DREW THEOLOGICAL SEMINARY

THE CHURCH AND COMMUNITY AS AN INTERSECTIONAL RESOURCE FOR MENTAL HEALTH AND TRAUMA

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PROJECT PROPOSAL

ABSTRACT

THE CHURCH AND COMMUNITY AS AN INTERSECTIONAL RESOURCE FOR MENTAL HEALTH AND TRAUMA

The context of this project is the Promised Land Missionary Baptist Church, located in Newark, New Jersey. The problem is that many people in and outside the church suffer from various degrees of mental illness. Unfortunately, the Promised Land Missionary Baptist Church has suffered from various degrees of mental illness. Furthermore, Black Baptist Churches are presently ill-equipped to help them. Moreover, the Church could familiarize itself with tools to help equip in the healing process. With these tools the Black Baptist Church would be able to help its members and community in the healing process. Project data will be collected using online surveys. The survey link will include instructions on how to complete the survey. After the data is received workshop, questionnaires, group discussions, and focused groups will be formed, to allow time of sharing with members the resources that are available. After participating in this project, participants will be equipped to effectively identify the resources that can be used to meet the needs of its members and its community.

Purpose Statement

This project aims to examine the prevalence of mental health and trauma within the Black Baptist Church and community to create a resource to support people in need of mental health services and trauma-informed care. There has been a widespread depression among Black Baptists and the surrounding Black community. First in the Black community, the church has played a critical role in shaping the life experiences of Black people. Regardless, more than 30% of Black Baptists experience depression and anxiety. Second, due to racial discrimination, structural racism, and low socioeconomic status, Black people experience higher rates of mental health issues and poor access to quality mental health services. Third the project will be conducted using a quantitative survey method, which uses a set of predetermined questions to explain features of a large research phenomenon or population. Fourth,data will be collected using surveys and analyzed using the Statistics Package for the Social Sciences (SPSS). The target population is Black Baptists, and a simple random sampling method will be used to recruit the participants.

By addressing these issues within the church and community, the project aims to provide a secure environment for people with mental health issues to seek help and healing. Due to racial discrimination and stigmatization in mental health facilities, the Black Baptists feel safer talking about their mental health issues and seeking help in the Black church. Through church, especially in the African American community, people with mental health issues can have access to healthy coping strategies that improve the quality of their lives. Furthermore, the findings of this project will help address the gap in the literature about mental health and trauma prevalence within the Black church and community.

Methodology

This project will be conducted using a qualitative single case study. Qualitative research utilizes participants' lived experiences to explore and provide detailed insights into the research phenomenon in its natural setting. The research collects participants' experiences, perceptions, and behavior to answer the how and why research questions. At its core, qualitative research utilizes open-ended questions that allow participants to elaborate their responses, resulting in in-depth data. Qualitative research is preferred in this study due to its ability to explain the patterns and processes of human behavior that cannot be quantified. By allowing participants to explain what, why, and how they feel, experience, or perceive at a particular point, the researcher is able to understand a phenomenon without any external manipulation. The research identifies patterns and themes in data that cannot be quantified.

Other research methods were considered but ultimately rejected. The quantitative method involves gathering and analyzing numerical data to determine or predict the nature of the relationship between variables. Quantitative data is collected using structured interviews, questionnaires, and experiments and statistically analyzed to show or compare relationships. A large sample size allows quantitative researchers to generalize the findings to the wider population. The study can be easily transferred to different contexts or conducted with different groups of participants. Since no numerical data will be collected in the current study, the quantitative method was deemed inappropriate.

Mixed methods research combines the elements of qualitative and quantitative research. Using qualitative and quantitative data, the mixed methods approach provides a more detailed picture of the research phenomenon than in a standalone qualitative or quantitative study. The method is suitable for a research process that cannot be adequately addressed using a standalone

qualitative or quantitative study. Mixed methods designs can be explanatory, exploratory, convergent, or embedded. The current study's research questions will be sufficiently answered by stand-alone qualitative analysis; therefore, the mixed methods approach is unsuitable.

A single case study is a qualitative research design in which a single program, activity, process, event, or group of people is explored. The design can be used to rigorously test an intervention's effectiveness on a specific case, such as an individual or organization. The case(s) examined are bound by activity and time, and data is collected over a specific period using specific data collection procedures. A case study is used to explore complex phenomena in their natural contexts without any external manipulation. This design is preferred in this study because it allows the researcher to conduct a detailed exploration of the research phenomenon within a specific community or context, leading to comprehensive insights. This project focuses on a specific population (black members of the Baptist church), making a single case study a suitable design. Researchers use a single case study when focusing on a unique phenomenon or population to develop deep insights and improve understanding of the complex phenomenon. Other research designs were also considered and rejected.

Phenomenological research design involves understanding a research phenomenon using individuals' lived experiences. The research collects and analyzes peoples' feelings, opinions, experiences, and perceptions in relation to what is being studied. Only the views of those who have interacted with the phenomenon in its natural context matter. The researcher's perceptions and assumptions about the research problem are not considered. Unlike other research designs that tend to go broad, phenomenological provides a detailed picture of the research problem. Phenomenological design is useful for research that needs to go deeper into participants' feelings, experiences, and perceptions, making it unsuitable for this study.

Ethnography is a descriptive method that involves close observation of the participants as they interact with the research phenomenon in its natural environment. Since ethnography focuses on cultural phenomena, the design was not suitable for this project. Similarly, grounded theory research involves the generation of a theory that is grounded in the research data. Grounded theory is effective in uncovering social relationships and individuals' behaviors. This project does not aim to uncover or develop a theory; therefore, grounded theory design is not suitable.

The project data will be collected using surveys. These surveys use open-ended questions and allow participants to elaborate on their responses in detail; it will also fill in the bubble, resulting in in-depth and information-rich data. Burgess (2984) referred to semi-structured interviews as "conversation with a purpose." The researcher will develop an interview guide that will contain the interview questions to guide the respondents. Creating the interview guide is informed by the research questions and begins with outlining the topics or issues to be included. The resulting interview data will be analyzed using Clarke and Braun's (2013) six-step data analysis process. The steps involve familiarizing with the data, generating codes, combining codes into themes, refining the themes, naming the themes, and developing a thorough report. The agreed-upon checkpoints for feedback with my mentors include literature review, feedback on methodology, analysis of interview findings, and recommendations for action.

Statement of Theme and Hypothesis

The problem to be addressed in this study is the widespread depression among members of Black Baptist churches. While mental health research and interventions have made incredible strides, there are still gaps in access, awareness, and treatment outcomes (Barksdale et al., 2022). Research shows that Black Americans are also more likely to experience serious mental health

concerns like depression than the general population (Adams et al., 2021; Yelton et al., 2022). Too few people in Black communities seek treatment for depression due to stigma, normative hurdles, and systemic barriers to care (Kogan et al., 2023).

As a cornerstone of cultural and spiritual identity in these communities, the Black Baptist church is presented as an ideal conduit to bridge people to mental health resources (Campbell & Winchester, 2020). However, to date, little empirical research has been conducted on how the church can effectively integrate both the roles of friend and companion with that of minister and priest, leaving knowledge gaps about the church's capability to alleviate the burden of depression in its members.

The Black Baptist church has been a place of resilience and advocacy against systematic oppression for much of Black history in the U.S. During the civil rights era, mobilizing communities and addressing social injustices took place in the church (Allen, 2023). While attention to mental health was not emphasized by all church denominations in the 1950s–1970s, Black Baptist churches were instrumental in promoting spiritual and social well-being. Researchers have revealed that in times of emotional distress, Black people often turn to the church for help and regard pastors as highly trusted confidantes (Campbell & Winchester, 2020; Williams & Cousin, 2021). However, conversations around mental health in these settings have been stigmatized, and those suffering from depression have largely been neglected.

The stigma around mental health has been a primary barrier to care for Black populations in underprivileged communities. Additionally, Hajizadeh et al. (2024) and Waqas et al. (2020) find that cultural norms prevent open dialogue around mental health and commonly link depression with personal weaknesses or spiritual deficiencies. Theological interpretations in the Black Baptist church have historically concentrated on faith and prayer as the primary means of addressing

mental health issues, while advocacy for professional treatment was not considered. As such, an essential group of people may delay or avoid seeking help, worsening their symptoms and overall health (Rivera et al., 2021).

Efforts to integrate mental health education into church settings have recently been promising, as national efforts aim to increase awareness of mental health as a societal issue. Churches are becoming more cognizant that depression is a genuine medical condition requiring professional treatment. However, these efforts have been met with resistance due to entrenched views, resource constraints, and other challenges.

Nevertheless, this does not diminish the substantial role that the Black Baptist church can play in addressing mental health needs. The church can serve as a community hub, providing emotional and social support, reducing stigma, and linking people to professional care.

According to social support theory, communities are essential in mitigating the effects of stress and mental health issues (Acoba, 2024; An et al., 2024). In certain cases, churches can be instrumental in providing support, such as operating counseling services, hosting support groups, or conducting mental health workshops. Indeed, faith-based mental health interventions have been effective, with decreases in depressive symptoms reported by participants (Ali et al., 2021), making church-led initiatives a vital bridge between faith and mental health care.

Religion and spirituality are the cornerstones of Black Baptist church life and can be powerful tools in addressing depression. A body of research suggests that practices such as prayer, meditation, and reading scripture offer people hope, purpose, and resilience (Aggarwal et al., 2023; Richards & Barkham, 2022). These practices align with cognitive reframing techniques used in evidence-based therapies such as Cognitive Behavioral Therapy (CBT), which may be integrated into church initiatives. However, little is known about reconciling spiritual interventions with a

clinical approach when religious interpretations conflict with mental health guidelines (Pečečnik & Gostečnik, 2022).

Despite the promising role of the Black Baptist church, many gaps remain in studies on its capacity to combat mental health disparities. Comprehensive evidence is limited regarding the efficacy of specific church-led interventions for treating depression (Ali et al., 2021; Berkley-Patton et al., 2021). Additionally, few scholars have examined the interracial dynamics of religion and mental health in the context of systemic inequities and cultural diversity (Nguyen, 2020). Furthermore, much of the existing research has focused on expert perspectives while overlooking the views of church leaders and congregants in mental health initiatives (Campbell, 2021; Williams, 2022). The intention of this study is to expand understanding of how the church can serve as a resource in spirituality, community engagement, and mental health care.

Theoretical Framework

The theory used in this study is the intersectionality theory coined by Kimberlé Crenshaw in 1989. According to Cho et al. (2013), Crenshaw argued that race and gender have often been dealt with separately and mutually exclusively. This method did not adequately capture the Black woman's experience because there were not enough cases addressing both race and gender discrimination.

