



The Role of Faith-Based Therapy in Treating Depression in African Americans

by

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ABSTRACT

Current research has indicated that there are disparities in mental healthcare treatment that are affecting African Americans. The literature has not strongly supported the use of spiritual leaders as counselors primarily because of a lack of certification in mental health counseling among clergy. However, the literature has shown that religious faith can have a positive effect on quality of life. The purpose of this critical literature review study is to review the existing research related to faith-based counseling and its specific use for treating depression symptoms among African American adults. Forty-seven peer-reviewed articles from the professional literature were selected for review based on relevance to Africans and faith based organizations. Result of the review indicated the need to critically evaluate efficacy of faith-based programs based on scientifically determined outcomes. The implications for positive social change include increased access to affordable healthcare in trusting environment, decreased prevalence rates for depression in African Americans, and reduction in disparities in mental healthcare delivery.

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CHAPTER-1

Introduction

Current research has indicated that African Americans face a disparity in receiving adequate mental healthcare treatment in spite of advances in technology and mental healthcare (Ojeda & McGuire, 2006). There is a need for alternative treatment options in conjunction with medical treatment to manage depression within the African American community. African Americans suffering from a mental health condition can benefit from resources within their community that are accessible and affordable. The focus of this study is to investigate the role of faith-based therapy in managing depression in African Americans. This subject is significant to African Americans because of the role religion serves in their community.

Faith-based therapy is designed not to impose beliefs on people, but to encourage them to use their existing spiritual beliefs as a coping mechanism to deal with life stressors such as death, divorce, or change in lifestyle. The literature supports the concept of faith-based therapy, which forms the theoretical basis for this study. Daaleman and Kaufman (2006) conducted a study using a cross-sectional analysis examining the correlation between spirituality and symptoms of depression in primary care patients. The study consisted of 401(78.8%) European American and 94(18.5%) African American participants. Daaleman and Kaufman (2006) used the Spiritual Index of Well-Being to gauge the participants' level of spirituality in relation to episodes of depression. The data indicated that the primary outpatient group members who reported a higher degree of self-efficacy as part of a significant spiritual well-being also reported less depressive symptoms (Daaleman & Kaufman, 2006).

Carrington (2006) explored clinical depression in African American women in regard to diagnosis, treatment, and research. Carrington indicated that a lack of research on African American women and depression was a major reason for conflicting

prevalence rates. The critical literature review will include research involving African American men and women aged 18 to 65 years to provide an understanding of the effects of depression throughout the African American lifespan. Also, the literature review will focus on research comparing other ethnic groups with African Americans to illustrate the significance of faith-based therapy within the African American population. Chapter 1 introduces the structure and foundation of the study, including the problem statement and the significance of the study.

Statement of Problem

African Americans face a disparity in accessing and receiving healthcare compared to other ethnicities (U.S. Department of Health and Human Services, Office of the Surgeon General, n.d.). African Americans are overrepresented in the population of U.S. adults diagnosed with depression (Williams et al., 2007). They are also less likely to seek treatment and more likely to have a mental disorder than European Americans (Centers for Disease Control and Prevention [CDC], n.d.). This disparity may be related to a lack of trust of medical professionals and access to healthcare in the African American community (Dossett, Fuentes, Klap, & Wells, 2005).

Depression is the seventh leading cause of death which is linked to a risk for suicide in the United States (CDC, n.d.). Researchers have found conflicting prevalence rates of depression among African Americans (Riolo, Nguyen, & King, 2005; Williams et al., 2007). The two most common forms are major depressive disorder (MDD) and dysthymic disorder; they do not affect African Americans equally. Dysthymic disorder is associated with feeling sad all the time for over 2 years and is characterized by symptoms less severe than those of MDD (Riolo et al., 2005). Dysthymia is more prevalent among African Americans than European Americans (the rates are 56.5% and 26.8%, respectively; Williams et al., 2007). MDD is characterized by acute (short-term) episodes of severe depressive symptoms. European Americans have a higher lifetime MDD

prevalence rate (17.9%) than Caribbean Blacks (12.9%) and African Americans (10.4%), which Williams et al. (2007) attributed to untreated depression in Caribbean Blacks and African Americans. This data reflects the need to expand the research of mental health care treatment among African Americans. African Americans carry a heavy burden when it comes to depression because they are less likely than European Americans to seek mental health services or to receive proper diagnosis and treatment (Williams et al., 2007). They are also more likely to have depression for longer periods, resulting in greater disability (Williams et al., 2007).

Background Data

Treatments for depression include antidepressant medications, psychotherapy, and self-help groups. A holistic approach to treatment, which affords the medical or public health professional a broader perspective of the client or target population and encompasses people's cultural and religious beliefs as well as their past medical history, may be important for African Americans who tend to have strong religious connections. The literature does not strongly support the use of spiritual leaders as counselors because of a lack of healthcare education among clergy. This thesis attempts to provide an understanding of faith as an alternative form of treatment for depression among the African American population through a critical literature review.

Having a supportive network is a key element to managing depression. Self-help groups, including those in the religious sector, can serve as resources for building a network of support. Several studies have been conducted to examine the role of religion in managing mental health disorders. Hodges (2002) examined the relationship between spirituality and human development, focusing on adults' emotional well-being. Hodges found that the concept of spirituality was a useful indicator of mental health stability and implied that an individual is part of a greater community. Hodges also indicated four

dimensions of spiritual well-being that correlated with emotional well-being that included meaning in life, intrinsic values, transcendence, and spiritual community.

Purpose of the Study

The purpose of this study is to examine the concept of faith and its relationship to the treatment of depression. Identification of a relationship between faith-based counseling and depression is beneficial to the secular community's efforts to build a positive health network. It is hypothesized that faith-based counseling enhances the reduction of depressive symptoms in African American adults.

The primary question this study seeks to answer involves the extent of the impact of faith on treatment of depression. Ai, Peterson, Rodgers, and Tice (2005) conducted a study among 224 middle-aged patients undergoing open-heart surgery. Ai et al. applied social cognitive theory (SCT) to explore the relationship of faith and mental health. The researchers defined *locus of control*, which is a concept of SCT, as one's perceived control in regard to a deity as a source of higher power, and *primary control* as one's control over the environment (Ai et al., 2005). A secondary control strategy was seeking help from God or some other deity (Ai et al., 2005). Ai et al. measured several factors such as routine of prayer and emotional coping to assess the relationship between faith and stress management and used a goal-oriented spiritual coping measure of prayer to assess individuals' faith-based personal control. The study found that older-aged minority patients with greater external control used private prayer as a source of coping (Ai et al., 2005).

Operational Definitions

Faith:

Though faith has several definitions, it is a concept common to different religions. Star (2008) described faith as self-transformation and willingness of finding one's emotional truth to accept the unknown. Faith and hope can be used interchangeably to describe a coping mechanism.

Faith-Based Therapy:

To further understand the concept of faith, one must understand faith-based therapy. The term *faith-based* "is used to describe religious organizations that provide transitional assistance, multi-service with a focus on social services" (Graddy & Ye, 2006, p. 309). Faith-based therapy is an outreach initiative to help facilitate community health needs among underserved and underrepresented populations.

Faith-Based Counseling:

Faith-based counseling is a form of faith-based therapy. It differs from secular counseling because it is centered on one's belief in God. "Faith-based counseling helps people find a balance between their life values, goals, and belief system" (Family Christian Counseling, n.d., p.1).

