easy to endorse the items in the instrument. Figure 4.4 shows that most of the respondents’ measures fell below the mean, and those respondents’ scores ranged from a low of 11.3 to a high of 86.5.

The items from Figure 4.4 indicated that there are several groups of treatment types that respondents believed treat depression. The first grouping included prayer and psychotherapy. The second grouping included Bible reading, exercise, meditation, nutritional counseling and group counseling. The third group included fasting and medication. The last group which respondents found the most difficult to endorse and therefore disagreed with the most was shock therapy.
FIGURE 4.5 Belief in Treatment for Depression

Persons - MAP - Items

EACH "#" IS 2. EACH "." IS 1.
Rasch Model Instrument Integration

The composite results presented in figure 4.6 provide depth and dimensionality to the specific instrument results used in this study. For each of the person-item tables the distances present are referred to as (item) separation. These are the number of distinct groups or strata in which all the items for the particular scale can be classified. The items on the map are clustered into groupings and there are gaps between them. When the primary groupings or strata of the Rasch person-item maps for each instrument are observed together, an enhanced understanding emerges regarding beliefs and psychological resistance. The numbers of strata for each instrument were BHBI (5), SS (4), RRMI (6), and BHBI – treatment (6).

Essentially, these highly evangelical Christian women operationalize their Christian beliefs through a personal relationship with Jesus Christ, the personal presence of God in their lives and the fundamental belief that God raised Jesus from the dead. When confronted with racial discrimination and stress, these optimal resistors utilize spiritual and socio-cultural psychological strategies to counter these experiences. If depression manifests in their lives, they believe that its existence and origin emanate from physiological and social causes. Lastly, if treatment is warranted for depression they would utilize prayer and psychotherapy as primary treatment modalities.
Figure 4.6 – Rasch Rating Scale Model Person-Item Map Summary for the Four Scales:
Braithwaite Hall Beliefs Inventory – (BHBI subscale 8,12), Shepherd Scale-(SS), Robinson Resistance Modality Inventory - (RRMI), BHBI (treatment)
N=(106)

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<tr>
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<tbody>
<tr>
<td>• personal relationship</td>
<td>• brain changes</td>
<td>• higher power</td>
<td>• prayer</td>
</tr>
<tr>
<td>• personal presence of God</td>
<td>• abuse history</td>
<td>• past struggles to inform present choices</td>
<td>• psychotherapy</td>
</tr>
<tr>
<td>• God raised Jesus from the dead</td>
<td>• sickness needing treatment</td>
<td>• pray for strength</td>
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<td></td>
<td>• health condition</td>
<td>• positive role model</td>
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Chapter Summary

This chapter presented a detailed description of the results of this study that examined the beliefs about depression and treatment in a sample of 106 African-American Christian women. The results were presented in two formats, the Classical Theory the Rasch Rating Scale Model. The findings were organized in four major sections. First, demographic characteristics of the sample were presented using descriptive statistics. Second, specific findings related to the Braithwaite-Hall Beliefs Inventory were presented. Third, descriptive results of the Robinson Resistance Modality Inventory and the Shepherd Scale were detailed. The chapter concluded with a presentation of the findings related to the research hypotheses.
Chapter Five
Discussion of the Findings

Introduction

The study explored beliefs about depression and its treatment in a sample of 106 African-American Christian women in the Boston area. The goals of the study were: 1) to examine levels of current depression, 2) to explore what variables influenced Black Christian women’s beliefs about depression, and 3) to determine what the sample deemed as appropriate treatment options for depression. This chapter presents a discussion of the major findings of the study across five sections. The first section provides a summary of findings. The second section presents the research hypotheses and discusses significant findings. The current literature on depression, Black women and treatment is provided. The third section presents theoretical implications for the research. The fourth section highlights issues of internal and external validity, as well as study limitations. Finally, the fifth section outlines recommendations for future work for the church, clinicians, and academic research.

Section One – Summary of Findings

Results from the Center for Epidemiological Studies Depression Scale indicate that sixty-four women were depressed. Never married women and the age groups of (20-59) had the highest percentage among the Clinically depressed. Educational attainment had a statistical significance on beliefs about the origins and existence of depression (BHBI subscale). This sample of women were found to be optimal resistors as scored from the Robinson Resistance Modality Inventory (n=82). Psychological resistance had a statistical significance on beliefs about the origins and existence of depression (BHBI scale). The sample was also found to be highly evangelical Christians as measured by the Shepherd Scale. Most had been Christians for
an average of twenty nine years. Results from the BHBI subscale revealed that study participants believed that depression emanated from brain changes, an abuse history, a sickness needing treatment, and a health condition. Lastly, women indicated that prayer and psychotherapy were the most acceptable forms of treatment for depression.

Section One- Research Questions and Hypotheses Discussion

Findings Related to Question #1

Research question #1: What is the prevalence of depression among African American Christian Women?

Hypothesis 1: There is a low prevalence of depression in a sample of African American Christian women.

This directional hypothesis was based on existing literature indicating the protective benefits that Christianity/religion has on depression. Research by Taylor and Chatters (1998) suggest that spiritual beliefs and church involvement hold protective benefits that impact on health, psychological, emotional and communal well being. Women who reported higher levels of spirituality and greater religious involvement (e.g. social support) had fewer symptoms of depression even after accounting for severity of exposure to violence, psychological aggression, and personal income (Watlington & Murphy, 2006). Similar results were found in a study where African Americans with higher orthodox Christianity scores (measured through attendance, education, involvement, membership and prayer) had fewer mental health problems (CES-D scores) than those African Americans with lower orthodox Christianity scores (Randolph-Seng et al., 2008)

Holt et al. (2005) found that religion and spirituality have an important role to play in coping with stress, enhancing social support, maintaining a healthy promoting behaviors,
enhancing a sense of meaning and purpose in life, and promoting social influence (Levin, 2001). Religious involvement such as religious attendance, prayer, sharing life’s difficulties provides group validation, promotes coping, and decreases negative states like depression and helplessness (Taylor et al., 1999, Taylor et al, 2004,). The demographic data from this study depict women who were deeply invested in Christianity through public and private practices, by way of weekly church attendance, participation in church ministries, daily prayer, and weekly Bible reading. Sixty-four women were depressed based on CES-D scores, indicating a moderate to high prevalence of depression in this sample of African-American Christian women. Theses study results did not support the hypothesis.

The research literature on Black women and depression presents a mixed set of results. Lack of inclusion in large scale studies, (Carrington, 2006), higher rates of clinical depression diagnosis (Jonas & Wilson 1997; Gazmararian et. al, 1995), high rates of depression in poor Black women (Women of Color Data Book, 2006), under diagnosis and treatment, stigma and access (Surgeon General Report, 2001), greater lifetime presence of presence of major depression, and anxiety disorders- simple phobia, agoraphobia, social phobia, and post traumatic stress disorder, (Brown & Keith, 2003) all indicate the presence and challenge in accurately capturing the extent of depression in Black women. Although African American women have lower rates of mental illness than European American women, only one in three receive mental health treatment (Office of Women’s Health, 2010). Therefore, the potential for prevalence rates to be high were instructive in the formulation of the research hypothesis.

Never married women and the age groups of (20-59) had the highest percentage among the Clinically depressed. This sample compositely represents women who are employed, raising children, providing some care for others who live with them, navigating midlife, maintaining a
marriage, participating in church activities and sustaining their Christian faith. They are living complex lives. As a result, awareness of and conscious attention to the cumulative impact of multiple responsibilities on their emotional and psychological health may be absent.

In large and small studies (Brown and Keith, 2003; Williams, et. al., 2004) have reported on the relationship between depression in black women and age. This study conveyed the striking reality that depression is present across the lifespan of Black women. The clinically depressed were represented in all age groups from 20-59 years old. Wang et al (2000) indicated that clinical depression occurs more frequently (18.9%) among younger (18-44) than older women (3.8%). The highest rates occur among those aged 20 to 29 years old. The results of this study partly affirmed these age related findings. Women over the age of 60 had the lowest rates of clinical depression. An important lifespan issue emerges. Specifically what happens when a women reaches 60 and beyond that make her less susceptible to depression?

The developmental implications of this finding are noteworthy. Brice (2003) indicates that contemporary, mid-life Black women could be getting married, getting divorced, becoming mothers or grandmothers, experiencing professional seniority or retirement, negotiating economic solvency while transitioning through menopause. Gaston and Porter (2001) indicate that although Black women have more physiological changes during menopause than white women, they experiences less psychological difficulties. Although the ongoing dynamic of being black and female are still present, the external stresses have less impact on the internal well being of these women.

In contrast, women in their early twenties through the late fifties have lifestyle issues that can potentially have negative impacts on their lives. Woods-Giscombe (2010) found that across age groups the meaning and interpretation of the Strong Black Woman manifested in the
following ways: obligation to manifest strength, obligation to suppress emotions, resistance to being vulnerable or dependent, determination to succeed despite limited resources, and obligation to help others. For women in this age group, the foreground of the Strong Black Woman heightens the ongoing developmental challenges that a woman experiences as she moves through her life cycle. There are also important developmental and lifestyle concerns with which young women grapple. These concerns include continued identity formation, career exploration, and professional affiliation. For many the instability of shifting away from family circles and the economic realities of self-sufficiency can be emotional and psychologically difficult. In addition, if these women are first generation college graduates and or from immigrant families the pressure to choose a specific pathway and not “explore” life can create great internal stress and anxiety (Robinson-Wood, 2009). Data from the National Center for Educational Statistics (2005) indicate that females comprise 65% of the Black student population on college and university campuses. This imbalance creates difficulties in dating, remaining in relationships with mates who have multiple partners, or choosing to date across racial lines. This situation is particularly acute for women born after 1981, known as members of the millennial generation (Henry, 2008).

Study results also indicated highest percentages of clinically depressed among never married women and lowest percentages of not depressed among married women. Almost half of the sample were not married (42%). The issues influencing these results among never married women are related to familial and social pressures, the pool of available men, economic stress, single parenting, intrinsic developmental challenges, and the stress that comes from living life without a partner (Brown, 2003). Single women in the 25 to 45 age group believed that because they didn’t have spouses and families, others expected them to have more time and they were
uncomfortable finding themselves delegated to more roles and responsibilities which had emanated from their feelings of obligation to help others (Woods-Giscombe, 2010).

Another possible explanation for these results in married women is related to social class. Married women may experience a greater level of economic security than never married women (Brown, 2003). Though there are a variety of stressors and multiple expectations that emanate from marriage, there are built in supports to process life challenges, share chores of daily life, support for physical health and overall well being. In a study of 40,000 African-American women (Williams, et. al, 2004) scores on the CES-D differed by age, educational attainment, marital status and occupation. Of note, lower depression scores were noted among women who were married and those working in professional or managerial positions. Beeghly et al. (2003) also found that single marital status, low-income, and single parenthood related to high CES-D scores for Black mothers during their first 18 months postpartum.

Findings Related to Question #2

Research Question #2: What is the relationship between income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women?

Hypothesis Two: There is a positive relationship among income, educational level, age and beliefs about the existence and origins of depression in African-American Christian women.

First, the great variability in income relative to depression beliefs showed little relationship and was therefore excluded from the final model. The examination of the significance of age on beliefs indicated that when there was an increase in age by 10 years, the belief index of depression (BHBI subscale) increased by 4 points. For example, as each woman aged by a decade, she found it more difficult to believe that depression was - contrary to God’s
presence, sign of the devil, indicates a weak spirit, lack of spiritual power, doesn’t exist, God’s punishment, is a sin, being female, and a sign of weakness.

Next, as a woman achieved higher education beyond the bachelor’s level, her education served to make it more difficult to endorse the belief that the existence and origins of depression was contrary to God’s presence, sign of the devil, indicates a weak spirit, lack of spiritual power, doesn’t exist, God’s punishment, is a sin, being female, and a sign of weakness, genetics, weak spirit, God’s punishment, Satan’s presence, happens to everyone, guilt, female changes, racism, sexism, being human, and being overweight.

Specifically, these women indicated that the existence of depression was a sickness needing treatment that originated from a health condition, brain changes, and an abuse history. Essentially, these results indicated that the maturation and aging process, and post secondary education combined to influence women’s thinking about depression. Further, one hundred and three of the women agreed (BHBI) that the conditions in Black women’s lives contribute to depression. They rejected the belief that sin based, God inflicted punishments were the originators of depression. It appears that the exposure to knowledge as a consequence of formal education positioned these women to heightened critique and analysis of problems and their solutions. The educational achievement of this sample is noteworthy. Approximately 60% of these women had earned at least one college degree. This may in part be due to the Massachusetts area which is densely populated with higher educational institutions. In addition, their social class of origin was predominantly from working and middle class backgrounds. Additionally, 44 percent of their mothers and fathers and 19% of the women emanate from the West Indies/Caribbean. Moreover, beliefs and attitudes of depression and mental health
treatment are especially stigmatized in the Caribbean and African communities (Miranda et al, 2005).

What is the relationship between the process of maturity/aging and women’s beliefs that depression has physiological and contextual origins? In the large scale previously cited by (Williams, et. al, 2004) women with less than high school had higher mean CES-D scores, while women with schooling beyond college had the lowest scores. These results confirm those findings related to educational attainment. Both educational attainment and maturation are processes of cognitive, emotional, and psychological expansion. The aging process creates physical changes that have emotional and psychological consequences, but often Black women are reluctant to pay attention to these changes because they have to deal with the daily realities of being strong (Etowah, Keddy, Egbeayemi & Eghan, 2007). The participants in the Etowah (2007) study, mid-life Black women, described their experience of being in an invisible grey fog which prompted their desire to get away from others and “fortify themselves” (p. 208). The mid-life development stage for these women raise many issues related to health, aging parents, professional growth, parenting, and intimacy needs. When unattended to these concerns can lead to depression or health related difficulties. Senior African American women who remain actively engaged post retirement age have been found to exhibit psychological constructs such as ego resilience, optimism and adaptive responses to discrimination (Baldwirn et al., 2010).