Crenshaw, for instance, in her analysis of legal cases, showed how Black women who were discriminated against at the intersection of race and gender were often not afforded legal standing due to not fitting into existing categories of discrimination against Black men or White women (Grabe, 2020). It has since become a fundamental framework in the social sciences. It has

also been key in studying how experiences of privilege or oppression result from how individual identity (race, gender, social class, etc.) affects interaction among people.

One of the significant theoretical propositions is the interlocking systems of oppression, which means individuals experience discrimination and privilege together due to the intersection of all their social identities and systems of oppression (Grabe, 2020). Grabe (2020) noted that racism, sexism, classism, and heteronormativity operate in concert with one another.

The second key proposition of the theory is that knowledge is contextual and situated. According to Grabe (2020), this proposition entails the situatedness and contextualized nature of knowledge in relation to political and economic power structures and how they shape individual experiences. It challenges universal truths and emphasizes the importance of how people live within specific social, historical, and cultural contexts. A part of the theory points out that social identities can be very complex and consist of multiple factors such as race, class, gender, sexuality, ability, and age (Kelly et al., 2021).

In addition to these propositions, the theory also forms several major hypotheses. One hypothesis is that the effects of multiple forms of oppression are multiplicative, not additive (Wyatt et al., 2022). This means that, for example, when subjected to both racism and sexism, the total impact is not merely the sum of each factor but rather an intertwined experience with compounded effects. This idea posits that social identities and systems of oppression are interconnected and should be analyzed in this way.

A second hypothesis is that power dynamics and structural inequities significantly influence how different people experience oppression and privilege (Wyatt et al., 2022). Intersectionality at the macro level is relevant in understanding massive social structures of oppression and privilege, such as racism, sexism, and heteronormativity, as explained by Kelly et

al. (2021). This hypothesis suggests that social inequality is systemic and structural, necessitating systemic and structural solutions. A third hypothesis is that social justice requires intersectional perspectives to address the multiple and intersecting experiences of marginalized people (Wyatt et al., 2022).

Simply put, this approach examines and tackles systems of oppression as interconnected phenomena that intrude into people's lives. As per Grabe (2020), intersectional investigations seek to expose the structural dimensions of power that have disastrous consequences on people's social, economic, and political lives. Furthermore, this hypothesis invokes the idea that a broad social justice approach is necessary.

Intersectionality theory has become ubiquitous in many fields, explaining the complex interdependence of social identities and systems of oppression. Acebillo-Baqué and Maestripieri (2023) examined intersectionality theory and applied it during the COVID-19 pandemic. In fact, the authors hypothesized that the effects of the pandemic were not the same for all social groups, including the Black community, which has long experienced inequality in many areas, including healthcare. The authors pointed out that intersectional approaches are insufficient for policy geared toward health since social stratification processes are highly complex and intertwined (Acebillo-Baqué & Maestripieri, 2023). However, they added that this same theory could be useful in understanding the effects of a global crisis on different social groups, as illustrated by the leveraging of church and community as an intersectional resource for addressing depression.

To illustrate, Kelly et al. (2021) considered the opportunities and challenges of incorporating intersectionality in the theory and practice of knowledge translation. The authors discussed the importance of an intersectional lens in health research and practice and the necessity of interdisciplinary teams. Intersectionality can elucidate large social structures of oppression and

privilege, such as sexism, racism, and heteronormativity, while also characterizing individuals. This perspective can be used to build more equitable and effective health interventions (Kelly et al., 2021). The study also aligns with Kelly et al. (2021), who utilized intersectionality theory to understand and respond to Black people's diverse experiences in the Black Baptist church community.

Lewis (2023) applied intersectionality theory to center Black women in the study of racism and health. To provide a conceptual biopsychosocial model of gendered racism, Lewis (2023) applies a theoretical framework to uncover the impact of gendered racism on Black women's health and well-being. This model integrates two distinct identities—race and gender—allowing for an examination of how these identities intersect to affect health outcomes.

In this study, the theory provides further knowledge regarding how race, gender, class, and religiosity intersect with the maintenance of mental health among Black members of the Baptist Church, specifically how each construct pertains to mental health treatment and services. Because the theory centers on how different social identities and systems of oppression interact, it is an ideal resource for investigating how Black people experience depression. Despite numerous critiques against intersectionality theory, its contributions to social justice and critical scholarship remain widely recognized. However, some scholars argue that it can lead to a fragmented view of oppression, making it difficult to explain how oppression is systemic. Others claim that intersectionality is not a theory in the traditional sense but rather an analytic framework. Supporters contend that these criticisms highlight the complexity of social injustice and call for further refinement and application of the theory.

Review of Literature

Literature Search Strategy

The approach for the literature search for this study was systematic and comprehensive, including the search for peer-reviewed research studies, dissertations, and conference proceedings exploring church and community as an intersectional resource and a space where the church can intervene in cases of depression. Library databases and search engines were used multiple times throughout the process to search the existing literature broadly and inclusively. Fifty-three different search engines and databases were trialed (listed in alphabetical order), including CINAHL (Cumulative Index to Nursing and Allied Health Literature), ERIC (Education Resources Information Center), Google Scholar, JSTOR, PsycINFO, PubMed, Scopus, and Web of Science.

Particular care was taken in selecting key search terms and combinations of search terms to efficiently retrieve relevant studies. The terms used included "Black Baptist Church" AND "mental health," "Black community" AND "depression," "Church" AND "mental health support," "Intersectionality" AND "depression," "Mental health stigma" AND "Black community," "Spirituality" AND "depression treatment," "Taboo" AND "mental health conversations," "Church resources" AND "depression treatment," and "Mental health advocacy." When appropriate, more detailed search terms were used, and additional terms were explored to capture the breadth of the topic.

Using search terms related to mental health and depression, the search also incorporated "Black community" and "church" as keyword markers. This served as the starting point for the iterative search process. The first search was broad, aimed at retrieving as many studies as possible, including studies of any type on this general topic. For example, in PubMed, searching for terms

such as "Black community AND mental health" retrieved a large number of results, which were then screened for relevance. From these initial results, more specific search terms were developed to narrow the focus. Additionally, terms such as "Black Baptist Church AND depression" were combined and searched in PsycINFO to yield more targeted results.

In addition to the primary search, combinations of search terms were used to explore specific themes, such as the taboo surrounding mental health discussions and the use of spirituality as a treatment for depression. For example, in JSTOR, a search for studies on taboo and mental health conversations was conducted using "Taboo AND mental health conversations." The references of all relevant studies found in the search were reviewed to identify any additional studies that may not have been captured in the initial search.

Mental Health Challenges in the Black Baptist Church

The Black Baptist church has been a spiritual, cultural, and political hub in Black life. By the early 18th and 19th centuries, during times of slavery, Black churches started to grow as places where spiritual expression, social organization, and communal support could serve during periods of systemic oppression (Haywood, 2023). For Black communities, the church was not only a place of worship but also a center for activism, education, and social services, where members faced the harsh realities of racial discrimination and economic struggle (Williams & Cousin, 2021).

The Black Baptist church played an important role in the Black community during Reconstruction, the Jim Crow era, and Rev. Dr. Martin Luther King Jr.'s civil rights movement. It was a source of solidarity and resilience (Williams & Cousin, 2021). Although cultural prejudices and theological interpretations sometimes skewed the church's approach toward mental health, it was undeniably effective in addressing social and political issues (Lloyd, 2023). Lloyd (2023)

argued that some evangelical communities may see mental illness as sinful and under demonic influence, resulting in shame and simplistic views of psychological suffering. This viewpoint has influenced not only Black Baptist churches but also other denominations.

Complexity abounds in Black cultural definitions of mental health, shaped by historical, systemic, and theological factors. Slavery, segregation, and structural racism in the United States led to a deep mistrust of healthcare systems, including mental health services (Bleich et al., 2021; Hamed et al., 2022). Historically, Black individuals have been systematically discriminated against in medical institutions (Bleich et al., 2021). The Black Baptist church interpreted mental health challenges within a spiritual context, often viewing depression, anxiety, and other psychological struggles as moral or spiritual weaknesses rather than medical conditions requiring professional care. This belief reinforced the idea that prayer, faith, and spirituality were the sole solutions to emotional pain, discouraging people from seeking outside aid and support.

The theological teachings of the Black Baptist church have played a dual role in shaping mental health attitudes. For many congregants, the church has been a source of hope, resilience, and community support (Lloyd et al., 2024). At the same time, the church's theological foundation and cultural significance make it an ideal institution for addressing unmet mental health needs, combating stigma, and providing culturally congruent services (Campbell & Winchester, 2020). Certain scriptural passages that emphasize joy and endurance may be misconstrued to imply that a life of faith cannot coexist with depression (Lloyd et al., 2024). Additionally, congregants suffering from psychological issues might feel pressured to appear spiritually strong and may avoid discussing their mental health for fear of shame or exclusion (Lloyd et al., 2024). In reality, silence only further ostracizes individuals and prevents them from receiving the care and support they deserve.

Generational gaps have also influenced perspectives on mental health within the Black community. Older generations, having lived through more explicit racial discrimination and economic instability, often adopted a survivalist mentality, relying on self-sufficiency (Peter et al., 2021). For many in this group, mental health was considered a distraction from more pressing concerns. However, discussions about mental health have become more common over time. Successive generations have become increasingly comfortable addressing mental health issues, partly due to increased societal awareness and advocacy (Peter et al., 2021). According to Baral et al. (2022), individuals exposed to frequent conversations about mental health are more aware of its significance.

Nevertheless, stigma remains pervasive in faith-based settings (Peter et al., 2021). Despite high psychological distress, Black individuals are less likely than other racial groups to seek professional mental health care (Harris, 2021). Cultural and historical mistrust of the medical profession, coupled with racial biases among some medical professionals, exacerbates this issue. Instead, many rely on informal support networks, such as family, friends, and church leaders, highlighting the need for culturally responsive interventions within trusted community institutions (Harris, 2021).

Pastors play a crucial role in shaping congregants' views on mental health. Black clergy have historically been pivotal figures in their communities, serving as both spiritual leaders and social advocates. However, research indicates that most pastors lack the training or resources to address mental health issues effectively (Fritz, 2023). Even pastors experiencing mental health challenges themselves may be unaware that they need professional help. Studies show that while many Black clergy are willing to assist congregants with mental health concerns, they often prioritize spiritual treatments over professional referrals (Eylem et al., 2020).

