Mental Health Perspectives Among Black Americans Receiving Services From a Church-Affiliated Mental Health Clinic

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Abstract Black Americans face substantial barriers to mental health services that are due, in part, to historical and contemporary issues of anti-Black racism. Identifying novel models of care that increase access and engagement in mental health services is important. One such model was developed by a predominantly Black church in Harlem, New York City, which built a free mental health clinic to serve the surrounding community. However, treatment barriers and facilitators of this care model have not been reported. Therefore, the authors conducted a qualitative study to identify Black Americans' (N=15) perspectives of their experiences seeking and receiving care from this church-affiliated mental health clinic and the role of the church in promoting mental health service utilization. Treatment facilitators included health care that was free of charge, services affiliated with a trusted institution, and access to culturally competent care that integrated their faith perspectives. Participants perceived the churches as having the potential to provide psychoeducation, destigmatization, and connection to mental health services. The perspectives shared suggest that this novel model of care may address several barriers to mental health care faced by some Black American populations.

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Mental health conditions, such as major depression, remain the leading causes of disability in the United States (1), but Black Americans continue to face substantial treatment barriers (2–4). Less than 30% of Black Americans with a mental health condition use formal mental health services (5, 6). Many of these barriers are shaped by historical and contemporary issues of anti-Black racism that operate on systemic, institutional, and interpersonal levels (7). For example, racial discrimination in employment directly contributes to Black Americans being more likely than White Americans to be under- or uninsured (8, 9). Other treatment barriers include stigma and distrust of medical institutions, both of which have been shaped by a long history of misdiagnosis and pathologizing of Black Americans (10, 11). Given these barriers, it is vital to identify novel, culturally relevant engagement strategies and care models that increase access to mental health services among Black Americans. One approach includes the development of mental health programming and supports with trusted institutions, such as churches.

THE BLACK CHURCH AND MENTAL HEALTH

The Black Church—which, as Lincoln and Mamiya report (12), comprises seven predominantly Black denominations of the Christian faith—is a trusted and central institution in many Black communities. Black Americans have the highest rate of church attendance among all racial-ethnic groups in the United States (13). Church-based health interventions have been used to address health disparities facing Black Americans for chronic medical conditions such as hypertension (14). Despite the demonstrated effectiveness of these

HIGHLIGHTS

- A qualitative study was conducted to identify the perspectives of Black Americans receiving services from a novel church-affiliated mental health clinic structured to address unmet mental health needs.
- Study results revealed that facilitators to receiving care in this setting included care provided free of charge, services that were affiliated with a trusted institution, and integration of individuals' faith perspectives and experiences in therapeutic care.
- Churches were perceived as having the potential to provide psychoeducation, destigmatization, and connection to mental health services that reduce psychological distress.

church-based health programs, few programs focus on mental health conditions (15).

It is important to note that Black clergy often provide spiritual and psychological support for a socioeconomically diverse group within their communities and can serve as "gatekeepers" for individuals seeking mental health support (16). Clergy provide informal counseling for a range of mental health conditions, including depression and substance use disorders (17, 18). However, seminary education provides limited formal mental health training (19, 20). Thus, access to evidence-based care through direct engagement with Black churches remains limited.

THE HOPE CENTER

To address this limitation, First Corinthian Baptist Church (FCBC) located in Harlem, New York City, opened its church-affiliated, freestanding mental health clinic, the HOPE (Healing On Purpose and Evolving) Center, in December 2016. People seeking care at the HOPE Center are referred to as "innovators," instead of "clients" or "patients," to reduce mental health stigma among community members. At the time when this study was conducted in 2019, the HOPE Center provided 10 free sessions of evidence-based psychotherapy; for example, cognitive-behavioral therapy (CBT), religiously integrated CBT (21), and interpersonal psychotherapy (IPT) to adult individuals, couples, and families, as well as group psychotherapy. Clinicians included licensed doctoral- and master's-level social workers and supervised social work student interns. All of the licensed clinicians at the HOPE Center self-identified as Black cisgender women. The executive director of the HOPE Center at the time of this study was a practicing clinician and also served as an associate pastor at FCBC.