Education for Black women has transforming impact on the woman and her family. The pursuit of education, especially higher education has extraordinary impacts on the quality of life, social networks, economic solvency, and enhanced self-concept for Black women. Further women who are first generation college educated (Gilford & Reynolds, 2010) and/ or immigrant women experience unique challenges to the realization of their dreams along with in inherent
family pressures and expectation (Tolulope Awokoya & Clark, 2008). Robinson-Wood (2009) detailed the particular stressors of love, academics and money that African American college age women encountered during their pursuit of higher education at a predominantly white institution. Certainly the process of educational achievement creates distinct challenges that can manifest in emotional, relational, financial and psychological distress. In addition, the desire for advancement and achievement is often intertwined with conflicting feelings about the fear of the loss of self, becoming alienated from their histories, their blackness, their mothers, their fathers, and their grandmothers (Woods-Giscombe, 2010; Turner, 1997). These highly educated women may have experienced emotional distress as a result of their educational experience. Data is not available about whether these women attended predominantly white or historically black colleges or universities. Nevertheless, the research indicates that the institutional and personal stressors that Black females endure to achieve their educational goals are significant and contribute to psychological and emotional distress (Henry et al., 2010; Henry, 2008; Smith, 2008).

More importantly, once the educational goals have been achieved the workplace presents distinct stressors that encompass the double jeopardy of being female and black. Women who are in professional and leadership positions encounter a complex interplay of racial and gender dynamics (Turner, 1997). Brown and Cohran (2003) detailed that everyday types of discriminatory experiences that were based in the workplace were with higher levels of psychological distress among African-American women. These more routine experiences (verbal insults, poor service, and disrespect) are distinct from the major discrimination acts like loss of employment due to race. When the incidences were prolonged and intense, participants
reported increase in depressive symptoms. Women in service positions as well as those in professional jobs are at risk for depression (Jackson, 2003; Keith, 2003).

Research Question #3: Is there a relationship among psychological resistance, conservative Christian views and African-American Christian women’s beliefs about the existence and origins of depression?

Hypothesis Three: There is a positive relationship among psychological resistance, conservative Christianity and beliefs about the existence and origins of depression.

The results indicated there was a statistically significant relationship between psychological resistance and beliefs about the existence and origins of depression. Women who were optimal resistors did not endorse the statements that depression was counter to God’s presence, sign of the devil, indicates a weak spirit, lack of spiritual power, doesn’t exist, God’s punishment, is a sin, being female, and a sign of weakness. No statistical significant relationship was found between conservative Christianity and women’s beliefs about the existence and origins of depression.

This research sample is comprised of women who are optimal resistors and evangelical Christians. Optimal resistance is characterized by a reliance on multiple resources- psychotherapy, pharmacology, exercise, community and spiritual resources that may be in the service of preventing depressive symptomatology and/or effectively intervening (Robinson & Ward, 1991). In Resistance theory, optimal resistance reflects an awareness of environmental stress and institutional oppression that press down on and depress Black women’s lives. The avoidance of negative and depressive thought patterns that directly impact behavior and emotional states is critical to optimal resistance (Myers, 1991). It appears the psychological
resistance present within the women mitigates against the belief often held by Christians that emotional problems are re-interpreted as character problems (e.g. lack of spiritual power, sign of weakness) which requires more sanctification (Carlson, 1998). This emotional-health gospel assumes that if you have repented of your sins, prayed correctly and spent time in God’s word you will have a sound mind free of emotional problems.

This sample of optimal resistors had depressive scores that indicated the presence of moderate and clinical levels of depression. Resistance is not a bifurcation of simply being an optimal or suboptimal resistor. A woman embodies both, but tends to utilize one that is more characteristic of her life. The suboptimal aspects of optimal resister’s lives may be contributing to depression. The life of a Black woman in American is marked by challenge great and small. The adaptive processes of resistance have and continue to be emblematic of Black women’s psychological resources. Without the utilization of short term adaptive strategies as manifested by suboptimal resistance or reliance on long term multiple resources, optimal resistance, Black women would cease to exist. These results implicate the serious complexity and stress that Black women must manage. Even with high optimal resistant scores that used spiritual and psycho-social strategies, these women still experienced depressive symptoms. Perhaps it is inevitable that a Black woman will experience depression in her lifetime. The intention now is to provide women with the tools to increase their awareness of the impact of constant resistance. To be fully whole, allowing for emotional vulnerability and the reduction of the reliance on sub-optimal strategies is crucial.

Findings for Question #4

Research Question #4- What are the mental health treatment types that a sample of African-American Christian women believe treat depression? BHBI (subscale item #16)
**Hypothesis Four:** There are a variety of mental health treatment types that a sample of African-American Christian women believes treat depression.

There were a variety of mental health treatment types that research participants believed treat depression. The results were grouped into four sets of treatment types. These findings underscore the centrality of their Christian beliefs, their middle income status (median income $81,000) and their post secondary educational achievement. In the first three groups, the treatments are a combination of faith-based actions as well as actions that would be found to be acceptable for more educated persons and those from middle or upper incomes. The first grouping included prayer and psychotherapy. The second grouping included Bible reading, exercise, meditation, nutritional counseling and group counseling. The third group included fasting and medication. The last group which respondents found the most difficult to endorse and therefore disagreed with the most was shock therapy.

Prayer for African-Americans is the primary source of religious expression in the public and private settings (Taylor, et al, 2004). This expression is the singular way that black women express their Christianity. Data from the National Survey of Black Americans (Taylor & Chatters, 1986a, 1986b, 1988) reveals that women pray 85% more than men; prayer is a regular form of spiritual expression; and while prayer serves as a coping activity, it can be used to mask problems. What is noteworthy about these results is that the literature refers to prayer as a primary coping mechanism, and means of expression for Christianity for Black women (Taylor, 2004; Mattis, 2000). The psychological research has limited reference to prayer as the treatment for depression. This researcher did not investigate Christian exclusive counseling materials to better understand the role and process that prayer may have exclusively in treatment. The results may *be* interpreted to mean that these women have an active Christianity that engages their
minds, hearts and will. As a consequence, their utilization of spiritual and socio-cultural psychological strategies to counter stress and discrimination indicates that an integrative process is present. More research is needed to better understand and deconstruct the interplay and interaction of these variables.

Robinson-Wood and Braithwaite-Hall (2005) indicate that prayer can be a part of the psychotherapy process, but not the sole clinical intervention. So what conclusions are drawn from this finding? It is conceivable that these women literally mean that God, the Supreme Being, aided by the power of the Holy Ghost will intervene and take away the feelings of depression. In addition the research sample may interpret the relieving of their oppressive depressive symptoms as treatment as opposed to a situational coping intervention that allows them to take steps to engage the ongoing/persistent issues related to the depression. The issue of treatment versus situational coping becomes an important distinction of how women perceive treatment for depression. Situational coping may not address underlying contributing issues to the depression such as health concerns, menopause, an abuse history, and mental illness. Moreover, this interpretation of prayer as treatment has important implications for the therapy process. Further research is warranted to better understand the phenomenon when women experience healing as a result of prayer.

Psychotherapy replicates a sacred space and internal exploration similar to a spiritual environment (Robinson-Wood & Braithwaite-Hall, 2005). Caldwell (2003) reported that women with more financial resources tended to use a therapist, while those who used ministers as a mental health resource, had less income, were married, attended church more regularly, and viewed themselves as religious. This research confirms the role of income in the use of a therapist because economic class supports the exposure, familiarity and means to engage therapy.
Detailed results from this study revealed that 70% of the women would use community resources for treatment and that 53% of them have sought treatment for depression outside of the church. Further, forty-seven percent note that counselors include Christian beliefs in treatment. Understanding what aspects of their Christian beliefs were utilized in their treatment is an area of inquiry that needs further study.

Boyd-Franklin (2004) notes that African-Americans have traditionally sought out pastors for counseling due to both the sacred, revered position of the person and the long standing mistrust and stigma associated with mental health treatment entities. In a survey of 99 pastors (Young, Griffith, & Williams, 2003), causes of mental illness noted were stresses of living (90%), unhealthy early family relationships (85%), a lack of a “right relationship with God” (72%), and biological reasons (60%). Of note was 60% indicated that stunted spiritual growth or un-confessed sin were causative factors. There are inherent challenges when pastors are the first line of contact for mental health care. Unless the clergy member has received some training in psychological care, then he/she may be only providing limited treatment for women. African American pastors are very direct in their relationships with their congregants. As a result, individuals may expect professional therapists to conduct themselves in a similar style (Wimberly, 1991).

Recently, Gonzalez (2010) investigated past year patterns of depression care among ethnic groups (Mexican Americans, Caribbean Blacks, Puerto Ricans, African Americans) in the United States. The results indicated that only 1 in 5 individuals with major depression receive treatment in line with the American Psychiatric Association guidelines. Only 21% of the total sample who met criteria for major depression used any type of depression treatment that was concordant with psychiatry guidelines (psychopharmacology and psychotherapy). African
Americans and Mexican Americans were least likely to receive care. Though treatments rates were still low, psychotherapy (African American 13%, Mexican Americans 11%) was higher than medication use (African Americans 4.9%, Mexican Americans 5.6%). Barriers to adequate care included cultural myths that African Americans won’t admit weakness, resistance to take antidepressants, give up treatment after having to re-apply for additional mental health coverage insurance, and reliance on pastoral care for therapy.

Section Three- Conceptual and Theoretical Implications

Dynamic of Strength, Resistance and Convergence

In the recent book Fierce Angels (2010) author Sheri Parks presents a compelling treatise on the evolution of the “strong Black woman”. The expansive historical framework details the Dark Feminine and its lasting role in the early civilizations of Greek, Sumeria, and West African cultures. Parks (2010) illuminates the powerful hijacking of this woman from the enslavement period and the ensuing stereotypes and myths that became part of the identification given to her. As a result, the Dark Feminine became the Mammy. Abdullah (1998) contends that this Mammy stereotype endures in our contemporary life. The enslavement process required the black woman to disconnect from her fundamental self and in its place to elevate the sexual, psychological and physical needs of the slave master above her own. These internalized concepts of the self become transferred across generations and through inter and intra group dynamics.

the Strong Black Woman role is overwhelming- it calls for incredible levels of emotional, spiritual, and intellectual energy, combined with a selflessness that is truly superhuman and wildly unrealistic p...xv) There are requirements to being a Strong Black Woman that nobody says but everyone knows. They are allowed to be strong, but only for the good of others. And they conspire in their own
invisibility by refusing to talk about their accomplishments (p. xviii)…Black women pay with their health when they keep responsibility for all that is around them yet place themselves behind black men and so expose themselves to the most dangerous types of stress- that tied to responsibility without control. The diseases that kill black women- diabetes, heart conditions, obesity, and hypertension- are all connected to and worsened by stress. (p.xix) (Parks, 2010, p. xx).

This presentation of the selflessness of many black women factors into the issues of coping, mental health and well being and the capacity to clarify what are authentically the needs of the woman. Bell and Nkomo (1998) note that regardless of socio-economic and family configuration, becoming self-reliant and being strong are persistent themes in the mental health of African American women. Armoring is the socializing processes taught often by the mother to the daughter as proactive response to the persistence devaluing messages and experiences of racism and sexism (Bell & Nkomo, 1998). Romero (2000) posits that the SBW (Strong Black Women) depending on how well she has developed coping skills may present as either inflexible and close-minded or as poised and competent. The African-American woman may not understand why others see her as so together when internally she feels anxious and depressed. This idealized persona gets challenged, impacted and buffeted in the social roles that occupy her life. The process of “shifting” between environments and expectation leaves the Black woman lacking and confused about her authentic essential self (Jones & Shorter-Gooden, 2003).

The BHBI reported that 74% and 84% respectively of the women believed that the image of the strong Black woman as well as conditions in Black women’s lives contribute to depression. These women did not endorse earlier in the survey that being female was part of why
depression existed. In contrast, when the strong Black woman was specifically named— the
of depression from a culturally, racially and gendered strength discourse, wherein women silence
their internal needs and drives. Woods-Giscombe (2010) investigated through qualitative
research the role and impact of the superwoman schema on the health, stress and well being. The
women articulated the negative consequences on relationships, health and psychological
functioning. This area of psychological functioning was deemed “embodiment”, where
symptoms like migraines, hair loss, panic attacks, weight gain, and depression were manifested.

The Convergence of Race, Gender and Christianity

The results from this study create an imperative to further investigate the issues of
convergence of race, gender, and Christianity. Multicultural psychology as the theoretical
framework for this research (Robinson, 2005; Reynolds & Constantine; Helms, 1999; Sue et al.,
1992) enhanced the scholarship and understanding of the distinct aspects of human difference
such as race, gender, ethnicity, sexuality and economic class and their influences on
psychological and social functioning of individuals from those groups. Feminists introduced the
concept of intersectionality (Combahee River Collective Statement, 1977), the confluence of
multiple identities in each individual, as well as social location, the elevation, and subjugation
associated with the identified. The evolution of intersectionality manifested in scholarship on
convergence whereby the merging of multiple parts of the women is constructed with varying
parts integrating the tensions and stressors of those processes (Mirkin, Suyemoto, & Okun, 2005;
multicultural psychology framed this research. With these theories as guiding frameworks, it is
posited that that the identities of Black Christian women is a co-constructed process that has
historical, cultural, religious, social, racial and gender underpinning. As a result the convergence of these three - race, gender and Christianity forge a particular way of being and experiencing the world. More thoughtful and creative research is needed to understand and conceptualize how this multi-layered experience and lived reality informs the lifestyle, choices, functioning and adaptive and maladaptive responses of this major segment of the Black community.