Depression:

Depression is a state of feeling sad, hopeless, and angry, that interferes with normal daily living and functioning (National Institute of Mental Health [NIMH], 2000). "Depression often co-exists with other illnesses and people do not all experience the same symptoms" (NIMH, 2000, p. 2); it can be a result of environmental or biological factors. Types of depression are classified based on symptoms, severity, and duration. The two most common forms are MDD and dysthymic disorder. For the purposes of this study, the researcher's discussion of depression refers to dysthymia, or MDD where otherwise indicated.

Significance of the Study

According to the CDC, 20.9 million Americans suffer from depression annually (CDC, n.d.). Nearly 25% of African Americans are uninsured, compared to only 16% of the general U.S. population (U.S. Department of Health and Human Services, Office of the Surgeon General, n.d.). This represents an inequality in diagnosis and treatment of depression in African Americans. The findings of this study can help to create a standard for faith-based therapy as an alternative form of treatment for depression. This study also can help to expand patients' health paradigm to include community-based care resources, which can help to ensure African American clients receive adequate healthcare in a trusting environment. Finally, this study helps to define a working relationship between faith-based counselors and secular medical professionals.

Research Questions

It is important to establish a working relationship between faith-based therapy and depression. However, it is imperative to conduct an evaluation of the effectiveness of interventions. This study answers the following research questions based on a critical review of the literature:

1. What is the relationship between faith-based therapy and depression in African American adults?
2. What is the impact of faith-based therapy on depression?
 - a. The independent variable in this study is faith-based therapy.
 - b. The dependent variable is depression.

Assumptions and Limitations

I assume that faith-based therapy is effective in treating depressive symptoms in African Americans based on the centrality of faith and spirituality within the African American community during times of hardship, from slavery to the Civil War. Incorporating faith measures has made African Americans resilient in surviving

limitations imposed by society (Bazargan, Bazargan –Hejazi & Baker, 2005). The scope of this study was limited to a critical literature review, which limits generalization of the findings. This research lacked empirical data to validate current literature findings.

CHAPTER 2

Literature Review

This chapter is dedicated to bridging the gap between faith and depression in African American adults. The loss of a loved one, divorce, unemployment and poverty are risk factors for experiencing depression. The effects of depression vary for each individual. Chapter 2 creates the foundation and purpose of this research and continues with the discussion of the African-American church's impact on treatment of depression. The church is a source of a social network and provides a self-help group. Several important concepts such as depression, faith-based therapy, and the role of the church in the African American community are discussed. Examples of faith-based organizations are presented as supporting data for alternative treatment of depression among African-Americans.

Overview of Depression

Depression is a mental health disorder that, if left untreated, can lead to suicide (Bazargan et al., 2005). The suicide rate among African Americans between the ages of 10 and 14 years increased by 233% between 1980 and 1995; this compares to a 120% increase among European Americans, which indicates that African American rates are significantly higher than those of European Americans (U.S. Department of Health and Human Services, Office of the Surgeon General, n.d.). Symptoms vary based on the type of depression and include an inability to eat, work, and enjoy life. Other symptoms of depression include a persistent sad mood, feelings of hopelessness, feelings of guilt, decreased energy, difficulty making decisions, changes in appetite and weight, suicide attempts, and persistent physical changes that do not respond to treatment such as digestive disorders and headaches (National Institutes of Mental Health [NIMH], 2000).

Depression has several classifications including MDD, dysthymia, and bipolar disorder. MDD is a combination of symptoms that can occur once or several times

throughout one's life. Dysthymia is less severe than MDD but nevertheless produces chronic symptoms that are detrimental to one's sense of well-being; it has been shown to be comorbid with MDD (NIMH, 2000). Bipolar disorder is composed of mania and dramatic mood changes.

There is no single cause of depression. However, family history, environment, life stressors, trauma, and certain health conditions may trigger a depressive episode (NIMH, 2000). Women experience depression twice as often as men, which may be related to hormonal changes and pregnancy; men are also less likely to admit they are depressed (NIMH, 2000). Dysthymia is more prevalent in African Americans and Mexican Americans than in European Americans (Riolo et al., 2005). The high prevalence of dysthymia among African Americans and Mexican Americans could be related to a lack of medical treatment upon first noticing changes in mood and thought and other symptoms associated with depression (Riolo et al., 2005).

Disparity in Diagnosis and Treatment

Ojeda and McGuire (2006) conducted a study to examine the use of outpatient mental health and substance services by depressed adults. Ojeda and McGuire used self-reported data from the 1997–1998 Healthcare for Communities Survey of 1,498 African American, Latino, and European American men and women 18 years of age and older meeting Composite International Diagnostic Interview (CIDI) criteria for major depression or dysthymia. The results indicated that African Americans and Latinos 18 to 44 years of age were less likely to use outpatient mental health services. Forty percent of African Americans and Latinos reported lost pay from work to attend medical appointments as a barrier to seeking or using medical treatment, compared to 12% of European Americans. African Americans also reported other barriers to treatment at a significantly higher rate than did European Americans, 40% stated that their mental healthcare provider did not accept their health insurance, compared to 29% of European

Americans, and 47% reported feeling embarrassed to discuss their problems with anyone, compared to 12% of European Americans (Ojeda & McGuire, 2006).

Ojeda and McGuire (2006) concluded, “services used by minorities were more affected by financial and social barriers” (p. 211). This conclusion is significant to this research because it helps to support the use of faith-based therapy with an African American population. Church- or faith-based community health centers can help to reduce barriers to treatment by providing access to healthcare in the community. This research also supports the need to improve mental health treatment for uninsured and underserved populations.

Lack of access to healthcare for African Americans is a common theme in research findings. Bazargan, Bazargan-Hejzai, & Baker (2005) conducted a study among African Americans and Hispanics to examine treatment for depression using the behavioral model for vulnerable populations as the framework for the study. The participants consisted of 391 residents of three public housing communities in Los Angeles. They were on average 45 years of age, and 89% of females who participated acted as head of household. Of the participants, 60% did not have a high school diploma, and 48% reported suffering from depression. Results indicated that one out of three people reporting being depressed also reported never having been diagnosed for depression (Bazargan et al., 2005).

Carrington (2006) discussed the prevalence rate of depression among African American women. Carrington's literature review revealed that "lack of adequate and sufficient research data on African Americans contributes to the problems of misdiagnoses, under diagnoses, and under treatment of depression in African Americans and more profoundly in African American women" (p. 780). Carrington inferred that holistic treatment could be successful in reducing depressive symptoms in African Americans and suggested the need for more evidence-based treatment approaches for depression, including faith-based therapy. Incorporating faith-based therapy as a part of one's healthcare plan could help to increase quality of life and improve access to healthcare. Laurencelle, Abell, and Schwartz (2002) examined the link between intrinsic religious faith and psychological well-being and found that people with high faith were lower in anxiety and depression were less likely to show symptoms of character pathology and had significantly stronger egos (p. 109). Role of the Church in the African American Community

For centuries, the church has been a central point of support for the African American community. Throughout U.S. history, the church has served an important role in the lives of African Americans (Markens, Fox, Taub, & Gilbert, 2002, p. 92). NIMH (2007) conducted a survey of 3,570 African Americans, 1,621 Blacks of Caribbean descent, and 891 non-Hispanic Whites 18 years of age and older regarding depression and treatment and showed that treatment rates for depression among African Americans is low. (NIMH, 2007). The structure of the church promotes safe behaviors such as no smoking, no consumption of alcoholic beverages, encouragement of peaceful relationships with neighbors, family, coworkers, and self-control of one's life.