According to Richardson et al. (2024), most Black churches lack the financial resources to establish partnerships with mental health professionals or provide clergy training in mental health care. Historically, Black Baptist churches have faced financial constraints and negative experiences with racism, limiting their ability to integrate mental health services (Bolger & Prickett, 2021). However, awareness is growing, and some churches are beginning to incorporate mental health education into their faith-based platforms. Increasing faith leaders' mental health literacy can enhance knowledge, confidence, and the likelihood of referring congregants to professional care (Allotey, 2022). Additionally, using faith-based language to explain mental health as a component of holistic well-being has proven more effective in engaging church communities (Foppen & van Saane, 2023). Church members in economically disadvantaged communities report higher levels of emotional distress, underscoring the significance of spirituality and church-based programs as coping mechanisms (Richardson et al., 2024).

Despite progress, challenges remain in scaling and sustaining mental health initiatives within Black Baptist churches. More research is needed to identify enablers and barriers to integrating mental health services in faith-based settings, particularly in under-resourced communities (Knott et al., 2021). Training church leaders in mental health literacy and developing networks with professional care providers can help the Black Baptist church maximize its potential as a mental health resource (Rasmussen et al., 2024).

Cultural and Social Challenges

Depression is a significant concern in Black communities, with rates similar to or higher than those of other racial groups. However, Black individuals are less likely to receive treatment (Yelton et al., 2022). This discrepancy is rooted in cultural stigma, systemic barriers, and distrust

of the healthcare system. Additionally, factors such as racial discrimination, financial disparities, and increased medical issues contribute to depression among Black individuals (Adesogan et al., 2023; Yelton et al., 2022). For instance, Feliciano et al. (2024) found that Black adults who perceive racial discrimination experience elevated levels of depressive symptoms. Structural inequities in access to quality mental health care and economic opportunities further exacerbate these challenges.

Studies indicate that Black individuals may exhibit somatic symptoms of depression rather than emotional symptoms in clinical settings, leading to underdiagnosis or misdiagnosis and widening the gap in care (Kogan et al., 2023). However, many Black communities demonstrate resilience, leveraging cultural and social resources such as family, religious institutions, and community organizations to navigate adversity (Arnold et al., 2024; Dark et al., 2025).

The Taboo of Mental Health in Underprivileged Communities

Blacks and underprivileged communities are still heavily stigmatized when it comes to mental health. However, the cultural silence around mental health challenges is often rooted in historical, societal, and religious contexts that define mental health struggles through a quiet voice (Boyd et al., 2024). In the Black Baptist Church, this stigma is doubled: in an ideal world, strength of spirit and mental health struggles would not walk hand in hand. The cultural silence on this topic creates cycles of misinformation, discouraging people from seeking help and making it a significant challenge in addressing mental health issues effectively (Lacy et al., 2021).

This silence is further reinforced by religious taboos, which label mental illness as a consequence of spiritual weakness or lack of religiosity. Research shows that congregants often connect mental health struggles with spiritual or moral failings (Hansen et al., 2023). This

association has negative consequences, as it deters individuals from seeking assistance within their religious community for fear of judgment and exclusion. There is societal pressure within disadvantaged Black communities to "be strong" and maintain a mask of resilience, contributing to the reluctance to discuss mental health (Al-Khalil et al., 2025).

Societal, structural, and cultural barriers are pervasive in underprivileged Black communities (Stein & Hutnyan, 2024), hampering open discussions on mental health. Cerutti et al. (2024) stated that socioeconomic disadvantage affects perceptions of mental health. Limited access to mental health resources and financial instability forces many to forgo psychological well-being for the sake of survival (Pérez-Stable & Webb Hooper, 2023). Mental health remains an unspoken burden perpetuated by structural inequities and historical injustices.

The Black community's distrust of mental health professionals presents another major hurdle. Historical injustices, including unethical medical practices, have deeply shaped Black individuals' experiences and fostered a profound distrust in healthcare systems, including mental health services (Pederson et al., 2025). The injustice of police violence against black people such as George Floyd in 2020, and the death of Trayvon Martin in 2012. The only difference is with George Floyd the cop got jail time. The Martin case the killer went free.

The church has traditionally served as the primary source of support and guidance, further contributing to skepticism toward professional intervention (Lacy et al., 2021). Cultural taboos surrounding mental health discussions exacerbate this issue.

In underprivileged Black communities, mental illness is often viewed as shameful or as a personal failure. Hajizadeh et al. (2024) and Ka'apu and Burnette (2019) noted that Black culture values strength and self-reliance, making vulnerability and seeking help particularly difficult.

While this cultural expectation for resilience is adaptive in overcoming systemic oppression, it frequently leads to the internalization of mental health issues.

From its inception, the Black church has been the hub of the community, offering spiritual, emotional, and social support. However, it has also perpetuated mental health taboos. Some religious beliefs promote prayer and faith as the best ways to overcome life's challenges, leading congregants away from seeking professional mental health services (Porter, 2018). Sweet (2022) acknowledges the connection between religion and mental health treatment, asserting that religion should not be sidelined in mental health care, as it has helped up to 80% of schizophrenic patients cope with their condition. The belief that faith alone is sufficient for healing creates a divide between spiritual solutions and medical interventions, suggesting that individuals should not have mental health issues if they put their faith in medication or therapy (Rogers & Tinsley, 2023).

Despite increased awareness, cultural and social barriers continue to hinder discussions about mental health. The church's role in promoting and hindering mental health conversations remains controversial (Lloyd et al., 2024). Some studies blame the church for stigmatizing mental illness, while others commend it as a bridge between communities and mental health resources. Mental health within a religious context is complex, and the church itself embodies both supportive and restrictive elements in addressing these issues.

There is an intersectionality to these barriers that remains a gap in the literature. Previous research does not fully explore how cultural, socioeconomic, and religious factors interact to shape mental health discourse (Eylem et al., 2020). Many studies fail to adequately examine how poverty, racial discrimination, and religious stigma collectively influence mental health discussions. Furthermore, there is growing interest in the experiences of Black men and women individually, but limited research focuses on church-driven identities of nonbinary individuals or

members of the LGBTQ+ community within underprivileged Black communities (Castro-Ramirez et al., 2021).

Researchers should also investigate the combined roles of race, gender, socioeconomic status, and religious affiliation in shaping mental health attitudes (Grzanka et al., 2020; Kelly et al., 2021). Additionally, longitudinal studies are needed to understand how cultural and societal outlooks on mental health change over time and how they relate to mental health advocacy and awareness (Viola et al., 2024). Berkley-Patton et al. (2021) further argued for the need to conduct studies on the influence of church-driven initiatives on people's mental health, especially in underprivileged communities.

Building awareness, trust, and integrating culturally sensitive interventions have been attempted to reduce mental health stigma in underprivileged and faith-based contexts. Any of these approaches are possible within the church and community as an intersectional resource for addressing depression (Hajizadeh et al., 2024). To challenge these entrenched taboos, however, one must understand both the cultural and religious contexts that frame mental health and the challenges researchers face working in such domains (Crockett et al., 2025). Faith-based organizations can play a crucial role in increasing trust, as Mosiichuk (2024) argued, emphasizing their strong influence in poor communities.

In recent years, faith-based organizations (FBOs), particularly church establishments, have emerged as leading platforms for diminishing mental health stigma in the Black community. Studies illustrate how church-based mental health education programs have successfully encouraged congregants to view mental health as a legitimate concern, deserving attention alongside physical and spiritual health (Berkley-Patton et al., 2021; Weir, 2020). These programs normalize mental health conversations and encourage congregation members to utilize

professional resources by leveraging the trust and respect pastors hold in their congregations. For example, clergy training on mental health awareness initiatives has equipped church leaders with the ability to detect signs of mental illness and refer individuals to appropriate health care (Boateng et al., 2024). This model has the potential to bridge the gap between faith-based support and professional interventions. Additionally, mental health screenings at church gatherings have effectively raised awareness and decreased stigma through culturally tailored messaging (Berkley-Patton et al., 2021).

Community partnerships have also been effective tools in addressing mental health stigma in underprivileged contexts. This approach brings together the spiritual, social, and medical resources offered by churches, mental health professionals, and other local organizations (de Alpuim-Gonçalves et al., 2025; Ngo et al., 2024). For instance, embedding mental health professionals within community and church settings has facilitated group therapy, psychoeducation, and peer support in a familiar and trusted environment (Chan & Funk, 2024; Dumont et al., 2022). Antioch Baptist Church located in San Jose, CA, offers worship services around mental health. These services are ones that I have implemented in my context at the Promised Land Baptist Church. Sermon series on mental health, small group teaching on the effects of mental health. (Copyright 2025 NAMI Santa Clara County)

Moreover, peer-led interventions have proven highly impactful. According to Gonzalez-Garcia et al. (2024), church-based interventions led by peers could effectively reduce depressive symptoms in individuals with major depressive disorder (MDD). Findings suggest that standardized peer-led programs can assist both patients and professionals by providing psychosocial support, decreasing relapse rates, and promoting healthy attitudes. Cooper et al. (2024) identified in their systematic umbrella review of 35 studies that peer support approaches

effectively enhance clinical outcomes, self-efficacy, and recovery in individuals with mental health problems. The demonstrated benefits of peer-led programs highlight the church's responsibility to address mental health issues through culturally appropriate and empathetic interventions.

To eliminate mental health stigma in underprivileged Black communities, where historical distrust of mental health care and cultural values shape attitudes, culturally tailored strategies are necessary. Molander et al. (2024) confirmed the need to scale up culturally adapted mental health treatments for minority populations, particularly those aligned with the culture and religion of the community. Similarly, Newberry et al. (2024) emphasized the importance of understanding cultural dynamics and building trust to overcome barriers for Latinx individuals seeking mental health care in urban communities. Richards and Barkham (2022) highlighted progress in spiritually integrated psychotherapies, demonstrating how these initiatives can increase acceptance and effectiveness. Bouwhuis-Van Keulen et al. (2023) conducted a meta-analysis supporting the use of religion- and spirituality-based therapy in reducing resistance among care providers compared to standard therapy. These studies collectively suggest that emphasizing the compatibility of faith and therapy can break down barriers to care by framing therapy and medication as complementary to faith rather than oppositional to it.

One persistent issue is that faith leaders and congregants often view mental health solely as a spiritual matter. Berkley-Patton et al. (2021) reported that Black Baptist leaders, as well as church leaders in general, emphasize prayer and belief as solutions to life problems, which can neglect mental health care and reinforce stigma. When researchers attempt to introduce mental health interventions in such settings, they frequently encounter skepticism or outright rejection because their methods involve practices not rooted in the religious customs of the community (Weir, 2020).