This researcher had theorized that highly evangelic African-American Christian women would embrace and internalize the dynamic of suffering with Christ as a means through which they make meaning of depression for themselves or for others. The response to the question of the BHBI which asks whether the suffering of Jesus Christ contributes to depression for black women was answered negatively. However, the Strong Black Woman Archetype steeped in the strength at all cost discourse is a socially constructed definition of what it means to be a black female. As a result, this construction provides an avenue for suffering as emblematic to black women.

A lingering question for this researcher is whether there is a distinct lived experience - that of the black Christian woman that theoretically is a convergence of race, gender and Christianity. The findings from this study do not equivocally answer this question. Black Christian women, especially those who are deeply committed to the tenets and values of Christianity are distinct. Christianity as experienced through the Black church is a complex community of faith expression and cultural embodiment. It provides for a vehicle for political, academic, artistic, economic and personal skill development (Reid, 2003; Cook, 2000). It serves as an instrument for identity and spiritual formation through prayer, meditation, attending worship services, music, fasting, dress, structured ritual participation, bible study class, reading the Bible, healing experiences of the body and emotions, being caught up in the spirit, testifying,
and specific methods of reference to one another, such as brother and sister. (Cook & Wiley, 2000). This lifestyle in combination with belief systems, racial identification and gender may converge into a distinct lived experience.

Though Christianity is a key mechanism for coping with the deleterious effects of the marginalized lives that many black people/women live- it also creates a covering to hide from engaging one’s personal problems. A woman can continue to have all of the external behaviors of her Christianity - praying, Bible reading, going to services, serving in various ministries and still mask her depression. The issue of what silences her within – the strong Black woman discourse, her interpretation of her Christianity or a phenomenon that uniquely derived from their converged reality. Further exploration and refinement needs to occur on this distinct convergence of race, gender and Christianity.

Christianity as expressed in the Black church not only promotes connection and adherence to the teachings of Christ, but also creates meaning and interaction with culture, gender, class, values, and beliefs (Taylor et al., 2004). The investigation of the co-construction and ultimate convergence of the identities of the Black Christian woman are merited. In psychological terms, the Strong Black Woman embodies a resistance to the expression of emotional vulnerability. As noted there are benefits and wide ranging psychological costs to this dynamic. Christianity as practiced within the Black church also manifests a resistance to maintaining emotional vulnerability. It is acceptable to get “caught up in the spirit” and “give it all to Jesus”, yet the enduring reality of feeling pain, suffering and being depressed runs counter to the expression and profession of Christianity. One of the many enduring legacies of the church has been to aid the Black community to overcome the enduring obstacles of racism and oppression (Gilkes, 1998; Lincoln & Mamiya, 1990). In order to accomplish this reality of
contending with oppression and racial subjugation, the embracing of sustained feelings of vulnerability had no place beyond respite and release. The psychological resistance as measured by the RRMI focuses on the strategies that Black women use to counter discrimination. The fact that they utilize a Higher Power and prayer as their fundamental strategies needs further investigation. As previously noted, this researcher believes there is a convergence in identities of race, gender and Christianity that is influenced by the dynamic of resistance. The phenomena of Divine intervention, altered states, faith healing and prayer are not fully understood by psychology or science (Kahl, 2004; Levin, 2001; Coleman, 2002). We know that resistance is a persistent theme for the Strong Black Woman and for those who believe in the saving grace of Jesus Christ. So, what happens in the converged identities of Black women who identify more as Christians and yet experience the contemporary challenges of living in a society where the imposed realities of being Black and female continue to endure? It would be extremely advantageous and empowering for Black Christian women to not only understand the interplay of these dynamics but to more actively choose to participate in the breaking of generational cycles of selflessness and superhuman support to others. The scriptures notes that even Jesus wept and went into the garden to rest.

**Beliefs about Depression**

This group of Christian women agreed that depression was the result of brain changes, an abuse history, a sickness needing treatment and a health condition. They overwhelmingly indicated disagreement in the belief that depression was the result of God’s punishment, sin, Satan, being female and personal weakness. In addition, guilt over something one should have done received a higher percentage of agreement than the presence of Satan being causative to depression. This is noteworthy given the sample being a high evangelical Christian group of
women. Even if there were methodological issues related to the Shepherd Scale which measured levels of Conservative Christianity, actual, ongoing Christian lifestyle as captured from demographic data indicate a consistently active group of women who had regular public and private practice of their Christianity. For evangelical Christians, the personal relationship with Jesus Christ and the presence of the Devil/Satan to create destruction and break down the kingdom of God are significant beliefs (Long-Cudjoe, 2004). Yet these women clearly say no— they do not believe this is so as it relates specifically to depression. There are theological issues that emanate from these results as well as the evident psycho-social implications.

These results reveal women who are not bound by conventional Christian teaching about the cost and punishments of the presence of sin. Furthermore, it appears that these women had to engage in some process of deconstruction and rejection of these Christian teachings based on their lived experiences. Previous studies on this issue offer conflicting results. Ward (2005) indicated that Black women believe that culturally specific factors (racism, discrimination and oppression) as well as trauma, stress, biology and environment can cause mental illness. NMHA (1996) indicated a persistent lack of clarity regarding the symptoms, definitions and progression of depression among AA. Further their study revealed that 63% of African-Americans believed depression is a personal weakness. Roughly, 40% of the sample would not seek treatment because of denial, 38% no treatment because of shame or embarrassment. Only 30% believed depression was a health problem.

The findings of this research study confirm and expand the understanding of the NMHA results. Forty percent of the women have heard a sermon on depression. This affirms the pervasive gap in the way that mental health issues such as depression are engaged in the church environment. Boyd-Franklin (2003) indicated that a more highly educated congregation requires
a more sophisticated response from the pulpit to life’s issues that include the word of God as well as connections to secular solutions and resources. This finding is noteworthy because these women attend church at least weekly. Clergy training, educational achievement, and years in ministry and their combined impact on perceptions and beliefs concerning depression and treatment warrant further examination (Taylor, et al., 2004). There is an overt message being sent when topics such as depression are absent from the discourse coming from the pulpit. This sample of women has spent many years in educational environments. They occupy para professional and professional roles where information and training are a regular part of their lives. They have been presented with the church doctrines and yet have received limited direct pastoral teaching on this topic. The fact that only 15 of these women have sought help from her pastor for depression, even though more than 15 women have been depressed is noteworthy. Their response may indicate lack of faith in the treatment offered, concern about confidentiality, shame for needing support from church, and the belief that a sickness like depression needs professional attention.

Furthermore, a higher percentage, 70% as compared to 61%, of women would choose the use of outside counseling instead of church based counseling. As previously noted with the lack of use of their pastors for counseling, these women are likely factoring e training, credentialing issues, and confidentiality in this decision. One slightly encouraging result was that 56 of these women who opted to seek outside treatment encountered 47% of their counselors who did not include their Christian beliefs in treatment. However, in comparison to the general public where 93% believes in God, only 43% of APA members believe in God. Furthermore, psychologists have lower levels of religious participation in comparison to other mental health professional (Weaver et. al, 1998). Clearly this fact still continues to be present.
Section Four- Limitations of the Research

The sample was not randomly selected. Twenty-five percent of the women did not respond to the income question. This made it difficult to really assess the link between and beliefs about the origin and treatment of depression. Essentially, this reduced the power of the study. Three congregations were represented in the sample with differing levels of completed surveys from each congregation. The denominations were different, though all women self-identified as Black Christian woman.

Internal Validity

The Rasch model enables the researcher to test if items in an instrument form a unidimensional variable, it calibrates the magnitude of differences among items on an interval scale, and it measures each person on the newly created variable (Fox and Jones, 1998). Importantly, it transforms ordinal data to log odd ratios or logits, and by so doing, it places them on an interval-level scale, thus enabling statistical tests to be conducted with real interval data. Moreover, unlike traditional analysis which produces a single measure of reliability and of validity, the Rasch model not only generates these, but it also produces a measure of reliability and validity for every Likert-type statement in a questionnaire. One of the strengths of the model is that it is “sample free”, in that it does not depend upon the necessity of a probability sample for its results to be valid. Both women and survey statements or items can be located along one continuum or construct on the same map. Probability curves were presented to indicate the categories that were redundant and therefore could be deleted the next time the instrument is used. This was especially useful for a new instrument developed by the researcher. The use of reliability indices such as the person separation reliability, approximately equivalent to
Coefficient Alpha, indicates if the scale discriminates among respondents. Also the item separation reliability indicates that the variable being measured is well defined.

The Rasch system provided an enhanced process for measuring the true distance between the responses and between the respondents. The ability for the research finding to be replicated by another researcher will require that that individual develop facility with this modeling system. The logit system is being used with greater frequency in the educational and social sciences arena. The decision for this researcher to use this analytical tool was done to ensure that results could be interpreted with some degree of validity while introducing a valuable model into the social sciences arena.

The study did not explicitly explore women’s response to stress or life challenges. Information was deciphered from the self-care practices section of the BHBI that indicate the practices that are used to promote well being. One could hypothesize the likelihood that these women would use spiritual/religious resources such as prayer, Bible reading, and attendance at services as resources to manage and deal with life challenges. There was no racial identity measure employed in the study. The totality of time required to complete the survey packet caused this researcher to decide against adding another inventory. The RRMI provides an understanding of the ways in which black women engage discrimination and psychological challenges. A racial identity measure such as the Multidimensional Inventory of Black Identity (MIBI; Sellers, Rowley, Chavous, Shelton, & Smith, 1997) would indicate the woman’s level of development of her racialized self. Perhaps an explicitly Womanist (Helms, 1990) instrument would have also provided a means through which the racialized and gendered self could have been rated and captured.
Methodologically, results from the study could have been enhanced with the use of additional qualitative techniques beyond the open response question on the BHBI. Because black women are culturally accustomed to the sister-circle, using a focus group format would have likely added rich content to the results. In addition, this process could have broken chinks in the strong black woman protective wall that many study participants and researchers have noted. The utilization of narrative collection of several women from each church would have added additional qualitative information. This method would likely seem similar to the “telling of one’s testimony”, a process in the black church where the narrative process is used to capture the essence of how God worked to bring a woman through a situation or circumstance. The average age of the study participants being in the mid-forties indicates the advent of peri-menopause or menopause. It is well known that there are both physical and emotional/psychological changes that happen to a woman during this time. Information could have collected on this vital issue for women. Responses to several questions on the BHBI, particularly in the existence and origin of depression subscale, refer to abuse and the use of therapy. There were no questions posed relative to abuse, and/or the use of therapy at any time. This would have provided a specific understanding of beliefs about depression and treatment from a Christian woman who has been through abuse and utilized therapy as a treatment modality.

*External Validity*

The study sample was not random. As such, the results of the study are best generalized to African-American Christian women who may or may not be active participants in a church community, but identify themselves as a Christian woman. Assumptions cannot be made that the results could be replicated with a sample that is not as highly educated as this study group. The RRMI was normed on a college sample, so education is a mitigating variable for this study. Age
has been determined to be a significant independent variable. The study occurred in the New England, a distinct region of the United States. Though a significant percentage of participants had immigrant backgrounds, the regional difference in the expression of Christian denominations may have specific impacts. For example there were no Roman Catholic, Holiness, Pentecostal, or Methodist churches in the study. Some of these churches have specific structures of governance that dictate the type of church support services that are offered. Churches that are more in line with strict Biblical interpretation may outline clearly individual responses to depression and mental distress.

**Measurement Reliability**

Twenty-five percent of the respondent did not report their annual income. The financial information that women who did provide represented such a wide range proved too extensive to utilize for the regression analysis. Women were more forthcoming in their depression responses, but were hesitant in sharing what may have been perceived as highly personal information. This dynamic may result from a combination of concerns of confidentiality, perceptions of being judged by the researcher, or simply that it was nobody’s business to know this information.

Previous research studies have raised questions about the accuracy of the CES-D in the diagnosing of depression in African-American women. It appears that even in samples with highly educated women there are elevated scores. Based on the consistent inconsistency in results, one study (Etowah et. al, 2007) suggests that the instrument should be used as a first line diagnostic tool that is subsequently followed up with more in-depth interviews or additional instruments. Moreover, the additional use of an item examination has been utilized in one study (Boutin-Foster, 2008) as a more accurate process for understanding the area of depressive symptomatology that is being reported.
The results from the BHBI revealed that 89% of the women agreed with the APA definition of depression. Similar findings were noted in the work of Ward (2009). The APA definition is the gold standard that is used by mental health and medical professionals. The symptom presentation used for diagnosis is frequently different for African American women. As a consequence, African-American symptom expression is often somaticized in the form of headaches, irritability, crying fits, busyness, poor self-care, and the masking or denial of symptoms (Boyd-Franklin, 2003, Singleton, 2003). As a result, clinicians need to aide women in understanding that the symptom expression of depression often shows up as more somaticized for Black women (Boyd-Franklin; Carrington, 2006). Care should be given to the misperception and historical racism, and under diagnosing that have combined to maintain an atmosphere of suspicion and mistrust.

Williams (2009) suggest that the explanation of type of theoretical orientation (psychodynamic, cognitive behavioral, integrative) and treatment types can be extremely useful for women to make informed decisions and feel empowered. Since emotional suppression and resistance to emotional vulnerability is often the norm for Black women, increasing emotional literacy and enhancing awareness of triggers to depressive feelings is an important goal in therapeutic work. Etowah et al., (2007) noted that Black women not only have difficulty in discussing depression, but also in the identification of it. This was also affirmed in the open response question. Some illustrative comments include:

*Not recognized early and tested, not used frequently to diagnose. Depression not given high visibility like other favored diseases like breast cancer, so women do not seek treatment. Mental health not embraced by Black community.*

*Black women often not willing to talk about depression with family, friends, co-workers. When I tried, I remember being told Black women don’t go to therapy- just get over it.*
Depression is not only seen by DSM symptoms. Watch for women who appear to be on top of it, but are clearly not managing these parts well. Strong Black women syndrome. Black women don’t want to be stigmatized.

