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## Increasing Mental Health Literacy in the Black Church

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**Final Manuscript**

**Increasing Mental Health Literacy in the Black Church**

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### **Abstract**

**Purpose:** The purpose of this project was to increase mental health literacy, assess stigmatizing attitudes, and increase help seeking behavior in leadership within an African American church.

**Background:** The Black church has historically been a central institution for community support and leadership within these churches are often ill equipped to address the mental health needs of congregants. African Americans underutilize mental health services and are reported to have more chronic mental illnesses. Lack of mental health literacy may result in difficulty recognizing the risk factors, signs, symptoms, and treatments related to specific mental illnesses.

**Evidence Based Intervention and Methods:** Participating leaders received a 75-minute presentation along with a discussion on specific mental health terms included in the Mental Health Knowledge Questionnaire (MHKQ) along with the Perceived Devaluation and Discrimination Scale (PDD). Pre and posttest surveys were used to assess improvement in mental health knowledge and assess the presence of stigmatizing attitudes. Confidence to recognize mental health disorder and refer to treatment was also assessed.

**Results and Conclusions:** Data were collected before and 6 weeks after the presentation. Participants noted an increase in mental health knowledge, confidence, and likeliness to refer to treatment. Participants identified lack of knowledge and cultural implications as major causes for low help seeking behavior. Increasing literacy directly within this community seems to be a promising step toward prevention, early intervention, optimizing diagnosis, and treatment of mental illness in underserved populations.

*Keywords:* mental health literacy, African Americans, Black church, mental illness, mental health knowledge, clergy, stigma

### **Background and Significance**

Health literacy is a term frequently used but its significance is seldom fully explored. In public health, this term is used to explain an individual's ability to understand health related information (Lopez et al., 2018). Although similar to health literacy, mental health literacy refers specifically to mental health conditions and attitudes that create any stigma surrounding engagement in mental health treatment. Mental health literacy consists of knowledge of a mental health disorder, knowledge of stigma associated with mental illness, and the willingness to seek treatment (Lopez et al., 2018). According to the National Institute of Mental Health, nearly 1 in 5 U.S adults live with a mental illness. Rates of mental illnesses in African Americans are similar with those of the general population but disparities exist in regard to mental health care services (American Psychiatric Association , 2017). Compared with non-Hispanic whites, African Americans with any mental illness have lower rates of mental health service including prescription medication and outpatient services but higher use of inpatient services. According to SAMHSA's 2018 national survey on drug use and health, 16% of African Americans reported having a mental illness and serious mental illness rose among all ages of African Americans between 2008 and 2018 (Mental Health America, 2022). Only 33% of African Americans who need mental health care receive it (American Psychiatric Association, 2017). Historically, African Americans are less likely to receive guideline-consistent care, less frequently included in research, and are more likely to use emergency rooms or primary care rather than mental health specialists (American Psychiatric Association, 2017). There have been recent efforts to improve mental health literacy for African Americans and other minority groups, but barriers remain. These barriers include stigma associated with mental illness, distrust of the health care system,

lack of providers from diverse/ethnic backgrounds, and lack of culturally relevant methods to improve literacy (American Psychiatric Association, 2017).

In the African American community, help-seeking behavior is affected by mistrust of the medical system and often begins with faith-based outreach (Mental Health America, 2022). African Americans are more likely to rely on coping with religious strategies such as prayer or utilizing church support members such as pastors and ministerial leaders. Church leaders are often primary gatekeepers who help facilitate making referrals to appropriate mental health services (Bilkins, Allen , Davey, & Davey, 2016). Forty percent of African Americans used the church as their primary resource for help, but less than 50% of the church clergy are properly trained (Anthony & Johnson, 2015). Because church leaders play a pivotal role in the well-being of their members, it is important they are provided the necessary tools relating to mental health knowledge and appropriate resources.