Cultural silence surrounding mental health in underprivileged Black communities remains a significant obstacle. As Lacy et al. (2021) noted, breaking this barrier and encouraging open conversations about mental health is challenging in a society where acknowledging mental illness can be seen as a personal weakness. Additionally, Dark et al. (2025) identified large disparities in racial and ethnic groups receiving mental health care, particularly among individuals experiencing both cardiometabolic and depressive symptoms, highlighting the systemic barriers to accessing care for underserved populations.

Structural barriers also impede researchers, such as lack of funding for culturally tailored interventions and restricted access to underprivileged communities. Newberry et al. (2024) highlighted that mental health resources are scarce in many underprivileged areas, making it difficult to conduct and sustain interventions in the Black Baptist Church community. Building trust and integrating faith-based mental health interventions are key challenges that require long-term commitment.

Complicating efforts to address mental health stigma in the Black Baptist Church are the intersectional challenges of race, socioeconomic status, and faith (Pérez-Stable & Webb Hooper, 2023). These factors together present researchers with the dilemma of how to navigate their interconnected effects while ensuring interventions remain inclusive and culturally responsive. Many interventions in Black communities fail to address the unique needs of subgroups, such as LGBTQ+ individuals, people with disabilities, or recent immigrants, leading to substantial gaps in coverage and efficacy (Kelly et al., 2021). Given the scope of studying the Black Baptist Church community, it is imperative to consider these intersectional challenges when developing effective mental health interventions.

Despite these challenges, there has been progress in reducing the stigma surrounding mental health in underprivileged communities, though much work remains. A major debate concerns the role of the church in both perpetuating and addressing this stigma. Some researchers, such as Coombs et al. (2022), argue that the church is a suitable platform for mental health advocacy, while others warn that excessive reliance on faith-based solutions may be counterproductive unless carefully managed, as it risks reinforcing stigma. The long-term effects of interventions remain a critical concern (Lloyd et al., 2024).

Freţian et al. (2021) criticized the tendency of scholars to focus narrowly on short-term outcomes, such as increased awareness or reduced stigma, without evaluating whether these changes lead to sustained improvements in mental health care access and outcomes. However, there is hope for interventions that target structural barriers, such as poverty and lack of insurance, which could provide lasting solutions (Arundell et al., 2020).

The Intersectionality of Faith, Race, and Mental Health Stigma

Black communities face a complex and multifaceted intersectionality between race, faith, and mental health stigma as it relates to mental well-being. In Black communities, there exists a cultural and religious stigma around mental health that influences help-seeking behavior and how individuals deal with mental health (Harris et al., 2020). Often steeped in the fear of being devalued and discriminated against, stigma within Black communities can discourage individuals from seeking help (Conner et al., 2024). Reischer et al. (2024) argued that community health workers have highlighted cultural stigma and logistical barriers, including insurance issues, as obstacles to accessing mental health care.

This historical and socio-cultural context has created a cultural and religious stigma within the Black community regarding mental health. According to Pederson et al. (2021), when many Black individuals view mental illness through the lens of Black culture and religion, they may perceive mental health issues as spiritual weakness or indicators of moral failing. Existing mistrust of the healthcare system, stemming from historical injustices and systemic racism, only exacerbates this stigma.

A more recent study (Eylem et al., 2020) revealed that Black individuals with higher religiosity and greater participation in religious activities are more likely to have higher levels of mental health stigma. For example, Pederson et al. (2021) found that individuals who attended religious services or activities regularly were more likely to associate with those who had concerns about mental health, yet they were also more likely to perpetuate stigma. This paradox describes the dual nature of religious institutions as both sources of support for mental health and maintainers of stigma against those suffering from mental health challenges.

Overlapping identities, such as race, faith, and cultural background shape one's mental health experience. The experiences of Black women in educational spaces illustrate the specific forms of marginalization that they face due to their intersecting identities, which impact their mental health and necessitate a more complex manner of storytelling (Ferrell, 2022). These findings emphasize that mental health discussions should not be isolated from faith and cultural context, as these factors play an integral role in understanding someone's lived experience and mental strength.

An important study by Lacy et al. (2021) points to the need to explore how cultural factors mediate Black individuals' ability to access mental health treatment. Trust in the healthcare system, historical trauma, and cultural beliefs about mental health influence help-seeking

behaviors. Historical experiences of discrimination have yielded a pervasive mistrust of healthcare systems, making clear, for instance, why Summers et al. (2021) observed that people are reluctant to engage with mental health services. These results emphasize the importance of creating and providing culturally sensitive psychosocial interventions that incorporate Black individuals' experiences and identities.

In Black faith-based communities, stigma plays a significant role in help-seeking behaviors. Many Black individuals prefer to speak with leaders of their faith community rather than mental health professionals because they feel safe and trust them (Bramesfeld et al., 2019). While this trust is beneficial, it can also discourage individuals from consulting professionals, as religious leaders are not trained to diagnose or treat mental health conditions. Given these discrepancies, Harris et al. (2020) explored Black perceptions of mental illness and treatment preferences. Stigma, cultural norms, and the preference for alternative resources such as the church were barriers to the formal use of mental health services. Participants also reported feelings of embarrassment about having a mental health issue, which further dissuaded them from seeking help (Harris et al., 2020).

Theological resistance—using a medical rather than a spiritual framework for understanding mental illness—impedes mental health care for Black Christians. Additionally, some evangelical Christians have reported being told that mental distress is purely spiritual, which perpetuates stigma and invalidates the experiences of those suffering from mental distress (Lloyd & Hutchinson, 2022; Lloyd & Waller, 2020). However, some individuals accept secular interventions and nonspiritual explanations for mental health issues (Lloyd & Waller, 2020). Religious involvement also serves as a protective factor for Black individuals, shielding them from the psychological distress associated with racism and discrimination. For example, in a qualitative

study, Lloyd and Hutchinson (2022) examined how Black churchgoers perceive struggles with mental health, and the majority of participants believed that their faith alone should be sufficient to overcome it. While this perspective provides spiritual comfort, it lacks clinical facilitation, which would likely result in better overall well-being. Experts also noted that while some churches address mental health in their teachings, many continue to discourage psychological support.

Over time, Black Americans have developed a deep mistrust of medical institutions due to systemic racism and unethical medical experimentation, such as the Tuskegee Syphilis Study (Cox, 2024). This historical trauma has created skepticism among younger generations towards mental health professionals, particularly among older generations who have directly experienced or witnessed medical discrimination (Lloyd et al., 2024). Additionally, Black attitudes toward mental health services reflect hesitation due to distrust in psychiatric institutions (Oji & Powell, 2024). Concerns about misdiagnosis, overmedication, and a lack of cultural competence among mental health providers further contribute to reluctance. Systemic neglect and discrimination have led Black individuals to recognize their mental health needs but feel uncomfortable engaging with the healthcare system, ultimately delaying or preventing necessary care (Oji & Powell, 2024).

In a blog post on Medium, Miller (2025) notes that social stigma surrounding mental health issues is even more acute in underprivileged Black communities, where emotional resilience and self-reliance are emphasized over vulnerability and professional help. Many Black individuals avoid discussing mental health issues due to fear of stigma, exclusion from social circles, or being perceived as weak (Grabe, 2020). In religious spaces, mental illness is often viewed as a sign of spiritual failure, making it taboo to seek help (Semrau et al., 2024). According to Smith et al. (2023), cultural expectations of strength and endurance contribute to Black women's reluctance to seek mental health care. This cycle of silence and mistreatment of mental health conditions is

further reinforced by societal pressure to prioritize family and community over individual well-being (Smith et al., 2023).

Despite acknowledging the lack of mental health care in Black religious communities, gaps in the literature remain significant. Song et al. (2023) notes that while research has focused on race or religion separately, studies have yet to investigate how race and religion intersect to influence help-seeking behaviors. Further research is needed to include race, faith, and socioeconomic status as key variables to understand how these factors interact and affect mental health stigma and treatment outcomes. Additionally, while studies have examined general attitudes toward mental health in Black faith communities, research is lacking on the effectiveness of specific interventions aimed at reducing stigma and increasing access to care (Semrau et al., 2024). Scholars recommend that future studies evaluate faith-based mental health programs to determine best practices and how interventions can be tailored to the needs of Black congregations (Semrau et al., 2024).

More specifically, little research has explored how faith interacts with gender and race to influence mental health help-seeking behaviors. According to Eylem et al. (2020), societal perceptions of masculinity may contribute to further stigma faced by Black men in revealing emotional stress. Research has not yet fully examined this dynamic within faith-oriented contexts, and Black men face potentially unique barriers to mental health care compared to Black women (Mitchell et al., 2021).

Collective Healing and Resilience in Faith Communities

The Black Baptist Church has historically served as a cornerstone in the African American community for healing, collective resilience, and psychological well-being. Communal support is at the root of faith-based traditions, providing individuals with a means of addressing emotional

struggles by engaging in shared religious experiences such as prayer, worship, and religious rituals (Campbell & Winchester, 2020). During the COVID-19 pandemic, the physical closure of Black churches posed a distinct challenge to the mental health of African Americans, particularly those of advanced age (DeSouza et al., 2020). Despite these challenges, Black churches were well-situated to address unmet mental health needs, reduce stigma, and provide culturally sensitive, community-based mental health services to African American communities (Campbell & Winchester, 2020).

Religious and spiritual practices serve as primary coping mechanisms for psychological distress, particularly in the Black Baptist tradition. Prayer, worship, and rituals structure consolations for expressing emotions, finding meaning in suffering, and seeking comfort (Morrison & Morrison, 2024). Scholars argue that the communal nature of these practices often encourages those who are distressed to participate in prayer circles, intercessory prayers, or corporate worship with the expectation of divine intervention (Campbell & Bauer, 2021).

Morrison and Morrison (2024) examined the effects of prayer and religious involvement on mental health in the African American context and found that several types of prayer, specifically communal prayer, were positively and significantly associated with lower levels of psychological distress. Morrison and Morrison (2024) also proclaimed that prayer is not the only coping mechanism; it also reinforces social bonds and a sense of belonging. Additionally, music and sermons that support faith-based healing are incorporated into worship services to aid perseverance (Simanjuntak, 2022). Historical biblical references support the use of music as a healing tool, enhancing the worship experience and facilitating emotional and spiritual healing. These elements create an emotionally supportive environment where individuals feel understood and validated in their experiences.

Black Baptist churches also express spiritual and emotional renewal through religious rituals such as anointing, laying on of hands, and fasting, in addition to prayer and worship (Derricotte-Murphy, 2021). These group rituals provide culturally appropriate ways to cope with suffering. Some researchers recognize how these practices bring comfort and religious reassurance to those who engage in them, while others argue that comfort and religious reassurance must be balanced with professional mental health interventions (Lucchetti et al., 2021).