In addition, the persistence of the socio-cultural relevance of the Strong Black Woman causes women to mask their distress behind a mask of strength (Giscombe, 2010). Coridan and O’Connell’s (2003) work with the NIMH indicate that a majority of women of color have experienced some form of childhood physical or sexual abuse that has an impact on functioning in adulthood. Clinicians should take important note of this finding. For example, one participant recognized the importance of childhood experiences, as reflected by the following statement: “Be persistent inquiring about childhood.” Furthermore, women who are mothers should be supported in examining the ways in which the strength discourse permeates their own development as well as the ways they raise their daughters and sons.

*It may take a very long time to let our guards down and feel comfortable in a therapy. This is especially true if we don’t feel provider can possibly relate to our frame of reference or experiences.*

*That it's typically masked in denial. That it is often a source of shame. It is unrecognizable to the sufferer.*

The tools that Black women use to navigate and negotiate their lives are important for clinical and psycho educational interventions. Prayer and psychotherapy were grouped as the key forms of treatment endorsed by the women. As previously discussed, the results from this study suggest that the role of prayer has multiple meanings and uses for Black Christian women. Prayer is an action utilized for coping with life’s challenges, a means for growing spiritually and being with God (Taylor & Chatters, 2000), and also noted as the treatment of choice for depression in this study. Two recent studies (Thomas et. al., 2010; Robinson-Wood, 2009) utilized the Africultural Coping Styles Inventory (Utsey et al., 2000), which measures the culture
specific coping behaviors (cognitive-emotional, collective, ritual centered and spiritual centered) used by African-Americans in stressful situations. One set of results indicate a cognitive more passive coping style (Thomas et. al, 2010) and the other (Robinson-Wood, 2009) a collective active style that utilized girlfriends for support. Prayer can be experienced in a passive and an active manner (Taylor, 2000). It therefore is important that the clinician explore the manner in which their Black Christian clients utilize prayer. For example, in those situations of gendered racism, a women could use prayer to have patience and remember that she is “fearfully and wonderfully made – Psalms 139) thereby nullifying the impact of the gendered racist encounter. This is in therapeutic terms, cognitive reframing with the use of spiritual Biblical/ spiritual themes. It not only distances the experience, but affirms the value and dignity of the women. In addition, the prayerful petitioning of God “to just give me strength to make it through” assuages the assaulted parts of the woman’s psyche so she can retain her dignity and move from the stressful situation.

Clinicians who are comfortable with engaging spiritual issues in therapy should explore ways to incorporate this in their work. Clinicians should examine their own beliefs about whether prayer is an avoidant style that perpetuates lack of engagement with critical issues or whether it can be used as an active intervention tool (Watlington & Murphy, 2008; Thomas, Speight & Witherspoon, 2008). Homework could be given that would have the women to use prayer to as a means to actively deal with the areas that are most difficult for them. Prayer can also be shared in the therapy experience (Robinson-Wood & Braithwaite-Hall, 2005). Responses from the open response and the research literature (Boyd-Franklin, 2003) indicate that black women are accustomed to direct and active engagement from their pastors.

Therapy needs to be more constructive and aggressive for Black women. Women tend to be hard on themselves so treatment has to be intense.
Counselors, doctors... need to understand the tremendous benefits of Christianity in helping depressed women.

As a result, many black women can benefit from a more engaged style of treatment. To that end, women can be encouraged to search for scriptures that can support her healing and wholeness. If agreeable to both parties these can be brought into the therapy for exploration and examination. The uses of rituals are emblematic in worship services, especially in black churches. Creative thinking could generate rituals that are specific to the issues that the woman is confronting (Wade-Gayles, 1995).

Depression is a clinical condition that can benefit from a variety of modalities and practices including spirituality, pastoral counseling, psychotherapy, medication, and self care strategies.

In this research study women preferred prayer and counseling to the use of medication. Similar results were noted for Ward (2009). Even when the diagnosis of depression has been made, African Americans were less likely to fill prescriptions and take anti-depressants (Jackson, 2006). The issue of medication as an aide in depression treatment must be appropriately discussed in the treatment process (Jackson, 2006). Consistently, the issue of suspicion of medication, inaccurate information, historical racism, and dosing levels are cited as barriers to the use of medication (Shellman & Mokel, 2010; Ward et al., 2009; Etowah et al., 2007; Jackson, 2006). African Americans are less likely than whites to accept anti-depressant medication treatment (Jackson, 2006). Therefore, an educational process that talks about what treatment can entail is important so that women can expect that medication may be part of a wholistic treatment approach and not the approach (Watlington & Murphy, 2008; Carrington, 2006).

Needs to be additional options before medication, which I consider short term fix and long term trap. Doesn't get to the root of our healing. Some may need meds. Can't
support it for casual use for any woman who comes into your office.

The deconstruction of the strong woman archetype can be invaluable for the women to begin to understand the ways in which this reality, though culturally and historically derived, are also socially constructed and maintained. Women have to be supported and challenged to sort out how Christianity supports their healing and wellness, as well as when their beliefs run counter to the best of what God would have for their lives. Suyemoto and Mirkin (2005) note that therapy is a co-constructive process in which the therapist and the client reconstruct identities, partially through exploring and explaining the construction process itself. In this manner increased awareness and action can be taken when there is an appreciation for the interactive, multilayered social, systemic, and political processes that are part of the client’s life. Theologian and preacher, Rev Cecelia Williams Bryant (1991) used the phrase co-journeyer to describe the process and identity of women of African ancestry who dare to discover and embrace the unique things that God has called the redeemed women of Africa to accomplish.

Further, Robinson-Wood and Braithwaite-Hall (2005) indicate that the sacredness of therapeutic space mirrors elements of the spiritual community that women of faith occupy. The importance of clarifying the meanings and interpretations of the faith history of clients is extremely important. Women may define themselves as spiritual, but not religious, even if they are Christians. Some exploratory spirituality modalities that can be an aide in the therapy include but are not limited to- spiritual/religious history, spiritual genograms (Hodge, 2001) and timelines, and utilizing of rituals (Robinson-Wood & Braithwaite-Hall, 2005; Moore & Skeete, 2000). Some clinicians may find that the use of a non-sectarian model like Fowlers Faith Development Theory (FDT) which focuses on universal structures that belong to all faiths can be utilized to deconstruct the women’s experience of Christianity (Parker, 2011).
The maladaptive uses of anger for black women, especially when repressed, have been indicated as an important area for clinical work (Williams, 2008; Brown & Keith, 2003, Boyd-Franklin, 2003, Singleton, 2003). Attitudes about the expression of anger were not explicitly examined in this research study. It is known that the connection to the suppression of emotion and the strength discourse are connected. Activism and advocacy (West, 2002) that are acceptable therapeutically for the Christian Black woman can be valuable to promote healing, deconstruct external stressors and re-direct psychological and emotional resources. Saussy and Clarke (1996) noted that the origins of depression is women’s repressed anger at the persistent expectation of care of everyone else at the expense of her needs and the silencing of her voice. Additionally, Martin (2009) cautions “that the challenge of managing one’s anger, which is described as an emotion-focused coping strategy, is that when left unresolved, it can be misdirected, destroying relationships with others” (p.175). To that end, clinicians need to support women in their examination of how anger shows up in interpersonal relationships and parenting.

This population of educated Black Christian, and likely other women with less education, could benefit from exposure to the writings of black women that discuss the challenges of living as a Black woman in society. Examination of the strategies that women in fiction and non-fiction employ to navigate their joys and sorrows can be used to compare and contrast with the clients own repertoire of adaptive responses to her life. Clinicians would necessarily look at the lifespan issues that are compelling for their Black Christian female clients. It may be especially useful for women to appreciate the notions of “seasons in her life” as described in the scripture of Ecclesiastes, thereby removing undue stress and emotionality for issues that are normal and typical for that period in her life. The study results highlighted that depression was present in all aspects of the age spectrum, other than women over the age of 60. Given the mid-life stage of
this population, exploring the physical, emotional and psychological changes that emanate from
the spectrum of menopausal changes is warranted (Etowah et. al, 2007). Information regarding
nutrition, light exposure, exercise, and relaxation modalities can be included (Surgeon General
Supplemental Report (2001). The women in this study endorsed the use of Bible reading,
exercise, meditation, nutritional counseling and group counseling.

Individual and/or group therapy increases self-knowledge, enhances understanding of
depression and self-esteem, and create appropriate alternative to managing life stressor (Surgeon
General Supplemental Report (2001). The issue of connection to other women is crucial for the
Black woman. African American women yearn for connection, and interconnection as a
deliberate means of negotiating the challenges inherent in their marginalization (Beauboeuf-
that most women search for love hoping to find recognition of our own value. The strength
discourse is a dynamic that can factor into the therapeutic alliance. This pervasive Black female-
identified trait can get projected onto and impact therapy when the Black female client expects
her African American therapist to mirror and exemplify this ideal and does not (Romero, 2000).
Many African-American women may recognize the benefits of the strength endorsement but may
be less aware of the ways that stress and strength affect their health (Woods-Giscombe, 2010).
Lastly, the role that the hip hop culture has played in the identity development of young adult
Black women (Henry, 2008) even those professing Christian beliefs warrants therapeutic
exploration.

Women should be encouraged to use sister girlfriend circles as a source of support
(Martin, 2010; Robinson-Wood, 2009; Williams, 2008). One of the many benefits of a
collectivistic culture rests in its members’ ability to access support and guidance from others in
times of distress (Martin, 2009, p. 176). Sociologist and Black feminist scholar (Collins, 1990) introduced the concept of standpoint which suggests that the inherited struggle against racism and sexism is a common bond among African American women. She gave voice and agency to the distinct role that *sistah* circles have in the lives of Black women to serve as an alternative community that empowers thereby providing a creative act of resistance. Special attention must be made to challenge women to not use this support entity as a means to maintain the mask of perpetual strength. This also holds true for their involvement in women’s ministries in church. Beauboeuf-Lafontant (2007) found that sister circles have indeed been a consistent strategy for coping for Black women. However, if women cannot work through their shame of the need for validation, authentic sharing, and self-care- then these groups of family and friends may simply reinforce the persisting dynamic. Lastly, the researcher concludes that the strength discourse normalizes struggle, selflessness, internalization strategies that compromise the health of Black women.

Self-care strategies that move beyond relational connections with a focus on physical activity, sleep, hygiene, diet, exercise, meditation, and fun/novel activities should be included in the work of therapeutic interventions. The Strong Black Woman archetype and its relationship to Christianity need greater exploration in the therapy process. The persistence of chronic health issues such as diabetes, hypertension and obesity may be connected to lifestyle and diet, but also to the issue of vulnerability and emotional suppression. Christianity is used as a vital coping mechanism for living, but not always as the catalyst for wellness. Woods-Giscombe (2010) noted that women recognized that negative emotions resulting from past experiences, combined with their habitual practice of forsaking their personal needs, were limiting their potential for creating and sustaining health relationships, self-care practices, and overall health functioning. The
stereotype of the “Angry Black Woman” grows from the Strong Black Woman. The anger becomes a response to the expectation of always having to be strong.

There was no question on the BHBI that investigated women’s experiences with the management of stress and life challenges. However, the employment of regular self-care strategies is well documented as an important preventative component of wellness and psychological functioning (Brown & Keith; Jones et al., 2003). The results indicate that 90% of the women in the study engage in self-care when they - go to church, volunteer/help others, and maintain healthy relationships. Going to church was reported as the major way that these women take care of themselves. These activities were relationally based. The next tier of 75% of the responses included - pray regularly, spend time with sister/girlfriends, and make time for fun and play. These were relational and included more direct self-care activities focused on pleasure enjoyment and stress reduction. The last set of 50% and above were eating properly, asking for help, getting plenty of rest, daily Bible reading, taking vacations, exercising regularly, setting boundaries, and shopping. Of note is that the items that related specifically to physical care were all rated lower than relational actions. Black women have alarming rates of hypertension, high blood pressure, obesity, and heart disease. The ranking of their self-care practices provide some insight into this reality. All of these chronic health issues have a point of origin in stress and lifestyle choice. The lowest percentage of self-care practices was for gardening and taking medicine for a pre-existing condition. Interestingly, the women rated spending time with sister girlfriends higher than spending time with significant others. The impact of sister friends and kitchen table circles has had a long history of being a refuge for black women (Beauboeuf-Lafontant, 2007). It is often through this communal circle that women are able to process important life dilemmas, affirm their decision making processes, and also get challenged on
items that are persistently creating pain and negative results. Hopefully, this self-care practice is an active mechanism for affirmation and stress release.

Lastly, the impact of women’s work life should also be examined in treatment (Keith, 2003). The impact of unemployment, underemployment, racism, sexism and professional advancement contribute to well being as well as economic solvency.

**Future Directions- Clergy/ Church Considerations**

Church leaders of black congregations must examine their collective and individual beliefs about depression and treatment. In this study the women indicated that they disagreed that God’s punishment or Satan caused depression; they had not heard a sermon on depression; would seek outside counseling over using the church’s services; and had been depressed or were currently moderately or clinically depressed. There are inherent theological and doctrinal issues that emanate from these results from this highly evangelical group of Christian women. This topic is as much a theological issue as it is a social justice mandate. In many ways it represents the evolution and maturity of the Black church as the social, economic, cultural and healing entity of the Black community. The maintenance and solvency of the Black church is as much of the demonstration of faith in God as it is a result of the strong Black Christian women in pews, on committees, running ministries and furthering God’s kingdom. Black women are the anchor and core of the Black church (Taylor 2004; Boyd-Franklin, 2003). It is long overdue that the institution of the Black church more deliberately addresses the emotional and psychological lives of Black women, as they simultaneously minister to the imperative of their spiritual growth and salvation. The role of male leadership within Black churches has contributed to this reality.