### **Problem Statement**

Over the past few years, some members in this faith-based institution have either died by suicide, attempted suicide, or have been admitted for inpatient psychiatric treatment of mood disorders. This church serves a predominantly Black congregation and there have been members who have voiced concerns about persisting anxiety, depression, difficulties with adjustment, and prolonged grief. Several studies on attitudes and beliefs about depression have shown approximately 63% of African Americans believe that depression is a personal weakness, and almost two-thirds said they believe that prayer and faith alone would successfully treat depression (Anthony & Johnson, 2015). Research suggests associations between educational programs tailored for specific communities can be a promising step to increasing factors related to mental health literacy (Hagen et al., 2020).

### **Purpose of DNP Quality Improvement Project**

The purpose of this Doctor of Nursing Practice (DNP) quality improvement project is to analyze research acquired from a literature review and translate it by launching an educational awareness program to increase mental health literacy within the leadership of a Black church. This project was an attempt to review mental health literacy within the leadership of this church by assessing mental health knowledge and attitudes towards mental illness. The project was also an attempt to clarify possible links between stigmatizing attitudes and how additional education can influence help-seeking and literacy among church leadership.

The *primary aim* is engagement and education of stakeholders (e.g., senior pastor, district overseer, and church leadership team) on the importance of mental health literacy.

The secondary aim is to assess current attitudes and beliefs about mental illness within the leadership to reduce stigma within the church community.

Although the leadership within this particular church were the primary members engaged in this project, results of any positive outcomes were aimed to be disseminated to the rest of the congregation if needed. Research suggested to reduce racial/ethnic disparities in unmet mental health care needs at the national level, local level efforts to target specific racial/ethnic minority groups having greater vulnerability should be made (Kim , et al., 2017).

### **Evidence Based Model**

The theoretical framework selected for this project was Dr. Nola Pender's health promotion model. Dr. Nola Pender is a nursing theorist who developed the health promotion model in 1982 (Gonzalo, 2021). This model defines health as a positive dynamic state rather than simply the absence of disease (Petiprin, 2020). Health-promoting behavior is the desired behavioral outcome and is the endpoint in the health promotion model (Gonzalo, 2021). Health

promotion is defined as behavior motivated by the desire to increase well-being and actualize human health potential. Pender's model primarily focuses on three areas: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes (Petiprin, 2020). This theory notes that each person has unique personal characteristics and experiences that ultimately affect subsequent actions (Petiprin, 2020). This model looks at biological, psychological, and sociocultural factors in relation to health promotion. This project utilized many aspects of this model by attempting to maximize the self-efficacy of all participants. The health promotion model makes a key assumption that when positive emotions or affect are associated with a behavior, the probability of commitment and action is increased (Petiprin, 2020). This is an important factor to this project due to one of its aims being addressing negative attitudes towards mental illness. It is important that individuals are committed to action plans and identify strategies necessary to perform desired behavior. Some of the strengths of this model are it promotes independent practice as the primary source of health promotion, and it is also highly applicable in community settings. Although the conceptual framework of Pender's health promotion model contains multiple concepts, the model provides great benefit to community programs that are focused on health promotion and illness prevention (Gonzalo, 2021).

### **Literature Review**

A review of literature was conducted using a multitude of databases, including CINAHL, PubMed, EBSCO Host, Google Scholar, Medline, and Cochrane Library. The primary focus was on research articles published in peer-reviewed journals within the past decade. The review also consisted of systematic reviews, randomized control studies, cohort studies, and meta-analyses. Information from organizations including the CDC, WHO, Mental Health America, National

Alliance on Mental Illness, and the American Psychological Association were utilized for this project. A detailed search for relevant information included the following keywords and combinations of search terms: *Mental Health Literacy, African American and Mental Health, Mental Health and the Black Church, Black Church Mental Health, Mental Health Education, African Americans and Mental Health Stigma, Mental Health Knowledge.*

The literature review focused primarily on mental illness as it relates to African Americans. Data about mental health literacy and ways to improve literacy in special or minority populations were also analyzed.