Krause (2003) conducted a study to provide a better understanding of the role of faith by analyzing positive and negative aspects of religion. Krause used a conceptual model that included the constructs of church attendance, religious forgiveness, race, connectedness with others, depressed affect, and somatic symptoms. Krause also

discussed religious variations by race, stating “there are both historical and cultural reasons for the distinct social emphasis in religion among older Blacks with the church becoming a social center for the Black community because of centuries of discrimination and prejudice” (p. 98). One of Krause’s findings indicated that religion is an important factor in the African American community, which fosters turning religious beliefs into action by forgiving others and promoting a bond among church members.

The National Council of Churches (NCC; n.d.) found increased church growth within the United States and Canada, and it expected membership in the four largest churches to increase by 1.04% annually. Almost 60% of the U.S. population attends church on a regular basis (NCC, n.d.). Churches have a strong impact on affecting health behavior changes in a safe, supportive environment (Peterson, Atwood, & Yates, 2002,). Therefore, the African American community and other ethnic groups might be likely to embrace faith-based therapy, if available. Marks et al. (2005) conducted a qualitative study to identify the relationship between religion and the health of African Americans. The sample consisted of 32 African American married couples who were interviewed together as couples. Interviews focused on active faith involvement, avoiding negative coping, evading violence, social support, and power of prayer. One theme expressed in the study was the belief that “giving up on faith is often equated with giving up on life in faith-based African culture” (Marks et al., 2005, p. 468). Marks et al. concluded that active religious involvement among the African American couples promoted a longer life span because the faith community encourages abstinence from drinking, smoking, and engaging in premarital sex as well as promoting forgiveness.

Markens et al. (2002) conducted a study to evaluate pastoral leadership and church involvement in a three-year health promotion program in Los Angeles. The health promotion program was aimed at increasing mammograms among African American women. The project was funded by the National Cancer Institute to evaluate

the effectiveness of churches as a community resource and church based interventions. Markens et al. conducted a process evaluation to determine the church's influence on promoting mammography screening with a post-intervention interview of the pastors. The findings indicated the need to employ volunteers within the church to promote continuity of church-based health promotion programs (Markens et al., 2002). A common theme surrounding active church involvement was the concept of holism, which is incorporating the care of one's mind, body, and soul to achieve change. Markens et al. suggested that churches could be important catalysts for promoting health, particularly among the underserved.

Faith-Based Therapy

Faith-based therapy poses several benefits not only for the African American community, but for the faith community in general. Peterson et al. (2002) discussed seven key elements or benefits of a faith-based program, including partnership, positive health values, and availability of services, access to facilities, community-focused interventions, health-behavior change, and supportive environment. Peterson et al. concluded "communities without access or resources for traditional health promotion programs may benefit the most from CBHPP [Church-Based Health Promotion Programs]" (p. 409). Ai et al. (2006) conducted a survey of middle-aged and older cardiac patients exploring differential effects of faith-based coping on physical and mental fatigue. The coping mechanisms used by the cardiac surgical patients included daily prayer, optimism, and hope. "The findings suggested that adaptive faith-based coping styles may have a favorable role over time in their own right and should not be interpreted as a tendency for optimistic report" (Ai et al., 2006, p. 360). The study supported faith-based coping skills and, thus, could be applied to evaluating mental health interventions for treatment of depression.

The need to develop a strong and supportive partnership between faith-based organizations (FBOs) and secular medicine was expressed throughout the literature. Canning (2003) highlighted a partnership with one psychologist and three FBOs. The partnership was centered on common goals, which were community development and participation. The psychologist interacted within three different settings, which included healthcare, education, and community. The purpose of the article was to illustrate the outcomes of the partnership that involved using psychological perspectives and methods (Canning, 2003).

Canning (2003) also demonstrated the importance of social networking among psychologists of faith. For example, the Circle Rock Preparatory School, a faith-based elementary and middle school, utilized the bible, community, church, and research to create a faith-based community. The collaboration between the psychologists of faith and the Circle Rock Preparatory School produced a full spectrum of services called Providing Assistance for School Success, which promoted social competence in low-income school-aged children. The program mirrored the school's mission as a faith-based organization to provide biblically based education, promoting academic excellence and building character, of acting as a faith-based organization (Canning, 2003).

Rural communities without public transportation and an unstable business economy may benefit from the support of faith-based organizations. Often, churches and faith-based health centers are strategically located in rural areas. Irving, Sutherland, and Harris (2006) conducted a case study to determine the efficacy of implementing an arthritis self-help curriculum within rural African American churches, using the faith prevention model as a curriculum guide. The model consisted of seven phases of development that included developing community relationships, prevention committee in-services, training, action, and fiscal planning, and outcome/impact process evaluation and design (Irving et al., 2006). The arthritis self-help course was a six-week intervention

program endorsed by the Arthritis Foundation. The principles of the course were community design and promotion of self-management for medication, nutrition, pain, and depression (Irving et al., 2006). The faith-based model allowed the incorporation of participants' spiritual and cultural beliefs.

The Arthritis Foundation evaluated the program based on outcomes of overall health, pain, well-being, physical activity, and self-efficacy. Outcome-based evaluation permits faith-based organizations to define success based on measurable goals (Fagan, Horn, Edwards, Woods, & Caprara, 2007). A pretest-posttest design study incorporated a survey to assess six qualitative and quantitative variables used to determine overall health, pain, function/disability, well-being, physical activity, and self-efficacy (Irving et al., 2006, p. 111). The project was successful in achieving a reported 18% increase in physical activity and a 20% increase in self-efficacy; however, there was no significant change in feelings of anxiety and nervousness (Irving et al., 2006). This case study illustrated a successful partnership that utilized the arthritis self-help course as an educational tool in conjunction with the faith-based prevention model.

The faith-based prevention model could be used as a framework for faith-based programs. The Potter's House Transformation Treatment Center utilizes faith-based education to instruct individuals on making informed decisions. The Center uses a multidisciplinary approach focusing on spiritual and clinical needs of each individual. The Potter's House is an example of a faith-based organization that offers faith-based counseling through a multidisciplinary team and psychiatrist. The treatment team specializes in mental health issues and chemical dependency with an ongoing discharge plan to meet outpatient needs (Psychiatric Solutions, n.d.).

Life and Work Solutions is a private faith-based outpatient mental health and substance abuse organization that provides treatment and substance abuse counseling (Life and Work Solutions, n.d.). The organization is unique because it is a private

institution and not government funded. Instead, it is reimbursed by major insurance plans including HMOs and PPOs. It provides a range of services for individuals, families, children, and groups, including training in faith-based counseling. This organization's counseling philosophy is based upon a cognitive-behavioral model. The organization is easily accessible to the community because its counselors travel to clients' place of work, home, and school and offer flexible appointments. Life and Work Solutions also encourages professional accountability by requiring the counselors to complete rigorous academic studies, real-life training, and 30 hours of annual counseling education.

Clarke (2006) explored transformational development between two Christian FBOs in post-tsunami rebuilding and development of Aceh, Indonesia. Transformational development involves one's belief in God through Jesus Christ and the Christian's role in the community. The two Christian faith-based organizations (Restore and Aceh Concern) utilized different approaches to achieve success and were evaluated on issues encountered and development initiatives used for post-tsunami transformation in Aceh, Indonesia.