Several case studies illustrate the effectiveness of collective healing in Black faith communities. For example, a study of a faith-based mental health program delivered in a Black Baptist church in New York found that members had a space to share their problems without judgment. The program combined scripture-based counseling sessions with group discussions on depression and anxiety (Pegram et al., 2016). Pegram et al. (2016) reported that participants perceived greater emotional support and less mental health stigma as a result. Bosley et al. (2022) discussed applying a healing justice framework to address generational trauma and violence in marginalized communities. Combining Afrofuturist feminist perspectives with Healing Justice provided a means of designing actionable, grassroots solutions to systemic traumas, focusing on community-led initiatives to facilitate collective healing and well-being.

Other researchers have identified difficulties in implementing formal mental health programs in faith-based settings (Jones et al., 2024). Challenges in locating suitable evidence-based programs (EBPs) for faith-based organizations (FBOs) include cultural relevance and financial constraints, as many FBOs lack access to affordable programs (Jones et al., 2024). Perez et al. (2025) found that faith communities often feel unprepared to respond to serious mental health issues and struggle to establish partnerships with mental health specialists.

Although religious coping with mental health problems has been extensively explored, Hall et al. (2023) highlighted a notable gap in knowledge regarding how collective resilience affects individual psychological outcomes. Much of the prevailing literature describes faith-based healing practices but does not empirically test their effectiveness in addressing clinical mental health conditions. Additionally, Foster et al. (2019) suggested that future studies examine the relationship between communal religious activities and specific mental health metrics, such as decreases in depressive symptoms or improvements in coping strategies.

Another significant gap in the literature is the lack of longitudinal studies assessing the sustainability of faith-based healing interventions. While previous research suggests short-term benefits of communal healing practices, there is limited research on whether these practices result in sustainable subjective well-being (Foster et al., 2019). Furthermore, researchers have not adequately examined how various demographic groups—such as men versus women and younger versus older congregants—experience or benefit from collective religious healing (Mukherjee & Mandal, 2022).

The Role of Technology and Social Media in Church-Based Mental Health Advocacy

The use of technology and social media for church-based advocacy on mental health is a significant step forward in how faith communities address mental health. Furthermore, churches have an even greater role to play in promoting mental health awareness as they increasingly turn to digital platforms to reach their congregations (Holleman, 2023). Social media platforms, including Facebook, Instagram, and Twitter, have become key tools through which churches communicate information about mental health issues. These platforms facilitate the rapid sharing of inspirational messages, educational content, and resource information to meet congregants'

needs (Holleman, 2023). According to Okoro et al. (2024), social media also aids in destigmatizing and increasing awareness of mental health problems within religious communities. Churches can leverage these platforms to initiate conversations about mental health, reduce associated stigma, and encourage individuals to seek help.

A growing number of users worldwide have increased accessibility to mental health support through social media platforms, which provide immediate and easily accessible assistance (Shalaby, 2024). Churches can use these platforms to share resources, host virtual counseling sessions, and create online support groups. Additionally, Latha et al. (2020) found that social media serves as a medium for strategic communication and messaging that promotes mental health awareness. Brown et al. (2021) argued that social media fosters a sense of community and belonging, which can be beneficial for mental health support. By creating online spaces where individuals can share their experiences and support one another, churches have the potential to play a greater role as a resource for mental health. Findings from these studies indicate that churches can capitalize on social media platforms to raise awareness about mental health issues.

However, the COVID-19 pandemic forced many faith-based organizations to shift to virtual platforms, leading to the creation of online support groups and digital mental health resources. Schønning et al. (2020) examined social media use and its effects on adolescent mental health and well-being. The researchers found that online support groups led by trusted community leaders, such as pastors or counselors, could provide safe spaces for sharing experiences and offering support, ultimately contributing to improved mental well-being. However, Shannon et al. (2022) found that problematic social media use among adolescents and young adults was linked to increased symptoms of depression, anxiety, and stress. Therefore, faith-based organizations

should consider creating and facilitating online support groups to counteract the negative effects of social media while providing mental health support.

Mental health interventions using digital technologies within religious settings must navigate several ethical and practical challenges. Shannon et al. (2022) outlined several ethical considerations related to digital mental health for young people that are also relevant in religious contexts. The researchers highlighted concerns regarding patient data privacy, informed consent, and the risk that digital interventions might exacerbate health disparities due to unequal access to technology. Shannon et al. (2022) emphasized the importance of developing culturally sensitive digital tools that align with the beliefs and values of religious communities. Furthermore, a systematic review by Berardi et al. (2024) identified several barriers to the adoption of digital technologies in mental health systems that are also relevant to church-based initiatives. Challenges include stakeholder resistance to change, limited digital literacy, and skepticism regarding the effectiveness of digital interventions. Berardi et al. (2024) suggested that involving community members in the development and implementation of digital mental health programs could enhance acceptance and effectiveness within religious contexts.

Despite these challenges, digital tools present an exciting opportunity to bridge the resource gap in mental health care, particularly for communities that have historically lacked access to mental health services due to financial or institutional barriers. Andalibi and Flood (2021) analyzed the potential of digital peer support platforms to extend mental health services to marginalized populations. Their analysis indicated that such platforms overcome transportation, cost, and stigma barriers, thereby improving access to care. These digital solutions enable faith-based organizations to reach congregants who might otherwise be unable to access mental health support. Similarly, Naslund et al. (2020) explored how digital technology can be leveraged to support the mental

health of underserved populations. Their findings suggest that mobile health applications and online interventions provide scalable and cost-effective approaches to addressing the scarcity of traditional mental health services. By integrating digital tools into religious support structures, churches can provide timely and culturally appropriate mental health support to individuals in underprivileged communities.

A major gap in the literature exists concerning the effectiveness of digital mental health interventions (DMHIs) in faith-based settings (Piers et al., 2022). While there are numerous studies on DMHIs in general, few focus on their application within religious contexts. Scholars have noted that while DMHIs hold promise for improving mental health outcomes, very few studies have specifically examined their efficacy in faith-based organizations or among religious populations (Alagarajah et al., 2024). This suggests that further research is needed to explore how these interventions can be tailored to meet the cultural and spiritual needs of faith communities.

The integration of technology into traditional church practices to support mental health presents another promising avenue for further exploration. A qualitative review by Berardi et al. (2024) indicated that digital technologies expand access to mental health services but should not replace the human connection that is integral to quality care. Traditional practices such as prayer groups and pastoral counseling have not been thoroughly explored as potential complements to digital mental health tools. Future research should focus on developing frameworks for integrating DMHIs into existing church practices in a way that aligns with congregations' values and beliefs.

Impact of COVID-19 on Mental Health and Church-Based Support Systems

The COVID-19 pandemic has had a significant negative impact on mental health worldwide, particularly in Black communities and church-based supports. The onset of the

COVID-19 pandemic saw an increase in mental health problems globally. The WHO scientific brief in 2022 indicated that there was a 25% increase in the global prevalence of anxiety and depression in the first year of the pandemic. Social isolation, fear of infection, and financial stressors were among the specific factors that contributed to this spike. In the context of Black communities, the mental health impact of the pandemic presents a complex picture. Owens and Saw (2021) examined how COVID-19 disproportionately affected the mental health of Black and non-Black Americans. As the world went into lockdown, it was expected that Black Americans would report more symptoms of anxiety and depression during the pandemic, but the opposite occurred: Black Americans were found to be less likely than their non-Black counterparts to report symptoms. This suggests that Black communities have resilience factors that protect against the psychological effects of the pandemic.(White, 2019)In black communities, reluctance to seek both physical and mental health care can often be attributed to a general distrust of the medical establishment. This distrust is not without merit: historically, African Americans have been misdiagnosed at higher rates than white patients, and black communities have been exploited by the U.S. government and medical community in the name of medical advancement. I agree with White; distrust has been a long-standing problem between African Americans and the medical establishment. Due to the lack of concern and care, being misdiagnosed, and not being treated due to the lack of healthcare insurance.

However, it is vital to note that cultural stigma or a cultural predisposition to prioritize collective well-being over individual suffering may result in underreporting of mental health symptoms (Mohankumar, 2022). Therefore, while reported rates of anxiety and depression may be lower, the actual mental health burden could be underestimated. Further research is necessary to explore these dynamics and identify specific resilience factors that contribute to the observed

disparities in mental health outcomes. The pandemic dramatically interrupted traditional religious practices, and strict public health measures such as social distancing and limitations on gatherings were implemented. Historically, churches in Black communities have served as an essential buffer by offering spiritual, social, and mental health resources (Richardson et al., 2024).

The suspension of in-person services, however, led to a reduction in communal worship and associated support activities (Sisti et al., 2023). This disruption had the potential to negatively impact congregants' mental health, particularly those who relied on church communities for emotional and spiritual support. However, many churches adapted to the situation by transitioning to online resources to maintain services and sustain a sense of community. While this pivot enabled worship and outreach to continue, it also presented its own challenges, such as technological issues for some congregants and the absence of the personal connection found in face-to-face assemblies (Campbell & Osteen, 2023; McKenna, 2024). More research is required to determine how well these virtual adaptations replicate the support provided by traditional in-person church activities.

When the COVID-19 pandemic forced religious institutions to limit in-person gatherings, community leadership and support shifted to virtual platforms. Zangani et al. (2022) reported that telehealth modalities were swiftly adopted for the provision of mental health services across the world during lockdowns and social distancing measures. Virtual services and online counseling became essential means through which church communities continued to provide spiritual and mental health support (Harris, 2024). Different churches developed various strategies to cope with the new normal. Many congregations used video conferencing platforms to hold worship services, prayer meetings, and counseling sessions. This approach allowed religious practices to continue while maintaining a sense of normalcy and connection during isolation. Some churches also

established online resources such as mental health webinars and support groups to address the mental health challenges their members faced due to the pandemic (Harris, 2024).

Issues such as low levels of digital literacy, unreliable internet access, and the absence of a physical community were cited as significant barriers (Harris, 2024). Additionally, this shift posed challenges in maintaining traditional rituals and spiritual experiences, which were particularly difficult for African Pentecostal worshippers who emphasize sensory worship (Addo, 2021). Researchers have postulated that in-person religious attendance is associated with better mental and physical health, whereas virtual attendance does not yield the same benefits (Upenieks et al., 2023). Nevertheless, the adoption of digital tools by churches demonstrated resilience, with an emphasis on supporting congregants' mental well-being during unprecedented times. Public health measures that enforced social isolation left lasting effects on mental health. Clair et al. (2021) revealed that during the pandemic, social isolation diminished individuals' well-being and life satisfaction.