### **The Black Church**

Historically, the Black church has been a major haven where many African Americans receive community support. During the many years of heightened discrimination where African Americans were treated unjustly and not given certain civil rights, the Black church created a dependable place in which individuals and their families could vote for and elect officers within the context of their spiritual environment (Allen et al., 2010). Over time, the church had become sociocultural environment where interactions such as communication between learners (congregants) and more knowledgeable members (church leaders) occur; this is how attitudes and beliefs are generally transmitted within the church (Bilkins et al., 2016). Social support has been found to be protective against depressive symptoms and psychological distress (Chatters et al., 2014). The church not only provides spiritual support to its members, but it often provides emotional, practical, and financial support to its members. Research on church-based support networks indicate they are effective in helping members cope with life problems by assisting in problem definition, resolution, and emotional responses to situational stressors (Chatters et al., 2014). African American clergy are then trusted to be on the front lines, often

operating as a 24-hour triage unit and serving as an alternative to mainstream health providers (Allen et al., 2010). According to the National Survey of Black Americans, approximately 68% of African American adults' report belonging to a church and approximately 92% regularly attend church services (Neighbors et al., 1998). African Americans happen to be among the most religious racial groups in the United States and often do not utilize mental health services within the church. African Americans are often relying on religiosity and spirituality to cope with mental health issues versus more formal mental health services (Bilkins et al., 2016). Research suggests that many African American individuals and families tend to first seek help from their pastors and church leadership when going through emotional difficulties (Mattis, et al., 2007). Unfortunately, these leaders are often the only professionals who individuals may encounter. This places church leadership in the role of not only spiritual leaders, but also personal counselors (Mattis, et al., 2007).

Despite protective and positive features of church support, there are specific aspects of church networks that may undermine mental health. Specific interactions such as gossip, disagreements, criticisms, and insults are all factors that play a role in interpersonal relationships within the Black church (Chatters et al., 2014). These types of negative interactions can ultimately lead to higher levels of psychological distress among church members (Chatters et al., 2014).

Because many in the African American clergy still associate mental illnesses like depression as a spiritual weakness, more education and training are needed to meet the needs of church members. Several studies revealed African American clergy lack knowledge about the biological and psychological causes of depression. Church leaders with a more theologically based view on mental illnesses are less likely to recognize certain symptoms and levels of

severity of mental illnesses, which renders less effective counseling (Anthony & Johnson, 2015). Without additional training and resources, church leaders may be ill-equipped to address mental health concerns, which may result in an escalation of symptoms experienced (Anthony & Johnson, 2015).

### **Mental Health Literacy**

Public knowledge about mental disorders compared to physical diseases has been comparatively neglected (Jorm, 2000). Health literacy has been defined as the ability to gain access to, understand, and use information in ways that promote and maintain good health (Nutbeam, 1993). In the realm of physical health, examples of health literacy would include things like taking steps to prevent skin cancer, performing breast self-examinations, having first aid knowledge, and utilizing a healthy diet. According to a review in the *British Journal of Psychiatry*, mental health literacy has three components, which include: (1) *recognition* (of disorders and types of distress); (2) *knowledge* (of mental illness, self-help, professional help, and where to find information); (3) attitudes/beliefs (that promote self-help and may influence treatment outcomes) (Jorm, 2000). There is a need for the public to have greater mental illness because, according to Kessler et al. (2005), the lifetime prevalence of mental disorders is up to 50%. Essentially, this indicates essentially everyone will either develop a mental disorder or have close contact with someone who does.

There have been efforts to improve public knowledge of mental health disorders, but they have been less common than physical illnesses like cancer and heart disease. There have been campaigns and initiation of specific mental health days to improve the public's awareness of mental illness (Jorm, 2000). Another approach to increasing literacy has been to target specific subgroups, including neighborhoods, schools, workplace environments, and community

strongholds like churches. In Australia and New Zealand, a mental health literacy program was developed specifically for farming populations. This program was successful in reaching farmers and increasing general mental health knowledge, improving attitudes towards those with mental illness, and increasing helping behaviors (Hagen et al., 2020). Effective components in programs geared towards improving mental health literacy require preliminary research on the intended audience to understand preferences of certain groups, utilization of appropriate media, and evaluation to ensure messages are reaching the target audience (Kelly et al., 2007). Along with educational awareness programs, knowledge-contact is a frequently utilized approach that involves providing knowledge about mental health in conjunction with social interaction with individuals from different groups (Pinto et al., 2011). Research suggested interventions aimed at improving mental health literacy must be adapted to the cultural context to maximize its impact (Hagen et al., 2020).