The first organization, Restore, an FBO developed to assist refugees, did not pay for job training nor did it provide for job security (Clarke, 2006). The rationale for this approach by Restore was to prevent dependency and encourage accountability. In contrast, the second organization, Aceh Concern, a partnership between two Christian FBOs, utilized local leadership to support programs to provide water, sanitation, and training in English, computer, and health skills. The latter organization's success was attributed to its perception of the community as a whole and to its success in developing and maintaining trusting relationships with residents (Clarke, 2006). In comparison with mental health and African Americans, trust is an important factor in utilizing available resources and developing a productive relationship between patient and healthcare provider. Even though the example presented is not directly related to mental health it

provides a substantial basis of the effectiveness of faith-based organizations in meeting transitional needs such as housing, job training and promoting self-help, which is needed for one experiencing an episode of depression.

A basic understanding of FBOs has been presented to illustrate faith-based therapy as an alternative form of depression treatment. The ideas presented can serve as best practice in developing a faith-based organization to address the mental health needs of African Americans. As discussed, several FBOs have been successful in meeting the needs of diverse communities in various settings, including the educational system, correctional system, disaster aid relief, and mental health and substance abuse treatment (Ai et al., 2006; Canning, 2003; Irving et al., 2006; Clark, 2006; Psychiatric Solutions, n.d., & Life and Work Solutions, n.d.). The connection was established with the role of the church in the African American community to serve as the foundation of faith-based therapy. However, further discussion is needed to create a cost analysis of FBOs compared to secular medicine to determine the possible benefits for uninsured and underserved populations within the African American community. A cost analysis defines the cost effectiveness of the program by exploring the cost and degree of goal attainment in relation to the consumer and organizational consideration (Shortell & Kaluzny, 2000). There is limited research on cost and outcome effectiveness of FBOs.

The National Council of Churches (NCC) has answered the call by conducting a study to provide quantitative and qualitative data about the delivery of faith-based services (NCC, n.d., para. 3). The NCC represents over 35 member denominations with 45 million Christians in 100,000 congregations. The purpose of their comprehensive report will be to demonstrate the role of the congregation in delivering health care (NCC, n.d., para. 6). The survey will be conducted among more than 100,000 congregations assessing the level of healthcare education, delivery and advocacy.

Challenges faced by FBO's

One reason for a lack of outcome-based evaluation of faith-based therapy is that most FBOs are small churches that lack grant writing skills and resources to conduct such research. This is not to imply that the organizations are not effective but to underscore the need to form healthy, functional relationships with the public sector to increase resource capacity. Employing reliable and valid research tools can serve to measure outcomes.

One barrier to developing a sound FBO is clarity of goals, mission statement, and grant writing skills to secure funds. Shortell and Kaluzny (2000) indicated that cost effectiveness may be difficult to measure if the program's goals are not clearly and explicitly defined. Frederick (2003) discussed separation of church and state, lack of accountability, and hiring discrimination as three challenges facing FBO. Receiving government funds causes controversy due to separation of church and state because the faith-based organization is then regulated by the government to supply adequate documentation of allocation of funds. Also, the FBO is then limited in how much it can express its religious views.

The most important challenge is lack of accountability and accurate record keeping. According to Frederick (2003), "many African American faith-based community development corporations have strong charismatic tendencies, with the mission focus being a stronger component of the organization than rational-legal factors such as grant writing skills" (p. 31). However, this challenge can be resolved by developing a partnership with the public sector. A strategy to improve faith-based and public sector relationships is to define the parameters of the working relationship.

The third challenge is hiring discrimination. Religious organizations are viewed as private organizations, which are not subject to anti-discrimination laws that are employed by the public sector. A FBO may hire the majority of the employees from within the congregation, which does not allow for diversity. This may result in biases in decision-making or community services.

Gee, Smucker, Chin, and Curlin (2005) conducted a study to analyze relationships between faith-based community health centers and neighborhood congregations. Gee et al. conducted semi-structured interviews of members of 23 neighborhood congregations and five faith-based urban community health centers. The results indicated the faith-based community health centers and neighborhood congregations shared a holistic vision of improving community health. But the two groups faced difficulty deciding on a common vision for future partnerships: Whereas religious leaders favored goals oriented toward their congregation, faith-based community health centers favored goals oriented toward the community (Gee et al., 2005). However, this problem could be resolved through effective discussion of each program's goals and producing a shared vision that reflects the missions, goals, and cultural beliefs of both organizations.

One important recommendation for a successful FBO is professional training as a requirement, which reflects accountability within the faith community. Dossett et al. (2005) conducted a survey of 56 faith organizations in Los Angeles to determine the obstacles to and opportunities for providing mental health services. The article indicated that 57% of the organization surveyed cited limited professional training as a barrier to providing mental healthcare in faith communities (Dossett et al., 2005). Educating religious leaders on the benefits of partnering the congregation and the general population could help increase resources and access to outpatient health services.

Faith-Based Services

One example of faith-based professional counseling is the Apostolic Christian Counseling and Family Services. The Apostolic Christian Counseling and Family Services (ACCFS) provide professional counseling for people suffering from depression, anxiety, marital problems, and child behavior problems (ACCFS, n.d.). The organization's style of counseling is based on early intervention, prevention, and

education. ACCFS is significant to this thesis because its counseling structure serves as a supporting foundation for faith-based counseling in the African American community.

Research conducted by Graddy and Ye (2006) indicated that FBOs offered more services than secular health providers. Table 2 shows a comparison of FBOs, secular nonprofit, public, and for-profit agencies in Los Angeles.

Table 2

Comparing Service Providers

	Faith- based	Secular nonprofit	Public agency	For profit
Service providers				
Number of service providers	388	1630	1216	227
Number of services offered	958	1727	1598	261
Average number of services offered per provider	2.5	1.7	1.3	1.1

Note: Permission Received. Adapted from “Faith-Based Versus Secular Providers of Social Services: Differences in What, How, and Where,” by E. Graddy and K. Ye, 2006, *Journal of Health and Human Services Administration*, 29, p. 316. Adapted with permission of author.

The data in Table 2 are consistent with the study’s hypothesis and highlight FBOs as a valuable resource. FBOs can help individuals cope with depression and function socially in the community (Graddy & Ye, 2006). In the study by Graddy and Ye (2006), FBOs offered 63% of all transitional assistance compared to 15% of secular nonprofit agencies. The table was presented as an example of current use of faith-based services and services rendered by faith-based groups. The data presented illustrates the connection of utilizing available faith-based resources within the African American community.

Discussion of Relevant Literature

Faith-based therapy can be used in different healthcare settings across a clients' lifespan. The Broward Intensive Halfway House in collaboration with the Faith and Community-Based Delinquency Treatment Initiative developed a program for character building to help prevent recidivism. The Broward Intensive Halfway House is a maximum-security state-operated residential facility for young men, ages 14–18 years (Department of Juvenile Justice, 2006). The core principles of the program include work ethic, sense of accomplishment, building skills, and promoting responsibility. Its 12-month pilot program used motivational speakers, family involvement, faith-based therapy, and partnering youths on a volunteer basis with mentors. The youth were allowed to practice their choice of faith whether it was Catholicism, Christianity, or Muslim. The pilot proved to be successful in helping the inmates enrolled in the Biblical Correctives to Thinking Errors to better monitor their thoughts and behaviors while in the study using a holistic approach involving social, spiritual, emotional, and physical components. Also an Honor Dorm was created for inmates with good behavior (Department of Juvenile Justice, 2006).

Current literature provides an extensive study of faith-based therapy within the African American community with respect to general health, but it is limited regarding empirical data on the efficacy of mental health outcomes. Moss, Gallaread, Siller, and Klausner (2004) conducted a study to determine the efficacy of faith-based therapy and adolescent STD screening. Moss et al. conducted the study in a predominantly low-income African American community in San Francisco. The research method consisted of 38 educational workshops and urine screenings at local sites between May and December 2002 (Moss et al., 2004). The role of Providence Foundation, an FBO, was to assist with fostering a positive environment in the African American community.