Notably, people seeking services (i.e., the innovators) at the HOPE Center neither have to identify with a particular faith tradition nor be a member of FCBC to receive care. Although addressing religious or spiritual issues in therapy was not an explicitly advertised service at the time this study was conducted, if an innovator expressed a desire to address a religious or spiritual issue, clinicians integrated this issue into their therapy sessions. The HOPE Center also provides access to a 24/7 crisis text line and referrals for long-term psychotherapy and medication management. By 2019, the HOPE Center served >400 individuals in Harlem through direct clinical services.

Despite the breadth of free services that the HOPE Center has been able to provide, little is known about the perspectives of individuals receiving care in this setting and what facilitated their treatment initiation. Elucidating these perspectives could have important implications for developing similar care models to address the mental health disparities that Black American populations face. Thus, the primary objectives of this qualitative study were to describe the experiences of Black Americans seeking and receiving care from this church-affiliated mental health clinic and to understand their perspectives on the Black Church's role in supporting mental health services.

METHODS

Participants

Study participants were adults (ages 27–69 years; individuals ages ≥18 years were eligible for the study) who were, at the time, receiving or had previously received any services at the HOPE Center. No minimum number of sessions that a participant had to attend was required to be eligible for this study. Participants were recruited through Sunday church announcements with study personnel available in person to answer questions and provide more information to interested individuals. Participants were also recruited through printed fliers and social media channels (e.g., Facebook) of the church and the HOPE Center.

Procedures

Individuals who expressed interest in the study were scheduled for either an in-person or a telephone interview. In-person interviews took place at the HOPE Center. Semi-structured interviews were administered by a Black, cisgender female psychiatrist who was neither employed by the HOPE Center nor involved in the treatment of any of the study participants. Interviews lasted on average 30 minutes. Participants were compensated with a $10 gift card for their time and travel.

At the start of each interview, participants provided informed consent and completed a demographic questionnaire. Interviews were audio recorded with a digital recorder, downloaded to a password-protected computer, and professionally transcribed. All study procedures were approved by the institutional review board of the New York State Psychiatric Institute and the Department of Psychiatry of Columbia University (protocol no. 7434).

Data Analysis

The team established a codebook and conducted thematic analysis of the transcripts (22). To ensure consistency in coding, reliability was calculated. Two coders check-coded four documents (27% of documents) masked to each other. Of 145 codes, primary coders identified 119 accurately, for a hit rate of 82%, within standards for qualitative reliability. A review of field notes and interviews indicated that data saturation was reached after interviewing 15 participants.

RESULTS

The study cohort (N=15) consisted of 13 cisgender women and two cisgender men, with a mean age of 48 and 51 years, respectively. Most participants identified as Black (N=14, 93%) and non-Hispanic or non-Latino (N=13, 87%). More than half of the participants self-identified as heterosexual (N=13, 87%), had never married (N=11, 73%), and had attended at least some college or technical school (N=14,

TABLE 1. Demographic characteristics of 15 people who received care from a church-affiliated mental health clinic

Characteristic	Cisgender men (N=2, 13%)		Cisgender women (N=13, 87%)	
	N	%	N	%
Mean age in years	50.5		47.6	
Race				
Black	2	100	12	92
Other[a]	0	—	1	8
Ethnicity				
Hispanic or Latino	0	—	2	15
Non-Hispanic or non-Latino	2	100	11	85
Marital status				
Married	0	—	0	—
Separated or divorced	0	—	2	15
Widowed	0	—	2	15
Never married	2	100	9	69
Sexuality				
Lesbian or gay	1	50	0	—
Heterosexual	0	—	13	100
Other	1	50	0	—
Education level				
12th grade or below	0	—	0	—
High school graduate	0	—	1	8
Some college or technical school	2	100	5	38
4 years of college	0	—	7	54
Total household income ($)				
0–14,999	2	100	3	23
15,000–29,999	0	—	4	31
30,000–44,999	0	—	2	15
45,000–59,999	0	—	0	—
60,000–74,999	0	—	3	23
≥75,000	0	—	1	8
Current work situation				
Working for pay	0	—	5	38
Full-time homemaker, parent, or caregiver	0	—	0	—
Student	1	50	1	8
Retired	0	—	2	15
Unable to work because of disability	0	—	4	31
Unemployed	1	50	1	8
Frequency of religious service attendance				
Never	0	—	0	—
Less than once a year	0	—	0	—
About once or twice a year	0	—	1	8
About once a month	0	—	3	23
Once a week or more	2	100	9	69
Importance of religion or spirituality				
Highly important	2	100	11	85
Moderately important	0	—	2	15
Slightly important	0	—	0	—
Not important at all	0	—	0	—