Congregants felt alone and lonely without the physical presence of fellowship, communal worship, and the church as a whole (Lasater, 2023). In the long term, these experiences may transform mental health attitudes within church communities. A study on Indonesian churches found that 62.7% of participants wanted to return to face-to-face worship, with 60–90% of the service deficit attributed to the absence of communal fellowship (Pakpahan et al., 2024). Research also indicated that churchgoers were more likely to experience chronic symptoms of loneliness than non-attendees, potentially leading to reduced social cohesion in church communities (Gibbes, 2022). However, frequent religious attenders had larger social networks than non-attenders, and these networks helped mediate the relationship between religious attendance and reduced loneliness (Okruszek et al., 2022). Health ministry teams addressed these concerns by

implementing connection strategies such as visitation programs and technology assistance (Lasater, 2023). Churches may enhance community engagement by incorporating cultural values into their digital ministry strategies (Pakpahan et al., 2024).

The Role of Music and Worship in Addressing Depression

Music is increasingly considered an essential resource in treating depression, with gospel music and worship practices serving therapeutic roles. As emotionally and spiritually cathartic outlets, music therapy and communal singing in faith-based settings have proven to be psychologically and physiologically beneficial (Bradshaw et al., 2014; Leung & Li, 2024).

In addition, music therapy has been found to reduce depressive symptoms (Hamilton et al.) Type of ReligiousSong.—Overall, the type of song used most frequently across the three age groups was Thanksgiving and Praise and least frequently, Memory of Forefathers. With the exception of the type of song reflecting Life after Death, the overall type of song used by each age group was not significantly different. The oldest group had higher numbers of participants using Life after Death songs. To Jill B Hamilton's point, the songs that are used are songs of thanksgiving. At Promised Land Baptist Church there is a Deacon that reflects on the treatment of being born in Alabama dealing with verbal abuse. It did something to him mentally. He would sing and I quote "Won't there be a time when we all get together." I asked what was the reason for this song? The Deacon reflected that his mom and dad taught him that when times get hard to remember that there will be a time when we all get together, the pain and mistreatment will all be over.

Tang et al. (2020) conducted a meta-analysis of randomized controlled trials and concluded that music therapy significantly reduces depressive symptoms. All methods of music

therapy, including recreative music therapy, guided imagery and music, and music-assisted relaxation, were shown to alleviate depression (Tang et al., 2020). This indicates that when integrated with practitioners, music therapy may be an effective way to reduce depressive symptoms. Bradshaw et al. (2014) investigated the effect of listening to spiritual music on mental health in later life. According to their findings, frequent listening to religious music, including gospel music, accounts for reduced death anxiety and increased life satisfaction, a sense of control, and self-esteem. This work emphasizes the central function of religious music as a socioemotional resource and a means of improving psychological well-being among older individuals.

Yende (2023) conducted an autoethnographic study illustrating the spiritual healing that gospel music and liturgical hymns facilitated during the COVID-19 pandemic. The authors pointed out that music plays an essential role in providing comfort and hope, reminding individuals of something greater than their loss and fostering a sense of attachment to God. Leung and Li (2024) also conducted randomized controlled trials implementing spiritual connectivity interventions for people experiencing depressive symptoms. Their research indicated that music therapy and other spiritual interventions can have highly effective impacts on reducing depressive symptoms by providing a sense of spiritual connectedness and emotional support.

Providing a contextual analysis of how the church and community can serve as an intersectional resource for responding to depression, these studies highlight the potential for music therapy and worship practices as powerful tools for emotional and spiritual healing. The church can function as a community hub that offers a space where people can sing together, listen to religious music, or attend music therapy sessions (Tamplin & Clark, 2019). This holistic approach addresses individuals' emotional and spiritual needs, promoting overall well-being and resilience.

Massive evidence shows that communal singing and music therapy positively affect psychological, social, and physical health. Helitzer et al. (2022) studied the effects of group singing on emotional, social, and practical aspects among women from socially disadvantaged backgrounds. They found that participating in a community choir significantly improved participants' health and well-being. Themes such as "positive emotions," "redefining identity," and "community interaction" suggest that singing builds resilience by elevating social and emotional support. Nyashanu et al. (2021) also studied singing's benefits on well-being, revealing that communal singing reduced negative affect while increasing positive affect and perceived social connection. While group singing provides an enjoyable pastime, it also serves as a therapeutic intervention with mental health benefits.

The physiological benefits of communal singing are equally compelling. Hendry et al. (2022) investigated the effects of choir participation on stress reduction and heartbeat synchronization. The authors discovered that collective engagement in singing lowered cortisol (a stress hormone) levels and synchronized heart rates among participants, contributing to a greater sense of relaxation and unity. Music therapy, in this physiological alignment, serves as a lighthouse for individual well-being and a bridge for collective harmony (Hendry et al., 2022). Research from the University of Oxford also showed that choir singing is a fast way to break the ice and create social bonds, which is essential in faith communities where group identity is built around shared worship activities. Communal singing improves happiness and reduces feelings of isolation, making it an ideal practice for promoting psychological and physical well-being.

From a social standpoint, communal singing in religious gatherings fosters a strong sense of community. Maury and Rickard (2020) stated that music therapy interventions in church settings help improve interpersonal relationships among congregants. Shared musical experiences

reduce stigma around discussing mental health by strengthening bonds and building trust between participants. Livesey et al. (2012) further supported this claim, demonstrating that choral singing reduces anxiety and stress while strengthening social bonds. Congruent with spiritual practice in religious settings, researchers found that singing together strengthens "togetherness," a sense of unity created when individuals synchronize breathing and sound production.

Recent studies have confirmed that communal singing and music therapy in faith-based settings provide psychological, physiological, and social benefits (Hendry et al., 2022; Maury & Rickard, 2020; Nyashanu et al., 2021). In addition to reducing stress and elevating mood, these practices promote community bonding through shared experiences. Faith communities can integrate these therapeutic interventions into existing programs to provide congregants with holistic mental health support. Future research should focus on adapting these interventions to fit the cultural and spiritual needs of different religious groups.

Historically, African American worship has been shaped by indigenous West African traditions and Protestant worship, forming a uniquely powerful spiritual and musical expression (Clark, 2025). This music is often improvisatory and emotive, serving as a vehicle for spiritual transcendence and community unity. Spirituals, hymns, and gospel music connect congregants to their heritage, providing a sense of belonging and emotional release (Clark, 2025). Brooks (2024) explored the perceptions of African American clergy regarding mental health issues and depression within their congregations. The author examined how music and worship function as therapeutic avenues for emotional expression and communal support in cultivating collective healing. Clergy recognize music and worship as essential tools for emotional processing and fostering community support. In concord singing, as seen in certain Protestant services, congregants are believed to process feelings collectively, drowning out stress and doubt in

communal worship (Brooks, 2024). The author suggests that mental health discussions should be incorporated into church activities and highlights ways in which music can facilitate these conversations.

While music and worship traditions play a critical role in the Black Baptist church as aids to mental health, gaps remain in the literature. One major gap concerns the specific impact of music and worship on depression outcomes within Black Baptist churches (Bradshaw et al., 2014). Although growing research demonstrates the global impact of music and spirituality on mental health, limited studies examine their effects on depression within this specific population (Bradshaw et al., 2014).

Also, research is lacking on how music-based interventions can be integrated into broader mental health support structures (Rodwin et al., 2022). While some music-based interventions have shown promise in improving mental health outcomes (Golden et al., 2021), there is insufficient research on how these interventions can be effectively implemented within existing mental health programs and services (Golden et al., 2021). This gap underscores the need for further interdisciplinary research to understand the mechanisms through which music-based interventions strengthen mental health support systems and expand access for underserved populations.

Mental Health Studies and the Role of the Church

Methodology Used

Utilizing qualitative and mixed methods, research has examined the historical and cultural elements of mental health challenges within the Black Baptist church. These methodologies capture lived experiences, cultural narratives, and social dynamics shaping mental health attitudes and practices. Qualitative research provides rich, contextual insights into historical stigma and cultural attitudes toward mental health in religious settings. Ethnography, phenomenology, and grounded theory methodologies have been employed to explore these complex issues (Dark et al., 2025). In-depth interviews reveal how Black church leaders perceive and respond to mental health challenges within their congregations.

While qualitative research offers valuable perspectives, it has limitations. Findings are often based on small, localized samples, limiting generalizability (Scârneci-Domnişoru, 2024). Additionally, qualitative research cannot establish causation, making it primarily exploratory (Aggarwal et al., 2023). These limitations highlight the need for complementary methodologies to enhance understanding and address mental health disparities in Black Baptist church communities.

The study of mental health within the Black Baptist Church has been explored through the application of mixed methods research to examine historical and cultural aspects. Mixed methods (qualitative together with quantitative) studies can provide more meaningful insights into complex phenomena compared to studies based on a single method. For instance, a mixed-methods design was used to examine the relationship among religiosity, mental help-seeking behaviors, and mental health among Black individuals by combining survey data with thematic interviews, offering both statistical perspectives and in-depth conversations.

The second key strength of mixed-methods studies is that they triangulate data to enhance the reliability and validity of the findings (Hutson & He, 2024). Furthermore, quantitative analysis can identify patterns and correlations, whereas qualitative investigation can reveal the underlying reasons for these patterns. For instance, the impact of racial discrimination on the mental health outcomes of Black church members was studied using mixed methods (Dark et al., 2025; Dubey et al., 2024), revealing that spiritual support mediated the negative impact of discrimination. However, mixed-methods studies are not without challenges; they require balancing the depth of data obtained from qualitative studies and the breadth derived from quantitative studies (Hutson & He, 2024). Substantial time, resources, and expertise are also necessary to conduct these studies. Integrating findings from qualitative and quantitative components can be complex, especially when the results are contradictory or difficult to reconcile (Dawadi et al., 2021).

Clergy Training and Mental Health Education

Over time, the church has always been a bedrock for Blacks to receive support, playing a vital role in fulfilling spiritual, social, economic, and psychological needs (Richardson et al., 2024). In the context of this study, faith leaders are of utmost importance in sustaining attitudes towards mental health and referring their congregants to professional mental health care. This means that spirituality serves as a lifeline to the emotions that poverty and violence give birth to (Richardson et al., 2024). Buffering against depression and despair tendencies is instrumental. The church relationships of older Blacks function as a buffer against the mental health consequences of racial discrimination, providing emotional support and resilience (Nguyen et al., 2022). Unfortunately, gaps in knowledge on mental health issues exist among neighborhood clergy, and this role is therefore not filled as effectively as it should be.