## **Methods**

### **Ethical Considerations**

This project received IRB approval from the University of San Diego prior to implementation. The organization in which the project was implemented also permitted the participation of its leaders. Data collected were only available to the project leader and all participants were deidentified. There were no ethical concerns in the implementation of this project.

### **Setting and Resources**

The facility chosen for this project was a Pentecostal faith-based institution located in San Diego, California. This faith-based institution has 151 members, of which approximately 15 hold leadership positions. This church assembly is a branch of a bigger body of churches

established throughout the United States and abroad. This church serves as a non-profit organization with its headquarters in New Jersey.

**Planning the Intervention**

After identifying an area of need within this specific population, the first step was to identify a team of stakeholders to review the current mental health needs within this organization and recruit possible participants. Due to this project’s nature and the COVID-19 pandemic, most of the communication and engagement with participants were completed virtually. There would also be a chance to utilize church leaders from districts outside the San Diego assembly to reach a larger number of members. The district overseer and pastor of the assembly in San Diego served as the main point person who helped identify areas of concern regarding mental health literacy within the organization. The recruitment process included email invitations, text messages, and phone calls to identified leaders within the church. Although the focus of the recruitment was done within the San Diego assembly, there were leaders in other districts who were identified and expressed interest in participating in the project. A minimum of 22 leaders were recruited.

The leadership was assured their participation was voluntary and confidentiality would be maintained. Prior to initial engagement, all participants filled out a demographic questionnaire detailing their gender, age, level of church attendance, utilization of mental health services, educational level, and specific church position.

**Table 1**

*EBP Project Timeline*

Task	Involved parties	Date of completion
Project proposal and approval	Clinical mentor	August 2021
IRB approval from USD	Project leader (PL)	October 2021

Letter of endorsement	Project advisor	November 2021
Mental health literacy training and discussion	PL, Clinical mentor, key stakeholders, church leaders	December 2021
Six-week follow up	PL, Clinical mentor, key stakeholders, church leaders	January 2021
Analyze data	PL	Feb 2022
Stakeholder presentation	PL, University of San Diego	March 2022
Submit manuscript	PL, project advisor	April 2022

*Project tasks, parties involved and approximate completion dates*

**Intervention**

The project leader utilized a tailored educational training program to reinforce key mental health concepts from the research gathered and from concepts from administered questionnaires. The project leader also facilitated a discussion to further assess and address perceived stigmatizing attitudes within the leadership of the church. Participants were invited to join the 75-minute educational program via zoom, which consisted of a power point including short videos on mental illness, statistics, misconceptions, common definitions, and resources. The information provided in the seminar was tailored to be specific to the culture of the Black church.

**Methods of Evaluation**

***Mental Health Knowledge Questionnaire***

The Mental Health Knowledge Questionnaire (MHKQ) is a 16-item questionnaire developed by the ministry of Health of China to evaluate public knowledge and awareness of mental health. This questionnaire contains 20 self-administered items (Li, et al., 2019). Items 1-16 require participants to select “true,” “false,” or “unknown” about statements concerning mental health. Items 17-20 are statements concerning previous knowledge about the four mental health promotion days (Li, et al., 2019). The project leader also added 2 additional questions from the CDC’s mental health quiz to the MHKQ for a total of 22 questions. The total score ranged from 0-22 with higher scores indicating greater knowledge of mental health issues. The

MHKQ was administered prior to the educational intervention to gain an understanding of each participant's level of knowledge and awareness of mental illness. The questionnaire was also administered 6 weeks later to assess the retention of knowledge in the subsequent time period.