*Male dominated churches don't do enough proper education on depression and anxiety for members and family who need to support each other. More positive recognition that some people need counseling and medication.*
Generational patterns regarding emotional disconnect to wholeness have been affirmed within our churches. Consequently, the church must become an instrument of breaking the very paradigms that it has reinforced. Young, Griffith, and Williams (2003) in their survey of 99 African American clergy revealed that nearly 50% agreed that people with severe anxiety or depression can cure themselves if they put their mind to it. A lack of a right relationship with God was cited as contributing to mental illness, though 60% identified biological issues as causative, the same percentage noted stunted spiritual growth and/or un-confessed sin as causative factors as well. This statement indicates the connection of persistent belief of Christianity and depression support.

They need not be ashamed of it. It's not a sign of being a weak Christian. We need to discuss it more in churches.

For example, a sermon series that targets mental health and depression with a focus on the ways that non-sin based issues and biological changes can precipitate a depressive experience would convey the importance of this issue to the congregation. Ideally, these sermons would specifically address the ways that black women can mask their pain, yet still be involved in multiple church activities. Furthermore, parishioners need to hear that mental illness warrants treatment similar to high blood pressure or a broken arm. Explicit language must be used to indicate that a person is neither demon possessed nor experiencing the consequence of sin if she is wrestling with a psychological disorder.

Relatedly, seminaries could assess the ways in which future pastors are trained to deal with emotional and psychological concerns of their parishioners, especially Black Christian women. Black female clergy are greatly increasing their numbers in seminary and church leadership (Taylor, 2004). As a result, they are strongly encouraged to investigate their beliefs and behaviors regarding depression. They are in a unique position to model and illuminate the
inherent tensions that Black Christian women wrestle with as they evolve spiritually and developmentally. Given the overwhelming female domination of most congregations, a sense of urgency needs to be present to address the wholistic needs of women in the church.

Linkages need to be encouraged with outside entities that can meet the treatment needs of women (Ward, 2009; Weaver, 2003; Queener, 2001; McRae, 1999. For churches that have counseling programs, care should be taken to ensure that adequate training is provided for their counselors. Simply because one is called to a ministry does not mean that those persons have the requisite skills to be effective. This may help to mitigate concerns about confidentially as well as treatment effectiveness. Often African American women turning to spiritually based setting may not be appropriately referred to mental health treatment (Jackson, 2006). Lastly, the results and experience of conducting this study informs the psychological community of the importance of conducting research within the Black church. The issues of mistrust of the academy, race of the researchers, and protective stance of the clergy had to be worked through so that Shellman and Mokel (2010) could determine that reminiscence was a valuable tool for relieving depressive in older African American because it built on the strengths of the oral story telling tradition of Black culture. The church is essential to supporting culturally and spiritually appropriate research and interventions that can aid in the healthy living and functioning of its members.

Future Directions- Research Considerations

There are a variety of areas for future research that are warranted as a result of this study. The use of qualitative research should be actively used for enhanced understanding of the unique lived experience of African American women (Woods-Giscombe, 2010; Dillaway et al., 2008,). There are challenges and benefits to the qualitative process. Quimby (2006) notes that there are advantages - such as placing a high regard on beliefs, attitudes, and assumptions of the group
under study, while increasing retention and rates of adherence to protocols. The disadvantages include- generalizing from smaller populations to large ones, and spurious results that perpetuate inaccurate reporting of data regarding ethnic and diverse groups. Even with those cautions a beneficial environment to understand Black Christian women is within the Black church. Shellman and Mokel (2010) outline the myriad challenges they experienced conducting an intervention study for older African Americans. Findings revealed challenges in getting buy-in from the church gatekeepers, race of the investigators, fragile university relationships, culturally insensitive instruments, stigma, and historical racism from mental health systems. This researcher found that the gatekeeper relationship proved to be most important in conducting this study.

The racial, gender and religious affiliation of this researcher (Black Christian female) aided in the process, though there was still difficulty in getting women to complete the surveys. The process evaluation method that Shellman and Mokel (2010) utilized aided in making changes in the process which improved relationships with the churches, as well as the research participants. In essence this stance invites the research population, though challenging, to co-construct the experience so that it is mutually beneficial to all. Building relationships with the clergy could aide in better understanding their beliefs about mental illness and depression treatment. This in turn could promote better linkages between the church community and the treatment community, which historically has been replete with difficulty (Taylor, et al., 2000; Queener & Martin, 2001).

Researchers need to be open to exploring multiple realms of theory and scholarship. This researcher has experienced a burgeoning body of scholarship in the nursing and social work fields that offer valuable insight on this topic. Several research studies have illuminated the
promise of creating interventions that are derived from the lived experience of the research population. This is one of the abiding tenets of the multicultural psychology field. For example reminiscence was used as an intervention to decrease depressive symptoms in an aging population (Shellman & Mokel, 2010), Mindfulness-Based Stress Reduction, Loving-Kindness, and NTU Therapeutic Framework to reduce risk for stress and strength (Woods-Giscombe & Black, 2010) and The Common Sense Model to examine African American women’s beliefs about mental illness (Ward et al., 2008).

Christian women’s experiences across the life span warrant greater investigation. Teenager’s multiple challenges with self-esteem, group identity, peer influence, physical growth, cognitive and spiritual development make them an important group for research and study. It would be instructive to create learning modules that would focus on the deconstruction of the strong Black woman persona. Connections would be made to the issues of being strong in Christianity. This work with teenagers would aim to break the generational cycles of the strength at all cost discourse, while enhancing their spiritual development. Further, the connections to health and overall physical would be included.

Developmental challenges and the aging process have a role to play in the experience and practice of Christianity. Research is needed to understand what those interactions are and their impact on psychological wellness and adaptation. The manifestation of these developmental changes could be studied across generations of Black Christian women in one family. These intergenerational dynamics could provide valuable data to better understand the interaction of these variables. Additionally, the centrality of prayer in the lives of Black Christian women needs to be examined for the psychological and therapeutic benefits. For example, how frequently do women engage in cognitive re-framing using scripture, in comparison to the use of
meditative /stress reducing contemplative prayer, and under what situations or circumstances? With further investigation, specific interventions can be taught to women as they grow their faith and enhance their Christianity. Explicitly making a connection between their walk with the Lord and their reduction of stress inducing responses may be a useful strategy. The reality of being a Black female in society and all of its inherent benefits and challenges will not change any time soon.

Psychometrically valid instruments that evolve from qualitative work are strongly encouraged. Ideally, an instrument that furthers the understanding of the Strong Black Christian Woman (SBCW) needs to be developed. To that end the theoretical underpinning of the SBCW instrument would emanate from scholarship that expands understanding of the convergence of race, gender, strength, and Christianity.

Over half of this research sample (53%, n=56) have sought treatment for depression outside of the church. Granted that there is still a need for scholarship on what enhances or derails access to and satisfaction with the treatment. Additionally, more insight is needed on the clinician’s experience with providing treatment to the Strong Black Christian Woman. Anonymous surveying of clinicians could begin to delineate the treatment techniques as well as personal clinician barriers to working with explicitly Christian women. What was the experience and process that these women used to find a therapist? Did the women proactively introduce their Christian beliefs into the treatment or did the therapist? How did the clinician introduce the multiple layers of the strength discourse? A mixed method study would detail this experience with a special focus on satisfaction with the therapy process and the secular and specific Christian interventions that were used.
Lastly the results from the BHBI indicate that there are important dynamic processes that are at play in the belief system of African American Christian women. Further refinement of the instrument would be useful in investigating results from a sample of Black Christian women in African and the Caribbean. Cultural difference and lifestyle norms in living a Christian life in a predominantly Black environment may create explicit or nuance differences in women’s experiences.

**Summary**

This chapter presented a discussion of the major findings of the study. The first section provided a general overview of noteworthy findings. The second section discussed key findings from the research hypotheses. The third section presented conceptual findings and theoretical implications for the research results. The fourth section highlighted issues of internal and external validity, as well as study limitations. Finally, the fifth section concluded the chapter with recommendations for future work.

**Conclusion**

The highly evangelical Christian women in this study operationalize their Christian beliefs through a personal relationship with Jesus Christ, the personal presence of God in their lives and the fundamental belief that God raised Jesus from the dead. When confronted with racial discrimination and stress, these optimal resistors utilize spiritual and socio-cultural psychological strategies to counter these experiences. If depression manifests in their lives, they believe that its existence and origin emanate from physiological and social causes. Lastly, if treatment is warranted for depression they would utilize prayer and psychotherapy as primary treatment modalities.
Beyond the women in this study, there are many Christian women who are living dynamic lives that are aiding in the continued growth and progress of families, churches, and communities. Yet, there also many women in emotional and psychological pain who are suffering in silence because of their deeply ingrained patterns of strength and denial of vulnerability. Their love for the Lord has not eradicated their distress. They need support and validation to accept that they can be strong and vulnerable. The unique lived experience of black Christian women is worthy of acknowledgement, understanding and further exploration. They are the center and anchor of the Black community and the Black church. This dissertation study concludes with these words from Taylor (1998, p. 370):

> Be for others, but be for yourself too. Our choices must be for mental, physical, and spiritual well being. We must attend whole-heartedly to our wholeness. Choosing what nourishes you may at times seem selfish, but it never is. It's smart, because when we continually subordinate our feelings and needs we lose touch with our reality, and we become disillusioned and depressed. What you do for yourself takes nothing away from anyone else; what’s good for you is good for your family and good for the community. Honoring your needs makes you stronger, happier, more willing and able to serve.
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APPENDIX LISTING

STUDY INSTRUMENTS

Braithwaite-- Hall Beliefs Inventory (BHBI)

Shepherd Scale (SS)

Robinson Resistance Modality Inventory (RRMI)

Center for Epidemiologic Studies- Depression Scale- (CED-S)

BHBI OPEN RESPONSE QUESTION #25

Raw Data

BHBI Themes

RASCH RATING SCALE MODEL

Frequency Figures

Data Table

INFORMED CONSENT DOCUMENTS

Participants

Senior Pastors

NORTHEASTERN UNIVERSITY INTERNAL REVIEW BOARD

Consent to Conduct Research

Sample Advertisement

PARTICIPANT RESOURCE INFORMATION

Listing of Local and National Resources

Scriptures for Hope and Encouragement
The Braithwaite-Hall Beliefs Inventory (BHBI)
This inventory asks about your beliefs about depression in African American Christian women. All of your responses will be kept confidential. Complete the entire survey as honestly as possible. Thank you for your help and support.

Demographic Information

1. Age:   2. Name of church: __________________________

3. How long have you been a member __________

4. Ethnicity   o African American   o Black   o West Indian   o African
   o Biracial / Multiracial _______________  o Other __________

5. Place of birth___________________________________________________

6. Marital status   o never married   o married   o divorced
   o separated   o widowed

7. Years in current marital status __________

8. Sexual orientation ______________________

9. City where you live: ___________________________________________

10. Number of people in your home _____________

11. Number of persons requiring dependent care __________

12. Social class of family of origin   o Poor   o Working Class
   o Middle-Income   o Upper-Income

13. Highest level of education ________________________________________

14. Current occupation _______________________________________________

15. Annual income  __________

16. Number of years a Christian ______

17. How often do you   __________ attend church   ____________ pray
   ____________ read the Bible

18. Number of ministries/activities involved __________

19. Type of ministries/activities (list)
   o
   o
The Braithwaite-Hall Beliefs Inventory (BHBI)

Clinically, depression is described as a mood disorder with a collection of symptoms persisting over a two-week period. These symptoms must not be the result of the direct effects of alcohol or drug abuse or other medication use. However, clinical depression may occur with these conditions as well as other emotional and physical disorders such as hormonal, blood pressure, kidney, or heart conditions. (American Psychological Association)

To be diagnosed with clinical depression, a person must have either a depressed mood or loss of interest or pleasure as well as four of the following:

1. depressed or irritable mood throughout the day (often everyday)
2. lack of pleasure in life activities
3. significant (more than 5%) weight loss or gain over a month
4. sleep disruptions (increased or decreased sleeping)
5. unusual, increased, agitated or decreased physical activity (often everyday)
6. daily fatigue or lack of energy
7. daily feelings of worthlessness or guilt
8. inability to concentrate or make decisions
9. recurring thoughts or suicidal thoughts

Please circle your responses to each statement. The rating is based on the following scale:

<table>
<thead>
<tr>
<th>1= Strongly Disagree</th>
<th>2= Disagree</th>
<th>3=Agree</th>
<th>4= Strongly Agree</th>
</tr>
</thead>
</table>

1. I believe that the definition of depression as listed above is correct.
   1 2 3 4

2. I have been depressed.
   1 2 3 4

3. I diagnosed myself when I was depressed.
   1 2 3 4

4. I have had a family member (mother, father, sister, brother, grandmother, grandfather, aunt, uncle, first cousins) who have been depressed.
   1 2 3 4