[a] The participant chose "other" but did not specify race; available options for race included American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, or other.

93%). Most participants attended religious services at least once a week (N=11, 73%) and found religion or spirituality highly important (N=13, 87%) (Table 1).

Receipt of Services at a Church-Affiliated Mental Health Clinic

Impact of religious affiliation and church promotion on care initiation. Participants stated that receiving therapy within a church-affiliated setting was important for them. They reported that services that could integrate their spiritual beliefs with their current mental health challenges enhanced the therapeutic experience. Several participants said that obtaining mental health treatment was contrary to what they had been previously taught or believed. One participant said, "Growing up in the African American community, our outlet has always been 'Take it to God, pray on it, go to church, not go sit in front of a provider and share what's going on with you.' And I think that's one of the things that hinder people of color [from] going out and getting help, especially Black men."

Another participant said, "I know so many people who are suffering mentally that are in church, and the way they think . . . they just say, 'Pray.' But you can't pray everything away. You have to get some help." Another participant said, "Black folk, we're still out here, still going to church, and we think that praying is one of the only ways to do it, but at some point, a professional has to get involved. There's a lot of work that goes into therapy. I did a lot of work on myself and a lot of reflection on myself, and I could've only got [this by] being pushed on a one-on-one basis by a therapist." Several participants said that prayer and therapy complemented each other.

Participants said that their decision to utilize mental health services offered by the HOPE Center was easier because of the positive messaging from the church and its senior pastor. A participant said, "If it wasn't for the congregation at the church, I wouldn't be in mental health services, period, because I've always believed that I can handle my own issues . . . but listening to the pastor always talking about the [HOPE] Center and not to be ashamed of if you have weaknesses, that's when I said, 'You know what, let me just start seeking mental health services because I really need [them].'" Another participant believed in the benefit of therapy and that opening the HOPE Center was important. The way it is promoted "by the pastors and the church as a whole, it's letting you know that it's okay. 'It's okay if you have an issue that needs to be addressed, that what we're here for.'" Several participants said that the "mindfulness moments"—group sessions in which mindfulness techniques were taught and practiced—were some of their favorite services offered at the HOPE Center.

The HOPE Center environment. Participants described the HOPE Center as a positive, peaceful, welcoming, and serene environment. One participant stated, "I love going there. Everyone is welcoming. They're peaceful. I walk in there one day, and I was messed up. My mind was paranoid. I smelled like cigarettes. I was nervous. I hadn't had any sleep. I walked in and said, 'I heard this is a safe place.' [. . .] No one made me feel like I was in the wrong place. It was really, really cool. I loved when I would come in. I loved the smell of the place. It's always a sweet aroma or freshening aroma going

on. The couches are soft. The colors are bright. So, it's just like, 'Hey, welcome.'" Another participant stated, "You don't have to worry about the outside forces affecting what's going on with you in your life. 'That's what we're here for'—that's the impression I feel when I come here." Several participants said that they had recommended to people they knew to visit the HOPE Center.

Accessibility of services. Participants said that it was important to them that the HOPE Center services and events were free of charge. One participant said, "There are solutions out there that friends and family have told me had worked for them, and I was a little concerned because of the financial cost of these types of services. But, luckily, the HOPE Center was really helpful, and I was able to get access to a therapist without having to pay, because I had actually seen a therapist before going to the HOPE Center. But again, cost had made me stop going." One participant said that establishing these resources more broadly within the community would be "a wonderful thing." Although participants said that it was helpful that the HOPE Center provided referrals to external providers and agencies for additional services, some said they wished that the HOPE Center would provide long-term therapy.