### ***The Perceived Discrimination and Devaluation Scale***

The perceived discrimination and devaluation scale (PDD) is a 12-item questionnaire used to assess expectations of devaluation and discrimination toward current or former psychiatric patients. Items on this questionnaire assess how “most people” or “most employers” think or act toward persons with a current or prior psychiatric disorder (Yin , Wardebaar, Xu, Tian, & Schoevers, 2020). For this DNP project, the project leader utilized the Chinese version of PDD, which has been tested with good validity and reliability. The PDD has been reported to have strong internal consistency (Cronbach's  $\alpha = 0.70$ ). (Li, et al., 2018). The term *perceived devaluation* refers to the expectations about how others see mentally ill individuals (e.g., being dangerous, untrustworthy) while *perceived discrimination* refers to expectations about how others will act toward mentally ill persons for example, keeping them at a distance or denying them opportunities (Yin et al., 2020). The PDD contains 12 items with each item rated on a 5-point scale. Total scores ranged from 12 to 60 with higher scores indicating lower levels of stigma. The PDD was utilized in this project to assess the degree of stigmatizing attitudes among the leadership in this Black church. The scale was also used to help facilitate some of the discussion that took place as part of the educational training provided. By reviewing key points on the PDD scale, the project leader was able to engage the participating church leaders in conversation some of their attitudes within the church including current practices, barriers, and considerations regarding mental illness. The PDD was administered to participants prior to the educational training and 6 weeks after the training was completed.

### ***Mental Health Confidence Assessment***

Pre and post educational intervention, the project leader utilized a self-made 2-item confidence scale meant to assess participants' ability to recognize someone struggling with mental health problems and also to refer individuals to appropriate resources. For the two questions proposed, the answer choices on the scale were; not confident at all, somewhat confident, confident, and very confident.

### **Cost-Benefit Analysis**

Due to the nature of this project and access to remote means, there were very few costs associated with this project. The project leader spent \$45 for 3 months of a Zoom pro account to have more lengthy group meetings and to have the meetings recorded. The presentation and educational material were provided at no additional cost. The project leader designed the educational intervention to not only tailor it to the specific cultural setting but also to keep costs minimal. There was no outside funding utilized for this project.

The exact cost-benefit analysis of implementing this project is challenging but there are indirect costs to poor mental health literacy. Traditionally the Black church has played a role in encouraging the economic advancement of its members and poor mental health literacy can financially affect the lives of congregants. For example, employees with depression miss approximately 27 days of work per year, which is \$4,426.59 lost per capita (SapienLabs, 2020). The National Alliance on Mental Health estimated that untreated mental illness costs up to \$300 billion yearly in lost productivity (National Alliance on Mental Illness, 2018). Delayed treatment of mental illness can also lead to co-morbid and co-occurring conditions such as substance use, diabetes, and heart disease.

If another organization were to implement this project, it would be important to consider the cost of having a mental health professional conduct the project if there are no volunteers present.