5. I have known someone who was depressed
   1 2 3 4

6. I knew the person was depressed because
   - person told me
   - behavioral changes
   - changes in mood
   - slept more
   - increase in irritability
   - changes in thinking
   - stopped eating regularly
   - stopped regular activities
   - didn’t want to pray
   - no interest in church
   - did more & more activities
   1 2 3 4
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Did the person seem different from just having the “blues”?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I believe that depression</td>
<td>Doesn’t exit</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Happens to everyone</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sign of weakness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Part of being female</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sickness needing treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Shows lack of spiritual power</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Is a sin</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sign of the devil</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Contrary to God’s presence in one’s life</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. My family believes that depression</td>
<td>Doesn’t exit</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Happens to everyone</td>
<td>1</td>
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<td></td>
<td>Sign of weakness</td>
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<tr>
<td></td>
<td>Part of being female</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Sickness needing treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Shows lack of spiritual power</td>
<td>1</td>
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</tr>
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<td></td>
<td>Is a sin</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Sign of the devil</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Contrary to God’s presence in one’s life</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. My pastor believes that depression</td>
<td>Doesn’t exit</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Happens to everyone</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Sign of weakness</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Part of being female</td>
<td>1</td>
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<td></td>
<td>Sickness needing treatment</td>
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<td></td>
<td>Shows lack of spiritual power</td>
<td>1</td>
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<td></td>
<td>Is a sin</td>
<td>1</td>
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<td></td>
<td>Sign of the devil</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Contrary to God’s presence in one’s life</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>11. I have heard a sermon in my church that specifically dealt with the subject of depression.</td>
<td></td>
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<tr>
<td>12. I believe depression comes from</td>
<td>Genetics</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Weak spirit</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>God’s punishment</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Satan’s presence</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Guilt over something you should have done</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Health condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Female hormonal changes</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Brain chemistry changes</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Racism</td>
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<td>2</td>
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<td></td>
<td>Sexism</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td></td>
<td>Part of being human</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
(1=strongly disagree  2= disagree  3=agree  4= strongly agree)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>Being overweight</td>
<td></td>
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<tr>
<td>Result of abuse history</td>
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</tbody>
</table>

13. I have sought assistance for depression from my pastor.

1   2   3   4

14. My church provides counseling services.

1   2   3   4

15. I would use my church’s counseling services if I needed treatment for depression.

1   2   3   4

16. I believe in the following treatments for depression.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Medication (Prozac, Wellbutrin)</td>
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<tr>
<td>Psychotherapy/counseling</td>
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<tr>
<td>Nutritional counseling</td>
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<tr>
<td>Exercise</td>
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<tr>
<td>Meditation</td>
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<tr>
<td>Group counseling</td>
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</tr>
<tr>
<td>Shock therapy</td>
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<td></td>
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<tr>
<td>Bible reading</td>
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<tr>
<td>Prayer</td>
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</tr>
<tr>
<td>Fasting</td>
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</tr>
</tbody>
</table>

17. I do not believe in the following treatments for depression.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication (Prozac, Wellbutrin)</td>
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<tr>
<td>Nutritional counseling</td>
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<tr>
<td>Exercise</td>
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<tr>
<td>Meditation</td>
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<tr>
<td>Group counseling</td>
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<tr>
<td>Shock therapy</td>
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<tr>
<td>Bible reading</td>
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<td>Prayer</td>
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<tr>
<td>Fasting</td>
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</tbody>
</table>

18. There are community resources that I would utilize if I needed treatment for depression.

1   2   3   4

19. I have sought treatment for depression outside of the church.

1   2   3   4
(1=strongly disagree  2= disagree  3=agree  4= strongly agree)

20. I believe that counselors/clinicians include the importance of Christian beliefs in treatment for depression.
   1 2 3 4

21. The image of the “strong black woman” plays a role in depression.
   1 2 3 4

22. There are conditions in Black women’s lives that may contribute to depression that differ in the lives of white women or black men.
   1 2 3 4

23. The identification with the suffering of Jesus Christ causes black women to endure conditions that may lead to depression.
   1 2 3 4

24. I take care of myself by:

<table>
<thead>
<tr>
<th>Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting plenty of rest</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Praying regularly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Eating properly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Exercising regularly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Setting boundaries (say no &amp; mean it)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Asking for help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Daily Bible reading</td>
<td>1</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>Going to church</td>
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<td>Spending time with my sister/girlfriends</td>
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<td>Spending time with significant other</td>
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<td>4</td>
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<td>Volunteering/helping someone</td>
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<td>4</td>
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<tr>
<td>Maintaining healthy relationships</td>
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<td>3</td>
<td>4</td>
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<td>Taking vacations</td>
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<td>3</td>
<td>4</td>
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<tr>
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<td>3</td>
<td>4</td>
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<tr>
<td>Shopping</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Taking medication for pre-existing condition</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Making time for fun and play</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Other: ____________________________________________________________________________

25. What do you want counselors, therapists, pastors, and doctors to know about depression in black women?
THE SHEPHERD SCALE
Bassett et. al, 1981

Instructions: These questions consider different aspects of Christian experience. Note that some of the items consider how you think about or act towards Christians. These items should not be thought of as exclusive. For example, having respect for Christians does not mean that you lack respect for non-Christians.

Please respond to all of the following items. Use the ratings listed below.
1 = not true 2 = generally not true 3 = generally true 4 = true

1. ____ I believe that God will bring about certain circumstances that will result in the judgment and destruction of evil.

2. ____ I believe I can have the personal presence of God in my life.

3. ____ I believe that there are certain required duties to maintaining a strong Christian life-style (i.e., prayer, doing good deeds, and helping others.)

4. ____ I believe that it is possible to have a personal relationship with God through Christ.

5. ____ I believe that by following the teachings of Jesus Christ and incorporating them into my daily life, I receive such things as peace, confidence, and hope.

6. ____ I believe that God raised Jesus from the dead.

7. ____ I believe that God will judge me for all my actions and behaviors.

8. ____ I believe that by submitting myself to Christ he frees me to obey him in a way I could never before.

9. ____ I believe in miracles as a result of my confidence in God to perform such things.

10. ____ Because of God’s favor to us, through Jesus Christ, we are no longer condemned by God’s laws.

11. ____ Because of my personal commitment to Jesus Christ I have eternal life.

12. ____ The only means by which I may know God is through my personal commitment to Jesus Christ.

13. ____ I believe that everyone’s life has been twisted by sin and that the only adequate remedy to his problem is Jesus Christ.

14. ____ I am concerned that my personal behavior and speech reflect the teachings of Christ.

15. ____ I respond positively (with patience, kindness, self-control) to those people who hold negative feelings toward me.
16. ___ I do kind things regardless of who’s watching me.

17. ___ Status and material possessions are not of primary importance to me.

18. ___ I do not accept what I hear in regard to religious beliefs without first questioning the validity of it.

19. ___ I strive to have good relationships with people even though their beliefs and values may be different than mine.

20. ___ It is important to me to confirm to Christian standards of behavior.

21. ___ I am most influenced by people whose beliefs and values are consistent with the teachings of Christ.

22. ___ I respect and obey the rules and regulations of the civil authorities which govern me.

23. ___ I show respect towards Christians.

24. ___ I share things that I own with Christians.

25. ___ I share the same feelings Christians do whether it be happiness or sorrow.

26. ___ I’m concerned about how my behaviors affect Christians.

27. ___ I speak the truth with love to Christians.

28. ___ I work for Christians without expecting recognition or acknowledgement.

29. ___ I am concerned about unity among Christians.

30. ___ I enjoy spending time with Christians.

31. ___ My belief, trust and loyalty to God can be seen by other people through my actions and behavior.

32. ___ I can see daily growth in the areas of knowledge of Jesus Christ, self-control, patience, and virtue.

33. ___ Because of my love for God, I obey his commandments.

34. ___ I attribute my accomplishments to God’s presence in my life.

35. ___ I realize a need to admit my wrongs to God.

36. ___ I have told others that I serve Jesus Christ.

37. ___ I have turned from my sin and believed in Jesus Christ.

38. ___ I daily use and apply what I have learned by following Jesus Christ.
Braithwaite Hall Beliefs Inventory- Item #26 Open Response

Open Responses- Raw Data

African-American women should not feel the need to hide behind the mask of the strong Black women. We are human. Endured a lot. Stop the denial.
An understanding of code switching and shifting.
Be aware of environmental/life conditions/cultural issues that might be different for Black women and experienced uniquely. Is important in understanding stressors.
Because of stress in our lives, we can become strained, but will not open up and admit that we are human and need help
Because of the status of Black males, the lack of them. Because of that many Black women have the weight of the world on our shoulders & there is nowhere to go with it as other Black women in the same situation or doing worse. We’re all in same boat.
Be persistent inquiring about childhood. Spirituality plays a great part in healing.
Black women are strong and carry the burden for the family caring and nursing especially for the children. It feels like no one cares. We are not stupid weak or children. We are women.
Black women often not willing to talk about depression with family, friends, co-workers. When I tried, I remember being told Black women don’t go to therapy- just get over it.
Black women are individuals, separate & different from one another. Don't try and group us as a Black women's thing!
Can't really say. Haven't dealt with it personally.
Can be difficult to detect, because most black women are strong and juggling many things at once. I believe we have a special resilience, especially when reaching out to others and occupying our time with quality activities.
Create a referral service for the type of counseling each woman prefers.
Depression can be masked by our role as person who holds things together at home and work. Detecting it and knowing how to detect it.
Depression is a clinical condition that can benefit from a variety of modalities and practices including spirituality, pastoral counseling, psychotherapy, medication, and self care strategies.
Depression is not only seen by DSM symptoms. Watch for women who appear to be on top of it, but are clearly not managing these parts well. Strong Black women syndrome. Black women don’t want to be stigmatized.
Depression is depression in both Black and white women. It should be diagnosed and treated not explained away as women's imagination
Depression is the same in every woman, but triggers may be different depending on race, culture, and experiences. Exercise, nutrition is very important for maintaining a healthy balance Depression is real and a normal part of life. There is help available when needed to cure depression.
Feel strongly that the Black church believes that depression is linked to spiritual strength more than other medical conditions. Many churches do not see depression as a disease but something to pray through. We need paradigm shift so women and men can get well.
Hard to admit you are depressed and have a problem. By that time you are close to edge. We learn to lie early about how you are feeling, because no one really wants to know.
Historical background of Black women back in slavery and always juggling many issues being perceived as strong at all times.
How to successfully manage the superwoman archetype knowing the role it plays in leading to feelings of loneliness, futility, and depression.
It's a complicated issue.
It's deeply rooted!!
It doesn't just go away. It is more that Black women who are depressed need love, education, guidance, and interaction.
It is a quiet disease among us. We don't even reveal it to friends close.
It is as prevalent in all women including Black women as others. Praying is key.
It is not a sign of weakness.
It is real and doesn't mean they are weak or a failure.
It may be deeper than it appears.
It may take a very long time to let our guards down and feel comfortable in a therapy. This is especially true if we don't feel provider can possibly relate to our frame of reference or experiences.
Just by being Black, our women have a difficult time because of racism, because their significant other may physically abuse them because of inadequacies in his life due to education, good job. Male dominated churches don't do enough proper education on depression and anxiety for members and family who need to support each other. More positive recognition that some people need counseling and medication.
Meds don't work and talk therapy doesn't work. Therapy needs to be more constructive and aggressive for Black women. Women tend to be hard on themselves, so treatment has to be intense.
Medications don't work and talk therapy doesn't work. Therapy needs to be more constructive and aggressive for Black women. Women tend to be hard on themselves so treatment has to be intense.
Many women know why they are depressed. They may just need support to say it, express it and then take action
Many Black women learned early to repress what they are feeling. Especially to the point of not recognizing their condition, depression because it has come to feel normal to them.
Myth of the "strong Black woman" works against us in recognizing, accepting, defeating depression.
Needs to be additional options before medication, which I consider short term fix and long term trap. Doesn't get to the root of our healing. Some may need meds. Can't support it for casual use for any woman who comes into your office. I haven’t used a counselor. Seemed callous to integrated approach.
Need more Christian counselors. More Black counselors who integrate that in treatment. Someone who respect our values.
Needs to be treated as a true disease like diabetes. It takes a combination of multiple therapies to help with treatment.
Never experienced it personally, not been depressed to where counseling was needed.
Not much about Black women specifically being different from white women unless they are Black women themselves.
Not recognized early and tested, not used frequently to diagnose. Depression not given high visibility like other favored diseases like breast cancer, so women do not seek treatment. Mental health not embraced by Black community.
Not sure. We have a lot of pressure in our lives. We carry Black community on our shoulders, especially when many of our men are not in the picture. Often transient flags, pressure often situational, don’t want meds without knowing effects of drugs; often talking is all that is needed. Often don’t know we are depressed to ask for help. Depression hasn’t surfaced on our radar. We think of a physical illness, not an emotional or counseling issue. Outside pressures can be more significant than those on white women. Example- lack of potential male partners, absentee fathers for children, etc. Pain and suffering carried through the mitochondria (energy part of cell), but only through the female. Thus if DNA is found in greater than 60+ of humanity, then we African women carry our pain and the pain of our ancestors and the world. Pervasive and intermittent. It comes and goes, seems like moodiness. Black women groomed to be strong, serve others, become depressed when there is no one groomed to service us. Have to do it ourselves. Recognize depression can be defined in many ways. A simple diagnosis puts a negative label on an individual. Depression may be related to a particular situation or due to an event. Sometimes other Black women or men contribute to a Black woman's depression because they put pressure on them-[white women or men would not childless] Black women often looked down upon by other African-Americans. Sometimes the transition into menopause can cause chemical imbalances which in turn cause depression. Sometimes we don’t know we are depressed. There needs to be intervention by a trusted friend. Symptoms may last less than two weeks, the person may bounce back, and faith did not come up. I struggled to trust therapist and my faith, whether my faith was strong enough. That Black women are not dark skinned white women. Our experiences, our lives are different. That it's an ongoing thing that we as a people have to deal with all the time. That it's typically masked in denial. That it is often a source of shame. It is unrecognizable to the sufferer. That it is real. That it is real & should be addressed with openness and honesty. That it is real and the woman may not always be aware she is depressed. That it is a real condition. That race issues factor into our issues. There is help for anybody (female, male, Black, white or any other race). There is little difference in a black or white woman becoming depressed. Problems such as drug addiction, alcoholism; domestic violence can cause either race to develop depression. There should be no differential in treatment. They need not be ashamed of it. It's not a sign of being a weak Christian. We need to discuss it more in churches. Counselors, doctors... need to understand the tremendous benefits of Christianity in helping depressed women. They should recognize the need for a higher power (God) in their treatment. This is a real condition among all people and should not mean a person is not trusting God because they seek help. That it can be addressed for them in their area of life. To find out what is making them depressed. To spend adequate time listening to their concerns and not to judge them.
You have the power to be delivered, set free, keep at bay, from the power and onslaught of depression.
Understand racism in employment, single motherhood, single headed households, greater income then male spouse.
Unsure.
Want them to be more balanced in context with cultural, social, identity and actual positions where black women exist and live.
What works for African-American women may or may not work for other ethnicities. Medical personnel must take into consideration one's culture.
Themes for BHBI Open Response Question #25