As a result of the strong collaboration with, Youth United Through Health Education (YUTHE), a HIV/STD peer education program, “470 individuals were screened for chlamydia and gonorrhea of which 83.5% were African American boys aged 15-25 years old” (Moss et al., 2004, p. 1082). The program also was able to provide field treatment and medicine to 19 individuals who tested positive for chlamydia and gonorrhea or both (Moss et al., 2004). This program illustrates the positive results of a strong partnership with a faith based group and public sector to promote healthy lifestyles and provide medical treatment to an underserved population.

The relationship between faith-based treatment and depression in African Americans is a positive one with definitive outcomes that builds upon several behavioral theories, such as the health-belief model and social-cognitive theory. Young, Griffith, and Williams (2003) described the structure of faith-based therapy through research conducted among 99 pastors of different denominations. Information was obtained through structured interviews to provide an understanding of how pastoral counseling worked among African American churches in a metropolitan area. Young et al. identified and described how African-American clergy work was a significant mental health resource for those who do not have adequate access and lack of insurance for mental healthcare.

The findings from the research of Young et al. (2003) helped clarify the role of faith-based therapy and depression in African Americans. The results reflected a strong relationship between clergy and secular medical mental health professionals. Among the 99 pastors interviewed, it was reported that counseling sessions lasted 15 minutes or more on a weekly basis extending from several months to two years, on average. Common problems reported were severe mental illness, substance abuse, and suicidal thoughts. The pastors referred individuals to a social worker, hospital emergency department, mental health agency, psychiatrist, or psychologist. Their therapy approach utilized

religious activities of prayer, meditation, and church participation; listening; and providing a nonjudgmental environment. Young et al. (2003) recommended expanding “efforts to enhance the continuing education available to [pastors] that would contribute greatly to the quality of services they are providing” (p. 692).

In the current literature, there is a need to examine the effectiveness of faith-based therapy for depression. Loewenthal et al. (2001) used a questionnaire to assess the perceived efficacy of six types of religious coping behaviors among 282 people in the United Kingdom. The results indicated that prayer was effective and most significant among Muslims, Christians, and Jews. Loewenthal et al. also indicated that prayer and faith were the most effective forms of religious coping.

Graddy and Ye (2006) researched the scope of services provided by faith-based, secular, and for-profit organizations and found that FBOs provided a higher volume of transitional services, such as food delivery and shelter, compared to secular and nonprofit organizations, which provided more comprehensive services. FBOs provided 17% of services observed among the 3,461 service providers, 388 of which were faith-based service providers. However, FBOs provided an average of 2.5% services offered per provider organization compared to secular healthcare and for-profit providers, which had an average of 1.1 % and 1.7% respectively of services offered (Graddy & Ye, 2006). This finding indicates FBOs are multi-service organizations.

Plante, Saucedo, and Rice (2001) investigated the role of faith as a coping strategy among 68 students and 64 faculty/ staff members from a Catholic, liberal arts university through a 10-item questionnaire. The questionnaire measured the strength of religious faith and the ability to cope with daily stress in a college environment. They found no association between religiosity and stress. Results were limited due to the demographics and environment of the participants. The sample consisted mainly of

healthy individuals and “thus the group may be generally homogeneous and certainly does not represent a clinical sample” (Plante, Saucedo, and Rice, 2001, p. 298).

Another study examined the importance of intrinsic spirituality in depression care among European American and African American patients (Cooper, Brown, Vu, Ford, & Powe, 2001). Cooper et al. used a cross-sectional survey of 76 patients to compare their views of depression care. The items were based on nine general areas of health that included professional interpersonal skills, primary care provider recognition of depression, treatment effectiveness, treatment problems, patient understanding about treatment, intrinsic spirituality, financial access, life experiences, and social support. Neither racial group viewed stigma as a health concern. The sample size consisted of 36% African Americans and 64% European Americans. Cooper et al. found that African Americans were 84% more likely to rate spirituality as extremely important for depression care compared to European Americans, who ranked spirituality as 25th on the scale.

Faith-based therapy can also be utilized within the correctional facility. Hall (2003) discussed the effectiveness of a faith-based program at one correctional facility and determined that cognitive behavioral therapy (CBT) is consistent with the goals of pastoral counseling. The study program used a 12-step cognitive restructuring curriculum among 38 inmates, with 10 in the experimental group and 28 in the control group. The group met once a week for 2 hours over 12 weeks with mini-lectures, class discussion, and small-group work focusing on using biblical principles to guide thinking error or providing alternative ways of thinking. As a result, there were no infractions reported among the experimental group, whereas there were 17 infractions reported among the control group with a statistically significant difference as evident by a mean of 0.214 and a *p* value of $> .01$ which means that members who completed the Biblical Correctives to

Thinking Error where able to monitor their thoughts and behavior during the study versus the control group (Hall, 2003).

Drayton-Brooks and White (2004) used the theory of planned behavior to explore the health perceptions and beliefs of 26 African American women from two large urban congregations. The focus groups were conducted during a 3-month period at two inner-city church facilities. The results from the focus groups indicated that the 26 participants were more influenced by a pastor, congregational nurse, or the church family to improve their health behaviors than they were by physicians (Drayton-Brooks & White, 2004).

Dehaven et al. (2004) conducted a systematic qualitative review to determine if FBOs were effective. The research included 28 articles with outcome measurements. Based on their analysis, the recommendation was that there needed to be collaboration between faith-based organizations and health professionals to increase the opportunity for evaluation of health promotion strategies as a collaborative. The critical review of literature focuses on identifying the effectiveness of FBOs on depression care for African Americans.

Conclusion

Chapter 2 served as the review of the literature. There is a disparity in the diagnosis and treatment of depression among African Americans, and the importance of the support of the church within the African American community for treatment appears justified. Several FBOs and communities have shown success in providing transitional services such as food shelters, housing and counseling, but further data are needed to evaluate the effectiveness of services rendered. Table 1 reflects 11 primary studies relevant to faith-based therapy and depression and provides a brief overview of the articles.

African Americans experience a disparity in access to healthcare based on several factors including lack of trust among medical professionals. Chapter 2 has shown that the

church can be effective and healthcare professionals can utilize the church as a valuable resource by bringing services to the client through formed partnerships. Such interventions can help to improve access to healthcare for underserved populations.

Table 2

Primary Studies Relevant to Faith-Based Therapy and Depression

Author	Sample (% African Americans)	Purpose	Major findings
Ai, Peterson, Rodgers, & Tice, 2005	224 (10%)	To examine faith and secular factors affecting locus of control in cardiac patients	Older age and minority status were associated with greater external control.
Daaleman & Kaufeman, 2006	550 (18.5%)	To examine spirituality and depressive symptoms in primary care outpatients	Spirituality was independently associated with fewer depressive symptoms.
Williams et al., 2007	6,082 (58%)	To identify prevalence, persistence, treatment, and disability of depression in AAs	Whites had higher lifetime rate of MDD (17.9%) than AAs (10.9%). Dysthymia was higher for AAs (56.5%) than for Whites (38.6%).
Cooper, Brown, Ford, & Powe, 2001	76 (36%)	To compare intrinsic spirituality and depression care among Whites and AAs	AAs were three times more likely to rate spirituality as extremely important for depression care. AAs and Whites rated importance of other aspects of depression care similarly.
Gee, L., Smucker, D., Chin, M. & Curlin, F., 2005	23 (not available)	To identify the relationship between federally funded community health centers and neighborhood religious congregations service delivery to underserved neighborhoods.	Collaboration was limited by inadequate resources and differing priorities, visions, and philosophies even though both groups desired greater collaboration.
Irvin, Sutherland, & Harris, 2006	75 (93.2%)	To examine strategies for implementing self-help (arthritis) curriculum within rural AA churches	After the course, there was a 64% increase in overall health, 185% in physical activity, and 20% increase in self-efficacy.
Laurencelle, Abell, &	210 (not available)	To investigate relationship between intrinsic religious faith and psychological	High-faith groups had a significantly lower level of reported depressive symptoms ($p < .008$) compared to the