Impact of services provided. Participants said they learned skills at the HOPE Center that they could then apply to practical life situations. Several expressed that, before using services, they felt stagnant and stuck in a cycle of unproductive behaviors, which began to feel "normal." One participant recognized unresolved trauma, found inner strength to process experiences, and learned self-love. A participant reported enjoying meditating at the HOPE Center and began meditating at home. Another participant said that, "If it wasn't for the HOPE Center, if it wasn't for me coming here . . . I'm not gonna say I wouldn't have been able to help [my niece], but I was better equipped to help her."

A common theme among participants was that the HOPE Center provided them with tools to destress, process trauma, and manage anxiety. One participant said that she would advise friends to get help for trauma-related mental health issues: "I would just let them know I went to counseling and I got tools. [. . .] I would not lie to them anymore, because I lied to myself for years, and I don't want them not to have help. I would tell everybody to go get help. [. . .] Minority people have been exposed [to trauma, and especially] Black people have been exposed to so much trauma."

Perspectives on the Role of the Black Church in Addressing Mental Health Needs

Participants said that, by consistently incorporating discussions about mental health into church services in an open and welcoming manner, church leaders can create spaces where members learn about mental health from trusted and knowledgeable sources while destigmatizing care. One participant said, "it's more meaningful and powerful from [. . .] a spiritual leader, especially somebody that you look up to, somebody that you can see yourself in, and somebody that is trusting." Another participant said, "They start reducing the stigma behind it because we have someone like [the executive director of HOPE Center] who is my color, who is LGBT, [. . .] who is educated, who is fashionable. I can look at her and say, 'Oh, okay, yeah. If she can do, I know I should be doing it, too.'"

Many participants said that there was significant potential for churches to help increase mental health education and facilitate mental health treatment on a community-wide scale. One participant said, "We need to start talking about it in the churches, because one of the biggest places that Black people go to [is] church." Participants said that the opportunity to engage in mental health conversations at church helped to open up a dialogue and offered guidance as members navigated the mental health treatment system.

Barriers related to church-affiliated or church-based mental health services. Participants said lack of funding, physical space, therapists, and church staff with mental health training were barriers to building and expanding church-affiliated mental health services. Participants found great value in the HOPE Center's hiring of trained individuals who have a "certain knowledge and wisdom" into leadership positions, so that, in turn, church leaders were better equipped to provide information to church members. Other participants said that individuals who identify with other faiths may feel discouraged from using the HOPE Center because it is affiliated with the Christian faith. One participant said, "I could say who I think could benefit from it and because they're Muslim and because it's the HOPE Center, and because the HOPE Center was funded by FCBC, which is a Christian place, they'd be like, 'Oh, I'm not gonna go there.' I just feel like religion is a little too thick."

Religious conceptualizations of mental illness as a barrier to treatment. A few participants reflected on the influence and impact of Christian conceptualizations of mental illness on stigma and shame experienced by some and suggested that these conceptualizations provided both barriers and opportunities for church-based care. One participant said, "Religion. I think that's the biggest [barrier.] [. . .] The whole, like if something is negative or bad in your mind, that's the devil. So, religion is the biggest barrier [to care] amongst African Americans." Another participant said that adding mental health resources to churches should be intentionally focused on repairing this history of disservice. Most participants said that establishing more mental health resources within faith-based spaces could accelerate normalization of seeking and receiving mental health care within religious Black communities.

DISCUSSION

To our knowledge, this is the first study that has examined the perspectives of Black Americans receiving mental health care

in a church-affiliated mental health clinic. Important treatment facilitators included services being free of charge, the clinic's affiliation with and promotion by the church, and the increased likelihood of their clinician providing culturally competent care on issues related to faith and trauma. They also identified the potential opportunity that churches have to provide psychoeducation, destigmatization, and connection to mental health services for community members.