Black communities hold great trust in faith leaders, and churches serve as habitual places of refuge during difficult times. Pastors and church leaders hold immense influence in shaping community attitudes towards mental health (El Malmi et al., 2024; Fitzgerald & Vaidyanathan, 2022). In many instances, before seeking professional mental health resources, congregants turn to their faith leaders when struggling emotionally or psychologically (El Malmi et al., 2024).

These interactions reveal that congregants deeply trust their religious leaders as spiritual advisors or informal counselors, providing comfort through prayer, scripture reading, or compassionate listening (El Malmi et al., 2024). Fitzgerald and Vaidyanathan (2022) also found that when pastors legitimize the use of mental health services and frame them in alignment with faith, congregants are more likely to access professional help. This underscores the potential power of faith leaders as intermediaries to help fight stigma and promote mental health care.

However, clergy attitudes towards mental health can differ dramatically.Those findings are somewhat at odds with the results from Payne's (2009) survey study with 204 California-based Protestant pastors (133 Caucasian American, 51 African American/Black, 20 other).Specifically, the Caucasian pastors were found to be more likely than the African American pastors to agree with a biological definition of depression, while the opposite pattern was observed for a spiritual definition of depression. (Karadzhov and White) To Karadzhov and White's point Black Clergy would take the stance that depression is from a spiritual issue. In my context as being a Black pastor I would have to agree with this because I do not feel that anybody can be born dealing with depression. I, moreover, disagree with having a biological gene of depression. I feel that being diagnosed with depression is due to something happening to a person in life. Some religious leaders perpetuate stigma by characterizing mental illness as a lack of faith or spiritual failure (Holleman & Chaves, 2023). These attitudes may discourage congregants from acknowledging their struggles

or seeking proper treatment, solidifying cycles of silence and untreated mental health issues in the community. Lacking formal education and training in mental health, many pastors and church leaders are not equipped to detect mental illness or refer congregants to mental health professionals (Cjuno et al., 2024). Boateng et al. (2024) found that while clergy were willing to support congregants' mental health needs, they were underprepared to do so effectively. According to Stull et al. (2020), reasons for inadequate mental health preparation include insufficient mental health training in seminary programs and a lack of continuing education opportunities for clergy.

Using data on clergy surveyed by Stull et al. (2020), researchers found that only a small fraction of clergy had received formal training in mental health. Many clergy felt uncertain about differentiating between psychological and spiritual issues, leading them to turn to spiritual interventions for problems that required professional mental health treatment. Additionally, clergy may lack awareness of available mental health resources in their communities and may struggle to make appropriate referrals (Campbell, 2021).

Clergy as Gatekeepers

The role of clergy as mental health gatekeepers has been widely studied and documented. Reports indicate that Black communities tend to believe in a cultural predisposition toward mental illness and often lack trust in the healthcare system, making them more likely to seek help from a pastor rather than a mental health professional (Cox, 2024; Wells & Gowda, 2020). For example, Heseltine-Carp and Hoskins (2020) found that among Black individuals who have experienced severe psychological distress, about 40% seek initial support from a religious leader before turning to professional therapy. This highlights the importance of equipping clergy with the tools to detect

early warning signs of mental health disorders and connect individuals with appropriate medical care.

Clergy have great potential as first responders to mental health issues, but they often lack formal training in psychological assessment and intervention.Moreover, I feel that this should be something that is a standard within a seminary curriculum, because it opens the heart of that clergy person. Fighting issues within themselves due to the fear of being open to getting help. At times, clergy struggle to support individuals suffering from depression, anxiety, and trauma while also attempting to provide spiritual guidance (Boateng et al., 2024). Hankerson et al. (2021) found that many Black clergymen were counseling congregants with mental health issues despite having no formal training. These gaps suggest a need for clergy to receive more education in mental health awareness, assessment, and referral skills.

This gap in clergy education mirrors larger structural and cultural challenges. Many seminaries emphasize theological training over practical skills such as counseling and crisis management, leaving graduates unprepared to handle the intricate mental health issues of their congregants (Steinwert, 2022). Additionally, a lack of funding for church mental health initiatives makes it difficult for faith leaders to sustain education and community programs (Richardson et al., 2024).

Role of Gender in Mental Health Stigma and Support within the Church

The intersection of gender dynamics and mental health in the Black Baptist church represents a complex interplay of social, cultural, and religious influences. The Black church has been the backbone of African American communities for generations, providing spiritual guidance, social support, and a sense of identity (Cosby, 2020). Within this institution, traditional

gender roles define expectations regarding responsibilities and behaviors. As Ikyernum (2023) demonstrated, men are typically portrayed as leaders and providers, while women are seen as nurturers and supporters. These roles significantly influence how mental health is perceived and addressed within the congregation.

A study examining gender roles in mental health stigma and support within the church found that prevailing gender norms play a major role in shaping mental health attitudes (Iheanacho et al., 2021). For instance, men were more likely to perceive seeking help as a sign of weakness and were therefore less willing to engage with mental health services. Additionally, women afflicted by depression showed clear preferences for their care providers, seeking clergy first (92.9%), followed by psychiatrists (89.3%) and psychologists (85.7%) (Iheanacho et al., 2021).

This finding suggests that women are more inclined to approach clergy due to the church culture, which historically fosters a supportive yet unspoken approach to mental health issues. Furthermore, discussions on gender roles in the Black church often diverge from those in predominantly white denominations. Unlike white evangelical churches, Black churches rarely frame leadership debates around terms like "egalitarian" or "complementarian." Complementarians advocate for male headship and believe leadership positions should be reserved for men, whereas egalitarians argue that both genders should have equal leadership opportunities (Stella, 2023). However, Mohamed and Cox (2021) suggested that Black churches often emphasize male leadership in finances and community work more than female leadership, which affects how mental health support and discourse unfold within the congregation.

Moreover, in faith-based contexts such as the Black Baptist church, these differences are shaped by religious doctrine, cultural expectations, and communal norms. Streb et al. (2021) explained that women often experience sadness, feelings of worthlessness, and fatigue, while men

tend to exhibit externalizing symptoms such as irritability, risk-taking, and substance use. Depression is frequently underdiagnosed or misdiagnosed due to variations in symptom presentation, especially in communities with low mental health literacy or high stigma surrounding mental illness. Robbins et al. (2022) used data from the Black Parish Study to investigate the interaction of gender and denomination in relation to depressive symptoms among Black Christians. Their analysis indicated that the expression of depression varies significantly by gender across denominations. For example, Methodist men had higher odds of experiencing depressive symptoms than Baptist men, while Presbyterian women had lower odds than Methodist women (Robbins et al., 2022).

Cultural stigmas within Black communities surrounding mental health often exacerbate gender-specific challenges. For instance, women may prioritize caregiving roles over their own mental health needs, while men may suppress emotional vulnerabilities to conform to societal masculinity norms (Robbins et al., 2022). Additionally, researchers found that Black women are more likely to employ religious coping mechanisms, such as prayer and church involvement, to manage psychological distress (Zhang et al., 2023). While these group coping strategies can be beneficial, they are only effective if the church provides an environment that is both supportive and non-stigmatizing in its approach to mental health discussions.

Some preachers discourage the acknowledgment of depressive symptoms or seeking professional help due to doctrinal beliefs (Robbins et al., 2022). Holleman and Chaves (2023) found that while the vast majority of clergy acknowledge medical explanations and treatments for depression, some still prefer a strictly religious outlook, which may discourage congregants from seeking professional care. Ultimately, clergy play a central role in shaping mental health attitudes within faith communities. Furthermore, clergy face the need of mental health support for

themselve, but refuse to acknowledge it due to the fear of being seen as weak.Their ability to support mental health initiatives depends on their personal beliefs and the doctrine of their church. Encouragingly, there is broad consensus that medical intervention for depression is necessary, and there is growing recognition of the need for increased education and support to bridge the gap between medical and religious approaches to mental health.

Barriers to Seeking Help Among Men in Religious Contexts

When it comes to men's attitudes toward mental health and seeking help, masculinity norms play a significant role. These norms include emotional restraint, self-reliance, and stoicism (Staiger et al., 2020). Furthermore, doctrinal teachings and community expectations reinforce these norms in religious settings. Berke et al. (2020) investigated how masculine discrepancy stress, or concern about not meeting traditional masculine standards, affects help-seeking behaviors. The researchers found that while these stressors alone do not prevent men from using psychotherapy, the combination of these factors and race creates significant barriers to seeking help. Religious teachings, particularly within the church, may further reinforce these barriers by promoting exhortations to endure hardships and selflessly serve others. This pressure discourages men from admitting their struggles and, consequently, from seeking the help they may need.

Advocacy, Awareness, and Community Engagement

Depression and other mental illnesses carry stigma, underscoring the need for mental health advocacy in faith-based communities. Raising awareness and educating Black Baptist churches, where faith is deeply integrated into culture, may promote better help-seeking behavior (Garner & Kunkel, 2020). However, sustaining these efforts over the long term remains a

challenge. Research suggests that faith-based advocacy efforts could play a role in creating a culture of mental health awareness (Berkley-Patton et al., 2021; Weir, 2020).

Providing education programs to church leaders and congregants about mental health has yielded positive results. For example, the Mental Health First Aid program has been modified in some Black Baptist churches to equip clergy and other church leaders with basic knowledge and skills for identifying warning signs of mental health challenges (Koenig et al., 2020). Research indicates that clergy trained in mental health literacy are more likely to identify symptoms of depression in congregants and encourage them to seek professional help (Yelton et al., 2022).

Faith-based groups have conducted mental health outreach programs to dismantle the culture of silence and stigma. Through these programs, churches help bridge the gap between religious communities and mental health professionals by incorporating mental health discussions into their initiatives (O'Connor, 2020). An example is the HOPE (Healing Our People through Empowerment) Project, launched by several Black Baptist urban churches, which includes mental health workshops, pastoral counseling, and community engagement (Codjoe et al., 2024). This project aims to destigmatize depression by making it a regular topic in sermons and community discussions. Similarly, Moon et al. (2024) introduced the CHURCH (Congregation as Healers Uniting to Restore Community Health) initiative, which trains Black church leaders in mental health work. Findings suggest that this training successfully prepared faith leaders to address mental health concerns within their congregations.