Schwartz, 2002		well-being	moderate-faith group.
Loewenthal, Cinnirella, Evdoka, & Murphy, 2001	282 (3%)	To examine perceived efficacy and its implications for help-seeking behaviors among different cultures in the United Kingdom	Religious coping activities were seen as relatively ineffective; however, Muslims and men had a higher degree of efficacy with religious coping compared to Jews and women.
Marks et al., 2005	32 (100%)	To investigate the impact of religion on AA longevity	Mean difference for AAs was 13.7 years compared to general population (7.6 years).
Ojeda & McGuire, 2006	1,498 (13%)	To examine depressed Latinos and AA adults' use of mental health services	Both ethnic groups reported low use of outpatient mental health services related to financial and social barriers.
Young, Griffith, & David, 2003	99 (100%)	To investigate role of pastoral counseling by AA clergy	Pastors reported a weekly average of 6 hours of counseling for mental health issues similar to those of secular mental health patients. Pastors' work represented a significant mental health resource for those with a lack of access to healthcare.

CHAPTER 3

Research Methodology

Introduction

This chapter provides a description of the research method used in this study to investigate faith-based therapy. The chapter explores the research design, sample, data collection, and analysis. The findings are based on a critical review of the literature. The purpose of this chapter is to highlight the research efforts surrounding faith-based counseling as an alternative form of treatment for depression in African Americans. The following discussion brings together the data in a clear and succinct manner. It identifies several themes in the literature including accountability and validity of faith-based leaders as health educators. Several advantages, including access to space and trust of community members, were made evident through analysis of faith-based programs.

Research Design

The research design consisted of a critical review of the literature, which takes a systematic and detailed approach to further explore the issue of interest. By comparing and contrasting data, researchers are able to identify gaps and the need for further research (Munro, 2005). A critical review can produce qualitative data, which can help to benefit the partnership between faith-based and secular healthcare programs through identifying successes of other faith-based initiatives. Qualitative methodologies and data analysis can be very useful in program evaluation studies (McKenzie et al., 2005).

The following keywords were used to commence the research: *faith-based*, *faith-communities*, and *depression and African Americans*. The use of several search engines including Google; Walden University's database, EBSCOHost; and Medline produced full-text, primary, peer-reviewed journal articles and secondary data. Resources were also retrieved from governmental websites, Centers for Disease Control and Prevention, and NIMH, to provide a current overview of depression and faith-based programs.

Sample

The sample consisted of 47 articles, which were drawn from the peer-reviewed literature. The selected articles represented varied discussions surrounding faith-based therapy including accountability of faith leaders, appropriate interventions, and outcome evaluations. The sampling method was appropriate because it allowed the author to make inferences based upon a diverse knowledge base of evidence. The sample size of 47 articles and sources represented a need to further study faith-based therapy for treatment of depression in African Americans. The goal of this study was to provide evidence that would allow program leaders to develop faith-based initiatives using a faith theory or faith-based framework as discussed in Chapter 2.

The inclusion criteria were based on publication year, source, location, and analysis of study variables. The timeframe used to validate current evidence of faith-based counseling was 1999–present. Data were collected between March 2007 and May 2008 and consisted of 11 primary peer reviewed articles, 21 secondary sources, 3 books, and 15 electronic sources and articles. I selected articles that used large samples of African Americans to allow for generalization of findings and that used grounded theoretical approaches.

Data Collection

Two hundred articles were retrieved and reviewed to develop an extensive literature review, of which 47 articles were selected to build this study. A visual search provided by Walden University’s EBSCOHost database was utilized to select the most appropriate and relevant articles. The visual search provided condensed articles and allowed the author to narrow the search by subject and relevance. Statistical data on incidence and prevalence of depression among African American was obtained from research articles and Centers for Disease Control and Prevention and NIMH websites.

The NCC website was beneficial because data were available on church growth and attendance, which helped to validate the beneficence of faith-based initiatives. One international article was used for contrast and comparison of faith-based therapy. A diversity of journals were used including *Aging & Mental Health*, *Journal of Healthcare for the Poor and Underserved*, *Journal of Psychology & Christianity*, *Journal of Clinical Psychology*, *American Journal of Public Health*, *Psychiatric Services*, and *British Journal of Medical Psychology*.

Exclusion Criteria

Exclusion of data was based on if the researchers reflected bias, if there was a lack of supporting statistical data, and if the research was out-dated. Also, editorials and commentaries were excluded, because they did not provide reliability and validity to this study. Data was excluded prior to year 2000 which would have yielded out-dated research. Titles and abstracts were reviewed and excluded if there was no discussion of outcomes with faith-based therapy and treatment of depression in the African-American population.

Data Analysis

Faith-based programs were shown in studies to help decrease the recidivism rate among inmates, to promote self-efficacy in an arthritis curriculum in a rural African American church, and to create a trusting, accessible environment for mental health treatment (Department of Juvenile Justice, 2006; Irving, 2006 and Canning, 2003, respectively). In analyzing the articles, there was a need to identify more peer-reviewed research articles, which would have included supporting and opposing faith-based therapy to provide a credible stance and eliminate research bias of the author. A common theme noted in the literature review was the use of small sample sizes, which limited generalization of findings.

The two largest samples were 6,082 and 1,498 (Williams et al., 2007, and Ojeda & McGuire, 2006, respectively). The Williams et al. sample included 58% African Americans, which allowed for broader generalization of findings to the African American population. The present study hypothesized that faith-based counseling would have a negative correlation to depressive episodes in African Americans and sought to answer the following research questions:

1. What is the relationship between faith-based therapy and depression in African American adults?
2. What is the impact of faith-based therapy on depression?

The reviewed articles were collected and analyzed to answer these questions with significant focus on structure of faith-based counseling, geographical data, diversity of ethnicity, and use of mental health services versus faith-based services.

The literature revealed the use of cross-sectional surveys, a conceptual model, process evaluation, semi structured interviews, educational workshops, focus interviews, and empirical data as research methods. These techniques were beneficial in retrieving data to explore faith-based therapy. The theoretical models used by researchers included the theory of planned behavior (explains the reason for one's behavior), the faith-based prevention model (is a program of health promotion/prevention planning strategies), and the behavioral model for vulnerable populations (used to investigate healthcare services utilization among ethnic groups). The theoretical frameworks used represented both psychological and developmental theories.

In the critical review of literature the researchers used several analytical strategies such as analysis of variance (ANOVA) and *t*-tests to analyze data. The researchers evaluated how independent variables such as race, education, geography, and religion impacted hopelessness or feelings of being depressed.

CHAPTER 4

Research Findings

Introduction

The goal of this study was to investigate how African Americans can capitalize on an available resource within the community: the church. The literature revealed African Americans face a disparity in access to healthcare due to a lack of resources and quality care and from medical providers. The literature recognized the importance of faith to the decision-making process, but faith-based programs need evidence to support and validate their value.