Our findings present opportunities to address some of the mental health treatment gaps faced by Black Americans who identify faith or religion as being important in their lives. Studies have shown that cost and issues related to insurance coverage are the leading barriers to mental health service utilization by multiple racial-ethnic groups, including Black Americans (6, 23). Thus, the HOPE Center providing care for free is a critically important aspect of their model. Additionally, pastoral staff and clergy destigmatization of seeking mental health was found to be an important facilitator, presenting a potential opportunity for other religious communities and their leaders.

Although we did not collect clinical data, several participants expressed how the care they received helped address their psychological distress, leading to overall improvements in their mental health. This observation has important clinical implications. It has been established that trust in the client-clinician relationship and the therapeutic alliance both are important for effectiveness in therapy (24). This setting and its affiliation with and promotion by leadership in a Black church may facilitate building early trust and alliance between care-seeking individuals and their clinicians. This model of providing mental health services adjacent to or supported by a trusted institution, with providers who may have a more nuanced and intimate knowledge of the experiences of and perceptions held by community members, may facilitate important therapy-mediating factors, such as trust (19). Services being provided for free may also facilitate participants remaining in treatment long enough to develop trust and build stronger therapeutic alliances without financial barriers impeding success.

More research examining the direct clinical outcomes of providing evidence-based therapeutic modalities such as CBT or IPT in this and any future church-affiliated clinical settings is needed. There are also opportunities to develop new therapeutic modalities within these settings that are tailored to the population being served (20). In traditional mental health care settings, Black Americans are more likely than White Americans to terminate care or find care less satisfactory (25). Black Americans are also more likely to receive inadequate depression care or to have guideline-discordant treatment (26). In light of persistent racial-ethnic mental health disparities, novel models of care should be developed that involve other trusted community-affiliated organizations or institutions such as historically Black colleges, mosques, and community centers. Increasing opportunities to receive information about the standard of care from both clinicians as well as trusted sources, such as pastors, may help individuals advocate for themselves in more traditional clinical settings.

The findings of this study could have important policy implications. At the time this study was conducted, the vast majority of the funding used to operate the HOPE Center, including the salaries of its licensed clinicians, was provided by the church through its nonprofit foundation. Increases in city and state funding to support clinics like this could also serve to improve data collection, analysis, and quality improvement activities while helping to increase service capacity.

This study had several limitations. Overall, the sample size was small (N=15), and individuals with positive experiences may have been more inclined to participate in this study, leading to selection bias. There was an overrepresentation of cisgender women, consistent with the disparities we have seen in both treatment initiation and research studies generally (3, 27). Additionally, although 33% of the clinic's clients identify as LGBTQ, there was an underrepresentation of sexual minorities and no representation of gender minorities in this sample. It is particularly important to capture the perspectives of individuals who experience intersectional marginalization, particularly given their increased vulnerability to experiencing religious trauma or negative experiences in church environments.

Although we collected and reported participants' frequency of religious attendance and the importance of religion or spirituality to them, we did not collect data on whether they were members of FCBC or on the frequency of their attendance there. Without knowledge of membership and attendance, it is difficult to determine how much membership or involvement in FCBC may have facilitated treatment initiation. Because we did not collect data on the number of sessions completed by individuals, we could not determine how well this particular care model was able to retain individuals in treatment, which is a key element in overall treatment engagement. Additionally, we did not evaluate clinical data or use validated scales or screening measures. We relied on the subjective experiences of individual participants, which is more vulnerable to social desirability bias.

CONCLUSIONS

As Black Americans continue to face disparities both in access to and engagement in mental health care, new models of care that address long-standing barriers to treatment and support are needed. In this qualitative study examining the perspectives of Black Americans receiving care at a church-affiliated mental health clinic in Harlem, several facilitators in seeking and receiving treatment were identified, including services being free of charge, being affiliated with a trusted institution, and therapy being culturally aligned with the individuals served. The perspectives shared by participants suggest that this model of care may address several important barriers to care faced by some Black American populations.

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