**Results**

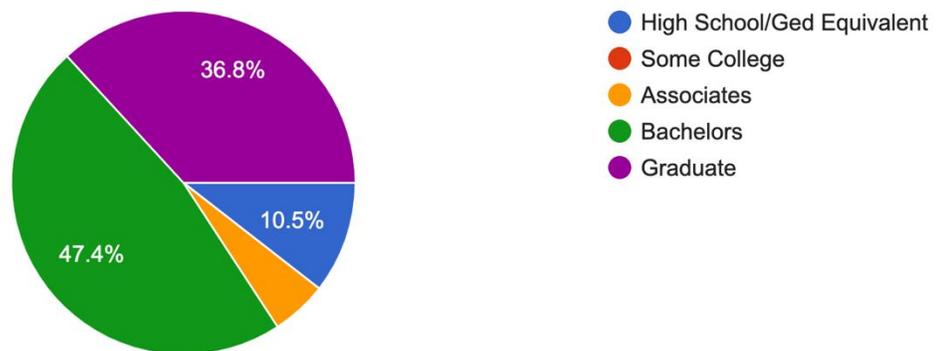
**Demographic Data**

Out of the 22 recruited leaders, 19 chose to participate and filled out the initial demographic questionnaire. The project started with 15 male leaders, and 4 female leaders. 8 Participants were between the ages of 35–44 and another 8 participants were between the ages of 25–34. One participant was between the ages of 18–24, 1 participant between the ages of 45–55, and another 1 participant who identified as being 56 years of age or older. Ninety-four percent of participants (18/19 people) reported attending church often; only 5.3% (1/19 people) reported attending church occasionally. Leaders were asked to describe their educational level and their level of utilization of mental health services (see Figures 1–2).

**Figure 1**

*Demographic Questionnaire Item*

Educational Level  
19 responses

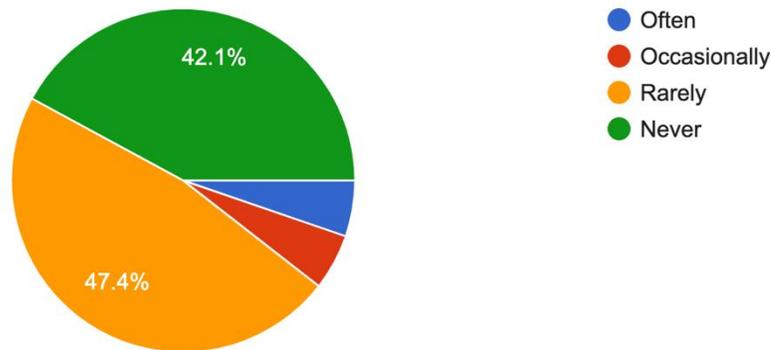


*Educational Level of Participants*

**Figure 2**

*Demographic Questionnaire Item*

Utilization of Mental Health Services  
19 responses



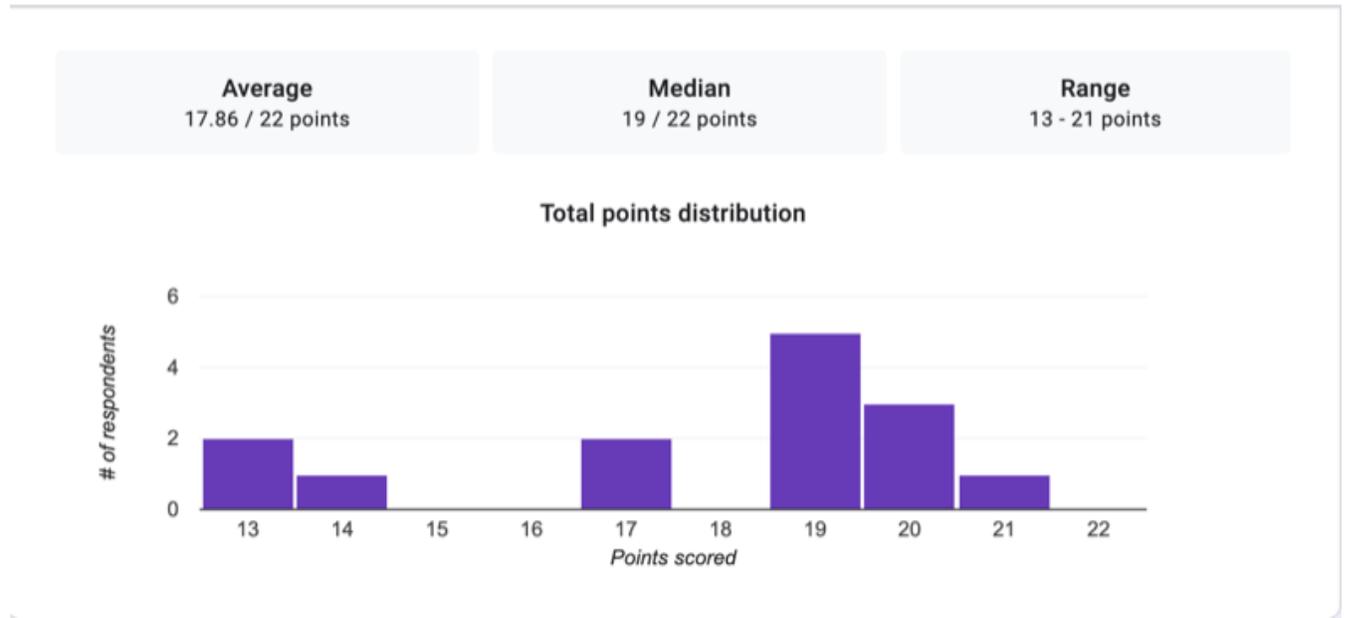
*Participant use of mental health services .*