Research Findings and Discussion

The literature revealed the importance of incorporating faith into healthcare decision-making. The two research questions were answered by the result of the literature review. The critical review of literature demonstrated the narrow scope of existing knowledge about the efficacy of faith-based interventions and the need for further research exploring their effectiveness. I hypothesized that people who are suffering from a mental illness such as depression, who have an active and supportive spiritual network, would experience fewer episodes of depressive symptoms. The literature suggests that faith-based therapy can be effective in treating depression among African-Americans (Gee et al., 2005; Daaleman and Kaufman, 2006; Cooper et al., 2001; Carrington, 2006, and Drayton-Brooks and White, 2004).

The next research question addressed the impact of faith-based initiatives on treatment of depression in African Americans. The results provided a definitive understanding of the positive influence of faith-based initiatives not only on the treatment of depression but on the educational system and behavioral modification for correctional inmates (Canning, 2003; Hall, 2003 and Department of Juvenile Justice 2006, respectively) . The critical review of the literature revealed several areas of study for

future research including addressing the inconsistency of prevalence rates of depression in African Americans and supporting data on efficacy of faith-based therapy in people of other ethnic groups experiencing episodes of depression.

Researchers used spiritual assessment tools to determine the impact of faith on depression in African Americans. One study used the Spiritual Issues in Supervision Scale (SISS) as a spiritual self-assessment tool for clinical mental health and supervisor training (Miller, Korinek, & Ivey, 2006). The scale measured four factors related to spirituality affecting clinical psychologists: assessment, marriage/divorce, culture, and ethical issues (Miller et al., 2006). The scale used a 5-point Likert scale measuring frequency of spiritual issues addressed in supervisor training from 1 = *never addressed* to 5 = *frequently addressed*. The scale also identified four themes of spiritual discussion: the client system, supervisory system, diversity lens, and lens of meaning and values (Miller et al., 2006). Although spirituality is difficult to measure, the tool proved to be valid and reliable which was determined by factor analysis and reliability testing of the scale. SISS can be used to improve psychological clinicians' practice through an awareness of clients' spiritual beliefs.

Ai et al. (2004) conducted a study on the effects of faith and locus of control among cardiac patients. Prayer coping, subjective religiosity, depression, social support, and socio-demographic factors were used to measure the impact of faith. The results consisted of subjective and objective data based on multiple regression analyses. The sample consisted of 225 patients, of which 10% were ethnic minorities. The average age was 62 years; the majority of the sample was comprised of Christian married men who had been diagnosed with a cardiovascular disease. Once again, the results were limited, but indicated the need to further explore cases to improve self-efficacy of elders and minorities (Ai et al., 2004).

Faith impacts mental health by creating a sense of well-being and purpose in life and by bridging one's cultural beliefs with a treatment plan to define appropriate interventions (Laurencelle, Abell, & Schwartz, 2002). A study by Plante et al. (2001) was inconsistent with other studies because the results did not show a connection between faith and coping with daily stress. The sample consisted of 132 participants in a college environment that lacked ethnic minority participants. The researchers used Pearson's product-moment correlation coefficients to examine the relationships between age, gender, strength of religious faith, anxiety, depression, and perceived stress and coping. Strength of faith was not significant ($p > .05$) for coping with daily stress. The significance with ineffective coping with daily stress may lead one to develop symptoms of depression such as feeling hopeless.

The purpose of the critical review of the literature was to identify the relationship between faith-based therapy and depression in African Americans. Cooper et al. (2001) conducted a survey comparing importance of intrinsic spirituality in depression care among Caucasians and African Americans. This study helped to define the relationship by analyzing depression care between two different ethnic groups. Cooper et al. found that African Americans were three times as likely to rate spirituality as extremely important for depression compared to European Americans.

Laurencelle et al. (2002) also researched the relationship between intrinsic religious faith and psychological well-being among 210 adults between two diverse groups: participants from two mid-size private Midwestern universities and participants from a large metropolitan religious organization. The sample was 57% European American, 43% African American and 75% were single. Laurencelle et al. used psychological and spiritual scales to measure intrinsic faith and psychological well-being. Intrinsic faith was categorized from high to low. Laurencelle et al. identified a positive

relationship between faith and emotional health, which supports the hypothesis of the current study.

Conclusion

As discussed in Chapter 2, the literature supports the author's hypothesis and underscores the need to further research the effectiveness of faith-based interventions. Analysis of studies showed that smaller sample sizes, limited geography, and limited ethnicity representation limited generalization of findings. Chapter 4 discussed the research findings which indicated the church or a faith community as a source of treatment for depression symptoms and also general well-being. The research findings suggested the need to further investigate the impact of faith-based therapy on depression with more research peer reviewed articles on depression.

Conclusion

Chapter 3 discussed the research methodology and data analysis of the thesis. The research questions were reviewed and discussion of data collection was presented in Chapter 3. This chapter served as the foundation for the thesis and how the data was managed to further guide the thesis based on the sample selection of articles and resources with inclusion and exclusion criteria. The objective for this chapter was to provide an understanding of the research method for the critical literature review so the reader could identify with the purpose of the thesis. However the data analysis revealed the need for additional primary peer reviewed articles reflecting supporting and opposing faith-based theories, which would lend credibility to faith-based therapy as being an approved alternative method in treating depression in African-Americans.

CHAPTER 5

Integrative Summary, Recommendations, and Conclusion

Introduction

The purpose of this thesis was to examine the potential impact of faith-based therapy as an alternative for treatment of depression in African Americans. The goal of the study was to assist faith-based organizations in capitalizing on their access to members of the African American community in promoting health treatment and education, specifically as it relates to treating depression.

A critical review of the literature was conducted to assess the current knowledge base of faith-based therapy and depression treatment in African Americans. The results indicated there was a lack of evidence evaluating the effectiveness of faith-based interventions. This topic was important to research because I experienced depression as a teenager. The depressive episode lasted for seven months and was related to the grief and sorrow of receiving information about the murder of my brother. At that time, having a faith network was key to resolving the depressive episodes.

Implications for Social Change

Social change involves providing data or evidence in a succinct manner that represents a need for significant action to improve social outcomes for a special population. One community organizational method of social change involves social action. Social action is task and process oriented with a focus on oppressed communities. Social action can be defined as “redistributing power or resources which enables institutional or community change” (McKenzie et al., 2005, p. 119). Faith-based therapy can become the catalyst to enable and empower African Americans experiencing depression to achieve a healthy lifestyle within the community. This can be a difficult task with the limitations imposed upon faith-based programs. Other implications for social change include increased access to affordable healthcare in a trusting environment,

decreased prevalence rates for depression in African Americans, and helping to eliminate disparities in mental healthcare delivery.

Recommendations for Action

The results from this study can be used to help build faith-based programs with measurable outcomes. Utilizing resources within the community makes healthcare more cost effective and accessible to potential users. Faith-based organizations can create trusting environments that can optimize the experience of the doctor–patient relationship (Frederick, 2003). The first plan of action would be to research the potential community or perform a community health assessment to determine the area of greatest need or potential impact. This would involve sharing community survey results with the local health department, nonprofit mental health agencies, churches, hospitals, and doctors to foster a network for referrals and follow-up visits. The main goal is to provide a clear and concise action plan to improve mental healthcare based upon faith principles.