Uniqueness of Black Women
- Need to hide behind Strong Black Woman
- Developed from slavery
- Superwoman archetype leads to futility and depression
- African-American women have endured a lot
- Humanity of African-American women
- Uniqueness of each Black woman
- Special resilience
- Pain and suffering carried through the mitochondria
- Groomed to be strong

Socio/cultural Stress
- There are unique stressors in African-American women’s lives
- Solo burden for child rearing
- Stress creates stress and limits ability to admit need for help
- Mental health not embraced by Black community
- Much pressure in the lives of Black women
- Status of Black men creates stress for women
- When men are not in the picture stress increases
- Condescending behaviors with other Black women
- Race issues contribute to depression

Psychological Processes
- Stop denial
- Learn how to lie about feelings
- Not a sign of weakness
- Early suppression of emotion leads to depression feeling normal
- Don’t know we are depressed to ask for help

Treatment
- Spirituality plays a great part in healing
- Persist in understanding childhood
- Referral system with treatment types
- Diet and exercise important for balance
- Praying is key
- Can take a long time to let guard down to a provider who can’t relate to our experience
- Treatment for Black women needs to be intense and aggressive
- Medication curtails ability to get to root causes
- Counselors callous to integrated approach
- Need more Christian counselors
Treat it like a disease
Multiple treatment types necessary
Address with openness and honesty
Providers need to understand helpful role of Christianity
Bring God into treatment
Cultural inclusion for medical personnel

**Silent suffering**
Isolation and helplessness
Need to be taken seriously
Little support to enter therapy
Masking of our symptoms
Not willing to talk about depression
When help is asked for in critical stage
Quiet secret disease
Futility of treatment
Masked in denial
Often a source of shame

**Diagnosis**
Difficult to detect because of strength
Process of detection
Symptom expression different in Black women
A simple diagnosis puts a label on an individual
Can be situational
Transition to menopause has emotional impact
Substance abuse and domestic violence can be part of origins of depression
Listen to the needs of the woman

**Black Church**
Links depression to spiritual strength
Wants the person to pray their way through
Paradigm shift needed in the church
Male dominated churches provide little education on psychological issues
Not a sign of weak Christianity
More discussion needed in the church

**Depression**
Same in Black and white women
Triggers are different for many women
Deeply rooted
Prevalent in all women
Deeper than it appears
Some people need counseling and medication
RASCH RATING SCALE MODEL

Probability Curves and Calibrated Measures

In order to derive valid measures from the Beliefs subscale, the scores from the 22 items in questions 8 and 16 were first calibrated in logit measures. In order to determine if the four response categories are optimal, it is necessary to examine the Rash rating-scale measurement diagnostics. One pertinent rating-scale diagnostic is a monotonic increase of the step calibrations or thresholds which shows distinction between the categories. Infrequently used categories are indicative of redundant or unnecessary categories. A visual method of inspecting the distinction between the response options is to examine the probability curves. Each category should have a distinct peak in the graph, illustrating that each should be the most probably response category.

The first figure shows that the four-category rating-scale of the BHBI instrument did not function well. The blue-colored curve represents the Disagree category, but it is evident that because its peak is never clearly above other curves for some portion of its range, it is never the most probable response category and is therefore redundant. This is an indication that respondents made little or no use of the Disagree category and could therefore be dropped in a future application of the instrument. Examination of the response frequencies suggests that the scores of the Strongly Agree and the Agree categories can be combined, and the results of the application under this condition illustrate the probability curves in the next figure. Each probability curve for this three-category response variable demonstrates a region where each response category is the most probable for some part of the continuum.
Other diagnostics of the BHBI survey instrument for the 22 items include the following. The person separation reliability, approximately equivalent to Coefficient Alpha, is 0.63, which suggests that the scale discriminates between the respondents fairly well. The item separation reliability of 0.96 indicates that the 22 items create a well-defined variable of beliefs about the existence and origins of depression.

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Figure 4.2. The Braithwaite-Hall Beliefs Inventory (BHBI) (Measures in Logits)

1. 1 Doesn't exist
reliability of 0.96 indicates that the 22 items create a well defined variable of beliefs about the existence and origins of depression.

The following table furnishes additional psychometric characteristics of the data. The key indices are in the second column. These calibrated measures of the items, with a mean of 49.4 and a standard deviation of 5.1, are arranged in order from highest to lowest. The first column lists the associated identification number of the items in column 2, and the last column lists the summary names of the items with their identification number. The lowest item in column 2, “Brain chemistry changes”, has the smallest measure of 42.1, and is a reflection that the
that the respondents found it easiest to endorse the belief that depression comes from chemical changes in the brain (item 17). They also strongly agreed that depression derives from a “Health condition” (item 15 with a measure of 42.8) and a little less so that depression is the “Result of abuse history” (item 22 with a measure of 42.9). The belief that depression is a “Sign of weakness”—item 3 with the highest measure of 58.6—received the lowest level of endorsement from the respondents. The belief that depression is “Part of being female” and “Is a sin”, items 4

<table>
<thead>
<tr>
<th>Statement Number</th>
<th>Measure</th>
<th>Standard Error</th>
<th>Outfit Mean Sq.*</th>
<th>Summary of Items</th>
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<tbody>
<tr>
<td>3</td>
<td>58.6</td>
<td>1.6</td>
<td>1.30</td>
<td>3 Sign of weakness</td>
</tr>
<tr>
<td>4</td>
<td>57.0</td>
<td>1.3</td>
<td>2.32</td>
<td>4 Part of being female</td>
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<td>7</td>
<td>57.0</td>
<td>1.3</td>
<td>0.77</td>
<td>7 Is a sin</td>
</tr>
<tr>
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<td>0.92</td>
<td>12 God’s punishment</td>
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<td>55.4</td>
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<td>1.73</td>
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<tr>
<td>6</td>
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<tr>
<td>11</td>
<td>52.6</td>
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<td>1.27</td>
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<tr>
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<td>1.12</td>
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<tr>
<td>9</td>
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<td>1.44</td>
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<tr>
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<td>1.20</td>
<td>13 Satan’s presence</td>
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<td>0.88</td>
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<td>1.14</td>
<td>20 Part of being human</td>
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<td>0.86</td>
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<td>1.09</td>
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<td>0.67</td>
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<td>15</td>
<td>42.8</td>
<td>0.6</td>
<td>0.56</td>
<td>15 Health condition</td>
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<td>17</td>
<td>42.1</td>
<td>0.6</td>
<td>0.72</td>
<td>17 Brain changes chemistry</td>
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</table>

Mean 49.4 0.8 1.15
Std. Dev. 5.1 0.3 0.45

*Outfit mean squares < 0.7 or > 1.3 are considered to be misfitting.
and 7 with measures of 57.0, respectively, was also very difficult for the responding women to endorse.

A major strength of the rating-scale model is that it computes a measure of reliability for every item (unlike the traditional method in which one is produced). These are shown in column 3 as standard errors of the measures in column 2. The values in column 4 provide an indication of how well the items fit the unidimensional variable; that is, they speak to the validity of each item. Items with mean square values less than 0.7 or greater than 1.3 are considered misfitting and deserving of further attention—especially if the instrument is to be applied again. From this criterion, one observes that there are six mean square values that exceed 1.3 and two less than 0.7. Thus about two-thirds of the items’ measures fit the unidimensional concept, and one may conclude that the items are indicative of a unidimensional construct of beliefs about the existence and origins of depression.
Northeastern University, Department of: Counseling and Educational Psychology  
Name of Investigator: Dr. Tracy Robinson-Wood and Marilyn Braithwaite-Hall, Ed.M  
Title of Project: Standing in the Need of Prayer: Beliefs about depression and treatment held among African-American Christian women.

Request to Participate in Research

I would like to invite you to take part in a research project. The purpose of this research is to examine responses from women in an AME Baptist and non-denominational church I am a doctoral student completing the final requirements for the completion of my Ph.D. in Counseling Psychology at Northeastern University. I have been a member at St. Paul A.M.E. Church for over 20 years.

You must be at least 18 years old to be in this research project.

If you decide to take part in this study, I will ask you to fill out a demographic questionnaire and four additional inventories involved in this research. It should take you approximately 45-55 minutes to complete.

There may be some risks involved in the completion of the survey that may affect some women. These may include: recognizing personal symptoms of depression and/or questioning your beliefs about the origins of depression. Your pastor is aware of these risks. A resource listing of local and national supports will be available to you.

There are no direct benefits to you for participating in the study. However, your answers may help us to better understand the beliefs about and experiences with depression among Black Christian women.

Your part in this study will be handled in a confidential manner. Any reports or publications based on this research will use only group data and will not identify you or any individual as being of this project. Since your name will not appear on any of the materials, I will not be able to connect your responses to identifying information.

The results from this research will be presented in my dissertation document. Denomination and demographic categories will be grouped and analyzed. Members of my dissertation committee will read the dissertation document. Results of the survey will be shared with the senior pastor. I will be available to present results of the research to the church.

The decision to participate in this research project is up to you. You do not have to participate and you can refuse to answer any question. If there is a question that you feel uncomfortable about answering you may choose not to respond. You have the option to stop at any time. I will be available to answer any questions or concerns. A bookmark will be given as small token of my thanks.

If you have any questions about this study, please feel free to call Dr. Tracy Robinson-Wood, Professor, Counseling and Applied Educational Psychology, Northeastern University, Boston, Massachusetts 02115, telephone: (617) 373-5936 or fax number: (617) 373-8892 or Marilyn Braithwaite-Hall, Ed.M. - Researcher, Ph.D. Candidate, Northeastern University, 781-341-4060, email address: africak@comcast.net.

If you have any questions about your rights in this research, you may contact Nan Regina, Division of Research Integrity, 413 Lake Hall, Northeastern University, Boston, MA 02115, telephone: 617.373.7570.

You may keep this form for yourself.

Thank you,

Marilyn Braithwaite-Hall, Ed.M

APPROVED
NU IRB # 97-03-08
VALID: 01/31/98
THROUGH: 01/31/99
Northeastern University, Department of: Counseling and Educational Psychology
Name of Investigator: Dr. Tracy Robinson-Wood and Marilyn Braithwaite-Hall, Ed.M
Title of Project: Standing in the need of Prayer: Beliefs about depression and treatment held among African-American Christian women.

Request to Participate in Research – Senior Pastor

I would like to invite you to take part in a research project. The purpose of this research is to examine responses from women in an AME, Baptist and non-denominational church in relationship to the interview responses from the senior pastor at each selected church. I am a doctoral student completing the final requirements for the completion of my Ph.D. in Counseling Psychology at Northeastern University. I have been a member at St. Paul A.M.E. Church for over 20 years.

You must be at least 18 years old to be in this research project. If you decide to take part in this study, I will conduct an individual interview that may take 60-90 minutes. This interview will be audiotaped and transcribed. Interview topics will include personal and church demographics, counseling training, beliefs about and knowledge of depression and treatment/community resources. Fifty women in your congregation will be completing four inventories related to Christian beliefs, depression, and psychological resistance.

There may be some risks involved in the participation of the interview. You may recognize personal symptoms of depression, question your beliefs about the origins and treatment of depression, and recognize limitations in ministerial support for depressed persons. A resource listing of local and national supports will be available to you.

There are no direct benefits to you for participating in the study. However, your answers may help us to better understand the beliefs about depression and treatment held among senior African-American pastors.

Your part in this study will be handled in a confidential manner. Any reports or publications based on this research will use only group data and will not identify you or any individual as being of this project. Your name will not appear on any of the materials. The results from this research will be presented in my dissertation document. Denomination, demographic categories and correlations between your responses with those of women in your congregation will be grouped and analyzed. Members of my dissertation committee will read the dissertation document. I will be available to present results of the research to the church.

The decision to participate in this research project is up to you. You do not have to participate and you can refuse to answer any question. If there is a question that you feel uncomfortable about answering you may choose not to respond. You have the option to stop at any time. I will be available to answer any questions or concerns. A bookmark will be given as small token of my thanks.

If you have any questions about this study, please feel free to call Dr. Tracy Robinson-Wood, Professor, Counseling and Applied Educational Psychology, Northeastern University, Boston, Massachusetts 02115, telephone: (617) 373-5936 or fax number: (617) 373-8892 or Marilyn Braithwaite-Hall, Ed.M. - Researcher, Ph.D. Candidate, Northeastern University, 781-341-4060, email address: africamk@comcast.net

If you have any questions about your rights in this research, you may contact Nan Regina, Division of Research Integrity, 413 Lake Hall, Northeastern University, Boston, MA 02115, telephone: 617.373.7570.

You may keep this form for yourself.