**Mental Health Knowledge Quiz Pre and Post**

The Mental Health Knowledge Quiz was administered prior to any educational intervention and 18 out of the 19 initial participants responded to the questionnaire. The average score for this pretest was 15.44 out of the available 22 total points. The most frequently missed question on the pretest was question #15, which asked, “Individuals with a bad temperament are more likely to have mental problems, true or false”. According to the questionnaire, the correct answer for this question was *True*. This was also the most missed question on the posttest after the educational intervention. Out of the 19 initial participants, 18 completed the MHKQ pretest and only 14 completed the MHKQ posttest. The average score on the posttest was 17.86 out of the available 22 points. Results from the MHKQ posttest can be seen below in Figure 3.

**Figure 3**

*Mental Health Knowledge Quiz Posttest*



*Participant scores after educational intervention.*

**Stigmatizing Attitudes Assessment Pretest**

The Perceived Devaluation and Discrimination Scale (PDD) was used to assess the degree of stigmatizing attitudes for this project. For this questionnaire, total individual scores ranged from 12 to 60, with higher scores indicating lower levels of stigma. There were 16 participants who completed the PDD pretest. The pretest indicated 17 responses but 1 attempt

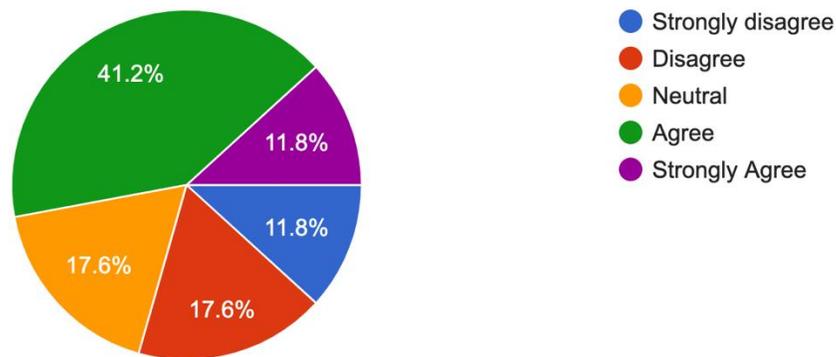
had to be removed because it was a duplicate entry. The average score of the pretest was 30.5. See Figure 4 for an example of a PDD scaling question and the distribution of responses.

**Figure 4**

*Example PDD question*

Most people think less of a person who has been in a mental hospital

17 responses



The same PDD administered 6 weeks after the educational intervention was completed by 13 participants with an average score of 32.9.

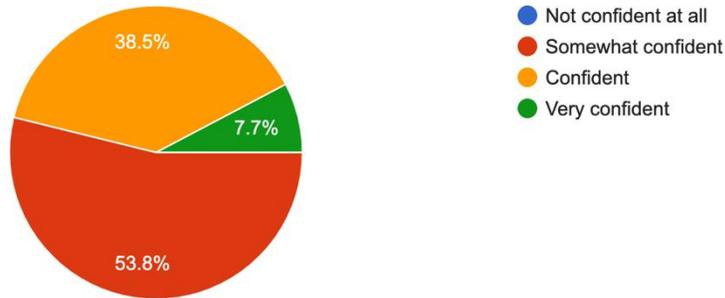
**Mental Health Confidence**

The self-made mental health confidence scale was completed by 13 on the participating leaders. Confidence in ability to refer to appropriate resources also increased with 30% of participants reporting being very confident and only 7% not being confident at all compared to only 23% being very confident and 15% not being confident before the project began. Examples of the posttest confidence questions can be seen in Figures 5–6.