To further validate the role of faith-based initiatives, faith leaders and counselors should establish faith-based certification as a prerequisite and a separate role for faith counselors. This will build a stronger network with the secular community. Developing a working relationship with other successful faith-based programs will help with program design, structure, and evaluation. For example, the National Alliance for the Mentally Ill in partnership with the Bexar County Mental Health Taskforce developed a faith-based mental health initiative in San Antonio, Texas. The San Antonio program is an interfaith collaborative effort that offers training for clergy and laity on mental health education, advocacy, and facilitating support groups (National Alliance on Mental Health San Antonio Taskforce, 2001). As a result of the collaboration, pastors have helped to reduce the stigma associated with mental illness through basic knowledge and improved spiritual counseling efforts with people suffering from a mental illness. Also, the pastors have formed support groups and have become advocates for mental health services (National

Alliance on Mental Health San Antonio Taskforce, 2001). This is a form of secondary prevention that can be useful in lessening depression symptoms (McKenzie et al., 2005).

The next step is to secure funds, which has been shown to be a barrier to faith-based programs, through grassroots lobbying of local health and faith organizations. One funding option is the Compassion Capital Fund, which is part of the White House Office of Faith-Based and Community Initiatives. The fund provides competitive discretionary grants for r Communities Empowering Youth Program and Demonstration Programs. Eligible groups which include non-profit organizations, for-profit organizations, tribal government organizations, public agencies and state/local agencies, may submit an application to the Compassion Capital Fund demonstrating grassroots efforts in either programs (United States Department of Health & Human Services, n.d). Once the location and appropriate funds are obtained, process implementation can begin. The most important step for action is program evaluation to determine if the interventions are benefiting the target group.

Faith-based programs also could partner with a local college or university that teaches religious studies and the institution could utilize an internship or fellowship as part of a program analyzing efficacy of faith-based programs. This initiative would benefit the FBO by providing important data for improvement of the program and students by allowing them to complete an internship in FBO planning. Potential stakeholders, including local faith leaders, local community service boards, faith counselors, social workers, key community members, psychiatrists, and psychologists, play an important role in the continued success of a faith-based program. By providing tangible documentation, access to multiple resources and serving as an icon of trust within the community, the stakeholders present themselves as a unified and cohesive body.

Recommendations for Further Study

This critical review of the literature explored the significance and impact of faith-based therapy for depression treatment among African Americans. Further study evaluating the effectiveness of faith-based interactions is needed. The results of this critical review of the literature suggest the need for further study of the impact of faith-based therapy on school aged children (ages 11 to 18 years of age) and the homeless population. These 2 populations were recommended throughout the literature because there is a limited knowledge of how faith may impact depressive symptoms in school aged children and the homeless which represents vulnerable populations. Additionally, further research would be needed to explore the impact of faith-based interventions with those suffering from other types of mental health illnesses such as bipolar disorder, posttraumatic stress disorder, and schizophrenia.

Another potential area of study is a comparison of coping behaviors reported by African American men and women aged 20 to 45 years who use faith-based support systems. One possibility for further research is to build upon the scholarly work of Drayton-Brooks and White (2004) who explored health-promoting behaviors among African American women who use faith-based support. The researchers used focus group interviews to identify social pressures influencing health-promoting behaviors in African Americans.

Reflection

Researching this subject was an important but challenging task. As a nurse, African American woman, and believer in Jesus Christ, the author maintained her strategic thought process to help eliminate personal biases. All these characteristics posed a risk for false reporting or underreporting of positive and negative effects of faith-based therapy. However, an experience of a major depressive episode led the author to explore an in-depth understanding of faith-based therapy. “FBOs should be considered an

important, but not the only, partner in community-based health promotion and advocacy efforts” (Olphen et al., 2003, p. 556). Providing mental health services that are holistic in nature is important for maintenance of healthy behaviors. In the completion of this research, the author’s knowledge base increased and she was motivated to further explore faith-based coping and mental health.

Conclusion

This critical review of literature has demonstrated the potential importance of faith-based therapy in conjunction with other forms of care in treating depression in African Americans. In this community in particular, the church can be a source of hope and a place of refuge. When faith-based programs are structured appropriately, they can help to improve health promotion and mental health outcomes in the African Community.

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Curriculum Vitae

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Profile

Solid background in providing nursing care to a diverse patient population in different healthcare settings. Experienced in handling and managing unlicensed personnel, orienting new hires to unit, and conducting public health presentations on health promotion and prevention in faith community.

Education M.S. Public Health, Walden University, degree pending, November 2011
B.S. Nursing, Virginia Commonwealth University, May 2002

Career history Nurse manager April 2008–
Maryview Medical Center, Portsmouth, VA present

- Supervise 26 staff members on an 18-bed telemetry step-down unit.
- Oversee patient acuity, safe staffing levels, and skill mix.
- Perform daily rounds to ensure standards of excellence are met.
- Handle patient, staff, and physician complaints.
- Plan and evaluate orientation of new staff.
- Assist in staff development through coaching and peer development.
- Complete performance improvement on telemetry unit (developed standard pathways for patient care plans and tool for enforcement of medication reconciliation documentation compliance).
- Audit charts for nursing care improvement monthly.
- Perform staff disciplinary action.
- Develop and coordinate monthly self-schedule.
- Manage weekly staff payroll.
- Assist with completing annual budget for telemetry unit.

Staff travel registered nurse December 2004–
Supplemental Healthcare Travel Nursing, Buffalo, NY January 2008

- Provided evidence-based nursing care to a multidisease population consisting of congestive heart failure, acute myocardial infarction, alcohol withdrawal, HIV/AIDS, sickle cell anemia, end-stage renal disease, diabetes mellitus, liver failure, etc.
- Interacted with the interdisciplinary team to provide effective care upon discharge, such as assisting with home placement, transportation, discharge teaching on medical condition, and prescription delivery.
- Completed additional travel assignments in San Diego, CA, as float nurse; Hopewell, VA, in 19-bed telemetry unit; Fairfax, VA, in 48-bed medical/surgical telemetry unit, and Petersburg, VA, in 15-bed mental health forensic unit for males.
- Previous assignment was in Rochester, NY, in 21-bed medicine unit within the emergency department.

Staff registered nurse December 2003–
Spectrum Healthcare Resources, Portsmouth, VA December 2004

- Prepared patients for orthopedic surgery including total hip and knee arthroplasties.
- Provided post-op care for orthopedic surgical patients.
- Functioned as team leader on team of registered nurse, licensed practical nurse, and naval hospital corpsman.

- Served as charge nurse on the night shift for 19-bed unit.
- Contracted as nurse at the Naval Medical Center of Portsmouth.

Staff registered nurse June 2002–
Riverside Regional Medical Center, Newport News, December 2004
VA

- Incorporated nursing process into patient care.
- Interacted with interdisciplinary team.
- Interpreted lab results, arrhythmias, and vital signs to provide adequate care.
- Provided patient education based on hospital's patient educational tool.
- Admitted and discharged patients accurately based on subjective and objective information.
- Oriented new graduates and nurses to the telemetry unit.
- Prepared patients for cardiac and general surgery.

Training
courses,
licenses,
and honors

- American Heart Association Basic Life Support and AED, 9/2009–9/2011
- Advanced Cardiac Life Support, 9/2009–9/2011
- Registered Nurse License, VA–0001179754, expires 12/31/2011
- Nurse of the Month–Naval Medical Center of Portsmouth, September 2004
- Perfect Attendance Award–Riverside Regional Medical Center, January 2003

Community
health
activities

Public health speaker

- Provided public health presentations to faith community on health promotion and awareness on:
 - Diabetes mellitus
 - How to prevent osteoporosis
 - Understanding and managing congestive heart failure
 - Kidney disease
 - What is in your brain? Depression in African Americans
 - Substance abuse awareness for teenagers
 - HIV/AIDS prevention and awareness
 - Discussion on oral sex

References available upon request.