Thank you,

Marilyn Braithwaite-Hall, Ed.M
NOTIFICATION OF IRB ACTION
RENEWAL APPROVAL

Date: October 17, 2008
Principal Investigator(s): Tracy L. Robinson-Wood
                        Marilyn Braithwaite-Hall
Department: Counseling and Applied Education Psychology
Address: 203 Lake Hall
         Northeastern University
Title of Project: Standing in the Need of Prayer: Beliefs about Depression and
                 Treatment Held Among African-American Christian Women
Approval Status: Project did not start – graduate student researcher does plan
                to start this project
Participating Sites: Union Baptist Church, Cambridge, MA – letter received
                    Bethel AME Church, Jamaica Plain, MA – letter received
                    Other Churches to be determined; researcher will submit
                    approval letters on a rolling basis
Original Protocol Approved: August 13, 2007
DHEIS Review Category: Expedited #6, 7
Informed Consents: One (1) unsigned consent for Pastors
                   One (1) unsigned consent for Church Members
Monitoring Interval: 12 months

APPROVAL EXPIRATION DATE: AUGUST 11, 2009

Investigator’s Responsibilities:
1. The informed consent form bearing the IRB approval stamp must be used when recruiting
   participants into the study.
2. The investigator must notify IRB immediately of unexpected adverse reactions, or new information
   that may alter our perception of the benefit-risk ratio.
3. Study procedures and files are subject to audit any time.
4. Any modifications of the protocol or the informed consent as the study progresses must be reviewed and
   approved by this committee prior to being instituted.
5. Continuing Review Approval for the proposal should be requested at least one month prior to the
   expiration date above.
6. This approval applies to the protection of human subjects only. It does not apply to any other
   university approvals that may be necessary.

C. Randall Colvin, Ph.D., Chair
Northeastern University Institutional Review Board

Nan C. Regina
Director, Research Integrity

Northeastern University FWA #4630
“Standing in the need of Prayer: Beliefs about depression and treatment held among African-American Christian women”

- 50 women are invited to participate in a dissertation research study
- Complete 4 surveys
- Responses are anonymous and confidential
- Takes about 45-50 minutes
- Light refreshments provided

Saturday - August 2008
Church Function Hall
3:00pm – 4:00pm

SAMPLE

Sis. Marilyn Braithwaite-Hall is a doctoral student at Northeastern University, Department of Counseling and Applied Educational Psychology.
She has been a member of St. Paul AME Church for over 20 years.
Further info: contact Coordinator of Women’s Ministries.
NUMBERS AND CONTACT INFORMATION

MA Department of Mental Health- http://www.mass.gov

Women’s Health Network  877-414-4447

Black Women’s Health Imperative
www.BlackWomensHealth.org

Domestic Violence  877-785-2020

Mass Health (Medicaid)  800-841-2900

Substance Abuse Info & Education Helpline  800-327-5050 / 617-292-5065

Mental Health America (formerly National Mental Health Association)
www.nmha.org

Boston Christian Counseling Center  627-523-1543
www.Bostonchristiancounseling.com

www.thriveboston.com

Christian Internet Search Engines- counselcarenconnection.org and CrossSearch.com

Alcoholics Anonymous- A 12-Step program for alcoholics
www.alcoholics-anonymous.org

Emotions Anonymous. A 12-step program for those working to improve their mental or emotional health, including those who are depressed.
www.emotionsanonymous.org

Al-anon Twelve step program for family members and friends of alcoholics.
www.al-anon.alateen.org

Overeaters Anonymous A 12 step program for those working toward recovery from compulsive overeating
www.oa.org

National Suicide Prevention Hotlines
Phone: 800-273-8255
www.suicidepreventionlifeline.org
### Mental Health Resources

**National Alliance on Mental Illness**  
[www.nami.org](http://www.nami.org)

**Depression and Bipolar Support Alliance**  
[www.dbsalliance.org](http://www.dbsalliance.org)

| **American Association of Pastoral Counselors**  
9504A Lee Highway  
Fairfax, Virginia 22031-2303  
Phone: 703-385-6967/ Fax: 703-352-7725  
[www.aapc.org](http://www.aapc.org) |
|---|
| **American Association for Marriage and Family Therapy**  
1133 15th Street NW, Suite 300  
Washington, DC 20005-2710  
Phone: 212-452-0109/ Fax: 202-223-2329  
[www.aamft.org](http://www.aamft.org) |
| **The Center for Mind-Body Medicine**  
5225 Connecticut Avenue NW, Suite 414  
Washington, DC 20015  
Phone: 202-966-7338/ Fax: 202-966-2589  
e-mail: center@cmbm.org / website - [www.cmbm.org](http://www.cmbm.org) |
| **American Association of Naturopathic Physicians**  
4435 Wisconsin Avenue, NW, #403  
Washington, DC 20016  
Phone: 866-538-2267/ Fax: 202-237-8152  
[www.naturopathic.org](http://www.naturopathic.org) |
| **American Counseling Association**  
5999 Stevenson Avenue  
Alexandria, VA 22304  
Phone: 703-823-9800/ Fax: 703-823-0252  
[www.counseling.org](http://www.counseling.org) |
| **American Psychiatric Association**  
1400 K Street, NW  
Washington, DC 20005  
Phone: 888-357-7924  
[www.psych.org](http://www.psych.org) |
| **American Psychological Association**  
750 1st Street, NE  
Washington, DC 20002-4242  
Phone: 202-336-5500 or 800-374-2721  
[www.apa.org](http://www.apa.org) |
<table>
<thead>
<tr>
<th><strong>Mental Health Resources</strong></th>
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<tbody>
<tr>
<td><strong>Association of Black Psychologists</strong></td>
</tr>
<tr>
<td>PO Box 44999</td>
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<tr>
<td>Washington, DC 20040-5999</td>
</tr>
<tr>
<td>Phone: 202-722-0808</td>
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<tr>
<td><a href="http://www.apsi.org">www.apsi.org</a></td>
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<tr>
<td><strong>National Mental Health Counselors Association</strong></td>
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<tr>
<td>801 Forth Fairfax Street, Suite 304</td>
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<tr>
<td>Alexandria, VA 22314</td>
</tr>
<tr>
<td>Phone: 800-326-2642 / Fax: 703-548-4775</td>
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<tr>
<td><a href="http://www.amhca.org">www.amhca.org</a></td>
</tr>
<tr>
<td><strong>RAINN: Rape, Abuse, &amp; Incest National Network</strong></td>
</tr>
<tr>
<td>635-B Pennsylvania Avenue, SE</td>
</tr>
<tr>
<td>Washington, DC, 20003</td>
</tr>
<tr>
<td>Phone: 800-656-HOPE, ext 1 / Fax: 202-544-3566</td>
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<tr>
<td><a href="mailto:rainnmail@aol.com">rainnmail@aol.com</a></td>
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<tr>
<td><strong>National Crime Victim Bar Association</strong></td>
</tr>
<tr>
<td>2000 M Street, NW Suite 480</td>
</tr>
<tr>
<td>Washington, DC 20036</td>
</tr>
<tr>
<td>Phone: 800-FYI-CALL or 202-467-8753</td>
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<tr>
<td><strong>American Massage Therapy Association</strong></td>
</tr>
<tr>
<td>500 Davis Street, Suite 900</td>
</tr>
<tr>
<td>Evanston, IL 60201</td>
</tr>
<tr>
<td>Phone: 877-905-2700/ Fax: 847-864-1178</td>
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<tr>
<td><a href="http://www.amtamassage.org">www.amtamassage.org</a></td>
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Suggested Reading

- Black Pain: It Just Looks like We're Not Hurting  
  Terrie Williams

- Broken Silence: Opening Your Heart and Mind to Therapy--A Black Woman's Recovery Guide  
  Kim Singleton

- Can I Get a Witness?: Black Women and Depression  
  Julia Boyd

- I will Survive--The African American Guide to Healing from Sexual Assault and Abuse  
  Lori Robinson and Julia Boyd

- In and Out of Our Right Minds: The Mental Health of Black Women  
  Diane Brown, PhD

- In the Company of My Sisters: Black Women and Self-Esteem  
  Julia Boyd

- Lay my Burden Down: Suicide and the Mental Health Crisis among African Americans  
  Alvin Poussaint, MD

  Dr. Suzan Johnson Cook

- Saving Our Last Nerve: Black Women's Guide to Mental Health  
  Marilyn Martin, MD

- Shifting: The Double Lives of Black Women in America  
  Charisse Jones and Kumea Shorter-Gooden, PhD

- Soothe your Nerves: Black Woman's Guide to Understanding and Overcoming Anxiety, Panic and Fear  
  Angela Neal-Barnett, PhD

- Straight Talk--Overcoming Emotional Battles with the Power of God's Word  
  Joyce Myer

- Prime Time: African American Woman's Complete Guide to Midlife Health and Wellness  
  Gayle Porter

- Unstuck: Your Guide to the Seven-Stage Journey Out of Depression,  
  Gordon, James, MD

- Willow Weep for Me: A Black Woman's Journey through Depression  
  Meri Nan-Ana Danquah
Bible Verses for Hope and Encouragement

"Those who know Your name will trust in You, for You, LORD, have never forsaken those who seek You." Psalm 9:10

"Peace I leave with you; my peace I give you. I do not give to you as the world gives. Do not let your hearts be troubled and do not be afraid." John 14:27

"The LORD gives strength to His people, the LORD blesses His people with peace." Psalm 29:11

"I will listen to what God the LORD will say; He promises peace to His people." Psalm 85:8

"Thou will keep in perfect peace him whose mind is stayed on thee, because he trusteth in thee." Isaiah 26:3

"The LORD your God is with you, He is mighty to save. He will take great delight in you, He will quiet you with His love, He will rejoice over you with singing." Zephaniah 3:14-17

"For I am convinced that neither death nor life, neither angels nor demons, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord." Romans 8:38-39

"He who dwells in the shelter of the Most High will rest in the shadow of the Almighty. I will say of the LORD, "He is my refuge and my fortress, my God, in whom I trust. He will cover you with His feathers, and under His wings, you will find refuge; His faithfulness will be your shield and rampart. You will not fear the terror of night, nor the arrow that flies by day." Psalm 91:1-2, 4-5

"God has said, 'Never will I leave you; never will I forsake you. So we say with confidence, 'The Lord is my helper; I will not be afraid.'" Hebrews 13:5-6

"There is no fear in love. But perfect love drives out fear, because fear has to do with punishment." 1 John 4:18

"For I know the plans I have for you, declares the LORD, 'plans to prosper you and not to harm you, plans to give you hope and a future. Then you will call upon me and come and pray to me, and I will listen to you. You will seek me and find me when you seek me with all your heart.'" Jeremiah 29:11-13

"His divine power has given us everything we need for life and godliness through our knowledge of Him who called us by His own glory and goodness." 2 Peter 1:3

"Finally, be strong in the Lord and in His mighty power. Put on the full armor of God so that you can take your stand against the devil's schemes. For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms. Therefore, put on the full armor of God, so that when the day of evil comes, you may be able to stand your ground, and after you have done everything, to stand. Stand firm then, with the belt of truth buckled around your waist, with the breastplate of righteousness in place, and with your feet fitted with the readiness that comes from the gospel of peace. In addition to all this, take up the shield of faith, with which you can extinguish all the flaming arrows of the evil one. Take the helmet of salvation and the sword of the Spirit, which is the word of God." Ephesians 6: 10-17
Bible Verses for Hope and Encouragement

Be strong! Be courageous! Do not be afraid of them! For the Lord your God will be with you. He will neither fail you nor forsake you. Deuteronomy 31: 6

All who are oppressed may come to Him. He is a refuge for them in their times of trouble. All those who know your mercy, Lord, will count on you for help. For you have never yet forsaken those who trust in you. Psalm 9: 9-10

He is my strength, my shield from every danger. I trusted in Him, and he helped me. Joy rises in my heart until I burst out in songs of praise to Him. The Lord protects his people and gives victory to his anointed king. Psalm 28: 7-8

Why then be downcast? Why be discouraged and sad? Hope in God! I shall yet praise Him again. Yes, I shall again praise Him for His help. Psalm 42: 5

When I pray, you answer me and encourage me by giving me the strength I need. Psalm 138: 3

“For I know the plans I have for you,” says the Lord. “They are plans for good and not for evil, to give you a future and a hope.” Jeremiah 29:11

“God is our refuge and strength, an ever-present help in trouble. Therefore we will not fear.” Psalm 46:1-2

“Say to those with fearful hearts, ‘Be strong, do not fear; your God will come….He will come to save you.” Isaiah 35:4

“When anxiety was great within me, your consolation brought joy to my soul.” Psalm 94:19

And I am sure that God who began the good work within you will keep right on helping you grow in His grace until His task within you is finally finished on that day when Jesus Christ returns. Philippians 1: 6

Fear not, for I have redeemed you; I have summoned you by name; you are mine. When you pass through the waters, I will be with you, and when you pass through the rivers, they will not sweep over you. When you walk through the fire, you will not be burned; the flames will not set you ablaze. For I am the LORD your God, the Holy One of Israel, your Saviour. Since you are precious and honored in my sight and because I love you.” Isaiah 43:1-4

“As I was with Moses, so I will be with you; I will never leave you nor forsake you. Be strong and courageous. Be strong and very courageous. Have I not commanded you? Be strong and courageous. Do not be terrified; do not be discouraged, for the LORD your God will be with you wherever you go.” Joshua 1:5, 6, 7, 9

“Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus.” Phillipians 4:6-7

“For God did not give us a spirit of fear, but of power, and of love, and of a sound mind.” 2 Timothy 1:7

“Cast all your anxiety on Him because He cares for you.” 1 Peter 5:7

“I, even I, am He who comforts you.” Isaiah 51:12