**Figure 5**

*Confidence Question 1*

If I were approached by someone with a mental health disorder, I would be able to recognize it.  
13 responses



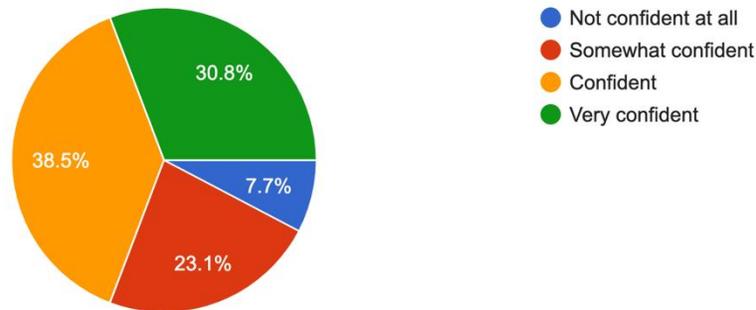
*te.*

*More than half of participants were at least somewhat confident in their abilities*

**Figure 6**

*Confidence Question 2*

I would be able to refer them to the appropriate resources  
13 responses



*At least 2/3 of participants reported confidence in referring members to appropriate resources*

**Discussion**

Throughout the course of this project, the church leaders were open to addressing stigmatizing attitudes and barriers to adequate mental health literacy within their organization. Some of these barriers identified included limited exposure to perceived mental illness within their own lives, fear of gossip within the church, lack of culturally relevant resources, and

mistrust of the health care system. The leaders disclosed having an increased level of comfort to participate in a mental health project, knowing the project leader was also from their community.

### **Limitations**

The African American leaders that participated in this project were not differentiated by factors including country of origin and background. This may have led to incongruencies in their cultural understanding of mental illness and its associated stigma. Another limitation of this study was the inconsistency in participation from the recruited leaders. There were 19 initial participants but due to unforeseen conflicts and difficulty with follow up, not all initial participants were able to complete the required questionnaires. Ultimately, the participant size of 19 proved to be a limitation of this study. The information gathered provided some insight into the mental health knowledge and attitudes held by the leadership in this church, but the participant size was too small to yield any statistically significant conclusions. Mental Health Literacy is a broad term, and it was difficult to provide more narrow educational material pertaining to specific mental disorders.

The tools also selected for this project were originally tested and implemented in a Chinese population. There are cultural considerations when it comes to assessing mental health literacy in the African American population that should be differentiated from a Chinese population. The cultural appropriateness of the MHKQ, and PDD should be assessed further to address their application to other ethnic groups.

### **Implications for Practice**

Studies indicate that African Americans have equal risk for mental illness as White Americans, yet they receive significantly less treatment (American Psychological Association, 2022). Low mental health literacy and attitudes towards mental illness are factors that affect

African Americans' willingness to seek treatment. To help improve health services to U.S. racial, ethnic, and immigrant groups, a report to the U.S. Secretary of Health and Human Services recommended increasing the collection of data on race and ethnicity. Fostering relationships with African Americans by directly engaging within their communities is something mental health providers can do to help improve disparities in care (Monitor Staff, 2006). Directly employing interventions within African American communities rather than waiting for members to seek out care can be a good step toward prevention, early intervention, and overall increase in help seeking behavior.

### **Conclusion**

Although results of this study were not statistically significant, there were insights gained not only from the project leader but the participating church leaders as well. Results of the educational intervention showed an increase in mental health knowledge, an increase in overall confidence in referring others to treatment, and a decrease in stigmatizing attitudes. The Black church is in a unique position to disseminate information to its members to improve their mental health. This project leader recommends further assessment of interventions and frameworks that can be used in community settings.

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