One of the most successful initiatives is the Pastors for Mental Health Awareness campaign, which encourages pastors from various denominations to dedicate sermons and events to highlighting mental health. Research has found that congregants who hear sermons on mental health are more likely to discuss their struggles and seek help (Acevedo et al., 2022). These

programs also provide a framework for churches to collaborate with local mental health providers as referral sources. However, while short-term successes have been noted, sustaining long-term engagement remains a challenge. Many church-led outreach programs rely on grants or temporary funding, making sustainability a pressing issue (Miller-Tejada, 2024).

While faith-based mental health initiatives have shown promise, long-term sustainability remains a challenge. Clergy generally lack formal mental health education, which hinders their ability to provide adequate support. Although pastors are keen to assist their members, they often admit feeling unprepared for this role (Weir, 2020). Without appropriate training, mental health myths and insufficient support may persist. As Berkley-Patton et al. (2021) suggest, integrating mental health training into seminary programs and offering continuing education workshops for clergy could be vital steps in addressing these gaps.

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Appendix

Appendix A

PROMISED LAND BAPTIST CHURCH COUNSELING RECOMMENDATION FORM

Date of Referral: _____ /_____ /_____ (DD-MM-YYYY) Is client aware of and agreeable to this referral? □ Yes □ No Is this referral urgent? □ Yes □ No

CLIENT/CONGREGANT INFORMATION Name:
_____
Last First Middle Initial
Birth Date: _____ /_____ /_____ Age: _____ Gender: _____
Parent/guardian (if under 18 years):
_____
Address: _____
City: _____State_____ Postal Code _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell Phone: _____May we leave a message? □ Yes □ No
E-mail: _____
May we email? □ Yes □ No

RECOMMEDING PROFESSIONAL
Name: _____
Last First Middle Initial
Address: _____
City: _____ Province: _____ Postal Code _____
Phone: _____ Fax: _____
E-mail: _____

REASONS FOR REFERRAL (PRESENTING PROBLEMS):
Anxiety Parenting Substance Abuse Depression Grief/Loss Job Loss/Unemployment Separation/Divorce Premarital Needs Relationship Problems (Marriage, Family) Life Transition Trauma (Physical/Mental) Self Esteem/Identity

Other_____

Appendix B
The Church and Community as An Intersectional Resource for Mental Health and Depression.

Mental Health and Depression Survey: Taking this survey will be instrumental in fostering a better understanding of mental health within our church.

Please circle the answer to the following questions honestly.
All responses will remain confidential.

Demographic Information
1. Age
o 18-24
o 25-34
o 35-44
o 45-54
o 55-64
o 65-or over

2. Gender
o Male
o Female
o Non-binary
o Prefer not to answer

3. What is your current role within the church?
o Attendee
o Member
o Leader
o Pastor
o Other _____ (Please Specify)

Mental Health Awareness

4. How familiar are you with the topic of mental health and depression?
o Very familiar
o Somewhat familiar
o Not familiar at all

5. In your opinion, how prevalent do you think mental health issues are in the black community?
o Prevalent
o Somewhat prevalent
o Not prevalent at all

Perception of Mental Health

6. How comfortable do you feel discussing mental health issues within your church?
o Very comfortable
o Somewhat comfortable
o Not comfortable at all

7. Do you believe that mental health is addressed adequately enough in sermons or church activities?
o Yes
o No
o Unsure

Support and Resources

8. Are you aware of any mental health resources or support groups available in your church?
o Yes
o No
o Unsure

9. If yes, please specify the resources or support groups:

Personal Experiences

10. Have you or someone you know experienced mental health challenges within the church community?
o Yes
o No
o Unsure

11. Have you been thinking about your mental health lately?
o Yes
o No
o Unsure

Improvement and Change

12. What do you think could be done to improve the mental health awareness and support within church? Select all that apply.
o More sermons on mental health topics
o Workshops and seminars on mental health
o The development of support groups for those struggling with mental health issues
o Collaboration with mental health professionals

13. Would you be interested in mental health programs or discussions if offered by your church? o Yes o No o Maybe

Appendix C

Mental Health Resource List

NAMI Education and Advocacy Programs (National Alliance of Mental Illness)

https://www.nami.org/Support-Education/Mental-Health-Education/

Mental Health Toolkit (Pathway To Promise)
https://www.pathways2promise.org/

Mental Health First Aid Training
https://www.mentalhealthfirstaid.org/#:~:text=First%20Aiders%20will%20complete%20a,%2C%20addiction

Suicide Prevention Resource Center
https://sprc.org/resources-programs/choosing-suicide-prevention-gatekeeper-training-program-comparison-table-1

Mental Health Crisis Toolkit

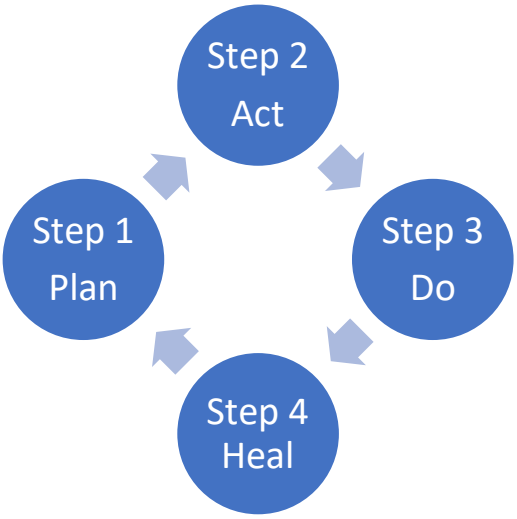
https://sptsusa.org/mental-health-crisis-toolkit/

Mayors Wellness Campaign Mental Health Toolkit
https://www.njhcqi.org/wp-content/uploads/2022/04/MWC_Mental-Health-Toolkit_2022_Digital_FINAL.pdf

Center of Faith and Community Health Transformation
https://www.faithhealthtransformation.org/trauma-informed-congregations-network/

Compassion in Action Guide
https://www.hhs.gov/sites/default/files/compassion-in-action.pdf

Steps that can be taken to help the Promised Land Baptist Church.



This plan will evaluate the efficiency of the mental health referral process for the mental health services. In this process the plan will identify when mental health service recommendations should be made.

Step 1 Plan: Create a system for mental health recommendation of congregants. We will create a checklist of indicators for mental health recommendations.

Step 2 Act: Pastor and staff along with community therapist team will meet quarterly to review the reasons the recommendations are being made. The health care ministry will host monthly congregation checkups to introduce mental health resources and community health partners to increase the members awareness of mental health services that are provided to the congregants and people of our community.

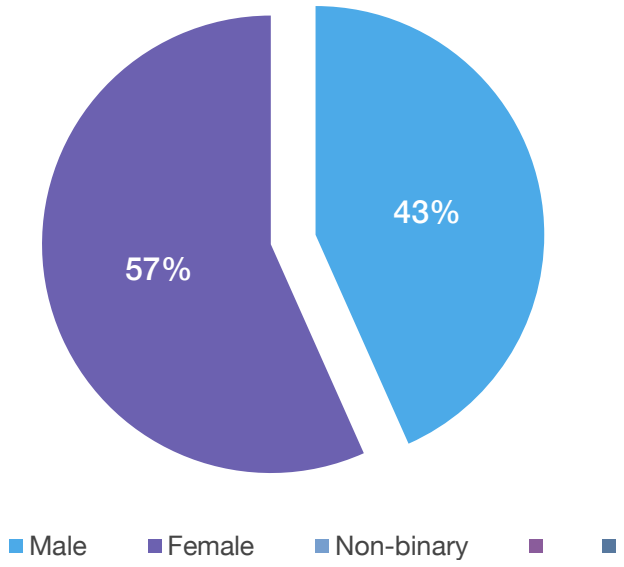
Step 3 Do: Assess the Pastor and Health care ministry's consistency of making recommendations. Assess the congregant's level of awareness of resources available to meet their mental health needs beyond coming to church seeking healing. Assess the issues for following through with recommendations from Pastor and Health care ministry team (cost, transportation and level knowledge of what resources are available).

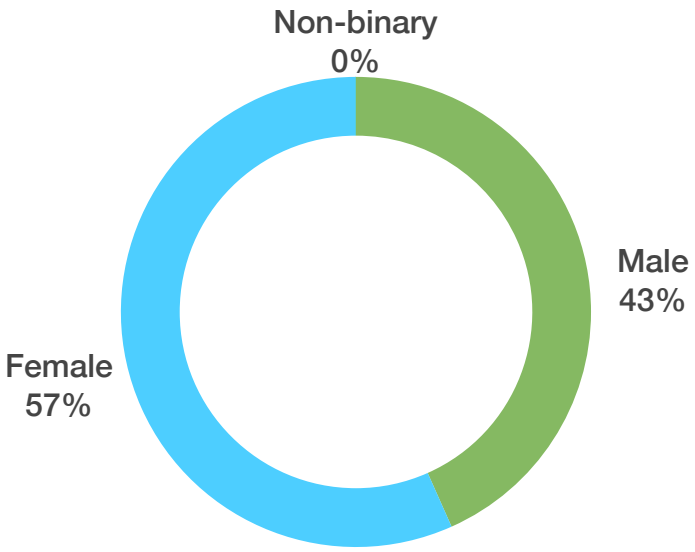
Step 4 Heal: The Community resource/ Health care ministry team will develop a mental health recommendation process. The Community resource/ Health care ministry team will investigate resources to help break barriers that prevent congregants from following through with mental health professionals.

Promised Land Missionary Baptist Church Communication Flow Plan

Who are Stakeholders	What Interest/Power	Why do they need this recommendation	When will they meet	How will they get it
Pastor /Ministerial staff	Training on the recommendation process	Educating Pastor and staff of mental health issues impacting congregants and how to train ministerial staff to know how to address the issues	Weekly, monthly,	Face to Face, Small groups, and Zoom, Email, Google Meet
Health Care Ministry	Plan Mental programs and events	Mental Health awareness workshops and resources	Monthly	Church Email, Digital Newsletter, Social Media page, Bulletin
Congregants	People needing access to mental health services	Seeking mental health services and getting connected with available mental health resources	Weekly, Monthly	Church Bulletin, Email, Social Media
Community Resource Partner	Mental Health Service Delivery	Helping develop the awareness of mental health services and partnering with the Ministerial staff on the appropriate recommendation for people seeking help.	Weekly, Monthly	Email,
Church Trustee Ministry	Mental Health Cost,	Contacting Mental Health partners for speaking event cost	Monthly	Email
New Hope Missionary Baptist Association	Denomination Support	Local and State Health survey and available resources	Quarterly	Digital Newsletter, Email, Association Website

This chart shows the responses that was received from the surveys that were given.




Non-binary
0%
Male
43%
Female
57%

AGE BREAK DOWN FROM THE SURVEY